Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ajay Robertson, a prisoner at HMP Hull, on 27 September 2019

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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 Ajay Robertson died in hospital on 27 September, the day after he was found hanging in his cell at HMP Hull. He was 20 years old. I offer my condolences to Mr Robertson's family and friends.

Mr Robertson had been at Hull for less than four days when he hanged himself. Reception staff failed to identify that he had a number of risk factors for suicide and self-harm, including a history of depression. As a result, staff did not consider whether he should be managed under suicide and self-harm prevention procedures (known as ACCT).

Healthcare staff appropriately referred Mr Robertson to the mental health team but I am concerned he was discharged without an assessment.

I am concerned that when Mr Robertson was found hanging, staff did not immediately call a medical emergency code and did not immediately consider entering his cell. This caused an unnecessary delay in Mr Robertson receiving emergency medical treatment.

It is disappointing that we have once again identified deficiencies in the use of medical emergency codes at Hull, and the Prison Group Director for Yorkshire will need to address this issue urgently.

I am also concerned that staff monitored Mr Robertson under ACCT procedures while he was on life support in hospital. This served no useful purpose at all and caused additional and unnecessary distress to his family.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **June 2020**

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Summary

Events

1. In March 2019, Mr Ajay Robertson was sentenced to 14 months in prison for burglary and sent to HMP Hull. He was released on Home Detention Curfew from HMYOI Deerbolt on 4 July.

2. On 23 September, he was recalled and sent to Hull, charged with assaulting his partner and her parents.

3. An officer assessed Mr Robertson's needs in Reception. He recorded that Mr Robertson did not report any thoughts of suicide or self-harm, but he did not identify that Mr Robertson had a number of risk factors. At his initial health screen, a nurse recorded that Mr Robertson was prescribed medication but did not specify what medication he took. She noted that Mr Robertson said that he had depression and referred him to the mental health team.

4. On 24 September, while on the induction wing, Mr Robertson made two phone calls to his partner using another prisoner's pin number. (He had not been issued with a pin number as he had an active restraining order.) At 11.40am, a prison pharmacist noted that he had been prescribed an antidepressant in July. A mental health practitioner discharged Mr Robertson from the mental health team without seeing him.

5. On 26 September, Mr Robertson was moved to a standard wing and prisoners who knew him told us that he seemed 'normal' and did not seem to be in distress. Mr Robertson tried unsuccessfully to contact his partner and mother several times that day, with the last attempt to his mother at 7.27pm.

6. At 8.09pm, an operational support grade looked through Mr Robertson's cell door observation panel to conduct a roll check and saw him at the back of his cell, with his head covered by a sheet and unresponsive. He left to find an officer and returned with one 50 seconds later. A general alarm was raised at 8.11pm and a custodial manager (CM) arrived with two officers at 8.12pm. The CM told us that he looked through the observation panel, saw Mr Robertson hanging, called a medical emergency code blue and entered the cell. An officer cut a ligature from around Mr Robertson's neck and the CM started cardiopulmonary resuscitation (CPR). In the meantime, control room staff called an ambulance and transferred the call to wing staff.

7. At 8.15pm, several nurses arrived to assist. Ambulance paramedics arrived at the cell at 8.25pm. At 8.39pm, they noted that Mr Robertson had a faint pulse. At 8.45pm, an officer started suicide and self-harm prevention procedures (known as ACCT). Paramedics took Mr Robertson to hospital at 9.09pm, unrestrained.

8. At 9.25am on 27 September, an officer recorded that hospital staff planned to withdraw Mr Robertson's life support equipment. At 10.35am, a prison manager authorised staff to reduce the frequency of Mr Robertson's ACCT observations from every 15 minutes to one an hour, as they were causing his family distress. An hour later, the manager authorised staff to stop all ACCT observations.

9. At 3.50pm, Mr Robertson died. His family were with him.

Findings

10. A reception officer failed to consider the information contained in Mr Robertson's warrant and identify his risk factors. We are concerned that staff missed an opportunity to explore his risk of suicide and self-harm in more detail and to consider whether he should be monitored and supported under ACCT procedures.

11. The clinical reviewer considered that most of the care that Mr Robertson received at Hull was equivalent to that which he could have expected to receive in the community. However, healthcare staff did not maintain accurate records or conduct a mental health assessment.

12. Staff did not immediately call a medical emergency code or enter the cell when Mr Robertson was found hanging. This caused a delay of three minutes. Control room staff transferred the ambulance service operator to the wing before confirming that an ambulance was required, causing a further one-minute delay. We have previously identified deficiencies in the use of medical emergency codes at Hull. Urgent action is needed to address the issue.

13. We are concerned that prison staff conducted ACCT observations while Mr Robertson was on life support with no chance of recovery, causing his family additional and unnecessary distress.

14. We consider it is important that staff learn from the concerns identified in this report.

Recommendations

- The Governor should ensure that, when assessing a prisoner's risk of suicide and self-harm, prison staff:
  - consider all relevant documentation and information; and
  - understand that they need to identify and consider a prisoner's risk factors and not just rely on how he behaves or what he says.
- The Operational Manager for Offender Health should ensure that:
  - healthcare staff accurately record information about prisoners' ongoing care in their medical record; and
  - mental health triage processes are monitored and reviewed frequently.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff:
  - promptly use an emergency code to communicate the nature of the emergency;
  - enter cells as quickly as possible in life-threatening situations; and
  - provide information about a prisoner's condition to the control room so that they have this information when requesting an ambulance.

- The Prison Group Director for Yorkshire should write personally to the Ombudsman setting out what he is doing to satisfy himself that meaningful action is being taken to improve the response to medical emergencies at Hull.
- The Governor should ensure that staff do not conduct ACCT observations for prisoners who are unconscious and on life support in hospital.
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with the staff concerned and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

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

16. The investigator visited Hull on 2 October 2019. He obtained copies of relevant extracts from Mr Robertson's prison and medical records and interviewed three prisoners.

17. The investigator interviewed eight members of staff at Hull on 19 November and five on 20 November.

18. NHS England commissioned a clinical reviewer to review Mr Robertson's clinical care at the prison. She jointly interviewed 12 members of staff with the investigator on 19 and 20 November.

19. We informed HM Coroner for East Riding and Kingston-Upon-Hull of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

20. One of the Ombudsman's family liaison officers contacted Mr Robertson's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Robertson's mother wanted to know

    - why nobody contacted her when Mr Robertson was taken to hospital;
    - whether staff knew that his father died at HMP Hull in 2005 and that 26 September was his father's birthday;
    - whether staff completed a suicide and self-harm assessment;
    - why hospital escort officers had to keep checking on Mr Robertson; and
    - why a letter addressed to Mr Robertson from the prison's mental health team was sent to her after he had died?

    We have addressed these points in this report and in separate correspondence.

21. Mr Robertson's mother received a copy of the initial report. The solicitor representing Mr Robertson's mother wrote to us pointing out some factual inaccuracies. The report has been amended accordingly.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Hull

23. HMP Hull is a local prison which holds up to 1,056 men in ten wings. City Healthcare Partnership provides health services at the prison. GP surgeries are held four days a week, with an out-of-hours' service at other times.

24. In August 2018, Hull was selected to be part of the "10 Prisons Project" which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering prisons and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Hull was in April 2018. Since their last inspection in 2014, inspectors found an increase in prisoners taking their own lives and incidents of self-harm. Although they acknowledged that the prison was working hard to tackle this, inspectors were concerned about the quality of casework for those in crisis and felt there was a greater need to offer support to vulnerable prisoners. Despite an increase in violence, inspectors noted that most prisoners felt safe, respected and knew of someone they could turn to for help. Inspectors found strong leadership and a positive staff culture which helped to maintain reasonably good outcomes for prisoners during challenging times.

Independent Monitoring Board

26. 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 ending 28 February 2018, the IMB noted that prisoners were treated fairly and humanely and every effort was made to prepare them for release. The IMB noted that officers were preparing for a 'key worker' scheme to improve their knowledge of individual prisoners and how to interact with them.

Previous deaths at HMP Hull

27. Mr Robertson was the sixteenth prisoner to die at Hull and the fourth to take his life since September 2016. There have been two deaths since, one self-inflicted and one unclassified. We have previously made recommendations about the use of medical emergency codes and the quality of medical record keeping which Hull agreed to implement.

Key Events

28. On 19 March 2019, Mr Ajay Robertson was sentenced to 14 months in prison for burglary and sent to HMP Hull. He was moved to HMYOI Deerbolt on 3 April. Prison records show that Mr Robertson did not have any significant mental health problems and did not disclose any thoughts of suicide or self-harm.

29. On 4 July, Mr Robertson was released from Deerbolt on Home Detention Curfew (HDC – a scheme that allows prisoners to be released early to a suitable address with an electronic tag). Probation records show that he initially lived at his partner's parents' address before moving to his grandmother's address.

30. On 23 September, Mr Robertson appeared in court, charged with assaulting his partner and her parents. He was remanded for the new offences and recalled to HMP Hull for breaching his HDC. In the vulnerability section of his recall notification, it states, 'subject has fragile mental health – possibly awaiting assessment. Previous suicide attempts'.

31. At 5.04pm, Mr Robertson arrived at HMP Hull. An officer assessed his immediate needs and noted that Mr Robertson did not report any thoughts of suicide or self harm. However, the officer failed to identify several potential indicators of increased risk, including that Mr Robertson had a history of self-harm and had been recalled to prison for violent offences against his partner. A Custodial Manager (CM) reviewed Mr Robertson's cell sharing risk assessment and authorised a single cell as he had been charged with arson in 2016.

32. At 7.08pm, a nurse completed an initial health screen and noted that Mr Robertson had said that he was prescribed medication. She did not specify what medication he took. Mr Robertson told her that he had depression and asked to be referred to the mental health team. She requested a mental health review and obtained his consent to request his community medical records. She also noted that although Mr Robertson did not report any current thoughts of suicide or self-harm, he said that he had harmed himself in the past.

33. At 7.47pm, an officer completed Mr Robertson's first night induction. She explained that he could speak to the Samaritans for support and recorded that he said he did not feel like harming himself. She gave him a vape pack (a supply of electronic cigarettes) but did not give him a telephone pin number as he had a restraining order in place. This meant that his contact telephone numbers needed to be checked to confirm that he was allowed to ring them.

34. At 9.30am, on 24 September, a healthcare administrator wrote to Mr Robertson's community GP to ask for his medical record. At 11.03am, a nurse conducted a secondary health screen. He recorded that Mr Robertson reported a history of depression and said that he wanted to complete an anger management course. He told us that he did not action the request as Mr Robertson was being referred to the mental health team.

35. At 11.13am, while on the prison's induction wing, Mr Robertson made an eight-minute phone call to his partner using another prisoner's pin number. (Prison records indicate that he traded vapes for pin numbers.) The investigator listened to

this call. Mr Robertson told his partner that she was his only family and asked her to urge her father not to go to court. His partner told him that she did not want to be with him anymore and he said that he should have addressed his anger issues. She then put the phone down. At 11.28am, Mr Robertson made a very brief phone call to his partner. He told her that her parents had been filmed hitting him and that social services would remove their baby.

36. At 11.40am, a pharmacist reviewed Mr Robertson's summary care record (an electronic record of important patient information created from GP records that healthcare staff can access through an NHS web portal) to carry out medication reconciliation (a process where medications that a person should be prescribed are matched against those that are prescribed). He found that on 31 July, Mr Robertson had been prescribed a 14-day supply of sertraline (an antidepressant) in the community and recorded, 'mental health admin tasked to review him'.

37. At 4.34pm, a mental health practitioner made an entry in Mr Robertson's prison medical record, stating that he had been sent a stress pack and had been discharged from the mental health team due to limited information. However, there is no record that she had conducted an assessment or reviewed Mr Robertson.

38. At 8.36am on 25 September, Mr Robertson made a four-minute phone call to his partner. He told her that he had a lot of respect for her father and that he loved her. He asked if she had spoken to her father about going to court and she said no. Mr Robertson said that he was never going to have another girl like her and ended the call.

39. At 10.52am, Mr Robertson called his partner and asked if she would like to visit him. She said no, and told him that someone had 'potted' (smashed) his mum's windows. Mr Robertson said that if he could not be with her, he could not be without her, and put the phone down. At 11.01am, he left a voicemail message for his mother to say that he was going to find out who had done it and skin them alive.

Events from Wednesday 26 to Thursday 27 September

40. At 10.08am on 26 September, an officer noted that Mr Robertson had had an altercation with another prisoner and that staff had diffused the situation. At 11.44am, another officer noted that another prisoner had assaulted Mr Robertson. A prisoner who was present at the time of the incident told the investigator that Mr Robertson was 'winding the kid up as he had had problems with him in the past'. He said that Mr Robertson was not being bullied and that he did not respond because he wanted to avoid losing any privileges.

41. At 12.02pm, a nurse recorded that he gave Mr Robertson paracetamol. He said that Mr Robertson attended the medication hatch, asked for pain relief and appeared normal. Later that afternoon, Mr Robertson moved to a single cell on D wing (normal location). He spoke to several prisoners who told the us that he did not say anything to cause them concern. One of the prisoners told us that he spoke to Mr Robertson in the showers and that he said he was going to be "out" in a couple of days as he was on recall.

42. Prison pin phone records show that throughout the day, Mr Robertson tried to call his partner 12 times and his mother four times, the last time at 7.27pm. However,

the calls did not connect as the numbers were on his 'not allowed' list. At 7.08pm, CCTV footage shows that an officer locked Mr Robertson's cell door. (CCTV footage was four minutes slow and we have adjusted the timings in this report accordingly.)

43. At 8.09pm, an Operational Support Grade (OSG) looked through Mr Robertson's cell observation panel to conduct a roll check. He saw Mr Robertson at the back of the cell with a sheet over his head and tried unsuccessfully to get a response from him. He ran to the office to alert an officer and they arrived back at the cell 50 seconds later. The officer looked through the observation panel and saw Mr Robertson hanging with a sheet over his head. The control room log shows that a general alarm was raised at 8.11pm.

44. At 8.12pm, a CM and two officers arrived. The CM told us that he looked through the cell observation panel, saw Mr Robertson hanging, called a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing problems) and entered the cell. An officer cut the ligature that was attached to the window bars and helped lower Mr Robertson onto the floor. The CM started cardiopulmonary resuscitation (CPR) and applied a defibrillator, which advised not to shock. In the meantime, control room staff called an ambulance and transferred the call to an officer on the wing.

45. At 8.15pm, healthcare staff entered Mr Robertson's cell and assisted prison staff with the resuscitation efforts. The control room log says that an ambulance arrived at the prison at 8.23pm and the ambulance log shows the first paramedic reached Mr Robertson's cell at 8.25pm. Paramedics provided emergency care and confirmed that Mr Robertson had a faint pulse at 8.43pm.

46. At 8.45pm, an officer started suicide and self-harm prevention procedures, known as ACCT. At 9.09pm, paramedics took Mr Robertson to hospital. Two officers went with him and did not use restraints. Hospital staff admitted Mr Robertson to the Intensive Care Unit and conducted a computerised tomography (CT) scan. ACCT records show that escort officers conducted four ACCT observations an hour and that Mr Robertson remained on life support.

47. At 5.15am on 27 September, a hospital doctor told one of the escort officers that Mr Robertson would not recover from his condition and that they would not attempt resuscitation if his heart or breathing stopped. At 9.25am, another officer recorded that hospital staff planned to withdraw Mr Robertson's life support equipment once additional family members had arrived. Mr Robertson died at 3.50pm, with his family present.

Contact with Mr Robertson's family

48. At 9.00pm, on 26 September, a prison manager tried to phone Mr Robertson's partner, his named next of kin, to tell her that he had been taken to hospital, but there was no answer. At 9.05pm, he contacted the police and asked if they could visit Mr Robertson's grandmother to tell her what had happened. At 9.20pm, the manager appointed an officer as the family liaison officer (FLO) and updated her about the situation. ACCT records show that Mr Robertson's mother arrived at the hospital at 11.30pm.

49. At 8.35am on 27 September, an escort officer contacted a CM and told him that hospital staff had moved Mr Robertson's family into the adjacent room. The CM suggested that the officers move to another room but continue with ACCT observations. At 10.35am, the escort officer contacted the CM to ask if the number of ACCT observations could be reduced as the checks were causing Mr Robertson's family distress. The CM liaised with a prison manager, who authorised staff to reduce the ACCT observations to one an hour.

50. At 11.05am, the FLO and a SO arrived at the hospital. She introduced herself to Mr Robertson's family and explained the FLO role. A family member asked why two officers had to be there when they were just waiting to turn Mr Robertson's life support off. She explained that this was the procedure. At 11.35pm, she obtained authorisation from a prison manager to stop all ACCT checks.

51. At 3.35pm, Mr Robertson's mother told the FLO that hospital staff were about to remove his life support equipment. Shortly afterwards, Mr Robertson's mother went into the waiting room and asked prison staff if they could leave as the family wanted the room. Prison staff waited on the ward but Mr Robertson's family continued to find their presence upsetting. The FLO contacted a prison manager and arranged for all officers other than herself to leave the ward. After Mr Robertson died, she spoke to his mother and provided her with her contact details.

52. At 9.45pm on 30 September**,** the FLO received a telephone call from Mr Robertson's mother asking them to visit her. At 11.00am, the FLO and an officer arrived at Mr Robertson's mother's address and explained the next steps. She continued to offer support to Mr Robertson's mother until his funeral, which took place on 15 October. The prison contributed towards its cost in line with national instructions.

Support for prisoners and staff

53. On 26 September, a prison manager debriefed staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. After Mr Robertson died, a prison manager debriefed the staff present at the hospital.

54. The prison posted notices informing other 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

55. The post-mortem report concluded that Mr Robertson died of multiple organ failure following a cardiac arrest that was caused by hanging. It found that although Mr Robertson had been resuscitated, his organs had been deprived of oxygen for a prolonged period and had developed extensive and irreversible damage. Toxicology results identified therapeutic levels of paracetamol. No illicit substances were identified in his system.

Events after Mr Robertson's death

56. Mr Robertson left a letter to his partner, in which he said that he was crying in his cell all day. He also said, 'I moved onto another wing today, the way that I plan on going out meant I needed to change wing, but I do not need to go into that right now'.

Findings

Identifying risk of suicide and self-harm

57. Prison Service Instruction (PSI) 07/2015 on early days in custody says that all prisoners should be assessed for the risk of harm to themselves, to others and from others and that prisoners assessed as at risk of suicide and self-harm should be supported. It says that the person escort record (PER) and any other available documentation must be examined in reception to assess a prisoner's risk of self-harm, harm to others and harm from others.

58. Mr Robertson arrived at Hull on 23 September with a warrant which contained information about his vulnerability. There is no evidence that the officer reviewed it. He told the investigator that the documentation with which Mr Robertson arrived did not indicate a risk of suicide or self-harm. We therefore consider it likely that the officer missed this potentially crucial piece of information.

59. The officer also failed to identify Mr Robertson's risk factors when completing his immediate needs' assessment: Mr Robertson had been recalled to prison, was charged with violent offences against his partner and was restricted from contacting his mother. While we recognise that reception can be a busy environment, it is critical that staff obtain as much information as possible so that any risk factors can be identified and explored and staff can consider whether ACCT monitoring is necessary.

60. We recognise that no-one who met Mr Robertson in the days before his death considered that he was at increased risk, and staff and prisoners described his death as unexpected. There is no indication that staff knew Mr Robertson's father had died at Hull 15 years previously or that his father's birthday was on 26 September. However, we would not expect them to have known unless Mr Robertson told them. There is no evidence that staff saw Mr Robertson crying and the prisoners, who spoke to him in the hours before he was found unresponsive, said that he appeared normal and did not seem to be in distress.

61. However, as we have said repeatedly, when assessing a prisoner's risk of suicide and self-harm, it is important that staff do not focus solely on how a prisoner presents or what he says, and that they also consider his risk factors. We are concerned that staff failed to identify indicators of his increased risk of suicide and self-harm and to explore these further and consider whether he needed the support of an ACCT. We make the following recommendation:

The Governor should ensure that, when assessing a prisoner's risk of suicide and self-harm, prison staff:

- **consider all relevant documentation and information; and**
- **understand that they need to identify and consider a prisoner's risk factors and do not just rely on how he behaves or what he says.**

Clinical care

62. The clinical reviewer considered that most of the clinical care that Mr Robertson received at Hull was of a reasonable standard and equivalent to that which he could have expected to receive in the community. Healthcare staff conducted appropriate health screens, requested his community medical record and referred him to the mental health team. There were, however, two aspects of Mr Robertson's care that fell short of expectations.

63. Healthcare staff failed to record the name of the medication that Mr Robertson said that he had been prescribed at his initial health screen, and they also discharged him from the mental health team without fully documenting the process in which the decision was made. The clinical reviewer considered that healthcare staff should maintain accurate medical records in line with the Nursing and Midwifery Council's Code of Conduct 2018 to ensure continuity of care.

64. The Operational Manager for Offender Health told us that a nurse conducted a mental health triage assessment and decided that due to limited information, self-directed care would be most appropriate. However, the clinical reviewer considered that staff should have conducted an initial mental health assessment as Mr Robertson had a history of depression and had recently been prescribed antidepressants. This information was available to healthcare staff and we therefore consider that a more through triage process is like to have resulted in an initial assessment.

65. The Operational Manager told us that the mental health triage process had been reviewed in line with National Institute for Clinical Excellence (NICE) guidelines and now ensures that healthcare staff base their assessment on historical, and not just current, information. Although we are satisfied that this action is appropriate, healthcare staff must use the form to ensure that it is effective.

66. While we cannot be certain whether more accurate record keeping and an initial mental health assessment would have changed the outcome for Mr Robertson, in other circumstances, it could be critical. We therefore make the following recommendation:

The Operational Manager for Offender Health should ensure that:

- **healthcare staff accurately record information and decisions about prisoners' care and treatment in their medical record; and**
- **mental health triage processes are monitored and reviewed frequently.**

Emergency Response

67. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two-code medical emergency response system. Hull's local policy instructs staff to use a medical code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and a code red when a prisoner is bleeding or has severe burn injuries. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for all healthcare staff to attend with the appropriate equipment.

68. PSI 24/2011, *Management and Security of Nights*, states that staff have a duty of care to prisoners, to themselves, and to other staff, and that preservation of life must take precedence over usual arrangements for opening cells. It says that where there is or appears to be immediate danger to life then a single member of staff can enter the cell alone, after performing a rapid dynamic risk assessment.

69. The OSG did not call a medical emergency code when he found Mr Robertson unresponsive, causing a delay of around three minutes before the code was called. He told the investigator that he decided to get an officer as Mr Robertson was covered up and he could not see him clearly. Although an officer and the CM both said they could see Mr Robertson hanging, it is possible the OSG did not notice this. However, regardless, we consider that he should have called a code blue when Mr Robertson failed to respond.

70. The control room log shows that a general alarm was raised at 8.11pm, followed by a code blue at 8.12pm. The OSG told us that he raised a general alarm and issued a code blue shortly afterwards. However, the officer and CM told us that they could not remember hearing a code blue prior to arriving at the cell. Irrespective of who called the code, we are concerned that there was a total delay of around three minutes before the control room knew to call an ambulance and healthcare staff were alerted. In a medical emergency every minute may be critical. We cannot say if the eventual outcome would have been different for Mr Robertson but, if the OSG had called the code blue when he first found Mr Robertson unresponsive, healthcare staff and paramedics would have arrived at the scene more quickly.

71. The OSG and officer waited outside until additional staff arrived and did not enter Mr Robertson's cell. At interview, the OSG told the us that he did not enter because he was not trained in control and restraint, and the officer said he panicked as he had not seen anything like that before.

72. We do not say that the OSG should have entered the cell on his own when he found Mr Robertson unresponsive. We accept that if he could not see that Mr Robertson was hanging, he may have considered it would be unsafe for him to enter on his own. However, the officer could see that Mr Robertson was hanging and was accompanied by the OSG. While we appreciate the distress of seeing a prisoner in such circumstances and that officers must have regard for their own safety when considering whether to enter a cell, we are concerned that they did not enter Mr Robertson's cell given the potential risk to life.

73. Following the code blue, a member of control room staff called the ambulance service and transferred the call to wing without providing the operator with any information. The officer who answered the call took over a minute to 1 minute to confirm that an ambulance was required as he was not in the immediate vicinity of Mr Robertson's cell and incorrectly told the operator that he believed Mr Robertson was breathing. Although we are satisfied that control room staff called an ambulance immediately, we consider that staff at the scene could have prevented a delay by providing control room staff with basic information, such as whether Mr Robertson was breathing, in the first instance.

74. We cannot say if these delays may have changed the outcome for Mr Robertson. We therefore 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:

- **promptly use an emergency code to communicate the nature of the emergency;**
- **enter cells as quickly as possible in life-threatening situations; and**
- **provide information about a prisoner's condition to the control room so that they have this information when requesting an ambulance.**

75. We have previously made recommendations to address Hull's failure to ensure that all staff are aware of the correct medical emergency codes and know when to use them. In response to an investigation in October 2018, Hull told us that they had issued a Governor's order on the correct use of medical emergency codes and planned to deliver training for staff working in high risk areas. In response to another investigation in June 2019, Hull said they would continue to issue a Governor's order annually and arrange a briefing on the use of medical emergency codes aimed particularly at staff working in high risk areas.

76. However, we are concerned that Mr Robertson's case shows that failures to call medical emergency codes promptly have continued and that the prison's response to our previous recommendations does not appear to have been effective. We therefore consider that urgent action is now required to ensure the correct use of medical emergency codes. We make the following recommendation:

The Prison Group Director for Yorkshire should write personally to the Ombudsman setting out what he is doing to satisfy himself that meaningful action is being taken to improve the use of medical emergency codes at Hull.

Contact with Mr Robertson's family

77. We are satisfied that, overall, there was appropriate contact and liaison with Mr Robertson's family. However, we are concerned that prison staff conducted ACCT observations while Mr Robertson was unconscious and on life support in hospital.

78. A prison manager told us that as the priority was getting Mr Robertson to hospital, a decision about the frequency of his observations was not made and escort officers did what they thought was suitable. However, the question is not how frequently ACCT observations should have taken place, but why it was thought necessary to carry out ACCT observations at all.

79. ACCT observations are designed to provide support to a suicidal prisoner and to reduce his risk of suicide or self-harm. As Mr Robertson was unconscious and on life support, it is very difficult to understand why prison staff thought ACCT observations were necessary at all. We note that they were conducted four times an hour for the first 12 hours Mr Robertson was in hospital, and that a prison manager authorised them to continue, albeit at a reduced level, even after hospital staff told prison staff that Mr Robertson was not going to recover and that they were planning to switch his life support off. This suggests a fundamental misunderstanding of the point of the ACCT procedures.

80. We do not consider that conducting observations on an unconscious prisoner with little to no chance of recovery is appropriate. By conducting observations, staff caused Mr Robertson's family unnecessary distress at what was already a distressing time. We make the following recommendation:

The Governor should ensure that staff do not conduct ACCT observations for prisoners who are unconscious and on life support in hospital.

Learning Lessons

81. We have identified a number of concerns in this report. We consider it is important that staff learn from our findings. We recommend the following:

The Governor and Head of Healthcare should ensure that a copy of this report is shared with the staff concerned and that a senior manager discusses the Ombudsman's findings with them.

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