Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Johanathan Rancijh a prisoner at HMP Bullingdon on 17 April 2018

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*

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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 I oversee can improve their work in the future.

Mr Johanathan Rancijh died on 17 April 2018, after being found hanging in his cell six days after arriving at HMP Bullingdon. He was 39 years old. I offer my condolences to Mr Rancijh's family and friends.

This was Mr Rancijh's first time in custody. He had no recorded history of physical or mental illness, was not prescribed any medication and had no recorded history of suicide or self-harm. However, I consider that Mr Rancijh should have been monitored under suicide and self-harm prevention procedures (known as ACCT) after he began to behave bizarrely and express paranoid ideas the night before he died.

I am also concerned that there was poor communication between prison and healthcare staff when Mr Rancijh was admitted to the healthcare unit shortly before he took his own life and that as a result he was not monitored during the night.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **March 2019**

Contents

Summary 1

The Investigation Process 4

Background Information 5

Key Events 7

Findings 12

Summary

Events

1. On 31 January 2018, Mr Rancijh was convicted at Oxford Crown Court of dangerous driving and bailed to appear at a later date for sentencing. On 12 April, Mr Rancijh appeared at court, was sentenced to ten months in custody and sent to HMP Bullingdon. He had not been in prison before. He came from Sri Lanka but understood English.

2. On Mr Rancijh's arrival at Bullingdon, staff assessed that he was not at risk of self-harm, and noted that he had no recorded history of physical or mental illness and was not prescribed any medication while in the community. He was allocated to a shared cell.

3. During the afternoon and early evening of 16 April, Mr Rancijh's cellmate complained about his bizarre behaviour. Staff observed Mr Rancijh with his jumper over his head, expressing paranoid ideas. At about 5.00pm, a prison paramedic saw him and assessed that he was having an anxiety attack, secondary to paranoid thoughts. At about 8.30pm, Mr Rancijh told an officer that people were trying to get into the cell. She made a request for an urgent mental health referral the next day.

4. At about 11.00pm, Mr Rancijh's cellmate pressed the cell bell and told an operational support officer (OSG) that he could not cope with Mr Rancijh's behaviour any more. He said Mr Rancijh had urinated in the cell, slapped him round the face and put a noose round his own neck.

5. The night orderly officer was called and moved Mr Rancijh to the healthcare unit because he thought he might have mental health issues. An OSG in the unit checked Mr Rancijh twice around midnight.

6. At 6.46am on 17 April, a member of staff found Mr Rancijh hanging in his cell. He had clearly been dead some time. An ambulance was called and staff began cardiopulmonary resuscitation. Paramedics arrived, but at 7.20am, they stopped resuscitation and pronounced Mr Rancijh dead.

Findings

Assessment of risk of suicide and self-harm

7. Mr Rancijh had no recorded history of mental illness or of suicide and self-harm. Staff made an appropriate assessment of Mr Rancijh's risk when he arrived at Bullingdon. However, we consider that staff should have monitored Mr Rancijh under suicide and self-harm prevention measures (known as ACCT) on the night of 16 April when he behaved bizarrely and they suspected he had mental health problems.

8. The evidence suggests that the OSG who was told that Mr Rancijh had tied a noose did not pass this key information on to the orderly officer.

9. We are also concerned that the orderly officer did not communicate the concerns about Mr Rancijh's mental health when Mr Rancijh was relocated in the healthcare unit and did not specify how often he wanted Mr Rancijh observed.

Clinical care

10. The clinical reviewer concluded that the healthcare provided to Mr Rancijh was not equivalent to that he could have expected to receive in the community.

11. We share the clinical reviewer's concern that the paramedic who saw Mr Rancijh did not make a detailed record of Mr Rancijh's behaviour to inform subsequent decision-making, and that Mr Rancijh was not assessed when he was admitted to the healthcare unit.

12. We are also very concerned that a nurse made a false entry in Mr Rancijh's medical records to say she had observed him sleeping through the night.

Resuscitation

13. We are concerned that staff tried to resuscitate Mr Rancijh despite there being clear signs that he had been dead for some time. This is undignified for the deceased and unnecessarily distressing for staff.

Previous deaths at HMP Bullingdon

14. This is the fourth death we have investigated at Bullingdon since 2016 where we found that staff poorly assessed the prisoner's risk of suicide and self-harm.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines and in particular that they:
    - open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent;
    - identify risk factors and assess a prisoner's risk based on their risk factors; and
    - share information to ensure effective communication between healthcare and prison staff when there are potential concerns about a prisoner's mental health.

- The Governor should share this report with the staff involved and arrange for a custodial manager (CM) and an occupational support grade (OSG) to receive refresher training in ACCT as a matter of urgency and let the Ombudsman know when this has been done.

- The Governor and Head of Healthcare should have a protocol in place which enables collaborative working and information sharing between discipline and healthcare staff.

- The Head of Healthcare should ensure that all clinical staff maintain accurate and comprehensive records in accordance with professional guidance.

- The Head of Healthcare should refer a nurse to the Nursing and Midwifery Council to consider undertaking a professional standards investigation to ensure competence to continue clinical practice.

- The Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

- The Prison Group Director for the South Central Group should provide the Ombudsman with an account of what he has done to ensure that meaningful action is taken at Bullingdon to address our recommendations.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Bullingdon informing them of the investigation and asking anyone with relevant information to contact him. No prisoners responded.

16. The investigator visited Bullingdon on 19 April. He obtained copies of relevant extracts from Mr Rancijh's prison and medical records.

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

18. The investigator interviewed nine members of staff at Bullingdon in May. Eight interviews were conducted jointly with the clinical reviewer.

19. We informed HM Coroner for Oxfordshire of the investigation. He gave us the results of the post-mortem examination and toxicology results and we have sent the coroner a copy of this report.

20. We contacted Mr Rancijh's wife through her lawyer to explain the investigation and to ask whether there were any matters she wanted the investigation to consider. Mr Rancijh's wife said her husband had phoned her. She wanted to know why he had moved cells and how he had been found. Mr Rancijh's wife received a copy of the initial report through her lawyer. They did not make any further comments.

Background Information

HMP Bullingdon

21. HMP Bullingdon is a training and local prison, serving the courts of Oxfordshire and Berkshire. It holds up to 1,114 men. Care UK is the healthcare provider. Cotswold Medicare Ltd provides general practitioner services. South Staffordshire and Shropshire NHS Foundation Trust provide care for those with severe and enduring mental illness and secondary mental health services. There is 24-hour healthcare and a 21-bed inpatient healthcare unit for prisoners with complex physical, mental health and social care needs.

HM Inspectorate of Prisons

22. The most recent inspection of Bullingdon by HM Inspectorate of Prisons (HMIP) took place in May 2017. Inspectors reported that Bullingdon was not safe enough. Assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide or self-harm was found to be weak and disorganised. Most staff did not have up-to-date ACCT training.

23. Inspectors found that while new arrivals were asked about thoughts of suicide and self-harm, there was no structured assessment of risk factors. This was of particular concern because recent investigations by the PPO following three self-inflicted deaths in custody had highlighted weaknesses in identifying risk on arrival. There was an action plan addressing recommendations from the PPO following these self-inflicted deaths, and some actions had been implemented. However, some crucial ones had not.

24. Inspectors found staffing vacancies in primary healthcare had resulted in the regular use of agency nurses, which caused considerable challenges in promoting a positive culture. Inspectors identified the inpatient unit as a serious area of concern. There was a regular lack of prison staff to unlock prisoners, which meant that, as health services staff did not have their own cell keys, access to prisoners was sometimes delayed.

Independent Monitoring Board

25. 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 most recent annual report for the year to 30 June 2018, the Board was concerned about the quality of ACCT records and procedures despite 282 staff having been trained in the ACCT process during the reporting year. The Board were also concerned about the level of provision for prisoners with mental health issues.

Previous deaths at HMP Bullingdon

26. Mr Rancijh was the eighth prisoner to take his own life at HMP Bullingdon since 2015. We have previously identified the importance of properly assessing a prisoner's risk of suicide and self-harm and having a clearly defined process for allocating cells in healthcare and responsibility for assessment.

Assessment, Care in Custody and Teamwork (ACCT)

27. 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. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held. As part of the process, a caremap (a 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. 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, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

28. On 31 January 2018, Mr Johanathan Rancijh, a Sri Lankan national, was convicted of dangerous driving and driving with excess alcohol. He was bailed to appear at a later date for sentencing. On 12 April, Mr Rancijh was sentenced to 10 months in custody. He was sent to HMP Bullingdon.

29. On his arrival at Bullingdon, a nurse saw Mr Rancijh in reception. She recorded that Mr Rancijh said that this was his first time in prison, that he had no health problems or disability and that he was not prescribed any medication. She noted that Mr Rancijh engaged well, an interpreter was not needed, his mood was stable, his speech was normal in tone and volume and he denied any thoughts of self-harm or suicide. She assessed there were no issues about Mr Rancijh occupying either a single or double cell or undertaking any work.

30. An officer saw Mr Rancijh as part of the induction process. Mr Rancijh told the officer about his offence, his family and his desire to be moved to a prison closer to his family. He said he had never tried to harm himself and had no thoughts of self-harm or suicide. The officer recorded that Mr Rancijh had made a phone call and had been issued with a pinphone card. Mr Rancijh was allocated a double cell, sharing with another prisoner.

31. The officer said that he was with Mr Rancijh for about 35 to 40 minutes. He said Mr Rancijh was able to communicate in English and he was focused on being transferred to a prison closer to his family in Birmingham. He said Mr Rancijh gave no indication that he was at risk of self-harm.

32. On 13 April, a nurse saw Mr Rancijh for a second healthscreen assessment. The nurse recorded that Mr Rancijh's mood appeared stable, and that he engaged well during the assessment and denied any thoughts of self-harm or suicide.

33. The nurse told the investigator that on both occasions that she saw Mr Rancijh she had no concerns that he was at risk of self-harm and he had no physical or mental health issues. His first language was Tamil but he was able to communicate in English. She said she asked Mr Rancijh whether he wanted an interpreter but he declined. He said he had lived in the UK for a number of years and was able to speak and understand English.

34. Prison records show that Mr Rancijh called his wife on 13 and 14 April. The calls were not monitored by prison staff. Mr Rancijh and his wife spoke in Tamil, their first language. Mr Rancijh's wife told the investigator that he asked about his children, discussed family issues and wanted to move to a prison closer to home. He also said he shared a cell with a prisoner who smelt of 'weed' (cannabis). Mr Rancijh's wife said he gave no indication he had any thoughts of suicide or self-harm.

35. Mr Rancijh's cellmate, told the investigator that, although Mr Rancijh's behaviour was fine in front of other people, when they were in the cell Mr Rancijh was "jittery and shaky" and could not sleep at night. He said his behaviour got steadily worse in the days before his death. He said Mr Rancijh did speak English, but he spoke in his own language at times.

Events of 16/17 April

36. On 16 April, during the afternoon and into the early evening, staff became concerned that Mr Rancijh's behaviour was very erratic and bizarre.

37. A Custodial Manager (CM) was the orderly officer that evening. He recorded in Mr Rancijh's prison computer record that wing staff had requested medical assistance at 5.00pm because Mr Rancijh was acting erratically and was hiding in the toilet area of his cell with his jumper over his head.

38. An on-site paramedic, responded and saw Mr Rancijh in his cell. He recorded in Mr Rancijh's medical notes that he spoke very fast, expressing paranoid ideas, his blood pressure was normal but his pulse was high. He recorded that there was no smell of any intoxicants. His assessment was that Mr Rancijh had had an anxiety attack "secondary to paranoid thoughts".

39. The on-site paramedic told the investigator that Mr Rancijh was talking about the police watching him. As there was no indication that Mr Rancijh had used any illicit drugs or alcohol, he assessed that Mr Rancijh's high pulse was due to an anxiety attack. He said Mr Rancijh understood and spoke English.

40. A CM told the investigator that he went to see what was happening. He said he did not speak to Mr Rancijh himself and that the on-site paramedic told him he had had a panic attack but had now calmed down.

41. At 8.30pm, an officer responded to the cell bell pressed in Mr Rancijh's cell. The officer told the investigator she spoke to Mr Rancijh who said he believed people were coming into his cell. She said it was hard to understand him because of his poor English, but he seemed to be having some kind of anxiety attack.

42. She rang a CM who told her to ask the member of healthcare staff who was on the wing at the time to see Mr Rancijh. However, they left before she could do so and the CM told her to make a mental health referral instead.

43. The officer said she tried to calm Mr Rancijh down and reassure him that no one was attempting to get into his cell. She offered Mr Rancijh the opportunity to move cells but he declined. She advised him to try to get some sleep. After doing a handover to the night operational support officer (OSG), she completed an urgent referral to the mental health team requesting that they assess Mr Rancijh the next day.

44. The CM said that another CM, who was the night orderly officer, was there when he was speaking to the officer and that he told him what had happened when he handed over to him.

45. The cellmate told the investigator that, over the next few hours, Mr Rancijh woke him up by slapping him around the head, and urinated over himself, on the floor and on his bed. He said Mr Rancijh shouted about his family and that someone was coming in through the door. He had a noose around his neck which he untied and removed. At this point he pressed the cell bell. He said he insisted that Mr Rancijh be moved as he could not tolerate his behaviour anymore.

46. At 11.00pm, an OSG responded to the cell bell. She recorded in the wing observation book that Mr Rancijh had made a noose, urinated both on the floor and over himself, and had woken his cellmate by slapping his face. She requested assistance from the night orderly officer, and told him that the cellmate was refusing to share a cell with Mr Rancijh.

47. The OSG told the investigator that she did not believe that Mr Rancijh had made a noose as she thought the cellmate may have made this up to get Mr Rancijh moved out of the cell. She said did not, therefore, think it was necessary to open an ACCT document. She said she told a CM that the cellmate had said that Mr Rancijh had made a noose.

48. The CM told the investigator that Mr Rancijh was not making sense and was saying that people were coming through the window and door and that he was banging on the window saying, "They are there."

49. The CM said that he had initially planned to move Mr Rancijh into an empty cell on the wing. However, once he spoke to Mr Rancijh he became concerned that he might have mental health issues which would make him vulnerable to bullying on the wing. He, therefore, took the decision to move him to healthcare "for observations" as he was concerned for his welfare. He said qualified staff could monitor him in the healthcare unit and he could be assessed by the mental health team the next day. He told the investigator that the OSG had not told him that Mr Rancijh had made a noose. He said that if he had been made aware of this, he would have immediately opened an ACCT document.

50. The OSG said that she called healthcare and spoke to a nurse to tell her that a CM was bringing Mr Rancijh to healthcare for his wellbeing. She said she did not pass on any details of Mr Rancijh's behaviour.

51. The CM said that he and another officer walked Mr Rancijh to the healthcare unit. He said that Mr Rancijh seemed very happy to be going to 'hospital' and he was laughing and joking and in high spirits on the way there. When they got to healthcare, the CM said that he was taken aback when Mr Rancijh suddenly dropped to his knees as if in prayer, saying, "Thank you, thank you." He said Mr Rancijh seemed very happy.

52. The CM said he spoke to the duty nurse and told her that Mr Rancijh was there because he thought he had mental health issues and he hoped he would see the mental health in-reach team more quickly if he was in the healthcare unit. He said the nurse was unhappy about admitting Mr Rancijh and said that he could have been supervised on the wing. She initially refused to admit him, but he told her "I'm in charge of the jail, I decide where he goes."

53. The CM said that on a day shift there would probably have been an expectation that he pre-warned healthcare staff before arriving at the healthcare unit with a prisoner, but at night his main concern was to get Mr Rancijh sorted as soon as possible. He told the investigator that the relationship between prison and healthcare staff was "a bit strained" at times.

54. The CM said that he also spoke to the OSG in the healthcare unit, and asked him to check on Mr Rancijh "sporadically" and make sure he was calming down. At

interview he said that he meant Mr Rancijh should be checked “a couple of times during the shift”.

55. The nurse said that an OSG had not contacted her and that she had not received any advance notice of Mr Rancijh’s arrival. She said the other nurse on duty that night had received a phone call asking how many empty cells they had. She was surprised when the CM arrived with Mr Rancijh and asked him for a private word. She recorded that the CM told her that Mr Rancijh had been displaying paranoid ideas and was being admitted to healthcare. She said by the time they had finished speaking, Mr Rancijh had been placed in a cell and the officers left.

56. She recorded in Mr Rancijh’s medical notes that she saw Mr Rancijh who appeared calm and spoke in a normal voice. He asked for a drink of water and asked her to turn off the light as he wanted to go to sleep. He also asked her not to tell people he was there.

57. At interview the nurse said that she did not carry out a thorough assessment of Mr Rancijh because, she understood from the CM that he was being located in healthcare because his cellmate had said he was paranoid and did not want to spend the night with him, and there were no single cells available on the wing. She said she, therefore, regarded him as a “lodger” in the healthcare unit, rather than someone who had healthcare issues. She said she had not been told about his unusual behaviour on the wing or that he had tied a noose and would have responded very differently if she had known. She said that she had read his electronic medical notes and had seen his initial health screens and the on-site paramedic note earlier that night.

58. CCTV footage of healthcare shows that an OSG checked on Mr Rancijh in his cell at 11.53pm and again at 00.18am on 17 April. No further checks were made on Mr Rancijh until 6.45am.

59. At 6.31am, the nurse recorded in Mr Rancijh’s medical record that she had observed Mr Rancijh, that he had slept well through the night and there were no issues or concerns raised. She admitted when interviewed, that she had not, in fact, observed Mr Rancijh during the night and had made the entry based on the assumption that no concerns had been raised.

60. At 6.46am, CCTV footage shows that an OSG arrived at Mr Rancijh’s cell to conduct the early morning roll check. He opened the observation panel and saw Mr Rancijh hanging from the window bars in his cell by a ligature made from bedding. He immediately radioed a code blue emergency, which indicates a prisoner is not breathing or having difficulty breathing, entered the cell and cut the ligature. Two nurses followed the OSG into the cell.

61. Clear signs of rigor mortis were present indicating that Mr Rancijh had been dead for some hours. The nurses began cardiopulmonary resuscitation (CPR) and used an automated external defibrillator, which administers electrical shocks to restore a normal rhythm to the heart if any is found. The defibrillator found no shockable rhythm.

62. The control room log shows the code blue was called over the radio at 6.46am and an ambulance was called at 6.48am. South Central Ambulance Service records say that the 999 call was received at 6.47am.

63. Paramedics arrived at 6.56am and took over Mr Rancijh's care. Following a period of treatment and assessment, at 7.20am, the paramedics pronounced Mr Rancijh dead.

Contact with Mr Rancijh's family

64. Mr Rancijh's next of kin was his wife. Two of Bullingdon's family liaison officers (FLO), visited Mr Rancijh's wife at the family's home in Birmingham at 10.50am on 17 April. They informed her of Mr Rancijh's death and offered their condolences and support. In the days that followed, Bullingdon maintained contact with Mr Rancijh's wife and, in line with Prison Service guidance, the prison contributed to the costs of the funeral.

Support for prisoners and staff

65. The head of business assurance, held a debrief for staff involved in the emergency response, including healthcare staff, to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.

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

Post-mortem report

67. A post-mortem examination found that the cause of Mr Rancijh's death was suspension (hanging). Toxicology results showed that Mr Rancijh was not under the influence of alcohol or any illicit drugs at the time of his death.

Findings

Assessment of risk of suicide and self-harm

68. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include a prisoner's first time in custody, recall to custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse, and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.

69. When Mr Rancijh arrived at Bullingdon, he had some risk factors for suicide and self-harm in that he had just been sentenced and this was his first time in prison. However, he appeared calm, engaged well, there was no warning form from court or escort staff, and he had no recorded physical or mental health issues and no recorded history of self-harm.

70. In these circumstances we think it was reasonable for staff to conclude that he was not at risk of suicide or self-harm when he arrived. However, we consider that an ACCT should have been opened in the light of Mr Rancijh's behaviour on the night of 16 April.

71. Staff first became aware that Mr Rancijh was acting oddly at about 5.00pm and were sufficiently concerned to call for healthcare assistance. The on-site paramedic, the paramedic who responded, noted that Mr Rancijh was speaking very fast and expressing paranoid thoughts. He concluded he was having an anxiety attack, "secondary to paranoid thoughts".

72. When an officer spoke to Mr Rancijh at 8.30pm, she noted that he was talking about people coming into his cell and made an urgent referral to the mental health team requesting that they assess Mr Rancijh the next day.

73. When a CM saw Mr Rancijh at about 11.00pm, he thought he might have mental health issues because he was talking about people or things trying to come through the door and being on the walls, and he therefore took him to the healthcare unit so he could be monitored and assessed by the mental health team the following morning.

74. It is, therefore, clear that the staff who saw Mr Rancijh that night thought he had mental health issues. By the time a CM saw Mr Rancijh he had been acting bizarrely for six hours and continued to act oddly when he was escorted to the healthcare unit. The CM recorded at the time that he had relocated Mr Rancijh to the healthcare unit "for observations" because he was concerned for his welfare. In these circumstances, and given that Mr Rancijh was in the early days of his first prison sentence, we consider that the CM should have opened an ACCT and that it was an error of judgement not to have done so.

75. We are also concerned that the CM did not communicate his concerns about Mr Rancijh's mental health clearly to either an OSG or the nurse, or specify what level of observations he thought necessary. As a result, Mr Rancijh was not observed after 00.18am.

76. We are also very concerned that no action was taken when the cellmate said Mr Rancijh had put a noose round his neck. Although an OSG recorded this in Mr Rancijh's electronic prison record, she told the investigator that she did not believe the cellmate was telling the truth. Whether she believed him or not, she should have acted on this information and either opened an ACCT herself or told the CM. She says she did tell him. The CM says she did not tell him. It seems extremely unlikely, given his concerns about Mr Rancijh's mental health, that CM would not have opened an ACCT if he had known about the noose. We also note that he did not mention the noose to an OSG or the nurse when he took Mr Rancijh to the healthcare unit and it seems very unlikely that he would have omitted this important information if he had known about it.

77. We make the following recommendations:

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

- **open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent;**
- **identify risk factors and assess a prisoner's risk based on their risk factors; and**
- **share information to ensure effective communication between healthcare and prison staff when there are potential concerns about a prisoner's mental health.**

The Governor should share this report with the staff involved and arrange for the CM and OSG to refresher training in ACCT as a matter of urgency and let the Ombudsman know when this has been done.

Clinical care

78. The clinical reviewer concluded that the healthcare provided to Mr Rancijh was not equivalent to that he could have expected to receive in the community.

79. We share the clinical reviewer's concern that the on-site paramedic, did not record a full account of how Mr Rancijh was behaving in his electronic medical record. As a result, there was insufficient information in Mr Rancijh's medical records to indicate what had led to his diagnosis of "anxiety secondary to paranoid thoughts". This would have assisted later assessment and decision-making by other healthcare staff. We make the following recommendation:

The Head of Healthcare should ensure that all clinical staff maintain accurate and comprehensive records in accordance with professional guidance.

80. The clinical reviewer noted that the established procedures for admission to the healthcare unit were not followed in Mr Rancijh's case. She was, however, satisfied that Mr Rancijh met the criteria to be admitted to the unit for an initial period of assessment.

81. We are very concerned that the CM did not give the nurse a full account of Mr Rancijh's bizarre behaviour and left her with the impression that Mr Rancijh had been brought to the healthcare unit because he did not get on with his cellmate and there was nowhere else for him on the wing. (We note that this was not the case as there was an empty cell on the wing.) As a result, the nurse said she regarded him as "a lodger" rather than as someone with healthcare needs and did not consider it necessary to assess him or monitor him. We share the clinical reviewer's concern that a CM's failure to communicate properly with the nurse meant that Mr Rancijh was not monitored after he arrived in healthcare.

82. We note, however, that the nurse was aware that Mr Rancijh had been expressing paranoid ideas, that she had read the on-site paramedic's, earlier note, and that she noted at the time that Mr Rancijh asked her not to tell anyone where he was. We consider that this should have prompted her to assess him.

83. We cannot say whether the poor communication between prison and healthcare staff on this occasion was an isolated incident or whether there was a poor relationship between prison staff and healthcare staff generally, but this is something the Governor and Head of Healthcare will need to reflect on. We make the following recommendation:

    The Governor and Head of Healthcare should have a protocol in place which enables collaborative working and information sharing between discipline and healthcare staff.

84. Shortly before Mr Rancijh was found hanged, the nurse made an entry in Mr Rancijh's medical records to say she had observed him sleeping through the night and there were no concerns. As Mr Rancijh had been dead for some hours when he was found, it is clear that he had not been observed during the night or he would have been found earlier. When interviewed, the nurse said she had not observed Mr Rancijh during the night and had made the entry based on her assumption that there had been no concerns because no cell bells had been used during the night. We are very concerned that the nurse made a false entry, which is unsafe practice. We make the following recommendation:

    The Head of Healthcare should refer the nurse to the Nursing and Midwifery Council to consider undertaking a professional standards investigation to ensure competence to continue clinical practice.

Resuscitation

85. Two nurses started CPR when they entered Mr Rancijh's cell even though a nurse said that rigor mortis was clearly evident, indicating that Mr Rancijh had been dead for some time.

86. European Resuscitation Council (ERC) Guidelines for Resuscitation 2015, Section 11 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.

87. HM Prisons and Probation Service, the Royal College of Nursing and the Royal College of General Practitioners jointly issued guidance on when not to perform resuscitation (September 2016). The guidance states that resuscitation must be started on all patients who are found not breathing and/or pulseless unless certain conditions exist, in particular rigor mortis.

88. We share the clinical reviewer's concern that the nurses attempted CPR even though rigor mortis was present and it was clear that Mr Rancijh was dead. Attempting CPR when someone is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

Previous PPO recommendations and prison actions

89. In our investigations into the deaths of Mr James Maughan on 11 July 2016, Mr John Wright on 15 December 2017 and Mr Daniel Davey on 12 January 2018, at HMP Bullingdon, we found that staff poorly assessed the prisoner's risk of suicide and self-harm and as a result no appropriate actions were taken. We made recommendations to address this and the prison said they would issue notices to remind staff of their responsibilities and provide further training. The similarities between these deaths and that of Mr Rancijh suggest that more sustained and effective action is required from the prison to address our concerns.

90. In light of the troubling similarities between these investigations, we make the following recommendation:

The Prison Group Director for the South Central Group should provide the Ombudsman with an account of what he has done to ensure that meaningful action is taken to address our recommendations.

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