Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Hall, a prisoner at HMP Ranby, on 14 December 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

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

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

Mr Thomas Hall died of synthetic cannabinoid toxicity on 14 December 2018, after being found unconscious in his cell in the segregation unit at HMP Ranby. He was 21 years old. I offer my condolences to Mr Hall's family and friends.

Mr Hall had a significant history of illicit drug use. I am satisfied that he was offered appropriate advice and support to help address his drug misuse problems in prison but that he chose not to access it.

I am also satisfied that Mr Hall was appropriately assessed by mental health staff.

I am concerned, however, that despite wide-ranging local policies and the efforts of staff to prevent the supply of and demand for illicit substances at Ranby, Mr Hall was apparently able to obtain and use drugs in the segregation unit.

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 **January 2020**

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Summary

Events

1. Mr Thomas Hall had a significant history of illicit drug use. On 18 September 2018, Mr Hall appeared at Northampton Magistrates Court and was remanded into custody at HMP Bedford, charged with burglary. He had been in prison before. On 22 October, Mr Hall was convicted and sentenced to two years in custody and sent to HMP Leicester.

2. On 5 November, Mr Hall transferred to HMP Ranby.

3. On 27 November, Mr Hall damaged prison property and gained access to the roof in the workshop. Later that evening, Mr Hall threatened to take a member of staff hostage in an attempt to obtain a set of keys. Mr Hall was moved to the segregation unit. He said he would continue his poor behaviour until he was transferred out of Ranby.

4. On 29 November, Mr Hall was given a punishment of 21 days cellular confinement in the segregation unit. While in the segregation unit, Mr Hall was checked hourly by segregation staff and seen daily by nurses and the duty governor.

5. On 3 December, the chaplaincy team broke the news to Mr Hall that his grandmother had died. After breaking the news, a member of the chaplaincy team saw Mr Hall daily to offer support.

6. On 14 December, at 8.12pm, staff found Mr Hall unconscious in his cell. Staff called an ambulance and started cardiopulmonary resuscitation. The paramedics arrived at 8.28pm and pronounced Mr Hall dead at 9.01pm.

Findings

Assessment of risk

7. The post-mortem found that Mr Hall died as a result of using psychoactive substances (PS). We are satisfied that there is nothing to suggest that this was anything other than an accident.

Psychoactive Substances

8. Mr Hall had a significant history of illicit drug abuse but declined support and advice from the substance misuse team. We are satisfied that appropriate advice and support was offered to Mr Hall but that he chose not to accept it.

9. Ranby has comprehensive policies to tackle the supply of illicit drugs in the prison. However, we are concerned that, despite this, Mr Hall was apparently able to access and use drugs in the segregation unit (where he had been located for the 15 days before his death).

Clinical care

10. The clinical reviewer concluded that the care provided to Mr Hall prior to the point at which he was found unresponsive was equivalent to that which he could have expected to receive in the community. Mr Hall was appropriately assessed by mental health staff. Mr Hall chose not to access any support from the substance misuse service.

Emergency response

11. The two officers who found Mr Hall unresponsive in his cell did not enter the cell but waited three minutes for other staff to arrive before doing so. As Mr Hall was in the segregation unit because he had made threats to staff, we do not say that they should have entered the cell, but we are concerned that they believed they could not do so under any circumstances.

12. The clinical reviewer found that the care provided to Mr Hall during the emergency response was not equivalent to that he could have expected in the community. The nurse who responded to the medical emergency code did not take the appropriate medical equipment with her and there was a delay before CPR was begun. We cannot say whether this made a difference to the outcome for Mr Hall.

Staff support

13. One member of staff involved in the emergency response did not consider he had been offered appropriate support.

Recommendations

- The Governor should ensure that the key drug issues at Ranby are identified and that the prison's local drugs strategy addresses these key issues.
- The Governor should ensure that staff fully understand the expectation that preservation of life must take precedence when considering entering a cell on their own, and that this expectation is reflected in local policies.
- The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, in particular:
    - an emergency code is called immediately a medical emergency is discovered;
    - where available, the duty nurse responds with the necessary equipment and assesses the patient;
    - where there is no nurse cover available, other staff respond with the necessary equipment; and
    - CPR should begin as soon as possible.

- The Governor should ensure, following a death in custody, that a member of the care team attends the ‘hot debrief’ and that all staff are offered, and can access, support when required.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact her.

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

16. NHS England commissioned an independent clinical reviewer to review Mr Hall's clinical care at the prison.

17. On 24 April 2019, the investigation was reallocated to a senior investigator.

18. The investigator interviewed five members of staff at Ranby in May, all jointly with the clinical reviewer. The investigator interviewed one member of staff in June.

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

20. The investigator contacted Mr Hall's brother to explain the investigation and to ask whether there were any matters he wanted the investigation to consider. Mr Hall's brother asked what treatment Mr Hall had received for his mental health. This is covered in the body of the report. Mr Hall's brother received a copy of this report. He did not make any comments.

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 NHS Foundation Trust provides primary healthcare services. Healthcare services are provided 24 hours a day with a minimum of one registered nurse on duty at all times of day, 7 days a week.

HM Inspectorate of Prisons

22. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Ranby between 4 and 15 June 2018. Inspectors were concerned about the prevalence and ready availability of illicit drugs, along with the associated issues of debt and violence. Inspectors noted incidents of PS use were common. Ranby had a comprehensive drug reduction strategy in place and a robust prison-wide approach to tackling the supply of drugs. This included scanning all incoming mail. Inspectors found the regime in the segregation unit to be poor with prisoners moved around individually, regardless of their risk.

Independent Monitoring Board

23. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Ranby between 4 and 15 June 2018. Inspectors were concerned about the prevalence and ready availability of illicit drugs, along with the associated issues of debt and violence. Inspectors noted incidents of PS use were common. Ranby had a comprehensive drug reduction strategy in place and a robust prison-wide approach to tackling the supply of drugs. This included scanning all incoming mail. Inspectors found the regime in the segregation unit to be poor with prisoners moved around individually, regardless of their risk.

Previous deaths at HMP Ranby

24. Mr Hall's was the third drug-related death to occur at Ranby since June 2015. In one of the other investigations (into the death of a prisoner in October 2017) we also made a recommendation about shortcomings in the emergency response.

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 such a way that prison staff think would put others in danger, or cause problems for the rest of the prison.

26. The units also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Once a prisoner's health has been assessed by a member of the healthcare team, an operational manager must authorise that the prisoner is fit for segregation.

Psychoactive Substances (PS)

27. Psychoactive substances (formerly known as ‘new psychoactive substances’ or ‘legal highs’) are a serious 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 PS 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 PS (still at that time 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 PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

29. HM Prison 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.

Key Events

30. On 18 September 2018, Mr Thomas Hall appeared at Northampton Magistrates Court charged with burglary. He was remanded into custody at HMP Bedford. Mr Hall had been in custody before and had been released from his last sentence on 9 July 2018.

31. When Mr Hall arrived at Bedford, he saw an officer in reception. Mr Hall said he had been in prison before, knew what was expected of him and acknowledged that he had to attend the prison's induction programme. The officer recorded that Mr Hall had no concerns or any thoughts of self-harm.

32. A nurse saw Mr Hall in reception. Mr Hall said he suffered from schizophrenia and had been sectioned twice under the Mental Health Act in the past 12 months. He said he was not currently on any prescribed medication but had been prescribed risperidone (used to treat schizophrenia) in the past. Mr Hall also said he self-medicated with cannabis. He said he wanted something to help him sleep. The nurse recorded that Mr Hall was not prescribed any medication and referred him to the doctor, the mental health team and the substance misuse team.

33. A prison GP saw Mr Hall in reception. Mr Hall said that he had been diagnosed with schizophrenia and had been prescribed risperidone and diazepam but he had not taken either medication for months. Mr Hall said he used cannabis instead of prescribed medication. The prison GP completed a mental state examination and recorded that Mr Hall appeared stable, not anxious and had no overt signs of psychosis. The prison GP noted that a referral to the mental health team had already been made. The prison GP prescribed diphenhydramine (for insomnia) for seven days.

34. On 20 September, a medical technical officer reviewed Mr Hall's community GP medical records. The GP summary stated that Mr Hall had received a diagnosis of suspected psychosis in April 2018, a psychotic disorder had been noted in June 2018, a drugs overdose recorded in July 2018, and auditory hallucinations noted in July 2018.

35. On 26 September, a nurse recorded that Mr Hall was discussed at a multi-disciplinary meeting. There were no current issues or concerns.

36. On 27 September, a member of the substance misuse team saw Mr Hall following the referral made by a nurse. Mr Hall said he did not want to engage with the substance misuse team and signed a disclaimer making clear that he declined any care and support for his substance misuse. The member of the substance misuse team saw recorded that she would see Mr Hall again in four weeks to see whether he had changed his mind about receiving support.

37. On 22 October, Mr Hall appeared at Leicester Crown Court. He was convicted and sentenced to two years in custody. From court, Mr Hall was sent to HMP Leicester.

38. When Mr Hall arrived at Leicester, a nurse who was a member of the mental health team, saw him in reception. Mr Hall said he had been diagnosed with schizophrenia and had previously been admitted to a mental hospital in Greater Manchester. He said he had previously been prescribed risperidone but had not taken it since July 2018. He did not want to take any medication as it made him feel

like a “zombie”. Mr Hall said he had a history of hearing voices telling him to kill others and himself. The nurse recorded that Mr Hall denied any intention to self-harm. She referred him for addition to the mental health team caseload.

39. On 31 October, a nurse saw Mr Hall for a mental health assessment. Mr Hall said he had been diagnosed with schizophrenia when he was admitted to a secure psychiatric unit in Manchester with acute psychosis. He and said he had been using cannabis at the time. Mr Hall also said he had been transferred to a hospital in Kettering where he was an inpatient for four weeks following an overdose of tablets. He said he heard voices, which he found distressing, as they told him to do “bad things”. He could also smell burning most of the time.

40. The nurse recorded that Mr Hall appeared calm, was able to communicate his feelings during the review and said he had no thoughts of self-harm. The nurse referred Mr Hall to be seen by the visiting psychiatrist.

HMP Ranby

41. On 5 November, Mr Hall was transferred to HMP Ranby. When Mr Hall arrived at Ranby he saw a nurse in reception. The nurse referred Mr Hall to the mental health team as Mr Hall said he had a history of schizophrenia and had been admitted to a mental health hospital. The nurse recorded that Mr Hall was not on any prescribed medication, and that he declined to be referred to substance misuse and smoking cessation services and denied any thoughts of suicide or self-harm.

42. On 12 November, a nurse who was a member of the mental health team, saw Mr Hall for a mental health assessment. Mr Hall said he had been admitted to a mental health hospital after being sectioned under the Mental Health Act and diagnosed with schizophrenia. He said he had heard voices over a three-year period, with a male voice telling him that others were “out to get” him. He said he used cannabis and did not take any prescribed medication.

43. The nurse recorded that Mr Hall had no thoughts of self-harm or suicide. He noted that Mr Hall seemed a little anxious and preoccupied but there was no evidence that he was responding to internal stimuli. The nurse told Mr Hall that he wanted him to see the psychiatrist. Mr Hall agreed to see the psychiatrist but said that he did not want to take any medication.

44. On 16 November, the nurse discussed Mr Hall’s care at the multi-disciplinary meeting. It was agreed that Mr Hall would both be seen by the secondary mental health team to complete a further review, and he would be seen by the psychiatrist. The nurse told the investigator that for non-urgent cases there was a five-to-six week waiting list for appointments with the psychiatrist.

45. On 27 November, Mr Hall gained access to the workshop roof. He told staff he had done this in order to be moved out of Ranby. Mr Hall came down from the roof and was taken to his cell on the wing. He was placed on report for breaking prison rules.

46. Later that evening, at 6.30pm, Mr Hall threatened to take a member of staff hostage in an attempt to get hold of a set of prison keys. He was again placed on report.

47. On 28 November 2018, a nurse recorded that she saw Mr Hall on the wing for a mental health review. Mr Hall said he was struggling at Ranby as the prison was "too big". Mr Hall denied he had any symptoms of mental illness. He also denied he had any thoughts of self-harm. He said he had gone onto the roof of one of the workshops in order to be transferred out of the prison. The nurse recorded there was no evidence that Mr Hall suffered from thought disorder or delusional ideation.

48. On 29 November, the Head of Reducing Reoffending, opened Mr Hall's disciplinary hearing. Mr Hall said he would continue with his poor behaviour to get a transfer out of Ranby. She recorded that Mr Hall was guilty of making threats to staff to take their keys. She gave Mr Hall a punishment of 21 days cellular confinement in the segregation unit.

49. A nurse completed the segregation unit risk assessment. The nurse recorded that Mr Hall was medically fit to be held in the segregation unit and that he had no thoughts of suicide or self-harm.

50. An officer who worked in the segregation unit, told the investigator that all prisoners in the segregation unit were seen daily by the duty governor and two nurses, one of whom was a member of the mental health team. Prisoners subject to cellular confinement were checked hourly throughout the day and night by segregation staff in addition to the daily checks. The officer said it was his understanding that it was a prison policy that three discipline staff were to be present before a cell door could be opened in the segregation unit, however this is not reflected in Ranby's local policy arrangements.

51. Prison service records show that while Mr Hall was in the segregation unit he was checked hourly and was seen daily by two nurses and the duty governor. There were no issues or concerns with Mr Hall's wellbeing or safety. He said he had no thoughts of suicide or self-harm while he was in the segregation unit.

52. On 3 December, a member of the chaplaincy team broke the news to Mr Hall that his grandmother had died. Prison service records show that, after breaking the news to Mr Hall, a member of the chaplaincy team saw him daily to offer support.

14 December 2018

53. An officer told the investigator that on 14 December he had been on duty in the segregation unit from 12.15pm. He said that he saw Mr Hall throughout the afternoon and he appeared fine. He was laughing and joking and caused no problems for staff. The officer said the last time he spoke to Mr Hall was at 6.55pm, when there were no issues or concerns.

54. CCTV footage shows that at 8.12pm, the officer went to Mr Hall's cell to carry out the required hourly check through the observation panel in his cell door. The officer saw Mr Hall lying on his cell floor unresponsive. He immediately went to fetch another officer from the segregation unit office. The officers could not get a response from Mr Hall and an officer radioed an emergency code blue, which indicates a prisoner is not breathing or is having difficulty breathing, and triggers the control room to call an ambulance immediately and healthcare staff to attend with the appropriate medical equipment.

55. An officer said at interview that he had received 'first on scene' first aid training from the armed forces and with the police, as well as the training he had received from the prison service. An officer said that when he arrived at Mr Hall's cell and looked through the observation panel, Mr Hall was lying on the floor. The officer could clearly see that Mr Hall's face and lips were blue and he had vomit around his mouth. As the officers present believed that to unlock a door in the segregation unit required three discipline staff to be present, both officers waited for additional discipline staff to be present.

56. A nurse responded to the code blue call, arriving on the segregation unit at 8.14pm. However, the nurse arrived without bringing any emergency equipment with her. At 8.15pm, other officers arrived and Mr Hall was carried out of his cell. The nurse asked both officers to fetch the automated external defibrillator from healthcare. The healthcare room was locked, however, and officers had to return to get the keys from the nurse. At 8.19pm, officers started cardiopulmonary resuscitation (CPR). CCTV footage shows there was a was a seven-minute delay from the time the code blue was called to when CPR began.

57. At 8.20pm, officers returned with an automated external defibrillator. This administers electrical shocks to restore a normal rhythm to the heart if any is found. The defibrillator found no shockable rhythm, so the officers continued with CPR. The paramedics arrived at 8.28pm and took over Mr Hall's care. After a period of treatment, they pronounced Mr Hall dead at 9.01pm.

Post-mortem report

58. A post-mortem examination found that the cause of Mr Hall's death was synthetic cannabinoid toxicity. Toxicology results showed that Mr Hall had taken 4F-MDMB-BINACA (a synthetic cannabinoid, a form of PS, often known as 'spice') before his death.

Contact with Mr Hall's family

59. Mr Hall had nominated his aunt as his next of kin but had not provided her address. Ranby contacted Nottinghamshire Police who established Mr Hall's aunt's address. Mr Hall's aunt lived in Northamptonshire, and Northamptonshire Police broke the news of Mr Hall's death. On 15 December, a family liaison officer (FLO) from Ranby spoke to Mr Hall's aunt on the phone to offer condolences and support. In the days that followed, Ranby maintained contact with Mr Hall's aunt and, in line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

60. The Head of Residence held a debrief for staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support. An officer told the investigator that he was not offered any support from the care team at any point following the incident.

61. The prison posted notices informing staff and prisoners of Mr Hall'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 Hall's death.

Findings

Assessment of risk

62. 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. 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.

63. Mr Hall had some risk factors for suicide and self-harm including mental health issues and a history of drug abuse. However, we are satisfied that after arriving in custody on 18 September 2018, there was nothing in his medical records or details of his contacts with clinicians or staff to suggest that he might be at risk of suicide.

64. We are also satisfied that there is nothing to suggest that Mr Hall intended to kill himself or that his death was anything other than an accident.

Psychoactive Substances

65. Mr Hall had a significant history of cannabis use while in the community. Toxicology results show that he had used PS before his death and the pathologist confirmed the cause of Mr Hall's death was synthetic cannabinoid toxicity.

66. Ranby has a strategy to address both the supply of, and demand for, PS and illicit drugs. It includes numerous actions intended to reduce the supply of drugs into the prison and the movement of drugs around the prison. Examples include photocopying mail to prevent sprayed PS entering the prison, and providing additional staff resources to carry out mandatory drugs tests and cell searches. There are also measures to educate prisoners about the dangers of PS and support those known to use the drugs, as well as additional disciplinary measures to deter drug use.

67. We are satisfied that Mr Hall was offered support and advice for his illicit drug use but that he chose not to access it.

68. However, we are concerned that Mr Hall was able to obtain PS while in Ranby. As he had been in the segregation unit for 15 days before his death it appears that he was able to access and use PS in the unit. Both HM Inspectorate of Prisons and the Independent Monitoring Board have also expressed concern about the ready availability of drugs at Ranby.

69. Drug taking and trading is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, the PPO has called for national guidance to prisons from HMPPS providing evidence-based advice on what works, and we welcome the fact that such guidance was issued in April 2019, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

70. In relation to reducing the supply of drugs, we note that the new Prison Service strategy states:

> "Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

71. We, therefore, recommend:

The Governor should ensure that the key drug issues at Ranby are identified and that the prison's local drugs strategy addresses these key issues.

Clinical care

72. The clinical reviewer judged that the care that Mr Hall received from healthcare staff at Ranby, was equivalent to the care he could have expected to receive in the community prior to the point he was found unresponsive in his cell on 14 December.

73. The clinical reviewer commented that Mr Hall's mental health assessments showed that while he said he heard voices which were making him feel paranoid, he did not demonstrate any external signs of psychosis. Mr Hall said he had stopped taking his prescribed medication as he did not find it effective and did not want to take it in the future. There was no delay with him accessing the mental health services at Ranby.

74. The clinical reviewer also commented that Mr Hall had used cannabis to manage his mental health symptoms while he was in the community. Mr Hall showed no signs of substance misuse or withdrawal, and he did not want to engage with the services offered by substance misuse services.

Emergency Response

Entering the cell

75. When Mr Hall was found unresponsive in his cell, two officers waited for three minutes for other staff to arrive before they entered the cell.

76. An officer told the investigator that it was a mandatory instruction that three discipline staff were to be present before a cell door could be opened in the segregation unit. However, Prison Service policy and Ranby's Local Security Strategy (LSS) instruction is that preservation of life must take precedence and that where there is, or appears to be, immediate danger to life, cells may be unlocked without authority and an individual member of staff may go into a cell on their own. However, staff should not take action that they feel would put themselves or others in unnecessary danger. Before going into a cell, staff should make every effort to gain a verbal response from the prisoner. This, together with what the member of

staff observes through the panel and any knowledge of the prisoner, should inform a rapid dynamic risk assessment of the situation and a decision about whether to enter immediately or wait for assistance.

77. Mr Hall was in the segregation unit because he had made threats to staff. We do not, therefore, say that both officers should necessarily have entered the cell when they found Mr Hall unresponsive. However, we are concerned that they thought that they were not allowed to enter a cell without waiting for a third colleague under any circumstances, even when, as in this case, they could see that Mr Hall's face and lips were blue and he had vomit around his mouth.

78. We recommend:

The Governor should ensure that staff fully understand the expectation that preservation of life must take precedence when considering entering a cell on their own and that this is reflected in local policies.

The response to the medical emergency

79. 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 ensure there are no delays in calling an ambulance.

80. This national instruction requires prisons to have a two-level code system, which differentiates between a blood injury (a code red), and all other injuries such as breathing difficulties, a heart attack or unconsciousness (a code blue).

81. The clinical reviewer judged that the care that Mr Hall received from a nurse was not equivalent to the care he could have expected to receive in the community. The nurse was an agency nurse who had worked at Ranby for six months at the time of Mr Hall's death. The nurse responded to the code blue but failed to take any emergency equipment with her.

82. The Healthcare Trust no longer employs the nurse as an agency nurse and has referred her conduct to the Nursing and Midwifery Council for an investigation into her clinical practice. We do not, therefore, make any specific recommendation about the nurse.

83. Examination of the CCTV and body-worn camera footage shows that there was a seven-minute delay from the time the code blue was called to when CPR began. There was a further one-minute delay before a defibrillator arrived and a further two-minute delay before the emergency healthcare equipment arrived. This was wholly unacceptable.

84. It is impossible to know, if CPR had started earlier, with medical equipment readily available, whether the outcome would have been different for Mr Hall. It is imperative that all staff respond to medical emergencies as quickly as possible, and that first aid is given at the earliest opportunity.

85. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, in particular:

- **an emergency code is called immediately a medical emergency is discovered;**
- **where available, the duty nurse responds with the necessary equipment and assesses the patient;**
- **where there is no nurse cover available, other staff respond with the necessary equipment; and**
- **CPR should begin as soon as possible.**

Action following a death in custody

86. Following a death in custody, in line with mandatory national instructions, a 'hot debrief' must be held for all staff involved in the emergency, and a member of the care team must attend.

87. The Head of Residence held the hot debrief for staff. However, from the notes made of the hot debrief, it seems that no member of the care team was present. He recorded that a member of the care team would come into the prison later to speak to staff before they went off duty.

88. An officer told the investigator that the care team had not contacted him at any time following Mr Hall's death, either that night nor over the weeks that followed.

89. Staff may experience anxiety or distress following a death in custody and may require support at any time and on more than one occasion. Governors have a responsibility to ensure that staff are offered, and can access, support as and when needed. We make the following recommendation:

The Governor should ensure, following a death in custody, that a member of the care team attends the 'hot debrief' and that all staff are offered, and can access, support when required.

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