Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ronald Roberts, a prisoner at HMP Bedford, on 11 June 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 we oversee can improve their work in the future.

Mr Ronald Roberts died on 11 June 2019 of a heart attack caused by heart disease while a prisoner at HMP Bedford. Mr Roberts was 86 years old. I offer my condolences to Mr Roberts' family and friends.

Mr Roberts was an elderly man with mobility issues and many complex medical conditions. These were managed well. On 24 May, Mr Roberts became unwell and was transferred to hospital for treatment for a chest infection. He initially responded well to treatment and, on 10 June, the hospital and prison staff discussed preparations for his discharge back to prison. However, Mr Roberts' health deteriorated overnight, and he died the following day.

I am satisfied that the clinical care Mr Roberts received at Bedford was equivalent to that he could have expected to receive in the community.

However, the clinical reviewer has identified some areas for improvement. Although these did not have a direct impact on Mr Roberts' health, they could make a difference in other cases.

I am concerned that Mr Roberts was taken to hospital in restraints. I am not satisfied that the decision to restrain him took account of his current state of health and mobility.

I am also concerned that staff were not de-briefed after Mr Roberts died and were not offered support.

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 **January 2020**

Contents

Summary

Events

1. Mr Ronald Roberts received an eighteen-year custodial sentence in 2006 for manslaughter. He spent time at HMP Swaleside, and at a medium secure psychiatric unit, before transferring to HMP Bedford on 13 April 2016.

2. Mr Roberts had several health issues, including paranoid schizophrenia, chronic obstructive pulmonary disease (COPD), heart disease, an abdominal aortic aneurysm (thinning and ballooning of the main artery from the heart), irritable bowel syndrome, urinary incontinence and osteoarthritis. He also had a history of self-harm.

3. Mr Roberts was seen and treated for shortness of breath, cellulitis and a leg infection during the months prior to his death.

4. On 9 May 2019, after an episode of deliberate self-harm, Mr Roberts was monitored under suicide and self-harm prevention procedures (known as ACCT). This was closed on the 21 May, when prison staff assessed that Mr Roberts' risk to himself had reduced.

5. On the afternoon of 23 May, Mr Roberts became unwell. He was seen by the prison doctor who treated him for a chest infection. He was monitored through the night and, at 3.25am, he was found on the floor after falling out of bed. An ambulance was called. Paramedics arrived and transferred Mr Roberts to hospital.

6. Mr Roberts was treated with antibiotics and oxygen in hospital. His condition improved and, on 10 June, discussions between the hospital and healthcare staff about his discharge back to the prison were started. His health deteriorated overnight, however, and Mr Roberts died at 5.00am the following day.

Findings

7. We are satisfied that Mr Roberts was well cared for at Bedford and that his care was equivalent to that he could have expected to receive in the community.

8. However, we are concerned at the lack of use of the NEWS2 scoring system which enables health professionals to monitor the deterioration in a patient's heath. Although this did not affect the outcome for Mr Roberts, it could make a difference in other cases.

9. We consider that a member of healthcare staff should have been present at Mr Roberts' ACCT reviews, particularly given his mental health concerns.

10. We are concerned that although Mr Roberts was acutely unwell, elderly and had poor mobility, he was restrained when taken to hospital.

11. Staff were not given the opportunity to attend a hot debrief when Mr Roberts died and were therefore not offered appropriate avenues for support.

Recommendations

- The Head of Healthcare should ensure the use of the NEWS2 score to monitor any deterioration in an unwell patient.
- The Governor and Head of Healthcare should ensure that healthcare staff participate in ACCT reviews, particularly in the case of prisoners with mental or physical healthcare needs.
- The Governor and Head of Healthcare should ensure that:
    - all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints;
    - healthcare staff contribute to risk assessments by providing information about the prisoner's current state of health; and
    - assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody and that all those involved in the incident, including healthcare staff, are invited to attend.

The Investigation Process

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

13. The investigator obtained copies of relevant extracts from Mr Roberts' prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Roberts clinical care at the prison.

15. We informed HM Coroner for central Bedfordshire of the investigation. The coroner informed us of the cause of death. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Roberts' daughter to explain the investigation and to ask whether she had any matters the family wanted the investigation to consider. She did not raise any issues.

17. Mr Roberts' family received a copy of the draft report. They did not make any comments.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out no factual inaccuracies.

Background Information

HMP Bedford

19. HMP Bedford is a local prison holding about 500 men. Northants Healthcare NHS Foundation Trust provide all healthcare services. There is an inpatient unit with nine cells and a four-bed dormitory.

HM Inspectorate of Prisons

20. The most recent full inspection of HMP Bedford was carried out in September 2018. Inspectors found that access to health services was good. Clinical rooms in the health centre were clean and well equipped. The waiting area was bright and welcoming, with plenty of health information on display. Wing treatment rooms were clean, and regular infection control audits were undertaken.

21. There had been five self-inflicted deaths since the previous inspection, the most recent taking place a year earlier. Inspectors found that progress against some PPO recommendations was too slow and some actions had not been completed. The number of incidents of self-harm had increased substantially since the previous inspection and was higher than the average in similar establishments. ACCT case management processes for prisoners at risk of suicide or self-harm were weak. Initial assessments were mostly adequate, but some care maps were missing or failed to address the issues of concern to prisoners.

22. Following the inspection, the Chief Inspector invoked the Urgent Notification process and wrote to the Secretary of State expressing concern about a continual and unchecked deterioration in standards at Bedford over the previous nine years.

23. HMIP carried out an independent review of progress in August 2019. In relation to ACCT, inspectors reported that there remained fundamental weaknesses in the completion of ACCT case management for prisoners at risk of suicide or self-harm. In particular, care maps were not always used effectively to deliver the right support. There were not enough ACCT assessors or case managers, and there was no local ACCT quality assurance process. There was also no system for ensuring multidisciplinary attendance at case reviews.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 30 June 2018, the IMB reported a good standard of healthcare, with waiting times for medical appointments comparing favourably with those expected within the community. Healthcare also scored positively from prisoner feedback. The Board did raise concerns, however, that a high percentage of medical appointments were not being attended by prisoners.

Previous deaths at HMP Bedford

25. Mr Roberts was the fourth prisoner to die at Bedford since 2017. Two of these cases were self-inflicted deaths and one from natural causes. We made a

previous recommendation about the inappropriate use of restraints and about staff support.

Key Events

26. On 25 April 2018, Mr Ronald Roberts received an eighteen-year custodial sentence for manslaughter. He pleaded guilty on the grounds of diminished responsibility. He was sent to HMP Swaleside, before being admitted to St Andrews medium secure psychiatric unit. He was transferred to HMP Bedford on 13 April 2016.

27. Mr Roberts had several health issues, including paranoid schizophrenia, COPD, heart disease, a pacemaker, an abdominal aortic aneurysm (thinning and ballooning of the main artery), osteoarthritis, urinary incontinence and irritable bowel syndrome/diverticulitis (bowel disease) which required a stoma bag. He also had a history of self-harm.

28. On 9 May, Mr Roberts made deliberate cuts to his arms due to depression and frustration at not being moved to a category C prison. An ACCT was opened. This was closed on 21 May, when staff considered that his risk of self-harm had reduced. There was no member of healthcare staff at the ACCT review where this was decided.

29. Mr Roberts was a frail and generally unwell man. He could be challenging at times and often refused to take prescribed medications (including his antipsychotic medication) or to attend medical appointments. Between October 2018 and April 2019, prison healthcare staff treated Mr Roberts for shortness of breath, cellulitis and a leg infection. He was given advice about pressure sores, which he often ignored.

Events of 23 – 24 May

30. On 23 May, at 5.14pm, Mr Roberts asked to go to bed as he was cold and chesty and showing signs of a fever. He was seen in his cell as an emergency by a prison GP. Mr Roberts was treated for a chest infection and the GP asked healthcare staff to monitor Mr Roberts and to send him to hospital if his temperature increased to over 38ºC.

31. Mr Roberts was monitored overnight, but his respiratory rate was not recorded and there was no record of a NEWS 2 score.

32. At 11.00pm, Mr Roberts' hygiene needs were met, and he was made comfortable in bed. At 1.30am, he was observed sitting on the bed. A nurse asked Mr Roberts whether he wanted assistance to get into bed, but he declined. At 3.25am, Mr Roberts shouted that he had fallen out of bed. He was found lying on the floor, complaining that he was cold. He was covered with blankets but refused to have his vital signs checked. An ambulance was called, but as a response time of five hours was given, a nurse arranged for the mattress to be placed on the floor and Mr Roberts was made comfortable on that. Paramedics arrived ten minutes later, however, and gave Mr Roberts a nebuliser. His vital signs began to deteriorate, and he was transferred to hospital at 5.00am.

33. Mr Roberts was admitted to hospital and treated for an infection with intravenous antibiotics and oxygen. Prison healthcare staff were in regular contact with the hospital to obtain updates. On 6 June, the hospital diagnosed Mr Roberts as

having a blood clot on his lung. On 10 June, prison nurse manager spoke to the ward nurse, who said that Mr Roberts had received physiotherapy and was able to sit in his chair. She said that he was ready to be discharged, although he would need to be accompanied with oxygen. The prison nurse manager said that she would need to speak with prison security to make them aware, and that she would make arrangements for Mr Roberts' discharge.

34. Mr Roberts' health deteriorated overnight, however, and he died on 11 June.

Cause of death

35. The hospital concluded that Mr Roberts died of: 1a) myocardial infarction; 1b) ischaemic heart disease; 2) current pulmonary embolism, chronic obstructive pulmonary disease, abdominal aortic aneurysm. (A heart attack caused by a narrowing of the arteries, with underlying conditions of a blood clot in the lung, lung disease, and thinning and ballooning of the main artery from the heart.)

Contact with Mr Roberts' family

36. On 5 June, the prison appointed a family liaison officer (FLO). The FLO had trouble locating the correct details for Mr Roberts' next of kin. These were not located until 7 June. He then contacted Mr Roberts' daughter to inform her that Mr Roberts was in hospital. Mr Roberts' daughter told him that she did not want to visit her father but wanted to be informed when he died. The FLO contacted Mr Roberts' daughter on 11 June to break the news of her father's death and to offer condolences.

37. The FLO kept the family up to date with funeral arrangements, but the family made the decision not to attend. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

38. The prison did not hold a hot debrief after Mr Roberts death, and staff were not given the opportunity to discuss the incident or discuss any issues arising, or for managers to offer support.

39. The prison posted notices informing staff and prisoners of Mr Robert's death, and offering support.

Findings

Clinical care

40. Mr Roberts had several complex physical and mental health conditions which healthcare staff managed well. The clinical reviewer found that, at times, Mr Roberts presented healthcare staff with some difficult challenges in his decisions to ignore their advice on how to keep himself safe and reduce his risk of ill health. This was particularly the case in relation to his risk of pressure damage and falls.

41. The clinical reviewer concluded, and we agree, that the clinical care extended to Mr Roberts was of a reasonable standard and at least equivalent to that which he would have received in the wider community.

42. The clinical reviewer said, however, that there were also areas for improvement, including the lack of use of the NEWS2 scoring framework to inform decisions about the deteriorating health of a patient, and the absence of healthcare staff at ACCT review meetings. While neither issue appears to have had a negative impact on Mr Roberts' health, they reflect variance with accepted community and hospital healthcare and prison practice.

43. As far as the ACCT review is concerned, Mr Roberts had complex mental health issues, and we agree that these should have been taken into account in the decisions taken about his management under ACCT.

44. We make the following recommendations:

    The Head of Healthcare should ensure the use of the NEWS2 score to monitor any deterioration in an unwell patient.

    The Governor and Head of Healthcare should ensure that healthcare staff participate in ACCT reviews, particularly in the case of prisoners with mental or physical healthcare needs.

Use of restraints

45. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

46. A judgment in the High Court in 2007, made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgement indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

47. When Mr Roberts was taken to hospital on 24 May, he was restrained with an escort chain and escorted by two officers. When he arrived at hospital, single

cuffs were applied. Restraints were removed for treatment but then reapplied. The restraints were removed at 8.00am the following morning and subsequently remained off.

48. There was no medical objection to the use of restraints despite Mr Roberts being acutely unwell and having poor mobility. Mr Roberts was deemed a high risk to females but having a low risk of escape. Given his age (86) and his poor health and mobility, we consider that the use of restraints was inappropriate. There is no evidence on the risk assessment form that staff took Mr Roberts' current state of health into account in assessing his risk, and nothing to explain why restraints were considered proportionate to the risk he posed, especially as he was escorted by two officers.

49. Although we acknowledge that Mr Roberts' restraints were removed after his health deteriorated, we have previously expressed concerns about the inappropriate use of restraints on very sick and elderly prisoners by HMP Bedford. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints;**
- **healthcare staff contribute to risk assessments by providing information about the prisoner's current state of health; and**
- **assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

Staff support

50. PSI 64/2011 sets out the actions that should be taken following a death in custody. This includes holding a hot debrief immediately after a death in custody and inviting all staff directly involved in the incident, including healthcare staff, to attend.

51. No debrief took place. We are concerned that the staff involved were given no opportunity to discuss any concerns that arose and were not offered support services. We make the following recommendation:

The Governor should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody and that all those involved in the incident, including healthcare staff, are invited to attend.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141