Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ashley Roberts, a prisoner at HMP Bristol, on 1 May 2020

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 l 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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 Ashley Roberts died in hospital on 1 May 2020 after having been found hanging in his cell on 20 April at HMP Bristol. He was 22 years old. We offer our condolences to Mr Roberts' family and friends.

Mr Roberts was a vulnerable young man who suffered from personality disorders and had autistic traits, as well as a history of self-harm and suicide attempts. During the 11 weeks he spent at Bristol, Mr Roberts self-harmed very frequently and was subject throughout to suicide and self-harm prevention procedures (known as ACCT). His self-harming behaviour meant that managing him safely was very challenging and we found much to commend about the way the ACCT procedures were managed. However, I am concerned that Mr Roberts' risk to himself was not always adequately assessed or recorded, including on the day he hanged himself.

One of Mr Roberts' key concerns was his wish to transfer to a prison nearer his mother (his only source of support) and I am concerned that the reasons why this did not happen were not properly documented or clearly explained to Mr Roberts.

I am also concerned that Mr Roberts was not assessed by healthcare staff following a restraint where he alleged he had been assaulted by staff, nor was a body worn camera used to record the incident as it should have been.

Mr Roberts' clinical care was largely equivalent to that he would have received in the community. He had appropriate support from the mental health team and neurodevelopmental service, although the clinical reviewer found that staff should have formally reviewed his antidepressant medication when he refused to take it.

However, as Mr Roberts' self-harm escalated over time, we consider it would have been prudent for healthcare staff to have asked the prison psychiatrist to review him and consider whether he should be referred for transfer to a secure psychiatric facility.

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 **May 2021**

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Summary

Events

1. On 16 January 2020, Mr Ashley Roberts was arrested and remanded in custody at HMP Exeter. He had personality disorders, autistic traits and a history of self-harm and attempted suicide. Staff started Prison Service suicide and self-harm monitoring procedures (known as ACCT). Five days later this ACCT was closed.

2. On 5 February, Mr Roberts appeared at court and was taken to HMP Bristol. He was distressed that he had not returned to Exeter to be near his mother, and said he wanted to take his own life. Staff opened ACCT procedures and he was subject to constant supervision.

3. He remained on an ACCT for the eleven weeks he spent at Bristol, including six weeks under constant supervision. During this time, he tied numerous ligatures and self-harmed, usually by cutting. The mental health team and neurodevelopmental service engaged with Mr Roberts to try to lessen his distress, but he continued to struggle in prison.

4. Staff restrained Mr Roberts on numerous occasions to stop him harming himself. Mr Roberts alleged that an officer had assaulted him during one of these restraints and submitted a complaint.

5. On 17 April, staff held an ACCT review and assessed Mr Roberts as low risk. He continued to be monitored on two observations an hour.

6. On the morning of 20 April, an officer removed a ligature from Mr Roberts, who said he still felt like harming himself. The officer told a Supervising Officer (SO) but the frequency of observations was not reviewed. That afternoon, the Deputy Governor told Mr Roberts that his allegation of assault had not been upheld. She asked the SO to support Mr Roberts. An officer checked him twice in the next twenty minutes. About twenty minutes after that, the SO and another officer went to check on Mr Roberts again at around 5.00pm and found him hanging. They cut him down and attempted to resuscitate him.

7. Paramedics attended and re-established a pulse. Mr Roberts was taken to hospital, but he died on 1 May, after his life support had been turned off.

Findings

8. Mr Roberts was a very vulnerable individual and his frequent self-harming made him very difficult to manage in prison.

9. We are concerned that ACCT documentation from Exeter did not travel with Mr Roberts to court and was not sent to Bristol when he was taken there.

10. Although we found much evidence of good practice in the ACCT management at Bristol, we found that staff did not always consider all known risk factors when determining Mr Roberts' level of risk to himself. We are also concerned that staff did not always record crucial information relevant to risk, did not always hold case

reviews whenever there was an event which may have increased Mr Roberts' risk, and that appropriate observations did not always take place.

11. Mr Roberts wanted to return to Exeter, and this was a key cause of distress for him. We recognise that this was a finely balanced decision, which needed to take account all the risk factors involved. However, the prison's decision making was not properly documented or clearly communicated to Mr Roberts.

12. The prison investigated Mr Roberts' allegation of assault. Although his complaint was not upheld, some concerns were identified: that Mr Roberts had not been assessed by healthcare staff after the restraint and a body worn camera had not been used to record the incident.

13. The clinical reviewer concluded that Mr Roberts' clinical care was of a reasonable standard and largely equivalent to that he could have expected to have received in the community. The notable exceptions to this were a delay in examining a hand injury and the lack of a formal medication review when Mr Roberts refused to take his antidepressant medication.

Recommendations

To HMP Exeter:

- The Governor should ensure that ACCT documentation travels with a prisoner when they are transferred or is sent the same day if the transfer is unexpected.

To HMP Bristol:

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that:
    - all known risk factors are considered when determining the level of risk of suicide and self-harm;
    - ACCT observations take place in line as specified, are unpredictable and are recorded individually;
    - ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk; and
    - all relevant information about risk is documented in the ACCT document.

- The Governor should share a copy of this report with CM A, the SO, Officer C and Officer D and ensure that a senior manager discusses the Ombudsman's findings with them.

- The Governor should ensure that decisions about a prisoner's potential transfer are carefully considered, documented and clearly communicated, ensuring their impact on a prisoner's risk to themselves is minimised.

- The Governor should ensure that unlock protocols, including the use of body worn cameras, are clearly documented, communicated and implemented effectively.

- The Governor should ensure that after a prisoner is restrained, they are assessed by healthcare staff.

- The Governor should share this report with the Deputy Governor and discuss the Ombudsman's findings with her.
- The Head of Healthcare should ensure that staff formally review a patient who repeatedly refuses to take their prescribed medication.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and asking anyone with relevant information to contact him.

15. Due to COVID-19, the investigator was unable to visit the prison. He obtained copies of relevant extracts from Mr Roberts' prison and medical records via post and email.

16. The investigation was reassigned to another investigator. She interviewed 15 members of staff and two prisoners in July and August. NHS England commissioned a clinical reviewer to review Mr Roberts' clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff. All the interviews were conducted by telephone because of the COVID-19 restrictions.

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

18. One of the Ombudsman's family liaison officers contacted Mr Roberts' mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She raised several medical issues which have been addressed by the clinical reviewer in his report.

19. Mr Roberts' mother received a copy of the initial report. She raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Bristol

21. HMP Bristol serves the local courts and holds up to 614 adult men. Healthcare services at Bristol are managed by Inspire Better Health, a partnership of eight health providers led by Bristol Community Health. GP services are subcontracted to Hanham Health Services, and Avon and Wiltshire Partnership provides mental health and substance misuse services.

HM Inspectorate of Prisons

22. The most recent full inspection of HMP Bristol was in June 2019. Inspectors reported that there was no effective strategy to reduce levels of self-harm and that Bristol was failing to keep prisoners safe. Inspectors found that levels of self-harm were higher than at comparable prisons. The number of prisoners subject to ACCT support was unmanageable and prevented staff from focussing on those at highest risk. Action to address levels of self-harm and implement the PPO's previous recommendations had not been well coordinated by the safer custody team.

23. Inspectors reported that all prisoners had been allocated a key worker and the quality of their interactions was good but that not enough sessions were taking place for the scheme to be fully effective. They also found that mental health services were good.

24. Following the inspection, HM Chief Inspector of Prisons invoked the Urgent Notification process and informed the Justice Secretary that he had numerous significant concerns about the treatment and conditions of prisoners at Bristol.

25. In September 2020, inspectors returned to Bristol to conduct a short scrutiny visit to investigate the conditions and treatment of prisoners during the COVID-19 pandemic. They found that Bristol had a strong leadership team and had carefully tried to balance the risk of the virus against the impact on prisoners' mental well-being of a very restricted regime. Inspectors remained concerned about the high levels of suicide and self-harm.

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 to July 2019, the IMB reported that the delayed key worker training was being rolled out and training had begun.

27. The Board noted that some coping strategies were offered to prisoners at risk of suicide and self-harm, but little else. They found this disappointing given the very high number of ACCTs that were open at the prison at the time (as many as 10% of the total prison population). They reported that prisoners frequently expressed concern about the lack of trained support to assist with their mental health needs.

Previous deaths at HMP Bristol

28. Mr Roberts was the third prisoner to die at Bristol since May 2018. Of the previous deaths, one was due to natural causes and one was self-inflicted. There has been one further death due to natural causes since Mr Roberts' death. A previous investigation raised issues about the quality of ACCT management.

Assessment, Care in Custody and Teamwork (ACCT)

29. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

30. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

August – December 2019

31. Mr Ashley Roberts had a history of mental health issues and had been assessed by the community mental health team in August 2019. They noted that he had schizoid personality disorder (characterised by detachment from social relationships and difficulty expressing emotions), emotionally unstable personality disorder (characterised by emotional instability, disturbed patterns of thinking and impulsive behaviour), possible autism spectrum disorder (a lifelong developmental disorder which affects how a person perceives and socialises with others) and maladaptive coping strategies, including self-harm. They suggested that Mr Roberts' GP should consider prescribing fluoxetine (an antidepressant).

32. Between 3 October and 25 October, Mr Roberts was in prison for the first time (at HMP Exeter). During that time, he was subject to Prison Service suicide and self-harm monitoring procedures (known as ACCT). Staff noted he was anxious, depressed, had suicidal thoughts, had attempted suicide in the community and felt lonely and isolated.

33. On 31 December, while in the community, Mr Roberts took an overdose of paracetamol to end his life and was admitted to hospital for a brief period.

January 2020

34. On 16 January 2020, Mr Roberts was arrested and charged with sending threatening emails to police and court staff. The emails included statements that he would end his life. At court he told staff that he would kill himself by not eating if he was sent to prison. He tied two blankets together to make a noose and refused to eat or drink. The court liaison and diversion service noted that Mr Roberts had autistic spectrum disorder and elements of disordered personality. They also recorded that Mr Roberts' mother had a serious illness and that he might have reactive depression in response. They noted that he was low in mood and anxious about being remanded to prison.

35. Court staff filled in a suicide and self-harm warning form and a person escort record (PER) including all this information and that he had recently taken an overdose of paracetamol.

HMP Exeter

36. Mr Roberts was remanded to custody and taken to HMP Exeter. A nurse assessed Mr Roberts on arrival and noted that he was a high risk of taking an overdose and had thoughts of suicide. She referred him to the mental health team. Staff opened an ACCT and he was subject to two observations an hour.

37. The next day, a mental health nurse assessed Mr Roberts. Mr Roberts said that the court were requesting another psychiatric report before his appearance on 5 February and that he thought he should have gone to a psychiatric hospital, rather than prison. He said that he had thoughts of suicide and that his mother was his

reason for living but that she was terminally ill. The mental health team noted they would consider prescribing fluoxetine. They made a referral to local community services for an autism assessment.

38. On 21 January, Mr Roberts told staff that he had no thoughts of self-harm but that this might change if he was not released when he next appeared in court. Staff closed Mr Roberts' ACCT but agreed that they would keep it open in the post-closure phase until after he had appeared in court.

39. On 27 January, Mr Roberts told a nurse that if he was not released from court, he would take the 32 paracetamol tablets he had stockpiled in his cell. Staff searched Mr Roberts' cell but found no paracetamol. Two days later, Mr Roberts told the nurse that staff had not found the paracetamol and gave them to her. On 31 January, staff held a post-closure review with Mr Roberts and noted that the ACCT would need to be reopened if Mr Roberts returned to prison from court.

February 2020

HMP Bristol

40. On 5 February, Mr Roberts appeared at Taunton Crown Court and was remanded in custody until 20 February. He was then taken to Bristol Crown Court on further charges and was remanded in custody until 4 March.

41. Mr Roberts was taken to HMP Bristol, where he refused an initial health screen. He was upset that he had been transferred to Bristol. He said he had autism and asked for a mental health nurse to assess him. He was referred to the mental health team and the neurodevelopmental service. He said that he had thoughts of suicide and self-harm and his mother was terminally ill. Staff opened an ACCT with hourly observations, and he was located in the Brunel Unit (a small, short-stay unit with 18 single cells and more healthcare staff available).

42. On 6 February, during his ACCT assessment, an officer noted that Mr Roberts had cut his arm and had a bruise on his neck. Mr Roberts said that he had tied a ligature (noose) around his neck the previous night, and that he had also tied ligatures at Exeter and in the community when he had attempted to take his own life. He said he thought he might tie a ligature again.

43. At the subsequent ACCT case review, Mr Roberts said that his main concern was being in Bristol rather than Exeter as his mother could not visit him. He said he struggled with change and new locations and that he wanted to take his own life and. Staff placed him under constant watch and said they would explore whether he could be transferred to Exeter.

44. A neurodevelopmental practitioner met Mr Roberts after the case review. She noted that Mr Roberts had no formal diagnosis of autism and had been on a waiting list for assessment and diagnosis in the community. She told the investigator that Mr Roberts had traits of autism, although she was not qualified to formally diagnose him, and that he had communication difficulties and struggled to initiate a conversation.

45. During the rest of February, Mr Roberts had an ACCT review every day apart from five days. Senior prison managers chaired these reviews with mental health staff also present. Mr Roberts was subject to constant supervision for most of the time. When his observations were reduced, he typically ligatured or harmed himself by other means and was made subject to constant supervision again within 24 hours.

46. Mr Roberts said he found it difficult to cope with noise and was worried about moving to a larger, potentially noisier, wing. Staff gave him ear plugs to try to lessen his distress and, later, some noise cancelling headphones. He asked about transferring to Exeter and staff said he needed to come off constant supervision first.

47. At times, staff also removed Mr Roberts' belongings from his cell, since he used items such as the television lead to tie a ligature. He was also given anti-ligature clothing and bedding for periods. The Deputy Head of Residence was involved in several of Mr Roberts' ACCT reviews when he was subject to constant supervision. He said that it was very important for Mr Roberts to have contact with his mother and he tried to encourage and facilitate this, but that Mr Roberts did not want her directly involved in his ACCT. The neurodevelopmental practitioner also said that Mr Roberts would not consent to her speaking to his mother.

48. On 12 February, the neurodevelopmental practitioner e-mailed the Head of Safety, as she was concerned about Mr Roberts' increased risk to himself. She said that his significant communication difficulties meant that he may not tell staff when he was feeling low. She also said that she thought it would be beneficial for Mr Roberts to be transferred to Exeter so that he could see his mother and engage with neurodevelopmental assessments from his local services. She did not receive a response to her email.

49. On 17 February, Mr Roberts was prescribed fluoxetine. He told staff that his hand hurt because he had punched a wall in frustration. The following day a prison GP assessed that he did not need an x-ray without examining him.

50. On 20 February, Mr Roberts appeared at Taunton Crown Court via videolink and all his offences were committed to Bristol Crown Court with his next appearance on 4 March.

51. On 24 February, a prison GP assessed Mr Roberts' hand injury and sent him to hospital, where it was confirmed his hand was broken and it was put in a cast.

March 2020

52. On 1 March, the Head of Safety chaired an ACCT review because staff had taken a ligature from Mr Roberts overnight. Shortly before the review Mr Roberts tied another ligature at the top of a staircase and said he had lost consciousness. The review took place in Mr Roberts' cell, where Mr Roberts was lying on his bed, with marks round his neck and a bump on his head. He said that he had tried to kill himself because his telephone credit had run out and he could not call his mother, but that the ligature had broken. Healthcare staff assessed Mr Roberts and he was taken to hospital in an ambulance. He returned to the prison later in the day. Staff agreed Mr Roberts should return to constant supervision (he had been on seven observations per hour).

53. Staff continued to hold ACCT reviews almost daily. Mr Roberts continued to see mental health staff as part of ACCT reviews and, sometimes, individually. He made superficial cuts, tied ligatures and said that he wanted constant supervision to stop so that he could end his life. He was given anti-ligature clothing and bedding. Prison and healthcare staff also discussed Mr Roberts at the weekly Safety Intervention Meetings (SIM). Mr Roberts also started working in the clothing exchange store (CES) which staff viewed as a positive step and he started to make friends with other prisoners there.

54. On 9 March, staff held an ACCT review and told Mr Roberts that he would be moving to D wing, a small wing for vulnerable prisoners. Mr Roberts said he would self-harm if he was moved. Staff explained that he had been assessed by mental health staff, who supported the move and would continue to visit him on D wing. After the review, Mr Roberts moved to D wing.

55. That afternoon and evening, Mr Roberts made numerous attempts to harm himself by tying ligatures, cutting himself and submerging his head underwater in the sink. Staff had to restrain him on multiple occasions to prevent him harming himself and he was given anti-ligature clothing. The next day, Mr Roberts continued to try to harm himself and officers continued to intervene and restrained him when he resisted. Mr Roberts said he would continue to harm himself until he was moved back to the Brunel Unit, as it was too noisy on D wing.

56. On 11 March, Mr Roberts tied two ligatures in the morning which were removed by staff. Mr Roberts' allocated mental health nurse saw him to discuss his risk management plan and reasonable adjustments with him. The plans included guidance for staff about the best way to communicate with Mr Roberts and how he may react in certain situations. A copy was put in his ACCT document. Mr Roberts refused to sign the plans and said he needed to return to the Brunel Unit.

57. A forensic consultant psychiatrist, who had been appointed by the court, assessed Mr Roberts, at the end of February and completed his report on 11 March. He concluded that Mr Roberts' behaviour was consistent with autism and that Mr Roberts also suffered from anxiety, depression, thoughts of suicide and self-harm and a degree of paranoia. He concluded that Mr Roberts needed a period of three to six months intensive assessment in a specialist secure psychiatric hospital to understand the complexities of his presentation, provide a diagnosis and plan a future care pathway. Mr Roberts received a copy of this report which he passed onto the Deputy Head of Residence, who gave it to healthcare staff on 27 March.

58. During mid-March, Mr Roberts tied several ligatures. He also wrote a letter to a female prison officer saying that he was going to murder her. The letter was passed to the police and security department. He later wrote the name of the officer in blood on his wall. Mr Roberts also told staff that he had been having increased thoughts of harming others and felt suicidal. As a result, it was decided that female staff should no longer work on their own with Mr Roberts and that he should only be unlocked when two officers were present with their body-worn cameras turned on. Mr Roberts believed he would be transferred to hospital at his next court appearance but said he would kill himself if he returned to prison. Mr Roberts also returned to work in the CES (he had not recently been allowed to attend due to the risk he posed to himself).

59. On 17 March, the allocated mental health nurse wrote to Mr Roberts saying that he had been discharged from the neurodevelopmental service as, following implementation of reasonable adjustments and a management plan, there was no further role for the service. She told the investigator that she does not hold a caseload and is not resourced to do so. Her role is to assess prisoners and create a plan. Prisoners can be referred back to her if necessary.

60. A nurse (accompanied by three officers) later spoke to Mr Roberts about the letter he had written and told him that he would be re-allocated a male mental health worker. He said he wanted to transfer back to the Brunel Unit, but the nurse explained this was not possible as it was a short-stay intervention wing.

The restraint on 18 March

61. On the morning of 18 March, Mr Roberts was seen trying to strangle himself with his anti-ligature blanket. He did not stop when requested so staff entered the cell and restrained him for his own safety.

62. Officer A was responsible for the constant supervision of Mr Roberts that afternoon. He told the investigator that Mr Roberts had seemed his usual self and they had been talking and joking. However, around 4.15pm, he became concerned that Mr Roberts was trying to self-harm with a plastic bowl under his bedding. Since Mr Roberts would not say what he was doing, he called to Officer B, who was on the landing above, for immediate assistance. Officer A then unlocked Mr Roberts' cell and went in. He said that when he pulled the bedding back, he could see that Mr Roberts was trying to cut his wrists with the bowl. He refused to stop when asked, so he tried to take the bowl, but Mr Roberts resisted. He said that in the struggle Mr Roberts fell out of the bed and he fell with him onto the floor.

63. Officer A said he took the bowl from Mr Roberts, but he continued to resist and became aggressive. He thought Mr Roberts was trying to take his keys as he had his hand on them. Officer B was in the cell by this stage but could not help because of the small size of the cell. Officer A said Mr Roberts refused orders to let go of the keys, so he hit him with an open palm on his chest. Mr Roberts let go of the keys and, once the officers had hold of his arms, stopped resisting. They spoke to him and retreated from the cell once Mr Roberts was calm. Officer A remained outside the cell to carry on the constant supervision. He said that after around ten minutes, he asked Mr Roberts why he had resisted, but Mr Roberts refused to speak about it. He told the investigator he was shocked as Mr Roberts had never resisted him before.

64. On 19 March, Mr Roberts appeared at Bristol Crown Court. The court requested a second psychiatric report and adjourned his case until early May. The PER noted that Mr Roberts had two black eyes and a bite mark on his arm. Later, during an ACCT review, Mr Roberts said he had been expecting this outcome at court and was positive about it. He showed staff a written statement saying that he had charged at the officers but said that he had been trying to use the key chain to ligature rather than trying to take the keys.

65. On 20 March, the Deputy Head of Residence chaired an ACCT review with a mental health practitioner. Mr Roberts said that having his television and telephone back the previous day had helped him and that he had not self-harmed since the

day before. He asked if he could be considered for transfer back to Exeter before his next court appearance. Those present agreed that constant supervision could be stopped, and Mr Roberts' observations were reduced to seven an hour.

66. Officer C told the investigator that he spent a lot of time with Mr Roberts over the following weeks, trying to build a rapport with him and gain his trust. He said that Mr Roberts was a quiet prisoner who "seemed nervous around people". He said that Mr Roberts told him that he sometimes self-harmed as he did not feel able to ask the officers simple requests. He said that during his time on D wing, Mr Roberts "changed a little bit", made friends with a few prisoners, spoke to staff a bit more and interacted more during association.

67. On 21 March, Mr Roberts submitted a complaint alleging that Officer A had punched him in the face several times when he had restrained him on 18 March. He said he had been refused healthcare on 18 March and asked that the disciplinary charge (for allegedly trying to take Officer A's keys) should be dropped. He also asked to be transferred to Exeter. Officer A told the investigator Mr Roberts told him a couple of days later that he thought submitting a complaint might help him get transferred to Exeter.

68. Prisoner A lived near Mr Roberts and told the investigator that he spoke to him every day. He said that he tried to encourage him not to harm himself and talked about the risks of tying ligatures. He said that Mr Roberts was upset as he thought he had let his mother down by being in prison and that he thought that staff at Bristol were "against him". Prisoner A said he told Mr Roberts that he saw no evidence of this. Prisoner A said that he thought staff became more used to Mr Roberts' risky behaviour over time and did not give him the assistance he needed. He said that he sometimes told staff that he was concerned that Mr Roberts was going to harm himself and they responded that they would deal with it when it happened.

69. On 23 March, a Custodial Manager (CM) A chaired an ACCT review. Mr Roberts said that he had written the threatening letter about the female officer because fluoxetine had made him psychotic. He later refused this medication. The CM took photos of Mr Roberts' black eyes at his request and let him use the office telephone to call the police about the alleged assault. Staff agreed to reduce Mr Roberts' observations to five an hour.

70. On 26 March, following an ACCT review, staff reduced Mr Roberts' ACCT observations to three an hour. CM A told Mr Roberts that his transfer to Exeter might take some time given the COVID-19 pandemic.

71. On the night of 30 March, an officer radioed a medical emergency code after finding Mr Roberts had tied a jumper round his neck and secured it to his locker. He cut the ligature using his anti-ligature knife and Mr Roberts recovered and started talking. Staff held an ACCT review 15 minutes later and increased Mr Roberts' observations to four an hour. He said he had tied a ligature as he was worried about his outstanding disciplinary hearing. On 31 March, staff reduced his observations to three an hour and to two an hour on 1 April.

April 2020

72. In the early hours of 5 April, Mr Roberts tied a jumper round his neck and attached it to the bed. Staff held an ACCT review half an hour later and increased Mr Roberts' observations to four an hour. At an ACCT review later that day, chaired by the CM, Mr Roberts said that he had been unhappy about an email he had received from his solicitor saying that he would not be able to get a further psychiatric report due to the COVID-19 pandemic and that his court date would probably be delayed. Staff reduced his observations to two an hour and assessed Mr Roberts as a low risk. Mr Roberts continued to refuse to take the fluoxetine he was prescribed.

73. A Supervising Officer (SO) worked on D wing. She told the investigator that staff made considerable efforts to engage with Mr Roberts, playing chess with him frequently. She said that he progressed while he was on the wing and was harming himself less and had also started to engage more with staff and prisoners.

74. On 6 April, the mental health practitioner met Mr Roberts and went through some grounding exercises with him (techniques to deal with anxiety). A Deputy Governor commissioned a CM to investigate Mr Roberts' complaint about the restraint on 18 March.

75. On 7 April, an officer radioed a medical emergency code after finding Mr Roberts unconscious in his cell. He had tied his jumper round his neck and secured it to the bed. Healthcare staff responded and examined Mr Roberts. Half an hour later, a CM chaired an ACCT review. Mr Roberts said that he was disappointed to be alive but also said that he did not want to die. Staff assessed his risk as 'raised' and increased his observations to five an hour.

76. On the morning of 8 April at 11.20am, CM A chaired an ACCT review. He recorded that he told Mr Roberts that he would not be able to work in the CES for the rest of the week and would not be able to transfer to Exeter while he continued to self-harm. Mr Roberts was not happy about this and staff assessed him as a high risk, with five observations an hour. The CM told the investigator that he had told Mr Roberts that he was unlikely to be transferred to Exeter because no prison transfers were taking place because of COVID-19. He said that he tried to give him hope that if he worked with prison staff and the mental health team, he would be transferred in the longer term.

77. Twenty-five minutes later, staff radioed a medical emergency code as they had found Mr Roberts with a ligature tied around his neck. When healthcare staff attended, Mr Roberts refused to be assessed. That afternoon, staff held another ACCT case review. They tried to encourage Mr Roberts not to ligature so that he could have his job back. His level of risk and observations remained unchanged.

78. On the morning of 9 April, Mr Roberts twice made superficial cuts to his legs and said that he felt depressed because he was not working at the CES and could not be transferred to Exeter.

79. On 14 April, Mr Roberts returned to work in the CES. CM A chaired an ACCT review. The CM noted (incorrectly) that Mr Roberts had not self-harmed since their last review. Mr Roberts was pleased that he had a video link appointment with a psychiatrist on 29 April to be assessed for court, but said he was still low in mood

and wanted to talk about antidepressant medication. The mental health practitioner said he would look into this and speak to him again. Staff assessed Mr Roberts risk as 'low' risk and reduced his observations to two an hour.

80. On the same day, Mr Roberts made an application to healthcare saying that he wanted to see his previous mental health worker and wanted to stay under the care of the neurodevelopmental team until they had a plan in place which he had signed and which worked. He said he wanted them to represent him as he found it difficult to ask for things himself.

81. On 15 April, staff discussed Mr Roberts at the SIM. They noted that he was back in work and enjoying it, that he had not self-harmed for over a week and that the frequency of his observations had been reduced.

82. On the afternoon of 16 April, an officer saw Mr Roberts making a ligature. He had also made superficial cuts to his wrists with a razor. The officer removed the ligature and razors and recorded this information in the ACCT ongoing record. A SO subsequently chaired an ACCT review and noted that Mr Roberts said he had self-harmed because he was feeling depressed and had not received his asthma inhaler. The SO asked Mr Roberts if he was going to self-harm again and he said he did not know. Staff assessed Mr Roberts' risk as low and kept his observations at two an hour.

83. On the morning of 17 April, an officer noted in Mr Roberts ACCT ongoing record that he was self-harming by cutting. Mr Roberts told the officer that it was because of his mental health. Half an hour later, CM A chaired an ACCT review with the mental health practitioner and Mr Roberts. Mr Roberts said had self-harmed because he felt low in mood. The mental health practitioner tried to encourage him to use the grounding skills they had practiced. They assessed Mr Roberts' risk to himself as low and kept the same level of observations. The CM told the investigator that although Mr Roberts had been negative at the start of the review, he seemed more positive and focussed on the future at the end.

84. The investigator listened to Mr Roberts' telephone calls from 18 April onwards. They were all to his mother who he rang several times a day. They spoke about his forthcoming court appearance and general life.

85. On 19 April, the mental health practitioner went to see Mr Roberts on the wing to discuss his recent application and to wish him a happy birthday. Mr Roberts said he was concerned he had bulimia and dementia and the mental health practitioner tried to reassure him that he did not think this was the case. He explained that Mr Roberts could not be referred back to the neurodevelopmental service as the neurodevelopmental practitioner did not hold a caseload, and that he could not have a female mental health worker because of the letter he had written. Mr Roberts said he wanted to try taking fluoxetine again to see if it made him start writing inappropriate letters again. The mental health practitioner challenged this. Mr Roberts said that he had not self-harmed since they last met and had been using the grounding techniques successfully. He said that he either wanted to be released or transferred to a psychiatric hospital when he appeared at court.

86. Mr Roberts rang his mother twice that evening. They spoke for around 30 minutes about various topics, including his hand injury and birthday.

Events of 20 April

87. Around 8.30am on the morning of 20 April, Officer C was monitoring the queue of prisoners waiting to receive their medication. He said that Mr Roberts looked unhappy, so he asked him how he was. Mr Roberts told him that he was a "bit low" and that he had tied a ligature the night before but had not tried to use it. He walked back to Mr Roberts cell with him and removed the ligature (which was a jumper and towel tied to the cage that surrounded the smoke alarm). As he did so, Officer D came into the cell to carry out a key working session with Mr Roberts.

88. Officer D told the investigator that Mr Roberts said he had had a "rough night with his mental health" and that was why he had tied the ligature but that he had not wanted to use it. He said that Mr Roberts told him and Officer C that he was still having thoughts of harming himself and tying ligatures. The three of them spoke about what Mr Roberts did before he was in prison and what he hoped to do afterwards. Officer C estimated that he talked to Mr Roberts for around 30 minutes before he left him in his cell with Officer D. He said that he told a couple of wing staff about the ligature when he left Mr Roberts' cell and that he told the SO when he got to the wing office. He did not record it in the ACCT document.

89. Officer D said that he talked to Mr Roberts about how he was coping and Mr Roberts said he should have had an autism assessment but the specialist had not been able to come into the prison because of the COVID-19 pandemic. After around 20 minutes, he thought that Mr Roberts was in a more positive mood and he left the cell. He recorded in Mr Roberts' electronic record that he told the SO about the ligature that Mr Roberts had tied but she was already aware of this (he assumed that Officer C had told her) and said the mental health team were already working with Mr Roberts. The SO told the investigator that she did not remember the conversations with Officers C or D.

90. At 8.56am, Mr Roberts telephoned his mother. He asked her to ring his solicitor to check whether he was appearing in court via videolink or in person as he had been told he could not transfer to Exeter because he needed to appear at Bristol Crown Court. He then changed his mind and said he would find out on the day. He said he would call his mother later.

91. Mr Roberts went to work in the CES. Prisoner A told the investigator that when they were at work, Mr Roberts had asked for extra bedding, which he had been given. Prisoner A said he was concerned about this because Mr Roberts had told him that he felt like harming himself by tying a ligature and that he had tied a ligature the night before but it had broken when he had tried to use it.

92. At 10.45am, Mr Roberts returned to the wing. Prisoner A told the investigator that he told the SO that he was concerned about Mr Roberts having extra bedding. He said that the SO said that they could not stop him having the bedding as he had not used it to harm himself. The SO told the investigator that she did not recall this conversation.

93. Prisoner B lived on the same landing as Mr Roberts. He told the investigator that staff "went out of their way" to try to help Mr Roberts cope. He said he saw Mr Roberts around 11.30am and that he seemed his "normal self". Prisoner A said that he saw Mr Roberts when they were back on the wing and he seemed happier than

earlier. According to notes in the ACCT document, Mr Roberts then watched television and ate his lunch in his cell.

94. An officer was responsible for doing Mr Roberts' ACCT checks that afternoon. At 1.30pm, she noted he appeared asleep. At 2.00pm, when she went to unlock him for work, Mr Roberts said he was not going as he felt dizzy. She said she asked if he wanted to see healthcare staff, but he declined and said he was just tired. She had no concerns about Mr Roberts and left him in bed.

95. At 3.00pm, the officer checked Mr Roberts, who was talking to a member of staff from education. She later noted at 3.45pm and 4.10pm that he was asleep. The investigator watched the CCTV from around 3.15pm onwards. (There is no time displayed on the CCTV, so it is difficult to determine the exact time.) The CCTV shows that the officer checked Mr Roberts more regularly than she documented in the ACCT.

96. A CM had completed his investigation report about Mr Roberts' complaint of assault on 18 March and submitted this to the Deputy Governor. He concluded that there was no evidence to uphold Mr Roberts' version of events, but that there was learning from the incident: Mr Roberts should have been unlocked by two officers with their body-worn cameras turned on, and healthcare staff should have assessed Mr Roberts for any injuries after the restraint.

97. Having considered this report, the Deputy Governor went to see Mr Roberts to speak to him about it. She had not met Mr Roberts before, although she was aware of him from management meetings, so she asked the Deputy Head of Residence to accompany her so that there was someone present who Mr Roberts knew. She said she asked a wing officer before the meeting how Mr Roberts had been that day and was told that he was "in good spirits" and "fine".

98. At 4.20pm, the Deputy Governor and Deputy Head of Residence met Mr Roberts in the wing office. She explained the outcome of the investigation, and the learning from the incident, which she said would be addressed. Mr Roberts had asked for his disciplinary hearing to be dropped and the Deputy Governor explained that this would not happen, but he would be given the opportunity to give his version of events. Mr Roberts had also requested a transfer to Exeter. The Deputy Governor told him that inter-prison transfers were not taking place due to COVID-19, and he was being held at Bristol for the court case at Bristol Crown Court, but that she hoped he could be transferred once his court case had concluded. She checked that he was still able to contact his mother and asked if there was anything he needed.

99. Mr Roberts said he had no questions, he talked to the Deputy Head of Residence briefly about his job and then asked to leave the meeting. The Deputy Head said that he did not have any concerns about Mr Roberts, who said he felt "so, so" and was enjoying work. The Deputy Governor noted that Mr Roberts smiled, said he was fine and thanked her for her time as he left. However, she noted on the ACCT that Mr Roberts was not happy with the outcome of his complaint. She told the investigator that, although she was not immediately concerned about Mr Roberts, she thought that he might be unhappy because of his body language. She said she told the SO that Mr Roberts' risk to himself may have increased and that the SO said she would arrange some support for him.

100. According to the CCTV, an officer let Mr Roberts back into his cell at about 4.28pm. She did not know he had met with the Deputy Governor but asked if he was okay. She said she had no concerns about him. Mr Roberts then left his cell briefly to collect his medication and she locked him in his cell around 4.30pm. She read the Deputy Governor's entry in the ACCT document, so decided to check him more frequently than the two observations per hour that were required. CCTV shows that she checked him briefly three minutes later and then again ten minutes after that. She did not speak to him as he was using the toilet, but he turned his head towards her. She noted on the ACCT document that it was 4.40pm.

101. Nineteen minutes later, the SO and Officer C went to Mr Roberts' cell. (Officer C recorded in the ACCT that this took place at 4.45pm, but it must have been closer to 5.00pm.) The SO told the investigator that she intended to hold an ACCT review to assess how he was feeling and his risk to himself. Mr Roberts had blocked his observation panel. They tried to open the door, but it was difficult as it was stuck. The SO could see that Mr Roberts was behind the door and his feet were on the floor. They managed to open the door and discovered that Mr Roberts was hanging by his duvet cover from the cage around the smoke detector. Officer C radioed a medical emergency code and the control room requested an ambulance.

102. The SO and Officer C tried to remove the ligature from Mr Roberts neck with an anti-ligature knife, but the material was too thick. The officer supported Mr Roberts' weight and the SO untied the ligature and they laid him on the floor. They checked for signs of life and started chest compressions. Another officer arrived and assisted with CPR, including rescue breaths.

103. Three nurses arrived with the emergency bags three minutes after staff had first gone into Mr Roberts' cell. They administered oxygen, attached the defibrillator and took it in turns to deliver CPR.

104. Paramedics arrived 12 minutes after staff had first gone to the cell. They took over Mr Roberts' care while prison staff continued to assist. They detected a pulse and, at 6.00pm, they took Mr Roberts to hospital. Mr Roberts was not restrained and was accompanied by two officers.

105. After Mr Roberts had been taken to hospital, a prisoner received a letter which Mr Roberts had written on 18 April. Mr Roberts wrote that he was struggling to determine what was real and what was not, that he "lived in his head" and struggled to communicate with people, and that his moods fluctuated and changed very quickly. He said that if he tied a ligature that night, "it would literally be for no reason" and that he was not always in control of his emotions or actions.

21 April – 1 May

106. On 28 April, Mr Roberts' life support was turned off and bedwatch staff were withdrawn. On 1 May at 6.15pm, a doctor confirmed that Mr Roberts had died.

107. Prisoner B wrote to the Governor after Mr Roberts died. He alleged that Prisoner A had been encouraging Mr Roberts to make ligatures to help him get transferred and had made a noose for Mr Roberts to hang himself with on 20 April.

108. Prisoner B told the investigator that no one had spoken to him about the letter. He said that, after Mr Roberts had been taken to hospital, Prisoner A had told him that he had shown Mr Roberts how to tie a more effective ligature that morning. Prisoner B said that Prisoner A told him that he had made a ligature out of bedding for Mr Roberts so that staff would take him seriously and he would be transferred to Exeter. Prisoner B said that there were other prisoners present when Prisoner A told him this, but he could not recall their names. Prisoner A told the investigator that these allegations were untrue.

Contact with Mr Roberts' family

109. The Clean and Decent Advisor was appointed as the family liaison officer on 20 April. He telephoned Mr Roberts' mother and told her that Mr Roberts was in hospital after having been found hanging. He remained in contact with her and arranged for her to stay in a hotel near the hospital at the prison's expense. After Mr Roberts' death, he offered a financial contribution to Mr Roberts' funeral in line with Prison Service policy.

Support for prisoners and staff

110. After Mr Roberts was taken to hospital, the Deputy Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

111. The prison posted notices informing other prisoners of Mr Roberts' 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 Roberts' death.

Post-mortem report

112. The post-mortem report concluded that Mr Roberts' cause of death was a brain injury caused by lack of oxygen to the brain and a lower respiratory tract infection (pneumonia) caused by a prolonged cardiac arrest, which had been caused by ligature suspension. The pathologist noted that pneumonia is a common complication in unconscious patients and can develop despite adequate medical and nursing care.

113. No illicit drugs or alcohol were detected in Mr Roberts' system. There was also no fluoxetine detected which he had been prescribed.

Findings

Assessment and management of risk

114. Mr Roberts was subject to ACCT support at Exeter between 16 and 21 January, when his ACCT was closed. Staff decided that his ACCT should remain in the post-closure period until after he had appeared in court on 5 February. He later told staff that he would overdose on the paracetamol he had stockpiled if he was not released from court. After appearing in court, he was taken to HMP Bristol. The ACCT did not travel with Mr Roberts, nor is there any record it was subsequently sent. Staff at Exeter told staff at Bristol that they could not find the ACCT. The investigator has not had access to it, and we cannot, therefore, comment on the quality of support Mr Roberts received while he was at Exeter. We make the following recommendation:

The Governor of Exeter should ensure that relevant ACCT documentation travels with a prisoner when they are transferred or is sent the same day if the transfer is unexpected.

115. As the clinical reviewer notes, Mr Roberts was particularly vulnerable. He found it difficult to cope with change and noise, he had difficulties expressing himself and asking for information, and he struggled to channel his frustration in meaningful ways. This frequently resulted in self-harm or tying ligatures when his stress levels increased, often shortly after he had seemed relatively well. The clinical reviewer noted that his risk could change within minutes and that this would have made it difficult for staff to predict his risk of harm accurately, even over the course of a day.

116. Mr Roberts was assessed as a risk of suicide and self-harm for the 11 weeks he was at Bristol. Staff held 45 ACCT case reviews during this time, and he was subject to constant supervision for around six weeks. There is much evidence of good practice within the ACCT: it is clear that staff tried to engage with Mr Roberts and lessen his distress, often in very difficult circumstances; mental health staff reliably attended case reviews; case managers were consistent where staffing allowed; and those involved continually reviewed Mr Roberts' caremap.

117. Despite this, our investigation identified some concerns about the operation of the ACCT process, meaning that Mr Roberts did not always receive an appropriate level of support.

118. PSI 64/2011, *Safer Custody*, states that ACCT observations "must be at unpredictable times". However, staff sometimes completed the observations at very regular intervals, particularly overnight: for example, every thirty minutes on the night of 19 and 20 April. In addition, observations were not always carried out in line with directions: for example, no one checked Mr Roberts between 2.00pm and 3.00pm on 20 April. And when he was subject to several observations an hour, staff notes were sometimes grouped into one entry, for example on 1 March.

119. We also consider that some of the assessments of Mr Roberts' risk were inappropriate, considering how recently he had self-harmed or tied ligatures. For example, on 6 April, after Mr Roberts had tied a ligature the previous day, he was assessed as low risk and observations set at two per hour.

120. On 16 April, after Mr Roberts tied a ligature and made cuts to his wrists, staff held an interim case review and assessed him as a low risk and set observations at twice an hour. CM A held the scheduled case review the next day, shortly after Mr Roberts had cut himself again. Although he noted that Mr Roberts had self-harmed twice as he felt low in mood, staff continued to assess his risk as low and to set observations at two per hour.

121. We are concerned that a prisoner who was low in mood and actively cutting himself and tying ligatures was assessed as a low risk, particularly as CM A acknowledged that Mr Roberts was impulsive and always had suicidal thoughts. We share the clinical reviewer's concern that observations of two per hour were probably inadequate to manage Mr Roberts' unpredictable behaviour at that point.

122. On 20 April, Officers C and D removed a ligature from Mr Roberts' cell. He told them that he felt low and was still having thoughts of tying ligatures and self-harming. Both officers said that they individually spoke to the SO after they left Mr Roberts' cell. However, we are concerned that neither officer updated Mr Roberts' ACCT document with information about the ligature or his thoughts of harming himself. We are also concerned that no one considered holding an ACCT review.

123. Officer C said that he did not think an ACCT review was necessary as Mr Roberts was already on two observations an hour, which he thought was relatively high. He was also satisfied that he had passed on the information to the SO, who could chair a case review if she felt it was necessary. He later became aware that a manager was going to talk to Mr Roberts about the assault complaint but thought that as he had passed the information about the ligature to the SO, he did not need to take any further action.

124. The SO said that she could not remember having a conversation with Officers C or D about Mr Roberts tying a ligature that morning, although she accepted that the conversations may have happened. She said that if she had been told about the ligature, she should have spoken to Mr Roberts and held an ACCT review to determine if his risk to himself had increased.

125. We are extremely concerned that this crucial information regarding Mr Roberts risk was not recorded or considered adequately. Given that he had tied a ligature, stated that he still wanted to harm himself and was feeling down, we consider that an urgent case review should have been held that morning. We are also concerned that the SO could not recall whether significant discussions about a prisoner's level of risk took place.

126. In addition, Prisoner A said that he told the SO that morning that he was concerned that Mr Roberts was a risk to himself and that he had taken extra bedding from the CES. The SO could not recall this conversation either but told the investigator that it was very common for prisoners who worked in the CES to take their own washing and return with new bedding. She said that prisoners would not be allowed excess bedding and that this would be checked by staff and any excess taken from them. Again, we are concerned that the SO cannot recall whether this conversation happened and that if it did, she did not take Prisoner A's concerns more seriously, particularly as Mr Roberts had used bedding to tie ligatures numerous times.

127. We make the following recommendations:

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

- **all known risk factors are considered when determining the level of risk of suicide and self-harm;**
- **observations take place in line with requirements, are unpredictable and are recorded individually;**
- **ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk; and**
- **all relevant information about risk is documented in the ACCT document.**

The Governor should share a copy of this report with CM A, the SO, Officer C and Officer D and ensure that a senior manager discusses the Ombudsman's findings with them.

Transfer to Exeter

128. Throughout his time at Bristol, Mr Roberts said he wanted to transfer to Exeter so that his mother, who was his only source of support, could visit him. Being unable to transfer to Exeter was a constant source of distress for him and was a key risk factor for his self-harm.

129. The Head of Offender Management Services told the investigator that he spoke to the Duty Governor at Exeter about Mr Roberts' transfer and they agreed to accept Mr Roberts for transfer whenever Bristol deemed it was appropriate.

130. The Head of Offender Management Services told us that, although it was difficult to transfer a prisoner who was subject to constant supervision, it could be done. However, we note that it was documented in Mr Roberts' ACCT that he would have to come off constant supervision before he could be transferred.

131. After the constant supervision ended, the Head of Offender Management Services said he assessed that it was not appropriate to transfer Mr Roberts until after his court case had concluded because he considered that Mr Roberts would find the two-hour journey between Exeter and Bristol Crown Court stressful in a court transfer vehicle. There was also the possibility that once Mr Roberts had appeared in court, he would have returned to Bristol depending on vehicle availability. He said he was also concerned that a transfer would be unsettling and put additional pressure on Mr Roberts, and that he felt Mr Roberts had started making progress at Bristol.

132. The Head of Offender Management Services also told the investigator that the COVID-19 restrictions did not affect Mr Roberts' transfer. However, Mr Roberts was repeatedly told, including on 20 April, that he could not transfer because of COVID-19.

133. There may have been good reasons why a transfer to Exeter could not take place, but we have found them hard to establish. Given the importance of this issue to Mr Roberts, we are concerned that the discussions with Exeter and decision-making

about Mr Roberts' potential transfer were not recorded or formally considered in the context of his ACCT caremap.

134. The Head of Offender Management Services told the investigator that he now kept a record of all discussions about outstanding, potential or completed transfers. He said, however, that he was satisfied that the decision made about Mr Roberts' potential transfer to Exeter was appropriate.

135. We are satisfied that staff were trying to act with Mr Roberts' best interests in mind. We note too that if Mr Roberts had transferred to Exeter, his mother would not have been able to visit him because all social visits were cancelled during the COVID-19 lockdown. However, we remain concerned that there was a lack of clarity among staff about why Mr Roberts was not being transferred and that Mr Roberts was given a variety of different explanations. We consider that it is likely this contributed to Mr Roberts' distress. We make the following recommendation:

The Governor should ensure that decisions about a prisoner's potential transfer are carefully considered, documented and clearly communicated, ensuring their impact on a prisoner's risk to themselves is minimised.

Use of force

136. Staff restrained Mr Roberts numerous times, sometimes several times a day, to prevent him self-harming or attempting to take his own life. Mr Roberts alleged that an officer had assaulted him during one of these restraints on 18 March.

137. At the time of the restraint on 18 March, Mr Roberts should only have been unlocked by two officers with their with body-worn cameras turned on. Officer A said that he but that he knew Officer B was very nearby and he was concerned for Mr Roberts' welfare and believed that he would hand him the bowl without resisting. He therefore made a dynamic risk assessment and decided to enter the cell and break the unlock protocol because he considered there was an immediate risk to Mr Roberts' life. We do not criticise Officer A for the judgement he made.

138. Officer A and Mr Roberts gave different accounts of what happened in the cell before Officer B arrived. We accept that in the absence of any independent evidence, it was not possible to know what had happened that it was not therefore unreasonable that Mr Roberts' complaint was not upheld.

139. We do, however, have some concerns. There is no body-worn camera footage from the incident. Officer A was not wearing a camera and said he did not know that this was part of Mr Roberts' unlock protocol. The only reference to the protocol is on 16 March in Mr Roberts' computerised record, indicating that he should remain subject to two officers unlocking him with a camera switched on. There is no reference to when this protocol started. Nor is there any indication on Mr Roberts' ACCT that he was subject to such a protocol. We consider that this protocol should have been communicated more clearly. A manager should have ensured that officers conducting the constant supervision were aware and wearing a camera. This would have protected both Mr Roberts and the officers. We make the following recommendation:

The Governor should ensure that unlock protocols, including the use of body worn cameras, are clearly documented, communicated and implemented effectively.

140. We are also very concerned that Mr Roberts was not examined by healthcare staff after the use of force. Prison Service Order (PSO) 1600, *Use of Force,* says that healthcare staff must examine any prisoner who has been restrained. Officer A said that, after the restraint, Mr Roberts said that he was fine and did not want to be assessed by healthcare staff. However, Officer A should still have arranged for him to be examined by healthcare staff and we are surprised that the wing manager did not ensure that this happened. This would have protected both Mr Roberts and Officer A.

141. When Mr Roberts went to court the next day, it was documented that he had two black eyes. They were apparently still noticeable enough to be photographed five days later. Officer A adamantly denies Mr Roberts' allegation that he punched him in the face during the restraint or that he caused this injury. Without a healthcare assessment following the restraint, it is impossible to know when the injuries occurred. Although it is possible that Mr Roberts caused them himself, he was under constant supervision at the time and it is therefore difficult to understand how he could have done so without staff noticing. We consider that the cause of his black eyes should have been investigated as soon as staff noticed them. We recommend that:

The Governor should ensure that after a prisoner is restrained, they are assessed by healthcare staff.

142. On 20 April, the Deputy Governor told Mr Roberts that his complaint about the alleged assault had not been upheld. She also told him that his disciplinary hearing would still be going ahead and that he would not be transferring to Exeter because of the COVID-19 restrictions. She said she thought he was upset and that she told the SO that she thought his risk might have increased and that the SO said she would provide him with additional support. Mr Roberts was found hanging about 30 minutes later.

143. Given Mr Roberts' frequent self-harming and the fact that she had just given him bad news, we are concerned that the Deputy Governor did not arrange for him to have an immediate ACCT review if she thought Mr Roberts' risk had increased. We recommend:

The Governor should share this report with the Deputy Governor and discuss the Ombudsman's findings with her.

Clinical care

144. The clinical reviewer concluded that Mr Roberts' healthcare was of a reasonable standard and was largely equivalent to that he could have expected to have received in the community. The only exception to this was the lack of a prompt examination following a hand injury.

Physical health

145. Mr Roberts injured his hand on 14 February. He told healthcare staff, and, on 18 February, a GP concluded, without examining him, that the injury was unlikely to need further treatment. The clinical reviewer concluded that this was a missed opportunity to assess a potentially serious injury. When another GP assessed the injury on 24 February, she made a prompt referral to the hospital and he was treated appropriately.

Mental health

146. Overall, the clinical reviewer concluded that Mr Roberts' mental health care was reasonable and that appropriate steps were taken to manage his vulnerabilities.

147. The clinical reviewer noted that Mr Roberts' combination of schizoid personality disorder, emotionally unstable personality disorder and autistic traits made him especially vulnerable. He was satisfied that Mr Roberts was promptly referred to the mental health team at both Exeter and Bristol and that he received appropriate ongoing treatment from them. The neurodevelopmental service at Bristol engaged promptly with Mr Roberts and tried to introduce reasonable adjustments to the prison environment to keep him safe.

148. Although Mr Roberts did not see a psychiatrist while he was at Exeter or Bristol, the clinical reviewer noted that he was discussed at multidisciplinary meetings, with the psychiatrist present, who could have asked to review him if they had felt it was necessary. However, we are concerned that, although Mr Roberts' self-harm escalated over time, there is a risk that everyone involved with him had come to see it as 'normal' behaviour for him, and we consider that it would have been prudent for healthcare staff to have asked the prison psychiatrist to review him with a view to considering whether he should be referred for a transfer to a secure psychiatric hospital.

149. Mr Roberts was seen by a consultant forensic psychiatrist appointed by the court. The psychiatrist recommended on 11 March that Mr Roberts needed a transfer under the Mental Health Act to an autistic spectrum disorder unit in a secure psychiatric hospital for assessment and diagnosis. The clinical reviewer noted that the psychiatrist did not recommend an urgent transfer to hospital for treatment and did not contact the prison health team to escalate any concerns about Mr Roberts. The court asked for a second psychiatric assessment and this was due to take place on 29 April. It is, therefore, possible that Mr Roberts would have been transferred to a psychiatric hospital if he had lived.

150. Mr Roberts repeatedly refused to take his fluoxetine during the last few weeks of his life because he said that it made him psychotic (although there was no evidence of this). No fluoxetine was detected in his system after he died. The clinical reviewer concluded that he could not find any evidence that corroborated Mr Roberts concerns about the effects of the fluoxetine, but that it would have been prudent for staff to have formally reviewed Mr Roberts' medication. We recommend that:

The Head of Healthcare ensures that staff formally review a patient who repeatedly refuses to take their prescribed medication.

Inquest

151. The inquest concluded that Mr Roberts' death was accidental due to an unintended consequence of a deliberate act.

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 l 020 7633 4100