Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Roberts, a prisoner at HMP Preston, on 14 November 2023

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Paul Roberts died in hospital from hypoxic brain injury (lack of oxygen to the brain) on 14 November 2023, two days after he was found hanging in his cell at HMP Preston. Mr Roberts was 37 years old. I offer my condolences to his family and friends.

Mr Roberts was the second self-inflicted death at Preston in three years.

Mr Roberts was identified as at risk of suicide and was being monitored using suicide and self-harm prevention procedures (known as ACCT) when he was found hanging in his cell. We found that the ACCT was managed reasonably well overall, but there were aspects that require improvement. I have recommended that the Governor should review the ACCT quality assurance process to ensure that systemic issues are identified and addressed.

The clinical reviewer found that the care Mr Roberts received for his mental health was of a good standard and at least equivalent to that which he could have expected to receive in the community.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **July 2024**

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Summary

Events

1. On 28 October 2023, Mr Paul Roberts was remanded in prison charged with carrying out a bomb hoax. He was sent to HMP Preston.

2. Mr Roberts had been on 15-minute checks in police custody as he said he wanted to kill himself. When he arrived at Preston, the reception nurse started suicide and self-harm monitoring (known as ACCT). The ACCT assessor set observations at two an hour.

3. At an ACCT review on 6 November, Mr Roberts said that he had been struggling with being in prison and that he had considered suicide. The case review team increased observations to three an hour.

4. At an ACCT review on 10 November, Mr Roberts said that things had improved since his last review. The ACCT case manager recorded that Mr Roberts appeared to be more positive and future focused. The case review team agreed that Mr Roberts should continue to be supported by the ACCT process, but they reduced observations to one an hour.

5. At around 11.10am on 12 November, an officer was returning Mr Roberts' cellmate to his cell after exercise. When she could not open the door, she looked through the observation panel and saw that a cupboard was obstructing the door. The officer did not have a radio so shouted for staff assistance, and then shouted code blue (a medical emergency code).

6. An officer responded and the two officers, together with two prisoners, kicked the door open. They saw Mr Roberts hanging.

7. A supervising officer arrived, cut the ligature and lowered Mr Roberts to the floor. Around a minute later, a custodial manager arrived and started CPR.

8. Staff in the control room called for an ambulance and at 11.29am, paramedics arrived and took over the management of Mr Roberts' resuscitation. The paramedics managed to regain a pulse and took Mr Roberts to hospital where he was put on a life support machine. On 14 November, a decision was made to end life support. Mr Roberts died shortly after.

9. The post-mortem report concluded that Mr Roberts died from hypoxic brain injury (lack of oxygen to the brain) caused by hanging.

Findings

10. We found that some aspects of the ACCT were managed well and others less so. It was good practice that case reviews were chaired by the same ACCT case manager and that there was consistent attendance by the same member of the mental health team. However, the Immediate Action Plan was not completed because there was no supervising officer on duty on the day Mr Roberts arrived, the ACCT document lacked records of meaningful conversations and several ACCT observations were missed.

11. The officer that found Mr Roberts hanging shouted a code blue, but because she did not have a radio, she could not call a code blue over the radio network. This caused a short delay in the control room calling an ambulance.

12. The clinical reviewer concluded that the care Mr Roberts received for his mental health was of a very good standard and was equivalent to that which he could have expected to receive in the community.

Recommendation

- The Governor should undertake a review of the ACCT quality assurance process to satisfy himself that systemic issues are identified, and suitable remedial actions taken in response.

The Investigation Process

13. HMPPS notified us of Mr Roberts' death on 14 November 2023.

14. The investigator issued notices to staff and prisoners at HMP Preston informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

15. The investigator visited Preston on 23 November. She obtained copies of relevant extracts from Mr Roberts' prison and medical records.

16. NHS England commissioned a clinical reviewer to review Mr Roberts' clinical care at the prison. The investigator and clinical reviewer conducted interviews with six members of staff by videoconference.

17. We informed HM Coroner for Lancashire and Blackburn of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's office contacted Mr Roberts' father to ask if he had any matters he wanted us to consider. Mr Roberts' father asked why the prison reduced the frequency of their observations on his son and whether it was appropriate. We have addressed these issues in the report.

19. We shared our initial report with HMPPS. They found no factual inaccuracies.

20. We sent a copy of our initial report to Mr Roberts' next of kin. They did not notify us of any factual inaccuracies.

Background Information

HMP Preston

21. HMP Preston is a Category B local prison. Spectrum Community Health C.I.C provides primary healthcare services 24 hours a day, seven days a week, as well as substance misuse services. Tees Esk & Wyre Valleys NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

22. The most recent inspection of Preston was in March 2023. Inspectors were positive about the quality of ACCT documents (case management for prisoners at risk of suicide or self-harm) and said that the quality assurance by leaders meant that the standard was consistently good, although there was scope for improvements in the quality of some support plans.

23. The inspectors reported that the Head of Healthcare was doing an outstanding job and standards had improved markedly since the last inspection. Inspectors said that healthcare had a strong and proactive staff team working to improve outcomes for a population that had many difficulties with mental health and substance misuse.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2023, the IMB reported that the number of self-harm incidents had been the lowest in the last four years. A total of 580 ACCT documents were opened with up to 35 being open at any one time.

25. The in-house mental health team (IMHT) was fully staffed, with a range of professionals including a psychiatrist, nurses, counsellors, senior counsellors, psychological wellbeing practitioners, a higher assisted psychologist and clinical psychology. They provided a service seven days a week. During the year, they had received 2184 referrals for mental health support and attended 1,967 ACCT reviews.

Previous deaths at HMP Preston

26. Mr Roberts was the tenth prisoner to die at Preston since November 2020. Of the previous deaths, one was self-inflicted and eight were from natural causes. There are no similarities between the findings from our investigation into Mr Roberts' death and the findings from our investigations into the previous deaths.

Assessment, Care in Custody and Teamwork (ACCT)

27. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

28. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a care plan (plan of care, support and intervention) is put in place. The ACCT should not be closed until all the actions on the care plan have been completed.

29. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

30. On 28 October 2023, Mr Paul Roberts was remanded in prison charged with carrying out a bomb hoax. He was sent to HMP Preston. It was Mr Roberts' first time in prison.

31. A nurse completed Mr Roberts' initial healthcare screen. He told her that he drank alcohol daily, that he had been diagnosed with anxiety and depression and had recently tried to take his own life. He said he was prescribed sertraline (an antidepressant) (though a subsequent check of his community GP records showed no current prescriptions).

32. The nurse noted that Mr Roberts had an extensive mental health history over the past three years, including suicide attempts. He had been on 15-minute checks in police custody because he had said he would take his own life. She recorded that despite Mr Roberts engaging well and saying he had no current thoughts of suicide or self-harm, she assessed that he should be monitored using suicide and self-harm prevention procedures (known as ACCT) given his history. She also made a referral to the substance misuse team and the mental health team.

33. A GP at Preston reviewed Mr Roberts' medical record and prescribed him with symptomatic relief for alcohol withdrawal.

34. Around an hour later, an officer completed Mr Roberts' ACCT assessment. She noted that Mr Roberts said he was feeling anxious and overwhelmed. She set observations at two an hour.

35. An Immediate Action Plan should have been completed by the reception supervising officer within an hour of ACCT monitoring starting. When we asked the Head of Safety why one was not done for Mr Roberts, she said that there was no supervising officer on duty in the first night centre on the Saturday that Mr Roberts arrived, so the Immediate Action Plan was not completed.

36. On 29 October, a mental health nurse saw Mr Roberts. Mr Roberts told him that he had been arrested after walking into a petrol station and telling them that he had a bomb, and he had hoped that a police firearms unit would shoot him. He said that his mood had been low due to a relationship breakdown, being homeless and excessive drinking. He said he wanted help with his drinking and low mood, and to understand why he did stupid things. The nurse noted that Mr Roberts was being supported using ACCT and that he would review any further support required once Mr Roberts had completed his alcohol detoxification.

37. The same day, a Supervising Officer (SO) held an ACCT review. A nurse attended. The SO recorded that Mr Roberts said that he was low in mood but denied any thoughts of suicide or self-harm. She completed a care plan documenting actions to support Mr Roberts, which included a referral to the GP for a review of medication to help with low mood, a referral to the substance misuse team for support with alcohol misuse and a referral to Healthy Heroes (a charity in the prison that supports veterans – Mr Roberts was an armed forces veteran). The case review team kept observations at two an hour with three conversations a day and scheduled the next review for 6 November.

38. Over the next week, Mr Roberts completed his induction and moved from the induction wing to a shared cell on A Wing, a standard wing.

39. On 31 October, a recovery coordinator saw Mr Roberts and referred him for bereavement counselling. The referral was triaged on 3 November and the plan for assessment and support was confirmed.

40. On 6 November, a SO held an ACCT review. A nurse attended. Mr Roberts said that he had been struggling being in prison and was feeling low in mood. He said that he had considered suicide but had not made any plans. The case review team considered that Mr Roberts' risk of self-harm had increased and set observations at three an hour with three conversations a day. They scheduled the next review for 10 November.

41. On 10 November, a SO held an ACCT review. A nurse attended. Mr Roberts said that things had improved a bit since his last review. He said that he was hoping to gain employment in prison. The SO told Mr Roberts that he had a GP appointment booked for a medication review and was on the counselling waiting list. Mr Roberts said that he felt reassured by this. She recorded that Mr Roberts appeared to be more positive and future focused. The case review team decided that Mr Roberts still needed to be supported by the ACCT process but reduced observations to one an hour and three conversations a day. They scheduled the next review for 17 November.

Events of 12 November

42. At around 10.10am on 12 November, Officer A was unlocking for exercise. She opened Mr Roberts' cell door and asked him and his cellmate if they wanted to go on the yard for exercise. Mr Roberts said he did not want to go, but his cellmate said he did and left the cell. She closed and locked the cell door.

43. Just after 11.10am, prisoners came back to the wing after exercise. Officer A began locking prisoners back into their cells. When she got to Mr Roberts' cell, the door would not open. She looked through the observation panel and could see that a cupboard was obstructing the door. She turned on the night light and saw that Mr Roberts was hanging from the ceiling using a torn bedsheet as a ligature. She did not have a radio, so shouted for staff assistance. She then shouted code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately). (The officer told us that she did not normally work on that wing and had not expected to be there for long that morning. As a result, she did not collect a radio, although she said that spares were available to staff detailed to work on wings.)

44. Officer B was working on the landing above and responded to Officer A's shout for help. However, he did not hear her call code blue. He pressed the general alarm to alert staff that there was an incident. Both officers and two prisoners kicked the door to try to gain access to Mr Roberts' cell. After around a minute the door opened.

45. A Supervising Officer (SO) also responded and cut the ligature and lowered Mr Roberts to the floor. Around a minute later, a Custodial Manager (CM) arrived and immediately started CPR.

46. At 11.17am, an operational support grade (OSG) working in the control room called an ambulance. (No code blue was recorded so it appears that a member of staff asked the control room to call an ambulance.) Body worn camera footage shows that paramedics arrived at 11.29am and took over the management of Mr Roberts' care.

47. The paramedics managed to regain a pulse and took Mr Roberts to hospital where he remained in a coma in the critical care unit. Doctors said that no brain activity could be found, and on 14 November a decision was made to end life support. Mr Roberts died shortly after.

Contact with Mr Roberts' family

48. Mr Roberts did not give any next of kin contact details when he arrived in prison. After Mr Roberts was taken to hospital, staff there found a number for Mr Roberts' mother in his medical records and gave this to the prison.

49. At around 2.05pm, a prison chaplain and family liaison officer (FLO) contacted Mr Roberts' mother to tell her that Mr Roberts was very unwell in hospital. Mr Roberts' mother said she would come straight to the hospital. The FLO agreed to meet her at 3.00pm.

50. Throughout the time that Mr Roberts was in hospital, the prison chaplain maintained contact with Mr Roberts' family and went to the hospital on several occasions.

51. The Prison Service contributed to the funeral expenses in line with national instructions.

Support for prisoners and staff

52. After Mr Roberts' death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

53. When the investigator visited Preston, prisoners told her that staff had been very supportive and that they had been offered counselling.

54. The prison posted notices informing other prisoners of Mr Roberts' death and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Roberts' death.

Post-mortem report

55. The post-mortem report concluded that Mr Roberts died from hypoxic brain injury caused by hanging.

Findings

Assessment and management of risk

56. Prison service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the processes (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm. The PSI provides a list of risk factors and triggers that may increase the risk of suicide and self-harm. Mr Roberts had several risk factors including a recent suicide attempt a history of depression and anxiety and it was his first time in prison.

57. During Mr Roberts' initial health screen, a nurse quickly identified Mr Roberts' risk factors and correctly started ACCT procedures.

58. We consider that it was good practice that a single case manager chaired all Mr Roberts' ACCT reviews and that there was consistent attendance by a member of the mental health team at each review. We found that the case review team increased and decreased the level of observations appropriately in line with Mr Roberts' assessed suicide risk. Mr Roberts was subject to one ACCT check an hour when he died. The decision to reduce the frequency of checks was made following a multidisciplinary review at which staff considered Mr Roberts' risk of suicide had decreased.

59. However, we did find some issues with the management of the ACCT process. The Immediate Action Plan was not completed because there was no supervising officer on duty in the first night centre on the day Mr Roberts arrived. This issue was highlighted in the HMPPS early learning review that was carried out immediately after Mr Roberts' death and it recommended that appropriate procedures were put in place to ensure that Immediate Action Plans were completed in the absence of a supervising officer. The Head of Safety told the investigator that it was very unusual for there not to be an SO working in the first night centre and that this was not a systemic issue. While we accept this, we bring it to the Governor's attention.

60. However, we also identified more serious concerns. We found that multiple ACCT observations were missed. On 3 November, when Mr Roberts should have been checked twice an hour, he was not checked for almost two hours, between 12.30pm and 2.25pm; on 8 November, when Mr Roberts should have been checked three times an hour, he was not checked for 95 minutes, between 4.45pm and 6.20pm; and on 12 November, when Mr Roberts should have been checked once an hour, he was not checked for 80 minutes, between 7.50am and 9.10am.

61. We found that the ongoing record lacked detail and there was no record of any meaningful conversations. In addition, there were missing supervisor checks which suggests a lack of commitment to quality assuring the ACCT process.

62. The Head of Safety told the investigator that there were regular ACCT quality checks using a standard template, and issues identified were discussed with the relevant member of staff. She said that if themes were identified across multiple quality assurance checks, they would be discussed at the monthly safety meetings. She said that the quality assurance process had identified some issues with ACCT

checks that had been addressed with individual staff. The prison shared copies of the quality checks with the investigator, and while it showed that issues had been identified, it did not specify the action that had been taken. We consider that the quality assurance form should be updated so it is clear what action has been taken to address any identified quality issues.

63. We consider that there is evidence of a systemic issue in relation to staff properly undertaking ACCT checks. We are not satisfied that sufficient action has been taken or that the quality assurance process is working as well as it should. We make the following recommendation:

The Governor should undertake a review of the ACCT quality assurance process to satisfy himself that systemic issues are identified, and suitable remedial actions taken in response.

Emergency response

Calling a code blue

64. PSI 03/2013 requires governors to have a medical emergency response code protocol in place so that the nature of the medical emergency is communicated efficiently. This ensures that staff respond quickly with the relevant equipment and there are no delays in calling an ambulance. Code blue is used when a prisoner is unconscious or having breathing difficulties, and code red when a prisoner has severe bleeding. The control room should call for an ambulance immediately when a code is called.

65. Officer A was not carrying a radio when she saw that Mr Roberts was hanging, so she shouted to staff for help, and then shouted code blue. Another member of staff did not hear her shout code blue but heard a commotion and pressed the general alarm bell instead. This meant that the control room did not know that there was a medical emergency and did not call an ambulance immediately. She explained that as she had not expected to be on the wing for long that morning, she had not considered collecting a spare radio. We are satisfied that this was not a systemic issue and the delay in calling an ambulance was minimal and, therefore, make no recommendation.

Clinical care

66. The clinical reviewer found that the care Mr Roberts received for his mental health was of a very good standard and at least equivalent to that which he could have expected to receive in the community. She noted that a medication review was due to take place on 13 December, the day after Mr Roberts died, with a view to him restarting antidepressants. This was seven days after the ACCT review on 6 December. The clinical reviewer noted that while this may reflect the equivalent wait in the community, she considered that there was an opportunity to expedite it for someone at risk in prison. However, she also noted that it can take several weeks before someone feels the benefit of antidepressant medication.

67. The clinical reviewer concluded that the physical care and substance misuse care that Mr Roberts' received was of a good standard and equivalent to that which he would have received in the community, except for some missed clinical

observations and visual checks related to alcohol withdrawal. The clinical reviewer has made two recommendations which the Head of Healthcare will wish to address.

Inquest

68. The inquest, held on 3 October 2024, concluded that Mr Roberts died by suicide.

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