

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Connors, a prisoner at HMP Ranby, on 25 June 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Michael Connors died from the toxic effects of a synthetic cannabinoid (a new psychoactive substance) on 25 June 2015, while a prisoner at HMP Ranby. He was 54 years old. I offer my condolences to Mr Connors' family and friends.

Mr Connors collapsed on 24 June and was taken to hospital. I am satisfied that the emergency response was prompt and well coordinated. Mr Connors had collapsed suddenly three times in previous months, without any obvious medical cause. Prison staff suspected he was using new psychoactive substances but took no action, such as referring him to the substance misuse team for support and advice about the dangers.

The prevalence of new psychoactive substances at Ranby is concerning and they have featured in a number of my recent investigations at the prison. Ultimately, prisoners have to take responsibility for their own actions, but the Governor needs to ensure there is an effective strategy to reduce the availability of harmful substances in the prison and that prisoners fully understand the risks they are taking when using them

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

December 2015

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Summary

Events

1. Mr Michael Connors had been in prison since April 2011, and was serving a seven-year sentence. He had a long history of substance misuse and drug and alcohol dependence. In October 2013, he absconded from an open prison. In March 2014, he was recaptured and sent to HMP Woodhill.
2. At an initial health screen at Woodhill, Mr Connors said that he suffered from asthma, was alcohol dependent and used heroin, subutex and cannabis. A prison doctor prescribed methadone and referred him to the substance misuse service. Mr Connors said he wanted to be clear of drugs and, in September, he decided to complete his methadone detoxification programme more quickly than planned.
3. Mr Connors moved to Ranby on 3 December 2014. He declined help from the substance misuse team when he arrived because he said he was now drug free.
4. Mr Connors collapsed three times, in January, April and May 2015. He was taken to hospital the first two times but refused to go in May. There was no obvious medical cause for the collapses and prison staff believed that Mr Connors had collapsed after taking a new psychoactive substance (NPS). There is no record that anyone referred Mr Connors to the substance misuse team.
5. On 24 June, Mr Connors collapsed again and stopped breathing. An officer radioed an emergency code, healthcare staff attended quickly and the control room called an ambulance. Staff began cardiopulmonary resuscitation and paramedics were able to establish a pulse when they arrived. They took Mr Connors to hospital but he did not recover and died the next day. Post-mortem tests showed that Mr Connors died of toxicity to a synthetic cannabinoid.

Findings

6. We are satisfied that there was a prompt and well-coordinated emergency response when Mr Connors collapsed on 24 June. It is clear that Mr Connors used NPS, which ultimately caused his death. Because of the earlier collapses, which staff believed were caused by NPS, Mr Connors should have been aware of the dangers of using NPS. However, we consider that staff at Ranby should have referred him to the substance misuse team when use of NPS was suspected. We understand that this is now done. We agree with HM Inspectorate of Prisons and the Independent Monitoring Board that the prison needs to do more to eradicate the supply of NPS. The prison had some intelligence that Mr Connors might have been coerced into using NPS to test a batch. We have found no evidence of this, but we are concerned that no one properly investigated the allegation at the time.

Recommendations

- The Governor should ensure there is an effective supply reduction strategy to help eradicate the availability of NPS, and that prison staff are vigilant for signs

of its use, and are briefed about how to respond when a prisoner appears to be under the influence of such substances.

- The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated; that alleged perpetrators are appropriately challenged; and that apparent victims are effectively supported and protected.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Ranby informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator visited Ranby on 2 July 2015. He obtained copies of relevant extracts from Mr Connors' prison and medical records.
9. The investigator interviewed six members of staff and three prisoners at Ranby on 27 and 28 August 2015. He interviewed two members of staff by telephone on 6 August.
10. NHS England commissioned a clinical reviewer to review Mr Connors' clinical care at the prison.
11. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Connors' son and daughter-in-law, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not have any specific issues about the circumstances of Mr Connors' death, but asked if he had any enemies in the prison.
13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.
14. Mr Connors' family received a copy of the initial report. They did not comment on the factual accuracy of the report. However, his family confirmed that they had yet to receive Mr Connors' property and this has been dealt with through separate correspondence with the prison.

Background Information

HMP Ranby

15. HMP Ranby is a medium security prison, which holds over a 1,000 sentenced men in seven houseblocks. Nottinghamshire Health and Care NHS Trust provide healthcare services.

HM Inspectorate of Prisons

16. The report of the most recent inspection of Ranby in September 2015 has not yet been published. At the time of the previous inspection in March 2014, inspectors were concerned that the prison was unsafe. There had been increased levels of violence and intimidation with inadequate direct supervision of prisoners. Inspectors were also concerned about the easy availability of undetectable new psychoactive substances (NPS), other illicit substances and diverted prescribed medication. The prison had taken some reactive measures in response, but there was no coordinated action plan to reduce drug supply and demand. Substance misuse and healthcare staff estimated that prisoners taking NPS had caused 25 acute medical situations in a six-month period.
17. Inspectors reported that substance misuse services delivered a high standard of care with good-quality interventions. They found that the prison had a wide range of health services and mental health support was very good.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2015, the IMB reported that the use of NPS placed pressure on healthcare staff, who had to respond to an increasing number of incidents and referrals to the substance misuse teams. The substance misuse team had worked to increase awareness about the dangers of using illicit substances but the problem with NPS continued to grow.

Previous deaths at HMP Ranby

19. Mr Connors was the eighth prisoner to die at HMP Ranby since January 2014. Since his death, there have been two further deaths. The high number of deaths at the prison is a concern and the possible use of NPS has been identified as a factor linked to some deaths in other investigations.

New Psychoactive Substances

20. NPS are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.

21. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances, while in prison can lead to debt, violence and intimidation.
22. In July 2015, we published a Learning Lesson Bulletin about the use of NPS including the dangers to both physical and mental health and the possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Key Events

23. Mr Michael Connors had been in prison since 15 April 2011, and was serving a seven-year sentence for offences, including burglary, handling stolen goods and driving offences. He had a long history of substance misuse problems. On 12 June 2013, Mr Connors transferred to HMP Ford but he absconded on 3 October. He was recaptured on 17 March 2014 and sent to HMP Woodhill.
24. At an initial health screen, Mr Connors said that he suffered from asthma and drank 200 units of alcohol a week in the community. A prison GP prescribed chlordiazepoxide (for alcohol withdrawal) and salbutamol (for asthma). The next day, at a secondary health screen, Mr Connors said he used heroin, subutex and cannabis. A GP prescribed methadone and referred him to the substance misuse service.
25. On 4 April, Mr Connors told a nurse practitioner from the substance misuse service that he wanted to stop taking methadone eventually. Over the next two months, members of the substance misuse team saw Mr Connors frequently to review and adjust his dose of methadone, which was decreased over time.
26. On 10 September, the nurse practitioner reviewed Mr Connors who wanted to stop taking methadone completely. He was prescribed lofexidine to help with the symptoms of suddenly stopping methadone. Mr Connors said that he was determined to remain drug free.
27. On 3 December, Mr Connors transferred to HMP Ranby, for sentence progression. At an initial health screen, he told Nurse A that he did not misuse drugs. Because of his recent methadone detoxification, the nurse referred him to the substance misuse team.
28. On 4 December, Mr Connors told a member of staff from the substance misuse team, that he did not want any help from the substance misuse team because he was drug free. He signed a disclaimer refusing treatment. The member of staff from the substance misuse team explained that he could change his mind and ask for help if he decided that he needed support. Mr Connors said that he had not used any illicit substances since coming off methadone. The member of staff from the substance misuse team noted that they discussed the risks of using drugs at this stage, because of his lowered tolerance.
29. On 12 January 2015, Mr Connors collapsed after feeling faint in one of the prison workshops. An officer called an emergency code blue (used to indicate a prisoner is unresponsive, unconscious or has breathing difficulties and to alert the control room to call an ambulance). Nurse B responded and found Mr Connors grey and sweaty but he said he was not in pain. An ambulance took Mr Connors to Bassetlaw District General Hospital where he had investigative tests, including blood tests and an electrocardiogram (ECG – used to assess the electrical and muscular functions of the heart). A doctor reviewed the test results and could not find any evidence of an infection. The hospital discharged Mr Connors back to Ranby later the same day.
30. On 13 January, a prison GP, Dr A, referred Mr Connors to a cardiology consultant to check his condition. In the referral letter, the GP said that security

staff at the prison strongly suspected that Mr Connors' collapse was caused through using NPS, though Mr Connors had denied taking any illicit substance. There is no record that anyone referred Mr Connors to the substance misuse team at the time.

31. On 2 April, Nurse B fitted Mr Connors with a cardiac monitor. However, after three days, Mr Connors removed the monitor, as he said he was unhappy with all the wires.
32. On 14 April, officers found Mr Connors unresponsive. Nurse C noted that he was gurgling, had been incontinent and had a low oxygen saturation rate of 86%. An ambulance took Mr Connors to Bassetlaw District General Hospital where he had blood tests and a CT scan. A doctor reviewed the test results and found nothing of note. The doctor recorded that Mr Connors had recovered spontaneously and that prison staff believed that his behaviour was consistent with taking NPS. The hospital discharged Mr Connors back to Ranby later that day. Again, there is no record that anyone referred Mr Connors to the substance misuse team, despite the suspicions he was using NPS.
33. On 7 May, Mr Connors told a prison GP, Dr B, that he had suffered a heart attack in April and that he occasionally had left-sided chest pain. The GP noted that Mr Connors' recollections were inconsistent with the records but referred him for an ECG. On 20 May, Mr Connors had an ECG test, the results of which were normal.
34. On 30 May, Mr Connors collapsed in his houseblock. Nurse B responded and found that his speech was slurred, he was drowsy and looked drunk. He had a low oxygen saturation rate of 85%. An ambulance attended but Mr Connors refused to go to hospital. The nurse considered his symptoms were typical of someone using NPS, but Mr Connors denied he had used this. No one referred Mr Connors to the substance misuse team.
35. On 31 May, Mr Connors told a healthcare assistant that he did not smoke NPS but another prisoner had blown it at him the day before.

24 June 2015

36. In the afternoon of 24 June, Mr Connors went to his job in one of the prison workshops. Approximately an hour into his shift, Mr Connors and some other prisoners went to toilet. Another prisoner told us that prisoners used the toilet to smoke NPS.
37. The other prisoners left the toilet but Mr Connors stayed there. At approximately 2.50pm, another prisoner went back and called to Mr Connors, who was in a locked toilet cubicle. Mr Connors did not respond, so the prisoner opened the door, using a pen, and found Mr Connors slumped on the toilet. He had vomited and his head and ears were blue. He could not find a pulse and went to tell Officer A, who was supervising the workshop, that Mr Connors was not breathing.
38. At approximately 2.54pm, Officer A checked Mr Connors but could not find a pulse. He radioed a code blue emergency and the control room called an

ambulance in response. Officer A asked other prisoners to move Mr Connors to the workshop, where there was more space.

39. At approximately 2.56pm, Nurse D, Nurse E and Nurse F arrived, followed by Officer B, Officer C and a custodial manager, Mr A. They started cardiopulmonary resuscitation (CPR), gave oxygen using a bag valve mask and fitted a defibrillator. The defibrillator did not advise a shock so healthcare and prison staff continued CPR.
40. At 3.22pm, paramedics arrived, followed by the crew from an air ambulance at 3.35pm. The paramedics inserted an airway and fitted an automatic CPR pump to Mr Connors. The paramedics established a pulse and took him to Bassetlaw District General Hospital. Mr Connors did not recover in hospital and he died at 8.50pm on 25 June.

Contact with Mr Connors' family

41. Mr Connors had listed his brother as his next of kin. When Mr Connors went to hospital, a prison chaplain called his brother but there was no reply. The prison chaplain then rang Mr Connors' son and told him that his father was in hospital. Later that evening, the prison appointed Officer D as the prison's family liaison officer. She and the prison chaplain met Mr Connors' son and daughter-in-law at the hospital at 10.10pm.
42. On 25 June, several members of Mr Connors' family visited him in hospital. When Mr Connors died, a prison manager, Mr B, visited the hospital to offer his condolences and support to Mr Connors' family.
43. Officer D and Officer E remained in contact with Mr Connors' son to offer support and guidance.
44. Mr Connors' funeral was held on 14 July. The prison offered a contribution towards the funeral expenses in line with national instructions.

Support for prisoners and staff

45. After Mr Connors' death, a senior prison manager, Mr C, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. A notice to staff also reminded them that support was available from the staff care team and the chaplaincy.
46. The prison posted notices informing other prisoners of Mr Connors' death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Connors' death. The prison chaplain also offered personal support to Mr Connors' close friends.

Post-mortem report

47. A post-mortem examination concluded that Mr Connors died of toxicity to MDMB CHMICA, a synthetic cannabinoid, which caused acute pulmonary oedema and congestion. (This is a condition where the lungs fill with excessive fluid and prevents the person from breathing.)

48. A toxicology report explained that toxicity from synthetic cannabinoids can cause various, serious adverse health effects including but not limited to agitation, delirium, hallucinations, acute kidney injury, chest pain, tachycardia, hypertension, seizures, respiratory depression and coma.

Findings

Clinical Care

49. During his time at Ranby, Mr Connors collapsed and required emergency medical attention three times in the months before his final collapse on 24 June. Each time, prison staff believed that Mr Connors had used NPS. However, despite his history of drug taking, previous input from the substance misuse service at Woodhill and officers' concerns about NPS, no one at Ranby referred Mr Connors to the substance misuse services.
50. As Mr Connors had declined help from the substance misuse service when he arrived at Ranby, it is possible that he would have continued not to accept help. However, when staff believe a prisoner is using NPS, or any other illicit substance, they should always be referred to substance misuse services for support and to be informed about the dangers of NPS.
51. The Acting Head of Substance Misuse Services told us that, since Mr Connors' death, Ranby have introduced a number of processes to ensure that prisoners are more aware of the dangers of NPS. These include automatic referrals to substance misuse services when a prisoner is suspected of using NPS, weekly awareness sessions including use of a DVD about NPS and posters, leaflets and flyers. We are satisfied that this is appropriate and therefore make no further recommendation.
52. When Mr Connors first collapsed, on 12 January, Dr A referred him for cardiology tests to rule out a heart condition. The clinical reviewer considered that this referral was appropriate and that healthcare staff at Ranby ensured that they did not overlook other possible causes of Mr Connors collapse.
53. When Mr Connors collapsed on 24 June, Officer A reacted appropriately by calling a code blue emergency. This resulted in a prompt and well-coordinated response from healthcare and prison staff.

NPS Strategy

54. We are concerned about the prevalence of NPS in prisons and the effect they can have on the behaviours and health of those taking them. During the investigation, several prisoners told us that Mr Connors used NPS frequently.
55. HM Inspectorate of Prisons report on the most recent inspection of Ranby in September 2015 is not yet available, but we note that they were very concerned about the prevalence of NPS at the prison when they inspected the prison in March 2014. Preliminary feedback from the recent inspection indicates that this is still a problem. In its most recent annual report, the Independent Monitoring Board for Ranby also identified this as a serious concern.
56. Toxicology tests indicated the presence of a synthetic cannabinoid in Mr Connors' body, which caused his death. We consider it is important that the prison does all it can to eradicate the use of new psychoactive substances and that staff understand how to respond when prisoners appear to be under the influence of such substances. We made a recommendation about this in another

recent investigation report into a death at Ranby in April 2015, one month before Mr Connors' death. We repeat that recommendation:

The Governor should ensure there is an effective supply reduction strategy to help eradicate the availability of new psychoactive substances, and that prison staff are vigilant for signs of its use and are briefed about how to respond when a prisoner appears to be under the influence of such substances.

Allegation of Bullying

57. On 14 April 2015, an Intelligence Report alleged that three prisoners who lived in Mr Connors' houseblock were forcing him to take NPS using a pipe. The Intelligence Report noted that Mr Connors was "very vulnerable." It listed one of the alleged perpetrators by name, one by a representative role he held in the houseblock and the other was unknown. The Security Department reviewed this intelligence and noted it was from an untested source and they could not judge its accuracy. The Security Department passed the information to the Safer Custody Department, but there is no record that safer custody staff followed it up.
58. We have come across evidence in investigations into deaths at other prisons that NPS is being "tested" by prisoners on other prisoners, often more vulnerable prisoners, to establish the safety and strength of batches received. This is a troubling phenomenon and another reason why Ranby needs to ensure there is an effective strategy to deal with the prevalence of NPS at the prison.
59. Mr Connors' close friends told us they did not believe that he was bullied. They said other prisoners had not forced Mr Connors to use NPS but had offered him "free" samples, apparently because he was an older prisoner and they wanted to see the effects of a particular batch.
60. There was a single allegation of bullying in the record, and Mr Connors' close friends denied that other prisoners were bullying him. However, because of the seriousness of the allegation, and because Mr Connors had been identified as vulnerable, we would have expected staff to have investigated this further. They knew the identities of two of the alleged perpetrators and should also have asked Mr Connors whether he was being threatened and whether he needed support. We make the following recommendation:

The Governor should ensure that all allegations of bullying are fully investigated and potential victims supported.

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