Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terry Lunnon a prisoner at HMP Ranby on 19 October 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Terry Lunnon died in the segregation unit at HMP Ranby on 19 October 2017 as a result of a laceration of the ulnar artery in his wrist and use of Psychoactive Substances (PS). He was 38 years old. I offer my condolences to his family and friends.

Mr Lunnon had a history of substance misuse. He had been moved to the segregation unit around three hours before staff discovered that he had self-harmed. Although he had self-harmed in the past, he had not done so for 16 months, and I am satisfied that he gave staff no indication that he was at risk of suicide or self-harm before his death.

The post-mortem showed that Mr Lunnon had used a Psychoactive Substance (PS) before his death. It is possible that this contributed to his decision to self-harm. It is also possible that the PS affected his circulation and so resulted in a greater degree of blood loss than might otherwise have been the case.

It is troubling that throughout his time in prison, Mr Lunnon appears to have been able to access and use illicit drugs, including the PS which may have played a role in his death.

It is unacceptable that it took staff 15 minutes to respond when Mr Lunnon rang his cell bell in the segregation unit. By the time he was discovered, Mr Lunnon had lost a significant amount of blood. While we cannot say whether the outcome would have been different for him, his chance of survival might have improved if staff had responded sooner to his cell bell. I am also concerned that staff failed to call an ambulance immediately.

HMPPS have rejected the recommendation we made that staff should respond to all cell bells within five minutes and have provided a full explanation in its action plan. Within this response, HMPPS have said that they are fully committed to ensuring that the response to emergency cell bells is prompt and that calls made by prisoners' subject to the ACCT process and in the segregation, are prioritised and answered within five minutes.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman May 2019

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Summary

Events

1. On 25 April 2016, Mr Terry Lunnon was recalled to HMP Woodhill after he broke the conditions of his probation licence. When he arrived at Woodhill, staff recorded that he had a history of attempted suicide, self-harm and substance misuse, and had depression. Healthcare staff prescribed him methadone detoxification medication, an antidepressant and pain killers.

2. On 15 June 2016, Mr Lunnon was transferred to HMP Ranby. Healthcare staff continued to prescribe his medication. From 22 June, he was monitored for six days under suicide and self-harm prevention procedures, known as ACCT, after he made cuts to his wrist and made a ligature.

3. Throughout his time at Ranby, Mr Lunnon used illicit drugs, including PS.

4. He received a high degree of support from the mental health team but had been discharged from their care two days before his death because he repeatedly failed to attend appointments.

5. In August 2017, Mr Lunnon was taken to hospital after injuring his chest with a home-made knife. He was adamant that this had been an accident.

6. At about 6.30pm on 19 October 2017, Mr Lunnon was taken to the segregation unit on suspicion of involvement in an assault on staff. Shortly afterwards, he was seen by prison staff and by healthcare staff, neither of whom had any concerns about him. He subsequently pressed his cell bell twice and asked for his medication but was told he would not be able to have it until the following day.

7. At 9.15pm, Mr Lunnon rang his cell bell again. Staff did not respond to it until 9.31pm when they found that Mr Lunnon had self-harmed by puncturing an artery in his hand. This had caused severe blood loss. Staff and paramedics attended and administered first aid. He was taken to hospital, where he died at 11.40pm.

Findings

Mr Lunnon's risk of suicide and self-harm

8. We are satisfied that it was reasonable for staff at Ranby to conclude that Mr Lunnon was not at risk of suicide or self-harm when he was located in the segregation unit a few hours before his death.

Response to Mr Lunnon's cell bell

9. The delay in responding to Mr Lunnon's cell bell before he was discovered bleeding heavily was unacceptable. Cell bells should be answered promptly, and HM Inspectorate of Prisons have an expectation, which we share, that they should be answered within five minutes. This is an issue of acute concern given Mr Lunnon was held in the segregation unit. If staff had responded to Mr Lunnon's cell bell promptly, his life might have been saved.

10. HMPPS have rejected the recommendation we made that staff should respond to all cell bells within five minutes and have provided a full explanation in its action plan.

Psychoactive substances

11. Despite Ranby's substance misuse strategy, which aims to reduce the supply and demand of drugs, there is evidence that Mr Lunnon continued to gain access to and abuse illicit substances. He had taken PS prior to his death and it is possible that this influenced his decision to self-harm.

Emergency response

12. There was a delay in the officer entering Mr Lunnon's cell and calling an emergency code red. This meant that an ambulance was not called immediately.

Post-mortem examination

13. Mr Lunnon died as a result of a laceration of the ulnar artery (caused by a screw) and use of PS. The post-mortem report shows that the injury Mr Lunnon made to his left wrist would not normally have been sufficient to cause the significant bleeding which caused his death. The clinical reviewer found that the combination of the delay in receiving prompt treatment and the presence of PS in Mr Lunnon's system might together have contributed to his death.

Recommendations

- **The Governor should ensure that staff check on prisoners' wellbeing at roll checks and that there are no immediate issues that need attention.**
- **The Governor should ensure that staff respond to all cell bells within five minutes.**
- **The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies.**
- **The Governor and Head of Healthcare should ensure that staff understand how to implement the strategy to reduce the supply of and demand for substances, including completing security intelligence reports and searching cells, prisoners, staff and visitors both at random and based on intelligence.**
- **The Head of Healthcare should ensure that the Head of IDTS and the Substance Misuse GP review all patients on long-term opiate substitute treatment at three monthly intervals.**
- **The Head of Healthcare and the prison GPs, should review the process for repeat prescriptions to ensure that all prisoners on regular medication are appropriately reviewed.**

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Ranby informing them of the investigation and asking anyone with relevant information to contact him. No one came forward.

15. The investigator obtained copies of relevant extracts from Mr Lunnon's prison and medical records.

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

17. The investigator interviewed eleven members of staff and one prisoner at HMP Ranby in November and December 2017, some jointly with the clinical reviewer.

18. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation who sent us the results of the post-mortem examination. We gave the Coroner a copy of this report.

19. One of the Ombudsman's family liaison officers, contacted Mr Lunnon's mother to explain the investigation. Mr Lunnon's mother asked for the investigation to explain fully the circumstances leading up to and including Mr Lunnon's death.

20. Mr Lunnon's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Ranby

21. HMP Ranby is a Category C prison for prisoners who do not require a high level of security but are not ready for open conditions. It holds over 1,000 men. Nottinghamshire Healthcare Trust provides primary healthcare services. Healthcare services are provided from 7.45am to 7.45pm on weekdays and between 8.30am to 6.00pm on weekends.

Her Majesty's Inspectorate of Prisons

22. The most recent inspection of Ranby was in September 2015. Inspectors found that safety remained a significant concern, fuelled by a surge in the availability of NPS which meant that healthcare services were at risk of being seriously overwhelmed. However, inspectors noted that healthcare services were reasonably good and continuing to develop. The report noted some concerns about staff not responding to cell bells within five minutes.

Independent Monitoring Board (IMB)

23. 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. The most recent IMB annual report for the year to March 2017 commended healthcare staff at Ranby for their continuing hard work and commitment to prisoners' wellbeing.

Previous deaths at HMP Ranby

24. Mr Lunnon was the first prisoner to take his life at Ranby since August 2015.

Segregation units

25. Segregation units are used to keep prisoners apart from other prisoners. This might be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Once a prisoner's health is assessed by a member of the healthcare team, an operational manager must authorise that the prisoner is fit for segregation.

Integrated Drug Treatment System (IDTS)

26. IDTS aims to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on early custody**,** improving the integration between clinical and drug counselling services, and reinforcing continuity of care from the community into prison, between prisons, and on release into the community.

Psychoactive Substances (PS)

27. PS, previously known as 'legal highs' and New Psychoactive Substances (NPS), are a major problem across the prison estate. They are difficult to detect and can

affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

28. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

29. HM Prisons and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continues to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

30. Mr Terry Lunnon had spent most of his adult life in and out of prison. He had a long history of substance misuse (heroin and other illicit drugs) and mental health problems.

31. In June 2014, he was sentenced to three years and eight months for robbery and assault. He was released on licence from HMP Highdown on 21 April 2016. Three days later, the police arrested him for causing a disturbance while under the influence of PS. On 25 April 2016, Mr Lunnon appeared in court and was recalled to prison.

32. Mr Lunnon arrived at HMP Woodhill with his person escort record and a suicide and self-harm warning form. Both documents noted that Mr Lunnon had self-harmed in 2011 when he had attempted to slit his wrist and throw himself in front of a car. He also had depression. During his reception screening, an officer noted that Mr Lunnon was detoxifying from illicit drugs, that he had been recalled, and that he had no thoughts of suicide or self-harm.

HMP Ranby

33. On 15 June 2016, Mr Lunnon was transferred to HMP Ranby. During his initial health screen, Mr Lunnon told the nurse that he had paranoid schizophrenia and a substance misuse problem. He said that he took mirtazapine (an antidepressant), methadone (an opiate substitute treatment) and pregabalin (commonly used for pain and anxiety). Mr Lunnon said that he had no current thoughts of suicide or self-harm. The nurse referred him to the mental health and substance misuse teams. (Although Mr Lunnon told the nurse that he had schizophrenia, there is no evidence in his medical records that this had been diagnosed and he did not exhibit any of the signs or symptoms of psychosis or thought disorder during his time at Ranby.) After Mr Lunnon's initial induction, he lived on Houseblock 2.

34. On 21 June, a substance misuse worker assessed Mr Lunnon. She considered that Mr Lunnon had a good knowledge of drug tolerance levels, signs of overdose and general drug misuse. He said that he had taken an overdose of prescribed medication which had resulted in his return to prison but he insisted that it was not deliberate. He said that he had stopped taking illicit drugs, including PS. She tried to explain some drug treatment options to Mr Lunnon. She said that he was despondent and that he said he felt "institutionalised". Nonetheless, she agreed that the Integrated Drug Treatment System (IDTS) team would support Mr Lunnon through monthly psychosocial interventions.

35. In the early hours of the morning on 22 June, staff found Mr Lunnon slumped in his cell after he had pressed his cell bell. Mr Lunnon had self-harmed by cutting his wrists - this did not lead to significant blood loss. He had also tried to hang himself, leaving a ligature mark around his neck. Staff found multiple ligatures in his cell and a suicide note. Mr Lunnon appeared to be under the influence of an illicit substance. He said that after his unsuccessful attempts to take his life, he pressed his bell in order to get the attention of prison staff. Staff started suicide and self-harm procedures, known as ACCT, placed Mr Lunnon under constant

observation and referred him to the mental health team. He was treated in hospital overnight.

36. Staff completed three multidisciplinary ACCT reviews over the next week, which noted a marked improvement in Mr Lunnon's mood and that he no longer had any thoughts of suicide or self-harm. A mental health nurse attended the ACCT reviews and supported Mr Lunnon during and after this period. He told the investigator that Mr Lunnon had a personality disorder, anxiety and low mood and was taking medication for this. Staff stopped ACCT procedures on 28 June. (There is no evidence that Mr Lunnon had been diagnosed with personality disorder.)

37. On 29 June, a prison GP with special interest in substance misuse, completed a substance misuse assessment with Mr Lunnon and had no concerns. Mr Lunnon told the doctor that he was happy with his current dose of methadone and had not used any illicit drugs.

38. A nurse continued to support Mr Lunnon at regular mental health reviews because of the serious nature of his self-harm. He used therapeutic techniques to try to help Mr Lunnon manage his anxiety and cope with the stress of being in prison. However, Mr Lunnon struggled to follow any psychological management treatment plans and often appeared to be focused on obtaining sleeping tablets. The healthcare team prescribed zopiclone, a sleeping tablet, three times a week for several months during his imprisonment. The nurse noted that Mr Lunnon did not display any symptoms of having an acute mental health problem.

39. On 7 September, a prison GP completed a substance misuse review with Mr Lunnon. They agreed to start reducing his methadone prescription. (By the time Mr Lunnon died, he had reduced his methadone dose from 40ml to 24 ml.) He did not see Mr Lunnon again although other members of the IDTS team reviewed him.

40. On 15 September, staff found Mr Lunnon under the influence of an illicit substance while he was working in a prison workshop. A nurse examined him and prison staff issued him with a warning. A substance misuse worker completed a substance misuse review and Mr Lunnon disclosed that he was using PS on a daily basis. She encouraged him to engage in drug misuse services and to use the substance misuse support network. Mr Lunnon said that although he had reduced his intake of drugs, he did not intend to stop taking them. Although staff submit intelligence reports after every incident of reported illicit drug misuse, there is no evidence that staff searched Mr Lunnon's cell.

41. At a mental health review on 11 October, a nurse noted that Mr Lunnon had had a recent altercation with another prisoner. Mr Lunnon said that he had felt a recent increase in paranoia, potentially due to his recent use of PS. The nurse noted Mr Lunnon had no current thoughts of suicide or self-harm and that the mental health team would continue to support him.

42. Healthcare staff withheld Mr Lunnon's medication on the afternoon of 5 November because he appeared to be under the influence of an unknown substance. Mr Lunnon was unsteady on his feet, had red puffy eyes, slurred speech and was drowsy. He denied taking any illicit substances.

43. On 10 November, a substance misuse worker saw Mr Lunnon after staff suspected that that he had taken an illicit substance. Mr Lunnon admitted talking NPS. Although she advised him about the potential effects of such drugs on his mental health, Mr Lunnon showed little motivation to stop taking illicit drugs or to take part in any psychosocial interventions.

2017

44. On 4 January 2017, Mr Lunnon tested positive for PS, and staff reduced his Incentive and Earned Privilege level to basic. This meant that Mr Lunnon's allowance of cash to buy canteen, association time, earnings and visits were reduced and his in-cell television was removed.

45. On 5 January, a substance misuse worker completed a substance misuse review with Mr Lunnon. He told her that he needed help with his drug misuse. He said that he had not taken any PS in the past week and although he was pleased about this, it had caused him to have feelings of rage, frustration and anxiety. She suggested acupuncture but Mr Lunnon declined. He wanted medication and believed this was his only option. He admitted that he had illicitly obtained and used quetiapine (an antipsychotic) over the last couple of days, which he said had helped him. She reminded Mr Lunnon of the risk of using illicitly obtained medication and told him to discuss this further at his next appointment with a mental health nurse.

46. The next day, a nurse completed a mental health review. Mr Lunnon told him that he had been taking PS and this had made him irritable. Healthcare staff had recently stopped his prescription of zopiclone and he asked for it to be re-prescribed to help him sleep better. Over the next few days, the nurse discussed Mr Lunnon's situation with a registered general nurse prescriber, and agreed to reinstate the medication.

47. The ITDS team had continued to offer Mr Lunnon support. In February 2017, mental health staff gave Mr Lunnon the opportunity to have counselling sessions with the prison's dual diagnosis nurse for drug and mental health problems. Mr Lunnon declined and said that he preferred to remain under the care of the mental healthcare team as they could support his sleeping and anxiety problems.

48. From April onwards, Mr Lunnon chose not to engage with the offender management unit to discuss his sentence planning. This meant that prison and probation staff were unlikely to be able to consider him for early release from prison.

49. On 25 July, a prison GP recorded that Mr Lunnon had failed to attend a number of mental health review appointments. (Mr Lunnon had missed four appointments between April and July.) Consequently, the doctor instructed healthcare staff to stop his prescription of zopiclone unless he attended his next review.

50. On 28 July, a nurse saw Mr Lunnon and completed a mental health review. He noted no concerns about Mr Lunnon's mental health and confirmed that the doctor could continue to prescribe him zopiclone.

August 2017

51. On 19 August, an officer responded to Mr Lunnon's cell bell and found him with a homemade shank (knife) protruding from his chest. Mr Lunnon told staff that he had fallen on an instrument he used for cutting rocks to find fossils, which was a hobby. The chest injury narrowly missed his heart and major arteries. He was adamant that the incident was an accident and that he had not intended to harm himself. Staff immediately transferred Mr Lunnon to hospital for treatment.

52. On 20 August, the hospital discharged Mr Lunnon with antibiotic medication. As a precautionary measure, a nurse emailed the mental health team to ask them to review Mr Lunnon after the incident. Prison intelligence noted that a prisoner said he had seen Mr Lunnon acting strangely before the incident and had said that if he could not get hold of any PS, he would kill himself.

53. On 23 August, staff again spoke to Mr Lunnon about his recent admission to hospital. Mr Lunnon denied having any thoughts of suicide or self-harm and reiterated that the wound to his chest was an accident and not caused by him taking an illicit substance.

54. A mental health nurse tried to see Mr Lunnon on the morning of 29 August but he was at work in the prison workshop. Staff on the wing told the nurse that they had no concerns about Mr Lunnon's mental health. Later that afternoon, a nurse saw Mr Lunnon to clean and re-dress the wound to his chest. Mr Lunnon appeared okay and again stated that the incident was an accident and that he had not intended to harm himself.

September 2017

55. On 11 September, while working in the prison workshop, staff believed Mr Lunnon was under the influence of an illicit substance. A nurse examined him in the healthcare unit and recorded that he appeared intoxicated and was likely to have taken a PS. She referred him to the substance misuse team for support. Prison staff returned Mr Lunnon to his cell as he was deemed unfit to operate machinery in the workshop.

56. A substance misuse worker assessed Mr Lunnon the next day. Mr Lunnon said that he had not taken any illicit substances and prison staff had simply misinterpreted his behaviour. He said that he was just tired. During the assessment, Ms Johnson had no concerns about Mr Lunnon and discussed with him the risks associated with taking any substances and non-prescribed medication.

57. Mr Lunnon failed to attend his mental health appointment on 29 September. A nurse recorded in his medical record that Mr Lunnon had a history of not attending appointments and in line with the mental health service's protocol, intended to write to Mr Lunnon to tell him that he would be discharged from the primary mental health service.

October 2017

58. On 16 October, Mr Lunnon attended the medication dispensing hatch. He showed a nurse a small scald on his left hand, which he said had been caused

accidentally when using his kettle. Another nurse dressed his wound and noted no concerns about Mr Lunnon's mental wellbeing.

59. On 17 October, a nurse wrote a letter to Mr Lunnon, discharging him from the mental health team's care because of his poor attendance at mental health appointments. A nurse noted in Mr Lunnon's medical record that the mental healthcare team's involvement in his care had been supportive in nature and he did not present with a mental illness. In addition, healthcare staff would continue to see him daily when he attended the medication dispensing hatch.

60. On 18 October, two prisoner officers prevented a prisoner from Houseblock 2, from retrieving a package in the houseblock's exercise yard. Another prisoner had thrown the package from an adjacent houseblock. A prisoner appeared to be intoxicated and while the officers tried to restrain him, a number of other prisoners assaulted them. Staff relocated the first prisoner to the segregation unit and placed him on report. In his police statement after Mr Lunnon's death, the prisoner said that Mr Lunnon was present during his altercation with staff. They were friends and he was aware that Mr Lunnon had accumulated debts on the houseblock because of his extensive use of PS.

61. The next day, because of the incident in the exercise yard, staff carried out a major security search operation on Houseblock 2. The search lasted all day and as all prisoners remained locked in their cells, all activities were cancelled. Healthcare staff were permitted to dispense the most needed medication to identified prisoners in the afternoon. A nurse confirmed that Mr Lunnon received his methadone and pregabalin medication. (Mr Lunnon was allowed to keep his other medication, mirtazapine and zopiclone, in his cell.)

62. Late in the day, security intelligence identified Mr Lunnon as one of the prisoners who were allegedly involved in the assault on staff the previous day. Mr Lunnon was segregated under Prison Rule 45, pending further investigation into the incident. One of the Heads of Residence, authorised Mr Lunnon's segregation.

63. CCTV footage shows that prison staff escorted Mr Lunnon to the segregation unit at 6.26pm, and then searched him. Two officers were on duty in the segregation unit at the time.

64. At 6.35pm, one of the Heads of Residence, and two officers visited Mr Lunnon in his cell. The Heads of Residence explained to Mr Lunnon why he was located in the segregation unit and said he would give him further information after staff searched his cell the next day. Mr Lunnon raised no concerns and did not display any signs of distress. He asked the Heads of Residence for a kettle and a television. The Heads of Residence told him that staff would give him some hot water but it was not possible to give him a television that day.

65. At 6.48pm, a nurse visited Mr Lunnon's cell, accompanied by two officers. She assessed that there was no medical reason why Mr Lunnon could not be segregated and described his mood as okay and very similar to previous occasions that she had had contact with him. Prisoners held in segregation are not allowed to keep their medication in their cell but instead staff dispense it to them. She amended Mr Lunnon's prescription (mirtazapine and zopiclone) so that he could not keep them in his cell. Mr Lunnon asked for his medication that

had been left in his cell on Houseblock 2. She told him that it was unlikely that staff would be able to retrieve it for him that evening. Mr Lunnon did not say whether he had taken his medication before he was moved to the segregation unit.

66. An officer recorded in the segregation unit logbook that he completed a roll check at 7.00pm and Mr Lunnon was okay. CCTV footage does not show that a roll check took place near Mr Lunnon's cell around that time.

67. Mr Lunnon pressed his cell bell at 7.34pm. When a cell bell is pressed, a light is activated outside the cell door and a buzzer activates on a control panel in the segregation unit's office. An officer responded to Mr Lunnon's cell bell within two minutes, opened his door observation panel and spoke to him. Mr Lunnon asked for his medication. The officer told Mr Lunnon that there were no healthcare staff on duty and he would have to wait until the next day.

68. An officer, who was the only officer on duty in the segregation unit overnight, started duty at 8.00pm and received a handover from two officers before their duty ended. Neither officer raised concerns about Mr Lunnon. (The officer was unavailable to be interviewed as he was subject to an internal prison investigation after his actions which are discussed later in this report. Subsequently, the officer resigned from the Prison Service.)

69. Mr Lunnon pressed his cell bell again at 8.07pm. An officer responded within two minutes, opened the door observation panel and spoke to Mr Lunnon. In his police statement, the officer said that Mr Lunnon asked for his medication that was in his cell. He told Mr Lunnon that it was unlikely that he would get his medication that night. The officer had no concerns about Mr Lunnon and described their conversation as short.

70. At 9.00pm, CCTV footage shows that the officer visited the servery to make himself a hot drink. After this, he can no longer be seen in the CCTV footage. The officer said that he went to the segregation unit's rest room for a break, watched television and had a snack. He said that from the rest room he was able to hear the noise of prisoners' televisions and music coming from their cells. He said that some prisoners were shouting at each other through their cell doors.

71. Mr Lunnon pressed his cell bell at 9.15pm. (Prisoners are only expected to use their cell bell for emergency situations.) The cell bell alarm sounded in the segregation unit's office and CCTV shows that the light outside Mr Lunnon's cell illuminated to indicate that he had rung his cell bell. The officer was still in the rest room and said that he did not hear any cell bells ringing. (Mr Lunnon was the only prisoner to press his cell bell between 9.00pm and 9.30pm.)

72. At 9.30pm, the officer left the rest room and started his pegging duty (a patrol of the landing). The light outside Mr Lunnon's cell remained lit. The officer said that it was at this point that he first noticed the light and went to Mr Lunnon's cell. The officer opened Mr Lunnon's door observation panel and said that he saw blood everywhere. Mr Lunnon was lying on his back on the bed, facing the wall. Mr Lunnon repeatedly said that he could not breathe.

Emergency response

73. The officer went to the office and used his radio to contact, a custodial manager (CM) who was in charge of the prison. He told her that a prisoner had "slashed up" (self-harmed). The officer did not use a medical emergency code red (which signifies significant blood loss) in line with the requirements of national prison procedures. The CM told the officer that that she would attend the segregation unit immediately and radioed for her three assistant officers to meet her there. (There are no nurses in HMP Ranby after 7.45pm.)

74. The officer returned to Mr Lunnon's cell at 9.33pm, two minutes after he had initially discovered Mr Lunnon had self-harmed. At night, officers carry a cell key in a sealed pouch that they can break and use to enter a cell in an emergency, subject to a risk assessment. The officer broke the key pouch, opened Mr Lunnon's cell door and stood in the doorway for around a minute before the CM arrived. During this time, the officer said that Mr Lunnon told him again that he was having breathing difficulties.

75. The CM told the investigator that when she arrived at Mr Lunnon's cell, she was utterly surprised by what she saw. Blood was everywhere, from the top of the bed to the bottom, the entire floor and walls. She told the officer to get some blankets or towels (to make the floor safe so that she could go into the cell and safely administer first aid). She radioed the control room and said that a prisoner had self-harmed, had major blood loss, tempered breathing and an ambulance was needed. (Ambulance Service records show that an ambulance was called at 9.35pm.)

76. The CM retrieved the first aid box and went into Mr Lunnon's cell, with blankets now on the floor. Mr Lunnon was lying half on his side with his left arm across and underneath his body. His right arm was laid out on the bed with a T-shirt wrapped around it. The CM could not see any active bleeding points on Mr Lunnon's body. She repeatedly asked him where he had hurt himself, while the officer helped her examine his whole body. Mr Lunnon refused to answer and told the CM to leave him alone. He told the CM to tell his children that he was sorry. He had also written a similar statement in blood on the wall of his cell.

77. Eventually, the CM found two puncture wounds, one on Mr Lunnon's left wrist and the other on the back of his left hand. Although neither wound was bleeding, she wrapped his hand in bandages. This proved difficult as Mr Lunnon started to thrash about. At 9.41pm, three other officers arrived at Mr Lunnon's cell and assisted. An officer held Mr Lunnon's arm in an elevated position and along with another officer tried to keep him calm. An officer saw a screw covered in blood on the side cabinet.

78. The CM supported Mr Lunnon while they waited for an ambulance. Mr Lunnon slipped in and out of consciousness and stopped breathing on at least three occasions. The CM was able to restart his breathing by tilting his head backwards to open his airway. She instructed two officers to collect the defibrillator (a device that monitors heart rhythms and administers an electric shock if required) and to collate Mr Lunnon's prison paperwork in preparation for his escort to hospital.

79. An officer brought the office's cordless phone to another officer so that she could update the ambulance control operator on Mr Lunnon's condition. She told them that Mr Lunnon's skin had become cold, grey and clammy. She and an officer managed to prevent any further blood loss and kept Mr Lunnon conscious until the paramedic and ambulance crew arrived.

80. At 10.06pm, paramedics arrived. They administered emergency treatment and took Mr Lunnon to hospital, leaving the prison at 10.40pm. Mr Lunnon died in hospital at 11.40pm. The Head of Residence attended the prison shortly afterwards.

Contact with Mr Lunnon's family

81. Prison staff identified Mr Lunnon's next of kin from prison records as his aunt who lived in Hampshire. Due to the distance from the prison, the Head of Residence asked the local police to visit her, which they did at around 4.20am on 20 October. The police informed Ranby at 4.35am that Mr Lunnon's next of kin had been informed. Mr Lunnon's mother later took on the role of the next of kin. Ranby offered help with the funeral arrangements and contributed to the costs, in line with national instructions.

Support for prisoners and staff

82. At 1.10am (20 October) The Head of Residence debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

83. The prison posted notices informing other prisoners of Mr Lunnon'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 Lunnon's death.

Post-mortem report

84. A post-mortem examination established the cause of death as laceration of the ulnar artery (caused by a screw) and use of NPS.

85. The toxicology results showed that Mr Lunnon had therapeutic amounts of his prescribed drugs, mirtazapine, pregabalin and methadone, in his system. He also had a small amount of clonazepam (used to treat seizures and panic disorder), which was not prescribed and therefore must have been acquired illicitly.

86. The toxicology report also noted that a significant level of PS (likely to be Spice) was found in Mr Lunnon's body when he died.

Other issues

87. In his police statement, the officer said that the cell bell control panel speaker in the segregation unit office was covered by sellotape that night, which muffled its sound. The IMB said that there was no evidence of this when they checked in January 2018.

Findings

Mr Lunnon's risk of suicide and self-harm

88. Mr Lunnon had a long history of attempted suicide and self-harm. However, he last self-harmed in June 2016, 16 months before his death. This attempt appeared impulsive and Mr Lunnon pressed his cell bell to call for help soon after he had self-harmed, as he did when he took his life in October 2017. Leading up to his death, Mr Lunnon had not expressed any thoughts of suicide or self-harm, nor did his behaviour give staff any cause for concern or indicate that he was at risk of harming himself.

Roll checks

89. An officer was responsible for completing the roll check in the segregation unit at 7.00pm on 19 October. He signed to say that he had done so and that Mr Lunnon was okay. However, CCTV footage does not show that a roll check took place near Mr Lunnon's cell around that time or indeed from 6.30pm. The officer said that he must have completed the roll check earlier.

90. The primary purpose of a roll check is to check that all prisoners are present for security purposes. Staff should also satisfy themselves of each prisoner's safety. In this case, Mr Lunnon rang his cell bell at 7.34pm and so we know that he was well at that time. However, an officer should have completed the roll check at the required time and assured himself of the wellbeing of Mr Lunnon and other prisoners located in the segregation unit. We make the following recommendation:

    The Governor should ensure that staff check on prisoners' wellbeing at roll checks and that there are no immediate issues that need attention.

Response to Mr Lunnon's cell bell

91. HMIP has an expectation that cell bells should be answered within five minutes. Inspectors noted at their last inspection of Ranby that staff did not respond to cell bells as promptly as they should. We found no evidence to suggest that the cell bell system was not functioning properly.

92. An officer had only been on duty for around an hour before he took a break of 30 minutes, went to the rest room and watched television. Records show that no other prisoners, except Mr Lunnon, rang their cell bell during this time. Mr Lunnon pressed his cell bell at 9.15pm. As he was in the rest room, the officer was unable to see and possibly hear if any cell bell had been activated. It was only when he began to patrol the unit that he noticed that Mr Lunnon's cell bell light had been activated.

93. We acknowledge that the unit might have been noisy but it was unacceptable that the officer did not respond promptly when Mr Lunnon pressed his cell bell at 9.15pm. No staff were available to do so from 9.00pm onwards. The segregation unit is a small unit of 15 cells and, knowing that noise levels could mask issues of concern, the officer should have ensured that he was in a position

to carry out visual checks for cell bells. Mr Lunnon self-harmed before or during the 15 minutes it took the officer to respond to him pressing his cell bell. If the officer had answered the bell promptly, staff might have been able to save his life.

94. The officer actions were the subject of a disciplinary investigation but he has since resigned from the Prison Service. We make the following recommendation:

The Governor should ensure that staff respond to all cell bells within five minutes.

HMPPS have rejected this recommendation that staff respond to all cell bells within five minutes and have provided a full explanation in its action plan.

Emergency response

95. PSI 03/2013 on medical emergency response codes contains mandatory instructions to ensure staff efficiently communicate the nature of a medical emergency, take the relevant equipment to the incident and that there are no delays in calling an ambulance. This national instruction requires prisons to have a two level code system, which differentiates between a blood injury (usually code red), and all other injuries such as breathing difficulties, heart attack, unconscious (a code blue). Ranby's own local emergency response protocol says that in cases of severe blood loss, staff should identify the emergency to the control room as a code red.

96. When an officer opened the observation panel on the cell door, he saw a lot of blood and Mr Lunnon said that he could not breathe. Contrary to national instructions, he did not call a code red or say how severe Mr Lunnon's self-harm was when he radioed the night manager. We know from the post-mortem that Mr Lunnon had cut an artery in his left forearm. It was a further two minutes before the officer opened Mr Lunnon's cell door. We are unsure why the officer delayed going into the cell when he first discovered Mr Lunnon. There is no evidence to indicate that he believed Mr Lunnon posed a high risk or that he was concerned for his personal safety.

97. We recognise that it can be difficult for staff in challenging circumstances to make instant decisions but, when there is a potentially life-threatening situation, it is essential to act quickly and exercise sound judgement. In emergencies, delays can have a significant impact on a person's chance of survival.

98. A CM was in disbelief at the amount of blood that she saw in Mr Lunnon's cell when she arrived and recognised within seconds that an ambulance was required. Yet, there was a delay of four minutes from the time the officer discovered the incident before an ambulance was called. It is unacceptable that the officer did not acknowledge the severity of Mr Lunnon's condition and call a code red when he saw what had happened.

99. Staff and paramedics were able to establish a slight pulse when treating Mr Lunnon. We cannot know whether earlier intervention might have changed the outcome for him. However, delays in responding to his cell bell, initiating basic first aid and calling an ambulance compounded an already critical situation. We consider that these were serious breaches of the prison's duty of care to Mr

Lunnon. His progressively significant loss of blood reduced the likelihood of him recovering from his injuries.

100. It is important that prison staff understand their roles in a medical emergency. The officers conduct was subject to a disciplinary investigation and he has since resigned from the Prison Service. Nonetheless, we make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies.

Clinical care

101. The clinical reviewer concluded that the standard of mental health care that Mr Lunnon received was generally equivalent to or better than the care he could have expected to receive in the community. However, the care he received in the way staff monitored his methadone and other medications was not as good as he could have expected to receive in the community.

PS

102. The toxicology examination found PS in Mr Lunnon's blood at the time of his death. The clinical reviewer's view is that this may have contributed to his decision to self-harm which caused his subsequent blood loss and death. She noted that the drug may also have had adverse effects on his circulation, causing his heart rate to speed up and the blood loss from his wrist injury to increase rapidly. PS can cause delirium, hallucinations and agitation. It is not possible to tell if or how these psychological effects might have impacted on Mr Lunnon's decision to self-harm.

103. Mr Lunnon had a history of substance misuse and had a good knowledge of its impact on his wellbeing. Yet, he continued to misuse drugs. There is evidence that staff offered Mr Lunnon support through the IDTS team and that they imposed sanctions to try to curb his use of NPS.

104. The prison issued its substance misuse strategy in February 2016 and November 2017. The strategy sets out how they intend to reduce the supply of and demand for PS, that staff should be vigilant for signs of its use and are briefed on how to respond when prisoners appear to be under the influence of such substances and that PS is included in regular drug testing. Staff are required to submit intelligence reports of all incidents of suspected use of illicit drugs and there is some evidence that Mr Lunnon's cell was searched as a result of this process. Nonetheless, staff need to continually reinforce the practices of the substance misuse strategy, as it in this case, it appears more certainly needed to be done to combat Mr Lunnon's misuse of substances. We make the following recommendation.

The Governor and Head of Healthcare should ensure that staff understand how to implement the strategy to reduce the supply of and demand for substances, including completing security intelligence reports and searching cells, prisoners, staff and visitors both at random and based on intelligence.

Mental health

105. Mental health services were heavily involved in Mr Lunnon's care and concluded that he had no significant mental health problems and did not show signs of mental ill health that were significant enough to indicate to staff that he was at risk of suicide or self-harm.

106. Mr Lunnon did not always attend his appointments and when he did attend, appeared to lack commitment and motivation to change his lifestyle. The clinical reviewer notes that it was unlikely that Mr Lunnon would have had as much mental health support in the community as he had at Ranby.

Substance withdrawal and detoxification

107. National Institute for Health and Care Excellence (NICE) guidance on substance misuse, published in 2017, says that IDTS practitioners should have regular reviews with prisoners who are prescribed detoxification medication and that the prescribing GP should review the medication at least every three months.

108. The clinical reviewer raised concerns about the way in which staff monitored Mr Lunnon's substitute opiate medication. Members of the IDTS team reviewed Mr Lunnon monthly for the first few months of his time at Ranby. A prison GP did not see Mr Lunnon after the first three months and there are no recorded reviews with any member of the IDTS team after February 2017. We make the following recommendation:

The Head of Healthcare should ensure that the Head of IDTS and the Substance Misuse GP review all patients on long-term opiate substitute treatment at three monthly intervals.

Repeat prescriptions

109. Records confirm that prison GPs prescribed Mr Lunnon two strong psychotropic medications, pregabalin and mirtazapine. Doctors should have reviewed the medication, but this did not happen during the 18 months that Mr Lunnon spent at Ranby. This also extended to Mr Lunnon's prescription of zopiclone, which was prescribed without GP consultation. While we acknowledge that Mr Lunnon was under the care of the mental health team, the clinical reviewer noted that it is unlikely that he would have been allowed these medications in the community without at least an annual medication review. We recommend that:

The Head of Healthcare and the prison GPs, should review the process for repeat prescriptions to ensure that all prisoners on regular medication are appropriately reviewed.

Post-mortem examination

110. The post-mortem report shows that the injury Mr Lunnon made to his left wrist would not normally have been sufficient to cause the very significant blood loss which caused his death. The clinical reviewer found that the combination of the delay in receiving prompt treatment and the presence of PS in Mr Lunnon's system might together have contributed to his death.

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