Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Axton a prisoner at HMP Ranby on 16 June 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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 Thomas Axton died on 16 June 2015, from a head injury, while a prisoner at HMP Ranby. He was 37 years old. I offer my condolences to Mr Axton's family and friends.

On 15 June 2015, another prisoner punched Mr Axton, who fell and hit his head on the floor, causing the injuries from which he died. The prisoner was charged with manslaughter, but found not guilty. This investigation has examined whether there was anything the prison could have done to prevent Mr Axton's death.

Sadly, Mr Axton's death seems emblematic of the increasing problems of violence in prisons, often associated with enforcing debts. However, there was no information to suggest that either Mr Axton or the prisoner were at risk from each other and I consider that it would have been difficult for staff to have known that there was any particular problem between Mr Axton and the prisoner.

However, I am concerned that Ranby lacked an effective personal officer scheme, which meant officers had limited knowledge of the prisoners in their care. There were also some initial communication problems between officers and healthcare staff after Mr Axton was injured, but I am satisfied that, once the seriousness of his condition was recognised, the emergency response was effective. Finally, both family and staff support could have been better.

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 **September 2016**

Contents

Summary

Events

1. In July 2010, Mr Thomas Axton was remanded to HMP Bullingdon charged with arson. He was later convicted and sentenced to four years six months imprisonment, with an extended licence to address alcohol problems. Mr Axton was twice released on licence, in June 2013 and in April 2014. Each time he was recalled to prison shortly afterwards because of concerns about his continued alcohol misuse.

2. On 22 December 2014, Mr Axton was transferred to HMP Ranby, after spending time at a number of different prisons. Staff and prisoners at Ranby said that he was a quiet person. He preferred to spend time alone and staff said he did not cause any difficulties.

3. Around 12.20pm on 15 June 2015, another prisoner punched Mr Axton, who fell and hit his head on the floor and appeared to be knocked out. Afterwards, he walked back to his cell. Staff noted that his head was bleeding and an officer asked a nurse to attend. At the time, no one considered it was an emergency, as Mr Axton could walk, was talking coherently, and did not seem distressed. The nurse therefore did not attend immediately.

4. About ten minutes after the officer had last seen him, Mr Axton rang his cell bell and the officer called a nurse again, as Mr Axton seemed distressed, disoriented, and could not stand up. At 12.45pm, he called an emergency medical code, to make sure staff understood the urgency. Nurses then responded quickly but when they arrived found that Mr Axton was unconscious with signs of a serious head injury. Paramedics arrived and at 1.30pm, took Mr Axton to hospital.

5. At 3.50pm, a prison family liaison officer phoned Mr Axton's mother and informed her what had happened. She arranged to meet Mr Axton's mother and his sister at the hospital that evening. Mr Axton had surgery for a cracked skull and bleeding on the brain, but his condition was critical and he was on life support. At 2.00pm the next day, life support was removed and Mr Axton died half an hour later. His family were with him at the time.

6. The prisoner was charged with Mr Axton's manslaughter. At the trial in January 2016, he was found not guilty. The circumstances of what happened are unclear. Other prisoners said that the prisoner had attacked Mr Axton, who was in debt to him for tobacco or money. At the trial, the prisoner said he was acting in self-defence and it was he who had been in debt to Mr Axton.

Findings

7. There was no intelligence to indicate that the prisoner was a threat to Mr Axton or vice versa. We do not consider that staff could have anticipated that Mr Axton and the prisoner were at risk from each other and prevented the attack. However, we are concerned that there was little evidence of any effective staff engagement with Mr Axton or other prisoners in the houseblock where the prisoner and Mr Axton lived. Dynamic security and knowledge about prisoners was therefore poor.

8. Initially, staff did not consider that Mr Axton's injuries needed emergency treatment. Mr Axton was coherent, able to walk and did not appear to be in any distress. We are concerned that initial communication between a nurse and staff on the houseblock was poor, but we are satisfied that once it became apparent that Mr Axton needed urgent attention, healthcare staff and prison staff responded quickly, radioed an emergency code and called an ambulance.

9. It took over two hours to inform Mr Axton's family that he had been taken to hospital, which is too long and not in line with the requirements of Prison Rules to inform families at once when prisoners are seriously ill. We are also concerned that staff we spoke to had not been appropriately supported or invited to attend any debriefs. .

Recommendations

- The Governor and Head of Healthcare should ensure that staff clearly communicate information about a prisoner's condition when requesting an urgent healthcare assessment, that nurses prioritise appropriately, and that an ambulance is called whenever there are serious concerns about a prisoner's health.
- The Governor should ensure that all prisoners have meaningful contact with a named officer who regularly checks their wellbeing and records their any contact in their case notes.
- The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.
- The Governor should ensure, in line with PSI 08/2010, that all staff, including healthcare staff, are included in hot and critical incident debriefs after a potentially traumatic incident or death and are offered support.

The Investigation Process

10. We issued notices to staff and prisoners at HMP Ranby informing them of the investigation and asking anyone with relevant information to contact us. No one responded.

11. We obtained copies of relevant extracts from Mr Axton's prison and medical records. In accordance with the Ombudsman's terms of reference and agreement with the police, the investigation was suspended while Nottinghamshire Police conducted a criminal investigation into the circumstances of Mr Axton's death. Another prisoner was charged with manslaughter. In January 2016, after a Crown Court trial, the prisoner was found not guilty. Nottinghamshire police shared all witness statements and evidence from their investigation.

12. The investigator interviewed five members of staff at Ranby on 27 April. The prisoner refused to be interviewed. She also wrote to four other prisoners who had either been released or transferred prison. One prisoner's letter was returned as addressee unknown and the other three prisoners did not respond.

13. We informed HM Coroner for Nottinghamshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Axton's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She wanted to know:

    - The circumstances surrounding Mr Axton's death.
    - Whether Mr Axton was bullied in prison because he had complied with prison rules.
    - Whether it was appropriate for Mr Axton to be located on the same wing as violent prisoners.

15. Mr Axton's mother received a copy of the initial report, provided feedback, and we made one factual change as a result.

16. The National Offender Management Service (NOMS) also received a copy of the report. They accepted all the recommendations.

Background Information

HMP Ranby

17. 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

18. The most recent inspection of HMP Ranby was in September 2015. Inspectors found that safety of prisoners was inadequate. The increase in availability of new psychoactive substances had led to high levels of debt and associated violence. Inspectors reported poorer outcomes for prisoners on houseblocks one to three, where there were a higher number of violent incidents and many more than in other comparable prisons. Assaults on staff and prisoners had increased significantly, and there had been a number of very serious incidents.

19. Inspectors found that the prison was attempting to respond to these concerns and there were signs of improvement in some areas. They concluded that good support was given to vulnerable prisoners, including victims of bullying and those subject to suicide and self-harm monitoring but some important elements of dynamic security were weak. Relationships between staff and prisoners were often distant and the supervision of prisoners was poor, particularly on houseblocks one to three where staff appeared very busy and there were a lot of prisoners in the houseblocks during the day, many of whom spent long periods of time locked in their cells.

Independent Monitoring Board

20. 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 bullying and self-harm associated with debt had increased, as had violence towards staff who were themselves suffering from low morale. 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.

Previous deaths at HMP Ranby

21. We have investigated thirteen deaths at Ranby since 2013. Six of the deaths, including that of Mr Axton, were in 2015. There has not been a further death at the prison since August 2015. In other cases, we have been concerned about issues of bullying, debt and associated violence, but there were no significant similarities between the circumstances of Mr Axton's death and the other cases.

Key Events

22. In July 2010, Mr Thomas Axton was remanded to HMP Bullingdon charged with arson. He was later convicted and, in March 2011, was sentenced to four years and six months imprisonment with an extended licence of two years for him to address alcohol problems.

23. On 23 April 2011, Mr Axton was transferred to HMP Isle of Wight and from there to HMP Woodhill on 21 January 2013. On 13 March 2013, Mr Axton told a doctor that he suffered from panic attacks and depression. The doctor prescribed him mirtazapine (an antidepressant). On 10 June 2013, Mr Axton was released on licence to probation approved premises (a probation hostel). On 20 August, his licence was revoked because of his continued misuse of alcohol and non-compliance with staff. He was recalled to Bullingdon and later transferred to HMP Coldingley on 12 September 2013. Mr Axton completed programmes to help address his alcohol problem.

24. On 4 April 2014, Mr Axton was released on licence to another probation hostel. Four days later, he was recalled to Coldingley after breaching the conditions of his licence due to continued alcohol misuse. On 8 July, Mr Axton transferred to Bullingdon. He said he felt depressed, suffered panic attacks and found it difficult to sleep in prison. The doctor prescribed him zopiclone (sleeping medication) and citalopram (an antidepressant). A nurse referred Mr Axton to the primary mental health team due to his depression and anxiety.

25. On 30 July, Mr Axton told a nurse that he had been diagnosed with depression and anxiety in the community and had no contact with anyone outside prison. He wanted to rebuild his relationships on release. He said he preferred to be alone and when he was out on the wing he looked forward to staff locking him back in his cell. He said he had no thoughts of suicide or self-harm and was motivated to abstain from alcohol when he was released and move on with his life.

26. A structured assessment tool indicated that Mr Axton had moderate anxiety. The nurse gave him guided self-help and distraction activities and tried to see him again on 14 August but he was not on the wing at the time. Mr Axton had no further mental health appointments at Bullingdon.

27. On 9 September, a Parole Board panel did not direct Mr Axton's release. His next parole review would be a year later. In November, he completed a six-week treatment programme for alcohol dependency.

28. On 22 December, Mr Axton was transferred to Ranby. A doctor continued his prescription of antidepressants. On 23 December, he told a nurse he felt well taking citalopram. The nurse did not consider he met the threshold for treatment from the mental health team.

29. On 20 January 2015, Mr Axton told a prison GP that he was not sleeping well and would like to increase his dose of antidepressants. The GP agreed. On 23 April, another prison GP reviewed his medication and recorded that Mr Axon looked well, was in a good mood and had no suicidal thoughts. She continued Mr Axton's prescription of citalopram.

30. An officer who worked on Houseblock One, where Mr Axton lived, told the investigator that Mr Axton was a polite man who kept to himself and did not associate with the more difficult prisoners. Other prisoners told the police that Mr Axton was quiet, calm and gentle, and did not socialise much with others.

15 June 2015

31. Mr Axton lived on the ground floor of Houseblock One, which is a general residential houseblock for prisoners convicted of any offence. The houseblock holds 148 prisoners on three floors arranged around an open central area. Each floor is visible from the others. Eight officers work in the houseblock at times when prisoners are out of their cells. Five of them carry a radio. Four officers cover the houseblock at other times. Between 11.45am and 1.00pm on 15 June, prisoners were allowed out of their cells for lunch and association (when prisoners are able to mix with each other, have showers, make telephone calls, and complete other domestic tasks).

32. Prisoner A, who also lived in Houseblock One, refused to speak to the investigator, but in his defence statement for his trial he said that he had owed Mr Axton tobacco. Around midday on 15 June, he said he was in Prisoner 1's cell, which was on the first floor of houseblock one, when Mr Axton came to the cell and asked him to pay back double the amount of tobacco that he had borrowed. He was unable to give him the tobacco and said that Mr Axton became increasingly aggressive and moved towards him. He thought Mr Axton was going to assault him and said he punched Mr Axton in self-defence. He said Mr Axton fell to the ground and he immediately left the cell. There was no CCTV on the houseblock at the time and no staff witnessed the assault. At his trial, the jury found him not guilty of manslaughter.

33. Other prisoners gave a different account of events to the police and the court. Prisoner 2 told the police that he saw Prisoner A walk out of Mr Axton's cell around 12.15pm, along with another prisoner, talking about the debt Mr Axton owed him. He said he asked them what they were doing but they did not reply.

34. Prisoner 3 told the police that, around 12.20pm, he was standing outside his cell on the ground floor and looked up and saw Prisoner A standing just inside Prisoner 1's cell. He said Mr Axton was standing facing Prisoner A, with his back to Prisoner 3. He saw Prisoner A draw his fist back and aim at Mr Axton's head. He did not see the punch connect but Mr Axton fell backwards, making no attempt to break his fall. He told police that the sound of his head hitting the floor made a loud crack. Prisoner A then left Prisoner 1's cell, went downstairs and walked past him. He told the police that someone pulled Mr Axton into Prisoner 1's cell and shut the door. He said a few minutes later, Mr Axton left the cell with blood on his head, ear, and down his neck and shoulder.

35. Prisoner 4 told the police that he was standing on the second floor when he heard an argument on the floor below about money. He looked down and saw Mr Axton and Prisoner A standing facing each other. He said he heard Mr Axton tell Prisoner A that he could not have his money. He saw Prisoner A punch Mr Axton, who fell back and hit the floor loudly. He then saw two prisoners drag Mr Axton into the cell by his ankles and close the door. He said that after a minute, Prisoner A came out and wiped the floor with a cloth.

36. Prisoner 1 did not respond when the investigator wrote to ask to interview him, but he gave a written statement for the police. He said that Mr Axton had come to his cell and, as he had turned to leave, another prisoner punched him and Mr Axton fell backwards into his cell. He said he and another prisoner had helped Mr Axton get up and sat him in a chair. He said that Mr Axton then got up and left the cell.

37. Officer A was sitting outside a cell on the ground floor, constantly observing a prisoner who was considered at high risk of suicide. She told the police that, around 12.20pm, she heard a loud thud and saw prisoners looking up at the landing above. As she could not leave the cell, she beckoned to Officer B and asked him to go upstairs to check what had happened. A short time later, Mr Axton walked past her, holding a cloth to his neck below his ear where she could see dried blood. Officer B came back downstairs and pointed to Mr Axton, who was going towards his own cell.

38. Officer B told the investigator he had seen Mr Axton holding a bloodstained cloth to his head and had followed him back to his cell. Mr Axton was sitting on his bed and told him that he was all right and that it was nothing. Mr Axton would not let him look at the injury and he said he would ask a nurse to examine him. He told the investigator that Mr Axton spoke clearly and coherently at the time. He saw a Supervising Officer (SO) nearby and told him what had happened.

39. Officer B went back to Mr Axton's cell with the SO and Mr Axton was sitting on the bed smoking a cigarette. The SO told the investigator that he thought it was apparent from Mr Axton's injuries that he had been assaulted. The SO asked what had happened, but Mr Axton said nothing had happened. The SO said he would ask a nurse to examine him, but Mr Axton said he did not want this.

40. The SO went to telephone healthcare staff and spoke to a nurse. He told the investigator that she said that she was in a meeting at the time, and that unless it was a 'code blue' she would not attend. (A code blue indicates a medical emergency in circumstances such as when a prisoner has breathing difficulties, has collapsed, or is unconscious. Staff should respond immediately by taking emergency medical equipment to the scene and the prison should call an ambulance automatically.) He said he told her that a prisoner had been assaulted and she had asked them to bring Mr Axton to the healthcare unit. He said he did not think it was appropriate for Mr Axton to walk to the healthcare unit with the injuries on his face and he needed assistance straight away. He told the investigator that she said that unless it was a code blue emergency, healthcare staff would not attend immediately.

41. The nurse recalled the conversation slightly differently. She said that she had told the SO she would attend as soon as possible, when her meeting finished. She said he did not tell her that he wanted her to attend immediately.

42. Around ten minutes after he had last seen him, Officer B noticed that Mr Axton had pressed his cell bell and he went straight to his cell. He said Mr Axton was distressed, disoriented, on his knees, and asked for help. He could not stand up. He told the investigator that he asked Officer C to stay with Mr Axton while he went to telephone healthcare staff.

43. Officer C went into Mr Axton's cell and closed the door behind him to give Mr Axton some privacy. He told the investigator that Mr Axton was distressed, lying on his back and said that his head really hurt. He had some dried blood on his ear. He tried to talk to Mr Axton to calm him down. He said that Mr Axton then suddenly stopped talking. He looked like he was trying to be sick, was struggling to breathe and appeared to be choking. He put Mr Axton in the recovery position. As he was not carrying a radio, he shouted to Officer A to call a code blue on her radio. He estimated he had been with Mr Axton for around a minute.

44. Meanwhile, Officer B had gone to the office and telephoned the nurse. He said he told the nurse that Mr Axton had been assaulted and he needed healthcare staff to come and see him. He said that the nurse again said that they would only come immediately if it was a code blue emergency. He said that it was not a code blue at that stage, as Mr Axton was talking to him but he had a head injury. She said that he would need to call a code blue if he wanted her to attend immediately. He then telephoned the control room to inform them that he had a code blue emergency. According to the incident log, this was at 12.45pm. He said he told the officer in the control room that Mr Axton had a head injury and was becoming less coherent. He and the SO (who was also in the office) then went back to Mr Axton's cell.

45. The nurse said that when Officer B called she had told him she would be there soon. She said he had said that the situation had nearly reached a code blue and she had told him that if Mr Axton was deteriorating he needed to call a code blue, but she was on her way in any event. She said that she and her colleagues were on the way to Mr Axton's cell when they heard the code blue announced on the radio.

46. East Midlands Ambulance Service records indicate that the prison requested an ambulance at 12.46pm. The investigator listened to the 999 call to request the ambulance. Prison staff told the operator that a prisoner had been assaulted, they believed he was unconscious and had a head injury. The Ambulance Service classed the request as a Green 2 call. This meant that they did not consider Mr Axton to be in a life-threatening situation but there were serious enough injuries to warrant an ambulance arriving within 20 minutes.

47. According to the medical record medical staff arrived at Mr Axton's cell at 12.47pm. Mr Axton was breathing but unresponsive, had blood coming out of his ear, and a large cut on his bottom lip. The nurse said he was agitated and moving his arms a lot. The level of oxygen in his blood was normal at 98%, as was breathing, but his pulse was very high at 167 beats per minute. Another nurse then arrived at the cell.

48. Mr Axton started foaming at the mouth, which indicated his airway might be blocked. His jaw was fixed and locked and they could not insert a tube to help him breathe, so they tilted his head back so his tongue did not obstruct his airway. The nurses recorded a Glasgow Coma Scale of three, which meant that Mr Axton was unconscious and not responding to any stimuli. They put a wound pad on his ear to stop the bleeding and used an Ambubag to help Mr Axton breathe.

49. At 1.03pm, an ambulance arrived at the prison and paramedics took over Mr Axton's emergency treatment. His condition was deteriorating rapidly; he appeared to have had a seizure and his arms were in a rigid and fixed position. Paramedics noted that all his symptoms indicated Mr Axton had suffered a brain injury. At 1.33pm, the ambulance took Mr Axton to hospital. Two officers accompanied him, but he was not restrained. At 3.15pm, a nurse contacted the hospital and found that a CT scan had showed Mr Axton had a fractured skull and had a large haematoma (blood clot) in his brain. He had been intubated, ventilated and transferred to another hospital for surgery.

50. At 3.50pm, an officer was appointed as the prison's family liaison officer. She telephoned Mr Axton's mother, who lived in Berkshire, explained what had happened and offered her support. They agreed to meet at the hospital that evening. At 7.50pm, a nurse rang the hospital, who said Mr Axton had had surgery, but his chances of survival were slim. The family liaison officer and the prison's Head of Operations met Mr Axton's mother and sister when they arrived at the hospital around 9.00pm that evening.

16 June onwards

51. On 16 June, at 2.00pm, hospital staff removed Mr Axton's ventilator and he died at 2.32pm. His family were with him at the time. The family liaison officer kept in contact with Mr Axton's family to offer support. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

52. After Mr Axton died, Prisoner A was charged with manslaughter. In January 2016, he was found not guilty.

53. The investigator examined Mr Axton's and Prisoner A's security records. There was no security intelligence linking them before Mr Axton's death. After his death, a number of prisoners told staff or were overheard saying that Prisoner A had punched Mr Axton, as Mr Axton was in debt to him or owed him tobacco. Staff told the investigator that Mr Axton and Prisoner A did not generally associate with each other. There was no information from staff or prisoners or in the security files to indicate that Mr Axton had been the victim of bullying.

Support for prisoners and staff

54. None of the staff the investigator spoke to were invited to attend a debrief after Mr Axton died. Some said they had received individual support from their line managers but had not been told personally, when Mr Axton died. A checklist compiled after Mr Axton's death indicated that the Governor had held two debriefs at 5.30pm and 9.30pm on 16 June. The prison has not been able to supply the notes of these debriefs to establish who was present but they seem to have involved managers, as none of the staff we interviewed had been invited.

55. The prison posted notices informing prisoners of Mr Axton's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Axton's death.

Post-mortem report

56. A post-mortem examination established that Mr Axton died as a result of a head injury. Mr Axton sustained a cracked skull and extradural haematoma. This involved the build up of blood between the skull and brain, which led to swelling and compression and ultimately to cerebral ischemia (insufficient oxygen supply to the brain resulting in the death of brain tissue, or stroke).

Findings

Mr Axton's safety

57. There was no intelligence to link Prisoner A with Mr Axton before Mr Axton's death. There was no information that Mr Axton was at risk from Prisoner A or any other prisoner until after his death. None of the information indicated that Prisoner A was in debt to Mr Axton. According to security information, neither Mr Axton nor Prisoner A had previously been involved in violence in the houseblock. Although Mr Axton and Prisoner A lived in the same houseblock, their cells were on different floors and staff had not seen them associate with each other.

58. Mr Axton's family was concerned that Mr Axton was living in the same houseblock as violent offenders like Prisoner A (who had been convicted of grievous bodily harm). Mr Axton had been convicted of arson. All prisoners at Ranby are the same security category and allocation in the prison is not made on the basis of their offences. We are satisfied that there was no reason why Mr Axton and Prisoner A should not have been allocated to the same houseblock as each other,

59. After Mr Axton died, several prisoners told staff that Mr Axton had owed Prisoner A or Prisoner 1 some tobacco and that he had been assaulted as he could not repay the debt, but there is no firm evidence of this. The jury found Prisoner A not guilty of manslaughter. Whatever the motivation, it is not disputed that Prisoner A punched Mr Axton and this led to his death. However, we do not consider that staff at Ranby could have predicted this or that there was any reason to keep them apart.

Emergency response

60. Prison Service Instruction (PSI) 3/2013 requires that each prison must have a medical emergency response code protocol that ensures that an ambulance is called automatically in a life-threatening medical emergency. The protocol should give guidance on efficiently communicating the nature of a medical emergency so that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. Prisons are required to have a two code medical emergency response system based on the instruction. Ranby uses code blue to indicate an emergency, such as when a prisoner is unconscious, having breathing difficulties or is concussed. Code red is used for severe bleeding, scalds, or fractures. The control room should call an ambulance immediately when an emergency code is used.

61. Prisoners and staff estimated that Prisoner A punched Mr Axton at around 12.20pm. It is possible from the prisoners' accounts that Mr Axton was briefly knocked out but when staff saw him he was talking coherently and able to walk back to his cell on his own. The pathologist recorded in the post-mortem report that an instant loss of consciousness, followed by an apparent recovery and then deterioration was sometimes typical for this type of head injury. Mr Axton would not tell staff what had happened and said he did not want medical attention. Nevertheless, the SO telephoned a nurse and asked her to attend. The nurse said he did not say it was urgent and the SO did not believe Mr Axton's symptoms were severe enough for him to call a code blue at that stage.

62. Officer B spoke to the nurse again about ten minutes later, when Mr Axton's condition had significantly deteriorated. Again, their recollection of the conversation differed. However, the outcome was that he called an emergency code blue at 12.45pm.

63. We are concerned about the differing accounts of prison staff and the nurse. The nurse said Mr Axton's condition was much more serious than had been conveyed, when she got to his cell but Officer B and the SO were concerned that nurses did not attend sooner. The Head of Operations told the investigator that since Mr Axton's death, all staff have been educated about the need to communicate information about a prisoner's medical condition clearly and the use of the emergency codes.

64. It took approximately 25 minutes from the time of the assault for staff to call a code blue. However, we accept that it was not immediately apparent to prison staff that Mr Axton had symptoms of concussion, which would suggest he needed an emergency ambulance. Once the code blue was called, we are satisfied that staff reacted quickly, calmly and competently.

65. Police told the investigator that the hospital consultant responsible for Mr Axton's care had told them that any delay in calling an ambulance would have made no difference to the outcome for Mr Axton. However, we are concerned about the apparent reluctance of healthcare staff to attend urgently, when prison staff were evidently very concerned about Mr Axton. He had suffered a head injury and a nurse should have seen him quickly for a professional assessment of whether he needed to go to hospital. Officers also appeared too hesitant to call a code blue, although PSI 3/2013 says that if staff "are in any doubt about the nature of the injury, they must call an ambulance. It is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required". We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff clearly communicate information about a prisoner's condition when requesting an urgent healthcare assessment, that nurses prioritise appropriately, and that an ambulance is called whenever there are serious concerns about a prisoner's health.

Prisoner support

66. The Head of Operations told the investigator that there is not a full personal officer scheme at Ranby, as they did not have sufficient staff to run one. In prisons where there is a personal officer scheme, officers are usually expected to get to know prisoners they are responsible for, to act as a first point of contact for any problems, help with resettlement issues and make regular entries in their prison records about their progress. However, she said that all officers at Ranby are allocated a number of prisoners and are expected to make monthly entries about them in their prison records.

67. From the time he arrived at Ranby on 23 December 2014, until his death on 16 June 2015, houseblock staff made no entries in Mr Axton's case notes in his prison record, which indicated any personal interaction with him.

68. In 2014, HM Inspectorate of Prisons (HMIP) recommended that, "the personal officer scheme should be effective in providing regular support and motivation to prisoners". At the 2015 inspection, HMIP described the personal officer scheme as ineffective. This was compounded by the extent that prisoners on houseblocks one to three spent locked in their cells, which limited contact between staff and prisoners on these houseblocks. The lack of knowledge of prisoners and limited staff interaction with them, leads to poor dynamic security and contributes to a lack of safety in prisons. We make the following recommendation:

The Governor should ensure that all prisoners have meaningful contact with a named officer who regularly checks their wellbeing and records their contact in their case notes.

Liaison with Mr Axton's family

69. Prison Rule 22 requires that when a prisoner becomes seriously ill, the Governor should "***at once*** inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed". When Mr Axton was taken to hospital at 1.30pm on 15 June, it was evident that he was in a critical condition. He was unconscious and had symptoms indicative of a brain injury and the prison should have informed his family straight away. No one informed his family until an officer was appointed as the family liaison officer at 3.50pm, over two hours later.

70. While Mr Axton's family were able to get to the hospital, any delay in informing families when a prisoner is seriously ill or has suffered sudden life-threatening harm can mean that families miss the opportunity to see them before they die. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

Staff Support

71. PSI 08/2010 about Post-Incident Care requires managers to hold a short 'hot' debrief meeting before staff go home when they have been involved in a potentially traumatic incident. All staff directly involved in the incident, including healthcare staff, should be invited. Managers did not hold a debrief for staff when Mr Axton was taken to hospital unconscious on 15 June.

72. There is a note on a checklist indicating that the Governor held two debriefs on 16 June, after Mr Axton had died. No details or notes of these debriefs were available and none of the staff the investigator interviewed recalled being invited to these debriefs. They all said they would have welcomed such an opportunity to discuss what had happened. Some said they were not offered any support after Mr Axton's death. A further critical incident debrief should be held five to ten days after the death to discuss the impact of the death and provide any support necessary. There is no record that the prison held a critical incident debrief. We make the following recommendation:

The Governor should ensure, in line with PSI 08/2010, that all staff, including healthcare staff, are included in hot and critical incident debriefs after a potentially traumatic incident or death and are offered support.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141