Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ainslie Rush, a prisoner at HMP Ranby, on 7 April 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.

This is the investigation report into the death of Mr Ainslie Rush, who hanged himself in his cell at HMP Ranby on 7 April 2015. Mr Rush was 34 years old. I offer my condolences to his family and friends.

Mr Rush began to behave bizarrely on 6 April. He was paranoid and thought that other prisoners were trying to contaminate him. Although prison staff did not consider that he was at risk of suicide and self-harm, a manager asked that staff should monitor his wellbeing during the night. I am concerned that those checks did not take place. The next morning, officers found Mr Rush had hanged himself. Despite clear signs that he had died, nurses began resuscitation. Mr Rush had been using new psychoactive substances and it is possible that this caused his paranoid state. The easy availability of such substances at Ranby is a serious matter, which the prison needs to address. Mr Rush's body was left on the landing for some hours after his death, which was inappropriate and disrespectful.

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 **January 2016**

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Summary

Events

1. Mr Ainslie Rush was remanded to HMP Norwich on 22 March 2006, charged with the murder of his ex-partner. Mr Rush had a history of drug and alcohol abuse. In September 2007, he was sentenced to life imprisonment. He had been at HMP Ranby since 24 January 2014.

2. During his sentence, staff had managed Mr Rush under Prison Service suicide and self-harm prevention procedures (known as ACCT) seven times between 2006 and 2007, when he was at HMP Norwich. He had been managed under ACCT procedures once at Ranby, in March 2014, around the time of the anniversary of his offence. There were a number of intelligence reports indicating that Mr Rush used and dealt drugs at Ranby.

3. On 6 April 2015, Easter Monday, wing staff noted that Mr Rush seemed paranoid and upset. He alleged that someone had stabbed him with a needle contaminated with hepatitis and HIV and was putting worms on his toothbrush. Staff tried to reassure him. They asked someone from the healthcare team to see him, but it was a Bank Holiday and the only mental health nurse on duty was too busy that day. No one had said it was urgent or that Mr Rush was in crisis and the nurse arranged to see him the next day. Mr Rush was moved to a single cell at his request. Later, he told an officer that someone had given him an apple containing ketamine (a powerful anaesthetic, which is mostly used on animals and can cause 'out of body' experiences and hallucinations). He did not want other prisoners to overhear him and held up a note asking staff to keep an eye on him.

4. At least five members of staff spoke to Mr Rush that day, including two custodial managers. None of them thought that that Mr Rush was at risk of suicide or self-harm. Another prisoner told us that he had told an officer that Mr Rush would kill himself that night, but none of the staff on duty remember this. Although the staff did not consider that Mr Rush was suicidal, they were concerned that his paranoia was distressing him and a manager asked staff to keep an eye on him during the night. An officer wrote this in the wing observation book and said she had briefed the staff who took over from her. The night patrol officer said he had read the observation book but did not check Mr Rush during the night as no one had asked him.

5. Around 7.35am on 7 April, an officer found the observation panel in Mr Rush's cell covered. Officers opened the cell shortly afterwards and found Mr Rush had hanged himself using shoelaces attached to the window. He had cut his feet and arms and had written on his body that he had hidden notes internally. He also left letters in his cell, indicating that he intended to kill himself. Nurses tried to resuscitate Mr Rush, even though it was apparent from the presence of rigor mortis that he had been dead for some time. At 7.52am, paramedics pronounced him dead. During the post-mortem, the pathologist found several letters in Mr Rush's anus. A toxicology report showed that Mr Rush had taken two different forms of new psychoactive substances before he died.

Findings

6. Mr Rush had no recent history of self-harm in prison and there was little to indicate that he was suicidal on 6 April. Staff considered that his paranoid behaviour indicated a mental health problem, but not one that suggested he was at risk of suicide. We consider this was not an unreasonable conclusion and do not criticise their decision not to begin ACCT procedures. We are surprised that no one appears to have considered whether his paranoia was the result of substance misuse, but recognise that this would have needed a mental health assessment to determine and would not have changed decisions about his management on the night of 6 April. The investigation found that the prison needs to do more to eradicate the availability of new psychoactive substances and train staff how to respond to their use.

7. Although a manager asked that Mr Rush should be monitored throughout the night, and an officer recorded this in the wing observation book, the night patrol officer said that he was not aware that he was required to do the checks. We are concerned that these checks did not happen. While Mr Rush had not been identified as at risk of suicide and self-harm, such checks might have identified further concerns about his risk.

8. When Mr Rush began to behave bizarrely on 6 April, a supervising officer asked a mental health nurse to see him. The nurse on duty did not have time to see him that day and made an appointment to see Mr Rush the next morning. The clinical reviewer said that, on the information the nurse had, this was appropriate. We are satisfied that this was a reasonable decision as the nurse had no reason to consider Mr Rush was in crisis or suicidal.

9. We are concerned that healthcare staff, tried to resuscitate Mr Rush when it was apparent from signs of rigor mortis that Mr Rush had been dead for some time. Mr Rush's body remained on the landing outside his cell for some hours after his death, which was undignified and disrespectful.

Recommendations

- The Governor should ensure that when prisoners need to be monitored because of concerns about their health or state of mind, there are explicit instructions, which staff follow, setting out responsibilities and the frequency required.
- The Governor should ensure there is an effective supply reduction strategy to help eradicate the availability of new psychoactive substances at Ranby, that prison staff are vigilant for signs of its use and are briefed about how to respond when a prisoner appears to be under the influence of such substances.
- The Head of Healthcare should ensure that healthcare staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.
- The Governor should ensure that a deceased prisoner's body is treated with dignity and respect at all times.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Ranby informing them of the investigation and asking anyone with relevant information to contact her. Three prisoners responded.

11. The investigator visited Ranby on 8 April 2015 and obtained copies of relevant extracts from Mr Rush's prison and medical records. She exchanged information with Nottinghamshire police.

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

13. In May 2015, the investigator interviewed eight members of staff at Ranby and the three prisoners who had responded to the notices of investigation. The clinical reviewer joined her for the interviews with healthcare staff.

14. We informed HM Coroner for Nottingham of the investigation who gave us the results of the post-mortem examination. The coroner has a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Rush's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked if Mr Rush had harmed himself in prison, whether this was identified and how he was managed. They also wanted to know whether the mental health team had assessed him, what medication he was receiving, and what help he had received.

16. Mr Rush's family received a copy of the initial report. The solicitor representing them wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

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 report of the most recent inspection of Ranby in September 2015 has not yet been published. At the time of the previous inspection in March 2014, inspectors were concerned that the prison was unsafe. There had been increased levels of violence and intimidation with inadequate direct supervision of prisoners. Inspectors 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.

19. Inspectors were concerned about the easy availability of undetectable 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.

20. 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

21. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. 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 accompanying rises in the levels of violence and debt. The IMB was concerned that Ranby did not have 24-hour healthcare cover. The IMB 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

22. There have been five deaths at Ranby in 2015, of which four were self inflicted, two of which were only four days apart. The investigations into three of these deaths, identified issues involving new psychoactive substances, bullying and ACCT procedures, which were also issues in this investigation. The number of deaths at the prison is a concern

Assessment, Care in Custody and Teamwork

23. Assessment, Care in Custody and Teamwork (ACCT) is the is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process

is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

24. Mr Ainslie Rush was convicted of murdering his ex-partner on 28 November 2006 and received a mandatory life sentence. He had a minimum period to serve of just over 13 years, before he could be considered for release. He transferred from Norwich to Garth on 27 September 2007 and from Garth to Ranby on 24 January 2014, as part of his sentence progression.

25. Mr Rush was managed under suicide and self-harm prevention procedures (ACCT) eight times. The first seven of these were while he was at Norwich between 22 March 2006 and 27 September 2007. In 2006, Mr Rush cut his arms, took an overdose and attached a noose to a cell window, but there is no record of any further self-harm after that. He was never regarded as at risk of suicide and self-harm while he was at Garth.

26. Mr Rush had a history of alcohol and drug abuse. In prison, he was found guilty of several disciplinary offences for possession of drugs (in particular at Ranby, for possession of "Mamba", a new psychoactive substance), mobile phones, making hooch, setting fire to his cell, flooding his cell, possession of weapons, and bullying.

27. On 5 March 2014, after Mr Rush had moved to Ranby, he became very anxious because the eighth anniversary of his offence was approaching on 18 March. Staff noticed that he was giving away his belongings, and began ACCT suicide and self-harm prevention procedures, which they ended on 2 April 2014. Until then, Mr Rush had not been assessed as at risk of suicide and self-harm since he had been at Norwich in 2007. After March 2014, he was not assessed as at risk again.

28. A mental health nurse told the investigator that in March 2014 Mr Rush had been very despondent and wanted a transfer to a prison that ran the Healthy Relationship Programme (HRP). She said that although he had positive plans for his release and had good family support, he had a lot of guilt and remorse about his offence.

29. On 10 March 2014, a GP prescribed Mr Rush lofepramine (an antidepressant). Mr Rush stopped taking it three weeks later, as he said it gave him headaches. He did not receive antidepressant medication after this.

30. Mr Rush's offender supervisor said that she had put in a request for him to move to either HMP Highpoint or HMP Erlestoke in October 2014 to do the HRP programme. Despite chasing, she was still waiting for a response.

31. On 24 January 2015, officers searched Mr Rush's cell and a handheld detector strongly indicated that Mr Rush had a metallic object (suspected to be a mobile phone) hidden in his anus. The next day, Mr Rush was taken to the segregation unit. He sent a note to his offender supervisor asking to go to a prison which ran the healthy relationship course, if he was moved from Ranby. She told him that the prison was trying to send him to a prison which ran the course. On 10 February, she noted in his prison record that Mr Rush had handed a pair of tweezers to an officer and said that this was what he had been concealing. Mr Rush then returned to the wing.

32. On 26 February, a nurse saw Mr Rush after he had asked to see a mental health nurse. Mr Rush told him that his cellmate had moved out, he did not want to share with anybody else and wanted a move to a single cell. The nurse said that this was not a matter for mental health staff and told Mr Rush to ask prison staff. Mr Rush agreed that he did not need mental health support.

6 April

33. Around 10.00am on 6 April, Easter Monday, an officer said Mr Rush was crying and seemed very upset and worried. She took him to the wing office and he told her that someone had stabbed him with a needle contaminated with hepatitis and HIV and that someone else was "messing with his head". He told her that someone had put something disgusting on his toothbrush. (He later told another officer that this was worms from faeces. He had received treatment for worms in 2014.)

34. The officer asked him who had stabbed him, when and how. At first, Mr Rush said he did not know who had done it but, when pressed, said that he did know but that he would not say because he was not a "grass". She said there was little she could do without a name and Mr Rush appeared to accept this. She noted that Mr Rush seemed paranoid and upset and not like his normal self. She suggested that they told a Supervising Officer (SO), so they went to his office and Mr Rush explained what had happened.

35. Mr Rush thought that healthcare staff could give him something to prevent an infection. The SO explained that they would need to take blood tests to check if there was any infection and that this might take some time. Because of his unusual behaviour, he thought that it would be helpful for someone from the mental health team to see Mr Rush and take blood tests to reassure him. He phoned a nurse and asked him to come and see Mr Rush.

36. As it was a Bank Holiday, the nurse was the only member of the mental health team on duty, and was too busy to see Mr Rush that day. He told the SO that he would make an appointment to see Mr Rush the next morning. He said that he did not question the SO further about Mr Rush's behaviour because he was busy. As the SO was an experienced officer, he expected he would have let him know if he thought that Mr Rush needed to see someone urgently. He noted the request in Mr Rush's medical record at 2.52pm.

37. The SO reassured Mr Rush that a mental health nurse would see him the next day. The SO and officer both thought that Mr Rush seemed more settled afterwards. The officer said that she did not think that Mr Rush would harm himself but he seemed worried that he might have been infected by a needle.

38. Mr Rush asked to move to a single cell as he had been in a single cell before he went to the segregation unit in January. As there was a single cell free, the SO arranged for him to move into cell 14 at lunchtime. The officer completed a security report about Mr Rush's allegations and she made a note in the wing observation book.

39. A prisoner at Ranby told the investigator that he had known Mr Rush for about seven years and they had been together at Garth. He said that when Mr Rush

was using “Mamba” (one of a group of new psychoactive substances (NPS)) he became paranoid and agitated but when he was not using it, he was “normal”. He told the investigator that a few days before his death Mr Rush had said that someone had contaminated him with a needle. He could not see any puncture wounds or anything else to suggest that Mr Rush had been stabbed with a needle and thought that he was under the influence of Mamba.

40. The prisoner said that on the morning of 6 April, Mr Rush was “off his head”, by which he meant that he seemed agitated, worried and paranoid. He said that Mr Rush had told him that he could not cope any more and that he had bought some Mamba, which was very strong. He told the investigator that Mr Rush said he was concerned about his family and thought someone was trying to harm them. He said that he would rather be hurt himself. He said that Mr Rush owed £475 to another prisoner who was putting pressure on him to pay him back. We have not been able to find any evidence to corroborate this.

41. During the afternoon of 6 April, Mr Rush spoke to an officer in the wing office and told her that he had been contaminated by an infected needle. She said that he was quite different to how he normally was, but she did not think that he was under the influence of any substances. She spent about ten minutes talking to him and reassured him that a mental health nurse would see him and take blood tests the next day.

42. At 5.00pm, Mr Rush pressed his cell bell and the officer went to see him. He held up a note to the observation flap, which said that someone had given him ketamine on an apple. She could not read it properly and asked Mr Rush to explain it further. He indicated to her to be quiet, as he did not want other prisoners to hear. She was the only officer on the wing at the time and called a custodial manager for advice. The manager said that she was coming to the wing to speak to another prisoner and would also speak to Mr Rush.

43. The officer wrote in the wing observation book that afternoon that Mr Rush had held up a piece of paper on which he had written, “Keep an eye on me today please”. She told the investigator that she could only recall the note about ketamine. She said that she had been concerned that Mr Rush might harm someone else out of fear, but he categorically denied that he had any thoughts of harming anyone and no thoughts of suicide or self-harm.

44. The prisoner in the cell next door to Mr Rush told the investigator that he had known Mr Rush for about seven years and had been at Garth with him. He said that Mr Rush had started using Mamba again about three months before his death. On the morning of 6 April, another prisoner had brought Mr Rush to him “because he was in a bad place”. He described Mr Rush as having sunken and dark eyes and looking grey, like a corpse. He said that Mr Rush told him “they have got me, contaminated me, there are air bubbles in my arm” and continued “talking rubbish” for a while, while he tried to get him to calm down. He said that Mr Rush told him that he was going to kill himself that night and told him not to tell officers. He said that during the day he became increasingly worried about Mr Rush, so he spoke to an officer about this.

45. The officer said that at about 5.00pm, the prisoner had told her he was concerned about Mr Rush, but did not say that he thought that Mr Rush was

likely to harm himself. She told him that staff were aware of Mr Rush's problems, but said that he should let the SO know of his concerns.

46. The prisoner said that he spoke to another officer before the SO. He said that he had told the officer only that he was concerned about Mr Rush but had later told the SO that Mr Rush had said that he was going to take his life that night.

47. The SO said that the prisoner did not tell him that Mr Rush had said he intended to kill himself. The SO is an ACCT trainer and assessor and therefore familiar with ACCT procedures. He said that he had considered whether to open an ACCT but did not believe that Mr Rush was at risk of suicide or self-harm. Mr Rush was on the basic regime level, which meant that he did not have a television in his cell, but the SO arranged for him to have one to help distract him from his thoughts.

48. At 6.00pm, two custodial managers went to see Mr Rush. One said Mr Rush told her someone was "out to get him". She said he seemed quite paranoid but she did not think he was suicidal. She said that he did not seem to be under the influence of any substances but was very agitated. She said that she would have asked a member of healthcare staff to see Mr Rush, but there was no one there at the time and she knew a nurse had arranged to see him the next morning. She asked an officer to keep an eye on him and to make a note for the night staff to do so.

49. The officer wrote a note in the wing observation book asking night staff to monitor Mr Rush because of his "bizarre behaviour" during the day. She told the investigator that as well as writing in the observation book she had briefed the night patrol officer and an officer during the shift handover, but the officer left the wing at 8.45pm to escort a prisoner to hospital and did not come back that night. The officer's shift finished at 9.00pm.

50. The night patrol officer was twice not available for interview. In emails to the investigator and to a prison manager, he said that he had read the wing observation book but no one had told him to check Mr Rush during the night and he had not monitored Mr Rush.

51. A prisoner told the investigator that in the evening, about 7.00pm, he chatted to Mr Rush through a gap where the central heating pipe went through the cell wall. He said Mr Rush was still paranoid and he tried to reassure him. Around 11.00pm, he heard banging in Mr Rush's cell. He looked through the gap but could not see anything, as it was dark. In the morning, at about 6.45am, he tried to look through the gap again but Mr Rush had blocked it.

52. The prisoner who was in the cell next to this prisoner, told the investigator that he had heard someone checking Mr Rush at about 10.30pm the night before but did not hear what was said. He said he knew this because Mr Rush's observation flap squeaked. He said he later heard someone open the flap at 11.00pm, 12 midnight, 1.00am and 2.00am, before he fell asleep. However, one officer was the only member of staff on duty on the wing at those times and he said he did not check Mr Rush.

7 April

53. At 7.35am on 7 April, two officers began to check that all prisoners were present in their cells. When Officer A came to Mr Rush's cell, he found that the observation panel had been covered from the inside. He did not know who was in the cell because it had been empty the day before, so he went to the office to check.

54. After checking who was in the cell, Officer A telephoned the custodial manager in charge of the operation of the prison at the time, who agreed he should open the cell. When he got back to Mr Rush's cell, staff arrived to assist him. According to the written log of events, this was five minutes after he had found the cell observation hatch covered.

55. Officer A opened the cell door and found Mr Rush had hanged himself from a ligature made of shoelaces attached to the window. He cut the ligature from the window and laid Mr Rush on the cell floor. Mr Rush had cut his feet and arms and there was blood smeared in the cell. An officer radioed a code blue emergency. (A code blue indicates a life-threatening situation requiring an immediate emergency response and should alert control room staff to call an ambulance.) The log of events indicated that the officer radioed the emergency code at 7.38am and control room staff called an ambulance at 7.40am. Two more officers also went to Mr Rush's cell after hearing the code blue call.

56. In a statement for the police, Officer A said that he had left the ligature around Mr Rush's neck and in a statement to the Governor he said that another officer had cut the ligature from his neck. An officer went to the wing office to get a defibrillator. Another officer told the investigator that she thought it was clear that Mr Rush was dead because there were signs of rigor mortis.

57. At 7.40am, two nurses arrived at the cell and three other nurses arrived with the emergency bags. One nurse told the investigator that the ligature was still around Mr Rush's neck at the time, but they did not need to remove it as it had been cut and was not restricting Mr Rush's airway. She said that the nurses made a joint decision to begin cardiopulmonary resuscitation.

58. The nurses opened Mr Rush's shirt to attach defibrillator pads and found that Mr Rush had written messages on his body, indicating that he had hidden items in his rectum. He had made cuts to his right upper arm, left arm below the elbow and on the inside of each ankle.

59. The defibrillator found no shockable heart rhythm and the nurses continued to attempt cardiopulmonary resuscitation. One nurse told the investigator that it had been difficult to fit an airway because of rigor mortis and Mr Rush's position, so they tilted his chin, lifted his neck and performed chest compressions. Paramedics arrived at 7.48am and assessed Mr Rush. At 7.52am, they pronounced him dead.

60. At 10.53am, staff moved Mr Rush's body from his cell onto the landing, apparently to allow the police to take photographs of his cell. Mr Rush's body remained on the landing in a body bag until 12.39pm, when undertakers arrived.

Prisoners and staff said they were upset that Mr Rush's body had remained on the landing for so long.

Contact with Mr Rush's family

61. Two prison family liaison officers went to inform Mr Rush's mother of his death that morning. On the way, they learnt that Mr Rush's mother was on holiday. Instead, they went to see Mr Rush's sister and informed her that he had died. They spoke to Mr Rush's mother by telephone later that day. One family liaison officer continued to support Mr Rush's family and helped with funeral arrangements. The prison contributed to the costs of the funeral, in line with national policy.

Support for prisoners and staff

62. The Head of Safer Custody at Ranby debriefed the staff involved in the emergency response and offered his support and that of the staff care team.

63. The Governor posted notices informing prisoners of Mr Rush'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 Rush's death.

64. Two prisoners told the investigator that they had asked for support from the mental health team after Mr Rush died but no one had been to see them. A member of the mental health team told the investigator that Navigators, a team of prisoners who had received basic mental health training, offer ongoing support to other prisoners when necessary. The team had visited the Mr Rush's houseblock on 8 April and offered individual support to all the prisoners there. Those two prisoners had chosen not to speak to them. On 1 May 2015, one prisoner's mother contacted the investigator and said she was worried that staff at Ranby had not supported her son after Mr Rush's death. The investigator referred this to the chaplaincy team at Ranby who said that a chaplain had spoken to him and offered support that afternoon.

Post-mortem report

65. The post-mortem examination concluded that Mr Rush died as a result of hanging. The pathologist found notes that Mr Rush had left in his body, which alleged that people were trying to infect him. Toxicology tests found traces of two synthetic cannabinoids (NPS) (5-fluoro-AKB-48 and MDMB CHMICA) in Mr Rush's blood and urine. The forensic toxicologist commented that these substances were likely to have caused Mr Rush's thinking to be adversely affected. He noted, "It is probable that the deceased was under the influence of synthetic cannabinoids at the time of his death". There was no trace of ketamine in Mr Rush's blood or urine.

Findings

Assessment and managing Mr Rush's risk on 6 April

66. Although Mr Rush had appeared paranoid on 6 April, none of the staff who had contact with him considered him to be at risk of suicide and self-harm. One SO, who is experienced in ACCT procedures, spoke to Mr Rush and asked a mental health nurse to see him because of his paranoid statements and behaviour, not because he believed he was suicidal. A prisoner said he had told the SO that Mr Rush had spoken about killing himself, but the SO did not recall this. We note that the prisoner said he did not say this to any of the other staff he spoke to that day. Mr Rush told staff that he did not have any thoughts of suicide and self-harm.

67. Staff were concerned about Mr Rush's mental health on 6 April but we recognise that there was little to indicate he was at any imminent risk of suicide and self-harm. Mr Rush had been managed under ACCT procedures at Ranby only once before, over a year earlier, and not because he had self-harmed. It was over seven years since he had previously self-harmed, shortly after he had been sentenced. We consider there was little to indicate to staff that Mr Rush was at risk of suicide and self-harm and they made a reasonable decision not to begin ACCT procedures. We do not consider that they could have been expected to anticipate his actions later that night.

68. Mr Rush had a history of smoking Mamba, a new psychoactive substance (NPS), which is known to cause paranoid behaviour. The use of NPS is a significant problem at Ranby. We are surprised that none of the staff, who said he seemed to be acting out of character, thought that this might have been a reaction to using an illicit substance, even if he did not appear to be under the influence at the time. However, even if they had identified the use of NPS as the cause of Mr Rush's mental state, it is unlikely that they would have been able to do any more than continue to monitor him for any other ill effects. A custodial manager appropriately asked officers to check Mr Rush during the night.

69. An officer wrote the custodial manager's instruction in the wing observation book asking night staff to monitor him, but did not say how frequently. She said that she had also briefed staff about this before she went off duty, one whom then left to take a prisoner to hospital, leaving the night patrol officer alone on the houseblock. The night patrol officer said that he had read the wing observation book but did not know that he was expected to do the checks. It is hard to reconcile these statements. We cannot know whether monitoring would have changed the outcome but we are concerned that this was not done. We note that there was no clear instruction about the level of observation, which we would expect when there are concerns about a prisoner's health or state of mind. We make the following recommendation:

The Governor should ensure that when prisoners need to be monitored because of concerns about their health or state of mind, there are explicit instructions, which staff follow, setting out responsibilities and the frequency required.

Availability of new psychoactive substances at Ranby

70. Mr Rush was known to use mamba at Ranby. Mamba, also known as Black Mamba, and substances such as spice, are new psychoactive substances (NPS), synthetic cannabinoids, which can produce experiences similar to cannabis. They usually contain dried, shredded plant material and chemical additives. They can cause rapid heart rate, vomiting, agitation, confusion, hallucinations and paranoia. Other effects include raised blood pressure and reduced blood supply to the heart.

71. We are concerned about the prevalence of NPS in prisons and the effect they have on the behaviours and health of those taking it. A prisoner who had known Mr Rush since they were prisoners at Garth together, said that when Mr Rush used Mamba he became paranoid and agitated. He said that Mr Rush had told him that he had bought some very strong Mamba and the prisoner considered his behaviour on 6 April was the effect of using this. As noted above, none of the prison staff who dealt with the prisoner that day seemed to consider this.

72. 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 this as a serious concern.

73. Toxicology tests indicated the presence of synthetic cannabinoids in Mr Rush's body. The toxicologist commented that it was probable that Mr Rush was under the influence of synthetic cannabinoids at the time of his death. While we cannot know for sure, it appears that Mr Rush's paranoid behaviour on 6 April might have been the result of using NPS or was a drug-induced psychotic episode. We consider it is important that the prison does all it can to eradicate the use of Mamba and other new psychoactive substances and that staff understand how to respond when prisoners appear to be under the influence of such substances. We make the following recommendation:

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

Clinical care

74. Overall, the clinical reviewer concluded that Mr Rush's clinical care at Ranby was equivalent to that he could have expected to receive in the community. He noted that there was one member of the mental health team working on 6 April, but this was a Bank Holiday. This meant that the nurse was not able to see Mr Rush that day, but in any event, there was little to indicate that this was urgent. He also noted that the healthcare provider had just completed a health-needs assessment to examine whether extra resource was required.

Emergency response

75. When staff found Mr Rush in his cell on 7 April, they appropriately radioed a code blue medical emergency. Control room staff called an ambulance quickly and there was no delay in nurses and other staff attending.

76. Nurses made a collective decision to attempt to resuscitate Mr Rush, although there were clear signs that he had been dead for some time. They noted that he was stiff, which is a sign of rigor mortis, and that there was mottling of the skin, a sign of hypostasis. Both of these indicate that death occurred some time previously.

77. We consider that it was not necessary to attempt to resuscitate Mr Rush. European Resuscitation Council Guidelines 2010 state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …". The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. Decisions should never be dictated by 'blanket' policies.

78. We understand that the natural inclination of healthcare staff is to begin emergency first aid by giving life support but attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We made a recommendation about this after a death at Ranby in September 2013. In response, the prison said that all nurses had been trained but it is apparent that, although nurses recognised signs of death, such as the presence of rigor mortis, they lacked the confidence to decide not to attempt resuscitation. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.

79. Two prisoners were very upset that Mr Rush's body was left in a body bag outside their cells for some hours after his death. An officer said that staff had to step over Mr Rush's body to give prisoners their meals. The prison's police liaison officer told the investigator that Mr Rush's body remained on the landing for some time because the police had to take photographs of his cell. She said that Mr Rush was in an opaque body bag and was not visible. We consider that this was disrespectful and upsetting for staff and prisoners. Mr Rush's body should have been moved back into his cell quickly and, if for some reason this was not possible, his body should have been appropriately screened. We make the following recommendation:

    The Governor should ensure that a deceased prisoner's body is treated with dignity and respect at all times.

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