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 in April 2014 at HMP Ranby

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 hanged in his cell at HMP Ranby, in April 2014. He was 40 years old. I offer my condolences to the man's family and friends.

An investigator was appointed. A clinical reviewer reviewed the man's clinical care at Ranby.

The man was sentenced to life imprisonment in May 2006. He had attempted to hang himself shortly after he was remanded to prison in 2005, and in September 2011 he took an overdose of prescribed medication. He transferred to HMP Ranby in April 2012. The man suffered periodically from anxiety but repeatedly said that he did not feel suicidal and did not attempt to harm himself again.

At Ranby, the man received treatment for some physical ailments. A week before his death, he told a nurse he was not sleeping and feeling low. He attributed this to the anniversary of his offence and anxiety about an imminent parole hearing. After a follow up consultation with a prison doctor on 16 April, the man became uncharacteristically angry and a mental health nurse assessed him. The man said that he felt let down by the prison GP and other healthcare staff. The nurse recognised he was anxious, but did not consider he was at immediate risk of suicide or self-harm. She made an appointment for him to see the doctor the next day to discuss treatment options for his anxiety.

At around 7.25am on 17 April, an officer conducting a roll check saw the man in his cell, sitting with his back against the door with one leg outstretched. He did not consider this strange and did not try to get a response from the man. At 8.20am, an officer went to the man's cell and discovered him in the same position. The man had a ligature made of torn sheeting around his neck and it was apparent that he had been dead for some time.

The clinical reviewer considered that the man's standard of healthcare at the prison was comparable to that he could have expected to receive in the community. He concluded that there was little to indicate that the man was at imminent risk of suicide. I agree that the man's actions were sudden and unexpected and it would have been difficult for prison staff to have anticipated his actions and prevented his death.

I am concerned that the officer, who first saw the man in an unusual position on the morning of 17 April, did not report this or check on his safety. Although it would not have changed the outcome for the man, I am also concerned that the emergency response did not follow expected procedures, an issue I have raised with Ranby before.

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 **December 2014**

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SUMMARY

1. In April 2005, the man was remanded to prison, charged with murder. Shortly afterwards he attempted to hang himself. In May 2006, he was convicted and sentenced to life imprisonment. In September 2011, he took an overdose of prescribed medication.

2. The man moved to HMP Ranby in April 2012. He had a heart condition for which he received treatment and also suffered from haemorrhoids. Although he had periods of anxiety, he had no diagnosed mental illness and said that he had no thoughts of suicide or self-harm.

3. The Parole Board was due to assess the man's suitability for transfer to an open prison at the end of April 2014. The man had very positive parole reports, but a close friend of the man said that he had often used an illicit drug, known as mamba (a synthetic form of cannabis). Shortly before his death, his friend said that the man had told him that he intended to stop using it, as he did not want to jeopardise his forthcoming parole review. His friend said that the man had recently sold some personal items and he believed this had been to pay off drug debts. Prison staff were unaware that the man had been involved in drug use.

4. On 10 April, the man told a nurse that he felt low due to the anniversary of his offence, a forthcoming parole review and because he was not sleeping well. He said he did not feel suicidal. A week later, on 16 April, the man became very angry after a consultation with a doctor. A mental health nurse assessed him and again he reported low mood and sleeplessness, as well as anxiety and panic attacks. He also disclosed some personal issues and said that he felt let down by doctors and other healthcare staff. He said he did not like queuing for medication and having to take it in front of staff. The nurse made an appointment for the man to see a doctor the next day.

5. At 7.30am the next morning, an officer completing a roll check saw the man sitting on the floor of his cell, with his back against his door and one leg outstretched. The officer did not consider this strange and did not try to get a response from the man, or otherwise check that he was all right. At 8.20am, another officer went to the man's cell as he had not reported for work. When he tried to open the door, it was obstructed and he had to force it open. He found that the man had been sitting against the door and had a ligature made of a torn bed sheet, tied around his neck. The officer radioed for help. As rigor mortis was present, it was evident that the man had been dead for some time and the staff did not attempt resuscitation. Paramedics arrived and pronounced the man dead.

6. The man was reported to have been unhappy that he had not received satisfactory medical care and found it difficult to be reassured that his haemorrhoids were not masking something more serious. The investigation found that his treatment was

appropriate and the clinical reviewer concluded that the standard of the man's healthcare at Ranby was equivalent to that he could have expected to receive in the community.

7. We agree with the clinical reviewer that it would have been difficult for staff to have predicted the man's actions. However, we are concerned that the officer who first saw him sitting against his door on the morning of 17 April, did not check on his well-being. Although it would not have changed the outcome for the man, the investigation found that the prison control room did not follow national Prison Service emergency procedures and call an ambulance immediately they heard an emergency code, an issue we have raised with Ranby before. We are also concerned that after the man's death, prison managers did not obtain statements from the staff involved or arrange adequate support.

THE INVESTIGATION PROCESS

8. On 18 April 2014, 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. Two prisoners responded.

9. The investigator went to Ranby on 22 April and obtained copies of the man's prison and healthcare records. He viewed the houseblock and the cell the man had occupied.

10. NHS East Midlands commissioned a clinical reviewer to review the man's clinical care and treatment at the prison. 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 a copy of this report to the Coroner.

12. On 30 June and 1 July, the investigator interviewed 14 members of staff and two prisoners. After the interviews, he wrote to the Governor to inform her of the initial findings of the investigation. The investigator subsequently interviewed another prisoner at HMP Gartree.

13. One of our family liaison officers spoke to the man's mother to explain the purpose of the investigation and give her the opportunity to raise any matters she wanted the investigation to address. His mother said that the man had told her that he felt he had not received the help he needed for his physical and mental health problems and that the doctor at Ranby had been ignoring him. The man's mother later told the family liaison officer that she had received a letter from her son, who had asked another prisoner (who had since transferred to HMP Gartree) to send on to her. In the letter, the man wrote that in spite of asking for help, he felt he had received none. He apologised to his mother and said goodbye.

14. The man's family were sent a copy of the draft report. A response was received form the legal representatives for the man's family on 14 November 2014 asking additional questions, and indicating a factual inaccuracies which has led to a slight amendment at paragraph 62. The questions raised have not altered the findings of the original report and have been dealt with in separate correspondence.

15. The Prison Service responded on 18 December 2014, and indicated that all recommendations made in this report have been accepted. A copy of the Prison Service Action Plan for addressing these has been attached.

HMP RANBY

16. HMP Ranby is a medium security prison which holds over a thousand sentenced men. Since 1 April 2013, Nottinghamshire Healthcare Trust has provided primary healthcare services at Ranby.

Her Majesty's Inspectorate of Prisons

17. The most recent inspection of Ranby was in March 2014, shortly before the man's death. The inspectorate was concerned that the prison was unsafe. There had been increased levels of violence and intimidation with inadequate direct supervision of prisoners. Inspectors noted that incidents of self-harm had risen significantly in the previous year and there had recently been two self-inflicted deaths. They reported that the action plan the prison had completed in response to the Prison and Probation Ombudsman's recommendations about one of the death's was insufficiently detailed. Inspectors found that there was increased availability of undetectable illicit drugs and diverted prescribed medication. The prison had a wide range of health services and mental health support was very good. Despite this, inspectors noted that most prisoners were dissatisfied with the quality of healthcare and inspectors considered that the prison needed to improve the management of prisoners' complaints about health services.

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 annual report for the year to March 2013, noted that black mamba and subutex were the main drugs found during searches. The IMB was concerned prisoners were bullied for medication at pharmacy queues as officers did not directly supervise them. .

Previous deaths at Ranby

19. Since 2013, there have been six deaths at Ranby including that of the man. In previous investigations, we have raised concerns about the emergency response procedures.

Assessment, care in custody and teamwork (ACCT) procedures

20. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. If a prisoner is considered to be at very high risk of suicide, staff can implement constant supervision, which means the prisoner must be watched at all times. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the

prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Use of illicit drugs

21. HM Chief Inspector of Prisons has recently reported that the use of substances often known as 'legal highs', such as 'black mamba', a synthetic cannabinoid, is a growing problem in prisons in England and Wales. Although initially legal, recent concerns about the effects of black mamba (and other similar substances) has resulted in the black mamba and other drugs being reclassified as illegal class B substance. Prisoners increasingly use such drugs as they can be easily disguised as tobacco, have no distinctive smell and cannot be detected in standard prison drug tests.

KEY EVENTS

22. The man was remanded to HMP Birmingham in April 2005, charged with the murder of his partner. At a reception health screen, he reported that he had suffered a heart attack in 1999 and took medication for his heart condition. (The man had further heart attacks in prison in February 2012 and February 2013.) Reception staff began ACCT suicide and self-harm prevention measures and staff constantly supervised the man because they were concerned about his mental state and his risk of suicide. The next day, he attempted to hang himself. Staff continued to manage the man under ACCT procedures until June 2005.

23. In May 2006, the man was convicted and sentenced to life imprisonment with a minimum time to serve of 10 years before he could be considered for release. In his sentencing remarks, the judge said that the man had a fragile personality with limited control over his emotions. He transferred to HMP Garth in September 2007 and then to HMP Gartree in January 2009. At his initial health screen at Gartree, he reported that he had been admitted to a psychiatric hospital in 1999, after a suicide attempt in the community.

24. Prison and healthcare staff recorded little of significance about the man for most of the time between 2009 and 2011, but on 3 June 2011, a GP at Gartree referred him to the mental health team as he had stopped taking his heart medication. A subsequent mental health assessment concluded that he had no mental health problems and had the capacity to make decisions about his health and treatment.

25. At the end of August 2011, wing staff became concerned about the man as his behaviour had changed; he had become withdrawn and had lost weight. A mental health nurse, assessed him on 1 September. The man attributed his change in behaviour to hostility from the prisoner in the next cell who blamed him for loud noises at night. He said that he felt genuinely threatened and wanted to move to a different wing. The mental health nurse agreed to speak to the wing manager and support a move. In the meantime, he asked wing staff to monitor any changes in his mood.

26. On 12 September 2011, the man said that he had taken an overdose of prescribed medication, paracetamol (a painkiller) and naproxen (an anti-inflammatory and painkiller). He went to hospital for observation and stayed in overnight. Prison staff began ACCT procedures. The man said that he had taken the overdose due to continuing issues on the wing that he had spoken about with the mental health nurse. The mental health team concluded that it had been an impulsive act and that he had not intended to kill himself. Staff closed the ACCT on 14 September, as the man had now moved wings and said that he felt settled. He agreed to contact the mental health team if he felt low or agitated in the future. The mental health nurse concluded that there was no immediate need for further mental health intervention.

27. The man transferred to HMP Ranby on 3 April 2012, as a standard sentence progression and had a brief reception health screen. On 25 April, he told his

offender supervisor, that since he had arrived at Ranby he had not received his heart medication. She said she would raise this with healthcare staff. On 3 May, a doctor assessed the man, recorded his cardiac history and prescribed all his medications.

28. Many prisons operate a personal officer scheme to allow an appointed officer to develop effective relationships with individual prisoners to help address their needs and act as a point of contact for advice and assistance. Personal officers should make regular entries in prisoners' records about their progress. The man's personal officer, wrote a number of positive comments about the man and described his behaviour as exemplary. The man's personal officer told the investigator that he had never had any concerns about the man using illicit drugs or that other prisoners were bullying him. No other staff had raised any concerns.

29. In early September 2012, the man told a prison GP, that he had been experiencing abdominal pain and vomiting and so had stopped taking his prescribed medication. The doctor referred him to a gastroenterologist, who diagnosed acid reflux and haemorrhoids.

30. On 5 February 2013, the man had another heart attack and spent two days in hospital. At a follow-up review on 14 February, The GP advised him to stop smoking and reminded him how important it was to take his medication as prescribed. The doctor also advised the man to attend cardiac rehabilitation sessions run in the prison.

31. The man's personal officer continued to report positively about him in his personal record, but in three security information reports (SIRs) submitted between May and September 2013, other prisoners had reported him as being involved in bullying. The staff who had submitted the reports told the investigator that discrepancies in the information given suggested that the allegations had been malicious. A security report submitted in July 2013, indicated that the man had reported that another prisoner had threatened him for tobacco, but he refused to give any further information or make a formal complaint.

32. In September 2013, the man began working as the cleaner in the segregation unit, a trusted prison job. On 12 December 2013, segregation unit staff recorded that the man worked above and beyond his duties, and often staying during the lunch period to clear up after disruptive prisoners had damaged cells. He sometimes spoke to nurses and doctors who visited the segregation unit if he had any health concerns and asked for medication if he needed it. The staff said that he had never raised any concerns about his treatment for health conditions.

33. A prisoner who was a close friend of the man from their time together at Gartree, told the investigator that he had never witnessed anything to suggest that he had been involved in bullying. However, he said that it was not widely known that in the last 18 months of his life, the man had frequently used black mamba. The man had told the prisoner that he intended to stop, as he wanted to concentrate on his forthcoming parole review, which was due at the end of April 2014. He wanted to

move to an open prison to prepare for release. The prisoner said that, in the weeks before his death, the man had sold personal items, such as his Playstation and clothing, to other prisoners. He believed that this was to pay debts for drug use. He had not seen any other prisoners approaching him about this or bullying him.

34. On 24 March 2014, the man refused to continue taking pregabalin (an anti-epilepsy drug also prescribed for neuropathic pain relief and general anxiety). This was because national instructions to prevent misuse of such medication now required prisoners to collect it daily and take it under supervision. Healthcare staff advised against this but the man signed a disclaimer to take responsibility for his decision. The prisoner told the investigator that the man had been frustrated about the policy change and felt that this was treating him like a child. (Ideally, prisoners should be responsible for managing their own medication and have the autonomy they would have in the community, but prisons also have a duty of care to ensure the security and the safety of prisoners. Allowing prisoners to keep stocks of medication in their possession can lead to bullying and intimidation or trading in medication and other misuse.)

35. On 10 April, a nurse practitioner and the clinical lead for primary care at Ranby, saw the man about his haemorrhoids. The nurse knew the man fairly well and said that it was clear something was bothering him. The man was tearful and said that he was feeling low. He explained that the anniversary of his offence was approaching, his parole hearing was imminent and he was having difficulty sleeping. The nurse said that they discussed starting ACCT procedures to support him. However, the man was adamant that he did not want this, and did not want the nurse to refer him to the mental health team as he thought this might have a negative impact on his parole hearing. As he had a good relationship with healthcare staff, she advised him to speak to the nurses in the healthcare team if he did not want to go to the mental health team.

36. The nurse referred the man to a doctor for assess his haemorrhoids and to discuss the possibility of medication to help him sleep. She told the investigator that she was unaware that the man had any concerns about his medical care at the prison and he had not complained to her. She did not believe that he was at risk of suicide or self-harm, but, with hindsight, considered that she should have spoken to the mental health team after their discussion.

37. On 16 April, the doctor told the man that he intended to refer him to a colorectal surgeon to consider the possibility of surgery for his problem with haemorrhoids. The doctor said that the man was courteous and polite during the consultation. He left the man in the waiting area and took his prescription for haemorrhoid medication to the pharmacy.

38. The doctor said that as he returned to his consulting room, the man was still in the waiting area and began shouting at him and saying that he was not being listened to. When he asked what was wrong, the man said that he needed to see him again as he wanted medication to help him sleep and to see a mental health nurse

as he was anxious about his parole hearing. The doctor told the man that he was unable to see him again at that time as there were other prisoners waiting, but he would make another appointment for him and speak to the mental health team. He said that the man became quite angry, which was out of character. Officers had to escort him back to his wing.

39. The nurse said she had not been present at the consultation, but was in the healthcare reception and recalled that as the man left, he had said, "So, you're not going to do anything about my zopiclone? Why aren't you listening to me?" (Zopiclone is a sleeping medication.) The nurse felt that the doctor had sounded dismissive and had told the man that another GP would see him the next week.

40. The doctor said he was concerned about the man's reaction. He said that he had told a mental health nurse, that the man was not himself and asked her to assess him as soon as possible and let him know the outcome immediately.

41. Another prisoner and friend of the man, told the investigator that after the man returned to the wing, he heard him say to an officer, "I am going to do something about this". The prisoner said the officer asked him what he was going to do and then just turned and walked away.

42. The investigator asked all the staff who had been on duty on Houseblock 5 that afternoon whether they had spoken to the man after he came back from his healthcare appointment, or recalled him saying what the prisoner had said. An officer said that the man was unhappy when he came back and said that the doctor had refused to treat him. He did not recall him saying he was going to do something about it. The officer said he had tried to reassure the man that the staff who had escorted him back to the wing had told him that they were going to speak to the doctor on his behalf about his prescription.

43. Later that afternoon, a nurse assessed the man. She recorded that he was angry 'very stressed, low in mood, anxious and not sleeping'. He had had panic attacks and wing staff had reported that he had not been collecting his meals or sleeping well. The man told the nurse that he felt overwhelmed by his current situation and was anxious and worried about the outcome of his upcoming parole review. He said that he had served nine years in prison and had worked hard to get to this point. The man told her about some personal family issues but she was not sure whether they were longstanding or new problems. He told the nurse that he felt let down by the GP and healthcare staff. He was unhappy that he now had to queue for his medication and take it in the sight of a nurse when he had not misused medication.

44. The man told the nurse that he did not want the mental health team involved as he felt it might put at risk his chance of gaining category D status and moving to an open prison. He said that he had no thoughts or intentions of suicide or self-harm. The nurse told the investigator that in assessing the man's risk, she took account of his forward thinking and planning about his recategorisation and comments about the future. She concluded that he was not at immediate risk of suicide or

self-harm and that his problems were to do with his anxiety about his imminent parole review and a lack of sleep. She therefore referred him to the primary care mental health team for possible crisis support.

45. The nurse reported to the doctor that the man was still quite upset and having difficulty sleeping. The doctor asked her to book a GP appointment for the man the next day, to discuss his medication. The nurse said that she had asked the wing staff to let the man know that she had booked the appointment but there is no written record that they did this. Wing staff said that they would not usually make a record of such messages passed from healthcare staff to prisoners, unless there were particular reasons for doing so.

46. Houseblock 5 is generally for well-behaved prisoners on an enhanced regime level, which allows them additional privileges. Unlike the other houseblocks at Ranby, the prisoners have keys for their cells, which allow them to leave them at any time. As a security precaution, gates at the end of each wing are locked during the night and staff do not routinely patrol the landings. If staff need to go onto a landing at night, the duty manager has to attend. There were no recorded incidents during the night of 16/17 April.

47. At around 7.25am on 17 April, an officer conducted the morning roll check (count) of prisoners and checked each prisoner was present by looking through the cell observation panel of the cell. When he looked into the man's cell, he said he was sitting with his back against the door, but he could only see the top of his head and one leg stretched out in front of him. The officer said that he did not consider this strange and assumed that the man was sitting on the floor waiting to go to work. He did not speak to him or otherwise try to get a response from him. The officer said that he did not notice anything tied to the outside of the man's door at the time.

48. The officer said that at approximately 8.20am, he called prisoners for work. The man did not appear, so he went to his cell. When he tried to open the door, something was blocking it so he forced his way in. As he went in, he saw the man sitting on the floor with his back against the door, with a ligature made from a torn bed sheet around his neck. The officer said that he immediately radioed a code blue (signifying a life threatening medical emergency such as when someone is not breathing, unconscious or found hanging).

49. The officer said that he was unlocking cells on the opposite side of the houseblock when he heard the code blue over his radio. When he arrived at the landing, another officer and an operational manager, were standing outside the man's cell and he heard the officer inside the cell talking to the man. The officer went in but the officer looked at him and shook his head and he saw that the man appeared to be dead. He said that the operational manager then came in and told them both to leave.

50. The operational manager's recollection was slightly different. He said that while he was in his office he heard a general alarm call. He went to the landing

immediately and said he saw two officers in the man's cell, trying to move him away from the back of the door. The operational manager said that, from experience and the man's appearance, he considered that he had died. He felt that staff could not do anything to help so he instructed them to leave the cell. The operational manager did not recall anything tied to the outside of the man's door.

51. The operational manager said he had known the man since he had been a residential manager at Gartree and would often speak to him at length when he met him around Ranby. He described him as generally upbeat and happy, but occasionally he would be low and tell him about things that were worrying him, mainly his impending parole review. He was not aware that the man had been involved in trading or using illicit drugs. The operational manager recalled that he had talked to him about three days before his death, and the man had asked, "If I get my D cat, will you get me out as quick as you can?" The operational manager said he had told him that he would do what he could. He had assumed that the man was simply keen to move on from Ranby.

52. There were conflicting accounts of how the emergency was raised. The officer said that he had called a code blue and one officer said that he and another officer had responded to this. However, the operational manager indicated that he had heard a general alarm and he had called a code blue after arriving at the man's cell. The nurse told the investigator that she had originally heard a general alarm over the radio at around 8.20am and, shortly afterwards, a colleague had alerted her that it was a code blue. The prison did not keep any control room logs and the staff involved in the incident did not complete statements at the time, as they are expected to do.

53. The incident log taken at the scene, shows, that after collecting the emergency bag and defibrillator, a nurse went to the cell with a healthcare support worker and arrived at 8.24am. The operational manager, who was outside the man's cell, told her that he appeared to be dead.

54. The nurse said that she left the emergency bag with healthcare support worker and went into the cell on her own. No one was in the cell when she arrived but the ligature had was no longer around the man's neck and was on top of a cabinet. The man was lying on the floor. His legs and arms were stiff indicating the presence of rigor mortis. The nurse knew it would not be of any use but, because she thought it would be good practice, she attached the defibrillator, which indicated there was no electrical activity in the man's heart. As she was not formally qualified to recognise death, she asked the staff to call an ambulance. No one had done so till then. The nurse said that her experience led her to estimate that the man had been dead for at least a couple of hours. The paramedics arrived at the cell at 8.46am and, after attaching their own heart monitor, pronounced the man dead.

55. The nurse recalled that she had seen black shoelaces tied around the outside of the door handle, through the side of the door and then tied to the torn sheet that the man had used as a ligature. None of the other staff remembered seeing

anything attached to the door. The man's friend, the prisoner, told the investigator that he had seen the laces tied around the door handle when he had left the wing earlier that morning. The other prisoner said that, after the man's death, another prisoner had told him that he had seen a lace tied around the door, threaded up and over the top of the door. The prisoner had said that he felt guilty as he should have mentioned it to staff.

Support for prisoners and staff

56. The chaplaincy team offered support to prisoners on Houseblock 5 and staff reviewed prisoners, including those on other wings, who were subject to suicide and self-harm monitoring in case the man's death had affected them. Staff displayed notices on all residential wings informing prisoners of his death.

57. Most of the staff interviewed said that they had been given very little or no support. Managers did not ask staff to write incident statements and did not hold an immediate debrief for the staff involved in the emergency response to offer support and check their reaction to what had happened.

Family contact

60. The man's mother lived around two and a half hours journey time away from the prison. The prison's family liaison officer, went to her home with an assistant family liaison officer and an operational manager. They arrived at 1.30pm but got no response. They then went to see the man's sister and, at 4.30pm, informed her of her brother's death. The man's sister telephoned their mother, and the family liaison officer spoke to her and agreed to contact her the next day to arrange another visit.

61. The family liaison officer remained in contact with the man's family and arranged for his mother to visit Ranby to see where he had lived and speak to his friend. The prison offered financial assistance towards funeral expenses, in line with Prison Service instructions.

62. The man had left a note in his cell, in which he said that he was unhappy with the way he had been treated by healthcare staff. He asked the prison not to notify his mother of his death before 10.00am. He wrote that staff had been good to him and he apologised to the staff who would find him. He said that his actions were not linked to mamba or any other drugs. Two weeks after the man's death, prison staff collecting the man's personal property, found another letter in his cell, addressed to the man's mother, which they passed to her.

62. The other prisoner told the investigator that the man had given him a sealed letter about two days before his death and had asked him to post it. The other prisoner said that the man had told him that he intended to go to the segregation unit as he was unhappy with healthcare staff and he wanted the letter posted to his family to explain his actions. The prisoner said that the man gave no indication of his intentions to kill himself. He did not put the letter in the post immediately. Shortly

after the man's death, he transferred to HMP Gartree and passed the letter, unopened, to his solicitor. The man's family following sight of the draft report that they had not seen this letter.

Post-mortem

63. The post-mortem report concluded that the cause of the man's death was hanging. The toxicology report indicated that no illicit substances had been detected in his system.

ISSUES

Clinical care

64. The clinical reviewer reviewed the standard of the man's healthcare at Ranby. He noted that the man had received frequent health checks, staff had given him prevention and lifestyle advice and they had tried to accommodate his wishes about medication as far as they were able within the context of the secure prison environment. The man had said to prison staff and in letters found after his death, that he had not received appropriate care for his health conditions. The investigation found no evidence to support this. The clinical reviewer considered that there had been good communication between the primary and secondary healthcare staff and that the man's care had been comparable to that he would have expected to receive in the community.

The risk of suicide and self-harm

69. During a medical appointment on 10 April 2014, a week before his death, the man became tearful and told the nurse that he felt low. It was almost the anniversary of his offence, his parole hearing was imminent and he had problems sleeping. The man insisted that he did not want staff to manage him under ACCT procedures, or to refer him to the mental health team, as he was worried about the impact on his parole hearing and his chances of the Parole Board recommending a move to an open prison. The nurse said that at the time, she had no concerns that he would harm himself, but felt, with hindsight, that she should have consulted the mental health team.

65. On 16 April, the day before he died, the man became upset and angry about perceived poor treatment by the prison GP. The GP asked a mental health nurse, to assess him, which she did that day. The mental health nurse considered that as he had no history of serious mental health problems, and was planning for the future, he was not at risk of suicide or self-harm. However, she referred him for to the primary care team for crisis support to help with techniques to cope with stress. She arranged an appointment with the GP for the next day, to discuss his medication.

66. The clinical reviewer noted that healthcare staff had documented previous episodes of anxiety and impulsive behaviour in the man's clinical record. Since 2009, various healthcare workers had recorded that he had repeatedly denied any suicidal intentions. The clinical reviewer considered that the man's behaviour on 16 April was consistent with previous presentations of anxiety. The GP had arranged for a mental health nurse to review him immediately and the clinical reviewer considered that referring the man for a further GP appointment the next day, at which his need for medication would be reviewed, was a reasonable course of action. None of the healthcare staff who saw the man considered that there was any imminent risk to his life.

69. We are satisfied that there was nothing to indicate to staff that the man was at risk of suicide and self-harm and that they could not have predicted or prevented his actions.

Roll checks

67. The primary purpose of a roll check is to account for all prisoners, but staff are also expected to satisfy themselves of each prisoner's well-being. When the officer conducted the roll check on 17 April the man seemed to be sitting on the floor against the door. Although he could only see the top of his head and one leg outstretched, he did not try to check the man's welfare or get a response from him.

68. We are concerned that the officer did not consider that the man's position, with his back against the door, was unusual. We would have expected him to check that he was safe and well. He cannot have seen that the man was breathing, which is the least we would expect. On the evidence available, it appears likely that the man was dead at that time, so it is unlikely that earlier intervention would have changed the outcome. However, a brief check might make a difference in similar circumstances in the future. We make the following recommendation.

    The Governor should ensure that staff check a prisoner's well-being if there is no sign that they are breathing at a roll check or there are other indicators of concern.

Emergency response

69. Prison Service Instructions (PSI) 03/2013 *Medical Emergency Response Codes,* issued in February 2013, contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies. It also stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. It should not be a requirement for a member of the healthcare team or a manager to attend the scene before staff call an ambulance.

70. In line with the PSI, Ranby issued such a protocol in February 2013. However, staff told the investigator that, until recently, the prison had generally not adhered to it. They gave conflicting accounts of the incident, so it is unclear whether the first call to report the emergency was a general alarm or a code blue. However, no one called an ambulance until after the nurse arrived at the man's cell. The clinical reviewer was satisfied that the description of the man's clinical condition and the presence of post-mortem changes indicated that the staff were correct not to initiate cardiopulmonary resuscitation and we agree.

71. We accept that earlier intervention by the emergency services would not have made a difference to the man. However, it is concerning that the system of calling

an ambulance immediately an emergency code is still not embedded at Ranby. In future emergencies, such a delay could be critical. We made a previous recommendation about this matter after a death at Ranby in September 2013. The prison accepted the recommendation and said that they had re-issued the guidance to staff. It is apparent that managers need to take more effective action to ensure that all staff understand and follow mandatory national instructions about emergency procedures. We make the following recommendation:

The Governor should ensure that all staff use the appropriate emergency medical code in a life-threatening situation and that the control room calls an ambulance immediately an emergency code is called.

Post-incident management

72. PSI 64/2011 which covers safer custody procedures and sets out mandatory instructions on actions after a death in a prison requires staff directly involved to complete incident report forms as soon as practicable. Managers should hold a debrief for the staff involved to offer support and discuss what happened.

73. The nurse, support worker and two prisoners mentioned that they saw a black shoelace tied around the handle and door of the man's cell. However, the officer who had conducted the roll check and the other wing staff, said that they had not seen this. The post-mortem report states that the ligature was made of a white cotton cord and black shoelace. None of the staff involved had completed incident statements and managers did not hold a debrief meetings. Most of the staff we interviewed felt that they had not received adequate support. Prompt statements and a debrief shortly after the man's death, might have helped to resolve the discrepancies and reassure staff. We make the following recommendation:

The Governor should ensure that all managers and staff follow the national guidelines for dealing with a death or serious incident, including:

- **Offering staff involved appropriate support;**
- **Ensuring that all staff directly involved complete incident statements; and**
- **Ensuring that a debrief is held promptly after the death of a prisoner and that all staff involved in the incident are invited.**

RECOMMENDATIONS

1. The Governor should ensure that staff check on prisoners' well-being at roll checks and that there are no immediate issues that need attention.

2. 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;
    - Ensuring staff called to the scene bring the relevant equipment; and
    - Ensuring there are no delays in calling, directing or discharging ambulances.

3. The Governor should ensure that all managers and staff follow the national guidelines for dealing with a death or serious incident, including:

    - Offering staff involved appropriate support;
    - Ensuring that all staff directly involved complete incident statements; and
    - Ensuring that a debrief is held promptly after the death of a prisoner and that all staff involved in the incident are invited.

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
1	The Governor should ensure that staff check on prisoners' well-being at roll checks and that there are no immediate issues that need attention.	Accepted	All staff will be reminded that they should check on the well-being of prisoners at roll checks and when unlocking and locking them in their cells. A notice to staff will be issued and Staff Performance and Development Review (SPDR) will include this as an objective.	1st February 2015 Head of Safety & Equality	
2	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; • Ensuring staff called to the scene bring the relevant equipment; and	Accepted	A notice is now displayed in the control room, and a staff information notice has been issued to remind control room staff that on receiving a code blue transmission, they must call the emergency services immediately. Control room Officer Support Grades have had their SPDR amended to reflect the requirement. All other staff have been reminded via a notice to staff and will also be reminded at monthly staff meetings. Staff will be reminded of the protocol to follow when a prisoner is discovered unconscious or not breathing and the importance of	1st February 2015 Head of Safety & Equality	

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
	• Ensuring there are no delays in calling, directing or discharging ambulances.		immediately alerting the control room to a code blue emergency. Staff will additionally be reminded via a notice to staff and a user friendly guide attached to all wage slips. A global e-mail will be attached and staff's SPDR's will be amended accordingly.		
3	The Governor should ensure that all managers and staff follow the national guidelines for dealing with a death or serious incident, including: • Offering staff involved appropriate support; • Ensuring that all staff directly involved complete incident statements; and • Ensuring that a debrief is held promptly after the death of a prisoner and that all staff	Accepted	All managers will be reminded of the national guidelines to follow when dealing with a death in custody or a serious incident. Contingency plans will be followed and reviewed to ensure compliant. All Senior Management Team (SMT) members have been reminded via the SMT meeting and Orderly Officers have been briefed on the requirement. A checklist is being devised to ensure after a death or serious incident all required actions have been completed. Staff will be reminded of the support staff available to them and managers will ensure that this support is offered and logged during all	1st February 2015 Head of Safety & Equality	

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
	involved in the incident are invited.		debriefs. Duty Governors and Orderly Officers will ensure that all staff complete the appropriate statement as soon as practical after the incident. Staff SPDR's will be amended to reflect their responsibilities and a user friendly guide will be completed and issued to all staff. Debriefs will be held as soon after the incident as possible and this will be minuted and a copy sent to the Head of Safer Custody.		