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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man at HMP Ranby  
in June 2013**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man who was found hanging in his cell in HMP Ranby on the morning of 8 June 2013. The man was 23 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the man's clinical care in custody. HMP Ranby cooperated fully with the investigation.

The man was recalled to prison on 17 May. He was first held at HMP Woodhill for six days then transferred to Ranby on 23 May. On 3 June, the man reported that his partner had been raped. He was given extra telephone credit to allow him to speak to his partner but does not appear to have been given any additional support and wing staff were not informed that he had received distressing news. Shortly afterwards his cellmate was moved, leaving the man on his own in the cell. On 7 June, the man's partner visited him. The man did not indicate any signs of distress after the visit or behave in any way that caused concern to staff or other prisoners who knew him. The next morning a friend of the man's went to his cell and found him hanging. Attempts at resuscitation were unsuccessful.

I agree with the clinical reviewer that some aspects of the man's clinical care were below standard. Although the man had suffered a brain injury two years previously, his GP records were never obtained. The man had disclosed at Woodhill that he had self-harmed just two months earlier but this did not result in a mental health referral and this information was missed at Ranby. While I accept that the man gave little indication of his feelings, making it difficult to predict and prevent his actions, there were a significant number of missed opportunities to identify and assess his risk at both prisons and there appears to have been no assessment of his risk of self-harm at Ranby at all. Finally, although it appears that it was too late to save the man, I am concerned that Ranby did not have a protocol to ensure an ambulance was called automatically as soon as an emergency code was called.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**March 2014**

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## SUMMARY

1. The man was 23 years old. In 2011, he had been sentenced to four years imprisonment and was released on licence on 15 May 2012. On 17 May 2013, the man was recalled to prison after breaking a licence condition preventing him from staying at his partner's address. He was also facing possible charges relating to domestic violence. He was taken to HMP Woodhill. At a reception health screen, he disclosed that he had cut his wrists two months previously and that, in 2011, he had suffered a brain injury in a motor accident. Although he had a number of known risk factors, he was not identified as a risk of suicide and self-harm at Woodhill and it is not apparent that these risk factors were considered.
2. On 23 May, the man transferred to Ranby. The nurse who carried out his initial health screen did not have full access to his medical records and was unaware that he had recently harmed himself. She did not ask him any questions about previous self-harm. The man told her about his accident and brain injury and she referred him to the doctor to have his prescriptions for painkillers confirmed. His GP records were not requested and he did not have a secondary health screen to allow a more detailed assessment of his physical or mental health and check how he had settled.
3. There were no reports or indications that the man had any problems in the prison. However, during a telephone call on 3 June, his partner told him that she had been raped. The man explained what had happened to an officer and applied for extra telephone credit, so that he could talk to his partner further. His request was approved, but there is nothing to show that he was given any other support or that other staff on the wing were made aware that he had received distressing news and might be upset.
4. On 6 June, the man's cellmate was moved, leaving him on his own in the cell. His partner visited him the next day and the man did not give staff or other prisoners who knew him any reason to have concerns about him after the visit.
5. No problems were reported during the night of 7/8 June. There was a technical problem with cell bell records at the time which means we have been unable to check authoritatively whether the man used his emergency cell bell that night but there is no indication that he did so. The officer who unlocked the man's cell on the morning of 8 June at about 9.00am said that he recalled seeing the man at the back of his cell, but he did not speak to him. Shortly afterwards, another prisoner went to the man's cell and found him hanging. An officer began cardiopulmonary resuscitation, which nurses continued when they arrived, although the nurses believed that the man had been dead for some time. Paramedics arrived and, shortly afterwards, at 9.52am they confirmed that the man had died. Later that morning, a prison manager went to see the man's mother to let her know her son had died.
6. We agree with the clinical reviewer that there were some shortcomings in the man's care, such as the failure to obtain his GP records to provide continuity of medical care. At Woodhill, he was not referred for a mental health assessment despite his recent self-harm and this information was missed by reception staff at Ranby. The man did not have a full health assessment at either prison and neither Woodhill nor Ranby considered he was at risk of suicide and self-harm,

although he had a number of risk factors for suicide which do not appear to have been considered.

7. Assessing the risk a prisoner poses to himself is not an exact science and involves balancing the prisoner's demeanour and behaviour against known risk factors. Although opportunities were missed to identify some of the man's vulnerabilities, we accept that overall he gave little indication that he might harm himself and it would have been difficult to foresee or prevent his death.

## THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Ranby informing them of the investigation and inviting anyone with relevant information to contact him. One prisoner responded but his information was not relevant to the investigation.
9. The investigator obtained the man's prison and medical records. He visited the prison on 12 June and spoke to the deputy governor and other prison staff, including on the wing where the man had lived. He later interviewed seven members of prison staff and one prisoner at Ranby. He gave preliminary feedback to the Governor about the initial findings of the investigation.
10. NHS East Midlands commissioned a clinical reviewer to review the man's clinical care and treatment in custody. The investigator liaised with the clinical reviewer and discussed his findings with him.
11. As is routine in a death in prison, the police initially looked into the circumstances of the man's death and found no evidence of criminal activity. The police shared their witness statements with the investigator.
12. The investigator informed HM Coroner for Nottinghamshire and Nottingham City of the PPO investigation and the Coroner provided a copy of the post-mortem report. Our investigation report has been sent to the Coroner.
13. One of our family liaison officers contacted the man's mother to outline the purpose of the investigation and to give his family the opportunity to identify issues they wished the investigation to cover. The man's mother said that she had not been aware of any signs that the man was feeling suicidal. She asked whether he had received appropriate care, support and medication in view of his previous brain injury and whether sharing a cell might have provided more support for him.

## **HMP RANBY**

14. HMP Ranby is a category C male prison, for prisoners who do not require a high level of security but are not ready for open conditions. It holds over a thousand prisoners. There is no CCTV coverage of the wings. Nottinghamshire Healthcare NHS Trust began providing the primary healthcare at HMP Ranby on 1 April 2013.

### **Her Majesty's Inspectorate of Prisons**

15. The most recent inspection of Ranby was in March 2012. Inspectors found that the prison delivered its core training and resettlement functions well. The report noted that levels of self-harm were low and suicide and self-harm procedures were reasonable.

### **Independent Monitoring Board (IMB) report**

16. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. The most recent IMB report for Ranby for the year to 31 March 2013 noted that medical records from other prisons were sometimes inadequate and that reduction in staffing had increased fears about violence and self-harm.

### **Previous deaths at Ranby**

17. The first self-inflicted death at Ranby, since the Ombudsman's office began investigating deaths in prisons in 2004, occurred in June 2013. The man died a week later. Although the methods were similar, there is no indication that the man and the other prisoner knew each other, or that there is any link between the two deaths. There has since been a further death at Ranby.

## KEY EVENTS

18. The man was born 17 January 1990. He had a number of previous convictions and had spent time in prison before. In 2011, while trying to evade arrest, the man had a road traffic accident and was seriously injured. He was in a coma for 15 days and suffered brain, chest and other physical injuries. He was subsequently sentenced to four years imprisonment for burglary.
19. While in prison, the man received medical care for difficulties with speech, arm movements and walking, resulting from his road traffic accident. He undertook several offending behaviour courses and trained as a Listener (prisoners who are trained by the Samaritans to provide confidential support to other prisoners in distress).
20. The man was released on licence in May 2012, but was recalled on 15 May 2013, after breaching his licence conditions about staying at his partner's address, and on suspicion of further offences. He was taken to HMP Woodhill. At a reception health screen with a nurse he referred to his accident and the resulting coma. He said that he was still taking painkillers for his injuries. He told the nurse that he had cut his wrists about two months previously, but had no thoughts of harming himself at that time. The nurse considered that he seemed to be in a stable mood. In spite of his reported self-harm, he was not referred to the mental health team. There is no further reference to self-harm in his medical record.
21. A prison doctor reviewed the man and discussed his back and shoulder pain. There was no reference to his previous self-harm. The man told the doctor that his GP had prescribed tramadol (a painkiller) and amitriptyline (an antidepressant, which is also used in low dosage for pain relief or insomnia). The doctor noted that his medication should be confirmed.
22. A nurse conducted a secondary health screen on 18 May. The man repeated that he had suffered a brain injury after a motorbike accident. The nurse completed a threshold assessment grid to assess the severity of any mental illness. She recorded the score as "1" and "mild" and noted no concerns about self-harm or suicidal intent.
23. At an interview with an officer later that day, the man said he was concerned about encountering his partner's brother, who he believed had assaulted his sister and was also in Woodhill. He said that he had no thoughts of harming himself.
24. On 23 May, the man transferred to Ranby. His escort record notes that he was prescribed medication. No specific risks were identified. When he arrived, the nurse carried out an initial health screen. When interviewed by the investigator, the nurse said that staff conducting health screens do not have access to the prisoners' previous computerised health records until they have completed the screening and saved the information to the system. She was therefore unaware that the man had told a nurse at Woodhill that he had recently cut his wrists. The nurse said that the initial health screen does not contain any specific questions about suicide and self-harm which would only be identified if the prisoner himself raised it. The Head of Healthcare at Ranby, subsequently confirmed that this was the case.

25. The man told the nurse about his accident and the associated injuries, but said that he had no outstanding hospital appointments in relation to his injuries. The nurse noted that the man might require a course of medication to treat hepatitis B and referred him to the prison doctor for his prescription of tramadol to be confirmed. The nurse did not consider that it was necessary to request his records from his community GP as the prison doctor would review his medication and he had no pending hospital treatment.
26. The man's cell sharing risk assessment (to identify prisoners at risk of seriously assaulting or killing a cell mate) indicated that he was a standard risk, with no issues relating to self-harm and he was allocated a shared cell on F wing. The man's cellmate on F wing said that the man was quiet. Although he was worried about whether he would be facing new police charges in relation to violence against his partner, the man's cellmate said he did not seem to have any other problems or indicate that anything else was troubling him.
27. On 28 May, the man moved to a double cell (3-15) on K wing, which he shared with another prisoner. The prisoner said he had not known the man before but after some initial shyness, they became relaxed with each other.
28. On 3 June, the man's partner told an officer that his partner had told him in a telephone call that she had been raped. As the man had no telephone credit left, he applied for extra credit to allow him to make further calls to her. He explained on the application form that his girlfriend had been raped and that the police were involved. He then gave the form to an officer who passed it to the wing manager, a Senior Officer (SO) for approval the same day. The prisoner told the police that when the man came back to their cell, after the telephone call, the man told him what had happened to his partner. He said that the man was quiet for the rest of the evening.
29. The SO told the investigator that he did not assess the content of applications before approving them to see if prisoners needed extra support. He said he relied on the officer submitting the application to have considered the reasons and taken other appropriate supportive action if necessary. He said he would have expected the officer to have assessed whether the man had been particularly affected by the news and, if necessary, to have started monitoring and support under suicide and self-harm prevention measures.
30. During an association period that week, when prisoners are able to mix with each other on the wing, the man's cellmate said that the man told him what had happened to his partner. He said the man was very agitated about it and had mentioned that his partner was due to visit him that Friday.
31. On Thursday 6 June, the prisoner moved to another cell, which left the man on his own in cell 3-15. The man's cellmate said that that evening, the man had told him that his partner was all right and that the police were investigating what had happened. The man's cellmate said that he seemed back to his normal self. The man also spoke to the prisoner that day, who thought that the man seemed happy at the prospect of a visit from his partner the next day.
32. At lunchtime on 7 June, the man went to his friends cell to use some aftershave before his visit that afternoon. The man's friend thought that everything

seemed normal. He said that he had reminded the man that his partner might be upset after what she had gone through.

33. A SO was in charge of visits that afternoon. He told the investigator that he had not been told in advance that the man had any problems and nothing had happened during the visit to alert staff to any potential problems.
34. A prisoner on K wing who knew the man, said that he saw him briefly, just in passing on the Friday evening after visits. He said they did not have any deep conversation and he did not notice anything in particular about the man's mood or demeanour to cause him concern or which indicated that the man was distressed.
35. After prisoners were locked into their cells, a roll check (a count of prisoners) was carried out at approximately 9.15pm. No concerns about the man were identified at that time. We do not know for certain whether the man used his cell call bell to alert staff for any reason during the night as there was a technical fault with the cell bell recording system at the time. However, there is no indication from staff or other prisoners that he did. Unless there is a specific reason to monitor them (such as prisoners identified as at risk of suicide and self-harm) prisoners at Ranby are not checked routinely during the night until a 6.00am roll check. Prison staff taking over from the night staff then conduct a further check at approximately 8.00am. An officer conducted the 6.00am check and did not report any problems. An officer came on duty on the morning of 8 June. Between 7.30am and 8.00am, he conducted a roll check on J wing and then K wing. The officer told the police that he did not notice anything untoward during his checks.
36. At approximately 9.00am, an officer unlocked the cells on the man's landing. He told the police that the routine is to open the observation panel, unlock the door, open it slightly and look in to ensure the prisoner is there. During this check, the officer said he does not speak to any of the prisoners. When he unlocked the man's cell, he said he saw him standing towards the back of the cell but said that did not notice anything out of the ordinary.
37. The prisoner who had talked briefly to the man the previous evening, had a cell on the ground floor of K wing. His cell was on the opposite side of the wing to the man's cell which was on the second floor (the third landing). The prisoner told the investigator that he had a friend in a cell a few doors away from the man and that shortly after being unlocked at 9.00am, he had looked up to see if his friend had come out of his cell. As he did so, he said he noticed the man standing in the doorway of his cell. Although the prisoner was looking for someone else, he said he was convinced that he had seen the man.
38. Shortly after the cells were unlocked, the man's friend went to the man's cell. When he arrived, he said the cell door was ajar but not open wide enough for him to see inside so he pushed the door open. The curtains were drawn and the only light in the cell was coming from the television set, which was on. He said it looked as though the man was sitting on the floor by his bed. He went in and called his name and then noticed that the man had something tied between his neck and the bed guard rail from the top bunk. The prisoner was shocked and stepped out of the cell and told another prisoner what he had seen. The prisoner then pressed the emergency button on the landing wall.

39. The officers were on the ground floor landing of K wing, supervising the distribution of orders from the prisoners' shop, when they heard the general alarm and the location which the control room had broadcast over the radio network. They ran up to the third landing, but could not see any sign of an incident. The officers then went along opposite sides of the landing and checked each cell individually. While they were doing so prisoners told them that someone was hanging in cell 3-15. The officers then both arrived at the cell at the same time. The officer estimated that it took about a minute from hearing the alarm.
40. The officers found the man hanging from the top bunk bed by a torn section of bed sheet. There were no signs of disturbance in the cell. One officer supported the man's weight while the other officer used an anti-ligature knife to cut the sheet and they lowered him to the floor. As they did this, another officer arrived and switched on the cell light. The officer radioed to tell the control room that this was a code blue emergency<sup>1</sup>. The officer noted that the man's lips were blue, his mouth and eyes were open and his arms were rigid. A further request was then put over the radio for healthcare staff to bring a defibrillator. The officer checked and found that the man was not breathing. Although he thought it highly likely that the man was dead, the officer began to perform cardiopulmonary resuscitation chest compressions. The officer noted that the man's arms were stiff and moved up and down as the officer pressed down on his chest.
41. A SO arrived at the cell and found an officer performing CPR. He cleared other prisoners from the area and radioed the control room for an ambulance. He offered to take over CPR, but the officer said he would continue. Other staff also responded to the alarm and, after a few minutes, the officer took over the resuscitation attempts from the officer.
42. When the code blue emergency was called over the radio, a nurse and Healthcare Support Worker were dispensing medication in the healthcare centre. They collected the emergency bag and were on their way to K wing, when a further request came over the radio to bring a defibrillator. The nurse then went back to the healthcare centre to collect the defibrillator. The support worker waited and they went to K wing together.
43. When the nurse and support worker arrived, the officer was performing CPR. The nurse said she noticed immediately that there clear signs of rigor mortis and considered that the man had been dead for some time. She could not find a pulse and noted that his pupils were fixed and dilated and his lips and skin were discoloured. His jaws were locked from rigor mortis, so she was unable to insert an airway into his throat. The nurse applied the defibrillator pads to the man's chest but the machine did not detect any shockable rhythm. She then put an oxygen mask on the man and took over the chest compressions from the officer, while he took charge of the oxygen mask. They continued until paramedics arrived, sometime between 9.46am and 9.49. The paramedics checked the man for signs of life, but were unable to detect any. At 9.52am, they confirmed that he had died.

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<sup>1</sup> Code blue means that a prisoner is not breathing or is unconscious.

### **Liaison with the man's family**

44. A manager at Ranby went to the man's mother's home that afternoon to break the news of her son's death in person. Another manager subsequently acted as family liaison officer. She arranged for the man's mother to visit the prison, see her son's cell and collect his belongings. The man's funeral was held on 4 July 2013. Ranby contributed to the costs, in line with national guidance.

### **Debrief**

45. A debrief was held with the staff involved in the emergency response to discuss any issues arising and offer support. It was noted at the debrief that the emergency equipment had been heavy for the healthcare team to carry to K wing. Although the healthcare staff went to the immediate debrief (known as a hot debrief) of all staff, they were not invited to the critical incident debrief held later'. (This appears to have been an oversight which the Governor and Head of Healthcare have subsequently discussed.)

### **Informing prisoners**

46. Notices were posted to prisoners and staff informing them of the man's death. All prisoners who were being monitored as a risk of suicide and self-harm were reviewed in case they had been adversely affected by the man's death.

### **Police information**

47. The police took a letter from the man's cell that he had written to his partner. The letter, which was not dated, indicated that he wished to end their relationship. The police did not consider that it appeared to be a suicide note.

### **Post-mortem**

48. A post-mortem examination showed that there was no evidence of significant natural disease and toxicological assessment showed no significant findings. The pathologist concluded that the man's death was due to hanging.

## ISSUES

### Clinical care

49. The clinical reviewer concludes that the standard of healthcare the man received in prison fell short of that available in the community. He has made a number of recommendations which healthcare managers need to consider. We include those most directly relevant to the man's death in this report.

### *Continuity of care*

#### *Reception and secondary health assessments*

50. Prison Service Order (PSO) 3050 Continuity of Healthcare for Prisoners, gives guidance on the clinical management of prisoners from reception through to discharge, with a focus on those with ongoing health needs. Prisons are required to carry out an initial assessment of healthcare needs of all newly-received prisoners within 24 hours of first reception, to identify any existing health conditions and plan relevant care. The PSO says that "In the week following first reception, every prisoner must be offered a general health assessment" to gather and provide further information and check how the prisoner is settling in. PSO 3050 also requires that healthcare staff should make efforts to obtain information from a prisoner's GP or any other relevant service with which he has had recent contact.
51. When he arrived at Woodhill on 17 May, the man had an initial health screen when he reported that he had sustained serious injuries in a road accident in 2011 and that he had cut his wrists two months before he was recalled to prison. This was followed by a review with the prison doctor, to whom he mentioned that he had been prescribed tramadol and amitriptyline. The doctor noted that his medication should be confirmed with his community GP and a fax was sent to request his records. (There is no record that they were ever received.) A secondary screen was held the next day. There were no concerns identified about self-harm or suicidal intent at the second screen and no further mention of the incident of self-harm in his medical records. No one appears to have explored the circumstances with the man to identify what had triggered it.
52. At his reception screen at Ranby on 23 May, the man told the nurse about his accident and injuries, including a brain injury. He said he had no outstanding medical appointments but was still taking medication. The nurse referred the man to the prison doctor for his prescriptions to be confirmed but did not request his community records. She told the investigator that the prison GP would have had access to the full electronic prison medical record. The nurse and the Head of Healthcare, the Head of Healthcare, both said that as part of the doctor's assessment, they would have expected the doctor to address whether the man required any follow up action in relation to his brain injury. We are concerned that nurses said that they did not have access to the man's electronic medical record from Woodhill when carrying out the initial health screen. This should be available and indicates the system was not being used appropriately. This issue is dealt with below.

53. The man's initial health screen at Ranby appears to have been cursory and, he was not offered and did not receive a secondary health screen, which is best practice when a prisoner transfers to another prison. Healthcare staff did not request his community medical records or chase up the request that had been made at Woodhill. The lack of a secondary health screen meant they did not have a full or informed understanding of any existing medical requirements or check his well-being as a new prisoner. This would have allowed them to verify the information about the man's previous injuries and medication, and to determine what, if any, continuing care he needed. We make the following recommendation:

**The Head of Healthcare at Ranby should ensure that the procedures for continuity of healthcare are consistent with the requirements of PSO 3050 and that healthcare staff:**

- **Routinely request prisoners' community medical records.**
- **Offer a full general health assessment to every prisoner within a week of their arrival at Ranby.**

#### ***Assessment of the man's mental health and risk of self-harm***

54. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)* and PSI 74/2011, *Early Days in Custody*, list a number of risk factors and triggers for suicide and self-harm. Of those listed, the man had or was subject to the following, transfers between prisons; deliberate self-harm; physical illness, especially those associated with pain; and recall to prison. In addition he was facing potential charges of violence against his partner. PSI 74/2011 states that all staff should be alert to the increased risk of suicide or self-harm posed by prisoners in those categories and act appropriately to address any concerns
55. At Woodhill, in spite of disclosing at his initial health screen that he had cut his wrists two months before, the man was not referred to the mental health team and no other action appears to have been taken following this disclosure. The circumstances of his self-harm were not explored with him to identify whether this could be a continuing risk in prison. At a secondary screening the next day, the medical record notes no concerns about self-harm or suicidal intent.
56. The clinical reviewer notes that disclosure of recent self-harm should have prompted a primary mental health review or a referral to the mental health in-reach team but there is no evidence that this was considered. He adds that, "brain injury can be associated with an increased risk of mental illness and can sometimes change mental capacity" and assessment would have clarified this. The man was referred to the doctor only for review of his prescription, not because of his previous injuries and the clinical reviewer considers that the prescription review might have been 'rubber stamped', rather than fully assessed. He concludes that, although there is nothing in the records to indicate any observed degree of mental distress, the management of the man's mental health problems was deficient. We share the clinical reviewer's concern that the man was not referred for a mental health assessment.

**The Head of Healthcare at HMP Woodhill should ensure that prisoners who arrive with a recent history of self-harm are referred for a mental**

## **health assessment.**

57. The nurse who carried out the man's reception health screen at Ranby, said she was unable to access his previous computerised records until she had completed the screen and saved the details on the system, so she was unaware of his recent self-harm. She said the reception health screen template did not contain questions about self-harm and this would only be explored if the prisoner raised the issue. Although the record containing this information would become available once the reception health screen was complete, if no concerns about self-harm had been raised during the screening, the person conducting the screen would not consider the newly-available electronic record. Therefore any causes for concern, such as recent self-harm, would not be identified. The Head of Healthcare later clarified that the electronic record system contains various filters. When certain filters are on, some of the recorded information is not accessible. We consider it is important that healthcare staff have access to all up to date medical information at health screens in order to make an informed assessment and therefore make the following recommendation:

**The Head of Healthcare at Ranby should ensure that all available information about a prisoner from the electronic prison record is accessible to staff carrying out reception health screens.**

58. The man had been recalled to prison and was worried that he was facing possible further charges of violence against his partner. He had deliberately harmed himself just two months before. All these factors are significant indicators of risk of suicide and self-harm. Set against these, the man said that he had no thoughts of suicide or self-harm when asked directly. His behaviour and demeanour gave no indications otherwise.
59. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. However, we are concerned that staff relied so heavily on the man's personal presentation, when he had a number of known risk factors when he arrived at Woodhill. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. We make the following recommendation:

**The Governor of Woodhill should ensure that all the known risk factors of newly-arrived prisoners are fully considered when determining their risk of suicide or self-harm and that this is recorded on the assessment.**

60. We are very concerned that the man's risk of suicide and self-harm was not assessed at all at Ranby. Prison Service Order 3050 (Continuity of Healthcare) and Prison Service Instruction (PSI) 74/2011 which covers early days in custody requires that this should be done. PSI 74/2011 says "All newly arrived prisoners must be assessed as part of the reception health screen process to determine whether they are at risk of suicide and self-harm....Prisoners returning to custody are at increased risk of suicide/self-harm, and the risk

occurs with transferred prisoners as well as those on initial reception into custody.” Despite this, the head of healthcare at Ranby confirmed that they do not routinely conduct such assessments unless the prisoner himself indicates he is at risk. This was a serious omission and, as should have happened at Woodhill, the man’s various risk factors should have been collated and considered in order to identify whether there was any risk.

**The Governor of Ranby should ensure that, in line with national guidelines, newly-arrived prisoners are assessed to determine whether they are at risk of suicide or self-harm.**

### **Opportunities to identify the man as vulnerable**

61. Prisoners who knew the man said that he was understandably upset when his partner told him that she had been raped. He applied for extra telephone credit to contact her and explained the reasons. The wing manager approved the application.
62. The SO said he did not assess the content or merit of the man’s application as he considered it to be the role of the officer to consider whether he had been particularly affected by the distressing news and, if necessary, to provide support or begin suicide and self-harm monitoring. While we understand that the SO would have expected the officer who had talked to the man about his application to have assessed whether he needed additional support it is difficult to see why an SO has to agree the application if he is not required to consider its “content or merit”. It is also the role of a manager to guide and advise staff. In cases like this where managers are authorising additional funds for prisoners because of personal circumstances we would expect them to check with the officers involved that appropriate support mechanisms were in place. The investigator was unable to interview the officer who was on detached duty to another prison when the investigator conducted interviews at Ranby and then on long-term sick leave, so we do not know whether he considered whether any additional support was necessary. None was put in place and there are no entries in the wing observation book to make staff aware that the man had received some highly disturbing news and he might be upset and potentially vulnerable. Again this is something we might have expected an SO to advise an officer to do.
63. PSI 64/2011 states:

“Information sharing is key to delivering safer custody that is coordinated around the needs of the individual. It is essential to enable early intervention and preventative work, to promote the prisoners wellbeing and ... Information sharing is a vital element in improving outcomes for all”.
64. The man’s circumstances were considered sufficiently pressing for him to have been given additional telephone credit to talk to his partner about her distressing situation yet no one else on the wing was informed that he might need additional support. Had this been done it is possible that he might not have been left without a cell mate at a crucial time when he could have benefited from someone to talk to. An entry in the wing observation book about the man’s distressing news might also have alerted staff to watch out for any change in the man’s demeanour and to have checked with him after he had had

a visit from his partner the day before he died. We cannot know whether this would have made a difference to the outcome, but this was a missed opportunity to consider the man's wellbeing and offer support if necessary.

**The Governor of Ranby should ensure that staff provide appropriate support for prisoners who receive distressing information about their families or relationships and that all wing staff are alerted to potential vulnerabilities.**

### **Staff checks on prisoners when unlocking cells**

65. Unless they are subject to special monitoring procedures, after being locked in their cells for the night, prisoners are not checked again until the roll check early the next morning and again when day staff take over from night staff. The officers who conducted the checks on the morning of 8 June did not notice anything remarkable about the man or his cell.
66. When nurses first examined the man, rigor mortis had already begun to set in, suggesting that the man had been dead for some time. The clinical reviewer estimates that the man's death had occurred between three and eight hours before he was found. Although the man's friend said he saw the man in the doorway of his cell not long after prisoners were unlocked at 9.00am, he must have been mistaken as it would have been impossible for the prisoner to have been found with rigor mortis so shortly afterwards. If the clinical reviewer's assessment of the time of death is correct it also calls into question the quality of the morning roll check at 6.00am and the one between 7.30am and 8.00am. We accept that the purpose of the roll check is primarily for security purposes to ensure that the correct numbers of prisoners are present but it ought to have been noticed if the man was hanging at the time. The local policy at Ranby says the purpose is to check that prisoners are "safe and secure."
67. Of more concern is that fact that the officer who unlocked the man's cell at around 9.00am, did not notice that there was anything amiss at that time. In his statement to the police the officer said he saw the man standing towards the back of his cell. At that time, the man must have been hanging but it appears the officer did not notice. He said that it was not his normal practice to speak to prisoners when unlocking cells. For their own safety, officers are supposed to make contact with a prisoner through the observation hatch before opening a locked cell door. At unlock they should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."
68. It appears that in this case it would have been too late to save the man who by the assessment of the clinical reviewer had been dead for some time by 9.00am but in other cases a failure to check prisoners' wellbeing at unlock could result in delay in treating someone who is seriously ill. We make the following recommendation:

**The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.**

## **Emergency response**

### ***Availability of emergency equipment***

69. When the nurse and the support worker received the radio message to go to K wing, they took the emergency bag and the defibrillator kept in the healthcare centre. In interview, the nurse said that the emergency bag was big, heavy and difficult to carry and K wing was the furthest away from the healthcare centre. The nurse and support worker took it in turns to carry the bag and the officer noted that when healthcare staff arrived they were out of breath. This was also discussed at the critical incident debrief.
70. The Head of Healthcare said that there are emergency bags at various points around the establishment, including one on K wing. There are also defibrillators positioned around the prison, but healthcare staff are only responsible for the one in the healthcare centre. It is important that staff are not delayed in responding to emergencies and they must be confident that the necessary equipment will be available to them.

**The Governor and Head of Healthcare should ensure that all staff know the location of emergency equipment, including defibrillators.**

### ***Calling an ambulance***

71. The timings of events given by staff contain some discrepancies. It is accepted that in an emergency staff's first reaction is not necessarily to check the time. In any case, individual watches and clocks will show slightly different times, so even when noted, exact times may differ.
72. The four officers who first attended the emergency, gave varying accounts of the time the alarm was raised, stating it was between 9.10am and 9.20am. The note of the debrief says the man was found at approximately 9.30am. The incident log and the prison's daily log, kept in the control room, shows 9.30am. Two officer and the SO said that they were in the cell within a minute of hearing the alarm. The incident log shows that staff were in the cell performing CPR at 9.31am, a minute after the alarm was sounded. Although it is hard to pinpoint when the alarm was activated, there does not seem to have been any delay in staff responding.
73. Once in the cell, the officer called a code blue emergency as soon as they had lowered the man to the floor. The nurse said the call came through at 9.29am. The gatekeeper's log shows that the nurses were in the cell by 9.34am, four minutes after the alarm was activated.
74. An ambulance was not called until the SO requested one. In his statement to the police, the SO said that he arrived at the cell, saw the officers attempting to resuscitate the man, cleared other prisoners from the area, then after two or three minutes called for an ambulance. The paramedics said in their police statements that the call came to them (from the ambulance service control) at

9.34am or 9.35am. Whatever the exact time was, an ambulance was not called automatically as soon as the code blue emergency was called.

75. PSI 03/2013 issued at the beginning of February 2013 required governors to have a medical emergency response code based on the instruction by 28 February 2013. The Ranby emergency protocol given to the investigator was issued in 2005 and does not reflect the mandatory requirements of PSI 03/2013. It is apparent from the response to this emergency incident that there was a lack of clarity about what should happen and respective roles. There is evidently a need for Ranby to tighten up and practice its emergency procedures. We make the following recommendation:

**The Governor of Ranby should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Ranby has a Medical Emergency Response Code protocol which:**

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment;**  
**and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that the procedures for continuity of healthcare are consistent with the requirements of PSO 3050 and that healthcare staff:
  - Routinely request prisoners' community medical records.
  - In line with best practice, offer a full general health assessment to every prisoner within a week of their arrival at Ranby.
2. The Head of Healthcare at HMP Woodhill should ensure that prisoners who arrive with a recent history of self-harm are referred for a mental health assessment.
3. The Head of Healthcare at Ranby should ensure that all available information about a prisoner is accessible to staff carrying out reception health screens.
4. The Governor of Woodhill should ensure that all the known risk factors of newly-arrived prisoners are fully considered when determining their risk of suicide or self-harm and that this is recorded on the assessment.
5. The Governor of Ranby should ensure that, in line with national guidelines, newly-arrived prisoners are assessed to determine whether they are at risk of suicide or self-harm.
6. The Governor of Ranby should ensure that staff provide appropriate support for prisoners who receive distressing information about their families or relationships and that all wing staff are alerted to potential vulnerabilities.
7. The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.
8. The Governor and Head of Healthcare should ensure that all staff know the location of emergency equipment, including defibrillators.
9. The Governor of Ranby should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Ranby has a Medical Emergency Response Code protocol which:
  - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
  - Ensures staff called to the scene bring the relevant equipment; and
  - Ensures there are no delays in calling, directing or discharging ambulances.

## ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	<p>The Head of Healthcare should ensure that the procedures for continuity of healthcare are consistent with the requirements of PSO 3050 and that healthcare staff.</p> <p>a) Routinely request prisoners' community medical records.</p> <p>b) In line with best practice, offer a full general health assessment to every prisoner within a week of their arrival at Ranby</p>	Accepted	<p>The 'New Reception' health screen at HMP Ranby is currently being updated in line with the wider Nottinghamshire Healthcare NHS Trust Offender Health Directorate.</p> <p>The reception process now includes questions relating to self harm and suicidal risk.</p> <p>Embedded within the reception screen template is a consent form to be printed off and signed by the prisoner in order to obtain information from the patients GP if this hasn't already been done at the previous establishment.</p> <p>Within the new template is a link to a further 'secondary screen' This will be implemented following the launch of the new health screen</p>	<p>April 2014</p> <p>Completed</p> <p>April 2014</p> <p>April 2014</p>	
2	<p>The Head of Healthcare at HMP Woodhill should ensure that prisoners who arrive with a recent history of self-harm are referred for a mental health assessment.</p>	Accepted	<p>All prisoners are assessed using a Threshold Assessment Grid (TAG) as part of the secondary health screen- the result of this will determine if a referral to mental health is needed. On receipt of the referral a full mental health assessment will be completed.</p>	<p>Completed</p> <p>Head of Healthcare.</p>	

3	The Head of Healthcare at Ranby should ensure that all available information about a prisoner is accessible to staff carrying out reception health screens.	Accepted	Information from previous establishment available on SystmOne following successful registration of patient.	Complete	
4	The Governor of Woodhill should ensure that all the known risk factors of newly-arrived prisoners are fully considered when determining their risk of suicide or self-harm and that this is recorded on the assessment.	Accepted	<p>All prisoners are screened when they enter the establishment. Information is sourced from the PER, 2050 if available, C-Nomis and any other information received from the Police via the escort contractor.</p> <p>In addition, any prisoner who has had their licence revoked will have their C-Nomis history live available when they are admitted into reception. This will now form part of our initial screening. The process includes a series of interviews in both Reception and the First Night Centre with both discipline and healthcare staff. Staff will use the ACCT process as appropriate.</p>	<p>31 Dec 13</p> <p>Governor of Induction unit</p> <p>Head of Reception</p>	
5	The Governor of Ranby should ensure that, in line with national guidelines, newly-arrived prisoners are assessed to determine whether they are at risk of suicide or self-harm.	Accepted	All newly arrived prisoners are assessed as part of the reception health screen process to determine whether they are at risk of suicide or self-harm by Induction Staff when the Ranby First Night/Induction Questionnaire is completed. This is part of the Prisoner Passport. If these questions are answered with a positive answer then the prisoner will be referred to Safer Custody for further investigation.	31.01.2014	

6	The Governor of Ranby should ensure that staff provide appropriate support for prisoners who receive distressing information about their families or relationships and that all wing staff are alerted to potential vulnerabilities.	Accepted	<p>A notice to staff will be issued to reiterate the procedure that staff should follow when appropriate support for prisoners is required when they receive distressing information in relation to their families/relationships.</p> <p>All staff will be required to record the details of issues arisen in the wing observation book which will ensure that staff on duty will be aware of any prisoner vulnerabilities. The peer support will be offered to the prisoner and support from any other relevant departments (chaplaincy, OMU, personal officer, wing manager)</p>	31.03.2014	
7	The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.	Accepted	<p>Notice to staff to be issued to reinforce this – also to be discussed as part of the wing meetings and with meetings with CMs. To be raised at the Safer Custody Meeting to be minuted.</p> <p>Consideration should be given as to being objective on the SPDR for discipline staff as part of a safer custody objective for the new reporting period.</p>	<p>NTS 31/1/2104</p> <p>Ongoing meetings throughout the next few months 31/3/14 SPDRs 30<sup>6/14</sup></p>	
8	The Governor and Head of Healthcare should ensure that all staff know the location of emergency equipment, including defibrillators.	Accepted	Notice published to all healthcare and discipline staff regarding the location of emergency bags and defibrillator	Complete	

9	<p>The Governor of Ranby should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Ranby has a Medical Emergency Response Code protocol which:</p> <p>a) Provides guidance to staff on efficiently communicating the nature of a medical emergency;</p> <p>b) Ensures staff called to the scene bring the relevant equipment; and</p> <p>c) Ensures there are no delays in calling, directing or discharging ambulances</p>	Accepted	<p>This action point to be made as an objective on all disciplines staffs SPDR</p> <p>Policy to be reviewed to incorporate points a), b), and c)</p> <p>Notice to staff to be issued following policy being ratified</p>	<p>30/6/14</p> <p>28 Feb 14</p>	
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