Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Shaun Davies, a prisoner at HMP Ranby, on 28 December 2021

A report by the Prisons and Probation Ombudsman

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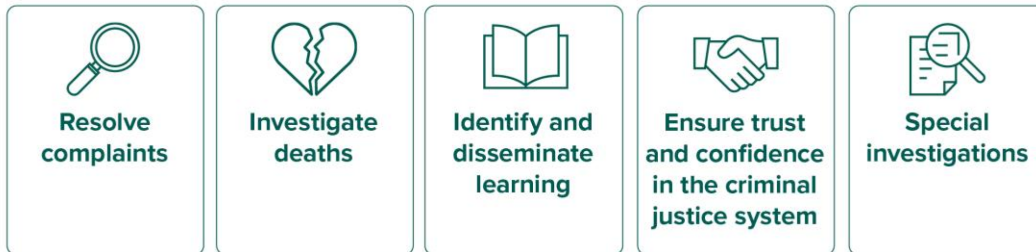
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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

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

Mr Shaun Davies was found hanged in his cell at HMP Ranby on 28 December 2021. He was 51 years old. I offer my condolences to Mr Davies's family and friends.

Mr Davies was given an Imprisonment for Public Protection (IPP) sentence in June 2008, with a minimum tariff of 20 months. He ended up serving more than nine years in prison before he was released in August 2017. He was subsequently recalled to prison three times, the last time in August 2020.

Mr Davies had a long history of mental health and substance misuse issues. He was sent to Ranby on 28 October 2021, after failing a drugs test while he was in open conditions at HMP Sudbury.

In the months before his death, Mr Davies became very agitated and harmed himself after doctors reduced his pregabalin, a prescribed pain relief medication (which is highly tradeable in prison). He had been taking pregabalin for around 11 years, and said it helped with his leg pain and epilepsy.

My investigation found that, while staff at Ranby provided a good level of support for Mr Davies's complex needs, there were some failings in staff assessing and managing his risk of suicide and self-harm. I am also concerned that when Mr Davies harmed himself by cutting his chest, the officer who responded did not tell healthcare staff so there was a delay of around four hours before a nurse saw him.

The clinical reviewer found that the decision to reduce Mr Davies's pregabalin medication was a reasonable one. However, I am concerned that Mr Davies's written complaints about his care were not properly addressed, which would have been a further source of frustration for him.

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 2023**

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Summary

Events

1. In June 2018, Mr Shaun Davies was given an Imprisonment for Public Protection (IPP) sentence for arson with intent to endanger life, with a minimum tariff of 20 months.

2. Mr Davies had a history of substance misuse and mental health problems. During his time in custody, Mr Davies was transferred to a secure mental health hospital for assessment and treatment on three separate occasions.

3. Mr Davies was initially released from prison on 30 August 2017. However, he was released and recalled to prison three times due to breaches of his licence conditions. He was last recalled on 1 August 2020.

4. On 27 July 2021, Mr Davies was sent to HMP Sudbury, a Category D open prison. On 29 September, a prison doctor decided to reduce Mr Davies's pregabalin medication (used to treat pain and epilepsy but also highly tradeable in prison). Mr Davies was unhappy about this and stopped engaging with the mental health and substance misuse teams. He subsequently failed a mandatory drug test and on 28 October, was returned to closed conditions at HMP Ranby.

5. On 5 November, Mr Davies threatened to harm himself if staff continued to reduce his pain relief medication. Staff started ACCT monitoring and set a caremap action that he would have a medication review with a doctor.

6. On 8 November, Mr Davies made a deep cut to his chest which required hospital treatment. Staff stopped ACCT procedures on 29 November. Mr Davies had not had a medication review by then.

7. On 15 December, Mr Davies's solicitor phoned the prison expressing concerns about Mr Davies's mental health. A supervising officer (SO) checked on Mr Davies, and he said he was fine. The SO did not tell the mental health team.

8. On 22 December, Mr Davies told a nurse that he was having suicidal thoughts, but the nurse did not start ACCT monitoring. The nurse told the mental health team, but no one went to see him. Instead, a mental health nurse asked an SO to check on Mr Davies. The SO assessed that he did not need ACCT monitoring.

9. At around 7.28am on 28 December, staff found Mr Davies hanged in his cell from a ligature attached to his medicine cupboard. They immediately called a medical emergency code and cut him down. They thought Mr Davies was dead, but they started cardiopulmonary resuscitation (CPR) while they waited for nurses to arrive. Healthcare staff arrived shortly afterwards and continued CPR until paramedics arrived at around 7.40am. Paramedics confirmed that Mr Davies had been dead for some time.

Findings

10. We found that there were missed opportunities for staff to fully assess Mr Davies's risk of suicide and self-harm in the two weeks before his death. We consider that the SO who checked on Mr Davies on 15 December, following concerns raised by his solicitor, should have told the mental health team. When Mr Davies said that he was having suicidal thoughts on 22 December, no one started ACCT procedures and no one from the mental health team went to see him.

11. We consider that staff stopped ACCT monitoring prematurely on 29 November as the only caremap action, a medication review, had not been completed.

12. We found that some staff were unfamiliar with the ACCT process and did not know whether or not they could start ACCT monitoring. When a newly qualified nurse failed to start ACCT monitoring, we found that no one communicated this error to him. Staff also raised concerns that the level of ACCT training was inadequate.

13. When Mr Davies made a cut to his chest on 8 November, the officer who responded did not tell healthcare staff so there was a delay of more than four hours before Mr Davies received medical treatment.

14. Mr Davies made a formal complaint about the incident on 8 November and, although he received an acknowledgement and was told that a custodial manager would come to talk to him about it, this did not happen by the time of his death. We consider this was an unacceptably long delay in responding to a complaint of such a serious nature. Furthermore, the officer about whom Mr Davies complained was unaware that a complaint had been made against him which indicates that the matter was unlikely to have been fully investigated.

15. One of the nurses involved in the emergency response said she was unaware that Mr Davies had been found hanged. We found that communication between the staff involved was poor, and that staff continued with CPR, even though there were clear signs that Mr Davies was dead.

16. Although staff at Ranby were aware that Mr Davies had been transferred from Sudbury due to a failed drug test, they were not given any other details. We consider that there should be better information sharing when prisoners are transferred in these circumstances. We also found no evidence that a formal investigation was carried out after Mr Davies arrived at Ranby with no pregabalin tablets, even though he left Sudbury with 73 tablets.

17. The clinical reviewer found that the decision to reduce Mr Davies's pregabalin was a reasonable one. She considered that the clinical care he received was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor and Head of Healthcare at Ranby should ensure that staff manage prisoners at risk of suicide or self-harm in line with national instructions, including that they:

- assess the level of risk based on all available information and known risk factors and not on a prisoner's presentation, and record the reasons for the decision;
- involve relevant staff involved in the prisoner's care, such as the mental health team, in the assessment and management of risk, even if a decision is made that ACCT monitoring may not be necessary; and
- ensure agreed actions are recorded on the caremap and the ACCT is not closed until all caremap actions have been fully completed.

- The Governor and Head of Healthcare at Ranby should ensure that staff are appropriately trained and supported in the management of suicide and self-harm and are fully aware of when it is appropriate to start ACCT monitoring.
- The Governor at Ranby should ensure that staff alert healthcare immediately if a prisoner has harmed himself and requires medical assistance, using the appropriate emergency code if necessary.
- The Governor at Ranby should ensure that:
    - prisoner complaints are responded to in accordance with the Prisoner Complaints Policy Framework; and
    - staff are made aware when a prisoner makes a complaint about them so that they have a chance to respond to any allegations made and it can be evidenced that the complaint was fully investigated.
- The Head of Healthcare at Ranby should ensure that:
    - staff responding to a medical emergency code blue should, wherever possible, obtain relevant information about the circumstances of the emergency from those already present; and
    - staff are familiar with the national clinical guidelines on resuscitation and, in particular, that they do not continue resuscitation attempts when there are clear signs of death, such as rigor mortis.
- The Head of Healthcare at Sudbury should review the procedures for ensuring a safe and secure transfer of prisoners, especially those who have recently used illicit substances, including but not limited to:
    - providing clear and accurate information to the receiving prison about the prisoner's circumstances and details of any illicit substances used; and
    - ensuring that any relevant medication, particularly controlled drugs, are securely transferred, with a means of tracking the medication so that any losses or anomalies can be fully investigated.

The Investigation Process

18. 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.

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

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

21. The investigator and clinical reviewer interviewed 13 members of staff at Ranby and one member of Sudbury staff. The interviews were conducted remotely by telephone and video between March and July 2022.

22. 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.

23. The Ombudsman's family liaison officer contacted Mr Davies's brother to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Davies's brother did not have any specific questions.

24. We shared our initial report with Mr Davies's brother. He did not raise any factual inaccuracies.

25. We shared our initial report with the Prison Service. The Prison service did not raise any factual inaccuracies with our report.

Background Information

HMP Ranby

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

HMP Sudbury

27. HMP Sudbury is an open Category D male and young offenders resettlement prison located in Derbyshire. The prison holds over 560 men. Practice Plus Group provides primary healthcare services and substance misuse services are provided by NHS Inclusion.

HM Inspectorate of Prisons

HMP Ranby

28. 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.

HMP Sudbury

29. HMIP carried out a scrutiny visit of Sudbury in April and May 2021. Inspectors reported that since their last full inspection in 2017, the pandemic had affected the prison's ability to maintain the progress they were making in preparing prisoners for release. Inspectors reported that, while some prisoners had regular contact with a prison offender manager, many had not had adequate contact for several months, resulting in considerable frustration. Inspectors were particularly concerned about the high level of negative feedback about staff that they received from their prisoner survey, with only 61% saying that they felt treated with respect and a third reporting victimisation by staff. Inspectors noted that the prison remained generally safe, with few incidents of violence or self-harm. However, they reported that use of force was far higher compared to other open prisons and prisoners had negative views of the use of segregation and the number of prisoners returned to closed conditions. Inspectors considered that these issues contributed to poor prisoner perceptions and undermined the rehabilitative purpose of the prison.

Independent Monitoring Board

30. 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.

HMP Ranby

31. In its latest annual report for the year ending March 2021, the IMB noted that COVID-19 restrictions had been in place throughout the entire period and felt that the Governor and staff had managed to prevent a major outbreak at the prison. It noted that reported acts of self-harm and violence had reduced significantly but suggested that this was probably due to the restricted regime. The IMB reported ongoing concerns about delays in answering prisoners' complaints.

HMP Sudbury

32. In its latest annual report for the year ending May 2021, the IMB were concerned about illicit drugs entering the establishment, although they recognised the practical difficulties facing security staff due to the open nature of the site. They noted that the prison had a zero approach to substance misuse although COVID-19 restrictions had meant that mandatory testing was not taking place. The IMB reported that incidents of self-harm and violence remained low, although they noted an increase in violence which they believed was due to restrictions put in place during the pandemic. The IMB also noted concerns about prisoners having limited contact with prison offender managers and understanding their sentence plan objectives.

Previous deaths at HMP Ranby

33. Mr Davies was the fifth prisoner to die at Ranby since December 2019. Of the four previous deaths, two were self-inflicted and two were from natural causes. We have previously made a recommendation about the prison's management of ACCT procedures.

Assessment, Care in Custody and Teamwork (ACCT)

34. 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.

35. 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.

Imprisonment for Public Protection (IPP)

36. Sentences of Imprisonment for Public Protection (IPPs) were created by the Criminal Justice Act 2003 and started to be used in April 2005. They were designed to protect the public from serious offenders whose crimes did not merit a life sentence. Offenders sentenced to an IPP were set a minimum term (tariff) of imprisonment, after which they can apply to the Parole Board for release. The Parole Board will release an offender only if it is satisfied that they no longer pose a risk to the public. IPP sentences were abolished in December 2012. However, as of 30 September 2022, there were still 1,437 unreleased IPP prisoners and the majority (55%) had been held for more than nine years beyond the end of their tariff.

Key Events

37. In June 2008, Mr Shaun Davies was given an Imprisonment for Public Protection (IPP) sentence for arson with intent to endanger life. His minimum tariff was 20 months.

38. Mr Davies had a history of substance misuse and mental health problems. During his time in custody, Mr Davies was transferred to a secure mental health hospital for assessment and treatment on three occasions.

39. Mr Davies was released from prison on 30 August 2017. He struggled to cope in the community, which resulted in his recall to prison less than a month later for breaching his licence conditions.

40. Mr Davies was released on 8 December 2017 but was recalled again on 19 February 2020.

41. On 22 June, Mr Davies was released to an approved premise (AP, a probation hostel), but was recalled again around five weeks later. He spent nearly a year at HMP Leeds before he was transferred to open conditions in July 2021.

HMP Sudbury

42. On 27 July 2021, Mr Davies was moved to HMP Sudbury, a Category D open prison. Staff identified that he had mental health and substance misuse issues and he was taking a variety of regular medication, including pregabalin which he had been taking for over ten years. (Pregabalin is a prescription medication used to treat nerve pain and epilepsy, but it can also be taken to increase the euphoric effects of other drugs and is highly tradeable in prison.)

43. On 28 July, a prison doctor questioned Mr Davies's need for pregabalin. He noted that there appeared to be no clinical reason for Mr Davies to have it and expressed concerns about the risks of him taking pregabalin given his history of illicit drug use. The doctor suggested a review with the psychiatrist before any changes were made to Mr Davies's medication.

44. On 16 September, Mr Davies had a review with the psychiatrist. Mr Davies was reluctant to reduce his medication and the psychiatrist accepted that a neurologist had previously noted a reduction in Mr Davies's epileptic seizures when using pregabalin. The psychiatrist told Mr Davies that he would not reduce his pregabalin.

45. However, on 29 September, another doctor decided to reduce Mr Davies's pregabalin and monitor any side effects. It is not clear from the records why the psychiatrist's previous decision was overturned or how this change was communicated to Mr Davies.

46. On 11 October, Mr Davies told a nurse and his offender supervisor that he was struggling to share a cell with someone who was using psychoactive substances (PS). He said that he needed to be in a cell on his own. He said that he did not understand why his pregabalin was being reduced and this affected his decision to

stop engaging with the mental health team. He acknowledged it was a poor decision but admitted the reduction in pregabalin and sharing a cell with a drug user had resulted in him using illicit drugs and he was worried that this would spiral out of control. His offender supervisor and the nurse praised him for his honesty and said they would look into moving him to a single cell.

47. Mr Davies subsequently missed several appointments with the mental health and substance misuse services over the following weeks. He later failed a mandatory drug test, which meant that he could no longer be held in open conditions.

HMP Ranby

48. On 28 October, Mr Davies was moved to HMP Ranby, a closed prison. Reception staff identified that he had a history of substance misuse and complex mental health needs, including a personality disorder, and referred him to the relevant teams for further assessment and support.

49. Staff were aware that Mr Davies had failed a drugs test but were concerned that they did not have enough detail about which illicit substances Mr Davies had used before he arrived at Ranby. They were also concerned that Sudbury said that Mr Davies had left with 73 pregabalin tablets but this medication was not with him when he arrived. Staff submitted intelligence reports about the transfer and missing medication.

50. On 5 November, Mr Davies told his substance misuse worker that he would cut himself if staff continued to reduce his pregabalin medication. She started suicide and self-harm monitoring (known as ACCT).

51. At the first ACCT case review, Mr Davies said that he had been on pregabalin for over ten years and that he was in pain due to the reduction. He said that he would have to self-medicate with illicit drugs if staff continued to reduce it. Staff agreed to monitor him on hourly observations and arranged his next review for 12 November. They set a caremap action for Mr Davies to have a medication review with the doctor.

52. At around 5.30am on 8 November, Mr Davies pressed his cell bell. Officer A attended and Mr Davies showed him a cut to his chest. He said he had cut himself as he was frustrated that he was in pain and healthcare staff were not listening to him or giving him the correct dosage of his medication. The officer wrote in Mr Davies's prison record that he had made a superficial cut to his chest and increased his ACCT observations from one to two an hour. The officer told the investigator that he thought the cut was superficial as it was not bleeding, and he did not consider it an emergency. He said that he told the night orderly officer and the staff who took over from him when he went off duty later that morning, but he did not tell healthcare staff.

53. At around 9.30am, Supervising Officer (SO) A collected Mr Davies from his cell to attend an ACCT review because he had harmed himself earlier in the morning. Mr Davies showed the SO the cut to his chest. The SO said that the cut was very deep, and he could see his pectoral muscle in his chest. The SO contacted healthcare staff who said that the cut required suturing at hospital. Mr Davies went

to the hospital but refused to wait for treatment. He returned to the prison with the open wound which healthcare staff dressed for him.

54. At 3.00pm, Mr Davies attended his ACCT review after returning from the hospital. He said he had cut himself as he was unhappy that no one was listening to him about his medication, and he was also experiencing stomach pain and vomiting. SO A agreed that he would look into why his medication had been reduced.

55. Later that day, Mr Davies submitted a complaint to the Governor about Officer A, saying that he had left him to stem the bleed from the cut to his chest and had not told healthcare staff.

56. On 12 November, Mr Davies attended his previously arranged ACCT review. SO A told him that he was on a waiting list to see healthcare about his stomach pains. The healthcare staff present told Mr Davies that, in order to comply with safer prescribing guidelines, it is likely that his pregabalin was being reduced because he had been using illicit drugs. Mr Davies disagreed with this, saying that he only started using illicit drugs when Sudbury started reducing his pregabalin and he was in pain.

57. On 15 November, Mr Davies received a response to his complaint from a prison manager. The manager said he was sorry for the distress caused to Mr Davies and he would ask a custodial manager (CM) to speak to him further about this.

58. Mr Davies had three further ACCT reviews on 16, 21 and 29 November. He continued to express frustration that no one was listening to him about the reduction of his pregabalin and the pain this was causing him. Mr Davies said he had no further thoughts of self-harm. Staff agreed that his issues related to healthcare and could be managed without the support of an ACCT, so they agreed to close the ACCT. However, Mr Davies had not had an appointment with a doctor to discuss the reduction of his pregabalin at this time, even though it was the only caremap action on his ACCT document. SO A said that he thought the issue with his medication had been resolved or he would not have closed the ACCT.

59. On 1 December, Mr Davies had an appointment with a prison GP to review his medication. The GP said that Mr Davies was focused on increasing his pregabalin medication and getting sleeping tablets. When the GP told him that he could not meet his requests and offered alternative solutions, Mr Davies became angry and left the room. The GP said at interview that he felt Mr Davies was at increased risk of suicide and self-harm due to his diagnosis of emotionally unstable personality disorder (EUPD).

60. Later that day, Mr Davies wrote to the Governor again saying that he had not heard anything further from the CM about his complaint. We found no evidence that the CM was aware of the complaint or spoke to Mr Davies or Officer A about it.

61. On 2 December, Mr Davies had an appointment with a prison GP to discuss the reduction of pregabalin and alternative options. The GP agreed with the decision made previously to reduce and eventually stop pregabalin. He prescribed an alternative pain relief medication, duloxetine, to use alongside the pregabalin until it was stopped.

62. On 10 December, Mr Davies said he wanted to speak to his mental health caseworker who was on leave at that time. Another nurse saw him on 12 December, and Mr Davies continued to express anger and frustration about his medication. He said he was in debt, and this was causing him stress which was leading him to use his vape more and resulting in further debt. He blamed healthcare staff for reducing his medication and said that he was in constant pain. He again requested sleeping tablets and said that the stress of his debts meant that he could not sleep. The nurse told him he would not be able to have these. The nurse recorded that Mr Davies's current issues were not related to his mental health issues and that he had capacity to take responsibility for the problems he was facing.

63. On 15 December, a safer custody manager responded to a query from Mr Davies about his complaint relating to Officer A. The safer custody manager wrote that there was no record that healthcare staff had been informed about his self-harm at 5.30am on 8 November, but he said that Mr Davies had been seen by healthcare staff later that morning and had an ACCT review. The safer custody manager provided details of avenues of support for Mr Davies, but he did not say why the CM had not spoken to him as previously promised or how he intended to resolve the complaint. We found no evidence that anything further was done to address Mr Davies's complaint. Furthermore, Officer A told the investigator that he was unaware that Mr Davies had made a complaint against him as no one had discussed it with him.

64. On 15 December, SO A carried out a welfare check on Mr Davies after the safer custody line received a phone call from his solicitor, expressing concerns about his mental health and medication. The SO noted that he knew Mr Davies quite well, having been involved in many of his ACCT reviews, and he did not have any concerns about him. At interview, he said that Mr Davies was making a cup of tea, watching television, and told him he was fine. He did not contact the mental health team about the concerns raised by Mr Davies's solicitor.

65. On 21 December, Mr Davies met his mental health caseworker, who noted that he engaged well in the session and seemed mentally stable. Mr Davies said he was not sleeping at all, but he refused sleep support and asked for sleeping tablets instead. He said he was in pain due to the pregabalin being stopped and the alternative medication was making him sick. The caseworker recorded that Mr Davies needed ongoing support from the mental health team and from his offender manager to work towards his parole in June 2022.

66. On 22 December, Mr Davies had a dressing clinic appointment with a nurse. While there, he told the nurse that he had pain in his leg, and he was feeling suicidal because of it. The nurse assessed him for deep vein thrombosis (DVT) which was found to be negative. He also ordered some blood tests. The nurse did not start ACCT procedures. At interview, he said that he was newly qualified and had not had any ACCT training, so he did not think that he could open an ACCT. He did, however, send a task to the mental health team, outlining his concerns about Mr Davies and his statement of suicidal thoughts.

67. On 23 December, the mental health caseworker picked up the task sent by the nurse the previous day. She was concerned that the nurse did not immediately start ACCT procedures. However, she did not go to see Mr Davies herself, but

instead she contacted the wing and asked staff to check on him to establish if he needed the support of an ACCT. SO B carried out a welfare check on Mr Davies and reported back to the mental health team that he was concerned about pain in his leg and told her he was having a blood test to establish if it was DVT. He was also pursuing a complaint against healthcare but was otherwise in good spirits and she had no cause for concern about him.

68. At interview, the mental health caseworker said she was unable to see Mr Davies herself because of workload pressures and she was unable to comment on why no one else from the mental health team was available to see him. She said she trusted the assessment of SO B. She said she arranged for an email to be sent to all healthcare staff telling them to immediately open an ACCT if Mr Davies made any further threats of self-harm or expressed suicidal thoughts. However, she agreed that, in hindsight, perhaps a plan could have been put in place for someone from the mental health team to check on him over the Christmas period, but this was not done.

Events of 28 December 2021

69. At 7.28am on 28 December, during the morning roll count, an officer saw Mr Davies hanging in his cell from his medicine cupboard behind the cell door. He had used a sheet as a ligature. She immediately radioed an emergency code blue and other staff attended. They went into the cell, cut the ligature, and put Mr Davies onto the bed.

70. SO A was among the first to respond. At interview, he said he had extensive medical training from his time in the army and he thought that Mr Davies was dead. He said he was not breathing, he had no pulse, was cold to the touch and blood had pooled in the lower half of his legs (known as lividity), indicating that he had been hanging for some time. Despite this, he said he did not feel it was his place to confirm that Mr Davies was dead, so he and his colleagues began CPR.

71. A nurse and two other members of healthcare staff arrived shortly afterwards with the emergency bag. The nurse said she took the lead in the resuscitation while waiting for the ambulance to arrive. However, she said she had not realised that Mr Davies had been found hanging. She thought he had perhaps had a heart attack or stroke and was found unresponsive on the bed. Despite not knowing what happened to him, and seeing visible signs of rigor mortis, she continued trying to resuscitate him until paramedics arrived at around 7.40am and confirmed that he had been dead for some time.

Contact with Mr Davies's family

72. At 11.45am on 28 December, the prison's family liaison officer and the prison's chaplain visited the home address of Mr Davies's brother to break the news of his death. The prison contributed to the funeral expenses in line with national instructions.

Support for prisoners and staff

73. A prison manager 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.

74. The prison posted notices informing other prisoners of Mr Davies'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 Davies's death.

Post-mortem report

75. The pathologist concluded that Mr Davies died from asphyxia due to hanging. Post-mortem toxicology results found traces of synthetic cannabinoids (PS) in Mr Davies's body.

Findings

Assessment and management of Mr Davies's risk

76. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others or from others (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.

77. We are concerned that in the two weeks before Mr Davies's death, there were missed opportunities to properly assess his risk of suicide and self-harm and put supportive measures in place.

78. Although SO A carried out a welfare check on Mr Davies on 15 December, after Mr Davies's solicitor phoned the prison concerned about his client's mental health, he did not tell the mental health team about the solicitor's concerns. He said that Mr Davies was making a cup of tea, watching television, and seemed fine. Given that Mr Davies's solicitor was so concerned about Mr Davies's mental health that he contacted the prison, we consider that the mental health team should have been alerted.

79. No one started ACCT monitoring on 22 December when Mr Davies told staff that he was having suicidal thoughts. A nurse thought he was unable to start ACCT monitoring. We consider that this was as a result of poor training. Although the nurse sent a task to the mental health team, no one from the mental health team went to see Mr Davies. Instead, a mental health nurse asked wing staff to check on him and SO B saw him the next day. The SO noted that he gave her no cause for concern and so she did not open an ACCT. There is no evidence that she considered the statements that Mr Davies had made the previous day when making this assessment.

80. Additionally, although ACCT reviews were generally well-managed, we found that staff stopped ACCT monitoring on 29 November before the only caremap action (a medication review) had been completed. We recommend:

    The Governor and Head of Healthcare at Ranby should ensure that staff manage prisoners at risk of suicide or self-harm in line with national instructions, including that they:

    - **assess the level of risk based on all available information and known risk factors and not on a prisoner's presentation, and record the reasons for the decision;**
    - **involve relevant staff involved in the prisoner's care, such as the mental health team, in the assessment and management of risk, even if a decision is made that ACCT monitoring may not be necessary; and**
    - **ensure agreed actions are recorded on the caremap and the ACCT is not closed until all caremap actions have been fully completed.**

The Governor and Head of Healthcare at Ranby should ensure that staff are appropriately trained and supported in the management of suicide and self-harm and are fully aware of when it is appropriate to start ACCT monitoring.

Requesting medical assistance

81. When Mr Davies made a cut to his chest at 5.30am on 8 November, while subject to ACCT monitoring, there was an unacceptable delay of around four hours before he received medical attention. Officer A said that he thought the cut was superficial and it was not necessary to call a medical emergency code red (which alerts the control room that a prisoner has severe blood loss, and an ambulance is required). He said that he did not call healthcare as he believed that, based on the information he would have relayed to them, they would not have assessed Mr Davies at that time. He considered that he acted appropriately in increasing Mr Davies's ACCT observations, informing the orderly officer, and telling his colleagues at handover.

82. While we agree that an ambulance was probably not necessary and Officer A put some appropriate plans in place, we are concerned that no one alerted healthcare staff and Mr Davies was not seen until 9.30am. Healthcare staff assessed that Mr Davies needed to go to hospital to have the wound sutured, so we can only conclude that the wound was significant rather than superficial. We recommend:

The Governor at Ranby should ensure that staff alert healthcare immediately if a prisoner has harmed himself and requires medical assistance, using the appropriate emergency code if necessary.

Response to Mr Davies's complaints

83. When Mr Davies made a complaint about Officer A's failure to get healthcare staff to assess him, he received a reply from a prison manager to say that a custodial manager would contact him to discuss this. However, this did not happen, and Mr Davies was forced to write again to chase the complaint three weeks later. A safer custody manager replied, indicating that the matter had been dealt with and pointed Mr Davies to sources of support. We do not consider that this adequately addressed Mr Davies's complaint and we believe this would have been a further source of frustration for him.

84. We were also concerned to learn that Officer A was not aware that Mr Davies had made a complaint about him until the time of his interview with the PPO investigator. We therefore consider it unlikely that Mr Davies's complaint had been fully investigated and given the serious nature of his complaint, we find this unacceptable. We recommend:

The Governor at Ranby should ensure that:

- **prisoner complaints are responded to in accordance with the Prisoner Complaints Policy Framework; and**
- **staff are made aware when a prisoner makes a complaint about them so that they have a chance to respond to any allegations made and it can be evidenced that the complaint was fully investigated.**

Emergency response

85. European Resuscitation Council Guidelines 2010 say that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …" The guidelines give examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased.

86. When prison staff found Mr Davies hanging in his cell, they cut him down and started CPR on his bed, even though they thought he had been dead for some time. When healthcare staff arrived, they continued with CPR, despite clear signs of rigor mortis. The nurse said she was aware of the guidance, but she felt she had to continue to try. She said she would do the same again in similar circumstances.

87. The nurse said that she was unaware that Mr Davies had been found hanging, but she did not know exactly what had happened to him until after the paramedics arrived. We consider that, as the nurse in charge of the emergency response, she should have communicated with other staff to establish what had happened to Mr Davies. We recommend:

The Head of Healthcare at Ranby should ensure that:

- **staff responding to an emergency code blue should, wherever possible, obtain relevant information about the circumstances of the emergency from those already present; and**
- **staff are familiar with the national clinical guidelines on resuscitation and, in particular, that they do not continue resuscitation attempts when there are clear signs of death, such as rigor mortis.**

Transfer from Sudbury and missing pregabalin

88. While staff at Ranby were aware that Mr Davies had failed a drugs test at Sudbury, they had no further details about his drug use. We found no evidence of a clear protocol or guidance about transferring prisoners who have used illicit drugs from Category D to Category C prisons. We share the concerns of staff at Ranby about the lack of information sharing. We also found no evidence of an investigation into how 73 pregabalin tablets went missing between Mr Davies leaving Sudbury and arriving at Ranby. We recommend:

The Head of Healthcare at Sudbury should review the procedures for ensuring a safe and secure transfer of prisoners, especially those who have recently used illicit substances, including but not limited to:

- **providing clear and accurate information to the receiving prison about the prisoner's circumstances and details of any illicit substances used; and**

- **ensuring that any relevant medication, particularly controlled drugs, are securely transferred with a means of tracking the medication so that any losses or anomalies can be fully investigated.**

Clinical review

89. The clinical reviewer considered that the care that Mr Davies received was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community. She considered that the decision to reduce Mr Davies's pregabalin was a reasonable one.

Inquest

90. At the inquest, held on 23 October 2023, the jury concluded that Mr Davies died by suicide.

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