Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Beresford, a prisoner at HMP Ranby, on 7 July 2023

A report by the Prisons and Probation Ombudsman

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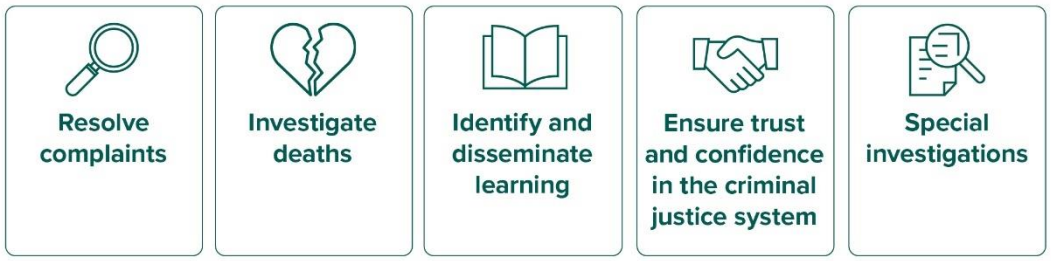
OUR VISION

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focussed, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Mark Beresford was found hanging in his cell at HMP Ranby on 3 July 2023. He was resuscitated, but died in hospital on 7 July, never having regained consciousness. He was 39 years old. I offer my condolences to Mr Beresford's family and friends.

Mr Beresford was subject to suicide and self-harm monitoring (known as ACCT) for some of the time he was in prison. He said he tied ligatures as a means of relieving stress, although he told staff he did not want to die.

There were occasions when Mr Beresford's risk to himself had potentially increased but staff did not adequately assess or manage this. Staff closed Mr Beresford's ACCT on 3 July, when it would have been prudent to leave it open. The next day, staff reopened the ACCT at 12.15pm but failed to complete his immediate action plan within specified timeframes. When Mr Beresford rang his cell bell at 12.53pm, the bell went unanswered as there was no lunchtime patrol officer on the wing. Staff found him hanging at 1.26pm.

We shall never know Mr Beresford's intentions when he began to hang himself, but his history was to use ligatures as a means to relieve stress and perhaps as a signal to staff that he needed help. When he rang his cell bell that afternoon, he would have expected someone to respond within a brief time but tragically no-one responded.

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

Adrian Usher
Prisons and Probation Ombudsman **July 2024**

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Summary

Events

1. On 24 February 2023, Mr Mark Beresford was remanded to HMP Nottingham charged with affray and being in possession of an offensive weapon in a public place. He was later sentenced to 12 months in prison. He was due to be released on 25 August.

2. On 6 March, Mr Beresford told staff that he had swallowed three razor blades following an altercation with his cellmate. Staff started Prison Service suicide and self-harm monitoring procedures (known as ACCT). Mr Beresford moved to a different wing.

3. Over the following weeks, Mr Beresford continued to speak about his fear of his ex-cellmate and also said that other prisoners were talking about him and that he was hearing voices. The ACCT was still open when Mr Beresford moved to HMP Ranby on 11 April,

4. Mr Beresford gradually settled at Ranby although he continued to be fearful of his ex-cellmate and at times placed ligatures around his neck. He said that he did this as a way to relieve stress.

5. Mr Beresford's ACCT had been closed for several weeks when he told an officer on 2 July that he wanted to hang himself. The officer re-opened the ACCT. Soon after, Mr Beresford was seen on the landing with a ligature draped around his neck.

6. The ACCT was closed at a review at 9.15am on 3 July but was re-opened at 12.15pm when Mr Beresford was again found with a ligature around his neck.

7. The wing supervising officer (SO) should have arranged for Mr Beresford to be seen within an hour for completion of an immediate action plan, but he thought that other staff were making those arrangements. As no immediate action plan was completed, no observations were set for Mr Beresford.

8. At the time Mr Beresford's ACCT was being re-opened, officers left the Houseblock to take their lunchbreak. Due to administrative errors, Houseblock 3 North, where Mr Beresford was located, had no lunchtime patrol officer.

9. Mr Beresford rang his cell bell at 12.53pm, but it remained unanswered.

10. Following lunch, officers began to unlock prisoners for work. A prisoner found Mr Beresford hanging in his cell at 1.26pm. Officers radioed a medical emergency code, went into the cell, cut the ligature and started cardiopulmonary resuscitation (CPR).

11. Paramedics arrived at 1.41pm and established a pulse. Mr Beresford was taken to hospital and placed in intensive care. He died in hospital on 7 July.

Findings

12. Mr Beresford was sometimes supported by the ACCT process. However, staff did not always adequately assess or act on his potentially increasing risk to himself. It would also have been prudent to have kept Mr Beresford's ACCT open at the review on the morning of 3 July.

13. The wing SO should have ensured that Mr Beresford was seen for completion of an immediate action plan over lunchtime on 3 July.

14. Houseblock 3 North should not have been left without a lunchtime patrol officer at the time that Mr Beresford hanged himself.

Recommendations

- The Governor should ensure that ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk and improve the quality assurance process that confirms this learning has been embedded.

The Investigation Process

15. HMPPS notified us of Mr Beresford's death on 8 July 2023. The investigator issued notices to staff and prisoners at HMP Ranby informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

16. The investigator obtained copies of relevant extracts from Mr Beresford's prison and medical records.

17. The investigator interviewed seven members of staff and one prisoner at Ranby in September 2023. He interviewed a further member of staff in September by video-link. He interviewed four further members of staff at Ranby in January and February 2024 and another member of staff by video-link in February 2024.

18. NHS England commissioned a clinical reviewer to review Mr Beresford's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with clinical staff.

19. We informed HM Coroner for Nottingham City and Nottinghamshire of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

20. The Ombudsman's office contacted Mr Beresford's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Beresford's mother asked:

    - Why had it taken 90 minutes for staff to respond when her son pressed his cell bell on 3 July? She did not believe that her son wanted to take his life; she said pressing the cell bell was a cry for help.

    - Why were items left in her son's cell which he could potentially use to kill himself?

    - Why was her son not sent to a mental health unit?

21. We have answered these questions either within this report or in separate correspondence.

22. We shared the initial report with Mr Beresford's mother and with HM Prison and Probation Service (HMPPS). Mr Beresford's mother did not make any comments. HMPPS did not find any factual inaccuracies.

Background Information

HMP Ranby

23. HMP Ranby is a medium risk training and resettlement prison in Nottinghamshire. Nottinghamshire Healthcare NHS Foundation Trust provides primary and mental health services.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Ranby was in March and April 2022. Inspectors reported that levels of self-harm at Ranby were much lower than in other similar category C prisons. They noted that there had been an effective focus on improving delivery of the ACCT process, including advice and feedback to staff through three-layer managerial checking. Inspectors noted that there was a named coordinator for each ACCT who conducted all reviews if possible. In addition, a member of the mental health team always attended initial case reviews.

25. Inspectors found that the keyworker scheme was operating to an extent in that most prisoners knew their named officer, but recorded interactions were often brief and prisoners did not generally find them helpful. Inspectors noted that response times to cell bells remained a concern and only 17% of prisoners said that cell bells were normally answered within the five-minute target time.

26. Inspectors noted that a skilled and experienced mental health team provided a range of support to prisoners and worked to the 'stepped-care' model to identify prisoners' needs (the 'stepped-care' model aims to deliver the most effective yet least resource intensive treatment first).

Independent Monitoring Board

27. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2023, the IMB reported that Ranby ran a generally courteous and respectful regime and in the main staff/prisoner relationships were generally good. The IMB also considered that Ranby was a safe prison.

Previous deaths at HMP Ranby

28. Mr Beresford was the sixth prisoner to die at Ranby since January 2020. Of the previous deaths, two were self-inflicted, two were from natural causes and one was from an overdose of stolen medication.

29. In our investigation into the death of a prisoner at Ranby in December 2021, we found several deficiencies in the ACCT process, including that an ACCT was not opened when the prisoner said that he was having suicidal thoughts and an ACCT that was opened later was closed prematurely.

Assessment, Care in Custody and Teamwork

30. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Checks made on prisoners should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a care plan to identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

HMP Nottingham

31. On 24 February 2023, Mr Mark Beresford was remanded to HMP Nottingham charged with affray and being in possession of an offensive weapon in a public place. He was later sentenced to 12 months in prison and was due to be released on 25 August 2023. It was not his first time in prison.

32. At a reception health screen on arrival at Nottingham, Mr Beresford said that he was feeling okay, and he had no thoughts of suicide or self-harm.

33. On 6 March, staff started Prison Service suicide and self-harm monitoring procedures (known as ACCT) after Mr Beresford said that he had swallowed three razor blades. At an ACCT review that afternoon, Mr Beresford was noted to be paranoid, anxious and agitated. He said that he felt unsafe in his current cell due to an altercation with his cellmate. He also said that he thought other prisoners on the wing believed that he was racist. Mr Beresford asked to move to the segregation unit. Immediately after the ACCT review, Mr Beresford climbed under the fourth landing netting. Staff moved Mr Beresford to a new cell on a different wing.

34. On 7 March, a nurse noted that Mr Beresford had previously been prescribed antidepressants in the community. He named three medicines he had been prescribed in the past but said that he had not found any of them very helpful. The following day, a doctor prescribed Mr Beresford sertraline (an antidepressant).

35. Over the following weeks, Mr Beresford made further comments about fearing his ex-cellmate, that other prisoners were talking about him and that he was hearing voices. He said that he preferred to be alone or in small groups. Mr Beresford isolated himself from other prisoners and, for a period of time, officers took his meals to his cell. On a number of occasions, Mr Beresford rang his cell bell and when staff responded they found him with a ligature around his neck. Mr Beresford generally used bedding or clothing as ligatures. On one occasion, he pressed his cell bell and then pushed a note under his door to say that he believed he would be better off dead.

36. Mr Beresford was also subject to a Challenge Support Intervention Plan (CSIP – used to support those who might be at risk from or a risk towards other prisoners). This noted that he engaged well with his key worker and mental health staff during ACCT reviews and completed in-cell education packs to keep him occupied.

37. Staff closed Mr Beresford’s ACCT on 20 March but re-opened it three days later. Mr Beresford’s ACCT observations were generally set at around one an hour to one every two hours, although there were times when his observations were more frequent than that, including from 14 March to 15 March when he was under constant supervision.

38. On 29 March, staff discussed Mr Beresford at a mental health team meeting and referred him to the psychiatrist. (When Mr Beresford transferred to Ranby, mental health staff considered that he did not meet the threshold for referral to a psychiatrist.)

39. On 4 April, during a CSIP review, staff noted that Mr Beresford continued to self-isolate and asked to transfer to another prison. Staff arranged for him to move to HMP Ranby. On the morning of 11 April, Mr Beresford had an ACCT review ahead of his transfer that day. Mr Beresford said that he was feeling positive as he had been in Ranby in the past and he had a good relationship with the staff there. He also said that he had a good relationship with his mother and partner, and he was eager for his release from custody. Mr Beresford said that he had no thoughts of suicide or self-harm, and staff maintained his observations at one an hour.

HMP Ranby

40. Mr Beresford arrived at Ranby in the early afternoon of 11 April and was seen by a mental health nurse for a reception health screen. Mr Beresford said that he had a history of cannabis misuse, suffered from depression and was struggling with paranoia and hearing voices. The nurse noted that Mr Beresford was prescribed sertraline, and this was continued.

41. At an ACCT review later that afternoon, Mr Beresford was noted to be visibly nervous. He said that he was concerned about sharing a cell (as he had been in a single cell at Nottingham), and he was advised to speak to induction staff about this. He also said that he had heard that his ex-cellmate, who had been released from prison, would stab him on his release. Staff kept Mr Beresford's ACCT observations at one an hour.

42. At around 9.13am on 12 April, staff radioed a medical emergency code blue (to indicate a prisoner is unconscious or having breathing difficulties) when Mr Beresford briefly lost consciousness after tightening a ligature around his neck. A nurse noted that Mr Beresford had a small cut from falling and banging his head. She also noted that by the time of his examination his clinical observations were normal. Staff increased his observations to two an hour. At an ACCT review later that day, chaired by a Supervising Officer (SO), Mr Beresford said that he used a ligature as he was scared that he would have to share a cell and he had already heard other prisoners using his name. He also explained that he used ligatures for stress relief and not as suicide attempts. Staff increased Mr Beresford's observations to two an hour.

43. On 13 April, staff discussed Mr Beresford at the weekly safety intervention meeting (SIM - where staff discuss prisoners who might need additional support to that already being provided). An SO told the SIM about Mr Beresford's fear that he would have to share a cell and that he used ligatures as stress relief. The SO said that he told Mr Beresford that he needed to find other, less dangerous ways, to calm down. The SIM decided that Mr Beresford should continue to be supported through his CSIP.

44. Mr Beresford pressed his cell bell at around midday and staff found him with a plastic bin bag hanging loosely around his neck. He said that he was stressed as he was still waiting for a phone and a television and that he needed these to

keep him calm. At 3.10pm, Mr Beresford pressed his cell bell again and when staff went to his cell he was unresponsive on his cell floor with a plastic bag around his neck. An officer placed Mr Beresford in the recovery position and radioed a medical emergency code blue. A nurse responded in a few minutes and by the time she arrived Mr Beresford was responsive and sitting on a chair. An SO chaired an immediate ACCT review and placed Mr Beresford under constant supervision in a constant supervision cell. He had a television and phone.

45. At an ACCT review on 14 April, Mr Beresford said that his reason for harming himself the day before was because he had been told earlier in the day that he would be getting a phone and a television, but the equipment did not arrive quickly enough so he did not think he would get them. The SO who chaired the review told Mr Beresford that using a ligature was a high-risk action and that he was putting himself at significant risk of accidental harm. Mr Beresford said that he understood the possibility of risk, but that was the method he used to deal with his emotions. He stressed that he did not want to die. Staff reduced Mr Beresford's observations to two an hour.

46. Mr Beresford did not engage fully at his next ACCT review on 17 April and staff kept his observations at two an hour.

47. On 20 April, staff discussed Mr Beresford at the mental health team multi-disciplinary team meeting. They decided that he did not meet the threshold for inclusion on the mental health caseload.

48. Mr Beresford's next ACCT review was on 24 April. Mr Beresford spoke again about his fear of retribution on release from prison. An SO (SO A) who chaired the review, noted that Mr Beresford lacked confidence in coming out of his cell and he spoke to him about steps to help him. Mr Beresford acknowledged that his past cannabis use might have made him paranoid. He also said that he had no present thoughts of suicide or self-harm. Staff reduced his ACCT observations to one an hour.

49. The next day, SO A held a CSIP review with Mr Beresford. SO A noted that Mr Beresford was gaining confidence and was not self-isolating anymore. He closed the CSIP and noted Mr Beresford continued to be supported through an ACCT.

50. On 27 April, SO A went to see Mr Beresford, as staff said that he was upset. Mr Beresford told SO A that everyone at Ranby knew he was "a grass" and that he was going to start self-isolating again. SO A noted that after they spoke for a while Mr Beresford agreed to co-operate with staff in trying to manage the situation and that he would be allowed to lock himself in his cell if there were times when he became overwhelmed.

51. SO A considered whether Mr Beresford needed to be subject to a CSIP again. He recorded that Mr Beresford did not feel under threat from prisoners at Ranby but was concerned that his cellmate from Nottingham would harm him, his partner or mother on his release. SO A informed the police liaison officer and concluded no CSIP was necessary at that time since Mr Beresford did not currently feel under threat.

52. At the early evening routine check on 29 April, Mr Beresford was seen sitting on his bed with a jumper loosely around neck. Officers went into the cell and took the jumper from him. Mr Beresford again spoke about his fear of retribution. An SO noted that he managed to calm Mr Beresford and he removed some items from the cell that could be used as ligatures. The SO also noted that Mr Beresford's actions presented no change to his level of risk. The SO (incorrectly) believed that Mr Beresford was being observed twice an hour and noted that observations should continue at that level.

53. At an ACCT review on 4 May, staff noted that Mr Beresford's state of mind had improved, and he was coming out of his cell to collect his meals. He said that he had a good rapport with the wing staff and Houseblock 3 was the best place for him at that time. He also said that he still needed the support of ACCT observations due to his tendency to self-harm in reaction to stress rather than working his way through his frustrations by other means. Staff reduced Mr Beresford's observations to one an hour. On 11 May, staff further reduced his observations to one every three hours.

54. On 12 May, the SIM noted that Mr Beresford was receiving support through ACCT and had contact with mental health staff as part of that. The SIM agreed that Mr Beresford was no longer in crisis and could be removed from the SIM workload.

55. At an ACCT review on 18 May chaired by SO A, Mr Beresford said that he had heard that his ex-cellmate had been 'scoping-out' his address. Other than that comment, Mr Beresford seemed well. SO A noted that all at the review agreed that the ACCT would be considered for closure at the next review. In the meantime, Mr Beresford would have two conversations a day with officers, but there was no need for observations.

56. On the evening of 18 May, Mr Beresford told an officer that he would kill himself at some point in the night but was waiting for telephone credit to be added at midnight so he could tell his partner what he was going to do. The officer noted the comment in Mr Beresford's ACCT, but there is no record that he took any action or reported the comment to the Orderly Officer, the senior officer on duty.

57. On 25 May, SO A held an ACCT review with Mr Beresford. A mental health nurse was also at the review. Mr Beresford again spoke about his fear of reprisal from his ex-cellmate, but also acknowledged that he "over-thought" matters and accepted that his past cannabis use might have affected his thinking. SO A noted that despite his anxiety, Mr Beresford was looking forward to his release and being with his family again. SO A noted that all agreed that the ACCT could be closed: the ACCT was then placed in 'post-closure', a seven-day period for staff to assure themselves that the prisoner is coping and is not at risk.

58. On 1 June, an officer introduced himself to Mr Beresford as his keyworker and explained that the role gave dedicated time to discuss his needs and any worries. Mr Beresford said that he believed staff and other prisoners talked about him "behind his back" so he was unsure who to trust. However, his only concern at that time was understanding the prison release process. The officer noted that since Mr Beresford's ACCT had been closed, he had made major improvements to how he was living on the wing and was socialising with other prisoners.

59. On 3 June, SO A saw Mr Beresford for an ACCT post closure review. SO A noted that Mr Beresford engaged throughout the review and raised no new issues of concern. He noted that the ACCT was to remain closed.

60. On 23 June, a GP saw Mr Beresford as he had not collected his sertraline tablets in the past few days. Mr Beresford said that he had been suffering cold and flu symptoms and he thought the sertraline might make his symptoms worse. The GP reassured him that that would not be the case and Mr Beresford said that he would start collecting his medication again. (Mr Beresford was frequently non-compliant with his medication giving various reasons including saying that sometimes he was anxious about joining the medication queue and that sometimes officers did not unlock him. Nurses reminded him to take more responsibility, including that he should ring his cell bell if officers did not unlock him for medication.)

61. On 30 June, the keywork officer had another keyworker meeting with Mr Beresford. Mr Beresford again spoke about his fears of his ex-cellmate upon his release, but he admitted that it was most likely a fear that he had built up in his mind. The keywork officer noted that Mr Beresford's confidence had improved during his time on Houseblock 3, he was collecting his meals and medication and regularly engaged with staff and other prisoners.

Events of 2 July

62. Mr Beresford rang his cell bell at 12.39pm on 2 July and told an officer that his ACCT should not have been closed and that he wanted to hang himself. The officer re-opened Mr Beresford's ACCT.

63. At around 2.00pm, an SO (SO B) saw Mr Beresford to complete an immediate action plan: a plan to keep him safe for the first 24 hours or until his first case review. Mr Beresford said that he did not want to die, but he again spoke about his fears of being attacked after his release. SO B agreed with Mr Beresford that he would be observed at intervals of no more than two hours and that he would have an ACCT review the following day.

64. At around 3.30pm, a prisoner told an officer that Mr Beresford was on the third landing with a bedsheet draped around his neck. The officer went to see Mr Beresford and asked him to take the bedsheet from his neck, which he did. The officer asked Mr Beresford if he wanted to see somebody from the safer custody team or healthcare, but he declined the offer. The officer told Mr Beresford not to do anything stupid, but to speak to staff instead if he needed anything. The officer said that he informed the wing SO about this incident, although the SO said that he was not informed.

65. The investigator viewed CCTV footage for the afternoon of 2 July when prisoners were free to mix on the wing from 2.00pm to 4.45pm. The investigator noted that Mr Beresford spent the entire period out on association. He occasionally spoke a few words to other prisoners, but generally spent his time walking alone around the wing and sometimes leaning on the railing. There was no indication from his body language to suggest that he had any fear of other prisoners.

66. At around 5.20pm, an officer noted that Mr Beresford began crying after speaking about what might happen to him or his mother after his release from prison.

67. The investigator listened to Mr Beresford's telephone calls for 2 July. He telephoned his mother in the morning and he telephoned his partner in the early afternoon and again in the early evening. In all three calls he talked about his fear of retribution from the ex-cellmate and that the family might have to move to a new area. (Mr Beresford and his partner lived at his mother's home.) During the calls Mr Beresford's mother and partner tried to reassure him including saying that they would move home if necessary.

68. Mr Beresford's ACCT contains no record of any ACCT checks between 5.00pm and 10.00pm. However, the officer on duty on Houseblock 3 that night noted that Mr Beresford had slept all night and that he had given no reason for concern.

Events of 3 July

69. At 9.15am on 3 July, SO A collected Mr Beresford from his cell for an ACCT review. A nurse also attended, along with another mental health nurse who was shadowing the nurse. SO A asked Mr Beresford why he had not been on association when he collected him for the ACCT review. Mr Beresford again said that it was fear of his ex-cellmate and that was why he sometimes did not come out of his cell to collect his medication. Mr Beresford confirmed that he was well supported by his mother and partner, and they had installed CCTV at the home. His mother had also contacted the police for rapid response protection upon his release. Mr Beresford said that he had no present thoughts of suicide or self-harm and that he would seek support from staff if necessary.

70. The nurse told Mr Beresford that sertraline would help him with his anxiety and Mr Beresford agreed he would start to collect his medication again. The nurse noted that Mr Beresford recognised that he was not under threat at Ranby and that other prisoners had helped him the day before when they saw him with a ligature. The nurse wrote that Mr Beresford engaged well at the review and that there were no signs of poor mental health.

71. SO A noted that all at the review agreed that the ACCT should be closed and moved to post-closure.

72. The investigator asked SO A whether he thought about keeping the ACCT open to see if Mr Beresford would start coming out of his cell again for association and to collect his medication. SO A said that Mr Beresford said at the review that he did not want to use ACCT as a crutch as he knew that support would not be there for him on his impending release from prison. He also never said at any time that he wanted to die, he just wanted help and a conversation. SO A said that if Mr Beresford had still been anxious at the end of the review he would not have closed the ACCT.

73. CCTV shows that Officer A went to Mr Beresford's cell at 11:42am after he rang his cell bell and again at 11:47am when he rang his cell bell once more. The officer spent a few seconds talking to Mr Beresford each time and he then told the keywork officer that Mr Beresford was being unusually aggressive towards him and suggested that the keywork officer should speak to him as they had a

better rapport. The keywork officer went to the cell at 12.06pm and, when he looked into the cell, he saw Mr Beresford with a pillowcase around his neck which he was tightening with both hands. Both officers went into the cell and Mr Beresford agreed to take the pillowcase from his neck. He said though that he was unsure whether he still wanted to be released as the problem with his ex-cellmate would follow him home and put his mother at risk. The keywork officer spent nine minutes in the cell speaking to Mr Beresford. He told him that he would re-open the ACCT and he would see him again in the afternoon.

74. The keywork officer B told SO B and another SO (SO C) that he was going to re-open the ACCT and he then started to complete the paperwork.

75. SO C telephoned a Custodial Manager (CM – CM A) , the officer in charge, to report the routine count of all prisoners and, in line with policy, she also told her that Mr Beresford's ACCT had been re-opened. Once the keywork officer completed the ACCT paperwork, he telephoned CM B, who was sharing an office with CM A, to give the details of why he had re-opened the ACCT.

76. A trained member of staff of at least SO grade should have seen Mr Beresford within the next hour to complete his immediate action plan, but this did not happen. CM B told the investigator that the wing SO was responsible for making those arrangements. As no action plan was completed, no observations were set for Mr Beresford.

77. SO C finished her shift at 12.15pm and left the prison. At around the same time, SO B left Houseblock 3 to take his lunch break. He told the investigator that he had completed the daily staff detail for Houseblock 3, which he had done the previous afternoon. He had gone through the published establishment detail which contained the shift patterns and allocation detail for all of the staff at Ranby. From that, he had entered the names of the officers on duty on Houseblock 3 throughout the day, including which staff were due to work on Houseblock 3 North (where Mr Beresford was located), and which staff were due to work on Houseblock 3 South.

78. The investigator was shown a copy of the establishment detail which comprised around 100 pages and was told that the only way for an SO to determine which staff were allocated to his or her wing was to work through all of the pages to pick out the names. From that information, the SO would then produce a single A4 page with the wing staffing detail for the day. During the lunch period, Houseblock 3 should be staffed by two patrol officers: one officer for the North side and one for the South. Staff completing the establishment detail for that day failed to allocate an officer for lunchtime patrol on Houseblock 3 North. SO B told the investigator that he had not noticed this omission when he produced the specific staff detail for Houseblock 3. When he went for his break that day, he did not realise that Houseblock 3 North was left unstaffed.

79. CCTV shows that the keywork officer left Mr Beresford's cell at 12.15pm. At 12.53pm, Mr Beresford rang his cell bell. The only officer on duty at that time on the Houseblock was Officer B, the lunchtime patrol officer for Houseblock 3 South. Officer C told the investigator about some of the duties he completed during that lunch period, which included answering cell bells on both the South and North sides of the Houseblock. He said that he did not hear Mr Beresford's

cell bell. The investigator visited Houseblock 3 and noted that cell bells were only audible in certain areas and that it was entirely possible for an officer on the South side to be unaware that a cell bell had been rung on the North side. Officer C acknowledged that at some stage during that period he realised that the North side was unstaffed. However, he did not take any action or alert the officer in charge.

80. At around 1.20pm, officers had returned from their lunch breaks and began to unlock prisoners on Houseblock 3 North for work. CCTV shows that at 1.26pm a prisoner noticed that Mr Beresford's cell bell light was on and when he looked into the cell, he saw him hanging. The prisoner shouted to staff and Officer A reached Mr Beresford's cell in around 30 seconds. He looked into the cell, called for further support, and went into the cell. Mr Beresford had looped a ligature around the window frame and was hanging in a slumped position with only his heels touching the floor. He lifted Mr Beresford's body. Another officer arrived 15 seconds later and cut the ligature. The officers then lowered Mr Beresford to the cell floor and started cardiopulmonary resuscitation (CPR). The keywork officer reached the cell a few seconds later and he radioed a medical emergency code blue. Staff in the control room immediately requested an ambulance.

81. A nurse was near Houseblock 3 when she heard the code blue and she arrived at Mr Beresford's cell at 1.29pm. She saw officers performing CPR and noted that while Mr Beresford had a good colour, he also had vomit in his mouth and nose. She tried to insert an airway device to give oxygen but there was too much vomit. She tried to suction the vomit but was only able to remove a small amount. She then used a different type of airway device and was able to maintain an airway and give oxygen. Officers took turns in giving CPR while the nurse continued giving oxygen. Mr Beresford was checked regularly with a defibrillator, but it advised each time that no shock could be given, and that CPR should continue.

82. Paramedics arrived at 1.41pm. They took charge of Mr Beresford's care and established a pulse. At 2.18pm, Mr Beresford was taken to hospital without restraints.

83. Mr Beresford remained in intensive care until he died in the late evening of 7 July.

Contact with Mr Beresford's family

84. At 3.15pm on 3 July, one of Ranby's family liaison officers telephoned Mr Beresford's mother to tell her that her son had been taken to hospital and was in a critical condition. Mr Beresford's mother said that she had no transport, so Ranby sent a prison vehicle to her home and took her to hospital where she arrived at around 5.00pm. Mr Beresford's mother and other family members were with him when he died on 7 July. Ranby contributed to the cost of Mr Beresford's funeral in line with national instructions.

Support for prisoners and staff

85. On the afternoon of 3 July, the Governor and 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.

86. After Mr Beresford's death, one of Ranby's functional heads debriefed the bedwatch officers who were with Mr Beresford when he died.

87. Ranby posted notices informing other prisoners of Mr Beresford'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 Beresford's death.

Post-mortem report

88. The pathologist gave Mr Beresford's cause of death as hypoxic brain damage (caused by a lack of oxygen) as a result of hanging. His toxicology report had no significant findings.

Findings

Management of Mr Beresford's risk of suicide and self-harm

89. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.

90. Throughout his time at Ranby Mr Beresford remained highly anxious about a real or perceived risk posed to him and his family from a prisoner with whom he had shared a cell at Nottingham. As a result, there were times that Mr Beresford would not come out of his cell. He had a habit of placing ligatures around his neck to relieve his anxiety. There were at least two occasions before 3 July that Mr Beresford briefly lost consciousness from tightened ligatures, but there is no evidence to suggest that he intended to take his life on those occasions. It also seems that sometimes Mr Beresford wanted to be seen with a ligature as that signalled to staff that he needed help. Staff advised him of the dangerousness of his actions and Mr Beresford said that he was aware of this, but it was his means of relieving stress.

91. The investigator asked the Head of Safety if Mr Beresford should have had enhanced ACCT case reviews (which are attended by more senior members of staff and a wider range of participants). He said that certain prisoners are deemed complex cases and will have a higher level of scrutiny. Prisoners who fall into this category are those who are under constant supervision, prisoners who have a mental disorder that might require transfer to a mental health unit and those who engage in prolific self-harm. Mr Beresford therefore did not meet the threshold. He had been referred to the SIM and discussed there twice before senior staff were satisfied that Mr Beresford was receiving appropriate support.

92. The majority of Mr Beresford's ACCT reviews at Ranby were multidisciplinary with reasonably consistent case management by SO A and good attendance by mental health nurses. Staff also tried to ensure that Mr Beresford understood how dangerous tying ligatures was.

Assessment of escalated risk

93. On the evening of 18 May, Mr Beresford told an officer that he intended to kill himself sometime that night but there is no record that the officer in charge was informed. Staff should have held an urgent case review, reviewed Mr Beresford's level of risk and considered whether observations needed to be restarted (he was subject to two conversations a day and no observations at the time).

94. It is also unclear whether the officer told the wing SO when he found Mr Beresford with a ligature around his neck at 3.30pm on 2 July. A review of Mr Beresford's risk should have taken place and consideration given to increasing his observations.

These were set at every two hours at the time which is arguably too low for someone who has just been found with a ligature around their neck.

Missing ACCT observations

95. Mr Beresford's ACCT contains no record of ACCT checks between 5.00pm and 10.00pm on 2 July. We note that this omission was identified during an early learning review following Mr Beresford's death.

Closure of ACCT

96. Staff closed Mr Beresford's ACCT in the morning of 3 July. At that review, Mr Beresford spoke again about his fears related to his previous cellmate and said that he had not been coming out of his cell to collect his medication. Mr Beresford said he was content for the ACCT to be closed that morning, recognising that support through ACCT would not be available to him after his release from prison. However, it is clear that Mr Beresford benefited from discussion with and reassurance from staff about his safety. While we acknowledge that ACCT support would not have followed Mr Beresford into the community, he would instead of course then had the support of his mother and partner. We consider, on balance, that it would have been prudent to have kept Mr Beresford's ACCT open pending his approaching release. Keeping the ACCT open would also have allowed staff to monitor Mr Beresford's promise to start coming out of his cell to collect his medication. This is particularly in light of the fact that he had tied a ligature round his neck the previous day.

Failure to complete an immediate action plan

97. When staff re-opened Mr Beresford's ACCT at 12.15pm on 3 July, arrangements should have been made for a trained member of staff of at least SO grade to see him within an hour to complete an immediate action plan. It seems that SO B believed that the officer in charge would be responsible for identifying a person to complete the plan during the lunch period. However, CM B was clear that the responsibility fell to SO B to complete the plan himself or identify a colleague to complete it. In the absence of an immediate action plan, Mr Beresford was not subject to ACCT observations over the lunchtime period.

Lunchtime patrol

98. When Ranby published its daily staffing detail for Houseblock 3 for 3 July, Officer B was identified as the lunchtime patrol officer for Houseblock 3 South, but no officer was identified as lunchtime patrol officer for Houseblock 3 North. When SO B went through the lengthy overall prison detail to produce a specific daily detail for Houseblock 3, he did not notice this omission. This meant that Houseblock 3 North was left unpatrolled that lunchtime.

99. Records show that Mr Beresford rang his cell bell at 12.53pm but the call was not answered. At 1.26pm, a prisoner found Mr Beresford hanging in his cell. We do not know at what time Mr Beresford began to hang himself, however the fact that staff were able to resuscitate him would suggest that he did not hang himself immediately after ringing his cell bell and it seems likely that he would have

expected staff to come to speak to him as had always happened previously. While we cannot be certain about Mr Beresford's intentions, it seems likely that his actions that afternoon started as a means of stress relief and getting help from staff, not as a determined effort to take his life.

Action taken since Mr Beresford's death

100. The Head of Safety told the investigator that he was aware of a number of the failures of care that had occurred in Mr Beresford's case. These included SO B's failure to complete an immediate action plan on 3 July or notice that the staffing detail did not identify an officer for lunchtime patrol on Mr Beresford's Houseblock. He said that SO B, who at the time was very new in post, had been subject to an internal investigation, at which he acknowledged his omissions. The Head said that the investigation resulted in SO B receiving targeted advice and guidance. In addition, the Head said that the since Mr Beresford's death, Ranby had introduced a secondary check to identify any omissions in the staffing detail and all SOs have been reminded about the need to check the detail when completing the specific detail for their own wing.

101. The Head of Safety also recognised that during the ACCT quality assurance process, staff occasionally identified ACCT observations that had been missed. Wing managers then addressed any missed checks with staff concerned.

102. We are satisfied that most of the issues identified in the assessment and management of Mr Beresford's risk to himself have been addressed since his death. However, we remain concerned that there were times when his potentially escalating risk was not assessed nor was an urgent ACCT case review held. We make the following recommendation:

The Governor should ensure that ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk and improve the quality assurance process that confirms this learning has been embedded.

Clinical care

103. The clinical reviewer concluded that Mr Beresford's care at Ranby was of a good standard and equivalent to that which he could have expected to receive in the community. She noted that he was assessed by the mental health team and found not to reach the threshold for inclusion on the mental health team caseload. She also noted that he continued to receive input from the mental health team during ACCT reviews.

104. The clinical reviewer noted that there had been problems with the manual suction machine during the emergency response on 3 July, but the prison has since acquired an electronic suction machine. The clinical reviewer made no recommendations.

Good Practice

105. We consider it an example of good practice that Ranby sent a prison vehicle to take Mr Beresford's mother to hospital so she could be with her son with a minimum of delay.

Governor to note

106. We note that Officer B recognised at some stage that there was no patrol officer on Houseblock 3 North at lunchtime on 3 July. He should have informed the officer in charge by radio. All staff should understand that they have a corporate responsibility towards the safety and security of the prison. The Governor will wish to ensure that all staff are aware of this responsibility.

Inquest

107. An inquest into Mr Beresford's death concluded on 15 October 2024 that his death was due to misadventure.

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