Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dorian Robertson a prisoner at HMP Onley on 4 July 2018

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions I oversee can improve their work in the future.

Mr Dorian Robertson died on 4 July 2018 after suffocating himself in his cell with a plastic bag at HMP Onley. He was 46 years old. I offer my condolences to Mr Robertson's family and friends.

Mr Robertson suffered from paranoid personality disorder and acute anxiety and had spent some years in a secure hospital before being transferred back to prison. I am concerned that, despite this, referrals to the mental health team were not followed up and that he received no support from the mental health team for the last six months of his life.

I am also very concerned that Mr Robertson was able to obtain and use psychoactive substances (PS) on a virtually daily basis at Onley.

Mr Robertson struggled with the fact of imprisonment and his distant prospects of release. He was managed under suicide and self-harm prevention procedures (known as ACCT) three times in 2017, and our investigation found deficiencies in the way these procedures were followed. I am also concerned that Mr Robertson was not managed under ACCT in May 2018 when he disclosed that he was being bullied over drug-related debts. However, I am satisfied that staff had no reason to believe that Mr Robertson was at heightened risk of suicide at the time of his death.

I am concerned that there was a delay before staff entered the cell when they could not get a response from Mr Robertson, and that there was a further delay before an ambulance was called. Although this did not affect the outcome for Mr Robertson, such delays could make the difference between life and death in other cases.

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

Sue McAllister CB
Prisons and Probation Ombudsman **February 2019**

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Summary

Events

1. On 17 April 2002, Mr Dorian Robertson was convicted of grievous bodily harm with the intention to endanger life. He was given a life sentence with a minimum tariff of six years.

2. On 21 March 2013 he was transferred to a secure hospital under the Mental Health Act. He was diagnosed with paranoid personality disorder and acute anxiety. He also had a significant history of illicit drug use.

3. On 12 December 2016, Mr Robertson was returned to prison custody at HMP Gartree. On 25 April 2017, Mr Robertson was transferred to HMP Onley.

4. In July 2017, Mr Robertson's application for release was rejected by the Parole Board.

5. On 5 July, 5 September and 21 December 2017, Mr Robertson said he had thoughts of ending his life and officers monitored him under Prison Service suicide and self-harm prevention procedures (known as ACCT).

6. He was found under the influence of drugs on a number of occasions and told staff that he was using psychoactive substances (PS) on a daily basis.

7. In May 2018, he told staff he felt vulnerable as he was in debt and was under threat. He said he did not think he would survive in prison until his next parole review in 2019. He was referred to the mental health team. The mental health team discussed the referral but concluded that Mr Robertson's problems were drug- and debt-related and that no further action was required.

8. On 4 July 2018, at 8.21am, a member of staff found Mr Robertson had suffocated himself in his cell. An ambulance was requested. Staff did not begin cardiopulmonary resuscitation as it was clear Mr Robertson had been dead for some time. Paramedics arrived at 8.43am, and at 8.45am, pronounced Mr Robertson dead.

Findings

Mental healthcare

9. The mental healthcare Mr Robertson received was not equivalent to the care he would have received in the community. The mental health team at Onley missed several opportunities to engage with Mr Robertson and seemed not to take account of his history of paranoid personality disorder and severe anxiety or the fact that he had spent many years in a secure mental hospital. It is unacceptable that there was a five-month delay between Mr Robertson being referred for cognitive behavioural therapy in July 2017 and seeing a therapist in December 2017, or that he received no ongoing mental health support after 10 January 2018.

Management of suicide and self-harm

10. We found that ACCT procedures at Onley were not conducted in line with mandatory national instructions. Officers did not carry out an assessment interview or first case review, not all case reviews were multidisciplinary, and there were some inappropriate assessments of Mr Robertson's risk of self-harm.

11. We are also concerned that Mr Robertson was not monitored under ACCT procedures when he told staff in May 2018 that he was not coping and was under threat because of drug-related debts.

12. We accept, however, that staff had no reason to believe that Mr Robertson was at heightened risk of suicide at the time of his death.

Psychoactive Substances

13. Toxicology results confirm that Mr Robertson had used PS before his death. We are very concerned at the ready availability of illicit drugs at Onley and that Mr Robertson was apparently able to access PS in the prison on a virtually daily basis without difficulty.

14. We have previously recommended that the Chief Executive of HM Prison and Probation Service (HMPPS) should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Chief Executive told us in response that HMPPS planned to issue a national drug strategy in the autumn of 2018. We are concerned that at the time of writing (January 2019), HMPPS has still not issued the strategy.

Emergency response

15. We are concerned that staff took too long to go into Mr Robertson's cell and to call an emergency ambulance after they discovered he had suffocated. While this did not affect the outcome for Mr Robertson, who had clearly been dead for some time, such delays could be critical in other cases.

Recommendations

- The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.

- The Head of Healthcare should:

    - review the reasons why there was a five month delay between Mr Robertson being referred for cognitive behavioural therapy in July 2017 and seeing a therapist in December 2017; why the mental health team did not arrange a face to face mental health assessment when Mr Robertson was referred to them in May 2018; and why, Mr Robertson received no on-going mental health support after January 2018 despite his history of paranoid personality disorder and his lengthy previous involvement with mental health services; and

- produce an action plan to ensure that similar failings do not occur in future and that all referrals for mental health assessments and support are promptly carried out whenever a referral is received to identify existing health problems and to plan and deliver subsequent care.

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

    - assessing a prisoner's level of risk on the basis of recognised risk factors and not just on the prisoner's presentation or what he says;
    - conducting ACCT reviews as specified in the national instructions; and
    - recording the reasons for decisions.

- The Governor should ensure that a SO receives further training in conducting ACCT assessments and reviews.

- The Governor should ensure that substance misuse strategies provide guidance for staff on the process to follow when prisoners appear to be under the influence of or suspected of using illicit substances, including submission of intelligence reports, referral to substance misuse services or for mandatory drug testing, and how to access clinical support and advice.
- The Governor should ensure that all information about bullying, intimidation, debt and the use of drugs is fully coordinated and investigated and victims are effectively supported.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

    - staff enter cells as quickly as possible in a life-threatening situation; and
    - control room staff call an ambulance as soon as an emergency code is broadcast.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Onley informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

17. The investigator visited Onley on 10 July. He obtained copies of relevant extracts from Mr Robertson's prison and medical records.

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

19. The investigator interviewed ten members of staff and one prisoner at Onley in July and August. All the interviews were conducted jointly with the clinical reviewer.

20. We informed HM Coroner for Northamptonshire of the investigation. She gave us the results of the post-mortem examination and toxicology results. We have sent the coroner a copy of this report.

21. The investigator contacted Mr Robertson's mother to explain the investigation and to ask whether there were any matters she wanted the investigation to consider. Mr Robertson's mother did not raise any concerns. Mr Robertson's mother did not wish to receive a copy or make any comment.

Background Information

HMP Onley

22. HMP Onley is a resettlement prison serving the Greater London area. It holds approximately 740 adult male prisoners. Northamptonshire Healthcare NHS Foundation Trust provides health services including primary care, mental health and Phoenix Futures provides substance misuses services. A GP is on duty during normal working hours. Onley falls under the jurisdiction of HM Coroner for Northampton.

HM Inspectorate of Prisons

23. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Onley between July and August 2016. Inspectors reported that there had been a dramatic decline in standards since their last inspection in 2012, particularly in relation to safety and drug management. They noted that, since the last inspection, Onley had been designated as a resettlement prison for London, and that this change in role had undoubtedly had a significant impact on the prison. Inspectors found that there were high levels of violence, often due to the prevalence of psychoactive substances, and that cannabis and psychoactive substances were easily available. Inspectors judged that Onley had become an unsafe prison.

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 annual report, published in September 2018, the IMB were concerned about the quantity of mobile phones and illicit substances that had been recovered through cell searches.

Previous deaths at HMP Onley

25. Mr Robertson's was the second self-inflicted death to occur at Onley since January 2015. In the same period there were also three deaths from natural causes and one death from an illicit drug overdose. In the previous self-inflicted death investigation, we made recommendations about the mental health services and the availability of illicit drugs, including psychoactive substances.

Assessment, Care in Custody and Teamwork (ACCT)

26. 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. 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. Regular multidisciplinary review meetings involving the prisoner should be held. As part of the process, a caremap (a 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. 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, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

Psychoactive Substances (PS)

27. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

28. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

29. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

30. In April 2002, Mr Dorian Robertson was convicted of wounding with intent to cause grievous bodily harm and given a life sentence with a minimum tariff of six years. It was not his first time in prison. He spent two periods at a secure hospital, a high security psychiatric facility, from June 2006 to January 2007, and from March 2013 to December 2016. He was diagnosed with paranoid personality disorder, emotionally unstable personality disorder and acute anxiety.

31. On 12 December 2016, Mr Robertson was transferred back to prison custody at HMP Gartree, and on 25 April 2017, he was transferred to HMP Onley.

32. When Mr Robertson arrived at Onley, he saw a nurse in reception. The nurse recorded that Mr Robertson had transferred from Gartree and was prescribed pregabalin (for pain and anxiety), risperidone (an antipsychotic), sertraline (an antidepressant) and tramadol (for moderate to severe pain). Mr Robertson said he had no thoughts of self-harm or suicide and refused to be referred to the mental health team. The nurse recorded that Mr Robertson appeared calm and relaxed and his blood pressure and pulse were normal.

33. On 22 May, a substance misuse recovery worker saw Mr Robertson. Mr Robertson said he had been in custody for 16 years, which included time at a secure hospital for his mental health issues. Mr Robertson said he had completed substance misuse awareness work at previous prisons. She explained how harmful PS use could be and how to contact substance misuse services in the future.

34. On 5 July, at 12.25pm, an officer started ACCT monitoring as Mr Robertson said he had continuous thoughts of self-harm because the Parole Board had rejected his application for release. He said that he had not acted on his thoughts because of his mother but that, if his mother died, he would kill himself as he would have nothing else to live for.

35. A custodial manager (CM) saw Mr Robertson and completed the immediate action plan. He assessed Mr Robertson as being at raised risk and set his level of observations at four times an hour throughout the day and night, plus one recorded conversation in the morning afternoon, evening and night, until the first case review.

36. On 6 July, at 12.15pm, an instructional officer assessed Mr Robertson as part of ACCT procedures. Mr Robertson said he had felt worse over the previous two weeks, he was depressed, was in debt for tobacco and wanted to see someone from the mental health team. He said his mother kept him going.

37. At 12.20pm, a supervising officer (SO) held the first ACCT case review with two officers and Mr Robertson. No-one from the healthcare team was present or contributed to the review. Mr Robertson said he had found it difficult to adapt to the regime at Onley, compared to the regime at Gartree. He said he would not harm himself while his mother was alive. He said he wished to work with the substance misuse and mental health teams but had only seen them once since arriving at Onley. The SO assessed Mr Robertson as being at low risk of suicide and self-harm, and reduced the level of observations to hourly throughout the

day and night, with one recorded conversation in the morning, afternoon, evening and night.

38. The SO completed the ACCT caremap which contained three actions: for Mr Robertson to see the substance misuse team, for Mr Robertson to see the mental health team and for Mr Robertson to obtain a job in prison. The next case review was set for 10 July.

39. On 10 July, a SO chaired an ACCT review with a nurse, a member of the mental health team, and Mr Robertson present. Mr Robertson said he felt ok, had no thoughts of harming himself and would speak to staff if necessary. The SO recorded that Mr Robertson had an appointment with the mental health team the next day, was due to see the substance misuse team and was due to start work in the assembly workshop. The SO and the nurse assessed that Mr Robertson was at low risk of self-harm and agreed to close the ACCT. The SO updated the caremap that all actions were completed. A post closure interview was set for 17 July.

40. The nurse recorded in Mr Robertson's medical record that Mr Robertson acknowledged that his suicidal threats were due to the Parole Board rejecting his application for release and he requested support from both mental health and substance misuse teams.

41. On 11 July, Mr Robertson did not go to his appointment with the mental health team. However, on 14 July, a nurse saw Mr Robertson for a mental health assessment. The nurse recorded that Mr Robertson was low in mood, but engaged well in the assessment and showed good insight into his diagnosis of multiple personality disorders. Mr Robertson said that he had no plans for suicide or self-harm and that his recent issue had been a reaction to his parole hearing. Mr Robertson accepted that he would benefit from some support from the mental health team, however, he requested that this was on a one-to-one basis as he did not like group work. The nurse referred Mr Robertson for cognitive behaviour therapy (CBT) and recorded that Mr Robertson should receive ongoing support.

42. The nurse told the investigator that he did not use any assessment tools and his assessment of Mr Robertson was based the structured template on the medical record system and personal interaction. The nurse said that all assessments are discussed at a weekly referral meeting and allocated for ongoing work at that point. The nurse said that urgent referrals to the mental health team should be seen within 24 hours, and non-urgent referrals should be seen in five working days. Mr Robertson's medical records show that after the nurse's assessment, he did not receive any support until 13 December.

43. On 17 July, a SO held the ACCT post-closure interview with Mr Robertson. Mr Robertson said he felt supported by staff, was working in the assembly workshop and was paying off his debt. Mr Robertson said he wanted a transfer to another prison.

44. On 4 September, a probation officer saw Mr Robertson to review his sentence progression. He recorded that Mr Robertson had been in custody since 2002, spent three years at a high secure hospital, returned to prison custody at Gartree

in February 2016 and received a progressive transfer to Onley on 25 April 2017. However, on 26 April, the Parole Board reviewed Mr Robertson's case and did not recommend release or transfer to an open prison, but recommended a transfer to the Psychologically Informed Planned Environment (PIPE) unit (a pathway for treatment of personality disorders within prison) at HMP Warren Hill. The Parole Board had set the next review for Mr Robertson in 2019.

45. Mr Robertson told the probation officer he was prescribed medication for paranoid personality disorder, acute anxiety and back pain. He said he was angry at the outcome of his parole review, was unhappy with the regime at Onley and missed the structure at Gartree. Mr Robertson agreed to transfer to the PIPE unit at Warren Hill.

46. On 5 September, at 11.30am, an officer opened an ACCT as Mr Robertson said he intended to take his own life. A SO saw Mr Robertson and completed the immediate action plan. He assessed Mr Robertson as being at raised risk and his level of observations was set at five times an hour throughout the day and night until the first case review.

47. At 3.30pm, an officer assessed Mr Robertson as part of ACCT procedures. Mr Robertson said he was at his "wits' end" with his sentence and other prisoners, and that he had no contact with his family and would not be released until he was old. Mr Robertson said he had no thoughts or intentions of suicide or self-harm. However, at this point he refused to engage further with the officer and left the room.

48. On 6 September, at 3.10pm, a supervising officer (SO) chaired the first ACCT case review with a nurse, a member of the mental health team and Mr Robertson present. (It is mandatory for first case reviews to be held within 24 hours of an ACCT being opened.)

49. Mr Robertson said he wanted a transfer to the PIPE unit at Warren Hill or a transfer to HMP The Mount where he felt he would be "in tune" with other prisoners. Mr Robertson said he had no thoughts of suicide or self-harm. The SO and nurse assessed Mr Robertson as being at low risk of suicide and self-harm, and reduced the level of observations to two per hour throughout the day and night, with one recorded conversation in the morning, afternoon and evening.

50. The SO completed the ACCT caremap which contained two actions: for Mr Robertson to submit a transfer application to The Mount and for Mr Robertson to apply for a transfer to a different wing at Onley. They did not discuss protective factors for his ongoing mental health issues or substance misuse. The next case review was set for 13 September.

51. On 9 September, a SO chaired an ACCT case review with an officer, a nurse, a member of the healthcare team, and Mr Robertson. Mr Robertson said he had said that he intended to kill himself out of frustration and said he had no thoughts of suicide or self-harm. He said he had re-established contact with his mother who was an important support for him. He said he had moved wings and no longer wanted a transfer to The Mount. Mr Robertson said he believed being on an ACCT was a sign of weakness. He was grateful for the support he had received but did not want the support anymore. All present agreed that Mr

Robertson's risk of suicide and self-harm was low and agreed to close the ACCT. The SO updated the caremap as all the actions had been completed. They set a post-closure review for 15 September.

52. On 15 September, a SO held the ACCT post-closure interview with Mr Robertson. Mr Robertson said he felt settled since he had moved wings and was supported by staff. He said he spent most of his time on the wing but was happy with his own routine. He said he mixed with the older prisoners on the wing and his mother was a real support to him.

53. On the same day the probation officer saw Mr Robertson for a welfare check. Mr Robertson said he was coping better now and enjoyed reading and listening to classical music. He said he was waiting to see a lady from the mental health team that a nurse had spoken about. He also said he would like to see someone from the substance misuse team. He referred Mr Robertson to the substance misuse team.

54. On 2 October, a substance misuse recovery worker recorded in Mr Robertson's medical record that, following a probation officer referral, a substance misuse recovery champion (a fellow trusted prisoner) was sent to see if Mr Robertson wanted to engage with the substance misuse team. On 17 October, a substance misuse recovery worker saw Mr Robertson for an initial assessment. She recorded that Mr Robertson had a history of alcohol dependence, occasional illicit drug use and had completed group work in the past at Gartree. Mr Robertson admitted he used "spice" (PS) whenever he got the chance and paid off his drug debts weekly from his prison account. He said he wanted to remain positive and work towards his next parole hearing. She told Mr Robertson she would be his substance misuse case manager.

55. On 13 November, a nurse saw Mr Robertson in his cell as officers had found him under the influence of an illicit substance. Mr Robertson admitted he had used PS. The nurse recorded that there were no issues with his breathing or circulation, and referred Mr Robertson to be seen by a doctor.

56. On 14 November, a prison doctor saw Mr Robertson following the nurse's referral. Mr Robertson said he used PS at least three times a week and used a pipe. The prison doctor recorded that using a pipe gave a higher concentration of PS and he advised Mr Robertson in the strongest possible terms not to do this as it put him at risk of overdose, coma or even death. Mr Robertson replied, "I know doc, I know". Later that day, a substance misuse recovery worker saw Mr Robertson for a wellbeing review. Mr Robertson said after he saw a substance misuse recovery worker in October, he had only managed to stay off PS for three days. He said he planned to try not to use PS in the New Year.

57. On 23 November, a nurse saw Mr Robertson in his cell as officers had found him under the influence of an illicit substance. Mr Robertson admitted he had used PS. A nurse recorded that Mr Robertson's speech was slurred, his eyes were red and he was under the influence of 'spice' but there were no medical concerns.

58. On 12 December, a probation officer saw Mr Robertson for a sentence progression review. He recorded that Mr Robertson was in very low mood and did not appear to be coping well. He noted that Mr Robertson was being seen by

a substance misuse recovery worker and waiting to be seen by the mental health team, but had declined counselling support sessions. Mr Robertson said he had contact with his mother who had sent him money, which he denied using for drugs. However, he readily admitted that he used PS daily. He said that other prisoners had stolen his television and a probation officer wondered if this meant he was being bullied. Mr Robertson still wished to apply to be transferred to the PIPE unit at Warren Hill. The probation officer gave Mr Robertson the prisoner part of the application form and arranged to see him again on 21 December.

59. On 13 December, an occupational therapist saw Mr Robertson for a cognitive behavioural therapy assessment. Mr Robertson said he was struggling to cope with prison life, was very low in mood and frustrated that he saw no end to his sentence with no hope of progressing from prison. He was not prepared to engage with cognitive behavioural therapy as he had received individual therapy in the past and did not think he would benefit from further therapy. He admitted that he used PS daily. Mr Robertson said he had thoughts of ending his own life but his mother was a protective factor and he looked forward to a transfer to the PIPE unit at Warren Hill.

60. The occupational therapist told the investigator she considered opening an ACCT but Mr Robertson was clear that he would not commit suicide as his mother was a protective factor. She said Mr Robertson agreed she could share how he felt and his ongoing 'spice' use with a probation officer. She recorded that she referred Mr Robertson to the mental health team for ongoing support. She said she did not know why Mr Robertson had not received any mental health support between July 2017 and her assessment.

61. On 21 December, at 11.00am, a probation officer saw Mr Robertson as previously arranged. Mr Robertson had partly completed the application form for the PIPE unit at Warren Hill. Mr Robertson said he wanted to transfer out of Onley to a higher category prison. He said he had not seen his substance misuse worker nor anyone from the mental health team. The probation officer recorded that he was very concerned about the deterioration in Mr Robertson's mood since he last saw him on 12 December, and he started ACCT monitoring.

62. At 2.00pm, a SO saw Mr Robertson and completed the immediate action plan. The SO recorded that, having spoken to Mr Robertson, he showed positive behaviour and she assessed that he did not need to be subject to ACCT monitoring and closed it. (It is mandatory for assessment interviews and first case reviews to be held within 24 hours of an ACCT being opened.) The SO set a post-closure review for 28 December.

63. On 28 December, a SO held the ACCT post-closure interview with Mr Robertson. Mr Robertson said he was fine, had no thoughts of self-harm, enjoyed music and was in contact with his mother by letter and telephone.

64. At the end of December, staff noted that Mr Robertson's television had been taken from his cell on three occasions and wondered if he was selling it to pay drug debts.

65. On 10 January, a nurse who was a member of the mental health team, saw Mr Robertson, as a result of an occupational therapist referral. Mr Robertson said

he had applied to a PIPE unit at Warren Hill. The nurse recorded that Mr Robertson was feeling unsettled on the wing and used PS on a regular basis. The nurse also recorded that she would continue to support Mr Robertson. However, this was the only recorded intervention in Mr Robertson's medical records that a nurse, or any other member of the mental health team, had with Mr Robertson before his death.

66. On 12 January, a substance misuse recovery worker saw Mr Robertson for a substance misuse wellbeing check. Mr Robertson again admitted he used PS daily. He said he was fully aware of the effects and consequences of using PS, however he said he would continue to use PS as "what's the point in not, I've nothing to work towards".

67. On 22 January, the substance misuse recovery manager recorded in Mr Robertson's medical record that Mr Robertson had attended the two-day 'psychological wellbeing' course. He recorded that Mr Robertson participated fully throughout the course and contributed to group work, as well as individual work.

68. On 13 March, staff recorded in Mr Robertson's medical record that Mr Robertson had attended the three-day 'drugs and you' course. She recorded that Mr Robertson participated fully throughout the course and contributed to group work, as well as individual work. Mr Robertson said, for him, the course had highlighted that "most drugs were more trouble than they are worth" and "to stay off drugs".

69. On 19 March, a substance misuse recovery worker saw Mr Robertson for a substance misuse wellbeing check. Mr Robertson said he was not in a good place and used 'spice' daily. He said he had attended the two substance misuse courses but did not learn anything from them and did not understand what she could do for him. She recorded that she made Mr Robertson aware of the dangers of using PS and that she would continue to support him.

70. On 5 April, a GP saw Mr Robertson as he said he felt he was falling apart, felt anxious, suffered from back pain and felt scared. He said he had no thoughts of suicide. The GP recorded that Mr Robertson looked anxious and his knees were trembling. He increased Mr Robertson's prescribed amount of pregabalin for his anxiety, referred him to the mental health team and planned to review him on 18 April.

71. Mr Robertson's medical records show that the GP's referral was not been actioned and that Mr Robertson was not seen or offered support by the mental health team.

72. On 17 April, a probation officer saw Mr Robertson to discuss his application to the PIPE unit at Warren Hill. He explained to Mr Robertson that there was concern about Mr Robertson's PS use and this could have an impact on the success of his application.

73. On 18 April, a GP saw Mr Robertson to review him as planned. Mr Robertson said he felt "really good" since the increase in his pregabalin prescription. The GP recorded that Mr Robertson was much improved, less anxious and looked

well. The GP told the investigator that he knew about Mr Robertson's mental health history, but that he was unaware of Mr Robertson's daily PS use.

74. On 3 May, a nurse saw Mr Robertson as officers had found him under the influence of an illicit substance. The nurse recorded that Mr Robertson admitted he had used 'spice' but that there were no physical medical concerns. Mr Robertson said he could not refuse PS as he was not coping on the wing. He said he felt vulnerable as he was bullied when he was unconscious as a result of PS use and not aware of prisoners coming into his cell. Mr Robertson said he did not think he would survive in prison until his parole date in 2019. The nurse referred Mr Robertson to the mental health team and the substance misuse team.

75. On 4 May, a substance misuse recovery worker saw Mr Robertson following a nurse's referral. Mr Robertson said he continued to use PS daily, was in debt to other prisoners and he had told officers about this. (There is no record that he spoke to officers about debt before this point.) Mr Robertson said he had no thoughts of self-harm or suicide. The substance misuse recovery worker told Mr Robertson she would see him in a few weeks' time.

76. Mr Robertson's security records show that he had a history of illicit drug use and a history of trading his prescription medication since 2007. On 5 May 2018, staff recorded that Mr Robertson said he was in debt and under threat but he had not given the names of any prisoners that he was in debt to or under threat from.

77. On 11 May, a mental health team support worker recorded in Mr Robertson's medical record that a nurse had asked for a review of Mr Robertson after she had seen him under the influence of PS. She also noted the entry made by a substance misuse recovery worker on 4 May, that Mr Robertson said that he was under threat and was being bullied. She recorded that Mr Robertson's issues were related to the use of illicit substances and being under threat due to being in debt from his 'spice' use. She recorded that the mental health team had discussed the referral but felt this was not a mental health issue and no further action was required.

78. The occupational therapist, told the investigator she was not present at that meeting on 11 May. She thought that, given Mr Robertson's history of paranoid personality disorder and his lengthy previous involvement with mental health services, the mental health team should have arranged a face to face mental health assessment.

79. On 14 June, a GP saw Mr Robertson for a review. Mr Robertson said he was in good spirits and things were better on the wing. The GP set a further review date for four weeks' time. The GP told the investigator that Mr Robertson gave no indication of thoughts of suicide or self-harm.

80. On 15 June, a substance misuse recovery worker saw Mr Robertson in his cell for a wellbeing check. Mr Robertson said he continued to use PS daily and was in a small amount of debt. He said he was waiting for a transfer to the PIPE unit at Warren Hill.

81. An officer told the investigator that he was Mr Robertson's personal officer. The officer explained the role of a personal officer was to be the first point of contact

for a prisoner if they had any issues or concerns. The officer said he had good contact with Mr Robertson who was polite and courteous. Mr Robertson mixed with a small group of prisoners his own age on the wing. The officer said he was aware that Mr Robertson had mental health issues and was on medication. He said Mr Robertson gave no indication he was being bullied. The officer's last recorded entry in Mr Robertson's prison computer record was on 15 June, when he recorded that he had spoken to Mr Robertson and there were no issues or concerns.

Events of 4 July

82. CCTV footage of the wing shows that at 8.17am on 4 July, an officer unlocked Mr Robertson's cell so that he could collect his medication. He opened the cell door, but remained in the doorway.

83. At 8.18am, CCTV footage shows an officer arrived at Mr Robertson's cell. He went into the cell and put the cell light on. An officer followed the other officer into the cell. At 8.20am, both officers left the cell, locked the door and left the wing.

84. At 8.21am, both officers returned to Mr Robertson's cell accompanied by another officer. An officer opened the cell door and went into the cell, followed by the other officers. Within ten seconds, an officer used his radio.

85. An officer told the investigator that he and another officer started to unlock prisoners to collect their medication at about 8.20am. An officer called him over as he could not get a response from Mr Robertson. An officer said he entered the cell and could see Mr Robertson under the covers on his bed, with his feet at the far end of the bed. He called Mr Robertson but he did not respond.

86. An officer said he and another officer then left the cell and locked the door and an officer went to fetch an officer from the adjacent wing so they could go into the cell safely. He said that they had been trained that if they did not feel it was safe to go into a cell, they should wait until there were three officers present. He said if a prisoner was under the covers, like Mr Robertson, he could be hiding a weapon and could pose a risk to their safety.

87. An officer told the investigator that he was working on K wing, the wing adjacent to J wing, Mr Robertson's wing. They had just finished locking up the prisoners who had collected their medication on K wing when an officer came and asked him to come and look at a prisoner on J wing who was "freaking him out". The officer said he assumed the prisoner was either under the influence of drugs or was 'kicking off' but as they walked to the wing, an officer sort of turned and shrugged his shoulders and said, "Oh, he's not responding."

88. When they got to Mr Robertson's cell, an officer was standing outside the door, looking through the observation panel. An officer said he told them to open the door. An officer seemed reluctant to enter the cell, so another officer said he went in. He said that from the door he could only see Mr Robertson's legs, with his body under the covers, but as he went in could see a bit of plastic and immediately realised something was wrong. As he stepped further in, he could see Mr Robertson had a plastic bag over his head and he said he shouted to the

other officers to call a code blue medical emergency code, which indicates a prisoner is unable, or having difficulty breathing.

89. An officer said he ripped the plastic bag off Mr Robertson's head to find his head covered with a t-shirt. He pulled this away to find a shoelace wrapped tightly around Mr Robertson's neck. The shoelace was not tied to anything and he cut it with his anti-ligature knife. By the time he had done this, the nurse had arrived. He said Mr Robertson's body was cold and stiff.

90. The control room log shows the code blue was radioed at 8.21am, but that an ambulance was not called until 8.25am. A nurse immediately responded to the code blue and the CCTV footage shows that the nurse arrived at Mr Robertson's cell at 8.22am.

91. The nurse told the investigator that she did not try to resuscitate Mr Robertson as it was clear that he had been dead for some time. Both rigor mortis and blood pooling were clearly evident.

92. Paramedics arrived at 8.43am, and, after a short assessment, they pronounced Mr Robertson dead at 8.45am.

93. Mr Robertson had left a suicide letter addressed to his mother. In the letter, Mr Robertson wrote, "I'm sorry I have to go before you, but it all hurts too much."

Contact with Mr Robertson's family

94. At 11.15am, the family liaison officers (FLO) from HMP Onley, visited Mr Robertson's mother at her home address to break the news of her son's death and offer condolences. In the days that followed, a FLO stayed in touch with Mr Robertson's mother and in line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

95. The head of residence, held a debrief for staff involved in the emergency response, including healthcare staff, to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.

96. The prison posted notices informing staff and prisoners of Mr Robertson's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Robertson's death.

Post-mortem report

97. A post-mortem examination, conducted by a Home Office forensic pathologist, confirmed that the cause of Mr Robertson's death was plastic bag asphyxia. She noted that the toxicology results showed that Mr Robertson had used a synthetic cannabinoid (PS) at some point before his death, but this neither caused or contributed to his death.

Findings

Mental healthcare

98. The clinical reviewer, concluded that the mental healthcare Mr Robertson received was not equivalent to the care he would have received in the community. We share the clinical reviewers concern that the mental health team at Onley missed several missed opportunities to engage Mr Robertson. The clinical reviewer was particularly concerned that support was offered, but there is no evidence that it was ever actually delivered.

99. We agree with the clinical reviewer conclusion that the mental healthcare that Mr Robertson received was not equivalent to that which he could have expected to receive in the community. It is unacceptable that there was a five-month delay between Mr Robertson's interventions with a nurse and the occupational therapist's assessment, and consider that it was a failure in care that he received no ongoing support after he saw a nurse on 10 January 2018.

100. In addition, a GP and a nurse both requested the mental health team to review Mr Robertson on 5 April, and 4 May respectively, but he was not seen. The occupational therapist, agreed that Mr Robertson should have been offered a review appointment. These were missed opportunities. The clinical reviewer comments that there appeared to be a lack of understanding of Mr Robertson's diagnosis of paranoid personality disorder and a missed opportunity to reassess Mr Robertson in May 2018.

101. Mr Robertson had a significant mental health history and, in the 15 months he was at Onley, he only had three interventions with the mental health team. We consider this to be a significant failing. We make the following recommendation:

The Head of Healthcare should:

- **review the reasons why there was a five month delay between Mr Robertson being referred for cognitive behavioural therapy in July 2017 and seeing a therapist in December 2017; why the mental health team did not arrange a face to face mental health assessment when Mr Robertson was referred to them in May 2018; and why, Mr Robertson received no on-going mental health support after January 2018 despite his history of paranoid personality disorder and his lengthy previous involvement with mental health services; and**
- **produce an action plan to ensure that similar failings do not occur in future.**

Clinical care

102. Despite his concerns about Mr Robertson's mental health care, the clinical reviewer judged the physical care that Mr Robertson received from healthcare staff at Onley was equivalent to the care he would have received in the community.

Management of risk of suicide and self-harm

103. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include a prisoner's first time in custody, recall to custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.

104. Prison staff appropriately started ACCT monitoring on 5 July, 5 September and 21 December, immediately after Mr Robertson said that he had thoughts of ending his own life.

105. The first ACCT case review on 6 July was not multidisciplinary, and the first case review on 6 September, was not conducted within 24 hours of the ACCT being opened. Both are contrary to national instructions. We consider that the decisions to close the ACCT on 10 July and 9 September were appropriate and consider that Mr Robertson had received appropriate support from staff and the actions on the caremap had been addressed.

106. We consider that a SO's decision to close the ACCT on 21 December was wholly inappropriate. There had been no assessment interview or first case review, which is contrary to national instructions. The SO did not speak to a probation officer, who had thought it necessary to start ACCT monitoring only hours earlier. We consider this was a significant failing and that the assessment of Mr Robertson's level of risk was not sufficiently rigorous and that the SO should have considered actions to address his evidently heightened risk.

107. We also consider that staff should have opened an ACCT in early May 2018, when Mr Robertson said he was not coping, that he was using PS daily, that he was being bullied, that he had drug debts and that he felt under threat. These were all clear risk factors for suicide and self-harm. We are also concerned that the mental health team appear not to have taken account of Mr Robertson's diagnosis of paranoid personality disorder and anxiety when they decided they did not need to assess him.

108. We accept, however, that Mr Robertson appeared to be in better spirits by 14 June, and that staff had no reason to consider he was at heightened risk of suicide at the time of his death. We make the following recommendation:

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

- **assessing a prisoner's level of risk on the basis of recognised risk factors and not just on the prisoner's presentation or what he says;**
- **conducting ACCT reviews as specified in the national instructions; and**
- **recording the reasons for decisions.**

The Governor should ensure that the SO receives further training in conducting ACCT assessments and reviews.

Psychoactive Substances

109. The post-mortem report found that Mr Robertson had used PS at some point before he died, although this had not contributed to his death.

110. We are very concerned that Mr Robertson was apparently able to obtain PS so readily at Onley and to use it on a daily basis. It is particularly concerning that staff seem to have regarded this as acceptable, if not normal. We note that both HM Inspectorate of Prisons and the Independent Monitoring Board have expressed concern about the ready availability of drugs at Onley.

111. In December 2017, staff suspected Mr Robertson might be being bullied over drug-related debts, and in May 2018 he told staff that he was being bullied because of debts. No action was taken.

112. Mr Robertson engaged with two substance misuse recovery groups and in face-to-face sessions with a substance recovery worker while at Onley. Nevertheless, his self-reported daily use would have had an impact on his wellbeing and might well have increased his vulnerability to debt and associated bullying. There are also concerns that the use of PS can induce paranoia.

113. In July 2015, we published a Learning Lessons Bulletin about deaths associated with the use of PS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of PS; the need for more effective drug supply reduction strategies; and better monitoring by drug treatment services.

114. Onley has a Drug and Alcohol (Substance Misuse) Strategy, dated May 2017. It states that the use of PS by prisoners has had a significant effect on Onley and the wider prison estate. We were told that the prison holds monthly substance misuse strategy meetings to discuss intelligence and identify areas of weakness around the prison to prevent the trafficking of drugs. On the evidence of this case, it appears that more needs to be done and we make the following recommendations:

The Governor should ensure that substance misuse strategies provide guidance for staff on the process to follow when prisoners appear to be under the influence of or suspected of using illicit substances, including submission of intelligence reports, referral to substance misuse services or for mandatory drug testing, and how to access clinical support and advice.

The Governor should ensure that all information about bullying, intimidation, debt and the use of drugs is fully coordinated and investigated and victims are effectively supported.

115. Onley is not alone in facing this problem – it is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, in the PPO's view there is now an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works.

116. In a previous investigation, we recommended that the Chief Executive of HM Prison and Probation Service (HMPPS) should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of drug-related deaths she was investigating. The Chief Executive told us in response that HMPPS planned to issue a national drug strategy in the autumn of 2018. We are concerned that at the time of writing (January 2019), this strategy has still not been issued. We therefore make the following recommendation:

The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.

Emergency Response

117. PSI 03/2013, *Medical emergency response codes,* says that governors must have a medical emergency response code protocol to ensure that prisons call an ambulance immediately in a life-threatening medical emergency. The PSI explicitly states that control room staff should automatically call an ambulance whenever an emergency code is called and that it is not necessary for a member of the prison healthcare team or a duty manager to attend the scene before emergency services are called.

118. We are concerned that two officers showed a lack of urgency when they could not obtain a response from Mr Robertson. There was a delay of four minutes from the time that an officer unlocked Mr Robertson's cell before staff radioed an emergency. Mr Robertson had no history of using weapons or attacking staff and we consider that they could reasonably have been expected to enter the cell to check Mr Robertson's wellbeing without waiting for a third officer.

119. We are also concerned that there was a further four-minute delay between an officer calling the code blue emergency code and the control room calling an ambulance.

120. While these delays did not affect the outcome for Mr Robertson, who had been dead some time when he was found, it is important that prison staff understand their roles in a medical emergency. Early intervention when someone is found unconscious or unresponsive can save their life. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

- **staff enter cells as quickly as possible in a life-threatening situation; and**
- **control room staff call an ambulance as soon as an emergency code is broadcast.**

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