Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Hart, a prisoner at HMP Ranby, on 5 December 2021

A report by the Prisons and Probation Ombudsman

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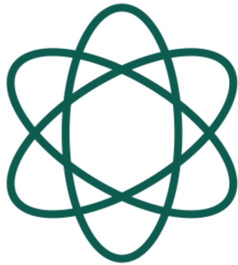
Our vision

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

OGL

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

If my office is to best assist HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Thomas Hart died of a haemorrhage into a cerebral abscess (when bacteria enters the brain through the bloodstream), caused by septic emboli (blood clots that contain bacteria) at Northern General Hospital on 5 December 2021, whilst a prisoner at HMP Ranby. He was 26 years old. I offer my condolences to Mr Hart's family and friends.

The investigation found that the clinical care Mr Hart received at Ranby was equivalent to that he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman **August 2023**

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Summary

Events

1. Mr Hart was recalled to prison on 4 November 2021, after breaching his licence conditions. He was sent to HMP Nottingham. At his initial healthcare screening, the nurse recorded that Mr Hart had suspected heart disease and substance misuse issues. She referred him to the substance misuse service. The GP at Nottingham reviewed Mr Hart later that day and noted that he used mamba (a synthetic cannabis). He also had a heart condition and a history of depression.

2. On 22 November, Mr Hart transferred from Nottingham to HMP Ranby at his request. On entry, an officer completed a body scan (an X-ray which identifies people who are trying to smuggle items into prison by secreting them internally). Mr Hart's results were initially inconclusive, then negative.

3. On 25 November, officers told healthcare staff that Mr Hart was acting strangely and seemed confused. He refused to go to hospital and officers agreed to check on him every 30 minutes.

4. On 26 November, Mr Hart appeared to be under the influence of drugs and refused to engage with staff. Prison and healthcare staff decided to move Mr Hart to the segregation unit for his own safety. Mr Hart was body scanned before he entered the segregation unit and the X-ray indicated that he had parcels internally secreted.

5. Officers rescanned Mr Hart on 27 and 28 November. The results were positive on both occasions. Nursing staff completed regular checks on Mr Hart during his time in segregation.

6. At 1.11pm on 29 November, healthcare staff carried out a routine review of Mr Hart, found him pale and short of breath and called a code blue (a radio code which tells prison staff that a prisoner is struggling to breathe and initiates the calling of an ambulance). Paramedics arrived and took Mr Hart to hospital.

7. At 4.00am on 5 December, Mr Hart died.

Findings

8. Mr Hart was transferred to segregation for his own safety due to concerns about illicit drug use and the impact on his heart condition. When he refused the transfer, staff explained the reasoning and used a low level of restraint to guide him into a wheelchair. We concluded that these decisions were appropriate in the circumstances.

9. The clinical reviewer concluded that the clinical care Mr Hart received was equivalent to that which he could have expected to receive in the community. However, she had some concerns about the lack of clinical observations taken by clinical staff while Mr Hart was in the segregation unit which are detailed in the annex review and the Head of Healthcare will need to address.

10. We found a lack of clear guidance on the use of body scanners and inconsistent approaches to follow up body scanning amongst staff at Ranby, which the HMPPS and the Governor will want to address.

Recommendations

- HMPPS Directorate of Security, Order and Counter Terrorism should review the national body scanner policy to ensure it provides clear instructions for operators on what to do in the event of an inconclusive result.
- The Governor should remind staff of their requirement to record the date, justification, radiation dosage and result of all body scans in the personal care needs section of the prisoner’s NOMIS report, as per *Use of X-Ray Body Scanners (Adult Male Prisons).*

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Ranby informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

12. The investigator visited Ranby on 24 January. She obtained copies of relevant extracts from Mr Hart's prison and medical records.

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

14. On 6 December 2022, another investigator took over the PPO investigation. The investigator and clinical reviewer jointly interviewed six members of staff at Ranby on 24 January 2023, and two members of staff by Microsoft Teams video on 28 and 31 January.

15. We informed HM Coroner for South Yorkshire West of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Hart's family to explain the investigation and to ask if they had any matters they wanted us to consider. We did not receive a response.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Ranby

18. HMP Ranby is a Category C prison in Nottinghamshire, holding over 1,000 men. Nottinghamshire Healthcare NHS Foundation Trust provides primary healthcare services. Ranby has no inpatient healthcare unit but it has 24-hour healthcare cover. Substance misuse services are provided by Reconnect.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Ranby was an unannounced inspection in April 2022. The inspectors said that the prison had addressed the concerning drug culture that they had seen in 2018 by use of better physical security, sniffer dogs and body scanners.

20. The inspectors reported that there was no prison-wide approach to health promotion. Health service delivery in some areas, particularly substance misuse provision, had been curtailed because of low staffing levels. However, the inspectors concluded that the Reconnect substance misuse service was good.

Independent Monitoring Board

21. 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 to March 2022, the IMB reported that the prison was reasonably safe and that violent incidents had reduced by 60% year on year before the pandemic. The Board commended the empathy shown by staff on the segregation unit.

Previous deaths at HMP Ranby

22. The were three deaths at Ranby in the two years before Mr Hart died, of which two were self-inflicted and one was due to natural causes. There have been two deaths since Mr Hart's death, one suspected to be self-inflicted and one drug related. There are no similarities between the findings in the investigation into Mr Hart's death and our previous investigations at Ranby.

Key Events

Background

23. On 30 June 2020, Mr Thomas Hart was given a sentence of two years and six months for drugs offences. It was not his first time in prison.

24. On 26 September 2021, Mr Hart was released from HMP Ranby on licence. While in the community, Mr Hart attended A&E with chest pain and hospital doctors found that he had an enlarged heart. The hospital referred Mr Hart to the cardiology department (heart specialist), who scheduled an appointment for 19 October. Mr Hart was under the influence of illicit drugs on the day of his appointment so the hospital rescheduled the appointment for 21 December.

25. On 4 November, Mr Hart was recalled to HMP Nottingham for breaching his licence conditions. At his initial healthcare screening, the nurse recorded that Mr Hart had suspected heart disease and substance misuse issues. The nurse referred Mr Hart to the substance misuse service. The GP at Nottingham reviewed Mr Hart later that day and noted that he used mamba (a synthetic cannabis), had a suspected heart condition and history of depression.

26. On 9 November, a GP reviewed Mr Hart and recorded symptoms of anxiety, palpitations and occasional chest pain. The GP asked administrative staff to confirm Mr Hart's cardiology appointment on 21 December, which they did.

27. On 15 November, Mr Hart attended a further review with the GP, who noted that he had no wheeze, no heart failure or shortness of breath. The GP also recorded that Mr Hart was sleeping better and was happy with his medications. The GP instructed staff to call 999 if Mr Hart developed chest pain.

28. On 18 November, Mr Hart made cuts to his arm and staff put additional monitoring in place to manage the risk of suicide and self-harm. Mr Hart said he had harmed himself because he had been recalled to Nottingham instead of Ranby, where his brother was in prison. Mr Hart was familiar with Ranby and the staff working there, having served previous sentences there.

Transfer to Ranby

29. On 22 November, Mr Hart transferred from HMP Nottingham to HMP Ranby. An officer completed a body scan (an x-ray which identifies people who are trying to smuggle items into prison by internally secreting them) as part of standard procedures for new receptions. The initial results were inconclusive. The officer completed a further scan, one hour later, and was satisfied that the scan was negative. He did not record the body scan result in Mr Hart's NOMIS record.

30. At the initial healthcare screening, a nurse recorded that Mr Hart initially failed the body scanner but passed wind and subsequently passed the body scanner. The nurse recorded that Mr Hart was constipated, which might have affected the result. The nurse also noted that Mr Hart was on methadone (a drug which is used to treat opiate addiction), was a smoker, had a history of depression and suspected heart disease. They referred Mr Hart to the substance misuse service and mental health

team. Mr Hart's heart condition was still under investigation by the local hospital, so no care plans were put in place.

Events of 25 November – 5 December

31. At 4.58pm on 25 November, officers told healthcare staff that Mr Hart was acting strangely and seemed confused. Mr Hart would not let healthcare staff take any clinical observations and refused to go to A&E. He signed a medical treatment disclaimer to confirm he was refusing treatment and officers agreed to check on him every 30 minutes.

32. At 9.40am on 26 November, healthcare staff visited Mr Hart's cell to take his clinical observations. They found another prisoner in his cell with him. When staff returned at 10.40am, Mr Hart appeared to be under the influence of illicit drugs and refused to engage. The duty governor, Head of Healthcare and Primary Care Matron discussed Mr Hart's suspected illicit drug use and the potential impact on his heart. They decided to move Mr Hart to the segregation unit for his own safety under Section 45 of the Prison Service Rules (1999).

33. At 1.53pm, officers and a senior practice nurse, transferred Mr Hart to the segregation unit. Body worn camera footage shows them enter the cell, where Mr Hart was asleep. Officers woke Mr Hart up and explained the decision to move him to segregation for his own safety. He stated that he would not go. The officers lifted Mr Hart from the bed in a guiding hold (the lowest level of restraint) and transferred him to a wheelchair.

34. Officers completed another body scan before Mr Hart entered the segregation unit and the scanner indicated that he had parcels internally secreted. Mr Hart said he knew nothing about it. He was placed in a cell with a trap over the toilet, which is used to catch items prisoners may have internally secreted.

35. While he was in the segregation unit, nursing staff visited Mr Hart every 30 minutes. They did not complete any formal clinical observations.

36. On 27 November and 28 November, Mr Hart went through the body scanner again which indicted secreted parcels. The scan on 27 November was recorded in the personal needs section and the case notes section of Mr Hart's prison record, along with the result and radiation dosage. The scan on the 28 November was recorded in the case notes section only and the radiation dose was not recorded.

37. At 1.11am on 29 November, healthcare staff were completing one of their regular checks of Mr Hart and found him pale and short of breath. They called a code blue (a radio code which tells prison staff that a prisoner is struggling to breathe and requesting an ambulance). Paramedics arrived and took Mr Hart to hospital.

38. On 30 November, a GP from Ranby spoke to the hospital, who confirmed that Mr Hart was very ill and likely to be suffering from valvular heart disease clotting anomalies and a bleed on the brain.

39. On 1 December, the hospital doctors discussed Mr Hart's condition with his family. Mr Hart's family agreed to sign a Do Not Attempt CPR order, which meant that hospital staff would not start CPR if Mr Hart stopped breathing.

40. At 4.00am on 5 December, Mr Hart died.

Contact with Mr Hart's family

41. On 1 December, Ranby appointed a family liaison officer, who informed Mr Hart's family of his condition and took them to see Mr Hart in hospital.

Support for prisoners and staff

42. After Mr Hart's death, the duty 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.

43. The prison posted notices informing other prisoners of Mr Hart's death and offering support.

Post-mortem report

44. The post-mortem showed that Mr Hart died of a haemorrhage into a cerebral abscess (a bleed on the brain), caused by a septic emboli (an infection which has blocked a blood vessel). Previous intravenous (through the vein) drug abuse, a dilated aortic root (where the connection between a major blood vessel and the heart is enlarged) and a myocardial infarction (heart attack) were listed as contributory factors.

45. The pathologist completed an examination of Mr Hart's bowel and did not find any packages.

Findings

Clinical Findings

46. The clinical reviewer concluded that the clinical care Mr Hart received was equivalent to that which he could have expected to receive in the community. However, she noted concerns about the lack of physical observations completed by nursing staff when Mr Hart was in the segregation unit between 26 – 29 November 2021.

47. Ranby's segregation policy states that healthcare must visit any prisoner located in the segregation unit daily and make a note of each visit in the medical record. They must make physical and mental health assessments.

48. One of the reasons for Mr Hart's move into the segregation unit was to enable better monitoring of his health condition. He was also thought to be secreting items, which requires monitoring according to Ranby's Secreted Items Protocol. These factors meant physical observations were particularly important for Mr Hart.

49. At interview, the Head of Healthcare, confirmed that Mr Hart was reviewed daily by a nurse but there was no record of any physical checks (such as blood pressure or oxygen levels). Since Mr Hart's death, she has sent a communication to staff to remind them that they need to record the physical observations of prisoners who are in the segregation unit with suspected packages.

50. The clinical reviewer made two recommendations to improve compliance with local policy which the Head of Healthcare will want to address but which did not impact on Mr Hart's death. We therefore do not make a recommendation.

Non-Clinical Findings

Location

51. Section 45 of the Prison Service Rules (1999) and Ranby's local segregation policy states that prisoners can be transferred to the segregation unit for their own safety. This measure can be considered if the prisoner's safety cannot be reasonably assured by other means. Prison Service Order 1700 Segregation states that prisons must consider alternatives before they approve a move to segregation, given the limitations on the environment.

52. On 26 November, the duty governor, Head of Healthcare and Primary Care Matron decided to transfer Mr Hart to the segregation unit for his own safety, based on his suspected heart condition and suspicions that he was using illicit drugs with another prisoner. We investigated whether that transfer was appropriate based on Mr Hart's vulnerabilities. We concluded that the location was justified based on the risk of substance misuse and impact on Mr Hart's health condition and the risk of the potential secreted item. While an inpatient unit might have provided a better environment for Mr Hart, Ranby does not have provision. We also considered Mr Hart's self-harm when he was recalled to HMP Nottingham and subsequent request for a transfer to Ranby, to be close to his brother and staff that knew him. We are

satisfied that in the circumstances, and with regular healthcare visits, segregation was in Mr Hart's best interests.

Use of force

53. When officers told Mr Hart they were moving him to the segregation unit for his own safety, he said he would not go. Officers used a guiding hold (the lowest level of force) to transfer Mr Hart from his bed into a wheelchair. We considered whether this use of force was appropriate. We viewed the body worn camera footage and found that officers explained the reason for the move supportively, and that a guiding hold was a proportionate approach when Mr Hart refused to move.

Body scanning processes

54. Prisoners may hide drugs internally by wrapping them in packages and then either placing them in their rectum or swallowing them. This will not be obvious during a visual search by officers but should be identified by the body scanning equipment now used in some prisons.

55. Use of X-Ray Body Scanners (Adult Male Prisons) May 2020 states that 'if a body scan is inconclusive and therefore it is not clear if a prisoner has internally secreted an item, another scan could be considered if it continues to be justified'. Ranby do not have a local policy on body scanning.

56. On Mr Hart's arrival at Ranby on 22 November 2021, an officer scanned him and recorded an inconclusive result. The officer rescanned Mr Hart an hour later and concluded the scan showed a negative result.

57. During our visit to Ranby on 31 January 2022, a Supervising Officer (SO) reviewed Mr Hart's body scans from 22 November 2021. At the time of the visit, the SO had 18 months experience of using the scanner and said that the interpretation of the scan and the resulting actions can differ between operators depending on their experience. He concluded that Mr Hart's first scan was suspicious and further monitoring should have taken place. He told us that items can take up to 18 hours to move through the digestive system and therefore significant change is unlikely to show after one hour.

58. The SO also reviewed Mr Hart's body scan from 26 November. The SO and the investigator agreed that the shapes on the scanner were very similar to those present on the image recorded on 22 November. The SO accepted that there was a possibility that Mr Hart had secreted items prior to his transfer to HMP Ranby from HMP Nottingham.

59. Our investigation showed that staff were not clear what to do in the event of an inconclusive result. We recognise that that body scanning is not an exact science but consistent practice on follow-up scanning is important for the safeguarding of individuals and reducing the risk of illicit drugs being bought into the prison. National policy should contain clear guidance for staff, specifically, how long to wait before rescanning a prisoner with an inconclusive result. We make the following recommendation:

HMPPS Directorate of Security, Order and Counter Terrorism should review the national body scanner policy to ensure it provides clear instructions for operators on what to do in the event of an inconclusive result.

Information recording

60. Use of X-Ray Body Scanners (Adult Male Prisons) states that the date, justification and radiation dosage of the body scan must be recorded in the personal care needs section of the prisoner's NOMIS record (the main electronic recording system in prisons). This is to manage the prisoner's radiation exposure and to ensure that it does not exceed the maximum annual allowance. The policy also states that the result of the body scan must be recorded in NOMIS.

61. On 22 November 2021, the officer body scanned Mr Hart when he arrived at Ranby. The scan and the result were not recorded in NOMIS. This is a breach of the Use of X-Ray Body Scanners (Adult Male Prisons) policy.

62. On 26 and 28 November, officers scanned Mr Hart while he was in the segregation unit. These scans and the results were recorded in the case notes section of Mr Hart's NOMIS record. The radiation dosage was not recorded in the personal care needs section of Mr Hart's NOMIS record. This again is a breach of the Use of X-Ray Body Scanners (Adult Male Prisons) policy. Therefore, we make the following recommendation:

The Governor to remind staff of their requirement to record the date, justification, radiation dosage and result of all body scans in the personal care needs section of the prisoner's NOMIS report, as per *Use of X-Ray Body Scanners (Adult Male Prisons).*

Inquest

63. The inquest into Mr Hart's death concluded on 9 August 2023, with a verdict of natural causes.

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