

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Scott Chilton a prisoner at HMP Ranby on 1 August 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 Scott Chilton was found hanged in his cell at HMP Ranby on 1 August 2015. He was 28 years old. I offer my condolences to Mr Chilton's family and friends.

The investigation found a number of deficiencies in the operation of suicide and self-harm prevention procedures, which the prison will need to address. In particular, in discussing Mr Chilton's risk of suicide and self-harm, staff did not recognise his frustration with his indeterminate sentence, which meant that he had served many years beyond his minimum term with little sign of progression towards release. Nor did staff consider how his use of new psychoactive substances affected his risk or ensure that actions agreed to help reduce his risk had been completed before ending support measures. There were also serious deficiencies in the emergency response.

Although it is not clear whether Mr Chilton's use of new psychoactive substances was linked to his death, I remain concerned about the evident prevalence of these substances at Ranby – an issue that has arisen in a number of my previous investigations. I am also very concerned at the number of self-inflicted deaths at the prison over the past year. There is an urgent need for Ranby, supported by regional and national resources, to address the issue and to ensure improved support for prisoners assessed as at risk of suicide.

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**

**May 2016**

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# Summary

## Events

1. On 3 March 2008, Mr Scott Chilton was remanded to HMP Lincoln charged with grievous bodily harm. This was his first time in prison. On 2 December 2008, he was given an indeterminate sentence for public protection (IPP), with a minimum term to serve of two years before he could be considered for release.
2. On 28 April 2009, Mr Chilton was transferred to HMP Stocken, where he had regular interventions with the mental health team. However, he refused medication for attention deficit hyperactivity disorder (ADHD). Mr Chilton was often warned about his behaviour and lost privileges as a result. Staff suspected he used new psychoactive substances (NPS) frequently.
3. On 23 October 2014, Mr Chilton was moved to HMP Ranby, where he was supported by the mental health team. He continued to behave poorly and use NPS. Mr Chilton was monitored under suicide and self-harm prevention measures (known as ACCT) in June and again in July 2015, after he said he had thoughts about killing himself.
4. On 13 July, Mr Chilton told his offender supervisor that he was thinking about cancelling his next parole hearing, which he said was pointless. He said he sometimes thought that he would leave prison in a body bag, and that officers were stitching him up. At an ACCT case review the next day, the case manager did not discuss these comments with him and ended ACCT monitoring.
5. On the morning of 1 August, Mr Chilton did not respond to a roll check and had covered the observation panel of his cell. At 7.32am, two officers went into the cell and found Mr Chilton hanging by a ligature attached to a picture board. They called an emergency, cut the ligature and placed Mr Chilton on the floor but did not try to resuscitate him and left the cell. A custodial manager arrived four minutes later and began cardiopulmonary resuscitation until paramedics arrived and took over Mr Chilton's care. At approximately 8.20am, the paramedics recorded that Mr Chilton had died. A toxicology report confirmed that Mr Chilton had recently taken a new psychoactive substance (NPS, or synthetic cannabinoid).

## Findings

6. Mr Chilton had a history of mental health problems and we are satisfied that he received appropriate support from the mental health team. His offender supervisor also gave him some good support. Mr Chilton was known to use new psychoactive substances. Although he declined help from the substance misuse team, we consider that there should have been more active intervention. It is evident that the availability of NPS is a continuing problem at Ranby and we have recently made recommendations about the issue in other investigations into deaths at Ranby. As we understand the prison is addressing this problem in

response to a recent recommendation, we do not make a further recommendation in this report.

7. ACCT procedures at Ranby were not completed correctly. There were no multidisciplinary case reviews and the levels of observations were not always appropriate for Mr Chilton's level of risk of suicide and self-harm. Case reviews did not consider all Mr Chilton's risk factors when assessing his risk factors, and ACCT monitoring ended without any evidence that his risk of suicide and self-harm had reduced and that all caremap issues had been addressed. Although Mr Chilton said he was down because as an indeterminate sentenced prisoner he had made little progress towards release from prison, this was not included as an issue on the caremap and was therefore not addressed as part of the ACCT process.
8. We are very concerned that the officers who found Mr Chilton hanged in his cell did not begin basic first aid, and left him locked in the cell, after cutting the ligature. This meant there was a delay of some minutes after he was found hanged before anyone began cardiopulmonary resuscitation.

## Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - A multidisciplinary approach for all case reviews with continuity of case management and healthcare staff attending first case reviews.
  - Assessing the level of risk using all available information and recording the reasons for decisions.
  - Setting appropriate frequency of reviews and levels of observations, which reflect the assessed risk, are adjusted as the perceived risk changes. Checks should be at unpredictable intervals.
  - Completing ACCT documents fully and accurately so that all incidents of self-harm and suicidal ideation are discussed and recorded at reviews with caremaps revised and updated.
  - Setting ACCT caremap actions which are specific and meaningful and which are aimed at reducing prisoners' risks to themselves.
  - Continuing ACCT monitoring until the risk posed by the prisoner has reduced and all caremap actions have been completed.
  - Completing post-closure interviews within seven days of an ACCT being closed and review progress against caremap actions.
- The Governor should ensure that there are sufficient staff on duty at all times with up to date training to administer basic life support in an emergency and that all staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity. Unless there are clear signs of death, staff first on the scene of an emergency should initiate basic life support and remain at the scene until qualified health professionals arrive.

## The Investigation Process

9. 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.
10. The investigator visited Ranby on 5 August 2015 and obtained copies of relevant extracts from Mr Chilton's prison and medical records. He interviewed six members of staff and three prisoners in August and September.
11. NHS England commissioned a clinical reviewer to review Mr Chilton's clinical care at the prison.
12. We informed HM Coroner for Nottinghamshire of the investigation who gave us the results of the post-mortem examination and toxicology results. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Chilton's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Chilton's family was concerned that he had suffered from mental health problems issues and wanted to know whether he should have been watched more closely. Mr Chilton's family received a copy of the draft report. The solicitor representing Mr Chilton's wrote to us pointing out one factual inaccuracy. The report has been amended accordingly

## Background Information

### HMP Ranby

14. HMP Ranby is a medium security prison, which holds over a thousand sentenced men. Nottinghamshire Healthcare Trust provides healthcare services at the prison.

### HM Inspectorate of Prisons

15. At the time of issuing this initial report, the report of the most recent inspection of Ranby in September 2015 had not yet been published. We understand from initial feedback that the Inspectorate had serious concerns about safety at the prison and the availability of new psychoactive substances. The report of the previous inspection in March 2014 recorded that there had been increased levels of violence and intimidation with inadequate direct supervision of prisoners. Procedures to tackle bullying and intimidation were poorly understood and not used to good effect. Inspectors noted that incidents of self-harm had risen significantly in the previous year and there had been two recent self-inflicted deaths. The prison's action plan in response to the Prisons and Probation Ombudsman's investigation into one of these deaths was insufficiently detailed.
16. 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.
17. 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

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 noted that there was an increasing amount of illicit substances, in particular new psychoactive substances (NPS) in the prison, with an accompanying rise in the level of violence and debt. The IMB was concerned that Ranby did not have 24-hour healthcare cover and noted that increased use of NPS had led to a rise in referrals to the mental health and substance misuse teams.

### Previous deaths at HMP Ranby

19. There were six deaths at Ranby in 2015, including Mr Chilton. The investigations into three of these deaths identified issues involving new psychoactive substances and ACCT procedures, which were also issues in this investigation.

### Assessment, Care in Custody and Teamwork

20. 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.

21. 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 multidisciplinary 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.
22. 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.

### **New Psychoactive Substances**

23. New Psychoactive Substances (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.
24. 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.
25. In July 2015, we published a Learning Lessons 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

26. On 3 March 2008, Mr Scott Chilton was remanded to prison charged with grievous bodily harm. This was Mr Chilton's first time in prison. He had been diagnosed with ADHD (attention deficit hyperactivity disorder) as a child and told staff at Ranby he had taken an overdose when he was 12. He also had a history of drug misuse. On 2 December, Mr Chilton was convicted and given an indeterminate sentence for public protection, with a minimum to serve of two years before he could be considered for release on licence.
27. On 28 April 2009, Mr Chilton transferred to HMP Stocken from HMP Leicester. The mental health team engaged with him frequently, but he refused to take medication for ADHD. He was often warned about his poor behaviour and lost privileges as a result. Records show that Mr Chilton often used new psychoactive substances (NPS) at Stocken. In August 2014 he told an officer from the prison's violence reduction team that he was being pursued for a large debt. He said this was because another prisoner had left drugs in his cell and he had flushed them down a toilet, as he did not want to get caught with them. While he was at Stocken, staff had no concerns that Mr Chilton was at risk of suicide or self-harm.
28. On 23 October 2014, Mr Chilton transferred to HMP Ranby. He was re-prescribed tramadol, an opiate-based painkiller, which he had been taking for a long-term hip problem. Between 23 October and 16 February 2015, he had four reviews with a member of the mental health team, two GP appointments, and a dentist appointment. There were three occasions recorded in Mr Chilton's medical records that he had been under the influence of NPS. He was referred to substance misuse services in January 2015, but declined their help.
29. On 4 February 2015, he met his offender supervisor. They discussed plans for his next parole hearing, which had been deferred because of his transfer. (A new date for the hearing had not been set.)
30. On 17 February a visiting psychiatrist saw Mr Chilton and noted that Mr Chilton had told him that he had first seen a psychiatrist when he was about six years old and had attended a special school. He said he had been diagnosed with ADHD, for which he was prescribed Ritalin, which he had stopped taking when he was 12. He had not taken any medication for ADHD since then. He said he had stopped going to school when he was 14 and began drinking and taking drugs. He said he had a son, who he had never seen. Mr Chilton said that he often got into trouble in prison because of his behaviour.
31. The visiting psychiatrist recorded that Mr Chilton's ADHD affected his ability to function and that he was liable to be unstable, have outbursts of temper, and be impulsive. He prescribed medication (Concerta XL 18mg) to help reduce his symptoms and, in turn, improve his behaviour. He scheduled a review for three weeks later.
32. Between 18 February and 4 June, Mr Chilton had nine reviews with a mental health nurse and one appointment with Dr A, a psychiatrist. The doctor increased the prescription of Concerta XL to 27mg. On 12 May 2015, the nurse

spoke to the learning disability nurse who told her that Mr Chilton was doing very well in the ADHD clinic.

33. A custodial manager told the investigator that he had spent a considerable amount of time with Mr Chilton, who was popular with other prisoners because he was good at art and did drawings for other prisoners. He said that, when Mr Chilton was told that he would have to move from Houseblock 1 (the induction unit) in July 2015, he named prisoners who were now at Ranby who he had previously had problems with elsewhere. The custodial manager said that, because of this, managers decided that Mr Chilton should stay in Houseblock 1.
34. The custodial manager said that that Mr Chilton was employed as a wing painter, servery worker and a cleaner on Houseblock 1. He said that Mr Chilton's behaviour was poor and he was sacked from each job for various reasons, including possession of a tattoo gun, cutting other prisoners' hair, refusing to return to his cell when told, and, most frequently, for using NPS. Intelligence reports indicated that Mr Chilton was one of a number of prisoners dealing in NPS and bullying other prisoners.
35. The custodial manager said that he had spoken to Mr Chilton several times about using NPS and tried to persuade him to stop. He said that Mr Chilton was a very nice, amiable man but as soon he used NPS he would fall over, slur his words, and go to his cell and curl up in a ball. (On 26 May, Mr Chilton was charged with a disciplinary offence for using NPS. It is not clear if this charge was concluded before Mr Chilton's death.) The custodial manager said Mr Chilton would deny using NPS while he was under the influence, but would admit it later. Officers were aware that Mr Chilton had mental health issues for which he took medication, but the healthcare team had told them that his medication would not make him fall over or have slurred speech.
36. At 12.20pm on 4 June, Officer A found a five-litre tub of fermenting liquid under the toilet lid in Mr Chilton's cell. Mr Chilton was charged with a disciplinary offence of unauthorised possession of the liquid.
37. At 11.00am on 5 June, Dr B, a psychiatrist, and the disability nurse went to see Mr Chilton in his cell, as he had not turned up at the healthcare centre for a mental health review. They found that Mr Chilton had made a superficial cut to his left arm. He said that he felt frustrated, angry, and low, and had thoughts of suicide and self-harm. The nurse immediately began ACCT procedures. Dr B increased his dose of medication.
38. At 12.15pm, Supervising Officer (SO) A completed an ACCT immediate action plan and told Mr Chilton how get help from the Samaritans and Listeners (prisoners trained by the Samaritans to support other prisoners), if he needed it. The SO noted that Mr Chilton was under the care of the mental health team. He assessed him as at raised risk of suicide and self-harm and asked staff to check him at least once an hour.
39. At 3.40pm, Officer B assessed Mr Chilton as part of ACCT procedures. Mr Chilton said he cut himself out of anger but he did not feel any different afterwards. He said he had ADHD and did not like the person he had become. He said he had a close relationship with his sister. He said he still felt angry and

he felt victimised by staff (because of the effect his ADHD medication had on him) and wanted to be left alone. He said he had no thoughts of suicide or self-harm. The officer noted that Mr Chilton would continue to receive input from the mental health team and that he was a very angry young man.

40. On the morning of Saturday 6 June, SO B held the first ACCT case review with no other members of staff present, although it is a mandatory requirement that a member of healthcare staff should attend first ACCT case reviews. The SO recorded that Mr Chilton was angry and frustrated. He said that he did not want to be managed under ACCT procedures but understood why this was the case. He said that he was fed up, as he had no job. He said he found working a good distraction and would often do other prisoners' jobs as well as his own. Mr Chilton was aggrieved that he had been put on the basic level of the Incentives and Enhanced Privileges Scheme because officers thought he had taken NPS. (This meant that he had lost privileges such as a television.) He said that he had been asleep because he had not felt well and not because he was under the influence of drugs. In the ACCT record, the SO noted that Mr Chilton said he was hearing voices.
41. SO B assessed that Mr Chilton was at low risk of suicide and self-harm, and reduced the level of observations to three during the day and three at night. The SO entered two actions on the ACCT caremap: for Mr Chilton to have a radio and television because he said he was constantly hearing voices; and for him to be given painting and cleaning jobs on the wing, as he had nothing to do. The next case review was set for 11 June.
42. That afternoon, Mr Chilton had a disciplinary hearing for possession of hooch. The charge was not proceeded with.
43. Over the next week, several officers made entries in Mr Chilton's ACCT record, noting their observations. On 8 and 10 June, officers noted that Mr Chilton had told them that his sentence was getting to him, and that he had had enough of trying to jump through hoops to get parole. However, he said that he did not have the bottle to commit suicide.
44. On 11 June, another, a custodial manager, and SO C held an ACCT case review with Mr Chilton. The custodial manager recorded that Mr Chilton now had a job, but there is no record of any discussion with Mr Chilton about his frustration about his lack of progress towards release. The review continued to assess his level of risk as low and kept the level of observations the same. The custodial manager arranged the next review for 18 June. He updated the caremap. As Mr Chilton now had a job and a television, he marked the first two actions as completed. He added another, for Mr Chilton to be given a stereo.
45. On 16 June, all prisoners assessed as at risk of suicide and self-harm were reviewed, after the death of another prisoner. SO D and Officer C held Mr Chilton's case review. The SO noted that Mr Chilton's level of risk remained low and there was no change to the frequency of observations. They did not review the caremap.
46. On 18 June, the second custodial manager and SO C held the next scheduled ACCT case review. No one else attended. Mr Chilton said that he felt much

better, was working as a painter and that if his mood got worse, he would let staff know. The custodial manager and the SO agreed that his risk of suicide and self-harm was low and they agreed to close the ACCT. They set a post-closure review for 25 June. No review was held that day.

47. On 26 June, a member of the substance misuse team, recorded on SystemOne (the electronic medical record) that Mr Chilton had claimed at a disciplinary hearing that his medication caused him to be drowsy and that he had not taken NPS. She asked a colleague, who told her that none of his medication would cause drowsiness. Mr Chilton's case was dismissed because of an error on the paperwork, but he was advised to refer himself to the substance misuse team. There is no evidence that he did this or that anyone from the substance misuse team went to see him.
48. On 30 June, Mr Chilton told Nurse A at a mental health review that he woke most mornings at 4.30am, despite not going to sleep until late at night. He said he kept himself busy on the wing as a painter. He said that he had not used NPS recently, but it was hard not to start taking drugs again to help him sleep. He said he felt anxious, angry, and full of pent up energy with no way to express it. He doubted whether the current dose of Concerta XL helped him. Nurse Tomlinson recorded that she would refer him to the psychiatrist to review his medication, and would review Mr Chilton three weeks later.
49. On 30 June, Mr Hague held an ACCT post-closure review, as he had noticed that the review scheduled for 25 June, had not been done. Mr Chilton said that he had a job as a wing painter. He said that he had previously been using NPS and acknowledged he had been in a mess at the time, but now thought he was fine..
50. At 10.50am on 3 July, Nurse A saw Mr Chilton who said he was upset because he had been sacked from his job as a wing cleaner because it was suspected he had used NPS. He said he had received a lot of support from the staff on Houseblock 1, did not want to move elsewhere, and would put razor blades in his mouth if he were moved. (We have seen no record that a move had been planned.) He told the nurse that he had recently tried to hang himself using the plastic coating from an electrical cable but it had snapped. She began ACCT procedures.
51. At 11.30am, SO D completed an ACCT immediate action plan. He recorded that Mr Chilton had seen a member of the mental health team and assessed him as at raised risk of suicide and self-harm. He noted that officers should check Mr Chilton at least twice an hour.
52. At 1.10pm, SO A assessed Mr Chilton and noted that he was frustrated about losing his job, had thoughts of taking his own life and would "string up" if he were moved from Houseblock 1. Mr Chilton said he kept in contact with his sister but was not bothered about how she would feel if he were dead. The SO decided that the level of observations should be raised to four an hour until his case review.
53. Later that afternoon, a second custodial manager, SO A and SO B held the first ACCT case review, with Mr Chilton. No member of healthcare staff was present, despite this being a mandatory requirement for first ACCT case reviews. The

custodial manager recorded that Mr Chilton was upset that he had lost his job because he had been suspected of using NPS. He said he was trying to change his behaviour, was low in spirits, but did not have any thoughts of suicide. She recorded that Mr Chilton was at low risk of suicide and self-harm, and reduced the level of observations to hourly during the day and night. She told the investigator that she assessed his risk as low because of his presentation, what he said, and from her previous knowledge of him. The custodial manager entered three actions on the ACCT caremap: to refer Mr Chilton to the substance misuse team; to allocate him a job on the wing; and to refer him to the chaplaincy to attend Friday prayers. (Mr Chilton was registered as Muslim, but there is no indication that he said he had wanted to attend prayers.) The next case review was set for 6 July.

54. On 4 July, Mr Chilton refused to supply a urine sample for a drug test because he was observing Ramadan and was charged with a disciplinary offence of disobeying a lawful order. On 6 July, a manager adjourned a disciplinary hearing to seek advice from the Imam, and for Mr Chilton to obtain legal advice. This hearing did not resume before Mr Chilton's death.
55. On 7 July (not 6 July as arranged), SO A and Officer D held an ACCT case review. Mr Chilton said that he still felt a bit down but had no plans to harm himself and did not want to die. The SO assessed Mr Chilton as at low risk of suicide and self-harm, and reduced the frequency of observations to one each morning and afternoon and every four hours during the night. The next case review was set for 14 July.
56. On 13 July, Mr Chilton's offender supervisor, saw him and noted in his prison record that he was quite fatalistic about his future. He had said that he sometimes thought the only way he would leave jail would be in a body bag. The offender supervisor submitted an intelligence report about this and noted what he had said in his ACCT record. Mr Chilton told her that he was considering cancelling his next parole hearing as he thought it was pointless and would result in an 18-month 'knockback' (before he could have a further hearing.) He said that he thought that staff were stitching him up by accusing him of using NPS. Mr Chilton said he would like to be released directly to a rehabilitation unit, but the offender supervisor recorded that he did not seem motivated when she advised him to engage with the substance misuse team to help him research this as a possibility.
57. On 14 July, SO D and Officer E held an ACCT case review. Mr Chilton said he had no thoughts or intention to harm himself and wanted to move forward. The SO and the officer agreed that Mr Chilton's risk of suicide and self-harm was low. The SO updated the caremap and noted the actions were complete, as Mr Chilton had an appointment with the substance misuse team. (We have not seen any evidence that an appointment had been made.) He was on the waiting list for a job and had been offered the opportunity to attend Friday prayers, but had chosen not to attend. There is no record that they discussed his comments to the offender supervisor the day before. They decided to close the ACCT and set a post-closure review for 21 July.

58. On 17 July, Nurse A saw Mr Chilton in his cell for a mental health review. She recorded that Mr Chilton was in bed and he said he was too tired to get up and get dressed. He said that he was no longer on an ACCT and had no thoughts of harming himself. The nurse recorded that she would arrange a further review in due course. She told the investigator that Mr Chilton was his own worst enemy as, because of his ADHD, he needed to be busy but, as he used NPS, he was unreliable and kept losing jobs.
59. On 21 July, SO A held an ACCT post-closure review with Mr Chilton. He said that he had the support of the mental health team for his ADHD and had support from his sister and staff. He said he hoped to live with his sister when he was released. There was no reference to the ACCT care map actions.
60. Mr Chilton's sister visited him three times at Ranby, the last time on 9 May. The last telephone call Mr Chilton made was to his foster mother on 23 July. In the call, Mr Chilton said it had been a long time since he had phoned and asked how she was. Mr Chilton's foster mother asked him if he had changed his behaviour but he said he had not. At the end of the call, Mr Chilton said he would write to his foster mother.
61. On 23 July, Mr Chilton asked to see a member of the mental health team. Nurse B, from the team, went to see him. Mr Chilton said that he found it difficult to cope without a job. The nurse did not note any further discussion about this in his note of the meeting, but he recorded that he had told Mr Chilton that the nurse would try and review him in the next four to five days. Mr Chilton's medical records show that, on 31 July, he received an appointment letter for a review with the nurse on 3 August.
62. In a note written in the houseblock observation book after Mr Chilton's death, an officer (it is not clear who) wrote that he or she had spoken to Mr Chilton when giving him his canteen (weekly order from the prison shop) at 6.00pm on 31 July. The officer recorded that Mr Chilton had appeared vacant and, when the officer asked about this, he had said, "I am always like this".
63. At 10.28pm, Mr Chilton pressed his cell bell. The night patrol officer answered the bell within a minute and recorded in a statement written after Mr Chilton's death that he asked for his night light to be turned off. He did not raise any other issues.
64. On 1 August, at 7.20am, Officer F started a roll check on Houseblock 1 to establish that all prisoners were present in their cells. When he got to Mr Chilton's cell, at approximately 7.25am, he found the observation panel in the cell door was covered. He called Mr Chilton's name but got no reply and continued to check the other cells. The officer went back to Mr Chilton's cell when he had finished the rest of the landing but was still unable to get a response. He went to the houseblock office and informed a custodial manager, the orderly officer responsible for the operation of the prison at the time. Officer G then joined Officer F in the office and the custodial manager agreed they should go into the cell to check Mr Chilton.
65. At 7.32am, Officer F and Officer G went into Mr Chilton's cell and found him suspended from the picture board with a ligature around his neck. Officer F

called to Officer H, who was nearby, to radio a code blue emergency. The communications log shows that the code blue was called at 7.32am, and an ambulance was called immediately. The officers cut the ligature and lowered Mr Chilton to the floor. Officer F and Officer G, who were not first aid trained, did not begin began cardiopulmonary resuscitation, but left and locked the cell.

66. The custodial manager responded to the code blue and reached Mr Chilton's cell, at approximately 7.35am. In a statement, the custodial manager said that Officer F and Officer G followed him to the cell. When he arrived, he found that Mr Chilton was warm and he immediately began cardiopulmonary resuscitation. He did not use an automated external defibrillator (which monitors the heart rhythm and administers electrical shocks to restore the normal rhythm when necessary). Paramedics arrived at 7.40am and took over the emergency treatment. At 8.20am the paramedics recorded that Mr Chilton had died.

#### **Contact with Mr Chilton's family.**

67. The prison's family liaison officer, was informed of Mr Chilton's death at 9.20am. She and a prison chaplain, went to Mr Chilton's foster mother's home at lunchtime but there was no one in. (Mr Chilton had originally named his foster mother as his next of kin, but in the last ACCT document he had nominated his sister.) The prison's family liaison officer and the prison chaplain then went to Mr Chilton's sister's home that afternoon, informed her that Mr Chilton had died and offered condolences. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

#### **Support for prisoners and staff**

68. After Mr Chilton's death, a prison manager, debriefed the staff involved in the emergency response and offered his support and that of the staff care team.

#### **Post-mortem report**

69. A post-mortem examination found that the cause of death was hanging. Initial toxicology results found no trace of any illicit drugs or substances but, at our request, further tests were completed in January 2016. These indicated that Mr Chilton had used synthetic cannabinoids.

# Findings

## Assessment and management of risk of suicide and self-harm

70. Staff appropriately opened an ACCT on 5 June, after Mr Chilton had cut his arm, and on 3 July, when he threatened to swallow razor blades and to hang himself. However, we have concerns about how effectively the ACCT procedures were implemented to assess Mr Chilton's risk, support him, and reduce the risk.
71. On 5 June, SO A assessed Mr Chilton as at raised risk of suicide and self-harm yet set the level of observations at hourly. We consider this level of observations is relatively low for someone at raised risk. At the first case review on 6 June, SO B assessed Mr Chilton's risk as low, despite his self-harm the day before, and reduced the frequency of observation to three conversations a day and three observations during the night. We consider that this assessment and level of observation did not reflect Mr Chilton's level of risk at the time.
72. For the second period of ACCT monitoring, when Mr Chilton was again assessed as being at raised risk of suicide and self-harm, the frequency of observations was recorded as twice hourly in the immediate action plan, but was raised to four per hour after the assessment. We consider this initial level of observations appropriately reflected his assessed risk at the time, but they were not recorded on the cover of the ACCT. Checks conducted between 3 and 7 July were mostly at very predictable intervals.
73. Prison Service Instruction (PSI) 64/2011 requires that ACCT case reviews should be multi-disciplinary where possible. The PSI notes that the ACCT process will operate more effectively if there is continuity in the attendance of staff from relevant departments/services in the prison. We are concerned that not one of seven ACCT case reviews held between June and July was multidisciplinary. The first ACCT case review on 6 June was held by one member of staff acting alone, which is inappropriate and poor practice. 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.
74. There was never any healthcare presence, even though Mr Chilton was under the care of the mental health team and had been diagnosed with ADHD, which made him more prone to impulsive behaviour. In particular, there was no healthcare representative at either of the initial case reviews, which is a mandatory requirement of the PSI. ACCT monitoring ended on both occasions without any involvement or input from the mental health team or substance misuse services, despite Mr Chilton's acknowledged mental health and drug problems.
75. There was little continuity of case management. During the first period of ACCT monitoring between 6 June and 18 June there were four case reviews, chaired by three different managers. During the second period in July, there were three ACCT case reviews, each of which was chaired by a different manager.
76. We found that little evidence that staff took into account wider evidence when assessing Mr Chilton's risk of suicide or self-harm at case reviews and relied too much on what Mr Chilton told them or their assessment of how he appeared at

the time. The lack of multidisciplinary involvement exacerbated this. On 6 June, SO Skelton assessed Mr Chilton's risk of self-harm as low, although he had cut himself just the day before. On 3 July, a case review assessed Mr Chilton's risk as low, despite the fact that he had told Nurse A that morning that he had tried to hang himself and his clearly stated suicidal intent when SO A had interviewed him earlier that afternoon.

77. In June, officers had noted that Mr Chilton had said he was down about his lack of progression in his sentence. Mr Chilton had served nearly five years over his minimum period to serve of two years, yet he had never been considered suitable for release or for a move to an open prison. There is no record that anyone discussed this with Mr Chilton at case reviews and considered whether this affected his risk of suicide and self-harm. His offender supervisor who was responsible for his sentence planning and helping him reduce his risk of reoffending, was not involved in any of the case reviews. On 13 July, the offender supervisor recorded that Mr Chilton was fatalistic about his future and sometimes thought that he might leave prison in a body bag. He seemed to have resigned himself to postponing his next parole review, which would have meant at least another two years in prison. The case review did not refer to these comments later that day and ended ACCT monitoring. The failures to discuss these issues were missed opportunities to help Mr Chilton address one of the substantive concerns he had raised with prison staff.
78. PSI 64/2011 states that caremap actions should be aimed at reducing the risk the prisoner poses to themselves. On 6 June, SO B set a caremap action of giving Mr Chilton a radio and television, as he said he was constantly hearing voices, rather than involving healthcare staff and trying to identify the root cause. The caremap actions in the ACCT document opened on 3 July amounted to referrals to services (substance misuse, chaplaincy and work allocations) and were insufficient in themselves to ensure that Mr Chilton's risk of suicide and self-harm had abated, that he received the support he needed or that the underlying issues that led to his self-harm had been successfully addressed. There was nothing about his lack of progress in his sentence. At the review held on 14 July, SO D noted that the caremap objectives had been completed, even though they had not resulted in any meaningful action and it is not clear that a referral to substance misuse services had been made.
79. Post-closure reviews should be held at a maximum of seven days after an ACCT is closed, to ensure that the improvement in risk of suicide and self-harm has been maintained and that there are no further issues. However, when the first ACCT was closed, the post-closure review was held five days late and only because Mr Hague realised it had not been done. Mr Chilton said he had needed help to stop using NPS. There was no reference to the caremap actions, which PSI 64/2011 requires, as these are not mentioned in the pro-forma for ACCT post-closure reviews.
80. Mr Chilton was supported under ACCT procedures for two brief periods at Ranby and ACCT monitoring ended on 14 July, just over two weeks before he died. There is little evidence to indicate that staff should have identified that Mr Chilton was at imminent risk of suicide immediately before his death, but we are concerned that there were significant failures in the ACCT process, which failed

to address his risk adequately and put in place measures to protect him. ACCT case reviews were not multidisciplinary, assessments of risk did not take into account all his risk factors, levels of observations did not always reflect his assessed risk and caremap actions did not address adequately his identified concerns. We cannot know whether continued ACCT monitoring would have prevented Mr Chilton's actions, but it is important that, as far as possible, ACCT procedures are implemented in line with national Prison Service instructions to ensure that prisoners at risk of suicide receive proper support to help reduce their risk. 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 instructions, including:**

- **A multidisciplinary approach for all case reviews with continuity of case management and healthcare staff attending first case reviews.**
- **Assessing the level of risk using all available information and recording the reasons for decisions.**
- **Setting appropriate frequency of reviews and levels of observations, which reflect the assessed risk and are adjusted as the perceived risk changes. Checks should be at unpredictable intervals.**
- **Completing ACCT documents fully and accurately so that all incidents of self-harm and suicidal ideation are discussed and recorded at reviews with caremaps revised and updated.**
- **Setting ACCT caremap actions which are specific and meaningful and which are aimed at reducing prisoners' risks to themselves.**
- **Continuing ACCT monitoring until the risk posed by the prisoner has reduced and all caremap actions have been completed.**
- **Completing post-closure interviews within seven days of an ACCT being closed and review progress against caremap actions.**

### **New psychoactive substances (NPS)**

81. It is evident that the use of NPS at Ranby is a continuing problem. The report of the most recent inspection of Ranby in September 2015 is not yet available, but we note that HM Inspectorate of Prisons was very concerned about the prevalence of NPS at Ranby 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, Ranby's Independent Monitoring Board also identified NPS as a serious concern.
82. We are concerned that there is little evidence that staff took into account Mr Chilton's use of NPS when assessing his risk of suicide or self-harm, although Mr Chilton clearly acknowledged that he used NPS. In July 2015, we issued a Learning Lessons 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. While it might not have altered the outcome for Mr Chilton, we consider that staff assessing risk of suicide and self-harm need to be alert to the risk of prisoners who have taken NPS and the possibility that they might react unpredictably.

83. Prisoners cannot be forced to engage with substance misuse services, but we are concerned that there was little evidence of active engagement with Mr Chilton to warn him of the dangers of using NPS and help him address his substance misuse problems. As noted above, it might have helped had a member of the substance misuse team been invited to ACCT case reviews. During the first period of ACCT monitoring in June, the issue of his use of NPS does not appear to have been discussed at any reviews. At the end of June, at a disciplinary hearing for use of NPS, which did not proceed for technical reasons, a manager simply advised Mr Chilton to refer himself to substance misuse services. In July, ACCT monitoring ended before it was established that Mr Chilton had an appointment with the substance misuse team. There is no evidence that he had an appointment.
84. In the investigation report into a death at Ranby in April 2015, we recommended that the prison should develop an effective supply reduction strategy to help reduce the availability of NPS at Ranby and that staff should be alert for signs of their use and briefed about how to respond when prisoners appear to be under the influence of NPS. Our report was issued after Mr Chilton's death.
85. In its response, the prison said that they had issued a staff information notice about NPS, and had started a weekly meeting to discuss all NPS-related incidents and to manage and support prisoners involved with the supply and use of NPS. NPS prisoner mentors had been appointed to work with the drug strategy team and be involved in the induction process for new prisoners to help promote awareness of the dangers of NPS and reduce the demand for such substances. The prison had published a protocol about how staff should respond when they suspected a prisoner of using NPS. As the prison has taken recent steps to address the supply and demand for NPS in response to our previous recommendation, we do not make a further recommendation, but stress the need for all staff to be aware of the risks of the use of NPS, particularly when prisoners are assessed as at risk of suicide and self-harm.

### **Clinical care**

86. The clinical reviewer concluded that Mr Chilton received good support and care from the mental health team and the wing staff to try to deal with his ADHD symptoms. She found that Mr Chilton's care was equivalent to that he could have expected to receive in the community. However, she noted that Mr Chilton was often reduced to the basic level of the incentives and earned privileges scheme, which, with fewer distractions to keep him occupied, might have exacerbated his ADHD symptoms. .
87. The clinical reviewer commented that Mr Chilton was suspected of NPS use a number of times because of recognisable symptoms and admission to its use. Mr Chilton frequently had the symptoms of red eyes and slurred speech, he also staggered, vomited, and was tired. Mr Chilton was taking prescribed pain relief medication (tramadol) but the clinical reviewer considered that this, combined with Concerta XL, would not have caused the symptoms that he displayed.

## Emergency Response

88. When Officer G and Officer F went into Mr Chilton's cell and found him hanging, they immediately cut him down. Officer H radioed an emergency code blue and the control room called an ambulance immediately.
89. However, we are concerned that Officer G and Officer F did not try to resuscitate Mr Chilton, and did not stay with him until help arrived. Ranby's Emergency Response Protocol states that, if staff find someone unconscious or seriously ill, they should deliver first aid or resuscitation if they are appropriately trained. Neither officer was first aid trained. We consider that all prison staff should have some rudimentary awareness of how to begin basic cardiopulmonary resuscitation, if only from widely broadcast public information films. We are also concerned that they chose to leave the cell before help arrived. We understand that the Governor has ordered a formal investigation into their actions, but this had not been completed at the time this report was completed.
90. The custodial manager arrived at the cell four minutes later and immediately started cardiopulmonary resuscitation. It is not clear whether these delays affected the outcome for Mr Chilton, but early intervention when a prisoner is found hanging can save their life. As there are no healthcare staff on duty at Ranby at night, it is essential that as many staff as possible understand their role in emergencies and are confident in locating and using emergency equipment and beginning emergency life saving procedures. We make the following recommendation:

**The Governor should ensure that there are sufficient staff on duty at all times with up to date training to administer basic life support in an emergency and that all staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity. Unless there are clear signs of death, staff first on the scene of an emergency should initiate basic life support and remain at the scene until qualified health professionals arrive.**

