PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Ranby in June 2013

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man, who was found hanging in his cell in HMP Ranby on the morning of 1 June 2013. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the man's clinical care in custody. HMP Ranby cooperated fully with the investigation.

The man had been in prison since 2009 and arrived at Ranby in May 2011. In April 2013, he had been subject to disciplinary action and expressed concern about its possible impact on a Parole Board hearing in May. In mid-May, he alleged that other prisoners were bullying him, but subsequently said the problem had been resolved. Two days before his death, the man had told a member of staff that he had feelings for her and, as a result, was prohibited from entering the department where she worked.

On 31 May, the man gave no indications that he had any problems. After prisoners had been locked in their cells for the evening, the prisoner in the next cell heard him ripping up bed sheets. He assumed that the man was making a way of passing contraband, but asked him what he was doing. The man said that he was not doing anything and did not appear to be upset or distressed. When staff unlocked the cell the following morning, the man was found hanging from a torn bed sheet. Prison officers took him down and laid him on the bed. When medical and ambulance staff attended they concluded that the man had died and therefore did not attempt resuscitation.

After the man died, rumours emerged that he had been distressed on the night he died, and had argued with a member of staff and damaged his cell. The investigation has not uncovered any evidence to suggest that this was the case. I am satisfied that the man received a reasonable standard of care in Ranby and that his death could not have been foreseen. However, I am concerned that the man's allegations of bullying were not properly investigated.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2014**

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SUMMARY

1. The man received an indeterminate sentence for public protection in 2009. He had been at HMP Ranby since May 2011. When he died he was 27 years old. During his time in prison, the man had sometimes come into conflict with staff. However, at Ranby, he took offending behaviour and other courses, had a number of prison jobs and generally appeared to settle well.

2. The man was undertaking a cognitive self-change programme as part of his sentence plan to reduce his risk. In March 2013, the man refused to leave the building during a fire alarm, which resulted in disciplinary action. He was also downgraded to a lower level of the prison's privileges scheme. The man was concerned that this incident would count against him when the Parole Board considered him for release in May 2013.

3. In May 2013, the man reported to a course facilitator that some other prisoners were attempting to bully him. She completed an anti-bullying form, which she sent to the man's wing manager and submitted a security report about this. We have found no evidence that any investigation or action was taken about the alleged bullying. The next week, the man told the course facilitator that the bullying situation had been resolved and also told her that he had feelings for her. The facilitator told the man that, although he had disclosed this respectfully, there had to be clear boundaries between staff and prisoners. She submitted a security report about the incident. As a result, the man withdrew from the course and was barred from the building where she worked.

4. On the morning of 31 May, the man complained of feeling unwell. Healthcare staff concluded that he was dehydrated and advised him about his diet and hydration. Later that morning, he discussed with a prison officer the situation that had led to him being barred from contacting the course facilitator. The officer did not detect any signs that the man was vulnerable and said that when he spoke to him later that afternoon, the man did not seem to be upset.

5. The man's cell was at the end of a row of first floor cells. At approximately 11.30pm on 31 May, the prisoner in the next cell heard the man ripping up bed sheets. He asked what he was doing, and the man replied "nothing". He told the man not to do "anything silly" but did not feel any reason to be concerned as prisoners often ripped up sheets for various reasons, including to make a 'line' to obtain or pass contraband to and from prisoners in other cells. There were no reports of any problems during the night, although the cell call bell recording system was not working at the time, so it has not been possible to check whether the man pressed his cell bell. Prisoners in the two cells next to the man said they did not hear any disturbance or unusual noise during the night.

6. At approximately 7.50am, the prisoner in the next cell said he thought he heard a noise from the man's cell. He called to him but did not get a response. Shortly afterwards, a prison officer conducting a roll check discovered the man hanging by bed sheets from the window. Officers went into the cell and cut him down. Nurses and paramedics attended but did not attempt resuscitation as rigor mortis had set in and it was clear that the man was dead.

7. We do not consider that staff at Ranby could have anticipated or prevented the man's actions. However, we have some concerns that staff did not follow the anti-bullying procedures after the man had reported he was being threatened. There is no direct evidence that the man was being bullied and it is possible that his allegations were not genuine. Nevertheless, it is important that all information about potential bullying is investigated promptly and any necessary action taken, including supporting victims.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Ranby informing them of the investigation and inviting anyone with relevant information to contact him. Three prisoners replied. One had no specific information about the man but the other two asked to speak to the investigator. Both had transferred from Ranby and the investigator spoke to them at their new prisons.

9. The investigator obtained the man's prison and medical records. He visited the prison on 12 June 2013 and spoke to the deputy governor and other prison staff.

10. NHS East Midlands commissioned a clinical reviewer to review the man's healthcare and treatment at the prison. The investigator liaised with the clinical reviewer and discussed his findings with him.

11. As is routine with deaths in prison, Nottinghamshire Police examined the circumstances of the man's death. No criminal charges were brought. The officer in charge discussed the case and shared witness statements with the investigator.

12. The investigator interviewed six prison staff, one member of probation staff, and five prisoners. He gave preliminary feedback on emerging findings to the Governor of Ranby during the investigation.

13. HM Coroner for Nottinghamshire was informed of our investigation and provided a copy of the post-mortem report. A copy of this report has been sent to the Coroner.

14. One of our family liaison officers and the investigator visited the man's father and uncle to allow them to identify issues they wished the investigation to cover.

15. The man's father believed that his son had been worried about a disciplinary hearing in April which he thought would be held against him at forthcoming Parole Board review of his suitability for release. The man had said that his probation officer had told him that he would not be released from prison for at least two more years and this had distressed him. The man's father asked the investigation to consider rumours that during the night before he was found dead, the man had been screaming so much that other prisoners had asked him to be quiet as they could not sleep and that he had argued with a prison officer who, at one point, went into the man's cell. The man's father wanted to know whether prison officers had responded to any calls for assistance. He wondered whether the man really meant to take his own life, or if he had expected to be found.

HMP RANBY

16. HMP Ranby is a category C male prison, for prisoners who do not require a high level of security but are not ready for open conditions. It holds over a thousand prisoners. There is no CCTV coverage of the wings.

Her Majesty's Inspectorate of Prisons

17. The most recent inspection of Ranby was in March 2012. Inspectors found that the prison delivered its core training and resettlement functions well. Most prisoners felt safe but significant numbers reported being victimised, often linked to gang and debt issues. The number of assaults in the prison was not high but staff reported fairly high levels of bullying. The inspection report noted that levels of self-harm were low and suicide and self-harm procedures were reasonable.

Independent Monitoring Board (IMB)

18. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. The most recent IMB report for Ranby for the year to 31 March 2013, noted that bullying and fighting were serious problems and a reduction in staffing had increased fears about violence and self-harm.

Previous deaths at Ranby

19. The man's was the first self-inflicted death of a prisoner at Ranby since the Ombudsman's office began investigating deaths in 2004. Sadly, another prisoner apparently took his own life a week after the man died. Although the methods were similar, there is no indication that the man and the other prisoner knew each other or that there is any link between the two deaths. There has since been a further death at Ranby, the cause of which is unknown at the time of writing.

KEY EVENTS

20. The man was born on 29 March 1986. On 17 August 2009, he was convicted of aggravated burglary and sentenced to an indeterminate sentence for public protection with a minimum time to serve of two years and 210 days. He had a number of previous convictions and had been in prison before. At the time of the latest offence, the man had been on licence from a previous prison sentence.

21. The man was first held at HMP Leicester and no concerns that he was at risk of suicide or self-harm were identified. In February 2010, the man's mother, from whom he was estranged, telephoned the prison to tell them that she was concerned that he might be at risk of self-harm. Staff began monitoring him under Prison Service suicide and self-harm prevention procedures[1] but monitoring ended the same day after staff spoke to the man and were satisfied that there were no concerns. The man insisted that he had never had any thoughts or intention of harming himself.

22. The man received several warnings for poor behaviour towards staff and breaching rules. He moved to HMP Channings Wood in March 2010. His personal officer[2] noted that he began to display a more mature attitude after he completed the Thinking Skills Programme in August. However, staff continued to report some negative behaviour and a poor attitude. As a result he was downgraded from the enhanced level of the Incentives and Earned Privileges (IEP) scheme[3] to standard.

23. On 5 May 2011, the man transferred to HMP Ranby to complete the cognitive self-change programme (CSCP) as part of his sentence plan. (The programme was created for violent offenders to give them skills to control their violent impulses and avoid repeat offences.) Initially, he did not like the prison and wanted to transfer, but by the end of June he had decided to stay and complete the CSCP. He then appeared to settle well. He attended the gym and mixed well with other prisoners. Although he received further warnings for his behaviour and attitude, by April 2012 he was working in a trusted position in the prison's staff canteen and received good reports for his work.

24. The Parole Board considered the man's case and notified him of their decision in May 2012 not to direct his release. They noted that, although he was usually polite and compliant, there had been several negative notes about disrespectful, abusive and aggressive behaviour towards staff. The Board recommended that the man be assessed for relevant offending behaviour courses, continue to engage with the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team[4] and maintain a sustained period of good behaviour. The man's case would be considered again a year later.

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[1] Known as Assessment, Care in Custody and Teamwork (ACCT).
[2] A nominated prison officer who is that prisoner's first point of contact for queries or problems.
[3] Under the IEP scheme, good behaviour is rewarded with extra privileges and poor behaviour results in some privileges being removed.
[4] A drug and substance misuse service for prisoners.

25. After receiving a warning in August for causing a disturbance, the man stayed out of further trouble and, in September, began the cognitive self-change programme. In November, he regained enhanced IEP status and, in January 2013, he moved to A wing, an enhanced wing with less structure and supervision.

26. The man's offender supervisor at Ranby and his community offender manager met the man on 3 March to compile a report for the Parole Board. The offender manager explained to him that she had to submit her report for the Board reflecting his progress at that stage. Until the man had finished the cognitive self-change programme, she did not feel that she could recommend him for a progressive move or release. She agreed to provide an update to the Board before they considered his case when she could take into account the final reports of the man's participation in the cognitive self-change programme. She told the investigator that she was confident that the man had understood the position.

27. One of the man's friends told the investigator that the man said that he was finding the cognitive self-change programme course and the staff difficult. However, the man's course facilitator said that he had been doing well and making progress.

28. On 5 March, while the man was in the prison's multi-function building undertaking a module of the CSCP, the fire alarm sounded. The building was evacuated and a group of prisoners and staff, including the man, went to the assembly point at the front of the building. The man then went back into the building. A member of staff followed him and told him that he had to go back outside, but he refused. (The man later told his father that it was a cold day and he was dressed in a t-shirt without a jacket.)

29. A member of psychology staff who knew the man, went into the building to tell him to go back outside. The man again refused. She explained that it was a safety issue, with the possibility that there was a fire, but he continued to refuse to move. The member of staff warned him about the consequences of refusing an order, but the man was unconcerned. The fire alarm was resolved seven minutes later, when it was confirmed that there was no fire.

30. On 11 April, the man attended an adjudication (a disciplinary hearing) for the incident about the fire evacuation. He was found guilty of disobeying a lawful order. As a result, he also lost his enhanced IEP status. He was moved from A wing (for enhanced prisoners) to E wing, a more structured residential wing. Wing staff explained to him that he would need to show a sustained period of good behaviour for the next three months before he would be able to have his enhanced status restored. The man later told his father and friends that he was concerned at how this adjudication would affect the Parole Board's consideration of his case.

31. The man had been diagnosed with an inguinal hernia (a condition in which an internal part of the body pushes through a weakness in the abdomen wall into the groin). On 12 April, he went to hospital to have an operation to repair it.

When he returned to the prison, healthcare staff monitored him. He was prescribed painkillers.

32. After a CSCP session on 16 May, the man went up to the course facilitator and was about to hand her a piece of paper when a prison officer came along and he put it back in his pocket. The course facilitator spoke to a colleague about this and then submitted a security information report (SIR). The next day, the course facilitator asked the man what he had been trying to do. He explained that he had been having problems with a group of black prisoners on E wing who were trying to provoke him. He suspected that it was because he was white with cropped hair and the prisoners thought he might have right wing tendencies. He told the course facilitator that he had used assertive communication and tried to ignore them, but the situation had persisted. He said it was becoming difficult to handle and he had discussed it with friends the previous day, as a source of support.

33. The man told the course facilitator that he had informed a wing officer that he was being bullied. (He did not give the officer's name and we have been unable to identify any officer on the wing who said they remembered the man speaking to them about this.) The man told the course facilitator that earlier that morning, his friends had come to his cell and told him that the issue was now closed but he did not know how. He discussed with the course facilitator other options open to him if the situation continued. She noted on the man's prison record that she had submitted an SIR and completed a zero tolerance incident reporting form, part of the anti-bullying procedures at Ranby.

34. As the course facilitator had not completed such an incident report before, she telephoned the Safer Custody department to seek advice. She was told to send the form to the man's wing manager. The course facilitator sent the form for the attention of the senior officer on E wing.

35. On 24 May, the man told the course facilitator that a wing officer had spoken to him about the form she had submitted and he had reported to the officers his concerns about being bullied. He did not give the officer's name and we have been unable to identify any officer who remembers speaking to the man about this. The man told the course facilitator that the situation had been resolved. He said that he had spoken to the prisoners with whom he had been having problems and told them that he was not interested in any trouble. He said that the issue was over and he no longer felt under threat. The course facilitator submitted a security information report with this information.

36. At 8.30am on 30 May, the man went to see the course facilitator and began a conversation with her, during which he said that he had heard rumours that some of the cognitive self-change programme sessions, which are video-recorded, had been published on the internet. The course facilitator assured him that this was not the case. The man then told the course facilitator that he had feelings for her. The course facilitator advised him that while he had disclosed this in a respectful manner, there were clear professional boundaries that could not be broken and that she would have to report the conversation. The man said that he did not wish to discuss the issue with anyone else and

was concerned that if it was raised at his forthcoming parole review it would suggest that he could not control his emotions. He told the course facilitator that he would not attend any further course sessions and would seek support from his friends on the wing. He left the multi-function building at 8.50am.

37. The course facilitator went to the security department and reported the conversation to a Senior Officer (SO). She updated the man's prison record and submitted a security information report about the incident.

38. The security department decided that, in light of what the man had said to the course facilitator, he should not be permitted in the multi-function building. An Officer made an entry in the E wing staff observation book that, "The man not allowed to go to the MFB … after declaring his undying love for the tutor". (This seems to have been an exaggerated account of what he had said.)

39. On the afternoon of 30 May, officers noticed a crowd around the showers on the third landing of E wing. When they went to the landing, they found that a prisoner, a friend of the man's, had been assaulted. The injured prisoner refused to say who had hit him. After the man died, a security report was submitted which alleged that the victim had been teasing the man about his feelings for the course facilitator and it had been the man who had assaulted him. That evening, the man telephoned his father but gave no indication of any problems.

40. The next morning, the man went to the healthcare centre as he felt ill. He had a dry mouth, felt dizzy and generally unwell. The nurse examined him and saw that he was dehydrated. His blood pressure, pulse, temperature and sugar levels were all normal. She advised him on diet and increasing his fluid intake and said that, because of his recent operation, he should not to use the gym for another four weeks. She booked an appointment to review him on 4 June.

41. At approximately 11.00am, an Officer spoke to the man in his cell. During this conversation, the man referred to the situation with the course facilitator, alleging that they had had some form of relationship which had included sexual activity on his part on one occasion. (These allegations were later put to the course facilitator and she denied them). He was concerned that the course facilitator might have video-recorded him and published it on the internet. The Officer told the man that he was being paranoid, as such a scenario was most unlikely. The Officer told the investigator that the man was calm during this conversation and did not appear angry or distressed. He told the man that he would speak to him again later. The Officer submitted a security information report about what the man had told him.

42. A friend of the man's saw him during the afternoon. The friend told the investigator that there had been nothing in their interaction to cause him any concerns about the man's wellbeing. The friend was a Listener (prisoners trained by the Samaritans to offer confidential emotional support) and used to detecting signs of stress in prisoners, but he said he saw nothing in the man's demeanour to indicate in any way that he was upset about anything.

43. Later that afternoon, the man told the Officer that he had been thinking about the advice the officer had given to him earlier. He said that the Officer had been right and that he had been worrying needlessly.

44. Another prisoner had been a friend of the man for around four years. He said he saw the man at approximately 4.50pm, just before prisoners were locked into their cells for the evening. He did not detect anything in the man's manner to indicate any problems. When they parted, he said the man said, "See you tomorrow".

45. The man's cell was at the end of a landing. The prisoner in the next cell said that he and the man had been friends for two years. During the course of 31 May, he said that they had been laughing and joking together and he was not aware of the man having any problems. As the Officer was locking them into their cells for the evening, they asked if the prisoner could borrow the man's tin opener before the doors were locked. The officer agreed. The Officer asked the man if he was all right. The man replied that he was and would see the Officer in the morning.

46. The prisoner said that when they were locked in their cells, he and the man often talked through a small gap in the wall by the heating pipe. They did so that evening and spoke normally. Again he did not notice anything unusual, and did not get any indication of anything being wrong. During the evening, he said he heard the man talking to a member of staff through his cell door, but there was no sign of a problem or the man being upset. The prisoner was clear that he did not hear the man screaming at any time during the night.

47. An Officer and Operational Support Grade (OSG) were on night duty on D and E wings that night. The Officer said that staff going off duty did not bring any problems to his attention during the routine handover. At approximately 8.30pm, he conducted a roll check (count of prisoners) on E wing, and ensured that he received a response from each prisoner. The Officer was the man's personal officer and remembered seeing him sitting on his bed, with his cell light on. There were no indications of any problems.

48. At approximately 11.30pm, the prisoner in the cell next to the man heard the man ripping up bed sheets. He assumed that he was making a length of material (a 'line') to pass messages or contraband, which prisoners often did. The man said he was doing "nothing" when be asked him what he was doing and told the prisoner that he was okay. The prisoner told the man not to do "anything stupid". He later told the police that the man had sounded the same as usual and nothing made him think that the man might harm himself. The prisoner then went to sleep.

49. Prisoners are not usually checked during the night unless they are being specially monitored but night staff walk around the wing at various stages and respond to any problems, requests or disturbances. To ensure they patrol, they are required to log into electronic points around the wing at set intervals, known as pegging. Any problems are brought to the wing officer's attention and noted in the wing observation book. The investigator was unable to interview the

OSG who had left the Prison Service. The Officer said that the OSG made the required patrols as well as the morning roll check, sometime between 6.00am and 6.30pm. Nothing was brought to the Officer's attention during the night, and there were no entries in the wing observation book to suggest any problems.

50. The prisoner in the next cell to the man said that at approximately 7.50am, he was woken by the sound of what he thought was the man's window slamming shut. He told the investigator that the windows did not move freely and were too stiff to blow shut, so the noise he heard must have been the man closing the window. Another prisoner was in the cell on the other side of the prisoner. He told the investigator that he closed his own window at some point between 6.00am and 7.00am that morning, so it is possible that the prisoner in the next cell to the man was mistaken about this and the time. The prisoner said that the noise of the window slamming was followed by a bang on the heating pipe. He said it was not unusual to hear a noise from the pipe as it ran the length of the wing through all cells, so if someone dropped something onto the pipe the noise would reverberate all the way along. The prisoner said he called to the man but got no reply.

51. An Officer arrived at E wing to begin his shift shortly before 8.00am. Night staff said that there had been no problems during the night. At approximately 8.05am, he began a roll check. After completing the ground floor landing, he went up to the first floor and began at the end cell, occupied by the man. The Officer estimated that it was between 8.10am and 8.15am. He looked into the cell and saw the man apparently standing with his back to the window, facing the door. The Officer began to move to the next cell, but said something about what he had seen made him turn back and look again. He noted that the man had not moved. The Officer unlocked the cell and went in. He later told the police that he looked at the man's face and knew that he was dead. A ripped green bed sheet was tied from the man's neck to plastic curtain rail clips on the wooden beam above the window. The Officer stepped out of cell and radioed a code blue emergency[5], giving his location. The prison's daily occurrence book gives the time of the code blue call as 8.16am.

52. The prisoner in the next cell to the man heard a member of staff outside his cell. As he had not had a reply from the man when he had called to him a few minutes before, he went to his door to attract the officer's attention. As he did so, he said he heard the Officer shout, "code blue, help me".

53. Another Officer had also just started duty and heard the code blue call. He ran to the man's cell. The Officer had gone back into the cell, moved the cell furniture and was supporting the man's weight. The other Officer saw the sheet around the man's neck and unhooked it from the plastic clips. The officers then lowered the man to the bed and removed the material from his neck. The Officer checked the man for signs of life. He was not breathing and had no pulse in his neck or wrist. His skin was clammy but not cold and his face was discoloured. The Officer radioed to ask the control room to call an ambulance,

[5] Indicating a prisoner is not breathing or is unconscious.

the police and the Coroner. He later told the police that he had specifically mentioned the Coroner to alert staff listening to the radio of the probability of a death. The prison's daily occurrence book shows that an ambulance was requested at 8.17am.

54. An OSG heard the code blue call on the radio and realised that, as it was the weekend, only one member of staff would be on duty at the prison main entrance. Anticipating that an ambulance would need to be escorted through the prison, he went to the gatehouse to assist. When he arrived, he was asked to contact the emergency services. He did not want to distract staff on E wing from a serious incident, so he told the ambulance service that a prisoner had been attacked, which he assumed to be the case. This call was made at 8.20am.

55. Two nurses were in the office in the healthcare centre when they heard the code blue call and one nurse went straight to the man's cell while the other nurse first obtained the emergency response bag from the dispensary on the second landing between D and E wings. The nurse arrived at the cell at approximately 8.20am and examined the man. His pupils were fixed and dilated, his face was discoloured and he had no pulse. There were obvious signs of rigor mortis on his jaw and lower right arm. The nurse believed that he was dead. The nurse then arrived with the emergency equipment. She too examined the man for signs of life and noted that his pupils were dilated, he had no pulse and had rigor mortis in his lower jaw which prevented her from inserting an airway into his throat. The nurses agreed that the man had died and that they should not attempt to resuscitate him.

56. The ambulance arrived at the prison at 8.24am and was escorted directly to E wing. The paramedic saw the nurses leaving the cell and spoke to the nurse. She briefed him and advised that they had not attempted resuscitation. The paramedic examined the man using his own equipment, but detected no signs of life. At 8.36pm, he confirmed that the man had died.

Debrief

57. After the death of a prisoner it is usual to hold a debrief meeting with the staff involved to ensure they have an opportunity to discuss any issues arising and to provide support. A debrief was held that afternoon. All staff who had been involved, including healthcare staff, were invited, although one Officer had already left the prison when the debrief took place. Support was made available to staff if required.

Informing prisoners

58. The Governor issued notices to inform prisoners and staff of the man's death. All prisoners subject to suicide and self-harm prevention monitoring had their level of observation raised until their circumstances were reviewed in case they had been affected by the man's death. Listeners were briefed and the number of Listeners on E wing was increased. The prisoner in the next cell to the man

had been particularly upset and told the investigator that he had received a good level of individual support.

Information passed on after the man's death

59. After the man died, various pieces of unsubstantiated information were passed to the security department. One prisoner said that he had heard a rumour that on the day before the man's death, he had made an attempt on his own life but had been stopped by another prisoner. During discussion with the investigator, he agreed that the details of the story he had heard might have related to the reported incident in which the prisoner in the next cell to the man had heard the man ripping his sheets.

60. Another prisoner made a telephone call in which he referred to the man, whom he had known for a number of years. He said that he had been told that during the night of 31 May to 1 June, the man's neighbour had heard him screaming and had asked if he was all right. The man had replied that he was not and that he had "had enough of this shit" and that everyone was saying that he was "saying shit". It then sounded as if the man was smashing up his cell.

Liaison with the man's family

61. A Custodial Manager was appointed as family liaison officer. The man had nominated a friend (who was unaware she had been listed) as his next of kin. The family liaison officer and the chaplain went to see her to break the news. While they were at her home, she gave them his father's contact details. However, in the meantime, the police had telephoned the man's father and told him of his son's death. The family liaison officer and the prison chaplain subsequently visited the man's father to offer their condolences and to explain what had happened.

62. The prison chaplain conducted the man's funeral service, which was held in Leicester. The prison contributed to the costs of the funeral, in line with national guidance. With his family's permission, the prison was represented at the funeral. A simultaneous service was held in the prison, allowing prisoners the opportunity to pay their respects.

Post-mortem

63. A post-mortem examination showed that the man died of asphyxiation. No illicit drugs were found in his system and, apart from ligature marks on his neck, there were no other signs of external injury.

ISSUES

Clinical care

64. The clinical reviewer considered the care and healthcare interventions that the man received in prison. This includes hospital referrals and post- operative care for an inguinal hernia, treatment for acute back pain and some minor, short term health conditions. The clinical reviewer concludes that healthcare staff at Ranby dealt with the man appropriately, made timely referrals and there were no significant shortcomings in his clinical management. We agree with the clinical reviewer that the man's clinical care was comparable to the care that he could have expected in the community.

Disciplinary action after the incident with the fire alarm

65. The man was reported to have been concerned about the effect of a disciplinary hearing in March 2013 and his loss of enhanced status under the incentives and earned privileges scheme. His Parole Board hearing was due to take place in May 2013 and the man worried about how the Parole Board would interpret his actions.

66. We are satisfied that the disciplinary hearing was appropriately conducted. The man along with staff and other prisoners had been evacuated for his own safety. Despite being warned of the consequences, he declined to cooperate. While the Parole Board is likely to consider conduct in prison and whether it reflects the prisoner's risk this was a relatively minor incident. There was nothing to suggest that the man was a heightened risk of suicide and self-harm as a result.

Allegations of bullying

67. The man told the course facilitator that a group of prisoners on his wing were bullying him. The investigation looked for evidence of this. There were no entries in the staff observation book to indicate any problems involving the man, other than those submitted by the course facilitator, there were no security reports of any activity relating to him which suggested bullying.

68. Two of the man's friends both said that he was not the type to be bullied and they had seen no evidence of this. Another prisoner on E wing who knew the man, said that he was not being bullied. His personal officer and the staff we spoke to on the wing were not aware of any issues suggesting that the man was involved in any bullying, either as victim or perpetrator. His friend and neighbour said that the man was not being bullied. The man's alleged involvement in the assault in the shower area on the Wednesday before he died, did not come to light until after his death. This would appear to have been the result of teasing between friends and does not tie in with the man's version of the attempts to bully him.

69. When the man spoke to the course facilitator on 17 May, he said that he had reported the bullying to an officer on the wing but he did not give the officer's

name. Enquiries as to who this might have been have failed to identify any member of wing staff who recalled having this conversation with the man. Had he reported any attempts at bullying to a member of wing staff, that person should have put an entry in the wing observation book and informed their colleagues of a potential problem. They should also have submitted a security information report and completed a zero tolerance incident reporting form. None of these things were done.

70. The course facilitator said that when the man disclosed the bullying and then, very soon afterwards, assured her that it had been resolved, she thought that the situation had been concluded rather "neatly". When the man subsequently revealed his feelings for her, she wondered whether he had made up the allegations to engineer a situation where he could be alone with her. After the man died, the course facilitator said she raised this with one of the prison managers. She recalled that the manager said that subsequent investigations had revealed that there might have been an issue of bullying. When the investigator raised this with the manager, however, she said that she had not been involved in any investigations of this type and had no knowledge of any problems that the man had been having. Although we are concerned that there appears to have been no investigation into the man's allegations at the time (see below) it remains the case) that other than the man's claims to the course facilitator, there is no additional evidence to suggest that he was the subject of any incidents of bullying. The sequence of events also suggests that the man might have said he was being bullied to explain why he had been attempting to pass a note to the course facilitator.

71. Ranby has specific forms for staff to use to report any possible incidences of bullying and once potential bullying is identified, there are two formal stages. Prisoners should be interviewed as part of the process.

72. When the man told the course facilitator that prisoners were attempting to bully him, she completed a zero tolerance incident reporting form as well as a security information report and made an entry in the man's electronic prison record. She said she had telephoned the Safer Custody department to seek advice. She believed that she had spoken to an Officer, but the Officer told the investigator that it had not been her. The course facilitator followed advice and sent the form marked for the attention of the wing senior officer as the instructions required.

73. Whether or not the man's allegations of bullying were genuine they should have been investigated. However, the form does not appear to have been seen until after the man's death and no officer said they had spoken to him about it. The Officer told the investigator that after his death, she looked for the form but could not recall what had prompted this. She made enquiries of staff on E wing, spoke to the course facilitator, and made physical checks of offices on E wing. She was unable to find it but after she had made enquiries, the form arrived in the Safer Custody office in an envelope. There was nothing to indicate where it had come from, or who had put it there.

74. We are concerned that information about potential bullying had been made by three separate methods, yet no substantive action was taken. The security information report, the note on the man's electronic case records and the zero tolerance incident reporting form all indicated potential problems. The man told the course facilitator that an officer on the wing had spoken to him about the form, but enquiries have failed to identify that officer. There are no notes on the form itself to indicate that staff had spoken to the man, as there should have been if that had happened. It is important for the safety of prisoners that all allegations of bullying are investigated to establish whether or not there is a problem which needs to be addressed. We make the following recommendation.

The Governor should ensure that all allegations of bullying are investigated promptly.

Reports of problems during the night of 31 May

75. The investigation looked into rumours that had been passed to the man's father, that the man was in distress and had asked for help during the night he died and that he had argued with a member of staff in his cell who was in his cell.

76. A prisoner had passed on a rumour that during the night of 31 May, the man's neighbour had heard him screaming and saying that he had had enough and had then smashed up his cell. The prisoner emphasised that it was only rumour and he could not verify it personally. Neither prisoners in the two cells near the man heard any signs of disturbance or distress from him that night. The Officer said that he had not spoken to the man during the night and there is no indication that the operational support grade spoke to him. The investigator examined the wing observation book and there were no entries that night to indicate any disturbances, either from the man or any other prisoner.

77. We found no evidence to suggest that the man created a disturbance during the night. The neighbour said he heard him talking to a member of staff some time before 11.30pm, but he did not hear them arguing and heard nothing further during the night.

78. At night, prison staff working on the wings do not carry a set of keys. They have a cell key in a sealed pouch, which should only be broken to enter a cell in an emergency. If a seal is broken it must be logged and the reasons given. The prison log for the night of 31 May -1 June 2013, shows that no night staff broke the seals on their pouches. There is therefore no evidence that anyone went into the man's cell. The prison officer who went into the man's cell the next morning did not find the cell in disarray and no furniture had been damaged. We found no evidence to substantiate the rumours that the man had damaged his cell.

79. Prisoners have cell call bells to call for help from staff if they have any problems when they are locked in their cells. At Ranby there is an electronic system to monitor when bells are used. A note in the wing observation book for 31 May indicated that the cell bells were not working on 31 May, but the problem had

been remedied before prisoners were locked up for the night. However, the system to monitor records for cell bell use for a period including the night of 31 May was not working. We cannot therefore know for certain whether the man had pressed his bell during the night before he died. There is no written record that he did.

80. The investigator also looked into the rumour that the man had made an attempt on his life the day before he died but had been talked out of it by another prisoner. The prisoner had only a limited amount of second hand information and he had no personal knowledge of the incident. He agreed that the details of the story were consistent with the neighbours' evidence about the man ripping his sheets and we are satisfied that there is no evidence to support his original account.

Emergency response

81. Healthcare staff did not attempt to resuscitate the man. Their checks indicated that he had already died. European Resuscitation Guidelines 2010, state "Resuscitation is inappropriate and should not be provided when there is clear evidence that it would be futile … ". Performing resuscitation in such circumstances is distressing for staff and undignified for the deceased. The clinical reviewer is satisfied that healthcare staff were correct in their decision not to attempt resuscitation.

RECOMMENDATION

The Governor should ensure that all allegations of bullying are investigated promptly.

ACTION PLAN:

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that all allegations of bullying are investigated promptly.	Accepted	We take a Zero Tolerance approach to Anti social behaviour and violence of any kind be it physical or verbal. All incidents are reportable through the Zero tolerance investigating report form. This form was changed after the recent loss of a ZTIRF associated to the man. The form is directed to the wing manager to investigate and the Duty Governor is then called to make appropriate recommendations all within the first 24 hours. We continue to review our current policies on Zero Tolerance and will complete a full review of this process to be completed by March 2014.	Immediate	