Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Roberts, a prisoner at HMP Isle of Wight, on 29 March 2025

A report by the Prisons and Probation Ombudsman

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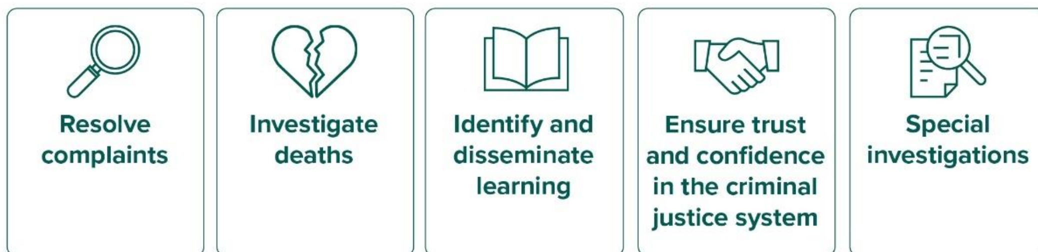
OUR VISION

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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Summary

1. 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.

2. 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.

3. Mr Christopher Roberts died of pneumonia, caused by carcinomatosis (cancer that has spread), which was in turn caused by cancer of the colon, on 29 March 2025, while a prisoner at HMP Isle of Wight. He was 57 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Roberts received at Isle of Wight was equivalent to that which he could have expected to receive in the community. She found evidence of good care, including appropriate care plans, continuous monitoring and an appropriate and timely emergency response from the healthcare team. The clinical reviewer made one recommendation that is not related to Mr Roberts cause of death, but which the Head of Healthcare at Isle of Wight will wish to address.

5. We found that decisions around the use of restraints were inconsistent. Although Mr Roberts had mobility issues, was frail and receiving palliative care, restraints were used on 28 and 31 January 2025. Isle of Wight has addressed some of our concerns by issuing a notice to staff, however there are no measures in place to ensure that staff read and understood the notice.

Recommendations

The Governor and Head of Healthcare should ensure that:

- **a process is put in place to satisfy themselves that prison staff have read and understood Notice to Staff 083 – 2025; and**
- **healthcare staff complete the medical information section of the escort risk assessment accurately to say whether the prisoner's current medical condition affects their mobility and risk of escape**

The Investigation Process

6. HMPPS notified us of Mr Roberts' death on 31 March 2025.

7. NHS England commissioned an independent clinical reviewer, to review Mr Roberts' clinical care at HMP Isle of Wight.

8. The PPO investigator investigated the non-clinical issues relating to Mr Roberts' care.

9. The Ombudsman's office wrote to Mr Robert's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She said that when she saw Mr Roberts he had lost weight and was in bad condition. She asked why nothing was done sooner when Mr Roberts started to lose weight and why his condition was allowed to become so bad. Her concerns have been addressed in the clinical review.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

11. Mr Robert's family received a copy of the draft report. They did not make any comments.

Previous deaths at HMP Isle of Wight

12. Mr Roberts was the twenty sixth prisoner to die at Isle of Wight since 23 March 2022. Of the previous deaths, 23 were from natural causes and two were self-inflicted. There are no similarities between the findings in our investigation into Mr Roberts' death and the findings from our investigations into the previous deaths. Up until the end of October 2025, four more people have died, two of which were from natural causes, one was self-inflicted and one is awaiting classification.

Key Events

13. On 1 December 2022, Mr Roberts was remanded to HMP Lewes.

14. On 13 January 2023, Mr Roberts was convicted of sex offences and sentenced to 13 years in prison.

15. On 22 February 2023, Mr Roberts was transferred from Lewes to HMP Isle of Wight.

16. On 5 March 2024, a nurse saw Mr Roberts due to him reporting black stools, abdominal discomfort and weight loss. He had a faecal immunochemical test (FIT - a sensitive screening tool used primarily for detecting colon cancer) and the results came back as normal. The nurse arranged for Mr Roberts to be weighed monthly.

17. On 27 June, Mr Roberts had a further FIT test, and the results returned as normal.

18. On 2 December, Mr Roberts had a blood test. Some results came back as abnormal. Healthcare staff arranged for him to speak to the GP.

19. On 6 December, a GP operating at Isle of Wight, saw Mr Roberts and reviewed his blood test results. She noted that Mr Roberts had lost weight and arranged for him to be reviewed the following week.

20. On 12 December, the GP saw Mr Roberts again. He reported intermittent black stools, abdominal discomfort and a family history of bowel cancer. A FIT test was conducted which came back as normal. He referred Mr Roberts to a lower gastrointestinal consultant under the two week wait referral for suspected cancer.

21. On 29 December, Mr Roberts attended the healthcare department to collect his bowel preparation for an upcoming gastroscopy and colonoscopy scheduled to take place the following day. He told a nurse that he did not want to attend his procedure and asked for it to be postponed. The nurse told him that it was in his best interests to attend, but he still declined. Healthcare staff recorded that Mr Roberts was deemed as having capacity and he signed a disclaimer. On 30 December, Mr Roberts again declined to attend his hospital appointment and was again assessed as having the capacity to make that decision.

22. On 6 January 2025, an officer saw Mr Roberts for a wellbeing check. She noted a decline in his health over the past two weeks and told him he must attend his next hospital appointment.

23. On 7 January, a GP saw Mr Roberts. She noted that he was very pale and struggling to mobilise due to light-headedness. He reported that he had been vomiting for the past week. Mr Roberts was admitted to hospital. The escort risk assessment shows that there were no medical objections to the use of restraints and a single cuff was recommended (a handcuff on one wrist, attached to a prison officer by the other handcuff). However, the Head of Segregation and Safety, decided restraints should not be used due to the nature of Mr Roberts' medical condition and mobility. Mr Roberts had a CT scan, and the results showed a malignant tumour of the colon. (A computerised tomography, or CT, scan is a

medical imaging procedure that uses a series of X-rays and a computer to create detailed, cross-sectional images of the inside of the body.)

24. On 8 January, an officer spoke to Mr Roberts' mother and offered her support. The hospital put a do not attempt cardiopulmonary resuscitation (DNACPR) order in place and it was agreed that Mr Roberts would receive symptom control care only. Mr Roberts told hospital staff that he did not want surgery for the obstruction in his bowel and his preferred place of death was in prison.

25. On 9 January, an officer arranged for the early release on compassionate grounds (ERCG - the Secretary of State may release a serving prisoner at any point in the sentence if they are satisfied that exceptional circumstances exist which justify the prisoner's release on compassionate grounds, including a terminal diagnosis) application process to begin. Mr Roberts told hospital staff that he had changed his mind and now did want the surgery.

26. On 10 January, Mr Roberts had an ileostomy (surgical procedure that creates an opening in the abdominal wall).

27. On 15 January, a nurse working in the prison, visited Mr Roberts in hospital. She noted that he had undergone a liver biopsy and was doing well.

28. On 16 January, Mr Roberts returned from hospital to the inpatient unit at Isle of Wight.

29. On 28 January, Mr Roberts attended a hospital appointment. An agency nurse completed the medical section of the escort risk assessment and decided that there were no medical objections to the use of restraints but noted that Mr Roberts had poor mobility and might need assistance walking. The Head of Segregation and Safety signed the escort risk assessment and authorised the use of a single cuff.

30. On 31 January, Mr Roberts attended hospital for a review following his liver biopsy. The consultant told him that the biopsy confirmed liver metastases (secondary tumours formed when cancer spreads). The escort risk assessment that had been used on 28 January was re-used with an updated date and note saying Mr Roberts should be restrained with an escort chain (a handcuff on one wrist, attached to a length of chain with a cuff at the other end, worn by a prison officer).

31. On 7 February, a GP reviewed Mr Roberts' DNACPR status with him. Mr Roberts stated that he did want active treatment and, if necessary, for staff to try to resuscitate him.

32. On 13 February, Mr Roberts attended a hospital appointment. The escort risk assessment stated that there were medical objections to the use of restraints due to Mr Roberts' frailty and because he was having palliative care. The Head of Segregation and Safety authorised that no restraints should be used.

33. On 18 February, a Family Liaison Officer saw Mr Roberts. She recorded that he had been due to go to hospital the previous day to receive the results of his liver scan, but he declined to attend. Medical records show that Mr Roberts signed a disclaimer on 17 February declining to attend his hospital appointment.

34. On 21 February, a nurse saw Mr Roberts and had a discussion with him about future care planning. He told her he would attend his next oncology appointment for liver scan results.

35. On 24 February, Mr Roberts attended his oncology appointment, and it was agreed that he would have one round of chemotherapy. The escort risk assessment stated that there were medical objections and restraints were not to be used.

36. On 2 March, Mr Roberts was sent to hospital after a decline in his health. The escort risk assessment stated that Mr Roberts required a wheelchair but there were no medical objections to the use of restraints. The prisoner escort record (PER) shows that restraints were not used. CT scan results showed an increasingly invasive tumour and signs of a perforated colon.

37. On 3 March, Mr Roberts returned to Isle of Wight. His records included a DNACPR form that stated he was for supportive care only and not for readmission for hospital treatment.

38. On 4 March, the palliative care team saw Mr Roberts and explained that chemotherapy was no longer an option. Mr Roberts commenced palliative care.

39. On 18 March, Mr Roberts started to receive morphine via a syringe driver.

40. On 19 March, Mr Roberts was due to attend a hospital appointment. He declined, stating that he did not feel well enough for the journey.

41. On 25 March, the palliative care team saw Mr Roberts. It was noted that his health was worsening, and he was in the last days of his life.

42. On 29 March, Mr Roberts was found not breathing and unresponsive in his cell. CPR was not started due to the DNACPR in place. Healthcare staff pronounced life extinct at 4.59pm. Paramedics arrived and completed second verification of life extinct at 5.03pm.

Post-mortem report

43. The post-mortem report concluded that Mr Roberts died of pneumonia, caused by carcinomatosis, in turn caused by cancer of the colon. It found that chronic kidney disease contributed to, but did not cause, his death.

Inquest

44. At an inquest held on 1 May 2026, the Coroner concluded that Mr Roberts died of natural causes.

Findings

Clinical findings

45. The clinical reviewer concluded that the care Mr Roberts received at Isle of Wight was of a good standard and was equivalent to that which would have been received in the wider community. She found that there was evidence of good care including appropriate care plans, continuous assessment and appropriate and timely emergency response from the healthcare team.

46. She found that there was a possibility that there had been a delay to Mr Roberts' cancer diagnosis due to at least two FIT stool sample tests returning a possible false negative. However, the clinical reviewer concluded that healthcare staff investigated Mr Roberts' presenting symptoms systematically, seeking and following specialist advice where appropriate. Apart from one occasion in March 2024, Mr Roberts did not report any bowel cancer related symptoms until December 2024, when all the correct action was taken.

47. The clinical reviewer made one recommendation that is not related to Mr Roberts' cause of death, but which the Head of Healthcare will wish to address.

Use of restraints

48. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. The Graham judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

49. Decisions around the use of restraints for Mr Roberts' hospital appointments from January to March 2025 were inconsistent. The Head of Segregation and Safety decided that restraints should not be used for Mr Roberts' hospital admission on 7 January due to the nature of his medical condition and mobility. However, for Mr Roberts' next appointment on 28 January, he decided that restraints should be used, even though Mr Roberts' condition had not changed and his risk had not increased.

50. The Head of Segregation and Safety told us that his decisions are based on the healthcare assessment. However, the assessment completed on 7 January stated that there were no medical objections to the use of restraints, and that Mr Roberts' current state of health/mobility did not affect his ability to escape, and he still decided restraints should not be used.

51. The healthcare assessment on 28 January stated the same as the previous one but it also noted that Mr Roberts' mobility was poor, and that he may need assistance

walking. Similarly, the healthcare assessment completed on 2 March stated that Mr Roberts required a wheelchair. There were no medical objections to the use of restraints on either assessment. It is concerning that the nurses had no objections despite identifying Mr Roberts' mobility issues.

52. The escort risk assessment from 28 January was used for Mr Roberts' next hospital appointment on 31 January, with just an updated date and comment about which restraints were authorised. New assessments should be completed for each appointment to ensure that the information is current and accurate.

53. The Head of Segregation and Safety told us that he had no security concerns about Mr Roberts, and it is noted he was well-behaved. Therefore, we conclude that in line with the Graham judgment, restraints should not have been used on 28 or 31 January.

54. Due to the concerns raised during our investigation, the Head of Operations, reissued guidelines to all staff on 13 June 2025 via a notice to staff. This covered issues about the inappropriate use of restraints on terminally ill prisoners, the emphasis officers place on the healthcare assessment and the importance of individualised risk assessments.

55. We appreciate that this addressed some of our concerns. However the Head of Operations told us that the notice is available on SharePoint, which all staff have access to, but there was currently no process in place to ensure that staff have read and understood it. Experience tells us that notices to staff are not generally effective in driving behavioural or cultural change among staff and that more proactive measures are often required. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **a process is put in place to satisfy themselves that prison staff have read and understood Notice to Staff 083 – 2025; and**
- **healthcare staff complete the medical section of the escort risk assessment accurately to say whether the prisoner's current medical condition affects their mobility and risk of escape**

Governor to note

56. Mr Roberts' early release on compassionate grounds was started on 9 January 2025, but it was not progressed before his death. The application should have been submitted for consideration of Mr Roberts being released to his mother's home or a hospice. However, as Mr Roberts told hospital staff on 8 January that his preferred place of death was prison and an officer told us that measures have since been put in place to track early release applications, we do not make a recommendation.

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