Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jamie Roberts a prisoner at HMP/YOI Glen Parva on 12 August 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Jamie Roberts was found hanged in his cell at HMP/YOI Glen Parva on 12 August. He was 24 years old. I offer my condolences to Mr Roberts's family and friends.

Mr Roberts had severe anxiety and depression and a long history of intermittent suicidal thoughts. He received a significant amount of very good care at Glen Parva from the mental health service and the therapeutic drug and alcohol service (TDAS). Sadly, despite the efforts of staff, he left a note indicating that he could no longer carry on.

Despite this good care, the investigation – with the benefit of hindsight - has identified some deficiencies in the way staff operated ACCT procedures from which the prison can learn. In particular, the actions on Mr Roberts's ACCT caremap were not sufficiently relevant to his key issues and ACCT monitoring was stopped before his issues were fully resolved. While it might not have changed the outcome for Mr Roberts, we also consider that ACCT monitoring should have restarted on two occasions, including on the day Mr Roberts was found hanged.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2017**

Contents

Summary

Events

1. On 30 June 2014, Mr Roberts was sentenced to four years for theft. On 20 June 2015, he received a further 15 months for wounding with intent. He had a significant history of anxiety, depression, self-harm, suicidal behaviours and substance misuse.

2. On 30 June 2016, Mr Roberts was transferred to HMP/YOI Glen Parva to prepare for his release on 26 September 2016. He told the nurse at an initial health assessment that he had taken 16 paracetamol tablets two weeks previously but had not told anyone. The nurse noted his history of anxiety, depression and substance misuse.

3. On 1 July, Mr Roberts had a full mental health assessment and began working with the primary mental health team. Mr Roberts was concerned about his accommodation and finances on release. He said he had no current thoughts of suicide or self-harm but he had fleeting thoughts of both. He completed depression and anxiety questionnaires, which showed he had severe depression anxiety.

4. On 4 July, Mr Roberts began work with the therapeutic drug and alcohol service (TDAS). On 11 July, his mental health nurse began ACCT suicide and self-harm monitoring after Mr Roberts said he was struggling with intermittent suicidal thoughts. Mr Roberts said he was struggling at work because of the size of the group he was in and was anxious about his release plans.

5. On 19 July, ACCT monitoring stopped when Mr Roberts started a different job in a smaller workshop and his mental health nurse had spoken to resettlement services on his behalf.

6. On 26 July, Mr Roberts started weekly visits to feed the prison's chickens with his TDAS worker. His mental health nurse referred him to the secondary mental health team in the first week of August because his anxiety appeared to be worsening. On 5 August, Mr Roberts told his TDAS worker that he had persistent but intermittent thoughts of suicide. She did not consider Mr Roberts to be actively suicidal and did not begin ACCT monitoring.

7. On 8 August, Mr Roberts took part in a telephone conference with his offender manager, offender supervisor and resettlement services that appeared to resolve his concerns about his release plans.

8. At 10.30am on 12 August, a nurse from the secondary mental health team assessed Mr Roberts. He told her about his intermittent suicidal thoughts. The nurse spent some time with Mr Roberts and put a detailed care plan in place. She did not consider Mr Roberts to be actively suicidal and did not begin ACCT monitoring.

9. At 2.45pm the same day, Mr Roberts was found hanged in his cell. The emergency response was prompt and efficient but Mr Roberts was pronounced dead at 3.00pm.

Findings

10. We found that Mr Roberts received a significant amount of very good care from the mental health teams and TDAS at Glen Parva.

11. We identified some areas of learning in the ACCT process applied to Mr Roberts. In particular, the actions on Mr Roberts's ACCT caremap were not sufficiently relevant to his key issues and ACCT monitoring was stopped on 19 July before his issues about his release were fully resolved.

12. With the benefit of hindsight, we found that ACCT monitoring should have restarted on 5 and 12 August when Mr Roberts told two different members of staff that he had suicidal thoughts. We do not criticise the individual members of staff concerned who both demonstrated a high level of care for Mr Roberts and made considered decisions.

Recommendations

- **The Governor should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national guidelines, including:**
    - **Holding multi-disciplinary case reviews attended by all relevant people involved in a prisoner's care. Where this is not possible, advice should be sought and documented as part of the review.**
    - **ACCT caremaps should have specific, meaningful actions aimed at reducing prisoners' risks to themselves, progress should be considered at each review and the caremaps updated if additional needs are identified.**
    - **Ensuring that all caremap actions have been completed before ACCT monitoring is stopped.**
    - **Ensuring post-closure reviews take place.**

- **The Governor and Head of Healthcare should ensure that all staff are aware of their responsibilities to keep prisoners safe and begin ACCT procedures when it is apparent that a prisoner is finding it difficult to cope and expresses any thoughts of suicide and self-harm.**

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP/YOI Glen Parva, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

14. The investigator visited Glen Parva on 30 August 2016. She obtained copies of relevant extracts from Mr Roberts's prison and medical records, watched CCTV of the emergency response and listened to the emergency radio message of 12 August.

15. NHS England commissioned a clinical reviewer to review Mr Roberts's clinical care at the prison.

16. The investigator interviewed six members of staff, one jointly with the clinical reviewer. She asked to speak to a prisoner but he declined to be interviewed. Leicestershire police shared statements taken from staff.

17. We informed HM Coroner for Leicester of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Roberts's sister, to explain the investigation. Mr Roberts's sister asked for details of how and when Mr Roberts was found and the emergency response. We have answered these questions in the report.

Background Information

HMP/YOI Glen Parva

19. HMP/YOI Glen Parva holds over 500 young offenders aged 18-21 and a smaller number of Category C sentenced adult male prisoners. Glen Parva is scheduled to close by the end of 2017 before being rebuilt as an adult male Category C prison.

HM Inspectorate of Prisons

20. The most recent inspection of Glen Parva was in November 2015, before they took adult prisoners. Inspectors found improvements since the previous inspection in 2014. Case management supporting prisoners at risk was reasonable. Psychosocial services were of a high quality and delivered a range of interventions that addressed harm reduction. The therapeutic drug and alcohol team (TDAS) was well advertised and significantly more prisoners than at the last inspection said they had received help for a drugs problem. Prisoners with dual diagnosis attended special projects, tending chickens and making art.

Independent Monitoring Board

21. 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 2016, the IMB reported that Glen Parva had faced a number of challenges. The TDAS provided a good range of recovery focussed treatment interventions. There was a clear commitment to reducing violence and ensuring safety.

Previous deaths at HMP/YOI Glen Parva

22. There were five self-inflicted deaths at Glen Parva between 2013 and 2015. In three of these, we found several aspects of good care, particularly from the mental health and substance misuse teams, but also some deficiencies in the ACCT process. These two themes are present in this case.

Assessment, Care in Custody and Teamwork (ACCT)

23. 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.

24. 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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

25. 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.

Incentives and Earned Privileges (IEP) Scheme:

26. Each prison has an IEP scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels: basic, standard and enhanced.

Key Events

27. On 30 June 2014, Mr Roberts was sentenced to four years in prison for theft. On 20 June 2015, he received a further 15 month sentence for wounding with intent. He had a significant history of anxiety, depression, self-harm, attempted suicide and substance misuse. He received a variety of psychological interventions in prison, but moved prisons frequently which prevented continuity. Mr Roberts took mirtazapine (an anti-depressant) daily.

Transfer to Glen Parva

28. On 30 June 2016, Mr Roberts was transferred to HMP/YOI Glen Parva to prepare for his release on 26 September 2016. He told a nurse at an initial health assessment that he had taken 16 paracetamol tablets two weeks previously but had not told anyone. She noted his history of anxiety, depression and substance misuse. Mr Roberts appeared calm and relaxed. He reported shortness of breath over the previous six months but said he was otherwise fit and well. A prison GP continued his mirtazapine. Mr Roberts occupied a single cell on Unit 15, the prison's induction unit.

29. On 1 July, the mental health team leader assessed Mr Roberts and referred him to the primary care mental health team and the therapeutic drug and alcohol service (TDAS). In addition to his history of anxiety, depression, self-harm and substance misuse, she noted that Mr Roberts was concerned about his accommodation and finances on release. Mr Roberts told her he had no current thoughts of self-harm or suicide but he had fleeting thoughts of both. He completed a depression questionnaire (PHQ-9) which showed he had severe depression. He also completed an anxiety test questionnaire (GAD-7) which showed he had severe anxiety.

30. The mental health team leader said that Mr Roberts told her he would not act on his thoughts of self-harm and suicide. She read Mr Roberts's past medical notes which showed his history of banging his head against the wall, overdosing, cutting his arms and attempting suicide. She said they discussed whether she should start ACCT suicide and self-harm monitoring. Mr Roberts said he did not feel he needed to be monitored and promised that he would ask to speak to her if he felt vulnerable to harming himself.

31. On 4 July, a worker from TDAS assessed Mr Roberts in a classroom in his unit. She said Mr Roberts came across as very anxious. He was unwilling to engage with any of the group sessions run by TDAS because he found large groups difficult. She left Mr Roberts some in-cell booklets on alcohol awareness to complete and said she would see him when he had completed them. She said she usually left new prisoners about a month to let them settle in before seeing them again.

32. On 7 July, Mr Roberts saw a prison GP. He said he had periods of shortness of breath when anxious. The GP said Mr Roberts was otherwise well and diagnosed an anxiety disorder. He prescribed propanolol (a beta blocker used to treat anxiety) and mirtazapine which Mr Roberts was already taking.

33. The same day, the mental health team leader spoke to Mr Roberts on his wing. He told her that a prison GP had given him more medication and said he was keen to take it. He said he was more settled now and was looking forward to starting work in a couple of days.

ACCT monitoring

34. On 11 July, Mr Roberts asked to see the mental health team leader. She said he was extremely anxious and told her he was struggling with fleeting thoughts of suicide and self-harm because he was exhausted dealing with his anxiety and depression. He said he felt overwhelmed in the workshop he attended because it was a large group and was worried that if he did not attend, his IEP level would be reduced to basic Mr Roberts said he was concerned about his accommodation, finances and support on release in September.

35. The mental health team leader discussed several coping techniques with Mr Roberts and began ACCT suicide and self-harm monitoring. She said his concerns about his release could be addressed under ACCT procedures. She said she would liaise with the education department about moving him to a smaller workshop. She put Mr Roberts on hourly checks until his assessment.

36. On 12 July, an officer assessed Mr Roberts. Mr Roberts said he was feeling low and had had suicidal thoughts but did not currently have any. If given the opportunity, he said he would take an overdose but would not consider cutting himself or hanging himself. He said he last self-harmed by taking 16 tablets about a month earlier. He said his family did not visit him in prison but he kept in touch with them by telephone and letters.

37. Later that day, Mr Roberts's first ACCT case review took place and with several staff. Mr Roberts said his main concern was the arrangements for his release in September. The mental health team leader told Mr Roberts she had spoken to a resettlement case worker, and that he would review him as soon as possible. She said a nurse had been assigned to be Mr Roberts's new nurse (because she had been promoted to a management role). Mr Roberts repeated that he found it hard to work in the workshop because of the size of the group. That afternoon, a Supervising Officer (SO) asked the instructor in the furniture repair shop to put Mr Roberts on his list for employment because it was a smaller group.

38. Mr Roberts said he continued to have thoughts of suicide and self-harm but found the hourly ACCT checks "annoying", especially at night because they made it more difficult for him to sleep. The review team decided to reduce Mr Roberts's observations to every two hours to help him sleep. Mr Roberts promised them that he would ask for support and help if he needed it or felt like acting on his thoughts. Mr Roberts said he was attending the gym and the SO agreed to put him on the list for Saturday sessions which were quieter.

39. The SO added two actions to Mr Roberts' caremap. There were for Mr Roberts to move to a smaller workshop and for the mental health team leader to contact the resettlement case worker. These were noted as already in hand.

40. On 13 July, Mr Roberts found out that he had tested positive for a sexually transmitted infection. When she found out, the mental health team leader went

to see him the same day to check he was not worrying. She said Mr Roberts was in a good mood, denied any thoughts of suicide or self-harm and spoke about his future plans.

41. On 15 July, a prison resettlement worker discussed with Mr Roberts his employment and training options for after his release. Mr Roberts said he was anxious about his debts and she put him on the list to see a specialist debt worker. She referred him to Sova (a charity supporting people in the community to avoid reoffending) for a mentor on release.

42. That afternoon, a mental health nurse in the secondary mental health team saw Mr Roberts briefly at his cell door after he asked wing staff if he could see a nurse. Mr Roberts said he was concerned that his medication was not helping with his anxiety. He had missed morning doses of propranolol because he found it difficult to wake up. She changed Mr Roberts's medication from the morning rounds to the lunchtime rounds and said she would ask the nurse he had been allocated to see him.

43. On 19 July, Mr Roberts attended an ACCT review with a SO and a nurse. The nurse said Mr Roberts appeared to be in good spirits and said he felt less anxious and more relaxed. He had just started work in the furniture repair shop. He had not yet spoken to Through the Gate (an organisation that supports prisoners on their release) about his concerns for his release but he had told his offender manager that he did not want to be released to his home area. The SO told Mr Roberts to continue to chase his referral to Through the Gate. The ACCT was closed with everyone's agreement and a post-closure review was scheduled for 26 July.

Work with mental health and TDAS

44. On 22 July, Mr Roberts punched another prisoner in the furniture repair shop and was suspended from his job. Mr Roberts' IEP level was reduced to basic.

45. On 24 July, a nurse said Mr Roberts appeared very anxious at their scheduled support session. He agreed that he had ongoing issues with anxiety but denied any thoughts of suicide or self-harm. He said he was happy in his single cell in Unit 15. (We were unable to interview her as she was absent on sick leave.)

46. On 26 July, the TDAS worker received Mr Roberts' completed alcohol awareness workbook and visited him to discuss further work. She said she was impressed with the high standard of his written responses. They discussed what activities Mr Roberts could do. He told her about losing his job in the furniture repair shop and said the prisoner whom he had punched was trying to force a drug debt on him. She said she would take him out to the garden with her on 29 July and gave him another workbook to complete in his cell.

47. On 29 July, the TDAS worker spent 90 minutes in the garden with Mr Roberts. They fed the chickens and she showed him the relaxation room in the healthcare centre. Mr Roberts told her about his home circumstances and said he did not want to go back to his home area on release because he thought he would get into trouble again. He said he was spending a lot of time in his cell because he did not like mixing with other prisoners. Mr Roberts told her about an incident in

HMP Ranby in 2015 when he had stabbed another prisoner after being put under pressure to keep a knife for someone. This had resulted in a further sentence. Mr Roberts said he preferred to keep to himself. She said she did not think that Mr Roberts had problems with anyone on Unit 15.

48. The TDAS worker explained to the furniture repair shop instructor what Mr Roberts had said about the fight. The instructor said he was willing to re-employ Mr Roberts as soon as the prisoner he had punched was released. She asked the Activities Hub to arrange for this to happen.

49. On 30 July, Mr Roberts attended an appointment with a nurse. He told her he had enjoyed feeding the chickens. He said he had no thoughts of suicide and self-harm. He was happy on Unit 15 but spent a lot of time in his cell because of his anxiety in groups. He asked to have his medication in possession because he often felt nervous going out to collect it. She said she would discuss this with the GP though she noted his history of attempted overdose.

50. On 3 August, the nurse completed a medication in-possession risk assessment questionnaire with Mr Roberts and said she would book him an appointment with the GP.

51. Mr Roberts case was discussed at the combined primary and secondary mental health teams weekly case meeting that week. A mental health nurse remembered suggesting to the nurse that she should refer Mr Roberts to the secondary mental health team (the in-reach team – who worked with prisoners with severe and enduring mental illness) because it appeared that his anxiety was worsening. She said she thought it was worth exploring whether therapy such as dialectical behaviour therapy offered by the secondary mental health team would benefit Mr Roberts. She also thought the visiting psychiatrist should review Mr Roberts' medication if he did not think it was controlling his anxiety.

52. On 5 August, the TDAS worker took Mr Roberts to the garden to feed the chickens again. Mr Roberts looked tired and pale and said he had not left his cell. Afterwards, they went to the library so Mr Roberts could collect some new books. On the way, she told him she knew about his history of attempted suicide and self-harm and asked him whether he felt suicidal. Mr Roberts said it was very tiring to be terrified all the time and he sometimes wished he was dead to avoid feeling that way. He told her he sometimes felt like killing himself but thought it was too selfish. He said he had last felt like that a couple of days earlier and he was worried he would never feel better. She tried to reassure Mr Roberts that there were people who would help him. She said Mr Roberts appeared genuinely keen to change his life and spoke positively about aspects of his future.

53. The TDAS worker said she considered starting ACCT procedures but was satisfied that Mr Roberts had no current intention to harm himself. She said he described his anxiety and fleeting thoughts of suicide as a perpetual state. There had been no new trigger to increase Mr Roberts' risk and he talked positively about looking forward to certain things.

Unit 5 and release plan

54. When they got back to Unit 15, Mr Roberts was told he was moving to Unit 5. The TDAS worker said he became even more anxious so she told him she would take him to his new cell. She asked if an officer was available to review Mr Roberts's IEP level because he had been on basic regime for a week. The unit staff were busy so she asked for the supervising officer from the Offender Management Unit to undertake the review. Mr Roberts was returned to standard regime which meant he could have a television in his new cell.

55. On 8 August, Mr Roberts took part in a telephone conference with his offender supervisor, the resettlement case worker and his offender manager. They discussed the arrangements for Mr Roberts' release. The resettlement case worker said he met Mr Roberts that morning to discuss his circumstances. Mr Roberts told him that he had two main issues – he wanted somewhere to stay and he did not want to be released to his home area. He said the telephone conference went well. The offender manager already had a plan for Mr Roberts to be released to a different area and had arranged accommodation in a probation hostel for him. The resettlement case worker said Mr Roberts appeared very happy with the outcome of the conversation and his concerns about release appeared to have been resolved.

56. The offender supervisor said Mr Roberts appeared to be in good spirits and was very appreciative of the release plan put in place. He had arranged for Mr Roberts to see a housing specialist from Through the Gate (a service providing support for prisoners on release). He said Mr Roberts appeared very positive and was aware of all the people who were involved in organising his release arrangements.

57. The same day, the mental health in-reach team received a referral from a nurse. The mental health nurse said she asked to do Mr Roberts' initial assessment because her specialism was psychological intervention.

58. On 9 August, the TDAS worker helped Mr Roberts complete a form from the probation service about his accommodation and needs on release. He told her he was happy on Unit 5 but was mostly staying in his cell. Mr Roberts had a meeting with a worker from Turning Point (a social enterprise that supports prisoners on release) that day. The TDAS worker explained that she had a meeting on Friday morning but would try to take Mr Roberts out to see the chickens in the afternoon.

59. On 10 August, a nurse discussed Mr Roberts's medication because he had not been coming to the hatch to take it. They agreed to move him to the evening rounds because fewer prisoners were out at that time.

12 August 2016

60. At 8.45am, the TDAS worker told Mr Roberts that she would be able to take him out to see the chickens that afternoon. She said he was still in bed and his cell was dark but he gave her a "thumbs up" sign.

61. At about 10.30am, the mental health nurse assessed Mr Roberts for the mental health in-reach team. She said Mr Roberts looked very anxious but engaged

very well and talked openly and honestly. She took a detailed account of his background because she wanted to refer him to community mental health services on release. She asked Mr Roberts about his history of self-harm and suicidal thoughts. He said he sometimes cut his arms superficially to get relief from his thoughts but did not find this very effective. He showed her old scars on his forearms and said he sometimes made cuts to his upper arms as well. He did not show her these but she did not think he had recently self-harmed.

62. Mr Roberts said he had had fleeting suicidal thoughts for a long time but was too scared to go through with them. He said he did not currently feel suicidal but he had continuous negative thoughts. He said he was unable to concentrate and had difficulty sleeping, and always woke up feeling exhausted. He agreed to work with the mental health nurse on a weekly basis and to see the visiting psychiatrist with her to explore whether different medication might help control his anxiety.

63. The mental health nurse discussed beginning ACCT monitoring. Mr Roberts said the frequent checks increased his anxiety, especially at night. She decided not to start ACCT monitoring. She said she took into consideration the facts that Mr Roberts was not in crisis; he did not have current suicidal thoughts or plans; he had agreed to work with her and that his problems were chronic or long standing rather than triggered by current circumstances. She did not want to put something in place that would increase his anxiety and felt that her plan to see him regularly and for the psychiatrist to review his medication was the most appropriate course of action. She said that if she had been concerned that Mr Roberts was actively suicidal or in crisis, she would have begun ACCT monitoring whether he wanted her to or not.

64. The mental health nurse said that she asked Mr Roberts whether he would like her to bring him a stress ball and he was very keen on the idea. She spoke to him about how to improve the effectiveness of his breathing exercises and said she would see him the next week.

65. CCTV showed that an officer took Mr Roberts' lunch to his cell at 12.15pm. There were no scheduled activities on Fridays apart from Friday prayers. This meant that no one returned to Mr Roberts's cell to unlock him after lunch.

66. Just before 2.45pm, the TDAS worker and a nurse arrived on Unit 5 to take Mr Roberts to feed the chickens. They asked an officer to unlock Mr Roberts. The nurse said Mr Roberts had obscured his observation panel by smearing something on it. The officer opened the door cautiously because they did not know why he had obscured the panel. The nurse called out, "Is it okay to come in?" When they opened the door wider, they saw Mr Roberts hanging from the top of the window, with a sheet around his neck. The nurse called a code blue emergency (which indicated a prisoner with breathing difficulties). The officer and a custodial manager cut Mr Roberts down and put him on the floor. The nurse began cardiopulmonary resuscitation. She said he had no pulse and was not breathing.

67. CCTV showed that the nurse and the TDAS worker opened Mr Roberts's cell at 2.45pm. The recorded emergency radio message indicated that the nurse called a code blue emergency at the same time. The control room officer instructed an

operational support grade to telephone an ambulance immediately and this is recorded on the control room log. Communication between all staff continued using the radio network so that the officers in Mr Roberts' cell could update the ambulance crew about Mr Roberts' condition.

68. CCTV showed that a nurse arrived at 2.46pm, followed by two more nurses, at 2.47pm. Emergency bags were brought to the cell at 2.48pm. A defibrillator was attached to Mr Roberts and showed no cardiac output. The nurses continued trying to resuscitate Mr Roberts and gave him oxygen. A prison GP was called, and examined Mr Roberts at 2.55pm. He told the nurses to stop resuscitation efforts because Mr Roberts was dead. The emergency ambulance, which had been called, was cancelled.

69. Staff found a suicide note in Mr Roberts' cell after he died, indicating that he could no longer carry on.

Contact with Mr Roberts' family

70. The Governor and the managing Chaplain drove to Mr Roberts' sister's house on 12 August and broke the news of Mr Roberts's death. Afterwards they drove Mr Roberts' sister to her grandparents' house to tell them, and then took her home.

71. The prison contributed towards the costs of Mr Roberts's funeral in line with national guidance.

Support for prisoners and staff

72. The Governor debriefed the staff involved in the emergency response before she left the prison to visit Mr Roberts's sister. A member of the prison's Care Team was present to offer further support.

73. The prison posted notices informing other prisoners of Mr Roberts's death and offering support. Staff reviewed all prisoners assessed as a risk of suicide and self-harm in case they had been adversely affected by Mr Roberts's death.

Post-mortem report

74. The post-mortem examination concluded that Mr Roberts died as a result of hanging. Toxicology tests showed levels of mirtazapine below the therapeutic range. There were no new (less than 24 – 48 hours old) self-inflicted cuts on his body.

Findings

ACCT procedures

75. Prison Service Instruction (PSI) 64/2011 provides guidance on ACCT procedures. The PSI requires a number of mandatory actions, including:

- Each caremap action must reflect the prisoner's needs and aim to address identified issues to reduce the prisoner's risk.
- The actions must be time bound.
- The caremap actions must be reviewed at every ACCT case review.
- Reviews must be multi-disciplinary where possible and a member of healthcare must be present at the first review.
- The ACCT plan should not be closed until all the actions of the caremap have been completed.

76. A nurse began ACCT monitoring appropriately on 11 July, and the first ACCT review was attended by her and two other mental health nurses. Mr Roberts said he had suicidal thoughts and was anxious about his plans for release and his situation at work. Staff made a good initial effort to resolve these issues. A SO talked to the workshop instructor to try to move Mr Roberts to a smaller group and the nurse had already contacted resettlement services on Mr Roberts' behalf about his release plans. Mr Roberts was receiving ongoing support from the mental health team about his anxiety. Staff added two actions to the ACCT caremap which were that Mr Roberts should move to a smaller workshop and that the nurse should contact resettlement services (which she had already done).

77. We do not consider it appropriate that actions, which had already been achieved, were added to the caremap, or that these actions properly addressed Mr Roberts's concerns. The fact that the nurse had contacted resettlement services did not resolve Mr Roberts' issue that he did not want to be released to his home area. There were still potentially difficult matters for different probation areas to discuss and resolve. (Because of his offence Mr Roberts was deemed to be high risk and had to be released to an approved premises.)

78. For this reason, it was inappropriate for staff to stop ACCT monitoring at Mr Roberts' next review on 19 July. Mr Roberts appeared in better spirits and had started working in the furniture repair shop. Yet, he had still not resolved the issues about his release plan and his release arrangements were not confirmed until 8 August. A wing supervising officer and a nurse who had not had previous contact with Mr Roberts attended the review. We accept that it is not always possible to have continuity in attendance at ACCT reviews. Despite this, it would have been appropriate to have someone from the offender management unit to provide input on resettlement issues or at least for staff to have contacted them for an update. We note that the post-closure review scheduled for 26 July did not take place. We therefore recommend:

The Governor should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national guidelines, including:

- **Holding multi-disciplinary case reviews attended by all relevant people involved in a prisoner's care. Where this is not possible advice should be sought and documented as part of the review.**
- **ACCT caremaps should have specific, meaningful actions aimed at reducing prisoners' risks to themselves, progress should be considered at each review and the caremaps updated if additional needs are identified.**
- **Ensuring that all caremap actions have been completed before ACCT monitoring is stopped.**
- **Ensuring post closure reviews take place.**

Decisions not to open an ACCT on 5 and 12 August

79. The guidance on assessing a prisoner's level of risk is contained within the ACCT plan. It includes the following guidance on whether a person is at low or raised risk:

    - 'Suicidal thoughts are fleeting and soon dismissed.' (low risk)
    - 'Suicidal thoughts are frequent but generally fleeting.' (raised risk)

80. The TDAS worker spent a significant amount of time with Mr Roberts on 5 August and explored how he felt. Mr Roberts said fleeting suicidal thoughts were a constant feature of his life. She decided not to open an ACCT because she did not think Mr Roberts had any current intent to end his life.

81. The mental health nurse also spent a significant amount of time with Mr Roberts on 12 August and completed a detailed assessment. Mr Roberts told her that he had fleeting suicidal thoughts, that these were an ongoing feature of his life and that he was too scared to act on them. She took into account a number of factors and made a considered decision not to begin ACCT monitoring.

82. The mental health nurse put in place a very good care plan for Mr Roberts which addressed his clinical and mental health needs. However, the ACCT process is not entirely about a prisoner's clinical needs. It is about teamwork and taking a holistic approach to caring for prisoners at risk. At the heart of the ACCT process is the principle of involving persons from different disciplines across the prison. Although she did not think Mr Roberts was actively suicidal, he made some worrying comments about his risk of suicide, and needed support for his ongoing anxiety and negative thoughts. Not beginning ACCT monitoring meant that the clinical avenue to keeping Mr Roberts safe was the only option pursued. Wing staff were unaware of the substance of either conversation on 5 and 12 August or that Mr Roberts had any form of suicidal thought.

83. Our investigations seek to learn lessons with the benefit of hindsight. Although starting ACCT procedures might not have prevented Mr Roberts' death, it would have meant wing staff were monitoring him more closely. In particular, 12 August was a Friday and Mr Roberts potentially had the weekend without support

from the mental health team or the TDAS worker. We consider that staff should begin ACCT monitoring in these circumstances because it is the most effective way of communicating to other staff that that a prisoner is at some risk of suicide or self-harm. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are aware of their responsibilities to keep prisoners safe and begin ACCT procedures when it is apparent that a prisoner is finding it difficult to cope and expresses any thoughts of suicide and self-harm.

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