

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man in May 2014 at  
HMP Ranby**

## ***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 report of the investigation into the death of a man, who was found hanged in his cell at HMP Ranby, in May 2014. He was 43 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Ranby was undertaken. The prison cooperated with the investigation. I apologise that there has been a delay in completing this investigation.

The man was sentenced to life imprisonment in February 2005. Since childhood, he had persistently self-harmed by cutting his arms and swallowing objects. While he was in prison, he had cut his wrists, swallowed razor blades, taken overdoses of prescribed medication and attempted to hang himself.

After spending time at other prisons, the man arrived at Ranby in October 2013. He wanted to complete an offending behaviour course, which he hoped might have helped him to transfer to an open prison but there was a long waiting list for the programme. He continued to take illicit drugs throughout his time in prison. At Ranby, other prisoners threatened him because of drug debts. In February, he swallowed some razor blades and was temporarily transferred to HMP Nottingham for observation. Ranby indicated that they would transfer him to a prison nearer his family in Wales but this was never done. One morning in May 2014, an officer found him hanged in his cell. He appeared to have been dead for some time.

The clinical reviewer concluded that the man's standard of healthcare at the prison was comparable to that he could have expected to receive in the community and that in many respects, the quality of his mental health and substance misuse support was better than he might have otherwise received.

The man had an extensive history of attempting suicide and harming himself, suggesting he was always at high risk, but there was no clear evidence that he was at particularly raised risk at the time of his death. However, I am concerned that the prison did not investigate his allegations of intimidation by other prisoners or consider sufficiently how this impacted on his risk of suicide or self-harm. The investigation identified a number of procedural failures in the operation of suicide prevention procedures which the prison will need to address. Although this would not have affected the outcome for him, I am also concerned that, as in other recent deaths at Ranby, officers did not follow the expected emergency response procedures.

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

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

**May 2015**

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## SUMMARY

1. The man had a long history of self-harm since childhood. As an adult, he had alcohol and drug misuse problems. In February 2005, he received a mandatory life sentence for murdering a friend, with a minimum period to serve of 13 years before he would be eligible for parole. He took a number of offending behaviour courses and progressed to lower security prisons. During his time in prison, he continued to harm himself seriously by swallowing razor blades, cutting his wrists and attempting to hang himself. Prison staff supported him, using ACCT suicide and self-harm prevention plans to manage and monitor his risk.
2. In June 2013, the man transferred temporarily to HMP Cardiff to receive visits from his family. He wanted to stay at Cardiff and then move to HMP Ranby to complete an offending behaviour course that he hoped would help him move to an open prison. Because there was a need to provide spaces at Cardiff, he moved to Ranby in October 2013 rather than to complete the course immediately. He told a reception nurse at Ranby that he had been taking illicit drugs in prison and had not been substance-free since 1995.
3. In February 2014, the man swallowed 30 razor blades. He said he was in debt to other prisoners who had supplied him with drugs and asked to move to the segregation unit, as he feared for his safety. Staff began ACCT procedures and constantly supervised him for two days. He then transferred to HMP Nottingham, which has 24-hour healthcare cover, to monitor the passage of the razor blades. The ACCT was closed on 10 March and he returned to Ranby the next day.
4. The man had a number of anxieties. He was afraid to leave his wing and mix with others as continued to feel threatened by prisoners he owed money to for drugs. This led to him missing health appointments and a videolink meeting with his offender manager. He continued to be frustrated that he would have to wait to take the course to help him progress. He wanted to move to a prison nearer his home and had little contact with his family as he had no money for telephone calls. In May, an officer making an early morning check of prisoners found him hanging in his cell with a strip from a bed sheet around his neck. He had been dead for some time.
5. We agree with the clinical reviewer that the man received a high standard of healthcare. However, we are concerned that staff at Ranby did not properly investigate or protect him when he said he was being threatened and intimidated for debts. Staff did not fully record the outcome of a key action of his ACCT caremap or hold a post-closure ACCT review.
6. Although it would not have changed the outcome for the man, the investigation found that prison control room staff did not call an ambulance immediately when they heard an emergency code, as Prison Service instructions require. Prison managers did not hold a debrief or obtain statements from the staff involved in the emergency. We have raised these issues with Ranby before. We make four recommendations.

## THE INVESTIGATION PROCESS

7. On 13 May 2014, the investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
8. On 16 May, the investigator went to the prison. She saw where the man had lived and obtained copies of his prison and healthcare records. The records were incomplete and the prison has not been able to find the missing documents. This has impacted on the timeliness of the investigation. We apologise for the delay. In August, she interviewed two prisoners and six members of staff, some jointly with the clinical reviewer. She later interviewed two members of staff by telephone.
9. NHS East Midlands appointed a clinical reviewer to review the man's clinical care at HMP Ranby.
10. The investigator informed HM Coroner for Nottinghamshire and Nottingham City of our investigation. We have sent a copy of this report to the Coroner
11. One of the Ombudsman's family liaison officers contacted the man's brother to inform him of the investigation and to ask if he had any issues he wanted the investigation to consider. He raised the following matters:
  - He was concerned that his brother had said it was a violent environment at Ranby and had been afraid.
  - His brother had hoped to progress from Ranby to an open prison, but had found out it would take three to four years for this to happen.
  - He asked why his brother had transferred temporarily to HMP Nottingham.
  - He wanted to know whether staff had closely observed his brother, how he had managed to take his life and whether he had left a note.
12. The man's family received a copy of the draft report. We have aimed to answer their questions in the report where they are relevant to the circumstances of his death.

## **HMP RANBY**

13. HMP Ranby is a medium security prison which holds over a thousand sentenced men. Since April 2013, Nottinghamshire Healthcare Trust has provided primary healthcare services at the prison.

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

14. The most recent inspection of Ranby was in March 2014. Inspectors were concerned that the prison was unsafe and noted that it felt like a prison in crisis. There had been increased levels of violence and intimidation with inadequate direct supervision of prisoners and ineffective monitoring systems. Inspectors noted that incidents of self-harm had risen significantly in the previous year, many in response to threats and intimidation from others, and there had been two self-inflicted deaths before the inspection and two shortly afterwards. They reported that the action plan the prison had completed in response to the Prison and Probation Ombudsman's recommendations about one of the deaths was insufficiently detailed.
15. Inspectors found that there was increased availability of illicit drugs including new psychoactive substances such as 'spice' and 'black mamba,' which were difficult to detect, and a lot of diverted prescribed medication. The prison had a wide range of health services and mental health support was very good. Despite this, inspectors noted that most prisoners were dissatisfied with the quality of healthcare.

### **Independent Monitoring Board**

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In the IMB's most recent annual report, for the year to March 2014, the Board was concerned that the significant reduction in staffing had led to a loss of experienced officers and that this had impacted directly on bullying, prisoners self-harming, assaults by prisoners on staff and other prisoners, barricades and hostage taking.

### **Previous deaths at Ranby**

17. Since 2013, there have been seven deaths at Ranby, including that of the man's, five of which were apparently self-inflicted. In previous investigations, we were concerned about the operation of emergency response procedures, the management of serious incidents and bullying.

### **Assessment Care in Custody and Teamwork procedures**

18. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a care-map to identify the prisoner's most urgent issues and how they will be met. Staff

should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## **KEY EVENTS**

### **2004 - 2006**

19. The man was remanded to HMP Cardiff in August 2004, charged with the murder of a friend. He had been in prison several times before. He had received psychiatric care from the age of 14, due to persistent self-harm in the form of cutting his arms, inserting items into his abdomen and swallowing objects. As an adult, he had a history of heavy drinking and drug misuse. In 2000, his twin brother died of a drug overdose. At the time of his arrest, he was on a methadone programme and also using heroin. He told the psychiatrist who prepared a pre-trial psychiatric report that he had had approximately 13 stomach operations due to swallowing objects, and that he had started to use heroin in prison in 1998 and continued to use it daily.
20. At Cardiff, staff managed the man under ACCT suicide and self-harm procedures between September and December 2004. In February 2005, he was convicted and sentenced to life imprisonment, with a minimum period to serve of 13 years before he could be considered for release. He was transferred from HMP Cardiff to HMP Swaleside in September 2005. Between July 2006 and March 2007, prison staff managed him there times under ACCT procedures after he had severely cut his arms and wrists.

### **2007 - 2012**

21. In April 2007, the man moved to HMP Elmley. Staff began ACCT procedures on 13 November 2007, after he told another prisoner he wanted to end his life. He had written letters to his family members to say goodbye and had kept two razor blades to harm himself. Staff closed the ACCT on 28 November 2007. Later that day, he transferred to HMP Dovegate. Staff opened another ACCT for a week from 20 February 2008, after he told an officer that he had taken a large amount of medication and wanted to die.
22. On 11 September 2008, the man moved to HMP Kingston. He told an officer on 25 February that he had tried to hang himself but could not go through with it. The officer noticed a red ringed mark around his neck and opened an ACCT, which was closed on 5 March 2009.
23. On 15 September 2010, the man moved to HMP Shepton Mallet as it was easier for his family who lived in Wales to visit him. Throughout 2011 and 2012, he settled well. He took offending behaviour courses and made good progress. His family visited him monthly.
24. On 9 July 2012, a prison psychologist prepared a report for the Prison Service on the man's risk of violence and serious harm to others. He noted that the man had completed a lot of offending behaviour work which he should continue, including drug and alcohol relapse prevention strategies, the significance of violence and alcohol on his level of risk, anger management and managing negative emotions such as anxiety, as well as gaining further insight into his borderline personality disorder. He concluded that, if the man continued to work effectively, he might be able to progress to an open prison.

25. On 5 October 2012, at 8.35pm, the man pressed his cell bell and handed an officer 12 razor blades in a cup. He said he had been thinking of harming himself as no one was listening to him. He had applied for an offending behaviour course called the Self-Change Programme, but had only been told that this had been referred to the programmes manager to consider. Staff opened an ACCT, which was closed on 8 October. The post-closure review noted that the issues which had prompted the opening of the ACCT were still present, but he had no further thoughts of self-harm.

## 2013

26. On 9 January 2013, the man told a member of staff that he had cut his wrist and swallowed at least six razor blades. Staff opened an ACCT and constantly supervised him. They closed the ACCT on 30 January.
27. On 28 February 2013, the man transferred to HMP Erlestoke, a category C prison, to take the offending behaviour courses necessary before he could apply for a transfer to an open prison. He told a member of the substance misuse team that he did not want or need their services.
28. A lifer officer (an officer trained to deal with the specific needs of a life-sentenced prisoner and help them meet their sentence plan targets) was assigned to the man. They discussed offending behaviour work and the officer told him he would need to do the Self-Change Programme before the Parole Board would consider a transfer to an open prison. On 27 March, an offender supervisor told him that there would be no places on the course at Erlestoke, until 2016. He said he would find out about the waiting lists at other prisons.
29. The man applied to move to HMP Cardiff temporarily, to allow his family to visit him. (When prisoners are a long distance from their homes and their families are not able to visit them, they can apply to move to a prison nearer to their families for 28 days.) He was sent to Cardiff on 14 June, for visits from his family. On 17 June, his personal officer wrote in his record that he wanted to move on to Ranby from Cardiff to do the Self-Change Programme. She had explained to him that, as his minimum time to serve before he was eligible for release was not until 2017, he might be given low priority for the course.
30. The man asked an offender supervisor whether he would be able to stay at Cardiff and move to Ranby from there. She advised him to apply and write in detail the reasons he wanted to stay.
31. On 17 October, after four months at Cardiff, the prison transferred the man to Ranby, as there was a shortage of places at Cardiff. Staff at Ranby did not expect him as his move had not been managed under the usual procedures for life-sentenced prisoners. (Apart from his medical records, no prison documents are available for the period between his arrival at Ranby and 9 December, so we do not know whether he received an induction.) At a reception health screen, he told a nurse that he used drugs, including subutex (an opiate substitute) and diazepam and injected heroin daily. She noted track marks on his left arm and he said he also injected in his ankles. He said he had been prescribed amitryptiline (an antidepressant) and had been

diagnosed with a personality disorder. She referred him to the prison's drug service and the mental health team.

32. On the same day, a modern matron wrote in the man's clinical record that he appeared to be under the influence of illicit substances and had told her the last time he had been completely drug-free was in 1995. His urine tested positive for benzodiazepines. He said he did not want to tackle his drug use and said he just wanted to get through his sentence. She referred him to a GP at the prison who specialises in substance misuse. On 18 October, the GP examined him and noted he had multiple injection sites on his body. He asked to begin a methadone detoxification programme. The GP referred him to the drug service and prescribed amitriptyline. The same day, an associate practitioner started a harm reduction plan when he disclosed to her that, until his arrival at Ranby, he had been taking heroin regularly.
33. During an assessment with a mental health nurse on 18 October, the man asked for support and help with his drug use but said he would harm himself if he could not get drugs. The nurse concluded that his mental state did not suggest any imminent risk of self-harm or serious intent to end his life. Although he was frustrated about his position, he showed no signs of thought disorder, psychotic phenomenon, or perceptual abnormalities.
34. On 22 October, a nurse spoke to staff in the prison's offender management unit about the man. She considered that he had chosen to continue drug use and had threatened to harm himself. She thought that he should go back to Cardiff as he could not fully understand or participate in the Self-Change Programme and the clinical evidence did not support a claim in his prison records that he was drug-free and motivated to remain so. Although he said he had used heroin daily for four months, this had not been detected in his urine samples.
35. On 4 November, at a mental health assessment with a nurse, the man said he wanted to start a methadone detoxification programme and had no thoughts of suicide or self-harm.
36. One of Ranby's offender supervisors met the man for first time on 9 December. He told her about his psychological assessment with a psychologist in 2012. She explained to him that the waiting list for Self-Change Programme at Ranby would be as long as at Erlestoke and it might possibly be 2016 before he could begin the programme. She told the investigator that he did not seem to mind and said he was happy at Ranby because he had a job in a workshop. He was adamant that he was drug-free and wanted to return to Cardiff for family visits. She told him this should be possible.

## **2014**

37. On 6 January 2014, a nurse asked the man whether he wanted further mental health support, but he said that he did not have any current concerns about his mental health. He told the nurse that he was due to go back to Erlestoke for an offending behaviour course, so the nurse discharged him. (There is no evidence of any plan to move him.)

38. On 24 January, a nurse reviewed the man at the request of wing officers. He said he felt 'stuck' and was not progressing at Ranby. The nurse agreed to discuss the situation with an offender supervisor, who advised that he should remain at Ranby until he could start an offending behaviour course. He applied to move to Houseblock 5, which was regarded as a quieter residential unit with older, better behaved prisoners. On 4 February, staff placed him on a waiting list for the houseblock.
39. On 24 February, the man told two nurses that he had swallowed over 30 razor blades since the evening before and he intended to cut his wrists with a razor. He said he had dull abdominal pain and had been taking a lot of drugs. He threatened to kill his cellmate. He said that he owed other prisoners £275 for subutex (used to treat opiate addiction) and black mamba (a synthetic form of cannabis). The nurses persuaded him to dispose of the blade safely. One nurse examined him but did not see any injuries to his mouth or tongue and noted that he was not in obvious distress. His pulse and blood pressure were normal.
40. A nurse opened an ACCT plan at 11.37am and a custodial manager completed the immediate action plan at 11.55am. The man asked to go to the segregation unit as he felt safe there. The segregation unit daily diary shows that he arrived there on 24 February, but the prison was unable to provide us with the segregation safety assessments or other relevant documents for this period.
41. A nurse assessed the man in the segregation unit and noted in his clinical record at 12.05pm that he had no current thoughts of deliberate self-harm. The observation period was five times an hour until assessment. (The prison did not provide the ACCT on-going record so we do not know whether any exceptional reasons to hold a prisoner at risk of suicide and self-harm in the segregation unit were given.)
42. As there are no in-patient facilities at Ranby, healthcare staff sent the man to hospital for observation that evening. A nurse wrote in his clinical record that he had been sent to hospital from the segregation unit.
43. On 25 February, a hospital consultant advised that the man should allow the razor blades to pass out of his body naturally and hospital staff would take daily X-rays to locate those not expelled. However, he discharged himself from hospital that day, saying that the bed should go to someone who needed it.
44. When he returned to Ranby, staff constantly supervised the man on Houseblock 1. Healthcare staff drew up a detailed nursing care plan to monitor his vital signs, any acute abdominal pain or passing blood in his stools and would refer him to hospital if his symptoms worsened. They encouraged him to eat extra sandwiches and drink water to ease the passage of the razor blades and noted that it was inadvisable for him to go to other areas of the prison as he might try to harm himself.
45. The man told the matron responsible for mental health that he was missing his family in Cardiff who were unable to visit him. He said he had no phone contact with them as he used all his money to pay his debts. He said he had

lost a substantial amount of weight due to trading his food for tobacco. He had not been able to see a way forward and had swallowed the razor blades as a way of removing himself from the situation. He told her that contact with the mental health team did not help as it was just talking. He agreed to see a psychiatrist and said he would consider taking medication.

46. At an ACCT assessment with an officer on 25 February, the man said his main concern was his debt to prisoners who had supplied him with drugs. He said that he had swallowed the razor blades as a way to leave his houseblock as he was afraid of being assaulted because of his debt. He insisted that he had not tried to kill himself but used self-harm as a coping mechanism. However, he then said that he did not care whether he lived or died and, unless things changed, he felt he had no future. He reported that he had lost three stones in weight because of drug abuse and the stress of being in debt. He said he had a good relationship with his family, but had not received any visits at Ranby because it was too far for them to travel and wanted to transfer to a prison nearer to them. He could not telephone them as, due to his debts, he did not have enough money.
47. On 26 February, a nurse noted in the man's clinical record that he was a risk to himself and others and might use any opportunity to try to kill himself. An ACCT case review took place that day, attended by a nurse, a community psychiatric nurse, the Head of Safer Custody and an officer. A GP advised that he should go back to hospital, but he said that he could not cope with hospital and refused to go. The GP considered that he needed to be in a facility with 24-hour healthcare, and he agreed to go to HMP Nottingham. He accepted an offer to have a phone call to his mother, but did not want to worry her by telling her about his current situation.
48. The ACCT caremap identified four action points. The community psychiatric nurse would refer the man to a psychiatrist; staff would give him suitable food to help his digestive system; the mental health team would arrange for him to telephone his family; and his offender supervisor would identify a suitable prison so that he could be nearer to his family in Wales.
49. Before his journey to Nottingham on 27 February, several staff and the officers escorting the man reviewed his risk of self-harm. He said that he had taken prescribed zopiclone (a sleeping tablet), which had given him some respite from his thoughts and he had passed some of the razor blades. The community psychiatric nurse wrote in his clinical record that they had told him that after he returned to Ranby and his risk had reduced, staff would arrange a transfer to a Welsh prison. He thought he would be 'fobbed off' and forgotten, but the Head of Safer Custody assured him she would start the process that day. She agreed he could write to her from Nottingham. (He did not write to her while he was there.)
50. The man said that he had no further thoughts of self-harm as he felt they were now managing his situation and he felt safer. The review team stopped the constant supervision and reduced the observation period to five times an hour. The community psychiatric nurse telephoned a member of Nottingham's mental health team, in advance of his arrival. The Head of Safer Custody said that she would tell his mother that he was safe and

moving to Nottingham, but as he had requested, would not disclose details of his mental or physical health.

51. The Head of Safer Custody told the investigator that she had asked the manager of the Observation, Classification and Allocation (OCA) department, who was in charge of transfers, to deal with the man's request to move nearer his family. The OCA manager informed her that Cardiff had refused his application as the prison had changed some of its functions and would no longer hold life-sentenced prisoners, except temporarily.
52. When the man arrived at Nottingham, a nurse conducted a health screen. The nurse was aware that he was being managed under ACCT procedures after swallowing razor blades. He made an appointment for him to see someone from the mental health team. He said that he had thoughts of self-harm but not suicide. He disclosed a history of mental health problems but not substance abuse. He was taken to the enhanced care area of the healthcare centre and constantly supervised.
53. A nurse and a manager reviewed the man at 4.00pm on 28 February. He said that he was no longer a risk to himself. He was happy not to be constantly supervised but concerned that he had not yet expelled all the razor blades. They arranged a mental health assessment for 3 March and a GP review, but advised him that in the meantime he should alert healthcare staff if he experienced sudden pain or bleeding. Later that night, he repeatedly complained of sharp, throbbing abdominal and lower back pain. A nurse consulted the on-call doctor and sent him to hospital.
54. The man returned at Nottingham in the early hours of 1 March. The escort officers reported to a nurse that an X-ray had shown he had two blades internally, one in his chest and the other in his bowel. The hospital had concluded that surgical intervention would cause more harm than good due to previous scarring.
55. On 2 March, the man handed a nurse 12 clean razor blades, which he said he had passed in stools. The next day a member of the mental health in-reach team reviewed him. She confirmed that he would stay at Nottingham until a further X-ray confirmed that he had expelled all the blades. He said he had no thoughts of self-harm.
56. On 10 March, a healthcare assistant noted in his clinical record that at an ACCT review that day the man had said he had no thoughts of suicide or self-harm, or any particular health issues. The ACCT was closed that day. (Records of the ACCT review are missing and there is no evidence of a post-closure review.)
57. The next day, 11 March, the man returned to Ranby from Nottingham. A nurse assessed him and wrote in his clinical record that he seemed a little stressed and that she would refer him to the mental health team. Another nurse noted that he was concerned that Nottingham had given no clinical handover and it was unclear whether he was free of razor blades as they had not sent any X-rays. He had tried to contact Nottingham's healthcare centre to find out the details of his recent care but there had been no response.

58. On 12 March, a doctor reviewed the man and advised that he should go to hospital for further X-rays. Healthcare staff informed the hospital, but there is no record that these X-rays were done. A nurse visited him on Houseblock 2 as he said he was unable to leave his cell due to threats from other prisoners. He had a single cell. The nurse noted that his mood was low. He said that he had had a poor night's sleep and was worried about his zopiclone prescription ending. He said that he believed he still had razor blades internally and his abdomen felt sore.
59. On 13 March, a psychiatrist assessed the man. He told the psychiatrist that he had swallowed the razor blades as he was stressed. He said he had been using 'black mamba' to block out thoughts about his life sentence and had been buying mirtazapine (an antidepressant) from other prisoners to help him sleep. He had felt increasingly desperate about whether he would ever get out of prison and said he feared dying in prison. He said 'I killed someone, I should be killed'. He said he felt low and hopeless, and suggested that he could not transfer to Cardiff if he was being managed under ACCT procedures. (In fact a transfer to Cardiff was no longer an option, as described at paragraph 51.) The psychiatrist suggested that he try lofepramine (an antidepressant), with a review after two to three weeks. He also prescribed mirtazapine. He assessed that the man's risk to himself was low at that time but would be higher in the long term given his history and diagnosis.
60. On 26 March, the man wrote to the Head of Safer Custody, asking about the progress of his application to transfer to a Welsh prison.
61. The psychiatrist reviewed the man on 27 March. He had stopped taking the lofepramine as it made him feel nauseous. He told the psychiatrist that he still had thoughts of self-harm and that life was not worth living but he did not intend to act on the thoughts. He said he would not swallow razor blades again, because of the pain he had experienced. They also discussed the possibility of him transferring to a regional personality disorder unit in the longer term.
62. On 28 March, a nurse went to see the man in his cell, as he felt under threat and unable to leave because of his debts. He said he did not want to discuss his past as he could not deal with thinking about it. She said she would make an urgent referral for disability pay as he could not work and had been unable to speak to his mother due to his debts. She noted in his clinical record that his cell was very sparse with only a television to distract him from his thoughts. She offered to send him some word puzzles.
63. On 2 April, the man received a reply to his enquiry about the possibility of a transfer. This said that the deputy governor was still dealing with the matter and he would be told when there was more information.
64. At a consultation with the psychiatrist on 10 April, on Houseblock 2, the man said that he spent his days in his cell thinking about harming himself, but he did not have any plans or intent to act on his thoughts. He felt very hopeless about the future and thought he needed to repeat all the offending behaviour courses he had done, as he had not taken them in. He said he had a great sense of shame that he had murdered a woman friend, but felt that as he had

not acknowledged this in his offending behaviour courses, he could not benefit from them.

65. The psychiatrist wrote that the man appeared depressed, gaunt, withdrawn and had a poor appetite but was not underweight. He considered that he had not progressed and again noted the possibility of treatment in a personality disorder unit. He noted that his future risk of further serious harm to himself was high and he should be monitored more frequently. However, he did not consider there was a need to start the ACCT process at the time.
66. The Head of Safer Custody told the investigator that she had met the man while she was walking around the prison and had told him that Cardiff had rejected his application but they would keep trying other prisons. They had tried other prisons but they would not take him as he was within three years of his earliest release date and due to have a review by the Parole Board to consider his suitability for a transfer to an open prison. (This would require staff who knew him to complete reports about his progress.)
67. The Head of Safer Custody was unable to find records showing when she had spoken to the man about this, or which prisons, other than Cardiff, Ranby had approached. She recalled that they had escalated the matter to the then deputy governor and had asked her to contact other deputy governors to facilitate the move. Again, there were no records of this.
68. On 11 April, the man asked a nurse for puzzles to help keep him occupied in his cell. A mental health nurse reviewed him on 15 April. He felt brighter and thought his medication might be helping his mood. However, he said he was bored but stayed in his cell because of threats he had received from other prisoners on his wing.
69. On 16 April, an offender supervisor booked a videolink slot for 8.30am on 24 April, with the man's offender manager, so they could discuss his sentence plan. She wrote to him, inviting him to attend.
70. A healthcare assistant requested a random check of the man's cell to ensure that he was not stockpiling medication. She was concerned that he appeared increasingly tired when he collected his daily mirtazapine tablet, which should have helped him to sleep well. He had asked for a box of paracetamol, but was vague about why he needed it. (It is not clear whether the check took place but a nurse spoke to him about the correct dose of paracetamol for a headache.)
71. On 24 April, an officer emailed an offender supervisor to tell her that the man would not leave his houseblock as he said he felt under threat from other prisoners. The offender supervisor telephoned the offender manager to cancel the videolink session and told an officer on Houseblock 2. The officer said this had been unnecessary as wing staff could have escorted him to the videolink.
72. The offender supervisor said during interview that she had not known that the man was afraid of leaving the wing and did not know how long that situation had existed. She said she did not go to see him in person as she felt there was no point. She had rearranged the session for 14 May. She said she

knew that wing staff had previously managed him under ACCT procedures but they had not asked her to take part in any case reviews. She had deliberately not informed him of the new date for a sentence plan discussion as she did not want him to get agitated and find an excuse not to attend.

73. On 24 April, a nurse went to see the man as he still felt under threat. He said he was still waiting to hear about a transfer to Wales and his assessment for the Self-Change Programme. The nurse noted that he seemed brighter in appearance. He said that this was because the mirtazapine was helping him sleep.
74. On 1 May, the man did not attend an arranged appointment with the psychiatrist, as he was afraid to leave his houseblock. The psychiatrist was unable to visit him in his cell, as he had to see another prisoner urgently. He asked that he should be given the next available appointment. There are no further notes in his medical record until his death. Two nurses told the investigator that the appointment had not been rearranged as there had been difficulties getting officers to agree to escort prisoners who felt under threat to healthcare appointments. The nurses said that there had also been a period of unrest in the prison, during which prison and healthcare staff resources had been diverted from routine reviews to dealing with incidents.
75. On 8 May, the man wrote again to ask for news of his proposed transfer. He did not receive a response. The Head of Safer Custody told the investigator that his application was 'still in the system' at the time of his death.
76. An officer said that, on 12 May, the man was upset because the laundry had not returned one of his T-shirts. The officer told him he would sort it out the next morning. At about 6.50pm, he gave a prisoner one of his T-shirts and asked another prisoner for a cigarette. The prisoner gave it to him and they said goodnight. He told the investigator that he has seemed normal and he did not detect that anything was wrong. He knew he did not have any money, but said that was not uncommon among the prisoners undergoing drug treatment on Houseblock 2, as those prisoners could only work for half a day.
77. An officer said that he had last seen the man at about 7.00pm, when he had locked his cell for the night. The night patrol officer began duty at about 8.15pm. She said the night had passed without incident and she did not recall seeing him.

### **Events leading up to the incident**

78. At about 7.00am the next morning, the night patrol officer handed over to an officer, who began to check that all prisoners were present in their cells. When he reached the man's single cell, 3-17, he was not in bed but then he saw him sitting at the side of the bed. He went on to the next cell, but thought that something had not been right about him and went back to his cell. He then saw that he was sitting on a heating pipe with a ligature, apparently made from a sheet, around his neck. The officer said he looked dead and the colour of his skin suggested he had been dead for some time.
79. The officer did not have a radio and shouted across to his colleague, who was checking prisoners on the other side of houseblock, to call a code blue

emergency. The code blue call was made at 7.10am. The officers went into the cell and the first officer cut the ligature from around the man's neck. He did not move and the officer noticed signs of rigor mortis. At 7.13am, he told the communications room that no healthcare staff were required, just the Coroner.

80. The custodial manager in charge of the prison said that he first heard a radio call for assistance on Houseblock 2. He called back to find out the nature of the problem. The officer had told him it was a code blue, so he went to the houseblock. When he got there he saw three officers, who explained that they had found the man hanged in his cell. They said that they had not attempted to resuscitate him as it was evident he was dead. Healthcare staff were not yet on duty.
81. The custodial manager went into the cell. He agreed that it was apparent that the man was dead and when he checked for signs of life, could find none. He then asked for an ambulance so that paramedics could confirm his death. He completed an incident report but did not ask the officers involved to write any statements.
82. The control room log shows that an ambulance was called at 7.18am. It arrived at the prison at 7.34am and at 7.48pm the paramedics pronounced the man dead.

### **Support for prisoners and staff**

83. Notices informing prisoners of the man's death were displayed on all wings and the chaplaincy team offered support. Staff reviewed prisoners subject to monitoring under the suicide and self-harm procedures in case his death had affected them.

### **Family contact**

84. The prison's family liaison officers drove to Wales that day to break the news of the man's death to his family and offer support. The prison offered financial assistance towards the funeral expenses, in line with Prison Service guidelines.

### **Post-mortem**

85. The post-mortem report concluded that the man's death was caused by asphyxia due to hanging. He did not leave a note.

## ISSUES

### Clinical care

86. The man had a long history of mental health problems, self-harm and substance misuse. Mental health staff at Ranby kept him under review and he was under the care of a psychiatrist.
87. The clinical reviewer described the man's standard of healthcare as high quality and found that mental health staff had conducted comprehensive and detailed mental health assessments and reviews, with appropriate care plans. However, the clinical reviewer was concerned about security arrangements for accompanying prisoners who felt under threat to healthcare appointments and noted that he missed more than one appointment because of this, including his last scheduled appointment with his psychiatrist on 1 May. Healthcare staff often went to see him in his cell, in the absence of an escort.
88. Although there was a gap of two weeks, shortly before the man's death, when there was no recorded review of his mental health state, he was not thought to be at immediate risk of suicide and self-harm. The clinical reviewer acknowledged that due to incidents of unrest within the prison at that time, staff attention might have been diverted from carrying out routine reviews. Nevertheless, he considered that, overall, the standard of healthcare the man received was at least as good as that available in the community and in many respects, the mental health and substance misuse support he received exceeded that which he might otherwise have received in the community.

### Assessment and management of the man's risk of suicide and self-harm

89. Before his imprisonment, the man had a long history of self-harm. This continued throughout his sentence and prison staff managed him under ACCT procedures several times. The clinical reviewer noted that he was always at high risk of suicide and had made many attempts at suicide in the past. We recognise that this does not mean that he always needed to be managed under ACCT procedures which would be self-defeating. However, some aspects of the ACCT process were not always well managed at Ranby.
90. On 24 February, the man was in the segregation unit while he was being managed under ACCT procedures. Prison Service Instruction (PSI) 64/2011, which covers safer custody procedures, says that prisoners subject to suicide and self-harm prevention measures should be placed in segregation units only in exceptional circumstances as this heightens their vulnerability. The reasons must be clearly documented in the ACCT plan and include other options that were considered but discounted. It appears that he was segregated because he was fearful of other prisoners but there is no record that staff considered this increased his risk of suicide and self-harm and there was no caremap action to address this.
91. A nurse wrote in the man's clinical record that she had carried out a risk assessment, the required safety screen to assess whether a prisoner is fit to be held in the segregation unit, and recommended that he should be observed five times an hour. His clinical record does not contain a copy of the assessment and the segregation unit was unable to find a copy. The exact

reason for segregation is unclear as Ranby has been unable to find the relevant segregation records and there is no explanation in the ACCT document.

92. The man was held in the segregation unit for only a relatively short time when he was on an ACCT. However, we are concerned that the absence of records about the decision, both in ACCT and segregation unit documents, means that we cannot be satisfied that the decision to segregate him was reasonable. We do not know what, if any, other options, staff considered. It is unacceptable that records of such decisions affecting the safety of a prisoner are not available.
93. At the time of his death, the man was anxious about several matters. One of the four actions on his ACCT caremap of 26 February was that Ranby would find him a place in a prison nearer to his family. It was signed by the Head of Safer Custody, Equalities and Segregation. She said that she had told him that Cardiff had declined his request but Ranby would look at other prisons. Although she maintained that he knew this, nothing was documented in his records and the prison could not provide any evidence that they had contacted other prisons about the possibility of a move.
94. The man clearly continued to be concerned about this and he submitted two applications in March and in May, asking what was happening about his transfer. In view of his vulnerability, we believe that he should have received a substantive written response about what was happening. Of more concern is that the ACCT was closed at Nottingham on 10 March, yet this caremap objective had not been achieved. (This documentation is also missing.)
95. PSI 64/2011 says that ACCT documents should only be closed:

“ ... once all the caremap actions have been completed and the case review team judges that it is safe to do so in that the risk posed by the prisoner has reduced. ACCT plans must not be closed to facilitate a transfer to another prison or within 72 hours of a planned transfer. Where a transfer takes place within the post-closure period, the receiving prison must be informed about the recent ACCT and the need for them to undertake the post-closure review.”
96. The man transferred to Nottingham on an open ACCT plan on 27 February, as part of a support plan after an incident of serious self-harm. Nottingham closed the ACCT on 10 March, the day before he returned to Ranby. As the ACCT caremap action to identify a suitable prison for him to transfer to nearer to his family in Wales had not been achieved, the ACCT should not have been closed.
97. While the ACCT was closed at Nottingham, the caremap target continued to be the responsibility of a named member of staff at Ranby; the man had transferred temporarily to Nottingham only as an alternative to going to hospital. We consider that the outstanding caremap action should have been identified when he returned to Ranby and the ACCT re-opened. In the absence of this happening, it should have been recognised at a post-closure interview a week after the ACCT was closed, as required by PSI 64/2011. However, there is no evidence that staff held a post-closure review.

98. On 24 April, a nurse thought the man seemed brighter. He did not consider that he was at imminent risk of self-harm. He spoke of still feeling fearful of leaving his houseblock and not having news of his move to a Welsh prison (which he still believed was being considered). He was still waiting for a Self-Change Programme assessment. He did not go to his appointment with the psychiatrist on 1 May, and the psychiatrist was unable to see him on the houseblock. The evening before his death, he gave a prisoner a T-shirt and was upset that a clean T-shirt he expected back from the laundry had not been returned.
99. Taken individually, there was little to indicate to staff that the man was at imminent risk of suicide and self-harm. However, there is little evidence that staff considered how his fear of violence and intimidation from other prisoners impacted on his risk of suicide and self-harm. Considered together, it is possible to see that he continued to be frustrated and disappointed at the lack of progress with solving some of his problems. Nevertheless, we consider it would have been difficult for staff at Ranby to have anticipated his actions on 13 May. However, the investigation identified a need for improvements in aspects of ACCT procedures outlined above. We make the following recommendation:

**The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including:**

- **Completing ACCT documents fully and accurately;**
- **That prisoners on ACCT plans are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances;**
- **That ACCT reviews discuss the impact of potential bullying on risk of suicide and action is taken;**
- **That all decisions taken as a result of caremap actions are properly documented and ACCTS are not closed unless caremap actions have been achieved;**
- **Conducting ACCT post-closure reviews, in line with Prison Service instructions and re-opening ACCTS whenever there is an indication of continuing or additional risk.**

### **Prisoner safety and handling allegations of bullying**

100. The man spent much of his time at Ranby in his cell. He feared for his safety as he had got into debt with other prisoners, buying illicit drugs. As well as money, he said he had given away food to pay his debt. He did not earn sufficient money to telephone his family regularly and told them that he was afraid of the violence at Ranby. Healthcare staff accepted his concerns were genuine and visited him on his houseblock when he was too afraid to go to the healthcare centre without an escort. An officer, a nurse and an offender supervisor readily accepted that it was not unusual for prisoners at Ranby to be afraid to leave their houseblocks.
101. At their inspection of Ranby in March 2014, not long before the man's death, HM Inspectorate of Prisons had serious concerns about safety at the prison

and found that there was inconsistent staff supervision in some areas, with high levels of illicit drug and alcohol available. Most intelligence and drug finds related to currently undetectable psychoactive substances, such as spice, black mamba and diverted medication. The prison was aware of the problem but had no coordinated action plan to reduce supply and demand. Too many prisoners felt unsafe and reported high levels of victimisation and intimidation from other prisoners for a wide range of reasons, including theft of medication, debt and drugs. There were high levels of violence and the procedures to combat bullying behaviour were not used effectively.

102. We are concerned that Ranby does not appear to have an adequate strategy to protect prisoners who feel threatened by other prisoners. The Head of Safer Custody initially professed not to understand why prisoners felt the need to be escorted by staff when moving around the prison. The man's offender supervisor said she did not know that he was afraid to leave his houseblock or how long that had been the situation, although he had made no secret that he was afraid of other prisoners because of unpaid debts. His concerns were clearly recorded in ACCT documents and had led to him missing important medical appointments. Despite this, there is no evidence that staff at Ranby took any steps to investigate them and ensure he was protected. We accept that he had not helped himself by getting into debt by buying illicit drugs, but all prisoners should be able to feel safe from the risk of violence, whatever the reasons for their vulnerability. We make the following recommendation:

**The Governor should ensure that allegations of violence, bullying or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected.**

### **Emergency Response**

103. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes issued in February 2013, contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately.
104. In line with the PSI, Ranby issued such a protocol in February 2013. However, our investigation into the self-inflicted death of a man at Ranby in April 2014 revealed that until recently, the prison had generally not adhered to it. The emergency code blue was called at 7.10am. Three minutes later an officer called the communication room to say that healthcare staff were not needed as it is clear that he was dead. While there was only three minutes between the two calls, and the outcome for him was not affected, we are concerned that the communications room did not call an ambulance immediately they received the code blue, as national and local instructions require. In other emergencies, such a delay could be crucial. We have made previous recommendations to Ranby about this issue and are concerned that calling an ambulance immediately in an emergency is still not happening. We make the following recommendation:

**The Governor should ensure that all staff working in the prison's communications room understand emergency procedures and call an ambulance as soon as an emergency code is broadcast.**

### **Post-incident management**

105. PSI 64/2011, which covers safer custody procedures and sets out mandatory instructions on actions after a death in a prison requires staff directly involved to complete incident report forms as soon as practicable. Managers should hold a debrief for the staff involved to offer support and discuss what happened.
106. Apart from a custodial manager, none of the staff involved completed incident statements after the man was found dead. The absence of these and other key documents also made it difficult for the investigator to establish the exact chain of events. We repeat a previous recommendation to Ranby:

**The Governor should ensure that all managers and staff follow the national guidelines for dealing with a death or serious incident, including:**

- **Offering staff involved appropriate support;**
- **Ensuring that all staff directly involved complete incident statements.**

## RECOMMENDATIONS

1. The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including:
  - Completing ACCT documents fully and accurately;
  - That prisoners on ACCT plans are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances;
  - That ACCT reviews discuss the impact of potential bullying on risk of suicide and action is taken;
  - That all decisions taken as a result of caremap actions are properly documented and ACCTS are not closed unless caremaps actions have been achieved;
  - Conducting ACCT post-closure reviews, in line with Prison Service Instructions and re-opening ACCTS whenever there is an indication of continuing or additional risk.
2. The Governor should ensure that allegations of violence, bullying or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected.
3. The Governor should ensure that all staff working in the prison's communications room understand emergency procedures and call an ambulance as soon as an emergency code is broadcast.
4. The Governor should ensure that all managers and staff follow the national guidelines for dealing with a death or serious incident, including:
  - Offering staff involved appropriate support;
  - Ensuring that all staff directly involved complete incident statements.

## ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including:</p> <ul style="list-style-type: none"> <li>• Completing ACCT documents fully and accurately;</li> <li>• That prisoners on ACCT plans are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances;</li> <li>• That ACCT reviews discuss the impact of potential bullying on risk of suicide and action is taken;</li> <li>• That all decisions taken as a result of care map actions are properly documented and ACCTS are not closed unless care maps actions have been achieved;</li> <li>• Conducting ACCT post-closure reviews, in line with Prison Service Instructions and re-opening ACCTS whenever there is an indication of</li> </ul>		<p>Guidance on good practice is attached to all ACCT documents to assist with the correct completion of the process.</p> <p>ACCT documents are quality checked daily by wing managers and Duty Governors conduct a weekly check of 10% at random. Information about common mistakes and examples of processes that have not been followed are shared with staff and managers through discussion groups, training, global e-mails and briefings.</p> <p>Only in exceptional circumstances are prisoners on an ACCT located in the segregation unit. Whenever this proves necessary the duty governor signs the authority for segregation.</p> <p>ACCT care maps are reviewed weekly by the Deputy Governor at the safeguarding meeting. Feedback is provided to wing managers who brief staff on the action required.</p> <p>An additional operational Band 4 member of staff has been appointed to the safer custody team and will provide on-the-job training to staff to ensure that all have a comprehensive understanding of ACCT</p>	<p>01/03/15 Head of Safer Custody Band 4 Safer Custody Manager</p>	

	continuing or additional risk.		documents and are able complete them in accordance with mandatory requirements.		
2	The Governor should ensure that allegations of violence, bullying or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected.		<p>All acts of violence and bullying at HMP Ranby are investigated using the Zero Tolerance Incident Form (ZRIF) process and are taken seriously. Also those prisoners that fear for their safety because of debt related incidents are offered the appropriate support and referred to resettlement services for debt management.</p> <p>Additionally funding has been secured for a band 4 Safer Custody Manager. This member of staff will be in place on 12<sup>th</sup> January 2015 and part of their role will be to manage the Zero Tolerance Incident Form (ZRIF) process on a daily basis.</p> <p>Any violence, insults, threats, or verbal abuse will be challenged in a constructive manner, whilst maintaining a good communications network. Appropriate sanctions for perpetrators will be applied robustly, in a fair and consistent manner. Victims will be supported and protected and where ever possible victims will not be transferred or made to move wing. Victims are made aware of the resources available to them for example, listeners and in some cases they may have a buddy prisoner as support.</p> <p>The perpetrators will be challenged and informed of need to change and address their anti-social behaviour supported by staff and with clear</p>	01/03/15 Head of Safer Custody and all managers	

			<p>expectations. Serious assaults are referred to the police.</p> <p>Offender Supervisors are advised accordingly and the prisoners OASys reflects any acts of violence as above. Prisoners are referred for offending behaviour programmes and in particular anger management.</p>		
3	<p>The Governor should ensure that all staff working in the prison's communications room understand emergency procedures and call an ambulance as soon as an emergency code is broadcast.</p>		<p>A notice to staff will be re-issued and an "Emergency Response Guide" was distributed to all staff, attached to their wage slips on 31<sup>st</sup> January 2015. This clearly states when a code blue or red must be called and what action must be taken as a result.</p> <p>The Governor and Head of Healthcare have commenced a series of meetings with operational Band 4 and 5 staff to ensure that they have a comprehensive understanding of the emergency code system and that they share this with their staff.</p> <p>All control room staff will receive further guidance on their responsibilities including in what circumstances they are required to call the emergency services.</p>	<p>01/03/15 Governor Head of Healthcare Head of Safer Custody</p>	
4	<p>The Governor should ensure that all managers and staff follow the national guidelines for dealing with a death or serious incident, including:</p> <ul style="list-style-type: none"> <li>• Offering staff involved appropriate support;</li> </ul>		<p>All staff involved in a serious incident or death will be seen by the post incident care team. Their line managers will also be made aware of their involvement so that follow up support can be provided where appropriate.</p> <p>The prison now has a Police Liaison Officer from</p>	<p>01/03/15 Head of Safer Custody Duty Governors</p>	

	<ul style="list-style-type: none"> <li>• Ensuring that all staff directly involved complete incident statements; and</li> <li>• Ensuring that a debrief is held promptly after the death of a prisoner and that all staff involved in the incident are invited.</li> </ul>		<p>Nottinghamshire police who will be involved in the response to any future deaths and will advise staff of the importance of writing statements as soon as possible after the event.</p> <p>Contingency plans will be reviewed to ensure they are compliant with national policy. All managers will be reminded of the processes to follow when dealing with a death in custody or other serious incident. This will be discussed at a Senior Management Team (SMT) meeting and all staff who take on the role of Orderly Officer will be briefed on what they are required to do.</p>		
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