Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Carroll, a prisoner at HMP Ranby, on 7 July 2020

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 Paul Carroll, a prisoner at HMP Ranby, was found hanged in his cell on 7 July 2020. He was 37 years old. I offer my condolences to his family and friends.

Mr Carroll appeared to settle well at Ranby and raised few concerns with staff. On the evening before he died, Mr Carroll spoke to his wife numerous times. These conversations seemed challenging and distressing for Mr Carroll and his wife and may have triggered Mr Carroll's actions. However, given the information that staff had at the time of his death, I am satisfied that staff at Ranby could not reasonably have prevented his actions.

I am very concerned that Mr Carroll, who was subject to public protection measures, was able to contact his wife by using an alias to access the prisoner telephone system.

I am also concerned about the emergency response. Although it is unlikely to have had an impact on the outcome for Mr Carroll, it may be critical in another emergency.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **March 2021**

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Summary

Events

1. On 11 April, Mr Paul Carroll was remanded to HMP Nottingham, charged with assaulting his wife. It was his first time in prison. He denied thoughts of suicide or self-harm but had a number of risk factors. On 24 June, he was sentenced to a year and two months in prison and was subsequently transferred to HMP Ranby. Mr Carroll appeared to settle well in prison.

2. Contrary to public protection measures in place, Mr Carroll spoke regularly to his wife, who was the victim of his offence, using his in-cell prison telephone. He got around the restrictions imposed on him by using aliases.

3. Mr Carroll was transferred to Ranby just a week before his death. In the days before his death, he continued to have significant telephone contact with his wife. These calls appeared challenging and distressing. The last of these calls was made just after 8.00pm on 6 July.

4. At around 4.34am on 7 July, an officer found Mr Carroll in his cell with a ligature tied around his neck. Officers tried to resuscitate him, but the prison emergency response nurse later told them to stop as Mr Carroll was clearly dead. Paramedics confirmed Mr Carroll's death at around 5.00am.

Findings

5. Although Mr Carroll had several risk factors for suicide and self-harm, we consider that staff reasonably concluded that he did not need to be monitored under suicide or self-harm prevention procedures (known as ACCT).

6. We are concerned that Mr Carroll was able to have telephone contact with his wife at both Nottingham and Ranby, despite being subject to public protection procedures. These calls appeared to have been distressing for both Mr Carroll and his wife and might have influenced the action he took.

7. We have several concerns about the emergency response, including the delay in staff entering Mr Carroll's cell when they could not get a response from him; that an operational support grade said that she did not know how to use an emergency cell key; and that healthcare staff were not able to access the emergency quickly.

Recommendations

- The Governors of Nottingham and Ranby should ensure that robust checks are made on prisoners' telephone contact numbers to ensure that they cannot have unauthorised contact with victims and individuals who are the subject of public protection orders.

- The Governor of Ranby should ensure that all staff are reminded that, subject to a risk assessment, they should enter a cell as quickly as possible if there is reason to believe that a prisoner's life is in danger.

- The Governor of Ranby should share a copy of this report with the CM, both OSGs and Officer A and arrange for a senior manager to discuss the Ombudsman's findings with them to ensure they are aware of the provisions of PSI 24/2011.

- The Governor of Ranby should ensure that all Operational Support Grades are trained in the use of the emergency cell key pouches.

- The Governor and Head of Healthcare at Ranby should ensure that nurses are able to reach prisoners as quickly as possible when there is an emergency at night.

The Investigation Process

8. 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 responded.

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

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

11. The investigator interviewed eight members of staff and two prisoners at Ranby, some jointly with the clinical reviewer. All the interviews were conducted remotely by Microsoft Teams because of the restrictions imposed as a result of the Covid-19 pandemic.

12. We informed HM Coroner for Nottinghamshire of the investigation. She provided us with a copy of the post-mortem report. We have sent her a copy of this report.

13. We contacted Mr Carroll's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked whether Mr Carroll had drawn attention to himself before taking his life and if anyone had heard anything the night of his death. They also asked at what time he died. While we have addressed her concerns in this report, we were not been able to establish exactly when Mr Carroll died.

14. Mr Carroll's next of kin received a copy of the initial report. They did not make any comments.

Background Information

HMP Ranby

15. HMP Ranby is a Category C prison in Nottinghamshire, holding over 1,000 men. Nottinghamshire Healthcare NHS Foundation Trust provides primary healthcare services.

HM Inspectorate of Prisons

16. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Ranby in June 2018. Inspectors reported that since their last inspection in 2015, a significant amount of work had been undertaken to improve the prison across a range of areas. Inspectors reported that self-harm was increasing and that the management of those in crisis was inconsistent and often poor. However, most prisoners they spoke to felt well cared for and said that staff treated them with respect. Inspectors reported that a strategic approach to understanding and reducing self-harm was developing and management structures to deal with it had improved.

17. HMIP issued an aggregate report of scrutiny visits in May 2020 to HMP Ranby, HMP Coldingley and HMP Portland. The visit took place in response to the risks presented by the Covid-19 pandemic. Inspectors noted that the Covid-19 measures at all three prisons appeared to have been effective in limiting the spread of the virus but had resulted in a reduction in the amount of time prisoners spent out of their cells. Inspectors noted that reported incidents of self-harm had reduced at Ranby.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year ending March 2020, the IMB reported acts of self-harm had generally remained static throughout the reporting year and were generally lower that the national average. The IMB reported that officers needed to be more visible on the wings and therefore more in touch with the prisoners under their care.

Previous deaths at HMP Ranby

19. Mr Carroll was the second prisoner to take his life at Ranby since January 2017. In our investigation of the two previous self-inflicted deaths (in October 2017 and January 2020), we found that the circumstances were not similar to the circumstances of Mr Carroll's death, but we made recommendations about the delay in staff entering the cell.

20. There was also a death from natural causes and a drug-related death during that period. There were no significant similarities between the circumstances of these deaths and Mr Carroll's.

Assessment, Care in Custody and Teamwork (ACCT)

21. 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. As part of the process, a risk reduction plan, also known as a caremap (a plan of care, support and intervention) should be put in place. The ACCT plan should not be closed until all the actions of the risk reduction plan have been completed. After closure, a follow-up interview should take place within seven days.

22. 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. Prison Service Instruction (PSI) 64/2011 on safer custody sets out how staff should operate ACCT procedures.

Key Events

HMP Nottingham

23. On 11 April 2020, Mr Paul Carroll was remanded into custody to HMP Nottingham, charged with assaulting his wife. Although he had previous convictions for battery and damaging property, it was his first time in prison.

24. At a first night interview, prison staff noted that Mr Carroll had a number of risk factors which put him at an increased risk of suicide or self-harm. These included that it was his first time in prison, which he felt "numb" about, he had a lack of social/family support (although the form also noted he had good support), and that he had committed a violent offence against his partner. A nurse assessed that Mr Carroll had no mental health or substance misuse issues. He denied any thoughts of suicide or self-harm.

25. On 15 April, an intelligence report noted that Mr Carroll had spoken to his wife and a minor through a third party despite the fact that a restraining order was in place restricting him from having contact with them. The report also noted that Mr Carroll "has a blade in cell and has looked up forensic science as to how to cut his arm if he loses his wife".

26. On 17 April, Mr Carroll was told that his telephone calls would be monitored due to public protection measures. He was told not to contact his wife, but that future contact would be considered if he made an application to do so.

27. During a welfare check on 21 April, Mr Carroll told an officer that he was struggling to understand prison processes but was "doing well". It was noted that Mr Carroll was polite, that his cell was clean and tidy, and that he appeared to get on with his cellmate.

28. On 28 April, Mr Carroll told an officer that he had no concerns but was anxious about whether he would get bail. On 29 April, Mr Carroll was refused bail, an officer reminded him of the support networks available to him and noted that he continued to engage well.

29. On 6 May, Mr Carroll was convicted of actual bodily harm.

30. On 8 May, intelligence reports noted that while monitoring Mr Carroll's telephone calls, it had been established that he had breached his restrictions by contacting his wife using a third party and aliases for his wife to get around the prison's telephone monitoring system. Nottingham barred Mr Carroll from using the third party and alias contact details to speak to his wife.

31. On 12 May, Mr Carroll was reminded of the public protection restrictions in place which prohibited him having contact with his wife, children and other family members. Mr Carroll told staff that his wife wanted the restrictions lifted. Mr Carroll was told that until the courts told the prison otherwise, they remained in place and he was not to have unauthorised contact with his wife or family. However, he set up a further alias and telephone number for his wife, which Nottingham approved. This enabled him to continue to have contact with her.

32. On 24 June, Mr Carroll was sentenced to a year and two months in prison.

HMP Ranby

33. On 29 June, Mr Carroll was transferred to HMP Ranby. (Due to Covid-19 measures, Mr Carroll was sent to a quarantine wing for 14 days.) An officer completed a first night interview. He told Mr Carroll of the support available at Ranby and noted that Mr Carroll raised no concerns.

34. At Mr Carroll's initial health screen, a nurse noted that he appeared fit and well and she prescribed creams for a severe skin condition. Mr Carroll denied any thoughts of suicide or self-harm.

35. That afternoon, Mr Carroll spoke to his wife by telephone, using the alias and telephone number for his wife which had been approved at Nottingham. (Prisoners' telephone calls are recorded, and we have seen Ranby's summary notes of some of Mr Carroll's calls.) Mr Carroll and his wife talked about his offence and the impact it had had on her.

36. Mr Carroll spoke to his wife again at 8.03pm for thirty minutes. Mr Carroll and his wife spoke about their relationship and Mr Carroll told her it was over. At one point, his wife told him that "killing himself" would not make things easier. Mr Carroll said he would rather die than live with guilt, which he said was too much to live with. Mr Carroll's wife said she would call the prison to tell them what he had said. Mr Carroll told his wife that he had not said he would kill himself and did not want her to call the prison. (There is no evidence that Ranby received any calls about Mr Carroll.)

37. Mr Carroll spoke to his wife four more times that evening. This amounted to an hour in conversation. However, the investigator could not listen to the calls as the CD was corrupt.

38. At a secondary health screen on 30 June, a nurse recommended that Mr Carroll should occupy a single cell due to his skin condition and recorded that he had no known mental health history. Mr Carroll was referred to the prison's substance misuse team for help with coping mechanisms for binge drinking. Mr Carroll had been under the care of community drug and alcohol services in 2016.

39. From 30 June to 5 July, Mr Carroll spoke daily to his wife, often multiple times and for up to three hours a day.

40. On 1 July, an officer checked on Mr Carroll's welfare as he had only recently arrived. The officer noted no change from when Mr Carroll had first arrived and that he denied any thoughts of suicide or self-harm. The officer told Mr Carroll to speak to staff if anything changed or if he had any issues.

41. On 3 July, an officer introduced himself to Mr Carroll as his keyworker. (The keyworker scheme is designed to help reduce violence and self-harm by encouraging meaningful contact and positive relationships between officers and prisoners. Although the prison's key worker scheme had been suspended during the Covid-19 pandemic, staff at Ranby continued to check on prisoners weekly, in addition to the usual daily welfare checks.) Mr Carroll told the officer that he had

settled at Ranby but wanted to move to a wing with an enhanced regime. The officer noted that Mr Carroll was very polite and that he had been keeping in touch with his family through regular contact, using his in-cell telephone.

42. During the day, a worker from the prison's substance misuse team assessed Mr Carroll. She noted that Mr Carroll was fully aware of the effects and risks of excessive alcohol intake but said that he did not require support. She said Mr Carroll had not demonstrated any evidence of low mood, anxiety or stress. She said his conversation was good and he had not mentioned any thoughts of suicide or self-harm.

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43. A prisoner who had arrived at Ranby from Nottingham at the same time as Mr Carroll told the investigator that he had got to know Mr Carroll as they had exercised together. He said Mr Carroll always seemed to be telephoning people.

44. The prisoner said that he exercised with Mr Carroll on 6 July, and he appeared to be enjoying it. He said that the only negative thing that Mr Carroll had said was that he had fallen out with the mother of his children, that he did not love her anymore. He said that he never heard Mr Carroll talk about suicide or self-harm.

45. Between 8.30am and 2.30pm, Mr Carroll tried to telephone his wife ten times, but the calls went through to voicemail. Mr Carroll managed to speak with his wife at 2.41pm and 3.07pm and they talked about their relationship. In a call at 3.15pm, they argued about their business. In a call at 3.22pm, Mr Carroll's wife said she would block his telephone number and told him that she did not want to speak to him again. At 3.29pm, Mr Carroll and his wife again argued about money and she told him that she no longer loved him.

46. Mr Carroll spoke to his wife again at 3.37pm, and then tried to call her a further three times between then and 4.00pm. His wife did not answer these calls.

47. A prisoner said that at about 4.00pm, he saw Mr Carroll on the telephone as officers were locking prisoners up for the night. He said he told Mr Carroll to keep his chin up and that, Mr Carroll nodded at him and put his thumb up in response. Mr Carroll spoke to his wife again at 4.40pm and again at 6.33pm.

48. At around 6.45pm, an officer carried out the evening roll check. The officer said that he recalled seeing Mr Carroll sitting on his bed but did not speak to him. The officer recalled that Mr Carroll appeared to be getting on well at Ranby.

49. Mr Carroll tried twice to call his wife at around 7.00pm.

50. At 7.53pm, Mr Carroll spoke to his wife for just over twelve minutes. The call appeared to be distressing to both parties. Mr Carroll said he was "losing his mind" in prison and his wife told him how his actions had affected her and her family. Mr Carroll told his wife that he would be gone if that is what she wanted and would hang up. Mr Carroll told his wife not to call the prison, that she would not hear from him again. Mr Carroll told his wife to tell his child that he just wanted to put things right and to tell him that he loved them. Mr Carroll was upset and said, "I am not

going to call you again, don't call the prison, don't do fuck all, you won't hear from me, yeah, so fuck you, this is on your head, yeah."

51. Mr Carroll and his wife discussed the events that led to his arrest and Mr Carroll asked his wife if she wanted him to die. His wife told him not to threaten her and after Mr Carroll made further accusations about her, she appeared to have hung up.

52. At 8.11pm, Mr Carroll spoke to his wife for a further four minutes. Mr Carroll told his wife that he wanted to put things right and then accused her of meeting someone else and looking for a reason to break up with him. They talked about Mr Carroll's behaviour and offence and his wife told him how his actions had impacted her, before hanging up. This was the last time that Mr Carroll spoke to his wife.

53. At 8.21pm, Mr Carroll tried to call his wife again. The call appears to have gone through to voicemail.

54. A prisoner who occupied a cell next door to Mr Carroll said he heard Mr Carroll arguing that evening on the telephone. He said that there had been rumours in the prison that Mr Carroll had had domestic issues with his wife

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55. At around 4.21am, an Operational Support Grade (OSG) A checked Mr Carroll's cell, having mistaken it for the cell of a prisoner who was being monitored under ACCT procedures. She looked through the cell observation panel and saw Mr Carroll sitting on the bottom bunk of his bed, with his legs stretched out and his arms by his side. However, she could not see Mr Carroll's face as it was obscured by a towel which had been hung at the end of his bed.

56. OSG B, who was with OSG A, also checked and knocked on the cell door, but neither could get a response from him. OSG A used her radio to call the Custodial Manager (CM), the night orderly officer, at about 4.24am. She established a telephone extension on which she could speak to her, and then spoke to the CM on the telephone in the house block's office at around 4.29am. She told the CM that she could not get a response from Mr Carroll. An officer, who was monitoring a prisoner under constant observation on the same houseblock, said he heard OSG A radio the CM at about 4.20am, and that she sounded panicked.

57. In the office, OSG A met Officer A, who said he had heard her radio the CM at around 4.25am and had made his way to the houseblock. The officer said that the OSG told him she could not get a response from Mr Carroll. The CM told the OSG to return to the cell to see if she could get Mr Carroll to respond. The CM said that the OSG did not sound alarmed. When the OSG returned to the cell, Officer A was banging on the cell door. OSG B was also present.

58. Officer A said that when he looked in the cell, he could only see Mr Carroll's legs as the towel hanging at the end of the bed was blocking his full view. He tried unsuccessfully several times to get a response from Mr Carroll, banging the cell door and calling out his name.

59. After around a minute, Officer A radioed the CM and asked her for permission to open the cell door so he could check on Mr Carroll. The CM refused the request

and told Officer A to wait until further assistance from other officers had arrived, and that he was not to enter the cell until he could see them. At around 4.30am, the CM radioed for officers to attend and assist as a prisoner was not responding. Soon afterwards, Officer A radioed the CM again to tell her that OSG A was going to relieve Officer B from the constant ACCT observations so he could assist him.

60. When Officer A saw Officer B arrive on the wing at around 4.34am, he unlocked the cell, went in and found that Mr Carroll had tied a ligature around his neck. Officer A immediately called a medical emergency code blue. (A code blue is used when a prisoner is unresponsive or having breathing difficulties and triggers an automatic request for an ambulance and for healthcare staff to attend.) Officer B followed Officer A into the cell. Officer A cut the ligature, which appeared to be cord from clothing. Both officers checked Mr Carroll for signs of life but there were none. The officers started cardiopulmonary resuscitation (CPR). Officer A said that Mr Carroll appeared slightly stiff and he believed that he had probably already died but instinctively started CPR.

61. A nurse said that before the code blue was called, she heard officers talking on the radio about having trouble getting a response from a prisoner who was being monitored under ACCT procedures. She said it took her around ten minutes to reach Mr Carroll's cell, a journey which would take about half the time during the day but took longer due to restricted movements at night. On her way to the cell, she collected the emergency response bag and arrived at the cell at about 4.40am.

62. The nurse assessed Mr Carroll and noted signs of death, including rigor mortis and pooling of the blood. She told the officers to stop CPR. Paramedics arrived at 5.00am, and confirmed Mr Carroll's death.

Contact with Mr Carroll's family

63. At 10.30am on 7 July, the Head of Safety visited Mr Carroll's wife to break the news of his death. Ranby contributed to the funeral expenses in line with national instructions.

Support for prisoners and staff

64. A residential governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

65. The prison posted notices informing other prisoners of Mr Carroll's death and offered support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Carroll's death.

Post-mortem report

66. As instructed by the Coroner, Mr Carroll's post-mortem examination was limited to an external examination. The pathologist concluded that Mr Carroll died from hanging. Post-mortem toxicology results found no substances in Mr Carroll's body.

67. Mr Carroll died some time between 8.21pm on 6 July when he tried to phone his wife for the last time and 4.21am on 7 July when he was found unresponsive in his cell. We cannot say exactly when he died but when staff entered the cell at about 4.40 am there were signs of rigor mortis, indicating that he had probably been dead for at least four hours.

Findings

Covid-19 restrictions

68. On 24 March 2020, in response to the Covid-19 pandemic and in line with Government advice, HMPPS issued an instruction to all prisons to introduce social distancing and a restricted regime for staff and prisoners, wherever possible. On 27 March, HMPPS issued operational guidance to prisons on exceptional regime and service delivery, which reflected government restrictions following the national lockdown of 23 March.

69. This guidance resulted in significantly restricted prisoner activities. Prison visits were suspended, education and non-essential work was cancelled, and healthcare delivery was also affected. This meant that prisoners spent up to 23 hours a day locked behind their cell doors.

70. At the time of Mr Carroll's death, prisoners at Ranby were allowed out of their cells for a minimum of an hour each day to exercise, have time in the fresh air, have a shower and mix with other prisoners on the wing. When prisoners were locked behind their cell doors, officers checked on them during daily roll and welfare checks.

71. Although the keyworker scheme at Ranby was officially suspended, officers were still assigned prisoners to check on their welfare, as the keyworker did with Mr Carroll on 3 July.

72. The Exceptional Regime and Service Delivery Operational Guidance required prisons to make every effort to ensure resources were available to support prisoners subject to ACCT procedures on the basis that for many, the risk of self-harm could increase as a result of prolonged periods in cells.

Assessment of Mr Carroll's risk

73. Prison Service Instruction (PSI) 64/2011 on safer custody requires that all staff who have contact with prisoners are aware of the risk factors and triggers that might increase the risk of suicide and self-harm and manage prisoners identified as at risk under ACCT procedures. The PSI lists several risk factors and states that potential triggers should be continually assessed.

74. Mr Carroll arrived at Nottingham with some risk factors: he had been charged with assaulting his wife, it was his first time in prison, and he told staff that he felt "numb", that he did not have family or social support (though he also said he had good support). However, Mr Carroll denied thoughts of suicide and self-harm and had no known history of mental ill health or substance misuse (although he later admitted to staff that he was a "binge drinker").

75. Despite these risk factors, we are satisfied that staff reasonably concluded during his first weeks at Nottingham and subsequently at Ranby that Mr Carroll did not need to be monitored under ACCT procedures. Mr Carroll gave no indication to staff that he was thinking about killing himself in the days or weeks before his death.

Although he appeared distressed and talked about killing himself in a phone call to his wife in the week before his death, staff at Ranby were not aware of this.

Impact of Covid-19

76. It is difficult to determine what effect the Covid-19 restrictions may have had on Mr Carroll but being locked in his cell alone for long periods may have affected his wellbeing and mental health. In normal times, staff would also have had more interaction with him and as a consequence may have become aware of his difficult relationship with his wife and been able to consider whether this increased his risk of suicide or self-harm.

77. However, we cannot know that Mr Carroll would have shared his issues about his wife with staff, and we note that he told his wife not to contact the prison. We are satisfied that there was little to indicate to staff that Mr Carroll was at immediate risk of suicide or self-harm at the time of his death, and they could not reasonably have prevented his actions. Even if prison staff had managed Mr Carroll under ACCT procedures at the time of his death, it is unlikely that monitoring levels would have been sufficiently frequent to prevent his suicide.

Public protection issues – Mr Carroll's contact with his wife

78. PSI 04/2016 on the interception of communications requires prisons to monitor communications to identify and manage threats and protect the public. The PSI says that prisoners must not contact the victim of their crime without prior authorisation and a record of all telephone numbers provided must be maintained and stored in prisoner's public protection file. It says that all prisoners must be informed about these restrictions as soon as possible in reception and during induction and made fully aware of the communication rules and policies.

79. PSI 04/2016 also says that staff must check the personal contact numbers of prisoners identified as posing a risk to children or as a domestic abuse perpetrator and of those subject to public protection measures. Staff are required to take proactive steps to block telephone communication with victims.

80. Mr Carroll, who was the subject of a restriction order forbidding him from contacting his wife, was in frequent contact with her during his time at both at Nottingham and Ranby. Mr Carroll got around the system by providing aliases for his wife in order for her telephone number to be authorised on the prison's telephone system. Although some of these numbers were identified at Nottingham and he was barred from using them, Mr Carroll registered a further number for his wife at Nottingham using another alias and this enabled him to have contact with her until the day of his death.

81. These calls appeared distressing for Mr Carroll and his wife, and it is likely that they had an impact on his decision to take his life. Mr Carroll should not have been able to have had contact with his wife as it was contrary to the instructions of PSI 04/2016. We make the following recommendation:

The Governors of Nottingham and Ranby should ensure that robust checks are made on prisoners' telephone contact numbers to ensure that they cannot

have unauthorised contact with victims and individuals who are the subject of public protection orders.

Emergency response

82. We are concerned about the emergency response in the early hours of 7 July. PSI 24/2011 on management and security at nights gives national guidance about entering cells at night. The PSI says that under normal circumstances, the night orderly officer must give authority to unlock a cell at night and a cell must be opened with a minimum of two or three staff present. However, the PSI says that preservation of life must take precedence over this. Where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. However, night staff should not take action that they consider would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid and dynamic risk assessment.

83. When both OSGs were unable to get a response from Mr Carroll, OSG A said they did not immediately go into the cell because she had been told she should never enter a cell at night and that, although she had an emergency cell key in a pouch, she had not been shown how to use it.

84. Officer A told the investigator that he did not know Mr Carroll, could only see his legs and did not have a good enough view to see what he may face if he went into the cell. He said he therefore considered that he did not have enough information to call a code blue. He said that if he could have seen more, it might have affected his decision. He also said his decision not to enter the cell was influenced by the fact that the two OSGs with him were not trained in restraints and in a worst-case scenario if Mr Carroll became violent, he did not feel confident going into the cell with them.

85. The CM said when she spoke to OSG A, she was not aware of the seriousness of the situation, given that a code blue had not been called. She said she had no indication that there was a potentially life-threatening situation, and instead deployed staff to assist. We note, however, that Officer B, who overheard the call, said that the OSG sounded panicked when she spoke to the CM. In addition, the OSG mistakenly told the CM that the prisoner who was not responding was on an ACCT. Although this was not the case, we consider that any situation in which a prisoner on an ACCT is not responding and cannot be seen properly should be treated as serious and urgent.

86. We recognise that it can be difficult for staff to make instant decisions in difficult and unknown circumstances. However, when there is a potentially life-threatening situation, it is essential that staff act quickly and exercise good judgement. While we understand the need for staff not to put themselves in danger or risk the security of the prison, we would normally expect staff to go into a cell as soon as possible in case there is a chance of saving someone's life. Although we recognise that the officers were not able to assess Mr Carroll's risk fully because they could not see his face, they were aware that Mr Carroll had not responded or moved for several minutes. We also note Officer A initially asked the CM for permission to enter the

cell, suggesting that he was confident in going into the cell with the operational support grades. We were not present and cannot therefore say categorically that Officer A and the OSGs should have gone into Mr Carroll's cell to help, having told the night manager and knowing that further assistance was on its way. However, we consider that Officer A's instinct to enter the cell was correct and we are concerned that the CM did not respond with more urgency and that OSG A did not know that she could enter a cell.

87. Officer A appropriately radioed a code blue after entering the cell and seeing that Mr Carroll had tied a ligature around his neck. However, this did not occur until 4.34am, almost 15 minutes after OSG A initially raised concern. This led to a delay in calling an ambulance.

88. The delay in entering the cell and calling a code blue did not affect the outcome for Mr Carroll as he had clearly been dead for some time. However, a delay of even a few minutes could make the difference between life and death in other medical emergencies. We therefore make the following recommendations:

The Governor of Ranby should ensure that all staff are reminded that, subject to a risk assessment, they should enter a cell as quickly as possible if there is reason to believe that a prisoner's life is in danger, in line with PSI 24/2011.

The Governor of Ranby should share a copy of this report with the CM, both OSGs and Officer A and arrange for a senior manager to discuss the Ombudsman's findings with them to ensure they are aware of the provisions of PSI 24/2011.

89. PSI 24/2011 requires local operating procedures to give clear instructions to staff about the issue, storage, and secure use of keys (including those in sealed pouches). Emergency cell keys, held in a sealed pouch, are issued to staff for use in a life-threatening situation. We are concerned that OSG A did not enter the cell because she said she had not been trained to use an emergency cell key. We make the following recommendation:

The Governor of Ranby should ensure that all operational support grades are trained in the use of the emergency cell key pouches.

90. The nurse said she was delayed in getting to Mr Carroll's cell because some of the prison's gates were double locked and when she arrived on the houseblock, officers were unable to unlock the double lock on the gate. She decided to take another route which added a couple of minutes to her journey.

91. At night, healthcare staff do not carry duplicate keys to enter the prison's houseblocks and must wait for the night orderly officer or their assistants to take them to the scene of an emergency. The nurse was delayed in getting to Mr Carroll's cell because of security arrangements, which we appreciate are necessary. However, we consider prisons should do everything they can to ensure that nurses are able to attend medical emergencies as soon as possible. We make the following recommendation:

The Governor and Head of Healthcare at Ranby should ensure that nurses are able to reach prisoners as quickly as possible when there is an emergency at night.

Clinical review

92. The clinical reviewer considered that the care that Mr Carroll received was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community. Healthcare staff had not identified any mental health problems and Mr Carroll had not expressed any thoughts of suicide or self-harm. A healthcare professional from the prison's substance misuse team saw him only four days before his death and he had not shown any signs of anxiety, stress or low mood. However, the clinical reviewer identified some deficiencies in the support offered to healthcare staff after a death in custody, which the Head of Healthcare will need to address.

Inquest Verdict

93. The inquest into the death of Mr Carroll concluded on 20 February 2023. It confirmed that the medical cause of Mr Carroll's death was hanging and concluded that his death was suicide.

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