Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven May, a prisoner at HMP Ranby, on 25 May 2015

A report by the Prisons and Probation Ombudsman
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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*

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 Steven May was found hanged in his cell at HMP Ranby on 25 May 2015. He was 29 years old. I offer my condolences to his family and friends.

Mr May had arrived at Ranby from another prison on 21 May. Two days later, he said other prisoners were threatening him. Staff moved him to another houseblock and assessed him as at risk of suicide and self-harm, as he had originally threatened to kill himself unless he was moved to the segregation unit.

The investigation found there were some deficiencies in the operation of procedures to protect him. However, I consider that it would have been difficult for staff at Ranby to have predicted or prevented Mr May's actions, as there was little to indicate that he was at imminent or high risk of suicide. I am concerned that there was a delay before a member of staff went into his cell after he was found hanged, although it does not appear that this would have changed the outcome for Mr May.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2016**

Contents

Summary

Events

1. On 6 September 2014, Mr Steven May was remanded to HMP Hull, charged with offences including dangerous driving and assault. In November, he was sentenced to 35 months in prison. In January 2015, he moved to HMP Humber. At Humber, Mr May was involved in a number of fights and said that other prisoners had threatened him because they thought that his alleged offences involved putting children at risk by riding his motorbike recklessly. He asked for a transfer because of the threats. On 30 April, after Mr May reported feeling depressed and anxious, a nurse referred him for a mental health assessment but this did not have take place before he moved.

2. On 21 May, Mr May moved to HMP Ranby. Two days later he said other prisoners were threatening him and he asked to go to the segregation unit. Instead, officers said they would move him to a different houseblock. On the way he told officers he would hang himself if he did not go to the segregation unit. An officer began Prison Service suicide and self-harm prevention procedures, known as ACCT.

3. On 24 May Mr May attended an ACCT case review and talked openly about his problems. That afternoon, he telephoned his partner and said he would speak to her again the next morning. At 10.00pm, a night patrol officer saw Mr May apparently making a hot drink in his cell. When he checked again at 1.20am he found that Mr May had hanged himself. Officers and paramedics tried to resuscitate him but, at 1.45am, paramedics recorded that Mr May had died.

Findings

4. ACCT procedures at Ranby were not completed correctly. The first ACCT case review was held with just one officer and without any healthcare input. We cannot therefore be sure that there was an appropriate assessment of Mr May's risks, although we recognise that, at the time, he appeared to have been reassured by the move to another houseblock and there was little to indicate that he was at raised of high risk of suicide.

5. The night patrol officer who discovered Mr May hanged, said he did not go into the cell as he thought Mr May was already dead. Although it would probably not have affected the outcome for Mr May, we consider the night patrol officer should have gone into Mr May's cell immediately to check for signs of life and attempt resuscitation, if appropriate.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:

    i. A member of healthcare staff attends the first ACCT case review.
    ii. Multidisciplinary case reviews are held with all relevant people involved in the prisoner's care.

iii. All known risk factors are considered when determining the level of risk of suicide and self-harm and the level of observations reflect that risk.

- The Governor should ensure that all staff understand their responsibilities during medical emergencies, including that:

    i. Subject to a personal risk assessment, staff should enter a cell at night in a life-threatening situation.
    ii. Staff take relevant equipment, including a defibrillator, to code blue emergency calls.

The Investigation Process

6. 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. No one responded.

7. The investigator visited Ranby on 3 June and met the Governor, the deputy governor, the Head of Safer Custody and visited Mr May's cell. He obtained copies of relevant extracts from Mr May's prison and medical records.

8. NHS England commissioned a clinical reviewer to review Mr May's clinical care at the prison.

9. The investigator interviewed 14 members of staff and four prisoners. The clinical reviewer joined the investigator for three of the interviews with healthcare staff.

10. 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.

11. One of the Ombudsman's family liaison officers and the investigator met Mr May's parents and partner to explain the investigation and ask if they had any matters they wanted the investigation to take into account. They had a number of questions about the circumstances of Mr May's death, which we have aimed to answer in this report. Mr May's parents received a copy of the initial report and did not make any comments.

Background Information

HMP Ranby

12. HMP Ranby is a medium security prison, which holds approximately 1,000 sentenced men in seven residential houseblocks. Nottinghamshire Health and Care NHS Trust provides health services at the prison.

HM Inspectorate of Prisons

13. 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.

14. Inspectors noted that incidents of self-harm had risen significantly in the previous year and there had been two recent self-inflicted deaths. Inspectors found that the prison's action plan in response to the Prisons and Probation Ombudsman's investigation into one of these deaths was insufficiently detailed. The quality of ACCT assessment, planning and monitoring was inadequate and attendance at ACCT case reviews was too limited. Inspectors were concerned about the easy availability of new psychoactive substances, other illicit drugs 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.

15. The prison had a wide range of health services and mental health support was very good. There were effective working relationships between prison and mental health staff but too few officers had received mental health awareness training.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its latest annual report for the year to March 2015, the IMB noted that there was a high number of ACCTs, which had led to a greater workload for staff. The IMB noted that was particular pressure on staff when prisoners require multiple observations and conversations. Most were carried out as required but this was always the case. The IMB considered that staff did not always have time to write up recorded observations of the required quality and fewer conversations reduced the possibility of officers becoming aware of prisoners' day to day anxieties. The IMB was very concerned about the low levels of staffing at night, especially on the larger houseblocks

Previous deaths at HMP Ranby

17. Mr May's death was the sixth self-inflicted death at Ranby since June 2013. In three of these deaths we found evidence of bullying and intimidation by other prisoners. In several previous investigations we have been concerned about the emergency response.

18. Since Mr May's death there have been three more apparently self-inflicted deaths at Ranby and an apparent homicide. The number of deaths at the prison is a concern.

Assessment, Care in Custody and Teamwork (ACCT)

19. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

20. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

21. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

22. PSI 64/2011 states that ACCT case reviews must be multidisciplinary where possible. It is mandatory that a member of healthcare staff attend at least the first ACCT case review. Where there are ongoing healthcare issues, particularly relating to mental health, we would expect consistent healthcare attendance at further reviews.

23. Whether or not reviews are multidisciplinary, it is implicit that ACCT reviews, which are based on teamwork, are not held by just one member of staff and this is poor practice.

Key Events

24. On 4 September 2014, Mr Steven May was arrested for several counts of criminal damage, dangerous driving (on a motorbike) and assaulting the police officer and community support officer who arrested him. At the time, Mr May was subject to a 12-month suspended prison sentence. (He was convicted on 17 September and sentenced to 35 months in prison, on 17 November.)

25. On 6 September, Mr May was remanded to HMP Hull. At an initial health screen he said that he had no thoughts of suicide or self-harm. The nurse noted that he appeared mentally stable and had no signs of emotional distress.

26. On 8 September, Mr May told a chaplain that nobody was taking any interest in him and he wanted to kill himself. The chaplain began ACCT suicide and self-harm prevention procedures. (Mr May's prison records confirm that an ACCT was opened on this date, but the Prison Service could not find the document.)

27. On the evening of 11 September, Mr May cut his wrists. An officer noted that he was 'storming' around his cell with a "weapon" in his hand and was very irate. Mr May threatened to harm himself again and to harm staff if they went into the cell. The officer managed to calm Mr May and persuaded him to hand over the weapon. He took Mr May to the prison's healthcare unit and a nurse noted that he had a deep cut to his left wrist and three less severe cuts to his right wrist. She dressed the wounds and sent him to hospital for further treatment. He returned around midnight and was admitted to the healthcare unit.

28. On 13 September, a nurse dressed Mr May's wounds again and noted that he seemed more settled. He said that he regretted cutting himself and he did not have any current thoughts of suicide or self-harm.

29. On 18 September, a doctor prescribed mirtazapine (an antidepressant), at Mr May's request. The next day, a psychiatrist held a multidisciplinary mental health review. Mr May said that he had cut himself as he had felt stressed after other prisoners had threatened him. He said he no longer had any thoughts of harming himself and wanted to move back to a standard prison wing. The psychiatrist noted that Mr May showed no evidence of mental illness and was fit to leave the healthcare unit. On 22 September, Mr May moved to J Wing. The ACCT monitoring ended on 3 October.

30. On 14 October, Mr May told a psychological wellbeing practitioner that he felt happy on J Wing. He said he was enjoying going to the gym and his partner visited him every week, which had improved his mood. Mr May said that he would not harm himself again and they agreed he would be discharged from the mental health team's caseload.

31. On 3 November, Mr May admitted punching another prisoner. He was taken to the segregation unit and later received a punishment of seven days cellular confinement.

32. On 21 January 2015, Mr May moved to HMP Humber, where he wanted to do courses in plastering and painting and decorating.

33. On 29 March, CCTV footage showed that Mr May appeared to have a fight in the showers with another prisoner. Both prisoners had facial injuries. Five minutes after the fight, Mr May smashed his television and cell locker and climbed onto the security netting. He was charged with a disciplinary offence.

34. On 30 April, Mr May told a nurse that he felt anxious and depressed. He said that he was still taking mirtazapine, but could not be bothered to talk to people and felt he had no energy. She referred him to the primary care mental health team. No one from the mental health ever saw Mr May.

35. On 10 May, Mr May had a fight with another prisoner and they were both taken to the segregation unit. On 14 May, an officer noted in Mr May's records that he was very compliant, but he wanted to remain in the segregation until he transferred to another prison. Mr May had been threatened by other prisoners who blamed him for potentially putting children at risk while driving his motorbike recklessly. It seems that Mr May fought back when he was threatened and thought he would be constantly involved in fights if he went back to a wing.

36. On 21 May, Mr May transferred to Ranby with a week's supply of medication (mirtazapine and an antacid). Three officers took him in a prison car. One of the escort officers noted that Mr May was happy with the move as it would be a fresh start and he was looking forward to getting back to a standard prison wing and having visits from his family.

37. At an initial health screen, Mr May said that he had no thoughts of suicide or self-harm. He said that he had misused drugs in the past but he did not want to be referred to the substance misuse team.

38. Mr May was allocated a cell on Houseblock 3 at Ranby. Just after 4.00pm, he telephoned his partner to let her know he had moved to Ranby and that it would be easy for her to visit. He said he thought it would take him a month to settle down and then the rest of his sentence would pass quickly.

39. Mr May telephoned his partner again in the late afternoon of 21 May and twice on 22 May. He told her that he did not like Houseblock 3 as the other prisoners seemed to be under the influence of drugs. He said that other prisoners had given him "funny looks" and he felt threatened by them, though he thought it might be paranoia.

40. Around lunchtime on Saturday 23 May, Mr May told an officer that he felt under threat because he had vandalised some cars in the community. He said he did not want to go down to the bottom landing of the houseblock to collect his lunch and wanted to be locked into his cell. However, he told the officer that no one had actually threatened him. The officer spoke to Mr May for around ten minutes and said he did not give the impression that he was thinking of harming himself. He locked Mr May in his cell and another officer took him lunch. The officer told a Supervising Officer (SO) what Mr May had said.

41. Later that afternoon, Mr May pressed his cell bell and told an officer that other prisoners had congregated outside his door threatening him and he wanted to move to the segregation unit. The officer told him that he could not go to the

segregation unit but he could move to a different houseblock. He said that Mr May seemed content with that option.

42. Staff on Houseblock 2 agreed that Mr May could swap cells with a prisoner on that houseblock, who was also under threat and refusing to come out of his cell. An officer said that she and another officer took the prisoner from Houseblock 2 to Houseblock 3 and collected Mr May. On the way to Houseblock 2, Mr May stopped and said he wanted to go to the segregation unit or he would hang himself. After two or three minutes they persuaded him to move. She said she would have to open an ACCT but Mr May had said that it did not matter whether or not she opened an ACCT, as if he wanted to hang himself he would. Quickly afterwards, he told her that he had only made the threat as he wanted to be segregated.

43. At 5.30pm, the officer began ACCT procedures. At 6.20pm, a custodial manager, responsible for the operational management of the prison that day, spoke to Mr May in his cell in Houseblock 2, for around 20 minutes and completed an ACCT immediate action plan. Mr May told him that he had received threats from people in the community, which had followed him to Humber. He mentioned that he had seen a prisoner at Ranby from his area, who had not said anything to him, but he thought he might be a potential channel for threats. He spoke positively about having family support. All the prisoners were locked in their cells for the rest of that evening and night but, immediately after their discussion, the custodial manager allowed Mr May out of his cell to telephone his partner.

44. Mr May spoke to his partner for almost ten minutes. He told her that he had felt threatened on Houseblock 3, that he had felt like killing himself and had stayed in his cell all day. He said that he had received papers for home detention curfew (which allows low risk prisoners to be released from prison up to 135 days before the half-way point of their sentence, subject to an electronically monitored curfew). He said that he would not come back to prison again. Mr May spoke to his partner about a television programme that he intended to watch that night.

45. The custodial manager spoke to Mr May again after his phone call. When he asked him if he still intended to hang himself, Mr May touched photographs of his son and his partner and said these were the reasons he would not harm himself. The custodial manager said that by the end of their conversation he did not think he was at great risk of suicide or self-harm. He noted in Mr May's ACCT document that he should be checked once an hour until his ACCT assessment interview.

46. The officer said that Mr May seemed more positive after the custodial manager had spoken to him. He spoke about his partner and his hope to get home detention curfew. He said that that he had only threatened to hang himself as he thought he could force a move to the segregation unit.

47. At 8.00pm, Mr May asked Officer B for a form to list the names of other prisoners who might be in Ranby who he would prefer to avoid. She gave him the form and asked if he would come out of his cell the next day. Mr May was worried about how he could explain to other prisoners why he had moved wings after lock-up time. She suggested he could say that staff had asked him to move to

help the other prisoner who had asked to leave the wing. Mr May agreed that this was a good idea. She told Mr May to let the staff know if he thought that any threats had followed him and they would consider a move to another houseblock, or a transfer to a different prison.

48. Officer A was on duty again on Sunday 24 May. At about 9.10am, she went to see if Mr May had come out of his cell. She found that he had not been unlocked with the other prisoners, as the staff on duty thought the previous occupant was still in the cell. Mr May agreed to come out of his cell and asked about cleaning it. She told him where to get a brush and a mop and he commented that the wing was quiet. She reassured him that he would be all right. She told the investigator that, as the two wings were far away from each other, he would not have been able to hear any threats or abuse if prisoners from Houseblock 3 shouted from their windows.

49. An officer said Mr May had spent time out of his cell on 24 May, talking to other prisoners and playing pool. He locked him in his cell after lunch and noted in his ACCT document that he said he felt slightly on edge, but would be fine. The officer said that Mr May seemed slightly wary of other prisoners if he thought they were looking at him in an odd way, or if they seemed to be deliberately avoiding making eye contact.

50. In the afternoon of 24 May, an officer assessed Mr May as part of ACCT procedures. Mr May told her that the main reason he was finding things difficult was because problems outside prison had followed him to Ranby. He said that he had almost knocked down a young girl and a friend of her family was threatening him. He named a prisoner at Ranby who he thought might be involved in the threats. However, he said he felt happier on Houseblock 2. She said they spoke about the possibility of a transfer to a prison in another area and she offered to help him complete an application. After the interview, Mr May joined other prisoners who were playing pool.

51. The officer said that she could not attend Mr May's first ACCT case review, as she had to do another ACCT assessment straight afterwards. At the weekend there were fewer ACCT assessors on duty, so it was not unusual to have to do more than one assessment. She briefed a Supervising Officer (SO) about the assessment and told him that Mr May was more settled now that he had moved. She did not think he was at risk of suicide or self-harm and had no concerns about his wellbeing. She completed a security report about the prisoner Mr May had named.

52. At 4.30pm, the SO held an ACCT case review with no other member of staff present, although it is a mandatory requirement to have a healthcare representative at first ACCT case reviews. He said that Mr May spoke openly and engaged well. Mr May said that people were after him because of his offences and the SO told him that the safer custody team were investigating the alleged bullying. Mr May said he did not want to die, but his thoughts of harming himself were up and down. They discussed mental health and Mr May said that he had been taking mirtazapine, an antidepressant, for the last 12 months and was expecting a medication review with a doctor the next day. The SO

wondered whether he might be suffering from paranoia. After initially dismissing this, Mr May said that he was paranoid.

53. The SO said that the review lasted between 10 to 15 minutes and he assessed Mr May as at low risk of suicide and self-harm. He instructed staff to check him three times during the night and to have three conversations with him during the day.

54. The SO listed four actions in Mr May's ACCT caremap (plan of care, support and intervention). Two were about his health concerns of depression and paranoia. Another was about being under threat, which he planned to raise at a safer custody meeting on 7 June. The last was about Mr May maintaining his relationship with his partner. He set the next review for 29 May, as it would allow time for the healthcare interventions and for Mr May to settle.

55. After the review, the SO telephoned a mental health nurse about treatment for possible drug-induced psychosis, as during the ACCT case review, Mr May had mentioned experiencing this in the past. The SO went to Mr May's cell to tell him about his conversation with the nurse. He told him that he was not due to see a doctor, but his medication would be reviewed the next day and the nurse had made an appointment for a mental health review on 27 May, to discuss his paranoia. The SO said that Mr May was happy about these arrangements.

56. The nurse said that the SO had telephoned him at around 4.45pm. He said that the SO had not asked him to attend the ACCT review but, in any case, he would not have been able to do so as he was the only mental health nurse on duty, as it was a Sunday. He said that nurses try to attend the first ACCT review if they can, but they are never given advance notice of reviews. He confirmed that he had made a mental health triage appointment for Mr May.

57. Just after 4.30pm on Sunday 24 May, Mr May telephoned his partner and they spoke for seven minutes. Towards the end of the conversation, he said that he would have to end the call as he did not have very much credit left on his account and would telephone her again the next day.

58. An officer said that as the day went on Mr May began to settle. He played pool and spoke to other prisoners. She saw Mr May a few times through the day and nothing happened to give her reason to observe him any closer. She said that after collecting their evening meals, prisoners would have been locked in their cells for the night at around 5.15pm.

59. The investigator spoke to four prisoners from Houseblock 2 about their contact with Mr May on 24 May. Prisoner 1 worked on the servery and when Mr May came to collect his lunch he gave the wrong prisoner number, which meant there was no meal for him. He said that he sorted out the problem and Mr May got his meal. Mr May had thanked him and seemed fine.

60. Prisoner 2 said that he had a very brief conversation with Mr May at about 5.00pm. He said that Mr May had asked him for some tobacco and said he was feeling suicidal. He said that he had no tobacco and that he had taken no notice of Mr May's comment about feeling suicidal, as he thought he was just saying it to get what he wanted.

61. Prisoner 3, who was in the cell on the other side, said that he did not speak to Mr May but he had overheard a conversation the previous day, when he had told an officer that he would harm himself and the officer had allowed Mr May to telephone his partner. After that, Mr May told the officer he would not harm himself. He said that on 24 May, he heard what sounded like a ripping sound at about 6.30pm, which he thought was the noise of a computer game.

62. Prisoner 4, who was in the cell next to Mr May's, said that Mr May had played pool during the association period and had said that he was okay. He said he had heard an officer check Mr May at about 10.00pm and just after that he had heard a ripping sound. At the time, he had assumed Mr May was tearing up paper, but had since realised that he was tearing his sheet.

63. The night patrol officer checked Mr May at 10.00pm and saw him standing at the back of the cell, apparently making a hot drink. When he looked through the observation panel of his cell to check him again at 1.20am, he saw that Mr May had hanged himself from a ligature made from a torn sheet, which he had attached to a wall bracket. He radioed a code blue alarm and confirmed that an ambulance was needed. He waited outside the cell until officers arrived at 1.25am. He did not consider going into the cell as he said that night patrol officers had been told not to enter cells alone. He said that he would have gone into the cell, if he thought there was a chance he could have saved Mr May's life, but he thought it was evident that Mr May was dead.

64. Staff responded to the emergency call and arrived at Mr May's cell at 1.25am. They cut the ligature and placed Mr May on the bed. An officer checked for a pulse. He said that he used to be a lifeguard and he thought that Mr May was already dead. However, he started chest compressions while waiting for paramedics to arrive. He said that he did not check Mr May with a defibrillator as he did not know where the defibrillators were held and he had not been trained to use one. A paramedic arrived at prison at 1.30am and reached Mr May at 1.35am. The paramedic took over the emergency treatment but, at 1.45am, recorded that Mr May had died.

65. The night manager said he did not initially hear the code blue alarm, as his radio was on the wrong frequency setting. By the time he arrived, officers were already attempting resuscitation so he left them to continue until paramedics arrived very soon after. He confirmed that only the night orderly officers had been trained to use defibrillators, although he understood that training for officers was going to start.

66. Mr May had left two letters addressed to his partner, in which he described feeling scared, and said that things had "been building up for weeks".

Contact with Mr May's family

67. Mr May had named his mother as next-of-kin. Two family liaison officers from Ranby left the prison at 7.45am and reached his mother's home at 8.40am. They told Mr May's parents that their son had died and offered to tell Mr May's partner and son. Mr May's mother said she would prefer to do this. The prison contributed towards the cost of Mr May's funeral, in line with national policy.

Support for prisoners and staff

68. The deputy governor debriefed the staff involved in the emergency response and offered his support and that of the prison's care team. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been affected by Mr May's death.

Post-mortem report

69. A post-mortem examination found that Mr May had died from hanging. A toxicology report showed the presence of prescribed medicines only.

Findings

Assessment and management of risk

70. Prison staff appropriately opened an ACCT in the late afternoon of 23 May, when Mr May threatened to hang himself. However, almost immediately afterwards, Mr May said that he had made the threat as he thought this would force staff to move him to the segregation unit and did not intend to hang himself.

71. Although we cannot say that this contributed to Mr May's death, we do not consider that ACCT procedures were managed fully in line with Prison Service Instruction (PSI) 64/2011. The PSI requires ACCT case reviews to be multidisciplinary where possible and that a member of healthcare staff should attend at least the first ACCT case review. Where possible, the assessor should attend. However, a SO held the ACCT case review alone, with information from an officer. The officer had to complete another assessment but we consider it should be possible for the prison to schedule ACCT assessment interviews to allow time for ACCT assessors to attend the first ACCT case review. It was inappropriate and poor practice for the SO to hold an ACCT review on his own. Even when multidisciplinary attendance is not possible, it is implicit that ACCT reviews, which are based on teamwork, involve more than one member of staff.

72. The PSI requires a manager to inform healthcare staff, including the mental health in-reach team where appropriate, within an hour of the ACCT being opened, so that healthcare staff can contribute to the assessment if they have relevant information. After the review, the SO telephoned a nurse to discuss Mr May's antidepressant medication and possible symptoms of paranoia but he had not informed healthcare staff before. The nurse said that Ranby has only a small mental health team and while nurses try to attend ACCT reviews, they receive no advance warnings. He did not know that an ACCT had been opened until the SO telephoned him afterwards.

73. None of the staff interviewed knew that, it is mandatory for a healthcare representative to attend the first case review (although a written report can be submitted in exceptional circumstances). This is concerning because Mr May's mental health concerns would have been an important consideration in the assessment of his risk and his ongoing care.

74. The SO said that Mr May engaged well at the review. He assessed him as low risk and set a low level of interactions: three observations through the night and three conversations during the day. Mr May had a number of risk factors for suicide and self harm: he had depression, he was sometimes violent, aggressive and impulsive, he felt under threat from other prisoners and he had previously self-harmed. Without effective multidisciplinary input into the ACCT review it is difficult to know whether this was a reasonable assessment of Mr May's risk at the time.

75. However, we recognise that at the time of the ACCT review, Mr May's main and immediate concern, about being under threat from other prisoners appears to have been addressed by the move to the new houseblock. There was little to indicate that he was at imminent risk of suicide and the SO took prompt action after the review to make an appointment for a mental health assessment. There

was little about his interactions with others that day that suggested that he was at high risk of suicide and in a telephone call to his partner he said that he would ring her the next day. We consider that it would have been very difficult for staff at Ranby to have predicted or prevented Mr May's death. We cannot know whether more considered assessment of risk and more effective support mechanisms would have prevented Mr May's actions, but we are concerned that the ACCT procedures at Ranby were not managed as well as they should have been. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:

- **A member of healthcare staff attends the first ACCT case review.**
- **Multidisciplinary case reviews are held with all relevant people involved in the prisoner's care.**
- **All known risk factors are considered when determining the level of risk of suicide and self-harm and the level of observations reflect that risk.**

Clinical care

76. Although he was concerned about the lack of healthcare staff input into ACCT procedures at the prison, the clinical reviewer found that the general standard of Mr May's healthcare in prison was appropriate to his needs. He was satisfied that Mr May's care was equivalent to that he could have expected to have received in the community.

Emergency response

77. PSI 24/2011 gives national guidance on entering cells at night. The PSI says that under normal circumstances, the night manager must give authority to unlock a cell at night and a minimum number of staff (according to local risk guidelines) should be present when it is opened. However, the PSI says that the preservation of life must take precedence over this. Where there appears to be a threat to life, staff should perform a dynamic risk assessment, inform the control room and open and enter cells on their own, if they feel safe to do so. Ranby's local policy reflects the guidance given in the PSI.

78. The night patrol officer said that he was aware of Ranby's local instruction, but said that night patrol staff had been told that they should not go into a cell alone at night. Despite this, he said he would have opened Mr May's cell on his own, if he thought there was a chance of saving his life. However, he believed he was already dead. His comments suggest that he did not consider that there was any danger or risk to himself, or to prison security, in entering the cell. We believe he should have gone in immediately to cut the ligature and at least checked whether it might have been possible to resuscitate Mr May.

79. Two staff said that only the night orderly officers had been trained to use defibrillators. An officer said that he did not even know where the defibrillators were held. After Mr May's death, the Governor issued a notice informing staff where defibrillators are kept and highlighting the British Heart Foundation advice

that training to use them is not necessary as the machine gives clear spoken instructions. We make the following recommendation:

The Governor should ensure that all staff understand their responsibilities during medical emergencies, including that:

- **Subject to a personal risk assessment, staff should enter a cell at night in a life-threatening situation.**
- **Staff take relevant equipment, including a defibrillator, to code blue emergency calls.**

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