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 September 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 died at HMP Ranby on 5 September 2013. He was 47 years old. A post-mortem examination recorded his cause of death as nefopam (a painkiller) overdose and ischaemic heart disease. 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 a history of back pain for which he had been prescribed painkillers. After a risk assessment in March 2012, he was permitted to keep his medication in his cell and expected to take his daily dose as prescribed. After becoming unwell a few months later, he tested positive for illicit drugs. Prison staff suspected that two further episodes of illness, in May 2013, were due to overdoses of drugs. On the day of his death, the man was reported to have obtained a large quantity of nefopam from other prisoners. While not apparently directly related to his death, there were troubling indications that the man had been subject to violent intimidation at the prison, but was not effectively protected.

The clinical reviewer concluded that the medical care that the man received at Ranby was comparable to that which he could have expected in the community. However, it is worrying that a prisoner with a history of drug misuse was allowed to retain a large quantity of medication after testing positive for illicit drugs in prison and after previous suspected overdoses of prescribed medication. At the very least, a further risk assessment should have been conducted to explore other options for dispensing his medication.

The investigation also identified a number of other areas for improvement. Anti-bullying arrangements appear to have been deficient. The procedures for unlocking cells were inadequate and the officer, who unlocked the man's cell on the evening he died, did not check for signs of life. The emergency response was poor and delayed, with discipline staff untrained in resuscitation techniques and unsure what to do, as well as a failure to adhere to national mandatory Prison Service instructions about communications in emergencies and the automatic calling of ambulances. Although these issues did not directly affect the outcome for the man, the Governor needs to ensure appropriate remedial action.

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

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

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SUMMARY

1. The man, a life-sentenced prisoner, was released on licence in 2005 after being in prison for 20 years. He was recalled to prison in 2008 and transferred to Ranby in 2011.

2. In 2012, the man was prescribed nefopam and diclofenac (painkilling and anti-inflammatory medication) for back pain. Two months later, the diclofenac was replaced with naproxen. The man remained on these medications, as well anti-depressants, until he died.

3. During his time at Ranby, the man was suspected of taking illicit drugs. In August 2012, after he became unwell at work, he tested positive for a synthetic cannabinoid known as mamba. In January 2013, he moved wings after being attacked by two prisoners. At the beginning of May 2013, wing staff noticed the man was acting oddly. They asked healthcare staff to examine him and he was subsequently taken to hospital. Three weeks later, there was further concern that his demeanour was consistent with drug use and healthcare staff monitored him until his condition improved. The next day a prison doctor diagnosed a vasovagal episode which causes fainting. A number of tests were carried out and the man's anti-depressant medication was increased because of anxiety and hypertension.

4. In June, two prisoners were moved to the wing where the man was living, one of whom was one of the prisoners who had allegedly assaulted him in January. The man told a nurse this caused him considerable anxiety. Shortly afterwards, he was seen to have a black eye which he said was the result of being assaulted by the two prisoners from his old wing.

5. On 5 September 2013, the man seemed generally unwell. The officer who unlocked his cell at 6pm for an evening association period did not check on him. At approximately 6.30pm, a prisoner alerted staff that he had collapsed in his cell. The officers who first arrived at the cell thought they could detect a faint pulse in the man's neck. Neither officer was first aid trained and did not begin resuscitation, but they tried to make him comfortable and put him in the recovery position. They did not promptly call an emergency code and, when one was used, an ambulance was not requested immediately. When healthcare staff arrived at the cell, they believed that the man had died because his jaw was stiff and he felt cold. However, they attempted to resuscitate him and continued until a paramedic arrived at the prison at 7.05pm. The paramedic examined him and at 7.15pm pronounced the man dead.

6. After his death, other prisoners disclosed that the man's often tried to obtain prescription drugs from them, especially additional nefopam tablets. They recalled that on the day of his death he had looked pale and sweaty and they had been concerned about him. One prisoner reported that the man had obtained a box of 64 nefopam tablets from another prisoner that day, as well as other medication. He had said that he had a very high tolerance to nefopam. Prisoners were also aware that he smoked mamba.

7. In March 2012, an assessment of the man's risk to hold his medication in-possession was incomplete and no action was taken to review his risk despite his history of drug misuse, suspected overdoses and a positive test for illicit drugs. There was evidently a degree of illicit trading in medication at the prison and we recommend that Ranby provides secure storage for prisoners' in-possession medication to reduce the potential for abuse. The incident when the man was attacked in January was not well handled. Although he moved wings, one of his alleged assailants was later moved to the same wing and he was attacked again.

8. We are concerned that the required emergency procedures were not followed. This led to delays in calling healthcare staff and an ambulance when the man was found unresponsive in his cell. Neither of the officers who responded to the emergency were trained in first aid and did not initiate basic life support. Healthcare staff attempted resuscitation although the signs of rigor mortis suggested this would be futile.

9. The man's next of kin details had not been recorded when he transferred to Ranby, which resulted in his probation officer informing his next of kin by telephone rather than in person by someone from the prison. Prisoners on The man's wing were unhappy that they had not been informed of his memorial service or this investigation.

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 her. Three prisoners responded.

9. The investigator obtained the man's prison and medical records. She interviewed staff at the prison on 24 October 2013 and three prisoners on 14 November. Another investigator spoke to a prisoner at HMP North Sea Camp, who had known the man.

10. NHS East Midlands commissioned a clinical reviewer to review the man's clinical care and treatment in custody. The investigator liaised with the clinical reviewer and they discussed his findings.

11. The investigator informed HM Coroner for Nottinghamshire and Nottingham City of the investigation, who provided a copy of the post-mortem report. We have sent the Coroner a copy of this report.

12. One of the Ombudsman's family liaison officers wrote to the man's family to outline the purpose of the investigation and to give them the opportunity to identify issues they wished the investigation to cover. They raised no specific issues.

13. The man's family received a copy of the draft report, but raised no issues.

HMP RANBY

14. 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. Nottinghamshire Healthcare Trust has provided primary healthcare services at Ranby since 1 April 2013.

Her Majesty's Inspectorate of Prisons

15. The most recent inspection of Ranby was in March 2012. Inspectors found high levels of illegal drugs and alcohol were available. The random drug testing rate was low, but drug finds indicated that prisoners were using substances such as 'spice', a synthetic cannabinoid, which did not show up on the tests. There was evidence that lots of prescribed medication was diverted. Approximately a third of prisoners were prescribed medication with the potential to be abused and many were allowed to keep the medication in their possession. There were no facilities to lock medication away, so there were many opportunities for diversion and theft. The Inspectorate identified the high level of illicit drug and alcohol availability as a serious concern and made a main recommendation that there should be an action plan to reduce supply and demand, which needed to cover the specific issue of diverted medication.

16. Significant numbers of prisoners reported being victimised, often linked to gang and debt issues. Although the level of assaults was not high, prison staff reported high levels of bullying. Inspectors reported as a main concern that the management of violence reduction was weak and failed to collate or analyse data to identify trends or look at ways of making the prison safer.

17. Inspectors noted that the healthcare department was staffed between 7.45am and 8.pm on weekdays and there was no nursing or medical cover outside those hours. Few officers had been trained in first aid or resuscitation and there was no access to resuscitation equipment out of hours.

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 2013 annual report noted that black mamba and subutex were the main drugs found during searches. The IMB was concerned that medication queues at the pharmacy were occasions for bullying as there was no direct officer supervision.

Previous deaths at Ranby

19. Since 2013 there have been two other deaths at Ranby. In the previous two investigations we also had concerns about the response to bullying, unlock procedures and emergency response.

KEY EVENTS

20. The man was a life-sentenced prisoner who had been released in June 2005, after serving over 20 years in prison. He was recalled to prison in May 2008, because he had not complied with the terms of his licence.

21. The man transferred from HMP Forest Bank to HMP Ranby on 20 October 2011. A nurse conducted a full reception health screen. They discussed his history of drug misuse in the community and depression and the nurse referred him to the prison's mental health team. The man had continuing dental pain since 2010, for which he was prescribed paracetamol and ibuprofen.

22. Security intelligence reports indicated that the man was involved in trading and using illicit drugs in the earlier part of his sentence. This continued after his recall to prison.

2012

23. A healthcare manager, completed an in-possession medication risk assessment on 6 March 2012. He assessed the man as suitable to keep up to 28 days' supply of medication in his cell at a time. The form was only partially completed and he did not record how he reached this decision.

24. In April, during a healthcare appointment about his cholesterol levels, the man complained about chronic back pain from an injury sustained seven years previously at an accident at work. The doctor prescribed tramadol.

25. At a consultation with a doctor on 6 July, The man complained that he had twisted his back and was in a lot of pain. The doctor prescribed nefopam 30mg (a non-opioid painkiller that is not a habit forming) and diclofenac 50mg (an anti-inflammatory which can help reduce pain). His back pain continued and, in August, another doctor replaced diclofenac with naproxen 500mg.

26. On 21 August, the doctor assessed the man's risk of heart disease over the next ten years, based on medically known risk factors. The man scored a risk of 7.67 per cent and no further action was warranted.

27. A week later, on 28 August, nurses attended an emergency call in the wood mill where the man worked. The man was sweating, did not appear to know where he was and his pulse was 120 beats per minute when the upper limit is normally 100. His pupils appeared small and he made no sense when he spoke. He admitted to having had 'a smoke', but did not say what the substance was. The staff suspected this was mamba (a synthetic cannabinoid). Nurses advised him to rest in his cell, drink plenty of water and asked wing staff to keep a close eye on him in case he deteriorated.

28. The next day, staff carried out a drug test which was positive. This was recorded as 'spice'. The man said that he had not knowingly smoked it, but admitted that he had shared a cigarette with a friend in the workshop. The

man would not name the other prisoner, but said that some prisoners were putting spice into cigarettes and offering them to unsuspecting prisoners to see how they reacted to the substance. Staff noted this information, but took no further action.

29. Just over a week later, on 6 September, the man reported persistent back pain to the prison GP. The doctor decided to avoid opiates and prescribed a trial of trazodone (an anti-depressant) to help with pain and poor sleep. For the next few months, the man continued to take nefopam and naproxen for back pain, as well as trazodone.

2013

30. In January 2013, it was recorded that the man had been bullied as a result of owing tobacco and was assaulted twice that month on D wing where he lived. On 18 January, the man alleged that he had been assaulted by two prisoners on D wing, while he was asleep in his cell, after refusing to smuggle in drugs for another prisoner during visits. He sustained multiple bruises and scratches and was diagnosed with concussion. The man was sent to the accident and emergency department of Bassetlaw Hospital for treatment and returned to Ranby later that day.

31. The next day, wing staff put in place a compact to give the man additional support. As part of the compact, the man moved to F wing where staff monitored him daily and recorded anything eventful. The monitoring ended on 4 February. The prisoner thought to have ordered the assault was sent to the segregation unit and was subsequently transferred to another prison. The two prisoners who were suspected of carrying out the alleged assault remained on D wing. There is no evidence that any further action was taken against them.

32. On 5 March, the man referred himself to the prison's mental health team as he felt depressed. On 14 March, he was accepted onto the team's caseload. He told a nurse that he had low mood, low self-esteem and little confidence. He said he had difficulty sleeping. He said he had not used illegal drugs since 2007 and had no thoughts of harming himself. He asked the doctor to increase his dose of trazodone as he felt his depression had returned. Another doctor increased the trazadone prescription from 100mg to 150mg.

33. The man had an appointment with the mental health team on 18 April. He appeared on edge and said that since he had been assaulted in January he only left his cell for healthcare appointments and refused to attend work. Wing staff became increasingly concerned about the man's mental health and, on 1 May, a nurse from the mental health team reviewed him again. The nurse noted that the man was anxious and paranoiac and she offered him some basic Cognitive Behavioural Therapy (CBT), which he accepted.

34. Later that evening, healthcare staff were called to the man's cell as he had collapsed. He seemed extremely disorientated, but his physical observations (pulse and blood pressure) were stable. Staff saw an empty packet of

trazodone (a week's supply) in his cell and suspected he might have taken an overdose. He was taken to the accident and emergency department of Bassetlaw Hospital. There is no record of the outcome in the man's medical record, but he returned to the prison later that night.

35. On 2 May, healthcare staff reviewed the man. He said he had not taken any illicit drugs and denied deliberately overdosing on trazodone. He thought it possible that another prisoner might have taken the missing trazodone tablets as they were not kept securely and he did not remember taking them himself. The next day, healthcare staff changed the arrangements for dispensing the man's medication so that he was given just a daily supply. However, on at least four days that week, he did not collect his medication.

36. A week later, on 9 May, the man was prescribed naproxen, nefopam and trazodone. Despite the suspected overdose eight days earlier, he was again allowed to keep weekly amounts in his possession.

37. At a healthcare appointment on 20 May, the man was noted as appearing to be under the influence of illicit drugs. The nurse asked officers to take the man back to his wing and said he would make another appointment for him. No other action was taken about the suspected drug use. Three hours later, wing staff asked a nurse to examine the man as he was behaving oddly. The nurse noted that the man seemed restless, it took a while for him to respond to simple questions and he spoke slowly. The man said that he had woken up with a 'heavy head' and felt dizzy. His blood pressure and pulse rate were high. The nurse suggested that he should go to hospital but the healthcare manager, decided to monitor the man for two hours before making a decision. By early afternoon, the man had improved, was fully conscious and interacting normally.

38. The next day, 21 May, a doctor examined the man and diagnosed that he had experienced a vasovagal episode (a malfunction of the nervous system which can cause fainting). The doctor told him to increase his fluid intake and arranged a CT scan and an electrocardiogram (ECG – a test to measure the electrical activity of the heart) which a healthcare worker booked immediately.

39. The doctor examined the man again on 11 June and assessed him as anxious and hypertensive. He requested blood tests and instructed that if his blood pressure rose higher than 140/80, the man should be referred to a doctor immediately. An ECG was completed on 18 June and the results forwarded to the doctor. Nothing abnormal was detected, but the results were not recorded in the man's medical record.

40. The next day, 19 June, a psychiatric nurse, raised concerns that the man was living on a wing with two prisoners who had assaulted him in January on his previous wing. (Two prisoners had moved from D wing to F wing on 3 June, because of trouble they had caused on the D wing. One of them was implicated in the January assault which led to the man moving off the wing. It was noted that there were few other places in the prison they could be

located.) The man had indicated that the presence of these two prisoners was causing him anxiety as they had told him there was "unfinished business". The psychiatric nurse submitted a security information report about this and told wing staff. The man had previously told wing staff that he was concerned that he would have to defend himself against the other prisoners and that this might jeopardise his recategorisation to category D.

41. On 5 July the man was seen to have a black eye. He said he had been assaulted by the two prisoners from D wing. An SIR was raised and staff noted in it that they would observe the situation between the man and the other prisoners. The man was asked if he wanted to move wings, but he did not. The other prisoners were not moved because they had been involved in incidents in other parts of the prison.

42. On 12 July, the man told a nurse that the issues with the other prisoners had not been resolved and it had been suggested that he should move to another wing. The man said he was unhappy about this as he was the victim and should not be moved.

43. On 23 July, the man told the doctor that the trazodone was no longer effective and requested a change of medication. The doctor agreed but explained that first he needed to be weaned off trazodone over a two-week period. On 13 August, the doctor replaced the trazodone with duloxetine (another anti-depressant). He noted that the man was nervous and anxious everyday and could not control his worrying.

44. The nurse assessed the man's mental health on 16 August. He was more relaxed and said he had had no further issues with the other prisoners. He said he was still spending a lot of time in his cell, but he was actively seeking a job as a cleaner which he hoped would resolve this. He appeared more settled and had no problems which were concerning him. The man was last prescribed nefopam tablets on 19 August, to be issued weekly. The nurse saw him again as planned on 28 August and found that his mood appeared settled. He had no major concerns and said he had no thoughts of suicide or self-harm.

5 September 2013

45. Another prisoner on the man's wing said he saw the man at 4.20pm on 5 September 2013. He said he did not look well and appeared grey and sweaty. The prisoner asked the man if he needed any help, but he said he was all right. The prisoner was still concerned and said he would look in on him when they were unlocked after tea. However, another prisoner told him that the man had been found unconscious before he had the opportunity to do so.

46. Another prisoner recalled seeing the man at approximately 5.00pm. They collected their meal and had a chat. He said that the man did not look well and appeared pale and sweaty.

47. At 6.00pm, an officer unlocked prisoners for the evening association. He did not look inside the man's cell through the observation hatch or look into the cell when he unlocked the door. The officer unlocked each door and moved straight onto the next one. The officer said he then went to see a prisoner in his cell as he had promised to do so earlier in the day. Just before 6.30pm, another prisoner (who has subsequently died) told the officer that the man had collapsed in his cell and was lying on the floor.

48. The officer went immediately to the man's cell with the two prisoners and found him on the floor, with his head on the radiator pipe which ran along the back wall. The officer shook the man but got no response. He knew that the man had collapsed in the past and went to find another member of staff. Another officer was nearby and he asked him to get healthcare assistance. The officer said he then went to the wing office and asked a Senior Officer (SO) to make a code blue emergency call which indicates that a prisoner is unconscious or has breathing difficulties. In his statement after the incident, the SO said that he made a code blue emergency call, but the control room has no record of this.

49. The officer went back to the cell and found the two prisoners trying to put the man in the recovery position. He again was unable to get a response from the man. The officer lifted the man's head and placed a pillow under it. He noticed that he had a black eye and thought he might have knocked himself out on the heating pipe. The two officers who had come to the cell after speaking to the SO, both thought they could detect a faint pulse in his neck. However, the man remained unresponsive and looked pale and felt cold. One prisoner said that he also thought that he could feel a pulse and he said that, on the officer's instructions, he counted the pulse beats while the officer wrote them down.

50. The officer said he then radioed an emergency code blue as he was surprised that healthcare staff had not yet arrived. An operational support grade (OSG) who was working in the prison's control room received this code blue call at 6.30pm. When interviewed, the OSG told the investigator that the procedure after receiving such a call is that the duty manager and a member of healthcare staff attend the emergency incident and then advise whether an ambulance is required. He said the control room would not request an ambulance automatically when a code blue was received, but would wait to be instructed to do so.

51. A custodial manager heard the code blue call and went to the man's cell. At 6.37pm, he asked the control room to call an ambulance and the OSG then called one straightaway.

52. Two nurses were in the healthcare department, but did not hear the emergency call. (A nurse said that if the volume on the radios is turned down too low, it can switch off, which might have accounted for this.) A manager who had heard the Code Blue, ran into the healthcare centre to tell the nurses. The nurse said they picked up the emergency bag and defibrillator (a life-saving device that analyses heart rhythm and automatically delivers

electric shocks to victims of cardiac arrest when it determines there is a rhythm that is likely to respond). The nurses arrived at the cell three or four minutes later at approximately 6.40pm. The officers and a prisoner thought it took a long time for healthcare staff to arrive and estimated this to be around 10 to 15 minutes. None of the staff who attended considered trying to resuscitate the man before the nurse arrived.

53. The officers left the cell to give the nurses more room. The nurse believed that the man had died because his jaw had become rigid, indicating the possibility that rigor mortis was beginning. She could not detect a pulse and his eyes were open and glazed. Nevertheless, she decided to start cardiopulmonary resuscitation (CPR). One of the nurses called the officer back in to help them. He helped to turn the man on to his back and the nurse attempted to insert an airway into his mouth, but was unable to do so as his jaw was rigid. She thought the stiffness might be due to a spasm or rigor mortis. They placed a monitor on his finger to record his oxygen levels and then started CPR. The officer held an oxygen mask over the man's mouth while the nurse carried out chest compressions. They applied the defibrillator, which advised that no shock should be given. The nurses therefore continued with CPR.

54. At 6.58pm, an ambulance arrived at the prison. An operational support grade escorted the ambulance part of the way and handed over to an officer who was waiting to escort the vehicle to F wing. The ambulance arrived at the wing at 7.05pm. A paramedic then examined the man and attached a defibrillator he had brought with him. At 7.15pm, the paramedic pronounced the man dead.

Family Liaison

55. Prison staff contacted the prison's family liaison officer, at home at 8.15pm and notified her of the man's death. The family liaison officer immediately went to the prison.

56. The prison did not have the man's next of kin details as they had not been recorded when he transferred to Ranby. At 9.10am the next morning, the family liaison officer spoke to the man's probation officer to ask for the contact details. The probation officer checked and rang back at 9.40am with the address and telephone number for the man's ex-partner. He said that he had already telephoned her to break the news and that she was waiting for the family liaison officer to call her.

57. The family liaison officer telephoned immediately and apologised for the way in which she had learnt of the man's death. The man's ex-partner said it was probably better that the probation officer had told her as she had spoken to him in the past. She said that their son was the man's next of kin, but he felt unable to deal with it at that time.

58. The family liaison officer and the prison's chaplain, the Reverend, visited the man's family on 10 September. The Reverend offered to conduct the man's

funeral and the family liaison officer said that the prison would contribute towards the cost.

Care for staff

59. A debrief was held on the evening of 5 September and staff were offered the services of the prison's care team.

Care for prisoners

60. The prison offered the prisoner the support of the prison's Listeners (prisoners who are trained by the Samaritans to provide emotional support to fellow prisoners in distress). Wing staff also closely monitored him overnight.

61. Prisoners on the man's wing told the investigator that they had been unaware of the Ombudsman's investigation as the notices she had issued had not been posted on their wing. One prisoner had found out while speaking to a prisoner from another part of the prison. Prisoners also complained that they were not told that the prison had held a memorial service for the man. A second service was held so prisoners from the man's wing could attend.

Information from prisoners

62. During his interview with the investigator, the prisoner said that he knew the man took prescribed medication daily. He told the investigator that on the day he died, the man had asked him and a number of other prisoners for ibuprofen or paracetamol and any similar drugs. One prisoner had told him that he had given the man a box of 64 nefopam tablets that day and he understood that he had also obtained more medication from other prisoners. The prisoner was aware that the man sometimes smoked mamba. No medication or drugs were found in the man's cell after his death.

63. Another prisoner told the investigator that the man frequently bought prescription drugs from other prisoners, especially nefopam, one of the drugs already prescribed to him. He said that, when they were at HMP Forest Bank together, the man had boasted to him that he could take high levels of nefopam.

Post-mortem report

64. A post-mortem was carried out on 9 September. The cause of the man's death was recorded as nefopam overdose and ischaemic heart disease. The pathologist concluded that he had underlying cardiac disease and this might have resulted in sensitivity to the known cardiotoxic effects of nefopam.

ISSUES

Clinical care

65. The clinical reviewer reviewed the man's clinical care at Ranby. He considers it likely that the man took extra painkilling tablets for their euphoric effect as there was no indication that he intended to harm himself. He presumed that it was an accidental overdose. We agree that the evidence is that the man often abused either illicit drugs or prescribed medication and there is little to indicate that the overdose of nefopam was an intentional attempt to kill himself. The clinical reviewer concludes that the healthcare treatment that the man received at Ranby was equivalent to that he could have expected in the community. Healthcare staff responded to his general health needs and offered the expected health promotion and vaccinations.

Risk assessments for in-possession medication

66. Prison staff should assess prisoners to determine whether it is safe for them to keep medication in their cells, taking into account the risk a prisoner poses from not taking the doses as prescribed, over-medicating or trading.

67. A healthcare manager carried out a risk assessment for in-possession medication in March 2012. The document was incomplete, but indicated that the man was permitted to retain up to a 28-day supply of medication, although his medical records show that he was usually given his medication weekly.

68. There is evidence in the man's prison records and in statements from staff and prisoners that he had abused his own prescribed medication and that of other prisoners. In spite of this, and a positive test for illicit drugs and behaviour consistent with drug use, healthcare staff conducted no further risk assessments to review his suitability to hold medication in his possession.

69. The clinical reviewer considers that until 2 May 2013, it was reasonable to allow the man's to keep his medication in his possession. This gave him the autonomy to take his pain relief medication as and when he needed it. However, after the man's suspected drug overdose on 1 May, healthcare staff should have conducted a new risk assessment with a view to restricting the man's supply of medication by dispensing it daily or requiring him to take it under the supervision of healthcare staff. Nurses changed the dispensing to daily on 2 May, but he did not attend to collect it and reverted to weekly possession on 9 May without any further assessment of the risk.

70. On 23 July 2013, the man's dose of nefopam was increased from two 30mgs daily to three. The reason for the increase is not explained in his medical record.

71. The clinical reviewer notes that if the man had been a patient in the community he would not have been prescribed medication daily and would have had responsibility for it. We agree that ideally prisoners should be

responsible for managing their own medication and have the autonomy they would have in the community. There are a number of benefits to this approach, but prisons also have a duty of care to ensure security and the safety of prisoners. Allowing prisoners to keep stocks of sought after medication in possession can lead to bullying and intimidation or trading in medication so the risks and benefits need to be carefully assessed. We note that HM Inspectorate of Prisons was concerned about the extent of diverted medication at Ranby at the time of the last inspection in 2012 and that a high percentage of prisoners had medication in their possession which had the potential to be abused. The man had been found collapsed in his cell previously and had appeared under the influence of drugs on at least two occasions. This should at least have led to closer monitoring. It had been over a year since the previous risk assessment, which was not fully completed and we consider that his risk for holding medication in possession should have been fully reviewed again in May 2013. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff fully complete risk assessments for in-possession medication and monitor prisoners' compliance. When there is any evidence of potential abuse, the risk assessment should be reviewed to ensure the safety of prisoners.

72. Ranby has no facilities for prisoners to store their in-possession medication safely and securely in their cells. This adds to their vulnerability to pressure from other prisoners and the risk that their medication might be taken. The lack of such secure storage facilities also makes it more difficult to monitor prisoners' compliance with their medication regime. We make the following recommendation:

The Governor and Head of Healthcare should provide secure facilities for prisoners to store in-possession medication.

Emergency response

73. We are concerned that there was a delay in summoning help when the man was found unresponsive in his cell. The first two officers to arrive at the cell did not radio for assistance. Instead, an officer went to the wing office and said he asked the senior officer to call an emergency code. There is no record that this happened. The officer subsequently radioed a code blue emergency when he became concerned about the length of time it was taking for healthcare staff to arrive. Neither officer had been trained in first aid and neither attempted resuscitation, although the man was unresponsive and they believed there were some signs of life at that stage. We are concerned that officers did not appear to know what to do in an emergency, which is a particular risk at Ranby as it does not have 24 hour healthcare. This is an issue the Inspectorate identified at its 2012 inspection of Ranby. There is a need for officers in prisons without full-time healthcare presence to have sufficient first aid trained staff on duty at all times and all officers should know how to administer basic life support until trained help arrives.

74. It took at least ten minutes for healthcare staff to arrive, partly because, at first, they had not heard the code blue call. The clinical reviewer points out that, “time to defibrillation is the most critical event to save the life of a patient in cardiogenic shock”. While the first officer on the scene should have radioed for help at the outset and begun resuscitation, there is no evidence that this delay impacted on the outcome for the man. Although the officers and one of the prisoners thought that they had detected a pulse, the nurses found no sign of life and there were indications of rigor mortis.

75. Prison Service Instruction (PSI) 3/2013 *Medical Emergency Response Codes,* sets out the actions staff should take in a medical emergency. As required by the PSI, Ranby issued a local emergency protocol on 18 February 2013. It stipulates that staff should ensure there are no delays in calling an ambulance and that it should not be a requirement for a member of the healthcare team or a manager to attend the scene before an ambulance is called. If staff are in any doubt about the nature of an injury, an ambulance must be called immediately. The instruction also says that if an emergency code is called over the radio, as in the man’s situation, an ambulance must be called immediately. Therefore, when the officer called the code blue, control room staff should have immediately called an ambulance. This was not done until a custodial manager requested one be called, seven minutes after the man was first found unconscious. The local protocol does not say anything about the need for the staff who are first on scene to begin basic life support.

76. The OSG, who received the emergency call in the control room, told the investigator that an ambulance is not called immediately an emergency code is received and the procedure is to wait until a member of staff specifically requests one. In a previous investigation of a death at Ranby in June 2013, we were critical that staff did not request an ambulance until a manager had arrived at the cell. It is apparent from the response to that incident and the death of the man, three months later, that staff at Ranby were still unaware of the correct procedures.

77. There was a delay of seven minutes in directing the ambulance from the prison gate to the man’s cell. Although Ranby is a very large site, this appears too long to get emergency help to an incident. In view of the various delays, the failure of officers to begin emergency first aid and the failure to comply with the national instructions on responding to an emergency, we make the following recommendations:

The Governor should ensure that there are sufficient first aid trained staff on duty at all times and that all officers understand how to begin basic life support until trained staff arrive.

The Governor should ensure that all staff are made aware of PSI 03/2013 (and the local instruction RNC 18/2013) and understand their responsibilities during medical emergencies, in particular:

- **Efficiently communicating the nature of the emergency;**
- **Initiating basic life support as needed until health care or other trained staff arrive;**
- **Ensuring there are no delays in calling, directing or discharging ambulances.**

78. The nurse found clear signs of rigor mortis and was in no doubt that the man was dead. Nevertheless, the nurses attempted CPR and continued until the paramedic arrived. European Resuscitation Guidelines 2010 state that, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it would be futile …" The clinical reviewer states, "Recognising deaths in these circumstances can be challenging when the immediate first aid response is to commence life support". He acknowledges the difficulties for staff in making the decision not to attempt resuscitation or to stop once it has started but considers that they would benefit from more training and support to increase their confidence in such situations. We agree and make the following recommendation:

The Head of Healthcare should ensure that staff are appropriately trained and supported to make decisions not to start or continue resuscitation if, in their professional judgement, the person has already died.

Bullying

79. We are concerned to note that the man was the victim of a number of assaults at the hands of other prisoners at Ranby during 2013. After a serious assault in January 2013, he moved from D wing to F wing. A few months later at least one of the alleged assailants from D wing also moved to F wing and the man told a nurse he was anxious about this as the prisoners had threatened him. The nurse reported this to wing staff and completed a security information report, yet it does not appear that anything effective was done to protect the man or that action was taken against the other prisoners. Shortly afterwards he was assaulted again.

80. In August, the man said that his differences with the other prisoners had been settled. We do not know if this was actually the case, but there is little to indicate that the threats and intimidation he received were in any way linked to his death. Nevertheless, it is a serious concern that the prison did not effectively protect him from acts of violence. This could not have helped his anxiety levels. The lack of effective response to violent incidents was another issues identified by the Inspectorate in its 2012 inspection of Ranby and is a matter we made a recommendation about in our investigation into a death at the prison in July 2013. We make the following recommendation:

The Governor should ensure that prisoners identified as at risk of violence from other prisoners are effectively protected through an active and responsive violence reduction strategy.

Unlocking cells

81. The officer who unlocked the man for evening association did not check on him, but simply unlocked the cell doors on the landing. We do not know whether the man was in a collapsed state at this time, but if he had been checked and was evidently unwell, this would have allowed prompt medical intervention. This is a matter we brought to the attention of Ranby in our investigation in June 2013. That case involved unlocking in the morning, but similar principles apply whenever a cell is unlocked.

82. For their own safety, officers are supposed to make contact with a prisoner through the observation hatch before opening a locked cell door. When unlocking a cell they should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead." We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Next of kin details

83. Ranby did not record contact details for the man's next of kin when he arrived at the prison and there was no check such as at annual sentence plan reviews to ensure that details recorded were up to date. This meant there was a considerable delay before his family were informed of his death. The family liaison officer contacted his probation officer for this information, who then broke the news to his ex-partner. This meant that the prison were not able to make arrangements to notify his family in person, which is the usual Prison Service expectation. We make the following recommendation:

The Governor should ensure that prisoners' next of kin details are recorded when they arrive at the prison and are updated annually, so that up to date information is available in an emergency.

Information to prisoners

84. Prisoners complained to the investigator that they had been unaware of the PPO investigation into the man's death as the notices issued by the investigator had not been displayed on the wing where the man died. They were also unhappy that prisoners on F wing had not been told that a memorial service had been arranged and were unable to attend. We make the following recommendation:

The Governor should ensure that prisoners receive all required and expected information after a death at the prison.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff fully complete risk assessments for in-possession medication and monitor prisoners' compliance. When there is any evidence of potential abuse, the risk assessment should be reviewed to ensure the safety of prisoners.

2. The Governor and Head of Healthcare should provide secure facilities for prisoners to store in-possession medication.

3. The Governor should ensure that there are sufficient first aid trained staff on duty at all times and that all officers understand how to begin basic life support until trained staff arrive.

4. The Governor should ensure that all staff are made aware of PSI 03/2013 (and the local instruction RNC 18/2013) and understand their responsibilities during medical emergencies, in particular:

    - Efficiently communicating the nature of the emergency;
    - Initiating basic life support as needed until health care staff arrive;
    - Ensuring there are no delays in calling, directing or discharging ambulances.

5. The Head of Healthcare should ensure that staff are appropriately trained and supported to make decisions not to start or continue resuscitation if, in their professional judgement, the person has already died.

6. The Governor should ensure that prisoners identified as at risk of violence from other prisoners are effectively protected through an active and responsive violence reduction strategy.

7. The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

8. The Governor should ensure that prisoners' next of kin details are recorded when they arrive at the prison and are updated annually, so that up to date information is available in an emergency.

9. The Governor should ensure that prisoners receive all required and expected information after a death at the prison.

ACTION PLAN: ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that healthcare staff fully complete risk assessments for in-possession medication and monitor prisoners' compliance. When there is any evidence of potential abuse, the risk assessment should be reviewed to ensure the safety of prisoners.	Accepted	There is an I/P risk assessment on S1 which is completed by prescribing clinicians. The I/P Policy will be reviewed yearly unless there are concerns. There is potential for abuse, however, medication spot checks will be carried out by HCC staff in order that medical in confidence is not breached. Those prisoners that do not comply to the agreed and signed I/P compact will have their medication withdrawn.	Completed	
2	The Governor and Head of Healthcare should provide secure facilities for prisoners to store in-possession medication.	Accepted	In possession medications are only issued on a risk assessed basis. Use of secured lockable cabinets and a supporting protocol will be in place for those who present an increased risk by the end of May 2014.	June 2014	
3	The Governor should ensure that there are sufficient first aid trained staff on duty at all times and that all officers understand how to begin basic life support until trained staff arrive.	Accepted	There are now sufficient staffs trained in first aid. Comprehensive plan to train all custodial managers has been completed and delivered.	Completed	

4	The Governor should ensure that all staff are made aware of PSI 03/2013 (and the local instruction RNC 18/2013) and understand their responsibilities during medical emergencies, in particular: a)Efficiently communicating the nature of the emergency; b)Initiating basic life support as needed until health care staff arrive; c)Ensuring there are no delays in calling, directing or discharging ambulances.	Accepted	A Staff Information Notice has been issued to address these recommendations (attached for ease for reference).	Completed Completed Completed	
5	The Head of Healthcare should ensure that staff are appropriately trained and supported to make decisions not to start or continue resuscitation if, in their professional judgement, the person has already died.	Accepted	H/C resuscitation policy has been shared with Healthcare staff and all staff are hospital life support trained. This policy is discussed at this training.	Completed	
6	The Governor should ensure that prisoners identified as at risk of violence from other prisoners are effectively protected through an active and responsive violence reduction strategy.	Accepted	Governor Lagden, Head of Safer Custody to produce a violence reduction strategy by 31st May 2014	Completed	

7	The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.	Accepted	This is in the Local LSS instructing that staff must make a dynamic risk assessment at the point of opening any cell door. Staff have been reminded via staff briefings and progress will be monitored at Safer Custody Meetings.	Completed	
8	The Governor should ensure that prisoners' next of kin details are recorded when they arrive at the prison and are updated annually, so that up to date information is available in an emergency.	Accepted	All prisoners NOK details will be updated accordingly. A weekly report is produced from CNOMIS and all prisoners that do not have NOK details are sent a template letter requesting details.	Completed	
9	The Governor should ensure that prisoners receive all required and expected information after a death at the prison.	Accepted	Prisoner Information Notices are produced immediately after a DIC. This has been reiterated to all staff via NTS and staff briefings	Completed	