REPORT

OF AN INVESTIGATION

INTO THE CIRCUMSTANCES OF AN ACT OF SELF HARM

BY WA AT HMP RANBY

COMMISSIONED BY THE SECRETARY OF STATE FOR JUSTICE

IN ACCORDANCE WITH

ARTICLE 2 OF THE EUROPEAN CONVENTION ON

HUMAN RIGHTS

June 2016

PRELIMINARIES

I am commissioned by the Secretary of State for Justice to conduct an investigation with the following terms of reference:

- to examine the management of WA by HMP Ranby from the date of his reception on 16 January 2012 until the date of his life-threatening self-harm on 18 February 2012, and in light of the policies and procedures applicable to WA at the relevant time;
- to examine relevant health issues during the period spent in custody at HMP Ranby from 16 January 2012 until 18 February 2012, including mental health assessments and WA's clinical care up to the point of his life-threatening self-harm on 18 February 2012;
- to examine the circumstances of WA's transfer from HMP Lincoln to HMP Ranby on 16 January 2012, including the transmission to HMP Ranby of relevant information about his clinical care;
- to consider, within the operational context of the Prison Service, what lessons in respect of current policies and procedures can usefully be learned, and to make recommendations as to how such policies and procedures might be improved;
- to provide a draft and final report of my findings including the relevant supporting documents as annexes;
- to provide my views, as part of the draft report, on what I consider to be an appropriate element of public scrutiny in all the circumstances of the case. The Secretary of State for Justice will take my views into account and consider any recommendation made on the point when deciding what steps will be necessary to satisfy this aspect of the investigative obligation under Article 2 of the ECHR.

The Interested Parties to the investigation are:

WA, through his mother and Litigation Friend, Mrs A, represented by Solicitors, Irwin Mitchell LLP

The National Offender Management Service (NOMS), through Mrs Rosemary Rand, Head of Safer Custody and Learning

NHS England, through Mr Anthony Nichols JP, Head of Health and Justice (East Midlands)

Medacs Managed Healthcare through their Solicitor, Ms Jemma Gillson, DAC Beachcroft LLP

Lincolnshire NHS Foundation Partnership Trust, through Ms Helen Norris, Legal Services Manager, specifically with reference to circumstances at the time of WA's transfer to HMP Ranby.

The investigators are:

Barbara Stow, Lead Investigator

Andy Barber, Assistant Investigator

The clinical reviewer is Dr Nat Wright MBChB, FRCGP, PhD.

Readers should be aware that I have not used the real names of witnesses and others in this report. In particular, please note that I have not used the true initials of the man at the heart of this investigation, nor of his family, in order to protect their privacy.

I now present my report.

Barbara Stow
BA (Hons), MSt (Cantab) Applied Criminology and Management

June 2016

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THE STRUCTURE OF THE REPORT

I have provided an executive summary, as required by the terms of my commission.

That is followed by a note of my views on what I consider to be an appropriate element of public scrutiny in all the circumstances of the case.

The main report is divided into parts as follows:

- Part One is about the investigation process. It explains the purpose of the investigation, how it was conducted and who was involved.

- Part Two is about the events. It gives a narrative account of WA's time in prison, based on the documentary evidence and evidence obtained from witnesses.

- Part Three examines the evidence and findings of limited investigations by HMP Ranby and by Medacs~~,~~ (which was the healthcare provider at Ranby at the time)~~,~~ into the circumstances of WA's act of self-harm.

- Part Four is the report by Dr Nat Wright of his review of WA's clinical care.

- Part Five examines relevant policies and procedures.

- Part Six is my examination, commentary, and findings on key issues flowing from the facts, the policies and the clinical review.

- Part Seven contains a summary of the findings and my recommendations.

The Annex to the report contains a note on the investigation procedure.

EXECUTIVE SUMMARY

1 The investigation is about WA, a young man who suffered serious cognitive impairment as a result of an act of self-harm when he was in the segregation unit at HMP Ranby in February 2012.

2 WA transferred to Ranby from HMP Lincoln on 16 January 2012. At the time of the transfer he was waiting to be assessed for a place in an NHS secure unit specialising in personality disorder.

3 The secondary mental health team at Lincoln were liaising with the NHS unit about the assessment but were not aware of the transfer until 25 January, nine days after WA had been moved.

4 An administrator in the mental health team at Lincoln told the NHS Unit they could close the referral down as WA had been transferred. This was not recorded in the patient record and no further action was taken by staff at Lincoln.

5 At Ranby, the reception healthcare screening was by a member of staff who was not a qualified nurse. She did not refer to the patient record and she did not record any consideration of whether WA was at risk of suicide or self-harm. On admission to his previous prisons, WA had disclosed to staff, at initial or follow-up health assessments, contact with mental health services from an early age and some past episodes of attempted self-harm.

6 At Ranby, WA missed two appointments with the primary care team. We do not know why. No further appointment was made. He was approved to hold medication in possession in spite of a warning against this on his patient record at Lincoln.

7 Except for receiving medication, WA was not seen by a qualified clinician at Ranby until he was taken to the segregation unit on 15 February, a month after his arrival.

8 WA was placed in segregation after climbing to a workshop roof. He told staff that other prisoners were threatening him about an alleged debt after illicit fermenting liquid (‘hooch’) was confiscated from his cell. He wanted to be transferred from Ranby and to stay in the segregation unit until then.

9 Healthcare staff identified no reasons why WA should not be held in segregation. They made no reference to the assessment for an NHS secure unit, nor to any concern about self-harm.

10 On 18 February, prison officers found WA in his cell in a state of collapse, having ligatured. They administered first aid including cardiopulmonary resuscitation (CPR). Paramedics arrived and WA was moved to hospital.

11 Since April 2012, WA has been held under the Mental Health Act 1983 in a secure hospital specialising in brain injuries. If he had remained in prison, WA would have been released on licence in August 2013.

12 The investigation has identified a succession of instances of poor practice in the healthcare provided to WA in prison. Their cumulative effect meant that he lost the chance of being assessed for admission to an NHS unit specialising in the treatment of personality disorder, and his mental health history and vulnerability were not identified at Ranby.

13 Failings occurred through the acts or omissions of individuals in both prisons but they flowed from a lack of appropriate systems and management to ensure consistent delivery and continuity of healthcare to an acceptable standard.

14 There were circumstances in WA's personal life that may have contributed to his state of mind. WA had been admonished for breach of a restraining order after writing to his former intimate partner and victim. In the letter he expressed regret and unhappiness about losing touch with his son and distress that he had heard that his former partner was pregnant. The act of self-harm occurred on the anniversary of WA's principal offence but staff had no reason to be aware of this. Some staff were aware of the breach of the restraining order, but not the content of the letter, which was not received by Ranby until later.

15 WA disclosed to prison staff that he felt unsafe on the wing from prisoners who held him responsible for a debt. The staff believed they had dealt with this by placing WA in segregation, as he requested, until he could be moved out of the prison.

16 The investigation finds that WA's act of self-harm could not reasonably have been foreseen by discipline or healthcare staff from the information immediately before them, but there was information in the healthcare records and in the OASys record that should have prompted further consideration.

17 Contrary to PSO 2205, there was apparently no system in place at Ranby for administrative staff to check OASys records for assessments of risk of harm to self or others when a prisoner was admitted to the prison.

18 WA’s superficial behaviour did not indicate a risk of self-harm but there is little evidence that staff at Ranby engaged with him or provided opportunities for him to speak privately with trusted staff. There is no indication that he had a Personal Officer, either on the wing or in segregation. At his previous prisons, WA had not been unwilling to disclose his mental health history, past episodes of self-harm and his aspirations.

19 The officers who attended WA and managed the emergency undoubtedly saved his life.

20 Procedures after the incident were not recorded satisfactorily: there was no record of the nature of the ligature; of whether the cell was sealed; whether the police were called to the scene; and of what became of the contents of the cell.

21 The ‘simple inquiry’ commissioned by HMP Ranby did not include consideration of the healthcare that had been provided to WA. Its scope was too narrow to examine adequately the circumstances of WA's self-harm, his care and management in the month he was at Ranby, or whether there were lessons to be learned.

22 The arrangements for notifying WA's mother were not satisfactory. Staff liaised constructively with WA’s mother for a period while he was in hospital but she felt that her contact with prison staff was terminated abruptly and that she was not given information and answers to her questions which prison staff had promised.

23 The investigation makes eight recommendations to those responsible for clinical governance at HMP Lincoln and at HMP Ranby, to NOMS and to HMP Ranby. The recommendations are designed to ensure that changes have been or will be made that specifically address the weaknesses the investigation has identified, and that changes are embedded and carried through into future practice.

NOTE ON A SUFFICIENT ELEMENT OF PUBLIC SCRUTINY

I am asked to provide my views as to what I consider to be an appropriate element of public scrutiny in all the circumstances of the case.

My objectives for the investigation have been:

- to bring to light, as far as is possible, the full facts that are relevant to the case;
- to discover any shortcomings in systems, or in the conduct of individuals, that adversely affected WA's care in prison;
- to allay any suspicion of neglect or wrongdoing that is unjustified;
- to draw from what happened any lessons that may help to save other prisoners in future from suicide or catastrophic self-harm.

In pursuing these objectives, I have tried, in particular, within the scope of my terms of reference, to find answers to the questions posed by WA's family. In any case of this kind, those closest to the person at the heart of the investigation usually have the most acute interest in securing understanding of why the tragedy happened and how others can be spared similar distress in future.

In conducting the investigation, I am satisfied that I have received full cooperation from the Interested Parties and from all those from whom I sought evidence. Where there are questions that I have been unable to answer, I believe that they have occurred because of the passage of time since the events and not through any wilful obstruction. At my request, the Secretary of State extended the scope of the investigation to include consideration of the circumstances of WA's transfer from HMP Lincoln to HMP Ranby, including the transmission of information about his clinical care.

It is for others to judge how far I have succeeded in meeting my objectives but, in my view, the publication of my final report without delay will best serve to meet the proper requirement for public scrutiny by enabling those who have an interest in prisons, and a capacity to affect what happens there, to promote action reflecting the lessons we can learn from what happened to WA.

THE INVESTIGATION REPORT

PART ONE: THE INVESTIGATION

Chapter One: THE INVESTIGATION PROCESS

The reason for the investigation

1.1 The investigation is about WA, a young man who suffered cognitive impairment as a result of an act of self-harm while he was in the segregation unit at HMP Ranby.

1.2 WA was born on 25 September 1984 and was 27 years old on 16 January 2012 when he was admitted to HMP Ranby. On 18 February 2012 he was found in a state of collapse, having ligatured in a cell in the Care and Separation Unit (the segregation unit). Prison staff called for emergency medical assistance and administered cardiopulmonary resuscitation (CPR). Paramedics attended and WA was taken to hospital by emergency ambulance. Sadly, deprivation of oxygen to the brain as a result of the ligature caused impairment to WA's brain function.

1.3 On 19 April 2012, WA was transferred to a secure hospital, under Sections 47 and 49 of the Mental Health Act 1983. Since his conditional release date of 22 August 2013, WA is no longer subject to restrictions directed by the Secretary of State and has been held notionally under Section 37 of the Mental Health Act 1983. He remains under licence until the expiry of his sentence on 22 August 2019.

Terms of reference

1.4 The terms of reference for the investigation are:

- to examine the management of WA by HMP Ranby from the date of his reception on 16 January 2012 until the date of his life-threatening self-harm on 18 February 2012, and in light of the policies and procedures applicable to WA at the relevant time;

- to examine relevant health issues during the period spent in custody at HMP Ranby from 16 January 2012 until 18 February 2012, including mental health assessments and WA's clinical care up to the point of his life-threatening self-harm on 18 February 2012;

- to examine the circumstances of WA's transfer from HMP Lincoln to HMP Ranby on 16 January 2012, including the transmission to HMP Ranby of relevant information about his clinical care;

- to consider, within the operational context of the Prison Service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved;

- to provide a draft and final report of my findings including the relevant supporting documents as annexes;

- to provide my views, as part of the draft report, on what I consider to be an appropriate element of public scrutiny in all the circumstances of the case. The Secretary of State for Justice will take my views into account and consider any recommendation made on the point when deciding what steps will be necessary to satisfy this aspect of the investigative obligation under Article 2 of the ECHR.

1.5 The investigation was commissioned on 31 July 2014. The clause relating to the circumstances of WA's transfer from HMP Lincoln was not part of the initial terms of reference but was added on 15 May 2015 at my request as a result of information obtained in the course of the investigation.

The purpose of the investigation

1.6 My commission specified that I must conduct the investigation in a manner consistent with the requirements of Article 2 of the European Convention on Human Rights.

1.7 A duty to hold an Article 2 investigation is most usually triggered when someone dies in circumstances in which the state has a role. In *R (Amin) v SOS Home Department, [2003] UKHL 51, [2004] 1 AC632* at paragraph 31 Lord Bingham stated the purposes of an Article 2 inquiry in such a case, as

- to ensure as far as possible that the full facts are brought to light
- that culpable and discreditable conduct is brought to light
- that suspicion of deliberate wrongdoing (if unjustified) is allayed
- that dangerous practices and procedures are rectified
- and [in the case of a death] that those who have lost a relative may at least have the satisfaction that lessons learned … may save the lives of others.

1.8 The courts have held that a similar obligation may arise when the victim does not die but sustains life-threatening injuries and that the obligation may arise even if the injuries are self-inflicted. Clearly, in such a case, there is a similar value in bringing the facts to light, securing accountability, allaying suspicion, and, perhaps most importantly, drawing lessons that may prevent future harm.

1.9 To meet the requirements of Article 2 an investigation must be independent, open, transparent and even-handed. These principles underpinned the investigation's methodology. The investigation does not consider any question of civil or criminal liability.

How the investigation was conducted

1.10 The investigation drafted its own procedures and guidance for witnesses. The Interested Parties at the time were consulted about the procedures in draft. A note of the investigation procedure is attached as an Annex to the report.

1.11 The investigation began by gathering documentary evidence relating to WA's time in prison. A chronology was prepared as a working document and issued to the Interested Parties with copies of the documents on which it was based. I met WA's mother and her representatives. In addition to answering my questions, they and some other witnesses shared with me written statements they had prepared for other processes. I identified lines of enquiry, and the members of staff and former staff at the prisons whom I wished to interview.

1.12 Interviews with 16 witnesses were held at HMP Ranby in March 2015, with three witnesses at HMP Lincoln in August 2015, and with an additional witness in January 2016. I have seen written statements prepared for other processes by some witnesses who have not been interviewed. Interviews with witnesses were held in private and were recorded and transcribed.

1.13 Documents and transcripts have been made available to the Interested Parties to enable them to participate in the investigation, but they are not for publication. Individuals whose acts or omissions were commented on adversely were given an opportunity to comment on relevant extracts from this report in draft. A draft of the whole report was then shared with the Interested Parties so that they could identify any errors or significant omissions and to comment if they wished. In completing the report, I have taken into account all the replies received.

1.14 The report does not contain the proper names of any of the witnesses or other individuals involved in the events described. In accordance with the terms of my commission, people's names have been replaced with pseudonyms.

Meeting with WA

1.15 In June 2015, Dr Wright and I met WA and his responsible clinician at the secure hospital where he is accommodated. WA was able to answer concise questions about his early life and memories of prison until about 2010. He told us he had no memory of being at HMP Lincoln or HMP Ranby or of the act of self-harm, but he made an oblique reference to his index offence. It is not part of this investigation's terms of reference to make any assessment of WA's medical condition or prognosis for the future.

The Interested Parties

1.16 At the outset, those identified as Interested Parties to the investigation were the National Offender Management Service (NOMS), National Health Service England, and WA's mother, who acts on his behalf through solicitors Irwin Mitchell in representing his interests.

1.17 Other Interested Parties were identified during the investigation. Medacs, who provided primary healthcare services at HMP Ranby from 1 September 2010 to 1 April 2013, was joined as an Interested Party on 7 April 2015. After the addition to scope to include circumstances relating to WA's transfer from HMP Lincoln to HMP Ranby, I agreed on 5 August 2015 that the Lincolnshire Partnership NHS Foundation Trust should be joined as an Interested Party specifically in respect of those aspects of the investigation that relate to the management of WA's healthcare at HMP Lincoln.

People who have contributed to the investigation

1.18 In conducting the investigation, I have received invaluable assistance from the clinical adviser to the investigation, Dr Nat Wright; Assistant Investigator, Andy Barber; the Article 2 Secretariat Personal Assistants; and from liaison staff at HMP Ranby and HMP Lincoln. I am also grateful to the Interested Parties for their constructive and helpful approach to the investigation and responses to my persistent enquiries.

1.19 The content of my report owes a debt of gratitude to all who gave evidence, including WA's mother, and staff and former staff from HMP Lincoln and HMP Ranby.

Giving evidence to an investigation is not a comfortable experience, but witnesses have been generous with their time, and open and thoughtful in responding to my questions. The most valuable object of any investigation like this is to learn lessons and I hope that all who took part feel that they have contributed to both collective and individual learning.

PART TWO: THE EVENTS

Chapter Two: THE PERIOD BEFORE WA WAS MOVED TO HMP RANBY IN JANUARY 2012

Background

2.1 WA had been in prison before. From the age of 17 he served three terms in a Young Offenders' Institution, including three years for robbery and a concurrent sentence of 18 months for assault causing actual bodily harm. In 2006, he was sentenced to two years' imprisonment for an offence of causing actual bodily harm.

2.2 In February 2011, WA was arrested on a charge of assault and remanded to HMP Holme House. He was already remanded on bail following a similar assault in September 2010. The case was remanded to Lincoln Crown Court. On 15 March 2011 he was transferred to HMP Lincoln.

2.3 On 24 May 2011 WA pleaded guilty to charges of assault occasioning actual bodily harm which took place on 12 September 2010, and assault and threats to kill which took place on 18 February 2011. The victim, who was 17 at the time, was the mother of his son, who was born in 2010. WA was sentenced on 18 August 2011. For the offences on 18 February 2011 WA was given an extended sentence of eight years with a custodial term of five years plus an extension period of three years. This sentence was to run concurrently with a term of 12 months for the assault on 12 September 2010.

2.4 In addition, the Court made a restraining order prohibiting WA from contacting directly or indirectly his former partner and victim, *'save for contact through solicitors, for the purpose of negotiating any possible contact with his son.'* The order states that it is issued to the defendant and the police.

2.5 My terms of reference refer to WA's period at HMP Ranby and the circumstances of his transfer there from HMP Lincoln. However, in order to see what information was available, or ought to have been available, to the staff responsible for his care at Ranby, I have examined prison records in the period from WA's arrest in February 2011 until his self-harm in February 2012, with particular reference to his mental health history and previous evidence of propensity to self-harm.

HMP Holme House

2.6 After his arrest, WA was escorted to a Magistrates' Court on 19 February 2011, then admitted to HMP Holme House on remand. The escort record form says that an ACCT was opened by a criminal justice liaison nurse as WA stated he had suicidal thoughts the night before. He denied any current such thoughts but stated that he took an overdose about four months previously. ACCT stands for Assessment, Care in Custody, and Teamwork. It is the National Offender Management Service's care and management system to identify prisoners who are thought to be at risk of self-harm and to support them, through assessment and care-planning.

2.7 WA's prison medical record (called the 'patient record') indicates that on admission to Holme House WA said he had no suicidal thoughts and had not been diagnosed with any mental health condition but thought he might have mental health issues. He saw a mental health triage nurse on 28 February. Her note of the meeting says WA described a troubled past, including contact with the Child and Adolescent Mental Health Services (CAMHS) at the age of 11, a head injury from a car crash, and experience of being abused. He reported recent contact with adult community mental health services and said he had been diagnosed as having a personality disorder.

2.8 He also described some history of self-harm: an overdose of medication outside prison which did not require hospital treatment; an attempt to hang himself but then changing his mind; cutting his arms on one occasion. The patient record says he spoke of fleeting thoughts of self-harm but that he said he would not act on them. He reported having drug-induced psychosis, hearing a constant voice in his head and having taken chlorpromazine (an anti-psychotic medication) for one year when he was in HM YOI Glen Parva. The nurse saw no evidence of response to internal stimuli. WA was to be considered in the mental health team meeting and was put on a waiting list for counselling sessions through MIND, the mental health charity.

2.9 The prison medical record that I have referred to has been printed from SystmOne, which is an electronic clinical records system. The core document is a contemporaneous clinical record of all interactions with healthcare staff listed in chronological order. It is sometimes called the 'tabbed journal'. Entries are usually made on the day of the interaction and are dated accordingly. Where an entry is made later there is an additional date showing the date the note was entered, as well as the date of the interaction itself. Throughout this report I refer

to the full medical record, including correspondence and other documents, as the 'patient record', and the tabbed journal or contemporaneous clinical record as the 'patient journal'. (SystmOne is considered further below; see especially paragraphs 8.15 to 8.21).

2.10 WA was transferred to HMP Lincoln on 15 March 2011. On 28 March, a mental health nurse from Holme House liaised with a mental health nurse at Lincoln and made a note that the mental health team there would follow him up.

HMP Lincoln

2.11 In March 2011, primary healthcare services at HMP Lincoln were provided by Lincolnshire Community Health Services, the provider arm of the local primary care trust. From 1 April 2011 until 1 October 2014 physical healthcare and primary and secondary mental healthcare were provided by the Lincolnshire Partnership NHS Foundation Trust. Since 1 October 2014 these services have been provided by the Nottinghamshire Healthcare NHS Foundation Trust.

2.12 On admission to HMP Lincoln, WA reported feeling agitated, angry and low much of the time and asked for anti-depressants. The patient journal says he had no current feelings of deliberate self-harm but the nurse who completed the reception health screen recorded that on 10 October 2010 WA had tried to harm himself outside prison by taking an overdose of morphine, paracetamol and co-codamol. The nurse made a note in the patient journal for the date of 10 October 2010. This appeared as the earliest entry in the patient journal.

2.13 WA was referred for a 'non-urgent' mental health assessment. On 24 March, he reported to a GP increasing problems with anxiety and sleep since admission and started mirtazapine (an anti-depressant).

2.14 On 8 April, WA attended a mental health triage interview. A mental health nurse completed the Manchester Care Assessment Schedule (MANCAS), a mental health screening tool. In the patient journal, she noted that WA said that the medication was not working. He said he felt as if in a dream and that he had nothing to live for but said he had never been on ACCT (the care planning system for prisoners identified as being at risk of suicide and/or self-harm) and did not want to be. He said he wanted to discuss the past and try to make sense of it.

2.15 In May, healthcare at Lincoln made enquiries about WA's contact with community mental health services. The patient journal says that in the community he had

been on Step 4 of the Stepped Care Model for common mental health disorders. The community psychologist said that WA had often been late for appointments or failed to attend so no progress had been made. She had planned to work on trauma with him.

2.16 WA was placed on a waiting list for Step 4 mental healthcare at Lincoln prison and from 29 June was allocated weekly sessions with a mental health nurse at Step 2 (guided self-help cognitive behavioural therapy). These continued until 23 August 2011. The mental health nurse wrote to the prison GP to keep her informed. Her letter of 30 June said that all documentation had been placed on SystmOne to reduce waiting time for further assessments if he moved to another prison.

2.17 On 2 July, wing staff opened an ACCT plan prompted by WA's anxiety about forthcoming sentencing. Sentencing did not take place on 5 July as expected. The ACCT Plan was closed on 6 July. An entry in the patient journal dated 5 July says that WA told them he was *'on the ACCT book'* and that mental health staff had not previously been made aware of this.

2.18 A psychiatrist's report commissioned by WA's then solicitors was received for the court. WA's present solicitors gave me a copy. I do not know when the prison first obtained a copy or which staff had access to it but various records show that some staff were aware of the content (see below and, for example, paragraph 2.30.) On 25 July, an entry in the patient journal by a mental health nurse says WA showed staff the report, which diagnosed a personality disorder, stated there was a high risk of reoffending, and did not recommend transfer to a mental health establishment. WA is reported to have been distressed by the report and to have told the nurse that if he got an indeterminate sentence he would kill himself. The nurse noted that she told staff on WA's residential wing and that he was to be seen on return from court.

2.19 WA also told the mental health nurse he was taking excessive doses of anti-depressants (135mg mirtazapine) to help him sleep. No treatment was needed but he was required to return his medication; the nurse noted on the patient journal an intentional overdose of prescribed medication and that WA's consumption of medication was to be supervised. He was given information to read on prisons that dealt with personality disorder.

2.20 On 2 August, while still awaiting sentencing, WA told the mental health nurse he was not coping in prison, reportedly saying, *'I want to go'*. Her note of the session

in the patient journal on 2 August says: '*…All medication MUST be supervised only, as has history of accidental overdose*.'

2.21 Lincoln prison is a 'local' prison, serving the courts in the area. Prisoners held on remand in local prisons are usually transferred elsewhere after sentence, to a prison appropriate to their sentence and security category. WA was sentenced on 18 August 2011. On 24 August, he was provisionally categorised as Security Category C with a recommended allocation to HMP Ranby. Category C is the category of prisoners who cannot be trusted in open conditions but who are unlikely to escape. An entry in case notes by WA's Personal Officer on 28 August says that WA had been allocated to HMP Ranby but was not happy about it as he felt that Ranby would not offer the courses he believed he required. The officer advised him to submit a general application to say which establishments he wanted to go to and the reasons why. On 7 September, the Personal Officer made a note that WA told him he had submitted an application for a transfer to a therapeutic establishment as he believed this would provide appropriate courses for him.

2.22 WA had a self-reported history of drug abuse, including cannabis, alcohol and cocaine, but he told the mental health nurse that he did not use drugs in prison. At Lincoln, WA had regular one-to-one sessions with a CARAT worker and completed an SDP (Short Duration Programme) in May. CARAT stands for Counselling, Assessment, Referral, Advice and Throughcare, and is an external agency, assessing and advising prisoners who have substance misuse problems.

2.23 The CARAT worker helped WA investigate the possibility of transfer to a prison specialising in personality disorder. On 26 August 2011, WA completed a self-referral application to move to a special unit at HMP Dovegate, which operated a regime based on the principles of a therapeutic community. The Unit would not take prisoners who were taking mind-altering medication. WA was taking medication for shoulder and back pain. In October, he told the CARAT worker he was willing to stop this, but in November medication increased and the application process was postponed.

2.24 After sentencing, WA attended Offender Management induction. On 5 September, WA told his offender supervisor that he had been diagnosed with personality disorder and post-traumatic stress disorder and wanted to go to a therapeutic community to examine this in more depth and to look at offending behaviour work.

2.25 An 'OASys' assessment is dated as having been completed on 28 October 2011 by WA's offender manager in the county Probation Service. OASys stands for Offender Assessment and Sentence Management. It is an IT-based system for recording assessment and management of offenders. It is described in PSO 2205 as a risk and needs assessment tool (paragraph 1.5 of the PSO) and was devised as a joint prison/probation programme, whose assessments are completed and used by both services (see also paragraphs 8.22 to 8.24 below).

2.26 The OASys assessment includes entries in Section 10 (Emotional Well-being) that the report to the sentencing court in August 2011 stated that WA was diagnosed with depression in September 2010 and made an attempt on his own life in October 2010; that he saw someone from a crisis team and was currently engaging with a doctor from the mental health team in prison. It also refers to a psychiatric report as diagnosing no mental illness but Mixed Personality Disorder Dissocial (Antisocial), Emotionally Unstable, Paranoid and Anxious traits.

2.27 Section R3 of the OASys report (Risks to the individual) indicates in the standard form that there are current concerns about suicide and self-harm and issues of vulnerability and coping in prison. Section R8 notes past and current concerns about suicide and self-harm and refers to an attempted suicide by overdose in October 2010. The standard form says that if there are current concerns about self-harm an ACCT must be opened. An ACCT was not opened at the time. The entry about past self-harm says '*needs monitoring*'.

2.28 The offender manager who completed the post-sentence OASys assessment said in a statement that the risk assessment for self-harm had been made initially by the probation officer who prepared the pre-sentence report on WA. The concerns noted at the time were based on WA’s self-reported attempted self-harm in October 2010. The offender manager said that WA’s engagement with mental health services and CARAT, and his negative drugs tests, indicated an improving picture in relation to mental health. She had thought it too soon to move him to a low risk, given the previous incident, but saw no reason to raise the previous assessment of medium risk.

2.29 A note of 28 October 2011 by the GP in the patient journal contains the text of a referral letter about WA asking to be reviewed by a consultant psychiatrist for other treatment options to be explored. The note says among other things that the writer has concerns about *‘medication seeking behaviour’* as WA persistently requested a certain medication for which there was no specific indication. She

said she felt it was important that this information was relayed to whomever was making prescribing decisions.

2.30 A note of 2 November 2011 in the patient journal by the mental health nurse says that WA was on the waiting list for Step 4 of the mental health Stepped Care model and that he had been happy to wait for this. The referral was for support regarding childhood abuse. The note says there was no mention of personality disorder at the first assessment and WA had only recently disclosed the psychiatric report prepared for the court, so no work had been done on personality disorder. It had been explained to WA that to facilitate a move he would need to be drug-free. He had initially agreed to this but continued to request medication, which had recently been increased. After discussion in the mental health team he was to be taken off the IAPT (Improved Access to Psychological Therapies) primary mental health team caseload and referred to the Crisis Assessment and Treatment Team (CATT). This was part of the secondary mental healthcare team. The referral is dated 9 November 2011.

2.31 Prison transfer records suggest that WA was listed for a transfer to HMP Stocken on 16 November 2011. This did not take place. I do not know why (see paragraph 9.16 below).

Referral for assessment for an NHS unit specialising in personality disorder

2.32 On 15 November 2011, the mental health nurse told WA that she had handed his care over to the secondary mental health team to help deal with his request to move to a specialist unit. On 23 November, WA saw 'Ms G', an Occupational Therapist from the secondary mental health team. According to the patient journal, they discussed the possibility of WA transferring to a personality disorder unit and she was to follow up in 10 days once his home health authority was confirmed.

2.33 An entry of 8 December 2011 in the patient journal records that the North East Mental Health Commissioner was to consider WA and report back in five days. On 16 December, a Senior Secretary from the Oswin Unit, St Nicholas Hospital, Newcastle, spoke to mental health staff at HMP Lincoln to confirm that WA had been accepted for assessment and that the consultant required an up-to-date MANCAS and working with risk document, and the psychiatrist's report for the court. The Manchester Care Assessment Schedule (MANCAS) is a 20-item generic screening tool for mental health needs (see also paragraph 2.14 above). The Oswin Unit is a 16-bedded ward providing a specialist service for men between the ages of 18 to 65 from the North East of England who have a primary diagnosis of

personality disorder. The Oswin Unit's target timescale for assessing a patient at the site from which they have been referred is 25 days, though we were told this timescale might be compromised if a patient was transferred to another prison during the process.

2.34 Ms G was to gather the required information and send it to the Oswin Unit. Her entry in the patient journal on 23 December 2011 says that she saw WA on the wing and told him what was happening; that he expressed some concern about the assessment and that it was agreed to review at the beginning of January 2012.

2.35 An entry in the patient journal for 4 January 2012 says that another member of staff, 'Ms B', left a message for the psychiatrist who prepared the report for the court, requesting a full copy of his report (see paragraph 2.18 above). Entries by Ms B say that on 11 January, page eight of the report was received and faxed to the Oswin Unit. It is not clear why the record refers only to page eight. There is no further reference in the patient journal to the possibility of transfer to the Oswin Unit. On 18 January, the Oswin Unit emailed to confirm that they had received the report but required more information (see paragraph 2.42 below).

2.36 Ms B is referred to in the clinical record once as a mental health support worker, and otherwise as a Mental Health Nurse. Ms B told us this was an error. She was not a nurse but an administrator and her role was to support the clinical staff with any paperwork required. This was not the only inaccurate staff designation we found on SystmOne - see paragraphs 2.39 and 3.3 below.

Downgrading to Basic regime and confiscation of an item from the cell

2.37 On Saturday 14 January 2012, WA was put on the Basic level of the Incentives and Earned Privileges scheme on grounds of refusing to work. This reduced the facilities he was allowed to have in prison. An entry in his case notes by his Personal Officer says:

'[W] has now been demoted to basic - which was a shame. I think he has tried his best to keep out of trouble. He says that in a month and a half he has had 1 warning and was annoyed at being put on basic. I have explained to [W] that it's not because of the red warning as such - it's ALL the red warnings he has received. He claims that he struggles to get out of bed in the mornings and that's what's delaying him in getting to work. [W] did have a bit of a mardy yesterday and said he wasn't banging up - because I was his personal officer I went to have a chat with him - I couldn't tell if he was joking or not as he has always got a cheeky grin on his face - anyway I

talked to him and told him to rethink and not to make matters worse, he took on board what I said and went behind his door. I know [W] is a bit of a nightmare but we have always got on ok.'

2.38 A Security Information Report dated Saturday 14 January says that a toilet-roll holder that could be used as a hook was found in WA's cell. It was being used for its proper purpose but was not standard issue so it was removed but would be returned if approved by Security. The confiscation was logged by Security in the afternoon of Monday 16 January. By then WA had already been transferred.

Fitness to transfer

2.39 At 16~~.~~:23 on Sunday 15 January 2012 a Practice Nurse, 'Nurse 1', assessed WA as fit for transfer and on 16 January he was moved to HMP Ranby. In the patient journal, Nurse 1's designation was 'Nurse Practitioner'. Nurse 1 told us this was not correct. This was one of several incorrect designations in the SystmOne records – see paragraphs 2.36 and 3.3.

Follow-up by the Oswin Unit and the response from Lincoln

2.40 The investigation's clinical adviser spoke to the Oswin Unit about the referral of WA for assessment and they have kindly supplied copies of minutes from referral meetings and of emails relating to WA.

2.41 At an Oswin Unit referral meeting on 16 December 2011 it was agreed to ask HMP Lincoln Healthcare for a copy of the psychiatrist's report for the sentencing court and up-to-date information on WA's current clinical and behavioural presentation. According to the minutes of the referral meeting, Ms G, the Occupational Therapist at Lincoln, was not sure whether she would be able to send the report but would provide more up-to-date information. Ms G told the investigation that the psychiatrist's report was a private report and healthcare did not have a copy it. The Oswin Unit secretary chased this on Wednesday 4 January 2012. According to the minute, Ms G said she would try to provide information by Friday but none was received so consideration of WA was deferred at the next two meetings, on 6 and 13 January.

2.42 An email from the Oswin Unit secretary on Wednesday 18 January to both Ms G and Ms B in Lincoln's mental health care team says she has received the court report requested but had still not received an up-to-date account of WA's presentation, as the information originally sent was dated 8 April 2011. She said

the referrals meeting would take place the following Friday and would need this information before WA could be allocated as a formal referral.

2.43 When still no information had been received in time for the meeting on 20 January 2012, the Oswin Unit secretary emailed on 26 January 2012 to say that in the absence of any further information the Unit was likely to discharge the referral. Ms B replied by email the same day, saying:

'Was just about to email you about this referral.

We found out yesterday WA left HMP Lincoln and is therefore not [sic] *longer our care.*

When my colleague [Ms G] is back in the office she will be in contact with his receiving Prison which I believe is HMP Ranby to appraise them of the situation.

Therefore you can go ahead and shut the referral down. '

2.44 Ms B copied the email to Ms G. The minutes of the Oswin Unit meeting on 27 January 2012 refer to an email received from a support worker at HMP Lincoln to the effect that WA was no longer at HMP Lincoln so the referral could be discharged.

2.45 Neither Ms G nor Ms B at HMP Lincoln had any recollection of the case or the email correspondence when they were interviewed during the investigation. I have found no evidence indicating that any further action was taken by staff at Lincoln. Ms B has commented that, as an administrator, she would not have made the decision to advise that the referral could be closed but would have been acting on an instruction from a clinician.

2.46 Ms G, the Occupational Therapist, commented that it appeared from the email correspondence that she was away from work when Ms B learned that WA had been transferred. She did not now recall seeing the email to the Oswin Unit that was copied to her but said they received hundreds of emails. In her view, the Oswin Unit should not have been asked to close the case. She would have expected the Unit to be encouraged to contact HMP Ranby to arrange the assessment.

2.47 Ms G told us that in her experience the secondary mental health team might make half a dozen or so patient referrals a year for assessment for transfer to NHS

mental health facilities. Such referrals would now be through a consultant. Ms G said she believed she met WA only on the two occasions recorded in the patient journal. She recalled a nurse in the primary mental health team asking her advice but said there was nothing on the records to indicate that WA had been part of her caseload. The secondary mental health team had no knowledge of WA's transfer at the time. In 2011/12 there was no system for them to be informed when their patients were transferred and usually they would find out only when they failed to turn up for an appointment. Similarly, in 2011/12 there was no formal system for communicating with a receiving prison, though they would try to do so if they were aware of the move and there was a particular need.

2.48 Ms G said that the current system (in 2015) was different: the mental health team is notified of transfers and releases through SystmOne, either in advance or on the day of the move; and the secondary mental health team rings the receiving prison in every case of a patient under their care moving to another prison, usually on the day of the move.

2.49 A Clinical Psychologist at HMP Lincoln has commented that it appeared that WA had been pushing for the referral through the primary mental health team. Under the current arrangements (in 2015) referrals would be through the consultant involved in the case; mental health meetings were now more formally constituted, with a secretary taking minutes; the Secondary Team meeting was always chaired by the consultant psychiatrist; and the team were robust about screening proposals for referrals.

2.50 Ms G said that SystmOne was in place in 2011 as a live running record of both physical and mental health. I note from HM Chief Inspector of Prisons' report on Lincoln in 2012 (paragraph 2.111) that mental health clinical recording was done on both SystmOne and the Maricis system for care programme approach (CPA) documentation. The report says that the two systems were not linked, which meant dual recording; other health professionals could not see what was recorded on Maricis; and there was a monthly retrospective trawl of all patient information on both systems to ensure dual recording.

Chapter Three:

16 JANUARY TO 12 FEBRUARY 2012 - THE PERIOD FROM WA'S TRANSFER TO HMP RANBY UNTIL THE WEEK OF HIS ACT OF SELF-HARM

Transfer to Ranby

3.1 WA was transferred to Ranby on Monday 16 January 2012. When prisoners are transferred, they and their property are registered by prison staff and each new prisoner sees a member of the healthcare team for registration as a new patient and to highlight any significant information about their health or treatment. WA was allocated to a single cell in the induction unit. He was placed on the Standard regime of the Incentives and Earned Privileges Scheme so certain facilities were restored. Having been downgraded at Lincoln, he would have remained on the Basic regime if he had not been transferred.

Arrangements for healthcare at Ranby

3.2 From October 2011 to April 2013, Medacs were responsible at HMP Ranby for primary care for both physical and mental health and the prescribing elements of substance misuse. Nottinghamshire NHS Foundation Trust was responsible for secondary mental health. Physical primary care staff would generally refer patients to the primary mental health team for mental health issues unless they were known already to be secondary mental health patients.

Initial health screen in reception

3.3 The initial health screen for WA was completed in reception by 'Ms C', who was an assistant practitioner specialising in substance misuse, with long experience of working in that field. Ms C was trained as an ACCT[1] assessor and had qualifications in working with substance misuse (Royal College of General Practitioners Certificate in the Management of Drug Misuse Parts 1 and 2) but she was not a qualified nurse. Ms C told the investigation that she worked mainly on Houseblock 1, working with the men and with doctors, working out care plans and drug-reducing regimes, but that she was occasionally asked by the Head of Healthcare to do other things. She said she was trained in first aid and would have called for a nurse if she had any cause for concern. We noticed that in the version of the patient journal printed on 20 February 2012 Ms C was given the designation 'Manager', which led the investigation, initially, wrongly to assume that she was

[1] ACCT stands for Assessment, Care in Custody, and Teamwork, - the system to identify and support prisoners who are thought to be at risk of self-harm.

the Healthcare Manager at Ranby at the time. In a copy of the patient record printed later, this designation had been changed to 'Assistant Practitioner.' This was not the only such anomaly we found – see, for example, paragraphs 2.36 and 2.39 above.

3.4 Ms C described the healthcare screening process at reception. She said that usually they had little information about new prisoners. They would log on to the arrival screen, which would give the names. Sometimes the sending prison would send a piece of paper listing medications but generally they had very little information until the prisoner was in the prison. The reception screen template had a lot of boxes for data to be entered for example, for height, weight, cell-sharing risk, smoking cessation, risk assessment for medication et cetera. Mainly answers were pre-coded but there was some scope for free text. Previous medical records were not accessible until the reception screen was completed and the document saved, registering the new patient. Ms C said that at that point the screening was done and others were waiting so she would not look back at the records at that stage unless the initial screen had given her any cause for concern.

3.5 The initial health screen for WA was completed at Ranby at 15:47 on 16 January 2012. It makes no reference to any history of self-harm or assessment as to risk of self-harm. The entry in the patient journal lists mental health problem, anxiety, *‘previously been on olanzapine’, 'drug induced'*, drug misuse, outside prison dabbling with cocaine, amphetamines and cannabis, and currently receiving prescribed medication. There is no reference to the pending referral to the Oswin Unit.

3.6 Ms C could not recall whether at the time there was a box in the reception screen template about history or risk of self-harm. From looking back at the record, she said she had no concerns about risk of suicide or self-harm but that on 20 January 2012 she referred WA to drug services and mental health and that was the end of her involvement with him. She had no knowledge of a pending referral to the Oswin Unit.

3.7 As part of the reception procedure, Ms C also completed in manuscript the healthcare section of a cell-sharing risk assessment form. Her note says that WA said he needed to be in a single cell because of past history of being abused and that, whilst she found no evidence of this on SystmOne, she recommended that he should stay in a single cell until *'after he saw a mental health nurse the following week'.*

3.8 We asked Ms C if prisons ever provided a specific handover when prisoners were being transferred. She said that this happened sometimes but she could not recall anything from Lincoln saying that WA had a pending referral. She would have expected this to be picked up once he was passed on to the relevant services. If there had been a handover she would probably have taken the letter straight to the mental health team and it would have prompted quicker action by them. Alternatively, if a prisoner with a diagnosis of personality disorder was coming, there might have been liaison between secondary mental health teams for the two prisons, and the mental health team would tell primary care.

3.9 'RMN1' (a registered mental health nurse) was part of the primary mental health team. He told us at interview in March 2015 that any phone call about a new prisoner from a previous prison would have been documented. There might be telephone handovers of secondary mental health patients but the secondary team was separate from the primary mental healthcare team at the time and had their own office. He said it was now more integrated. They now worked together more as a team and the care pathways were clearer. RMN1 said he would not have expected there to be a phone call about the transfer of a prisoner just because they had a diagnosis of personality disorder. In a statement, RMN1 commented that the majority of prisoners have a complex mental health history and that personality disorders and depression were relatively commonplace in the prison environment.

CARAT assessment

3.10 Having been referred for drug services, on 23 January 2012 WA saw a CARAT worker. She noted one deliberate overdose in October 2010 but not repeated. Her note says that WA stated that he no longer wanted to go to a 'TC' (therapeutic community) as he would have to 'detox' off pregabalin (for relief of neuropathic pain) and was not completely confident the therapeutic community would be of benefit (see paragraph 2.23 above - in August 2011 WA had completed an application to HMP Dovegate's special unit that operated on the principles of a therapeutic community, but in November 2011 the application had been postponed.). The CARAT worker opened a care plan and the next day noted that she had referred WA to join groups on managing relapse, triggers and cravings, cannabis awareness and for one-to-one sessions on harm-minimisation and overdose. She was to see him again in four to six weeks. He said he did not want any other department to know he was engaging with CARATs.

Referral for mental health

3.11 RMN1 told us that prisoners could be referred to the primary mental health team by Reception, by Healthcare, by prison staff or by themselves.

Referral to the mental health team from reception healthcare screening

3.12 A record provided by the SystmOne Configuration Manager at HMP Ranby indicates that Ms C added WA to a waiting list at 08:52 on 17 January 2012. This was prompted by her assessment when she conducted the healthcare screening the previous day. The reason given for the referral was *'states he has anxiety'* and the priority was '*normal*'. There was no contemporaneous entry in the patient journal. An entry in the patient journal made by Ms C for a referral dated 20 January 2012 was entered on the system only on 20 February 2012. It states:

'Reason for referral (XalpS) - states he suffers from anxiety and has previously been on olanzapine.'

3.13 Ms C told the investigation that she assumes that she logged the entry on SystmOne after WA's self-harm in order to be sure that there was an accurate audit trail. She said that she was well aware that SystmOne shows the date that information is entered and that this could not be amended or altered, and she had no intention to mislead.

Self-referral to the mental health team – 2 February

3.14 On 1 February 2012, WA moved from the induction unit to F wing. A note in the patient journal entered in the evening of 2 February states:

'Referral to mental health team (XalPw). Application procedure (XaBlo)'

I understand this to mean that WA also made a personal application for referral to the mental health team but I have not seen the application. RMN1 amended the waiting list at 09:42 on 3 February. The report of the Medacs investigation says that the *'self referral document contained no information other than a request for an appointment, as he wished to talk to a member of the Mental Health Team.'* (See paragraph 6.20 below).

Missed appointment – 8 February

3.15 The patient journal says that WA did not attend an appointment for the primary mental health clinic on 8 February. RMN1 told the Medacs investigation in April

2012 that when he was administering medication on 7 February he took the opportunity to inform WA that he had an appointment to see him the following day. When WA did not attend the appointment, RMN1 said he booked a replacement appointment. He told the Medacs investigation he had no concerns, as the previous day WA had presented well and been interacting in good spirits with other prisoners (see paragraph 6.21 below).

Medication risk assessment – 9 February

3.16 On 9 February, RMN1 conducted an initial drug risk assessment and decided that WA could receive his medication in weekly batches. RMN1 had not interviewed WA. In a written statement for the Ministry of Justice, RMN1 confirmed that WA would not have been present for this assessment. RMN1 told the investigation that he would have completed a risk assessment for in-possession medication using a checklist, but we have not seen any record of this.

Missed appointment – 10 February

3.17 The patient journal states that WA also did not attend an appointment with a nurse on 10 February. The patient record does not state the purpose of the appointment but the Medacs report says it was a routine appointment for a secondary health screen as WA had arrived at the prison with prescribed medication. The report says the nature of the appointment was looked at by the bookings co-ordinator and, as there was no specific cause for it, no further appointment was made (see paragraph 6.22 below).

3.18 We have not seen evidence of any further booking for a mental health appointment.

3.19 As a result of this sequence of events, WA's only contact with members of the healthcare team from his admission to Ranby on 16 January until his admission to the segregation unit on 13 February were the reception healthcare screening and when he was routinely issued with medication.

Inaccurate entry in the patient journal

3.20 The patient journal also says that WA did not attend an appointment on 15 February for a visiting professional's clinic. However, the Clinical Matron at HMP Ranby told us this entry was wrong. The Matron said it referred to a smoking cessation clinic but that the date of the appointment logged on SystmOne was not correct and the appointment should have been for 22 February.

The system for medical appointments

3.21 Ms C explained that healthcare staff would book appointments on the SystmOne 'ladder'. Healthcare administrative staff would transfer them to a spreadsheet on Quantum (the National Offender Management Service information system) and email the list to Regimes staff who would put the spreadsheet onto the shared computer drive which could be accessed by the wings.

3.22 Each morning, the wings would print off the list and tell prisoners about appointments for that day when they unlocked their doors. RMN1 said prisoners were handed appointments slips. If they failed to attend they would be re-booked and notified in the same way.

3.23 It was then up to the prisoner whether he attended the appointment. Ms C said that if a prisoner missed two appointments she would follow up with an officer, who might say that the prisoner had not attended as they had a visitor, or give some other reason. If she was told that the prisoner *'couldn't be bothered'* or didn't want to attend she would go and speak to the prisoner.

3.24 'Senior Officer 1' had formerly been an NHS nurse then a healthcare officer, but he had left healthcare to become a generic discipline officer and in 2012 was manager of G wing. He said there were *'always problems about healthcare appointments being sent to the wings on time'*.

3.25 In the report of an inspection of Ranby in March 2012 HM Chief Inspector of Prisons (HMCIP) commented that the number of prisoners missing healthcare appointments was high. The inspection report said that over the previous three months 'did not attend' rates for GP and Nurse appointments averaged 17% and 29%, respectively, and were not being addressed (HMCIP*: Report on an Announced Inspection of HMP Ranby, 5-9 March 2012*, paragraph 2.68).

Case notes at HMP Ranby

3.26 Case notes are records of significant events maintained by the prison discipline staff for each prisoner. An entry in WA's case notes says that on 17 January he was seen during induction by the officer who was allocated as his offender supervisor at Ranby. The acting Senior Probation Officer at Ranby at the time, 'SPO1', said this referred to a group induction session not a personal interview. WA's gym induction is noted as completed on 24 January. There are no other entries in the

case notes until an alert on 10 February that he had breached the restraining order that had been made by the court when he was sentenced (see paragraph 2.4 above).

3.27 We were not able to discover whether WA had been allocated a Personal Officer. G wing manager, Senior Officer 1, could not recall exactly how the Personal Officer scheme operated in 2012. He said that, generally, Personal Officers were expected to touch base with the prisoner at regular intervals and to make a note on the case notes but mostly this said no more than that the prisoner had been spoken to and everything was OK. Senior Officer 1 could not remember whether the required frequency of entry at the time was weekly, fortnightly or monthly and said it had rather fallen by the wayside though he believed it was coming back.

3.28 SPO1, the Acting Senior Probation Officer, told the investigation that, because of the nature of his offence, WA was classified as high risk and was subject to public protection procedures but that this did not appear to have been picked up at the time. It was not unusual for public protection files to be sent after a transfer rather than carried on the 'bus' and SPO1 could not say when or whether a public protection file was received. SPO1 said that, ideally, WA should have been seen by his offender supervisor within 10 days of arrival to consider targets and sentence plan but there was no record that WA ever had an individual meeting with his offender supervisor at Ranby. The OASys assessment was updated on 10 February after WA was brought to the attention of Offender Management when the county Probation Service reported a breach of the restraining order made by the court when he was sentenced.

3.29 We asked SPO1 who would have seen the references in the OASys document to history and risk of self-harm (see paragraphs 2.27 and 2.28 above). He told us that information would have been shared if there had been any concerns prompting, for example, opening of an ACCT document, but if there was thought to be no immediate risk the historical concern might have prompted referral to secondary mental health.

Breach of the restraining order

3.30 The breach of the restraining order occurred on 24 January 2012, when WA sent a letter intended for his former partner and victim to her mother's address. The letter expressed attachment and regret and asked for pictures of their son and the chance to write to him, but it was in breach of the Court's restraining order forbidding WA to contact his former partner directly or indirectly, other than

through solicitors for the purpose of negotiating possible contact with his son. In a postscript to the letter WA said, *'I heard you pregnant. It killed me inside.'* The text of the letter was not sent to Ranby until 20 February 2012.

3.31 On 8 February, the letter came to the attention of the WA's new Offender Manager in the Lincolnshire Probation Service who had been allocated the role only on 6 February. She asked HMP Ranby to take action to prevent this happening again. A member of staff investigated but found no record of the restraining order in WA's records and her note says that the public protection department at HMP Lincoln told her that they had been unaware of the restraining order, so WA's communications had not been monitored there. On the basis of a risk assessment, a Governor at Ranby approved monitoring of WA's communications. On 10 February, the G wing manager, Senior Officer 1, was asked to place WA on Basic regime in accordance with the prison's public protection policy for prisoners who did not comply with public protection restrictions. He arranged to hold an IEP Review Board.

Chapter Four:

13 FEBRUARY TO 18 FEBRUARY 2012: EVENTS DURING THE WEEK OF WA'S ACT OF SELF-HARM

Monday 13 February - find of illicit fermenting liquid

4.1 In the evening of Monday 13 February 2012 a large quantity of 'hooch' (illicit fermenting liquid) was found in WA's cell. An officer was alerted by the smell and found three five-litre containers. WA was charged with a disciplinary offence.

4.2 That evening WA spoke to his mother on the telephone for about nine minutes. To prison staff when WA was in hospital, and later, in a statement that she made in June 2014, WA's mother said that WA had spoken about mental health and drug issues, and said that he could not cope at Ranby and no-one was listening to him. She took this to mean that prison staff were not listening. WA said he had expected to be placed at Moorland, 'Stockton' [possibly HMP Stocken] or Lindholme and that he had expressly requested at Lincoln that he not be transferred to Ranby. He expressed concern about his mental health.

Tuesday 14 February – IEP Review Board

4.3 The IEP Review Board, chaired by G wing manager, Senior Officer 1, was held on Tuesday 14 February. WA made representations that he did not know there was a restraining order and would not have written the letter if he had known. He said he just wanted contact and to see how his son was, having not heard anything for seven months and being worried about him. SO1 reported that WA was apparently unaware of the order but had now signed to confirm that he understood the restrictions. SO1 said that if it had not been for the find of hooch he would have deferred downgrading to Basic. He said that being downgraded to Basic meant that WA would lose his television, he would have to wear prison clothing and his association would be restricted.

Wednesday 15 February

4.4 On Wednesday 15 February, a hearing was opened on charge 575507 under Prison Rule 51 paragraph 12, having an unauthorised article in possession (the illicit fermenting liquid). I have a note that the charge was referred to be heard by the Independent Adjudicator on 2 March but I do not have any other record of the hearing.

Thursday 16 February - WA climbed to the roof apparently to obtain a transfer

4.5 WA was working in the workshops. At about 14:40, he broke a window in a workshop toilet and climbed to the roof. 'Principal Officer 1', who was the Orderly Officer (the duty uniformed staff member with responsibility for overseeing the daily regime of the establishment) and 'Prison Officer 1' found WA on the roof. The incident report says he was compliant but placed in handcuffs and taken to the Care and Separation Unit (CSU - the segregation unit). The Use of Force record says there were no known events leading up to the incident, that WA was compliant but verbal reasoning was used to de-escalate the situation and prevent him changing his mind. Control and restraint was not required, but ratchet handcuffs were applied on the authority of the Principal Officer to ensure staff safety and to prevent WA from running away. The record says no healthcare presence was required and that there were no injuries to WA or staff. It appears an F213 Injury to Inmate form was not completed by a health professional, although the Use of Force form says that this is compulsory after use of force (which includes use of mechanical restraints) even if no injuries are visible.

4.6 Principal Officer 1's Orderly Officer's report on the incident says he was contacted by a workshop instructor who informed him a prisoner had kicked out a window of the toilet area and climbed out. Principal Officer 1 and Officer 1 climbed onto the workshop area roof through the works compound where they found WA alone. WA was called, and was compliant at all times. He identified himself to the Principal Officer, who instructed WA he would be ratchet-cuffed and taken to the CSU. Principal Officer 1 removed the handcuffs in the CSU.

4.7 A report about the incident dated 16 February 2012 says that WA said he *'wants out of the jail because he's not safe at Ranby'*. The Security Manager considering the report noted that WA was placed on report and informed he will need to *'complete Rule 45'* and name all those who he suggests it is not safe for him to be near and the reasons why he is not safe~~.~~ – Prison Rule 45 regulates the removal of prisoners from association for good order or discipline or in their own interests~~.~~).Another report of the incident states '*possible debt issues, more information required*' but also notes that a plan is in place to move WA.

4.8 Principal Officer 1 told the investigation that WA was taken down from the roof in a cherry-picker then walked to the segregation unit; he was saying that he could not go back on the wing because he was in debt and he asked to be taken to the segregation unit. At the segregation unit the staff there took over. PO1 said they would have taken off the clothes he was wearing, placed him in clean sterile

clothing and allocated a cell, and healthcare staff would have checked him on admission to the segregation unit.

4.9 Principal Officer 1 said he had no concern for WA's safety during the incident. He had not thought that he was at risk of self-harm. He was frightened of others, not a risk to himself, and as soon as the officers said he would go to the segregation unit he was quite happy to go.

Segregation under Prison Rule 53 to await adjudication

4.10 There is ambiguity about the reason recorded for WA’s segregation. Prison Rule 53 provides that a prisoner who is to be charged with an offence against discipline may be kept apart from other prisoners pending the Governor’s first inquiry. WA’s segregation history sheet says he was initially held in the segregation unit under Prison Rule 53 to await the opening of an adjudication on a charge of being in an unauthorised place. Prison Rule 45 regulates the removal of prisoners from association for good order or discipline or in their own interests. The notice completed by ‘Prison Officer 2’ informing him of targets, facilities and the reason for segregation is the one for segregation under Rule 45, not Rule 53. Officer 2 noted in the History Sheet that WA was to borrow a unit radio/CD player until his own arrived.

4.11 ‘Nurse 2’, a Clinical Nurse, completed an initial segregation healthcare screen. This consists of an algorithm, which asks questions, including, whether the prisoner is *‘awaiting transfer to/being assessed for a bed in an NHS Secure setting*’, whether there has been any instance of self-harm during the current period in custody, whether the prisoner is on an open ACCT, and whether they are taking any anti-psychotic medication. Instructions on the form say the screen should be completed after: discussion with the prisoner; reference to the clinical record and any other relevant documentation; information from other staff members; and reviewing the nature of the incident to check for indications of mental distress. In the event that a prisoner is being assessed for a bed in a secure NHS setting, the algorithm states:

- *'There are healthcare reasons not to segregate at this time'*
- *'Discuss with Health Team'*

4.12 The second question on the algorithm is:

- *'Has the person self-harmed in this period of custody/are they on an open ACCT Plan OR is the person currently taking any anti-psychotic medication?'*

If the answer is yes, the clinician is asked to say whether segregation is likely to cause significant deterioration in mental health.

4.13 Nurse 2 answered 'No' to the questions about assessment for an NHS secure setting and any episode of self-harm in the current period of custody. She recorded no adverse indicators and concluded that there were no apparent clinical reasons to advise against segregation. The screen was endorsed by 'Governor F'. The times given on the screen are anomalous. The form says that Governor F signed at14:25. The nurse's signature is timed at 15:20 but apparently corrected from 13:20. Nurse 2 recorded in the patient journal at 15:09 the occurrence of procedure relating to control, restraint, seclusion and segregation, and that WA had been admitted to the segregation unit and she had done an environmental risk assessment.

Friday 17 February

4.14 'Governor B' was Duty Governor in charge of the prison. WA's segregation 'history sheet' records that another governor, 'Governor C', made the 'duty governor's round' of the segregation unit. Mr C was deputy head of Security and Operations at the time. He said the usual practice was for the governor who was attending the segregation unit for adjudications to do the Governor's round of segregated prisoners. That day he conducted adjudications. Mr C said he could not recall WA from that day, indeed he had no recollection of him before he visited him in hospital later, but he would certainly have seen him, and the cell door would have been opened for him by an accompanying officer. He said he would not simply have spoken to him through the hatch.

4.15 Medication was issued to WA at 08:34 by RMN1, then at 09:56 RMN1 recorded that WA said he felt OK and was waiting to be transferred.

4.16 One of the Chaplains ('Chaplain 1') visited the unit at 15:05 and recorded '*no issues*' in WA's history sheet. Chaplain 1 no longer works in the Prison Service and the investigation was unable to contact him but has read a statement that he

made in June 2014. ‘Officer 3’ and Officer 2 recorded that there were *'no issues*' when WA collect his meal at 17:00 and was given hot water at 19:00.

Saturday 18 February

4.17 This was one year since the date of WA's principal offence.

4.18 There are no entries in the patient journal for 18 February. The segregation history sheet records that ‘Nurse 3’ gave WA his medication at 08:30 and recorded ’*no issues*' in his history sheet.

4.19 Chaplain 1 visited at 11:15 and also recorded no issues.

Segregation under Prison Rule 45 'in own interests’

4.20 WA was charged under Prison Rule 51, paragraph 18, with being absent from any place he was required to be or present at any place where he was not authorised to be (Charge 576976). Specifically, he was charged that at approximately 14:40 on 16 February 2012 he climbed on to the workshop compound roof. Principal Officer 1 was the reporting officer but was not on duty. Governor B was the adjudicator. The hearing opened at 11:45. According to the record of hearing, WA pleaded guilty but asked to have legal advice. Governor B asked why he went on the roof. According to the record of hearing, WA replied, *'I was told that if you want a ship out to go on the roof. A prisoner told me*.' The Governor remanded the charge to the Independent Adjudicator.

4.21 Mr B no longer works for the Prison Service. He has not been interviewed but has provided a statement that he prepared in June 2014. In the statement, he said that he did not remember the adjudication or WA but interpreted the record as meaning that WA was helpful throughout, and that he pleaded guilty but wanted legal advice. Mr B said he remanded the charge to the Independent Adjudicator because of the request for legal advice. The documents indicated that WA asked for segregation for his own protection immediately after the hearing.

4.22 At 11:56 Governor B recorded in WA's segregation history sheet that he *'stated he was OK'*.

4.23 WA and Governor B completed forms relating to a request to be segregated. WA wrote on the form that he asked to be segregated for his own protection under Rule 45. He states on the form that he has gang-related trouble at Ranby and now

more trouble as some people made him hold their hooch and, as it was gone, they said he owed £200. He said he needed to get out of Ranby before he got hurt or hurt someone. He said he was down for Stocken or Lindholme and had written it down on an 'app' (an application) so he did not understand why he was at Ranby.

4.24 Governor B supported the request for segregation. The form to be given to the prisoner recording authorisation for initial segregation is not completed in full but states '*you are to remain in segregation because other offenders were demanding money from you*.' Interventions include: to look for a transfer to another establishment.

4.25 RMN1 completed an initial segregation health screen at 12:00. The entries were the same as those in Nurse 2's Initial Segregation Health Screen, with no adverse indicators. RMN1 told the investigation that he completed the algorithm and as far as he could remember he had asked WA if he was all right and had documented it. He recalled that WA was happy to be in the segregation unit waiting for a transfer. There is no entry in the patient record of the fresh assessment of fitness for segregation.

4.26 Governor B endorsed the screen.

The afternoon

4.27 That afternoon WA tried to make telephone calls. Three of the numbers were not on his approved list. He tried three times to call a woman friend but there was no reply. He succeeded in telephoning his mother at 14:32 and they spoke for about six minutes. The call was monitored in accordance with the interception of communications approved after WA breached the restraining order.

4.28 Call monitoring recorded that WA told his mother he was in the CSU as he had climbed on the roof as a way of getting transferred out of Ranby. He told his mother he had written to the OCA (the Office for Classification and Allocation of prisoners) department at Lincoln saying he did not want to go to Ranby and was told he could go to Stocken or Lindholme (I have not been able to locate any correspondence to this effect). According to the note of the call monitoring, he said staff told him *'If you don't go back to the wing we will take you back.'* And that he told them, '*If I go back to the wing and kick my sink off you will bring me back up*. ' He told his mother he '*just wants out this jail.'* When asked what's going on to make this happen he said '*nothing*'. WA's mother advised him to keep his head down, and tell them you want to be moved because it's stressing you out. WA also

asked his mother to tell a woman friend not to come and visit as he was down the block and could not get a haircut or anything. The record says that at no time in the conversation did he indicate that he would make any attempt to take his own life.

4.29 Later, when WA was in hospital, his mother told Governor F and the Family Liaison Officer about this call. She said it had been difficult to hear as she was working in a noisy public environment and she had asked him to call at another time.

4.30 WA's mother told the investigation that in the telephone call WA said he was not happy at Ranby; that he did not know why he was there when he thought he was going to a '*mental health prison'*; that no-one would tell him why he was at Ranby; that he wanted to stay in the segregation unit and if he was sent back to his cell on the wing he would smash it up so he would be sent back to segregation; and that he said he '*could not do this anymore and that he could not stay at HMP Ranby*'.

Afternoon exercise

4.31 In a statement taken by the prison Security Manager at 11:15 on 19 February 2012, 'Prisoner 1', who was located in S1-01, stated that he had known WA for several years and,

'On the afternoon of 18 feb I was on exercise yard with [WA] and was having a discussion with him. He stated he was finding it difficult being in the seg and asked me if I had any medication, when I asked him why he said that he was considering taking an overdose. I told him he was being daft and not to be stupid. I honestly thought that he was joking. [WA] had told me that he had problems on the out. I told him that he ask to see a listener.

At the end of the exercise period [WA] had assured me that he was <u>not</u> going to do anything stupid and I was happy with his answer and thought no more about it.'

4.32 WA was located in cell S1-04. 'Prisoner 2' was in the cell next door. In a statement taken by the Security Manager, Prisoner 2 said that WA came to his cell window during exercise and spoke about the reasons he was on the unit. He made no mention of having any thoughts about harming himself.

After exercise

4.33 ‘Prison Officer 4’ noted in the history sheet that at 16:50 WA collected his evening meal and asked for a prison letter (official notepaper for prisoners' private correspondence). At 18:00, ‘Prison Officer 5’ took the letter and spoke to WA. In a statement written on 19 February 2012 Officer 5 said he put the prison letter through the door at about 18:00. WA asked him when his adjudication was. Officer 5 checked and told him it would be before the judge and to ask his solicitor to book in, three days before the date, if he wanted to attend. WA had said, *'Thanks, Guv, I'm sorry to bother you*.' (In a statement he made in June 2014, Officer 5 said that it was specifically a solicitor’s letter that WA asked for – special arrangements apply for prisoners to write confidentially to solicitors.) At about 19:00, Officer 5 was delivering hot water with Officer 4 and ‘Officer 6’. He could not remember whether WA had taken a flask or declined.

4.34 At 19:00, Officer 4 and Officer 6 were issuing hot water to the prisoners in the unit. In his statement later, Officer 4 recalled that WA declined hot water. Officer 6 says that each cell was opened individually so that prisoners could exchange flasks and clear any rubbish. Officer 6 recalled that WA was the only person to decline a flask but he did have some rubbish. Officer 6's statement does not say what the rubbish was. Officer 6 has left the Prison Service and has not been interviewed.

4.35 Officer 8 told the investigation that he remembered opening WA’s door so he could collect his evening meal and that WA had asked him how to go about getting a transfer out. Officer 8 had told him it was usually by application but in the segregation unit staff worked closely with operations and would probably be looking to transfer him anyway without him having to put in an application and, in any case, he would see a Governor and a chaplain every day.

Chapter 5:

WA'S ACT OF SELF-HARM AND THE RESPONSE OF THE STAFF

WA was found in a state of collapse

5.1 At 19:38 in the evening of Saturday 18 February 2012, WA was discovered by 'Prison Officer 7' slumped behind the cell door with a ligature round his neck tied to a tall locker. Officer 5 was nearby and gave assistance. 'Senior Officer 2' was the Orderly Officer (the most senior officer on duty in the prison, known by the call sign Oscar). Officers 4 and 6 were also called to the scene. The account of events below is based on the statements made in the following days by all the officers involved.

Statement of Officer 7

5.2 Later that evening Officer 7 gave an account of what happened in an entry in the Segregation Observation Book and subsequently in a statement. Officer 7 had arrived early for his night shift and was checking cell doors. At first he could not see anyone in S1-04 then saw WA on the floor directly behind the door. He shouted but got no response from WA. He saw a ligature. He stayed at the door and called for assistance. Officer 5 was only a few feet away and arrived immediately. He shouted through the door and kicked it but WA made no response.

5.3 Officer 5 called Control by radio and asked for more staff at the CSU and for permission to enter the cell. He opened the cell with his keys and kicked the bottom of the door to open it. Both officers entered and saw that WA had secured a ligature round his neck attached to a tall locker. Officer 5 called Control for a Code Blue (call for emergency assistance).

5.4 Officer 7 removed his cut-down tool from his pouch and cut the ligature above the knot to release it from the locker while Officer 5 supported WA's head. Officer 5 felt a pulse. He took the cut-down tool and cut the ligature to release it from round WA's neck. The two officers placed WA in the recovery position.

5.5 The Orderly Officer, Senior Officer 2, arrived. He advised moving WA to the bed and the officers lifted him onto the bed on his back. Officer 5 was continually talking to WA, trying to gain a response and reassure him. Officer 5 carried out a number of compressions on WA's chest to get some air circulating again. WA gave

out a loud breath/wheeze noise from his mouth, so was placed in the recovery position as he seemed about to vomit.

5.6 Around this time the ambulance arrived and paramedics took control and took WA to Bassetlaw General Hospital for further care.

Statement of Officer 5

5.7 At about 19:40 Officer 7 called him to check on WA in S1-04. Officer 5 looked through the observation glass and saw him lying on the floor right in front of the door. When he gave no response, Officer 5 called Control for another member of staff so he could open the cell, as the staffing limit for patrol state was three. He then looked closer into the cell and saw WA's condition and advised Control he was entering the cell. Inside he saw WA slumped with a ligature round his neck. Officer 7 cut the ligature then Officer 5 cut it from round WA's neck.

5.8 Officer 5 initially thought WA was dead but he felt for a pulse at the neck and found a weak one. Officer 5 thought the Senior Officer had arrived by this time and helped him to lift WA on to the bed. Senior Officer 2 said something like *'we need to get some air into him'*. They put WA on his back and Officer 5 performed CPR (cardiopulmonary resuscitation) *'for what seemed like an eternity'*. Eventually, WA gave a loud gasp and intake of breath. Officer 5 continued compressions until he was maintaining sporadic breathing. Then he kept rubbing his back. At this point the paramedics arrived and took over.

Statement of Senior Officer 2

5.9 At about 19:40 Senior Officer 2 received a Code Blue emergency call from the CSU. On arrival he found WA on the floor and Officers 5 and 7 with him. Officer 5 said WA had a pulse but was not breathing. SO2 contacted Control by radio and asked for an ambulance immediately. He told Officers 4 and 6 to make sure the ambulance was on its way and came straight in without holdups. He also asked them to get Control to inform the Duty Governor. WA's eyes were dilated. SO2 asked for a face mask (an oxygen mask) and gently lifted WA's head to clear the airway. Before the mask was needed, WA gasped a breath and then another. With the two officers, he gently lifted WA onto the bed in order to work and monitor him better. WA was put in the recovery position with his head back to aid breathing. Officer 5 was talking to him and working *'tirelessly'* to bring him round. They lost the pulse and put him on his back and Officer 5 commenced CPR. WA gasped again. They located a pulse and put him back in the recovery position. His

breathing was laboured but more regular and Senior Officer 2 could feel air coming from his mouth. The ambulance arrived and the paramedics took over. The ambulance left at 20:05 with WA and Officers 4 and 6. Senior Officer 2 commented that Officers 5 and 7 deserved great credit for their actions.

Statement of Officer 4

5.10 Officers 4 and 6 were working on A wing and a Code Blue call from Control instructed all 'externals' (staff deployed to various different areas as required) to attend CSU. When they arrived, Senior Officer 2, Officer 7 and Officer 5 were in cell S1-04, with Officer 5 performing CPR.

5.11 Senior Officer 2 asked Officers 4 and 6 to prepare an escort bag (containing items needed when a prisoner was taken outside the prison) and ensure the ambulance could get access as quickly as possible. Senior Officer 2 instructed Officer 4 to get Control to inform the Duty Governor. Officer 4 then collected all the information required to go with WA to hospital.

5.12 A fast-response paramedic arrived about 19:55, with the ambulance arriving a couple of minutes later. WA was transferred to stretcher by the ambulance staff and left the prison at about 20:05 accompanied by Officers 4 and 6. When they arrived at the hospital the doctor asked for handcuffs to be removed. Permission was granted by Governor B.

Statement of Officer 6

5.13 Officer 6 arrived at the CSU at about 18:40 to help Officers 5 and 4 with hot water flasks. WA was the only person to decline a flask but he had some rubbish to be disposed of. Officers 6 and 4 were then instructed to go to A wing for roll check. This was completed by 19:35 and they were in A wing office. A Code Blue came over the phone at about 19:40. They ran to CSU where Officer 5 was performing CPR, with Officer 7 kneeling beside him.

5.14 At Senior Officer 2's instruction, Officer 6 ran to get the escort bag and Officer 4 went outside CSU so the ambulance knew where to go. Then Officer 6 went to the vehicle lock entrance and met the paramedic car and brought him in. Some two minutes later Officer 6 directed the ambulance in. There was no delay or stopping as they had established a free flow.

5.15 The Senior Officer asked the officers to go to the hospital. Officer 4 got into the ambulance with the closeting chain on and Officer 6 returned radio and keys and shut the prison gates and jumped in to the ambulance. At the hospital, WA was taken to the resuscitation room for treatment. Governor B gave permission by telephone from home for the closeting chain to be removed. A closeting chain is a length of chain cuffed to one hand that allows a prisoner to use a closet (toilet) whilst still being physically and securely attached to a member of staff.

The Control Room log

5.16 The Control Room log records that Officer 7 made an emergency call at 19:38, that the ambulance was called at 19:40, arrived at 19:50 and left the prison at 20:05. Governor B, as Duty Governor, was informed at 19:50 and the Independent Monitoring Board at 20:26.

Additional information obtained by the investigation

5.17 Among all the records of the incident we were unable to find any information about the nature of the ligature, the contents of the cell, whether it was sealed and whether the police were informed of what happened. Officer 7 told us that the ligature was a green prison-issue bed-sheet that had been ripped but tied with several knots to give it extra strength. It was long and had been tied to the top hinge of the tall locker, round the locker, then round the hinge again. WA was sitting with his back against the cell door as if purposely blocking it.

5.18 Officer 7 said that as far as he could recall there was nothing extraordinary in the cell. WA was wearing prison clothing and did not have a lot of kit there. He knew that the door was locked that night (after the incident) and staff put some tape across the inside of the hatch to prevent prisoners looking in. He believed that later, but not that night, the door was secured with an additional *'boot lock'* through the handle with a padlock (this would prevent unauthorised access by staff). After working his night shift and again on Sunday night, Officer 7 was off duty until Tuesday 28 February. The cell was still locked then but was back on line a day or so later.

5.19 We have not been able to discover whether WA had property in his cell on the wing that he was not allowed to have in the segregation unit, and, if so, what happened to it.

5.20 Senior Officer 2 was on Evening Duty. He said that once WA was out of the prison he informed the Duty Governor and would have handed over to the Night Orderly Officer. He closed the cell and no one would have had access during the night. He did not know what action had been taken about the cell or the contents after that or whether the police were called. It would have been for the night shift Duty Governor to authorise what happened to the cell.

Sunday 19 February

5.21 The following morning Nurse 3 telephoned the hospital to provide information from the patient record. Her entry in the patient journal says that, according to the notes, WA had attempted suicide several times in the past, through overdoses and an aborted hanging, and that he appeared to have had longstanding psychiatric problems since the age of 11 and a longstanding history of drug misuse.

5.22 According to the incident log, prison staff spoke to the police on Sunday morning, first in Lincolnshire at 09:10 then in the north-east at 10:15. This seems to have been to enlist their help in telling WA's family what had happened. WA's mother says that police came to her home that morning at about 11:00. They told her that WA had attempted to hang himself and been taken to Bassetlaw Hospital. Mrs A said she was angry not to have been told earlier. She said she had raised this with staff at Ranby and was told there was a mix-up with her contact details and they were not up to date in WA's records. She said she was surprised by this explanation as her contact details had not changed for some time and, in any event, the prison would have had a log of WA's telephone calls and would have known her telephone number.

5.23 Following the visit by the police, Mrs A telephoned the hospital and the prison. She said she was told she would need to speak to the Governor, Mr D, and that he would meet her at the hospital the next day.

5.24 Mrs A travelled from her home in the north-east and, on 20 February, spoke to Mr D on the telephone between about 08:30 and 09:00 and he said he would meet her at the hospital. However, when she reached the hospital, another governor, Mr F, told her that Mr D was unwell and would not be attending the hospital. Mrs A found that odd having spoken to him a short time ago.

PART THREE: PREVIOUS INVESTIGATIONS

Chapter Six:

THE INVESTIGATIONS BY HMP RANBY AND BY MEDACS

6.1 The present investigation was commissioned in July 2014, more than two years after the events. Delay is unhelpful to effective investigation. Records not seen to be relevant at the time are not preserved. Witnesses' memories fade, especially when they are asked to recall events that did not seem unusual or significant at the time and became so only in light of what happened later. Delay can be distressing for family members and also for witnesses who are suddenly called upon to testify about events from a long time ago that may have been traumatic at the time.

6.2 I have examined HMP Ranby's report of the incident and two limited investigations that were made much closer than the present investigation to the time of the events examined.

The incident report

6.3 On 20 February 2012, Mr E, Ranby's Safer Custody Manager at the time, completed an incident report. It described the method of self-harm as ligature from a medium in-cell locker. The report noted that WA was not subject to ACCT and there was only a limited self-harm history, with one ACCT open for four days from 2 to 6 July 2011.

6.4 Mr E told the investigation that he had no prior knowledge of WA and was notified of the incident on Sunday 19 February. He looked at the information on the Incident Management System and talked to the staff involved. He was aware of the previous ACCT from the computerised record. If WA had been on an open ACCT this would have been highlighted prominently on every page but a closed ACCT was recorded only by a small entry.

6.5 Mr E was not able to say what the ligature was. The nature of the ligature was not reported to the Safer Custody Meeting. Mr E was not on duty at the time of the incident and he did not enter the cell, which he understood had been sealed for the *'scene of crime'* police officer. He said the Orderly Officer would have been in control.

Inquiry by Governor F

6.6 On 24 February 2012, Ranby's Deputy Governor commissioned a Simple Inquiry from Governor F to establish:

- The appropriateness of WA being held in CSU
- The effectiveness of procedures to identify prisoners at risk of self-harm in CSU
- Any prior indication of self-harm by WA
- The sequence of actions on the discovery of WA hanging.

6.7 The objectives of the inquiry were said to be to establish the facts and present any evidence in relation to the incident and to decide whether a formal investigation should take place; and to identify learning points that might prevent and/or reduce the likelihood of such an event recurring in the CSU.

6.8 For the purpose of the inquiry, statements were taken from staff and from nine prisoners in the CSU. The report notes that, with the exception of one prisoner, the prisoners said they had no or little knowledge of WA, they were not aware of his intentions and did not suggest any reason why he had acted as he did. I have seen these statements and have taken them into account in the narrative of events above.

6.9 One of the prisoners, Prisoner 1, said WA said he was finding it difficult in the segregation unit. He asked for medication and said he was considering taking an overdose. Prisoner 1 thought it unlikely and that he was joking, though WA did say he had problems outside. Prisoner 1 did not pass this information on to staff nor did WA ask for a Listener as advised by Prisoner 1.

6.10 The inquiry report says that WA's mother (CA) and brother (JA) were interviewed, but records are not appended to the report. From his inquiry, Governor F concluded:

- There was no evidence against WA being held in the CSU and no special or mitigating issues. The CSU was the most appropriate location in Ranby. WA made a determined effort to get off the wing and asked for Rule 45.

- WA had been seen in the CSU, and healthcare screens completed, in compliance with procedures. There was no evidence that the procedures to

identify prisoners at risk of self-harm in the CSU were not operating correctly.

- There was no history of previous self-harm. No prior evidence of self-harm and staff were not aware of any risk or intention.

- Actions by the staff on discovery of WA were commendable and life-saving.

What Governor F told the present investigation

6.11 Governor F told us that after an incident of this kind a *'near miss'* self-harm form is always completed and a safer custody investigation follows. Some governors will sanction an investigation immediately; others will do a simple investigation to see what, if any, immediate learning needs flowed from the event. A safer custody investigation tended to be a little deeper than a simple investigation. Governor F said his terms of reference were to look at some specific areas. Normally, depending on the outcome, there would be a recommendation for either a formal investigation, commendations or any concerns.

6.12 Mr F said that, after an incident of this kind, the cell should always be sealed and any ligatures, tools, equipment, bedding or clothing used would be preserved and sealed and, normally, would be handed over to the police if they requested it. Governor F did not know what had happened in this case, nor could he say what property was in WA's cell in segregation, or in his cell on the wing, or what happened to it. He said it was not within his terms of reference to look at how the incident was managed. He expected that the police would have been informed, as they would normally pick up the information from a 999 call. He said the detailed information we asked for would be in the Incident report held in the security department. The Orderly Officer and the Duty Governor would have been responsible for that. We have not been able to discover any document containing information about the ligature, the contents of the cell, the sealing of the cell, and whether the police were called.

6.13 With respect to the interviews with WA's mother and brother referred to in the inquiry report, Governor F said that his meeting with Mrs A was not a formal interview but took place at the hospital and was recorded in the Family Liaison Officer's log (the FLO log). WA's brother had reluctantly consented to see him but there were no notes of any worth as the questions Governor F asked him were answered with either a shrug or a 'don't know'. Governor F said he recalled asking if JA knew of any reason why WA would self-harm and his response was *'No'*.

When asked if he was aware of any issues at Ranby or elsewhere, JA shrugged his shoulders.

6.14 The investigators asked Governor F why his report said there was no history of self-harm when there had been an open ACCT and self-reported excessive use of medication during the current sentence, and reference to risk and previous incidents in the OASys document and healthcare records. Mr F said he had no access to healthcare records and it was not part of his terms of reference to examine these. He said there was no information since he had arrived at Ranby to suggest WA was at risk of self-harm until the day he went on the roof. Following that, he said he did not believe, in the circumstances, that there was any indication that segregation was inappropriate, and WA seemed to have made a determined effort to get there.

6.15 The investigators told Mr F that Mrs A had understood there would be another investigation. Mr F said that he understood that another governor was to undertake a more formal investigation. He had not recommended further investigation based on the objectives set for the simple inquiry. He thought that was more likely to be the outcome of the more detailed 'near miss' investigation by the Safer Custody Manager. He suggested the Family Liaison Officer's log (FLO log) might cast more light on the question of further investigation.

6.16 The FLO log notes that on 20 February Governor F and the FLO met Mrs A for the first time. Among other things, it says that Mrs A asked questions about how WA had attempted to take his life and the circumstances surrounding it. Mr F explained that HMP Ranby would be carrying out a full investigation regarding the circumstances leading up to and surrounding the incident. The FLO assured Mrs A she would feed back answers to her questions as soon as the preliminary investigation had taken place and she would keep in touch with her on a regular basis. The log says that WA's younger brother (not JA) had appeared to be angry that WA's requests not to be transferred to Ranby had been ignored and Governor F had said this would be looked into to try to ascertain the circumstances surrounding this.

6.17 Mrs A told the investigation that, at first, the FLO, Governor F and other staff met her once a week at the hospital but after about six weeks the meetings suddenly stopped, without explanation or notice even though there was information she had asked for that they had promised to find out about. Mrs A was disappointed that the Governor never met her. She said that after WA was moved to the secure

hospital she sent the family liaison officer a text message to say he had settled well there but she did not hear back from the FLO.

Investigation by Medacs

6.18 Medacs were contracted to provide primary healthcare services at HMP Ranby from 1 October 2010 to 1 April 2013.

6.19 An internal investigation into the incident of WA's self-harm was conducted by Medacs' contract manager. The report is not dated but interviews with staff were held in April 2012. I am grateful to Medacs for sharing the report with my investigation.

6.20 The investigation report stated that WA's reception assessment included nothing of note save that he was taking medication (pregabalin) prescribed for general anxiety. He is said to have self-referred to the primary mental health team on 2 February 2012 and that the application (which I have not seen) gave no details but simply asked for an appointment.

6.21 RMN1 told the Medacs investigation that he saw WA on the wing on 7 February 2012 when giving out medication and told him that his appointment would be the next day. RMN1 said he appeared in good spirits and to be mixing well with other prisoners. WA did not attend his appointment and a further appointment was made. RMN1 had no immediate concerns because of his demeanour the previous day.

6.22 The report notes that WA also failed to attend a nurse triage appointment on 10 February 2012. It says this was a routine appointment for a secondary health screen as he had arrived at Ranby with prescribed medication. The healthcare bookings coordinator considered the nature of the appointment and that there was no specific need for it so no further appointment was made.

6.23 On admission to the CSU, Nurse 2 followed the standard protocol - completion of an algorithm - and assessed WA as fit to reside in the CSU, which is where he said he wanted to be. On 17 February 2012 RMN1 visited and assessed his mental state. WA said he felt well and was waiting for a transfer. RMN1 reported that, again, WA presented well with no obvious concerns.

6.24 On the morning of 18 February 2012, Nurse 3 saw WA on the daily segregation round. He confirmed he was fine. The investigator identified a record-keeping error in that Nurse 3 did not make an entry in the patient record in SystmOne.

6.25 At the time WA was discovered in a state of collapse there were no healthcare staff in the prison as it was after 18.00 on a Saturday.

6.26 The report says that, subsequently, the secondary mental health team *'tracked down'* WA's NHS records through external NHS systems. They showed a history of interventions for personality disorder. The report says this information was not recorded in his prison health records nor disclosed by WA.

6.27 The investigator concluded that:

- All interventions required of primary health staff occurred in the correct manner and at no time had WA showed nursing staff any cause for concern.

- The fact that WA's mental health history was not available to prison healthcare staff showed an issue with the level of information that can be accessed on reception to a prison.

6.28 He recommended:

- While correct action was taken after WA did not attend for appointments, it was identified by Medacs that there was no formal policy in place for the process to be followed in this instance. There was a need for a formal policy to be drawn up and staff instructed in its application.

- Discussions needed to be held between primary healthcare, secondary mental healthcare and the Primary Care Trust Information Governance Group to review information access.

- SystmOne training needed to be reviewed to ensure requirements relating to CSU assessments are included and that staff understood the process.

PART FOUR:

HEALTH ISSUES

Chapter Seven:

CLINICAL REVIEW PERTAINING TO THE STANDARD OF CARE OFFERED TO WA

BY DR NAT WRIGHT MBChB, FRCGP, PhD

INSTRUCTED BY BARBARA STOW

REPORT COMPILED AUGUST 2015

Introduction

7.1 I am a General Practitioner and the Clinical Research Director for Spectrum CIC - a national social enterprise providing primary care to vulnerable groups.

7.2 From 2013-15 I was the Associate Medical Director for Specialist and Vulnerable Groups at Leeds Community Healthcare which entailed providing medical leadership to primary care services for homeless people, prisoners, asylum seekers and refugees. The role also entailed providing medical leadership to community services pertaining to musculoskeletal conditions, dental health, contraception and sexual health, smoking cessation and health promotion.

7.3 I hold a title of Visiting Associate Professor at Leeds University. This role entails working with academic partners to conduct applied health research in local NHS services to improve the quality of healthcare provision to patients in services for Specialist or Vulnerable Groups.

7.4 I undertake regular clinical work in both mainstream primary care and prison settings. Between 2003 and 2010 I held positions as a GP advisor to the National Treatment Agency for Substance Misuse (England) and the UK Department of Health Offender Health Unit). I qualified in medicine in 1989 and qualified in General Practice in 1994. I have been a member of the Royal College of General Practitioners (MRCGP) since 1994 and was awarded Fellow of the Royal College of General Practitioners (FRCGP) in 2004. I co-founded the Royal College of General Practitioners Secure Environments training module which between 2005 and 2010 was the preferred national training course by the Department of Health for the training of prison-based primary care staff seeking to gain core competencies in delivering drug treatment for those in custodial settings. I have delivered primary healthcare (with a special interest in the management of substance misuse) to socially-excluded groups since 1996 and have published extensively in this area. I

was granted a PhD in 2008 for research undertaken in this field. In June 2000 my first book, *Homelessness: a primary care response,* was published by the Royal College of General Practitioners and in January 2010 I self-published a book, *The Offender and Drug Treatment: making it work across prisons and wider secure environments,* which is endorsed by the World Health Organisation through its Health in Prisons Project. I have also been (or am currently) a member of a number of guideline development groups for health issues pertaining to social exclusion. These include groups/committees organised by the World Health Organisation, Department of Health, the National Institute for Clinical Excellence, and the National Patient Safety Agency. I have undertaken medico-legal work pertaining to the healthcare offered to patients in community and prison primary care settings since 2004. I have provided expert witness reports for the General Medical Council, the Prisons and Probation Ombudsman, Coroners in England and Northern Ireland, the UK Home Office, Ministry of Justice, Scottish Sheriffdom, and private law firms across the UK.

Remit and Documentation

7.5 I have been tasked with providing a clinical review by Barbara Stow (hereafter referred to as "the Lead Investigator"), who was commissioned by the National Offender Management Service to undertake an Article 2 European Convention on Human Rights investigation into the case of WA.

7.6 I can confirm I have no conflict of interest in preparing this report.

7.7 I have received a folder containing copies of the documents called Disclosure 1 listed in Annex 2 of the Confidential Annexes to the report compiled by Barbara Stow.

7.8 In addition, I have received from Barbara Stow:

- further copy of the patient record sent by recorded delivery 3 June 2015 (referred to in my report as "Second Copy of the Clinical Record")
- witness statement of Nurse 2
- forensic report prepared by an independent forensic psychiatrist commissioned by WA's defence solicitors

and referred to documents in electronic form as follows:

- correspondence from DAC Beachcroft LLP containing Medacs' *Investigation into Self Harm Incident at HMP Ranby on 18 February 2012*

- transcripts of interviews which I undertook with Barbara Stow (Lead Investigator) at HMP Ranby on 20 March 2015 with 'Ms C', who conducted the healthcare reception interview with WA at Ranby and mental health nurse, 'RMN1'

- record of interview undertaken on 24 June 2015 with the consultant forensic psychiatrist who is currently WA's responsible clinician

- transcripts of interviews which I undertook with Barbara Stow at HMP Lincoln with 'Ms B', a mental health support worker, and 'Nurse 1'

- transcript of interview which Barbara Stow undertook at HMP Lincoln with 'Ms G', an occupational therapist in the secondary mental health team

- record of teleconference which I held on 10 April 2015 with the Consultant Forensic Psychiatrist, the Oswin Unit, and the Caldicott and Legal Affairs Lead for Northumberland Tyne and Wear NHS Foundation Trust

7.9 I have received the following documents electronically from the Caldicott and Legal Affairs Lead for Northumberland Tyne and Wear NHS Foundation Trust:

- Risk Assessment conducted at HMP Lincoln to support referral to the Oswin Unit

- six emails respectively entitled: 1st email dated 26/01/2012; 2nd email dated 26/01/2012; 3rd email dated 26/01/2012; email dated 10/01/2012 from YN; email dated 12/01/2012 from SB; email dated 18/01/2012

- a copy of Referral Meeting Minutes dated 16/12/2011

- a copy of Referral Meeting Minutes dated 06/01/2012

- a copy of Referral Meeting Minutes dated 13/01/2012

- a copy of Referral Meeting Minutes dated 20/01/2012

- a copy of Referral Meeting Minutes dated 27/01/2012

Instructions

7.10 I have been instructed to prepare a clinical review to support the investigation which is being conducted according to the following terms of reference:

- to examine the management of WA by HMP Ranby from the date of his reception on 16 January 2012 until the date of his life-threatening self-harm on 18 February 2012, and in light of the policies and procedures applicable to WA at the relevant time;
- to examine relevant health issues during the period spent in custody at HMP Ranby from 16 January 2012 until 18 February 2012, including mental health assessments and WA's clinical care up to the point of his life-threatening self-harm on 18 February 2012;
- to examine the circumstances of WA's transfer from HMP Lincoln to HMP Ranby on 16 January 2012, including the transmission to HMP Ranby of relevant information regarding his clinical care;
- to consider, within the operational context of the Prison Service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved;
- to provide a draft and final report of findings including the relevant supporting documents as annexes;
- to provide views, as part of the draft report, on what the Investigator considers to be an appropriate element of public scrutiny in all the circumstances of this case.

The investigation does not consider questions of civil or criminal liability.

Chronology and Summary of Relevant Medical Events

7.11 This chronology is informed by the version of events provided in the chronology prepared by the Lead Investigator and disclosed to the Interested Parties in November 2014. I have highlighted in this Section the key events relevant to the clinical care provided to WA.

7.12 WA was received into HMP Holme House on 21 February 2011. Prior to reception into prison, there was a history of previous episodes of self-harm and illicit drug use over the period September-October 2010. There were also reports of physical violence towards his intimate partner.

7.13 On 21 February 2011, during his first healthcare assessment, WA denied current suicidal thoughts. The Escort Record states that an ACCT had been opened by a criminal justice liaison nurse as WA stated he had suicidal thoughts the night before and he had taken an overdose about four months previously.

7.14 WA was assessed by a mental health triage nurse on 28 February 2011 and gave a history of a head injury from a car crash in the past, experience of being abused, contact with the Child and Adolescent Mental Health Service (CAMHS) when he was aged 11, and that he was currently under the care of a forensic psychologist and psychiatrist at the Beaconsfield Centre in Grantham and that he had been diagnosed as having a personality disorder. The outcome of the triage assessment was to refer WA to MIND.

7.15 WA was transferred to HMP Lincoln on 15 March 2011 and during first healthcare assessment he expressed a wish to restart anti-depressants. As a result, he was referred to the prison GP who assessed WA on 22 March 2011 and started mirtazapine anti-depressant medication. On 1 April 2011 Healthcare provision was transferred to Lincolnshire Partnership NHS Foundation Trust (LPFT).

7.16 On 2 July 2011 an officer opened an ACCT to monitor WA's behaviour following an expression that he would self-harm if his court appearance that week for sentencing was not favourable. The ACCT was closed on 6 July 2011 with no date set for sentencing.

7.17 On 25 July 2011 WA underwent further mental health assessment. During the assessment the outcome was noted of a previous psychiatric assessment which concluded that there was no indication for transfer under the Mental Health Act. During that assessment WA further discussed his previous diagnosis of personality disorder and that he would commit suicide if he received an indeterminate sentence relating to the charges of grievous bodily harm against his previous partner.

7.18 On 25 July 2011 a staff nurse recorded in the clinical record a phone call from the mental health team that instead of 45mg WA had been taking 3 x 45mg

mirtazapine a night which was three times the recommended maximum dose stated in the British National Formulary. He was required to return his medication. There were 16 tablets missing in four days. Drug overdose was noted and duty doctor would review. The GP did not see WA but instructed 12-hourly clinical observations and that WA was to start supervised consumption of 45mg daily. There were no other episodes of overdose during WA's period of imprisonment at HMP Lincoln.

7.19 Following a clinical interview by an independent forensic psychiatrist commissioned by WA's defence solicitors on 12 July 2011, a diagnosis of personality disorder was made. Subsequently, a referral was made to the Personality Disorder Services at the Oswin Unit, St Nicholas Hospital, Newcastle, although the date of referral is not apparent from the clinical records. In December 2011 healthcare staff at HMP Lincoln were informed that the referral to the Personality Disorder Services had been accepted for assessment. In the period between referral and assessment WA was transferred to HMP Ranby.

7.20 WA was deemed fit for transfer on 15 January 2012 and was transferred to HMP Ranby on 16 January 2012. Subsequent email correspondence between Ms B, HMP Lincoln mental health team administrator, and Oswin Unit staff led to the referral to the Oswin Unit being closed. 'Ms G', Occupational Therapist in the mental health team at HMP Lincoln, was included in the email correspondence.

7.21 On 16 February 2012 WA was transferred to the Care and Separation Unit (CSU) following a rooftop protest as a means of being transferred out of HMP Ranby. WA had requested transfer to the CSU on account of fear for his safety on general location due to coercion by other prisoners. An initial Segregation Healthcare screen was completed, and determined that WA was fit to be detained on the CSU.

7.22 On 18 February 2012 at 19.40 WA was discovered slumped behind his cell door with a ligature round his neck tied to a tall locker. He was not breathing but did have a pulse. Paramedic support was requested and WA was transferred to Bassetlaw Hospital where he was ventilated on account of being unable to breathe independently.

Commentary

7.23 **In this section I will provide an opinion regarding the following:**

- appropriateness of referral to the Oswin Unit Personality Disorder Service

- significance of WA consuming a dose of mirtazapine in excess of the maximum recommended therapeutic dose

- appropriateness of closing the referral to the Oswin Unit Personality Disorder Service upon transfer to HMP Ranby

- appropriateness of healthcare received by WA at HMP Ranby, with particular reference to first assessment; management of missed appointments; the keeping of contemporaneous records; assessment for fitness to be detained on CSU; standard of resuscitation

Appropriateness of referral to the Oswin Unit Personality Disorder Service

7.24 In my opinion, it was reasonable to refer WA to the Oswin Unit. The report by the independent forensic psychiatrist, highlights that WA suffered from personality disorder as highlighted in the excerpt below from the report:

'[WA} seems to suffer from a disturbance of personality amounting to a Personality Disorder. Personality is the way in which one relates to others and society. Personality disorder is a severe disturbance of personality, involving several aspects of personality and nearly always associated with considerable personal and social disruption' (paragraph 13.2).

7.25 It is my opinion that there was evidence of considerable personal and social disruption to WA. I do note that at the time of assessing WA, the independent psychiatrist suggested that referral to a secure mental health facility was not indicated on account of risk of non-engagement due to problematic illicit drug use. However, he did suggest that referral could become a possibility should WA engage in treatment and address his illicit drug use problem. There was no evidence subsequently that WA was failing to engage in treatment services and also no evidence that he had an uncontrolled illicit drug problem. Therefore in my opinion subsequent referral to the Oswin Unit was warranted.

Appropriateness of closing the referral to Oswin Unit Personality Disorder Service upon transfer to HMP Ranby

7.26 In my opinion, it was not appropriate to close the referral to the Oswin Unit upon WA's transfer to HMP Ranby. Rather, a reasonable course of action would have been to make the receiving prison aware of the outstanding referral. Clinical

responsibility for such a decision in my opinion rested with Ms G, Occupational Therapist in the mental health team at HMP Lincoln, who was included in the email correspondence. It was reasonable to delegate the administrative tasks that resulted from clinical decisions to a member of the administration team (in this instance 'Ms B', mental health team administrator). However, responsibility for failure to follow such a course of action, which meant that WA's personality disorder remained untreated whilst at HMP Ranby, rests with the clinical co-ordinator (in this instance the occupational therapist, Ms G) and not the administrator.

7.27 The excerpt below from the report compiled by the independent psychiatrist highlights the impact of personality disorder:

'*…Thus he shows features of Dissocial Personality in that he is incapable of maintaining enduring relationships, has a very low tolerance to frustration with a low threshold for discharge of aggression, persistent irresponsible attitudes and a proneness to blame others or offer rationalisation for behaviour that has brought the patient into conflict with society. There are also features of emotional instability and paranoid traits in that he finds it hard to trust others. He also feels persistently anxious and he is very preoccupied with being rejected in social situations, suggesting avoidant/anxious traits*' (paragraph 13(5)).

7.28 In my opinion, there was no evidence at HMP Ranby that WA was reasonably controlling symptoms relating to personality disorder. Therefore, in my opinion WA's episode of serious self-harm was possibly avoidable had the referral to the Oswin Unit not been closed.

Significance of WA consuming a dose of mirtazapine in excess of the maximum recommended therapeutic dose

7.29 Upon reviewing the clinical record, I could find no evidence that WA suffered serious morbidity on account of taking mirtazapine medication in excess of the therapeutic dose. Typical symptoms would be drowsiness or even loss of consciousness. There would be no long-term irreversible adverse effects from consuming such a high dose and therefore it is my opinion that consuming such a dose of mirtazapine did not contribute to WA's subsequent episode of serious self-harm.

Appropriateness of healthcare received at HMP Ranby

7.30 I note that the first healthcare reception screen was undertaken by 'Ms C' who was a substance misuse practitioner with long experience of working in prisons. However, she does not hold a registered nurse qualification. In mainstream general practice new patient assessments are conducted by qualified nurses (sometimes with healthcare assistant support to elicit demographic details). Such a standard applies equally to prison healthcare and therefore it is my opinion that Ms C was acting outside her area of competence in undertaking a new patient healthcare assessment screen.

7.31 I also note that the assessment constituted a series of coded entries with little free text support (which is in contrast to the first night assessments conducted on 21 February 2011 at HMP Holme House and on 15 March 2011 at HMP Lincoln). I also note that regarding the referral to mental health services made by Ms C on 17 January 2012, an entry to that effect was only made on the clinical record four weeks later on 20 February 2012 (however I do note that Ms C did in fact make the referral at the time of making the assessment). Therefore, I conclude that the overall first-night assessment undertaken by Ms C was below the standard that would reasonably have been expected of a prison nurse. The significant delay in making the entry threatened the validity of the contemporaneous record and therefore I conclude that such note-keeping was below a standard that would reasonably be expected of a prison nurse.

7.32 Having reviewed the Initial Segregation Health Screen carried out by 'Nurse 2' on 16 February 2012, I note she recorded that WA was not awaiting a bed in an NHS secure setting. It is my understanding that at the time of carrying out the assessment she would not have had access to the records from HMP Lincoln which documented the referral to the Oswin Unit since at that time SystmOne clinical records were not linked between prisons. If this was the case, then I am of the opinion that the clinical decisions were adequate and appropriate. There is a clear record of having followed the clinical algorithm to inform a decision regarding whether the patient was fit to be detained on the CSU. The algorithm did not highlight any obvious risk factors to suggest that WA's mental health would deteriorate if segregated. Therefore, I conclude that the clinical decision that WA was fit to be transferred to CSU was of a standard practised by a reasonable body of clinicians. However, if Nurse 2 did have access to the clinical records pertaining to treatment received by WA at HMP Lincoln then she would have had access to information suggesting that a referral to the Oswin Unit had been made. Such information may have indicated that WA should not have been deemed fit to transfer to the CSU and failing to let such information form part of the assessment

would have constituted a failing below the standard practised by a reasonable body of practitioners.

7.33 I note that, according to the clinical records, WA did not attend (DNA) the following appointments:

- appointment with RMN1, mental health nurse, on 8 February 2012
- appointment with [professional role not stated] on 10 February 2012
- appointment with [professional role not stated] on 15 February 2012 (although I have been told that this is recorded in error).

7.34 I was unable to find any reason in the clinical records regarding the reason for the DNAs, i.e. whether it was patient choice or a failing in the call-ups regime. The DNA with RMN1 on 8 February 2012 is possibly significant since it was an opportunity to undertake a full assessment of WA's mental health at which time there would have been an opportunity to explore the referral to the Oswin Unit Personality Disorder Service.

7.35 I am unable to pass comment regarding the other 'DNAs' recorded at Ranby since I am not aware of the clinical indication for the appointments as the professional roles are not apparent on the clinical records.

7.36 I note that on 9 February 2012 mental health nurse 'RMN1' made a decision that WA was suitable to receive weekly in-possession medication. RMN1 did not see the patient when making such a decision. Many such decisions regarding prescription administration regimes are made by reviewing the clinical record rather than consulting the patient. However, typically such decisions are made by completing a checklist regarding the risk of changing administration regimes. I was unable to find such a checklist in the records and if in fact this was not undertaken then it constitutes risk assessment practice below a standard offered by a reasonable body of practitioners. My understanding is that RMN1 remains of the view that he did complete a checklist. If this is the case, then a copy would be readily retrievable in the clinical records. Upon further reviewing the records, I was unable to find such a checklist.

Appropriateness of resuscitation

7.37 In my opinion, the attempts made at resuscitation were of a standard carried out by a reasonable body of professionals. In particular, paramedic support was called without delay and the response time was reasonable (arrival at the scene at 19.50

hours following a call at 19.38 hours). I also note that CPR was administered, leading to WA starting to breathe with a palpable pulse.

Summary Opinion on Standard of Care

7.38 Having reviewed the bundle, and from my experience of providing primary healthcare in prison settings for 12 years, I was able to identify three episodes of healthcare provision that were below the standard practised by a reasonable body of clinicians.

7.39 The first related to the failure to handover to the receiving prison (i.e. HMP Ranby) the open referral to the Oswin Unit Personality Disorder Services by the HMP Lincoln mental health key worker. Such a failing possibly contributed to WA's serious episode of self-harm.

7.40 The second related to the assessment of WA upon reception into HMP Ranby whereby the first healthcare assessment was not undertaken by a qualified nurse. Also, there was evidence of a delayed entry in the clinical record pertaining to the referral made to mental health services by Ms C.

7.41 The third related to the decision to allow WA to receive in-possession medication without having completed a risk assessment checklist. (Whilst RMN1 is of the view that he did complete the checklist, I was unable to find a copy of such an assessment and therefore have to conclude that on the balance of probabilities such an assessment was not undertaken.)

7.42 Additionally, if it can be established that HMP Ranby healthcare staff had access to the healthcare records of HMP Lincoln then there was a failure properly to complete the risk assessment algorithm upon transfer to the CASU.

7.43 Additionally, if it can be determined that WA was not responsible for his failure to attend mental health appointments then there were failings in ensuring timely mental health assessment.

Nat Wright MBChB, FRCGP, PhD
Clinical Research Director Spectrum CIC

PART FIVE:

POLICIES AND PROCEDURES APPLICABLE TO WA AT THE RELEVANT TIME

Chapter Eight:

POLICIES, PROCEDURES AND INFORMATION SYSTEMS

8.1 I am asked to examine the management of WA in prison in the light of the policies and procedures applicable at the time; and, further, to consider, within the operational context of the Prison Service, what lessons in respect of current policies and procedures can usefully be learned, and to make recommendations as to how such policies and procedures might be improved.

8.2 Prison Service policies and procedures are contained within a large body of Prison Service Orders, Instructions (PSOs and PSIs) and Standards covering, often in fine detail, every aspect of the management of establishments and those who live and work in them. Some policies and procedures are mandatory. Others are for guidance. Establishments draw up local policies and procedures based on national policies.

8.3 For the purposes of this investigation I have given particular consideration to the following policies, procedures and systems.

PSO 3050 Continuity of healthcare

8.4 PSO 3050 was issued in 2006.

First reception

8.5 Chapter 2 sets out the processes to be followed when a prisoner is received into prison. Paragraph 2.6 states, as a mandatory requirement, that for a prisoner's first reception into custody,

'an initial assessment of the healthcare needs of all newly received prisoners is undertaken within 24 hours of first reception by an appropriately trained member of the healthcare team to identify any existing problems and to plan any subsequent care.'

Transfers

8.6 Chapter 5 sets out processes to be followed when a prisoner is transferred from one establishment to another. Paragraph 5.3 quotes from the Health Standard for Prisons performance standard as follows:

'*Current healthcare needs are assessed and continuity of care ensured when prisoners are transferred between establishments ...*

Written and observed guidelines are in place setting out the procedures for reception, transfer and release that include:

- *The identification of physical and mental health problems, indicators of recent substances abuse and the potential for self-harm.*

- *Ensuring information on continuing care is conveyed to establishments on transfer and to NHS hospitals for outpatient and in/outpatient appointments …*'

The responsibilities of a prison transferring prisoners out

8.7 PSO 3050 says:

'*Previously, prisoners have been passed 'fit' for transfer. In future local policies should ensure that there are systems in place to ensure appropriate and continuing clinical care in any transfer or release. These should include systems for:*

a) clinical hold
b) restrictions on transfer
c) continuity of care between establishments.' (paragraph 5.4)

8.8 Clinical hold (also called 'medical hold') is the system for patients to be withheld from transfer for clinical reasons. The PSO says the system will require local audit through clinical governance to ensure that clinical risk is managed but the operational running of the prison is not adversely affected by excessive numbers of clinical holds. By way of guidance, the PSO comments (at paragraph 5.6) that:

'*For instance, it will almost never be appropriate to transfer a patient awaiting urgent cancer referral. Where turnover is high, as in local prisons, it may only be possible to hold those patients with clinically urgent appointments. Training prisons may be able to hold more patients awaiting outpatient appointments.*'

8.9 Paragraph 5.8 states that, in exceptional circumstances, prisoners may need to be transferred for security reasons and these may take priority.

8.10 With reference to Continuity of Care between Establishments, the PSO states:

‘*Ensuring continuity of care and the effective communication with colleagues that this implies is essential to patient care and thus central to good practice. This will vary depending on the patient needs.*’ (paragraph 5.11)

‘*An up to date patient summary card (significant events/problems page), the clinical record and a sufficient supply of medication will often be all that is required. However, patients with more complex healthcare needs may require more detailed planning such as communicating directly with the receiving healthcare team in advance of transfer.*’ (paragraph 5.12)

The responsibilities of a prison receiving prisoners transferred in

8.11 The PSO says:

‘*Receiving a new prisoner, following transfer, is equivalent to registering with a new NHS primary care practice. This process in the community often takes place some considerable time after registering. There are good reasons in the prison system to ensure that prisoners are seen by a member of the healthcare team before the prisoner's first night of arrival as follows;*

morbidity within the prison population,
increased risk of self-harm and suicide following the stresses of transfer,
the need to ensure supplies of medication.’ (paragraph 5.24)

8.12 The PSO goes on to say that, as well as making appropriate enquiries and examinations about general medical issues,

‘*Taking into account the morbidity in the prison population it will be appropriate … to specifically note*

- *mental health*
- *substance misuse*
- *potential for self-harm*’ (paragraph 5.26)

8.13 It is a mandatory requirement that:

‘*Each establishment must develop a local protocol and procedure for the reception of transfers to its establishment that meets its local needs ...*’ (paragraph 5.27)

Healthcare providers in prison

8.14 Since the publication of PSO 3050 there have been radical changes in the commissioning and governance framework for the provision of health services in prisons. The current arrangements are described in the National Partnership Agreement between the National Offender Management Service, NHS England and Public Health England for the Co-Commissioning and Delivery of Healthcare Services in Prisons in England (2015-2016). Annex B of the Partnership Agreement confirms that PSO 3050 remains in force.

SystmOne

8.15 There have also been radical changes in the healthcare information systems used in prisons and in the community. I am advised that in 2011/12 SystmOne, the electronic healthcare records system, was not fully in use by all healthcare providers. Consequently, there remains some doubt about whether healthcare staff in HMP Ranby had access to complete healthcare records. In his Clinical Review (Chapter Seven of this report), Dr Wright expressed doubt as to the operation of SystmOne at the time and some of his findings are contingent on whether staff were able to access previous health records. Information obtained during the investigation indicates that SystmOne was in use at both HMP Lincoln and HMP Ranby in 2011 and 2012 but that some information was held on other systems.

8.16 I have been told that the mental health team at HMP Lincoln at the time used a different record-keeping system in addition to SystmOne and that their detailed records were not accessible to the primary care staff (see paragraph 2.50 above).

8.17 I note that the Medacs investigation report says *'subsequently the secondary mental health team tracked down WA's NHS records through external NHS systems. They showed a history of interventions for Personality Disorder*'. The report says that this information was not recorded in his prison health records nor disclosed by WA. The report goes on to say that the fact that WA's mental health history was not available to prison healthcare staff *'showed an issue with the level of information that could be accessed on reception to a prison'*, and that *'Discussions needed to be held between primary healthcare, secondary mental health care and the Primary Care Trust Information Governance Group to review information access.'*

8.18 However, the Medacs investigation report recommended that *'SystmOne training needed to be reviewed to ensure requirements relating to CSU [Care and Separation Unit] assessments are included and that staff understand the process.'* and it seems evident from the Medacs report, and from the evidence examined by the present investigation, that SystmOne was in use at HMP Ranby at the time. Although the mental health team at HMP Lincoln apparently had an additional separate records system, the SystmOne contemporaneous clinical record (the patient journal) contains numerous entries made by staff from both the primary and secondary mental health teams at HMP Lincoln.

8.19 I note in particular the following:

- In a letter of 30 June 2011, a member of the primary mental health team at HMP Lincoln said that documentation had been placed on SystmOne (see paragraph 2.16 above).

- Ms C, who completed the healthcare reception screen at Ranby, understood that WA's previous healthcare records would have been accessible once he was registered as a new patient at Ranby by completion of the reception screen (see paragraph 3.4 above).

- I have a hard copy of the contemporaneous clinical record (the patient journal) from SystmOne that was printed at HMP Ranby on 20 February 2012. It contains entries running from 21 February 2011, including entries by staff in the secondary mental health team at Lincoln in December 2011 and January 2012 (see paragraphs 2.32 to 2.35 above).

- The note made by Nurse 3 at 11:58 on Sunday 19 February of information she provided to Bassetlaw Hospital, appears to draw on SystmOne records predating WA's admission to Ranby (see paragraph 5.21 above).

- In her written statement, Nurse 2 says it was her practice, when assessing fitness for segregation, to read patients' notes thoroughly to see if there was anything of concern in the previous three to six months and that she would, therefore, probably have known that WA had been on an ACCT in July 2011 but not since.

8.20 Moreover, HMCIP's report on an inspection of HMP Ranby in March 2012 says, *'SystmOne was used for all clinical recording, except for dental charts, for which traditional paper records were used.'* (paragraph 2.100), and, *'Clinical recording was*

via SystmOne, including separately scanned care programme approach (CPA) documentation, and the recording we reviewed was thorough and appropriate.' (paragraph 2.108)

8.21 I conclude:

- that primary care teams at both HMP Lincoln and HMP Ranby were using SystmOne while WA was a patient in their care;
- that entries were made in the SystmOne contemporary clinical record (patient journal) by primary care staff at HMP Lincoln and by the mental health team there;
- and, on the balance of probabilities, that these records were accessible to primary care staff at Ranby once WA was registered as a patient at Ranby;

PSO 2205 - Offender Assessment and Sentence Management

Risk assessment

8.22 PSO 2205, *Offender Assessment and Sentence Management – OASys,* was issued in July 2003 and reissued in April 2005. It provides instruction and guidance on OASys, the IT-based Offender Assessment System developed jointly by the Prison and Probation Services. OASys is described as a risk and needs assessment tool. It is used for supervision and sentence-planning and includes assessment of risk of harm to others and to the offender.

8.23 An OASys assessment is mandatory for offenders sentenced to 12 months or over and should be completed within eight weeks of sentencing. The assessment must be reviewed at least annually. A full review is not mandatory after transfer but paragraph 15.6 says:

'*Prevention of suicide and self harm*

'Since the OASys assessment may contain essential risk information on these issues, it is vital that information from it is sent to the right place in a prison. The OASys Clerk must check the Risk of Harm section of OASys for any offender received into the establishment, or newly receiving an assessment. If risk to others or risk of self harm is positive in the assessment, the Clerk must immediately notify the area where the offender is located as soon as the risk is identified…'

8.24 This check is a mandatory requirement.

PSO 2700 and PSI 64/2011 - Preventing suicide and self-harm

8.25 PSO 2700 *Suicide Prevention and Self-Harm Management* was initially issued in October 2007. It was replaced by PSI 64/2011 *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)* which took effect from April 2012 and was revised in September 2013. Both documents are lengthy, containing extensive guidance on, for example, the roles and responsibilities of staff, information-sharing, identifying risks, planning and providing for prisoners at risk of self-harm. The later document contains new material on risks and triggers, on understanding mental health and mental illness and much practical guidance, and it reflects an understanding that violence-reduction and reduction in suicide and self-harm are related, and that both are integral to safer custody.

The importance of staff-prisoner relationships

8.26 Both documents emphasise the importance of positive staff-prisoner relationships. For example:

In PSI 64/2011

'*Good staff/prisoner relationships are fundamental to the management of safe and decent prisons. They are integral to the reduction and management of self-harm and violence.*' (paragraph 25 page 8)

In PSO 2700

'*Prisoners emphasise the value of having a member of staff listen to them and take their problems seriously. Interviews with suicidal prisoners confirm that staff who take time to help them are greatly appreciated. In particular, several prisoners who had attempted suicide talked about how they wanted staff to talk to them and engage with them, not just to observe them. This is one of the areas of work that the key worker or personal officer are so important ...*' (paragraph 2.2.1)

8.27 In PSI 64/2011 there appears to be no similar reference to the value of the key worker or Personal Officer, - not only to those identified to be at significant risk, but for all prisoners.

8.28 PSI 75/2011, about Residential Services, emphasises the importance of good staff-prisoner relationships to the successful management of a decent prison, to the reduction of self-harm and violence and to the engagement of prisoners in activities designed to reduce re-offending (paragraph 2.1). It states, at paragraph 2.3, that residential staff play a key role in spotting signs of distress, anxiety or anger which might lead to self-harm.

8.29 It is left largely to the discretion of the Governor of each prison to decide how to cultivate positive interaction between staff and prisoners. Paragraph 1.3 says that the specification for residential services and PSI 75/2011:

'*highlight the particular importance of staff in residential units building good relationships with prisoners, interacting with them regularly and providing positive role models. It is for Governors to decide the best way of achieving this locally. It is not (and never has been) mandatory to operate a Personal Officer Scheme* [in adult and young/adult prisons].'

Mental Health

8.30 PSI 64/2011, states in paragraph 17 that *'… The majority of prisoners have one or more mental illnesses …'*. Chapter 9 is concerned with complex behaviour, and contains helpful information for prison staff on understanding common mental disorders, including personality disorder:

'Personality disorder is a recognised mental disorder. Studies have estimated that it affects between 4 and 11% of the UK population and between 60 and 70% of people in prison' (page 47).

8.31 The PSI refers readers to the *NOMS Practitioners Guide to Working with Personality Disordered Offenders (January 2011),* produced to support offender managers but also recommended to prison staff and available on Ministry of Justice and Department of Health websites.

Identifying risk

8.32 PSO 2700 says at paragraph 4.7.1 that an assessment of possible risk of suicide or self-harm will be made by a member of the healthcare team on the day of reception as part of the health-screening procedure for all receptions (including transfers and returns from court) and that an ACCT Plan will be opened if necessary.

8.33 Chapter 3 of PSI 64/2011 gives an analysis of risk and triggers that may increase a prisoner's likelihood of self-harm. It distinguishes between static factors that are unchangeable and relate to a person's life experiences, dynamic factors that change over time (examples given are misuse of alcohol, attitudes of carers), which may be chronic and subject to change only slowly, or acute factors (triggers) that may change rapidly. Risk factors for suicide, among many cited, are said to include a diagnosis of personality disorder, relationship instability, and an offence of violence against another person, especially against a family member or partner. Triggers known to increase risk of self-harm, suicide or violence are said to include: anniversaries and key dates, segregation, transfers between prisons.

PSO 1700 Segregation

8.34 PSO 1700 regulates the authorisation of segregation of prisoners and the requirements for their care and engagement with staff while in segregation.

8.35 Section 2.2 of PSO 1700 states as a mandatory requirement that:

'*A designated/personal officer(s) is to be allocated to each prisoner. Whilst continuity is ideal there may be a need to change the designated officer on a daily basis for reasons such as meeting staffing requirements. The designated officer should engage into purposeful dialogue and record this on the segregation history sheet. At least 3 quality entries are required daily (am/pm/eve).*'

8.36 Section 2.3 of the PSO requires a registered nurse completing the Initial Segregation Health Screen to complete a Health Algorithm first. The first question in the Algorithm asks whether the prisoner is awaiting transfer to, or being assessed for, a bed in an NHS Secure setting, and indicates that if the answer is 'yes', there are healthcare reasons not to segregate at this time and there should be discussion with the healthcare team.

8.37 The second question asks if the prisoner has self-harmed in the current period in custody and whether they are on an open ACCT Plan. If so, the nurse is asked to say whether they think the prisoner's mental health will deteriorate significantly if segregated.

8.38 Clinicians are asked to complete the safety screen after:

- a discussion with the prisoner;
- reference to his/her clinical record and any other relevant documentation
- gathering information from other members of the care team/discipline staff

- reviewing the nature of the incident which led to segregation being necessary to check for indicators of mental distress.

Other policies and procedures

8.39 I have also considered the following policies and procedures which specifically regulated the management of WA during the week leading up to the incidents.

PSO 1600 Use of Force

8.40 On the basis of the incident reports, the correct procedures were used to remove WA safely from the roof and the reports were completed in accordance with requirements.

8.41 Although physical force was not used in the sense of physical coercion by the attending officers, ratchet handcuffs were applied as a precaution. Paragraph 4.38 of the PSO says that the application of handcuffs is an assault and therefore unjustified unless it can be shown that, in the particular circumstances, it was a reasonable use of force. Paragraph 6.9 says that whenever force has been used to restrain a prisoner, an appropriately qualified healthcare professional (a doctor or registered nurse) must be informed, must examine the prisoner as soon as possible and must complete a Form F213 in all cases even if the prisoner appears not to have sustained any injuries. Form F213 is the form used to record injuries to prisoners.

8.42 I have no reason to suppose that WA sustained any injury during the incident and I note that he saw a registered nurse shortly after it occurred, but I have not seen any indication that Form F213 was completed and I note the requirement to do so.

PSI 47/2011 Prison discipline procedures

8.43 PSI 47/2011, effective from October 2011, is about prison discipline procedures. In the week beginning 11 February 2012, WA was charged under the Prison Rules with two offences relating to two separate incidents.

8.44 The adjudication for the first offence, for being in possession of fermenting liquid, was opened on Wednesday 15 February 2012 and adjourned for referral to an Independent Adjudicator (IA). I have not seen the record of the initial hearing or any associated papers for this charge, and I do not know the adjudicator's reasoning for referring the charge. Broadly, the decision whether or not to refer an offence depends on the seriousness of the charge and the likely punishment if the prisoner is found guilty. PSI 47/2011 says:

'2.20 … If the prisoner is eligible for additional days…, and the adjudicator considers that the offence is serious enough to merit this punishment, if the prisoner is found guilty, the case should be referred… If the prisoner is not eligible for additional days the case should not normally be referred, since the IA can only give the same punishments as the governor.'

'2.23 … The test for seriousness (paragraph 2.20) is whether the offence poses a very serious risk to order and control of the establishment, or the safety of those within it. Governors/Directors should also bear in mind that IAs are an expensive resource, as is the legal aid that prisoners may claim for representation at IA hearings. Each case must be assessed on its merits…'

8.45 In the case of charges for possession of unauthorised articles, PSI 47/11 says at paragraph 2.23 that referral:

'… will depend on the nature and quantity of the item(s). Lethal weapons, Class A drugs, large quantities of other drugs, or mobile phones will usually be referred. Similar criteria apply to selling or delivering, or taking improperly.'

8.46 The second charge followed WA's climbing to the workshop roof and was for being in an unauthorised place. The hearing was opened at 11:45 in the morning of Saturday 18 February 2012. The record of the hearing completed by the adjudicating governor states that WA pleaded guilty and asked to have legal advice. The governor remanded the case to be heard by the Independent Adjudicator on the basis that it was a serious charge and WA had asked for legal advice.

8.47 Paragraph 2.8 of PSI 47/11 makes clear that a prisoner should be asked whether they want to obtain legal advice and only when that issue has been dealt with, should they be asked whether they pleads guilty or not guilty.

'2.8…. If the prisoner does not want legal advice or representation, or when this has been obtained (or representation refused) and the adjourned hearing is resumed, the adjudicator should ask whether the prisoner pleads guilty or not guilty to the charge. If the prisoner equivocates or refuses to plead a not guilty plea should be recorded….'

In this case, the governor recorded a plea and only then asked whether WA wanted legal advice.

PART SIX:

COMMENTARY AND FINDINGS ON KEY ISSUES

Chapter Nine:

ALLOCATION AND TRANSFER TO HMP RANBY

9.1 There is some evidence that WA did not want to be sent to Ranby. I have examined this evidence to see whether there is any reason to believe WA was at particular risk there and whether prison staff ought to have been aware of it before he climbed to the workshop roof on 16 February 2012.

Indications that WA did not want to be at Ranby

What WA said

9.2 In a handwritten note on the adjudication documents on 18 February 2012, saying why he should not be returned to the wing and should be transferred out of the prison, WA said:

'We got trouble in this jail. I wrote to OCA in my last jail and then they said OK you can go Stocken or Lindholme!! I don't know why we ended up here. (I got the app [an application form for a prisoner's request] *in my cell). I got trouble with ... on K and J wing. I've also got trouble with … on D wing. It's all caught up with me and someone's going to get hurt. I'm doing a 5-year sentence and I don't want another charge for fighting.*

Someone put hooch in my cell … the screws found it and the lads are stressing at me saying I've grassed then up … my next door …

It's all too much … I need to move for my safety and someone else's safety. I'm not going back to the wing or any wing in this jail. I want to go somewhere else … anywhere! if I have to do my time down the block I will …or I'll try to get out myself …'

9.3 In his request for segregation in his own interests, WA wrote that he had *'gang-related'* trouble as well as *'trouble as some people made me hold their hooch'*, and that:

'I *was down for Stocken or Lindholme. I have it written down on an app. I don't understand why I'm here.'*

9.4 A Security department note, assessing the information given by WA in support of his request for segregation for his own safety and for transfer out of Ranby, found no obvious links between WA and the prisoners he named, nor any evidence that any of them had any record of being involved with hooch. It was noted that three of the prisoners named had previously been in another prison where WA's brother had been involved in an altercation, but any connection was said to be speculative.

What WA told his mother (Mrs A)

9.5 In a statement that she made in July 2014, Mrs A said that in December 2011, in a telephone call, WA told her that medical staff said he had a personality disorder and might be transferred to a *'mental health prison'.* He seemed keen at the prospect of this and mentioned it again in subsequent phone calls. Also in December 2011, WA mentioned that he might be transferred to Ranby. He said he did not want to go there and wanted to be transferred to a '*mental health prison'* to receive treatment. He did not say why he did not want to go to Ranby.

9.6 After the transfer to Ranby, WA told his mother that he had been woken up by prison officers on the morning of 16 January 2012 and was told he was being transferred straightaway to Ranby. WA said he asked why he was going to Ranby but the officers did not tell him a reason. Mrs A recalled that from 16 January until the incident on 18 February, WA repeatedly told her that he did not know why he had been transferred to Ranby and that he did not want to be there but he did not say why.

9.7 WA told his mother that on 16 February 2012 he went on the roof in order to get a transfer to another prison and that he had told the staff that this was the reason.

9.8 In the afternoon of 18 February 2012, WA telephoned Mrs A and told her that he was not happy at Ranby; that he did not know why he was there when he thought he was going to be transferred to a *'mental health prison'* and that no one would tell him why he was at Ranby; that he wanted to stay in the segregation unit and not go back to his cell; that if he was sent to his cell on the wing he would smash it up so he would be sent back to segregation; and that he *'could not do this anymore and that he could not stay at HMP Ranby'*.

9.9 When I met Mrs A in November 2014 she told me that, after moving to Ranby, WA said he still wanted to go to a '*mental health prison'*. She said that when WA was in hospital she tried to find out from staff at Ranby why he had been sent to Ranby instead, but the staff attending the meetings kept changing and no-one ever gave her

any information about this. Mrs A said she would like to know how it was decided not to send WA to a mental health prison and why her question was never answered. Mrs A told me that from about August 2011 WA told her he did not want to go to Ranby but she did not know why he did not want to go there.

What the records say

9.10 HMP Lincoln is a Category B local prison serving the courts in the area. After being sentenced on 18 August 2011, WA's security category was Category C. Sentenced Category C prisoners could expect to be transferred to a Category C training prison.

9.11 On 24 August 2011, an administrative officer completed a Form ICA1- Initial Categorisation of Adult Male Prisoners, recommending Security Category C and allocation to HMP Ranby. The form includes a section for any information which *'might impact on the prisoner's allocation or provide useful information about the required future management of the prisoner'*. There is a note that WA had been placed on report for an alleged assault on a prisoner in April 2011. The charge was dismissed but WA was placed on a Violence and Bullying Monitoring scheme.

9.12 On 26 August 2011, WA signed and dated an application to the therapeutic community unit at HMP Dovegate.

9.13 An entry in case notes by WA's Personal Officer on 28 August 2011 says that WA had been allocated to HMP Ranby but was not too happy about it as he felt that Ranby would not offer the courses he believed he required. The officer advised him to submit a general application to say which establishments he wanted to go to and the reasons why. I have not been able to find out whether WA made such an application, though I note that he says in the note of 18 February 2011 that an application about his allocation was in his cell. As explained above, I do not know what happened to WA's property (see paragraphs 5.17 to 5.19 above).

9.14 On 5 September 2011, WA told his offender supervisor that he had been diagnosed with personality disorder and post-traumatic stress disorder and that he wanted to go to a therapeutic community to examine this in more depth and to look at offending behaviour work.

9.15 On 7 September 2011, his Personal Officer made a note that WA told him he had submitted an application for a transfer to a therapeutic establishment as he believed this would provide appropriate courses for him.

9.16 A list of transfers for WA on the computerised prison record system refers to a transfer on 16 November 2011 to HMP Stocken. It was categorised as a *'normal transfer'* but it did not take place. I have not been able to discover why. The patient record states that, at 08:01 on 15 November 2011, WA asked to be allowed to rest in his cell because he had been vomiting. The entry says he was unable to say when the last bout of vomiting occurred and he was required to attend work. There is no reference to him being assessed for fitness for transfer. WA again reported vomiting on 17 November 2011 and was signed off work for the day. It is possible that the transfer did not take place because WA was unwell, but this is conjecture.

9.17 An officer in the Offender Management Unit at HMP Lincoln ('the OMU officer') helped me to examine the records to try to find out why WA was transferred to Ranby in January 2012 and whether there was any record showing that he had requested other prisons, or given any reason why Ranby was unsuitable. The OMU officer advised me that there was nothing in the records to suggest that the transfer to Ranby was anything other than routine. There were no recorded security alerts suggesting that WA would be unsafe at Ranby (or any other prison) because of association with other particular prisoners. Other than those mentioned above, I was unable to discover any records that WA gave staff at Lincoln any reason why he should not go to Ranby.

9.18 It is disappointing that I have not been able to find the application that WA refers to about his allocation but it seems unlikely that in a general application he would have voluntarily disclosed sensitive information about other prisoners sufficient to persuade the authorities that he should not be sent to Ranby. Prisoners do not choose the prisons where they are held and, though they may express a preference, the need to manage a complex and constantly changing prison population means that logistics rather than prisoners' preferences will normally determine allocation.

9.19 There is no record showing why WA was transferred to Ranby without prior notice.

Conclusion

9.20 When WA was at Lincoln he told staff that he would prefer not to go to Ranby Prison because he did not think Ranby offered the courses or treatments he needed.

9.21 I have seen no evidence that WA gave prison staff at Lincoln any reason to believe that he would be at risk from other prisoners at Ranby, nor that they were, or should have been, aware of this from any other source.

9.22 WA was told he was being transferred to Ranby only in the morning of the move. Transfer without notice is disorienting for prisoners and undesirable unless there are overriding security reasons not to inform the prisoner in advance. There is no evidence that there were any such reasons in this case. If there were, they should have been documented.

Chapter Ten:

THE ASSESSMENT OF FITNESS TO TRANSFER

10.1 At 16:23 on Sunday 15 January 2012 Nurse 1 assessed WA as fit for transfer from HMP Lincoln and on 16 January he was moved to HMP Ranby. WA told his mother that he had no advance notice of the move but was told by an officer on Monday morning 16 January that he was being moved straightaway. The OMU officer at HMP Lincoln told me in August 2015 that in 2012 prisoners were likely to be notified only on the day of transfer or the day before. Healthcare staff would go round the night before to do a health check but in 2012 they would not have told the prisoner the reason for this. The OMU officer told me that now prisoners are normally told the night before they are due to be transferred.

10.2 When we spoke to Nurse 1 in August 2015 she could not recall this particular case. From looking at the record, Nurse 1 inferred that she was aware of the proposed transfer only on 15 January 2012, which was a Sunday. She said that, in the case of a routine transfer, healthcare might be informed a week or so before the move. Healthcare staff could then check the medical files and see the prisoner at some point and, the night before the move, they would make sure that necessary information was printed off, bagged and enveloped, with any prescription charts and medication. Nurse 1 told us that at the other end of the scale there were 'Governor's moves', or 'security moves', where healthcare staff might get a list of names of prisoners who were not to be told they were being transferred, or where it was very much at the last minute, with healthcare staff not being told until the night before or the morning of the move.

10.3 Nurse 1 said it was not for healthcare staff to tell prisoners they were moving, so it might be a case of prisoners being called down or seen during distribution of medication, with healthcare staff able to say only that they were fit and healthy to get on the van and be transferred. All treatment rooms had access to SystmOne. Staff would not necessarily look at the records before issuing medication but Nurse 1 said she would look back when putting the entry on the system. In this case, though, the prison would be locked up at 17:00 on a Sunday night and prisoners would be unlocked for transfer first thing next morning. She thought it probable that on the Sunday afternoon it would have been a very quick procedure for getting the records on the system in time for the morning.

10.4 We asked Nurse 1 whether the previous entries in the record about assessment for transfer to hospital would have affected her actions if she had been aware of them.

She thought that it would not necessarily have made a difference. If mental health staff had been on duty she might have liaised with them but they were not on duty on Sundays and there would have been no access to mental health records. At the time, there was no set-down procedure for alerting a receiving prison to healthcare issues. Given enough time, and in a complex case, staff had been known to phone a prospective prison, but it was not a set routine. Nurse 1 thought that it was slightly different for problems of physical health. From a physical health point of view, it was easier for a general nurse to define whether a prisoner was fit for transfer. It was much more difficult for a general nurse to do that from a mental health point of view, especially if it was a case of looking at the notes and trying to resist a transfer that was said to be for security reasons. Moreover, Nurse 1 said that, at the time, the mental health team was very separate from the general nursing team and that they had their own clinical system that the general nurses did not have access to. I understand that, at the time, the secondary mental health staff entered information on the patient journal on SystmOne but also had a separate records system – see paragraph 2.50 above.

10.5 I have set out in paragraphs 8.4 to 8.13 above certain requirements in PSO 3050 Continuity of Healthcare that have been in force since 2006. With particular reference to the assessment of fitness for transfer, the PSO says at paragraph 5.4:

'Previously, prisoners have been passed 'fit' for transfer. In future local policies should ensure that there are systems in place to ensure appropriate and continuing clinical care in any transfer or release. These should include systems for:

a) clinical hold
b) restrictions on transfer
c) continuity of care between establishments.'

10.6 Ms G, the occupational therapist from the secondary mental health team at HMP Lincoln, said that, from the documents, it appeared that the mental health team were not aware of WA's transfer until after it happened. At that time there was no formal arrangement for the general nursing staff to inform the mental health team that a patient had been transferred and they might not be aware until he failed to attend an appointment. There was now an improved system in place (see paragraphs 2.48 and 2.49 above).

10.7 Ms G did not recall any instance of putting someone on 'medical hold' because they were undergoing an assessment and she did not think that was something that was

available to the team. She said that they do now put people on 'hold' if they are undergoing particular treatments.

10.8 We asked the Consultant Forensic Psychiatrist at the Oswin Unit, whether he would expect a patient referred by a prison to be placed on medical hold while in the process of being assessed. He told us:

'Whilst some would argue that best practice standards would suggest that patients should be placed on medical hold, in reality transfers do occur for justifiable reasons e.g. serious danger to the prisoner … a patient with a severe personality disorder has caused significant disruption to the prison regime or abused (physically or psychologically) professional staff such that either staff safety or the therapeutic alliance is irreversibly compromised. In such circumstances staff from the Oswin Unit would still assess the patient in the new prison although the 25-day timescale could have been breached.'

Conclusion

10.9 The logistics of managing prison allocations may sometimes require last-minute decisions, but hasty arrangements for transfer make it more difficult to provide continuity of healthcare. In this case, the nurse assessing fitness for transfer on a Sunday afternoon would not have had time to review WA's medical record before the prison was locked down at 5pm.

10.10 PSO 3050 requires that prison healthcare systems should ensure that the assessment of fitness for transfer includes arrangements for delivering continuity of healthcare. From the evidence of this investigation, no such systems were in place at HMP Lincoln at the time. In particular, there was no system for informing the secondary mental health team of planned or actual transfers of patients in their care.

10.11 The secondary mental health team did not flag the pending referral for assessment by the Oswin Unit as a reason for 'medical hold', that is, for WA to have been withheld from transfer while the assessment took place. PSO 3050 makes clear that there will sometimes be overriding operational reasons why a transfer cannot be deferred and in those circumstances I would expect there to be appropriate consultation between discipline and healthcare staff. The Oswin Unit was working to a 25-day target time for completion of assessments. Holding WA at Lincoln for the duration of the assessment would have been a reasonable and proportionate measure.

10.12 Medical hold would have been convenient, but it was not essential provided that Lincoln, the sending prison, and Ranby, the receiving prison, paid due attention to ensuring continuity of healthcare. In this case, there were failings by both prisons which are considered in the next chapter.

Chapter 11:

THE CONSEQUENCES OF THE TRANSFER FOR CONTINUITY OF HEALTHCARE

11.1 Multiple factors militated against continuity of healthcare for WA once he moved to Ranby:

Lincoln

11.2 At Lincoln:

- Healthcare staff were not aware of his impending transfer until a Sunday afternoon when a general nurse was asked to say whether he was fit for transfer the next day.

- WA himself was not informed of this transfer until the morning of the move when he would have had little opportunity to digest the implications of the move or to consult healthcare or discipline staff.

- Even though WA was on their caseload, the secondary mental health team were apparently not aware that WA had been transferred until nine days later, when they were prompted by the Oswin Unit.

- When the mental health team was alerted, an administrator told the Oswin Unit that the referral could be closed. It is not clear who made the decision but the only reason given was that WA was no longer in Lincoln's care.

- There is no evidence that any member of the mental health team, even at this late stage, informed Ranby of the pending referral for assessment by the Oswin Unit.

Ranby

11.3 At Ranby

- The reception screening process seems to have been largely concerned with registering data. It was conducted by a member of staff who, although highly experienced in her specialism, was not clinically qualified, and reception screening was not part of her normal duties as substance misuse manager.

- The information system, SystmOne, apparently did not permit access to previous medical history until the screen was completed and the member of staff said she would not have looked at previous history unless she had cause for concern from the preliminary screen.

- WA did not attend the mental health appointment on 8 February even though he had asked for it a few days before. Nor did he attend a nurse clinic appointment on 10 February. I do not know why WA missed the appointments. He had at times missed medical appointments in his previous prison, but I note that HMCIP remarked on there being a high percentage of missed appointments at Ranby; a senior officer at Ranby, who had previous experience as an NHS nurse then a prison healthcare officer, recalled difficulties in notifying appointments; and we have been told that an entry in the patient journal for an appointment on 15 February 2012 was wrong. I cannot be sure that WA was aware of the appointments and chose not to attend.

- RMN1 told the Medacs investigation that he booked a further mental health appointment for WA after he failed to attend on 8 February 2012 (see paragraph 6.21 above). However, the Medacs report says the appointment on 10 February 2012 was a routine nurse triage appointment because WA was taking medication prescribed at his previous prison and the bookings co-ordinator decided it was not necessary to make a further appointment (see paragraph 6.22).

- No further appointments were recorded as being scheduled for WA.

11.4 I have considered what weight can be attached to the fact that WA apparently took no steps himself to enquire about the abortive referral to the Oswin Unit. At a CARAT interview at Ranby on 23 January 2012, he is reported to have still expressed ambivalence about whether he wanted to go to a therapeutic community, though he correctly made a distinction between this and what he called a 'mental health prison'. WA's mother says he consistently told her that he was hoping to be transferred to a 'mental health prison'.

11.5 I do not think that responsibility for the failure of the referral to the Oswin Unit can reasonably be laid at WA's door. He would have had limited access to information about the institutional options available and the referral pathways, and he would not have been privy to the communications between Lincoln and the Oswin Unit. Transferred suddenly to a new prison with staff he did not know, I do not find it

surprising that he apparently did not make assertive enquiries about what had happened to the referral.

Contrast with previous transfers

11.6 The reception screening and handover arrangements when WA moved from Lincoln to Ranby are in contrast to what happened when he was admitted to Holme House and when he moved from Holme House to Lincoln. Both include free-text entries about past incidents of self-harm, what WA said of his emotional state and mental health, and the practitioner's assessment. WA was not unwilling to disclose his history and problems, given an appropriate opportunity.

11.7 WA arrived at HMP Holme House on 21 February 2011 with a suicide/self-harm warning form completed by a Criminal Justice Liaison Nurse. It said he stated he had thoughts of suicide the previous night and took overdoses about four months previously, but denied any current thoughts of self-harm.

11.8 The note of the reception healthcare screen at Holme House says, among other things:

'*no thoughts self-harm or suicide good eye contact and body language…Prisoner has tried to harm themselves (outside) prison – few months ago he took an overdose of morphine and subutex … again asked states he has no thoughts of suicide good eye contact and body language … has not been diagnosed with any mental health condition thinks he may have mental health issues therefore referral] to cmht [community mental health team] states at the moment he is mentally fine with no thoughts self-harm or suicide.*'

11.9 WA saw the mental health triage nurse at Holme House on 28 February 2011. He gave a history that included his contact with CAMHS (Child and Adolescent Mental Health Services) at the age of 11, recent contact with a psychologist and psychiatrist, a possible diagnosis of personality disorder, three incidents of deliberate self-harm and currently fleeting thoughts of self-harm which he said he would not act upon. He was allocated to the primary mental health caseload and placed on a waiting list for counselling by MIND.

11.10 When WA was transferred to Lincoln on 15 March 2011, the staff nurse who conducted the healthcare reception screen at Lincoln on 15 March 2011 noted evidence of mental health problems and that WA *'says he feels agitated, anxious, low and angry much of the time*' but had *'No feelings of self harm or suicide'.* The nurse's impressions of WA's behaviour and mental state was *'slightly agitated'*. He referred

WA to the mental health team for an assessment and to the GP because he asked to go on anti-depressants, and he entered a note in the patient record that on 10 October 2010 WA had tried to harm himself with a deliberate overdose. This appeared as the first entry in the clinical record in SystmOne.

11.11 When WA transferred from Holme House to Lincoln there was a handover to the mental health team by telephone.

11.12 At Ranby, the record of the reception screening of WA notes that there is a history of mental health problems and lists anxiety and drug misuse. There is no reference to WA's own assessment of his current emotional state or mental health and, contrary to the requirements of PSO 2700, there is no reference to consideration of risk of self-harm.

11.13 The healthcare assistant who saw WA in reception made a referral to the mental health team but this was not recorded in the patient journal until after WA's act of self-harm.

11.14 As noted above, WA missed two healthcare appointments: one with the mental health team which would have appeared in the record to have been made at his own application, and one with the general nursing team because he was on medication. When the bookings coordinator decided not to make a further appointment, he would not have been aware of the referral to the mental health team from reception.

11.15 I do not know why WA missed the appointments, but the consequence was that the first time WA saw a clinically-qualified health professional at Ranby other than to collect medication was when Nurse 2 saw him in the segregation unit on 16 February 2012, one month after his admission to Ranby. Medacs have commented that the contact with a qualified professional for the purpose of collecting medication should not be discounted, as there is the possibility of arranging further assessment if the professional has concerns about a prisoner's presentation. This is of course true, but I also note that in the report of an inspection of Ranby in March 2012, HM Chief Inspector of Prisons commented that:

'Prisoners collecting medication were unable to discuss their medicines in confidence because queues were unsupervised' (HMCIP, paragraph 2.91).

11.16 A mental health nurse at Lincoln had advised in August 2011 that, because of a *'history of accidental overdose',* WA should not hold medication in possession. In October 2011, a GP had written a note expressing concern about *'medication-seeking*

behaviour'. Staff at Ranby decided to continue WA's medication and to issue it to him in weekly batches without having seen him other than on reception or in passing when giving out medication.

11.17 I notice that in an inspection of Ranby in March 2012, inspectors from Her Majesty's Inspectorate of Prisons (HMIP) reported that they had observed a reception interview being conducted by a non-clinical manager. HM Chief Inspector of Prisons (HMCIP) recommended that:

'*Reception screenings should be conducted by a registered health professional*~~.~~' (HMCIP, paragraph 2.86).

Medacs have commented that Prison Service Order 3050 did not specify that healthcare screening in reception should be conducted by a registered clinician but by *'an appropriately trained member of the healthcare team'* (PSO 3050 paragraph 5). Medacs say that their reception screening policy was subsequently updated to reflect the recommendation made by HMCIP following their inspection in March 2012.

11.18 HMCIP also noted that there was no routine provision for a secondary health assessment after the healthcare screening in reception. The inspection report recommended:

*'All prisoners should be given a follow-up health assessment within 72 hours of arrival to ensure that health problems are identified at an early stage.' (*HMCIP, paragraph 2.87).

11.19 Clinical staff working in prisons are called upon to assist in procedures that are particular to prisons, and are not encountered in the same way in community healthcare. Segregation is the prime example, but the arrangements for receiving new prisoners, for safeguarding prisoners against self-harm, and for the administration of medicine, also raise particular issues in a closed environment~~,~~ and because of the prevalence of mental disorder and poor physical health in the prison population. Clinical staff working in prisons require induction in understanding the special requirements of healthcare in prison and familiarity with the special protocols and standards that govern procedures in prison that do not apply in community settings.

Conclusion

11.20 In the opinion of the clinical adviser to the investigation, referral to the Oswin Unit was warranted and reasonable. We cannot be certain that WA would have been admitted to the Oswin Unit if the assessment had proceeded but, on the face of it, there is no evidence to indicate that he would not have been accepted. WA lost his chance of being assessed for admission to the Unit as a result of failings at Lincoln and Ranby Prisons.

Lincoln

11.21 The mental health team at HMP Lincoln did not deal satisfactorily with the referral to the Oswin Unit. There is evidence of delay in providing the information required for the assessment to proceed. It was quite wrong for Lincoln to instruct the Oswin Unit to close the referral and, doubly so, without informing Healthcare staff at Ranby of the position.

11.22 The transfer to Ranby would have been inconvenient while healthcare staff were liaising with the Oswin Unit who had agreed to assess WA for a place there. But it would not have been an overwhelming impediment if there had been an effective handover from Lincoln to Ranby or if healthcare staff at Ranby had examined WA's history.

Ranby

11.23 The healthcare assessment on reception at Ranby was by a member of staff who was not a qualified nurse. That was not appropriate.

11.24 If healthcare staff at HMP Ranby had examined the patient record, preferably at reception, or if not, at a prompt further screening shortly afterwards, they would have been aware of WA's history of contact with mental health services.

11.25 The references to the gatekeeping assessment by North East mental health services are brief, they do not give a full picture of the current status of the referral, but they were sufficient to prompt further enquiry.

11.26 WA may or may not have been responsible for missing two appointments but it was not satisfactory that he was at Ranby for a month without seeing a qualified clinician except to receive medication.

11.27 In spite of past cautions recorded in the patient journal, it was decided to give WA his medication in weekly batches without him having been assessed in person by a nurse or the GP. The patient record contains no checklist or other document showing how that decision was made.

11.28 The referral to the mental health team from reception was not recorded in the patient journal until after WA's self-harm. This meant that a significant item of information was not available to the staff who decided not to re-book healthcare appointments, to issue medication in possession, and that WA could safely be held in the segregation unit.

Overall

11.29 The failings in this case occurred through the acts or omissions of individuals in both prisons, but they flow from a lack of appropriate systems and management to ensure consistent delivery and continuity of healthcare to an acceptable standard.

11.30 I have been told that practice in providing information to ensure continuity of healthcare is now much improved. It is the responsibility of healthcare managers in both the sending and receiving prisons to ensure that systems are in place to provide continuity of care and that there is rigorous adherence to these in practice.

11.31 In the case of prisoners in the care of the mental health team, good practice requires an explicit handover, in writing, or by telephone, or both, that is recorded in the patient journal.

11.32 As indicated by HMCIP, all prisoners should receive a full healthcare assessment by a qualified clinician, including review of previous history, within 72 hours of admission.

11.33 Clinical staff working in prisons require induction in understanding the particular requirements of healthcare in prison, and familiarity with the protocols and standards that govern procedures in prison that do not apply in community settings.

11.34 There is a diversity of healthcare providers operating in prisons, so there is an overarching responsibility for NHS England and the National Offender Management Service (NOMS) to ensure that appropriate arrangements are in place, and that consistent standards of information management and staff induction are achieved throughout the prison estate.

Chapter 12:

SEGREGATION

12.1 It was appropriate for the staff who escorted WA from the roof to take him to the segregation unit. This was a serious and dangerous breach of discipline, that WA might have a mind to repeat. Moreover, he asked to be segregated from other prisoners. At the segregation unit it was for the responsible governor, with the advice of healthcare staff, to determine whether WA could safely be held in segregation and whether any special precautions were required.

12.2 The correct procedures were followed to the extent that:

- segregation was authorised on both 16 and 18 February by a governor of appropriate seniority;
- a nurse attended and completed a healthcare screen that was then endorsed by a governor;
- a governor, a chaplain and a nurse recorded a visit each day that WA was in segregation;
- regular entries were made in a history sheet recording events and interactions with staff.

12.3 However, forms were not all completed correctly or in full; I have some reservations about the extent of enquiry informing completion of the healthcare screen; and questions about the extent of interaction with other members of staff.

Healthcare screening for segregation

12.4 When WA was admitted to the segregation unit on Thursday 16 February 2012, Nurse 2 completed the healthcare screen including the algorithm that guides decision-making. A further screen, including the algorithm, was completed by RMN1 on Saturday 18 February 2012 when WA's status in the segregation unit changed from awaiting adjudication to segregation in his own interests.

12.5 Instructions on the reverse of the health screening form are to complete the screen after:

- discussion with the prisoner
- reference to the clinical record and any other relevant documentation
- information from other staff members

- reviewing the nature of the incident to check for indications of mental distress.

12.6 The first question in the algorithm asks whether the prisoner is being assessed for a bed in an NHS secure unit. The second question on the algorithm asks about self-harm during the present period in custody. Nurse 2, and subsequently RMN1, answered 'No' to both these questions. This raises questions about whether there was sufficient consideration of WA's medical history.

12.7 Nurse 2 told the investigation she had no direct recollection of the particular occasion but that her practice would have been to look at the records and then to go to speak with the patient in a confidential space. As WA had only recently arrived in the prison, she would have looked in particular at the reception screen, which she would have expected to provide a summary, a snapshot, of the person. Looking at the record now, at her interview in January 2016, Nurse 2 noted that there was no mention in the reception screen that WA had been referred to gatekeepers for assessment for an NHS unit, nor that there was a history of self-harm. She also noted that WA had been assessed as able to hold in-possession medication.

12.8 Nurse 2 could not recall whether the SystmOne records from WA's previous prison were fully accessible to her at the time. She said that in the early days of SystmOne there were well-known problems in relation to the passing of information between prisons and it was sometimes the case that staff in the new prison did not immediately have access to a patient's history. Nurse 2 said that, since then, the system had developed and improved and the transfer of information is now much better, though it was still the case that if a record was not properly 'closed' by an author it would not appear to someone else looking at the record.

12.9 Nurse 2 said that, with the benefit of hindsight, and having seen a copy of the patient journal printout as provided to the investigation, she noted that she could have answered differently the question about a referral to an NHS secure setting and WA's history of self-harm. However, she said that if she had answered these questions differently her decision to support WA being in segregation would not have changed as:

- WA was telling her that he wanted to be in segregation;

- in addition to the algorithm, an important part of her decision was based on her assessment of his clinical presentation and WA did not give any cause for concern;

- she knew he would be subject to a further medical review the next morning and every day that he was in segregation; and

- staff ratios were higher in the segregation unit than in the general prison population.

12.10 Nurse 2 inferred that if she had completed the algorithm differently, the only difference it would have made to WA's care on that day is that he would probably have been reviewed by the medical team the same day, rather than the following morning. However, in any event, the subsequent review decided to keep WA in segregation.

12.11 RMN1 completed an initial segregation health screen at 12:00 on Saturday 18 February 2012. The entries were the same as those in Nurse 2's Initial Segregation Health Screen, with no adverse indicators. RMN1 told the investigation that he completed the algorithm and, as far as he could remember, he had asked WA if he was all right and had documented it. He recalled that WA was happy to be in the segregation unit waiting for a transfer.

12.12 I have explained above in paragraphs 8.19 to 8.21 that, on the balance of probabilities, I conclude that the patient journal would have been accessible to staff at HMP Ranby when WA was placed in segregation. In particular, when Nurse 3 examined the records on 19 February 2012 after WA's self-harm, her reading of the record highlighted past instances of self-harm, and a long-standing history of psychiatric problems since childhood.

12.13 I have a hard copy of the patient journal that was printed at Ranby from SystmOne on 20 February 2012. This contains references to all the entries referred to in this report except the referral on 20 January 2012 to the mental health team that was logged in the journal only after the act of self-harm (see paragraphs 3.12 and 3.13 above).

12.14 Nurse 2 and other staff attached importance to the fact that WA insisted that he wanted to be in the segregation unit rather than going back on a wing. That was undoubtedly the case, but it is also necessary to take account of the relative isolation, austere environment and restricted regime of the segregation unit.

Interaction with other staff

12.15 Section 2.2 of PSO 1700 states as a mandatory requirement that a designated Personal Officer is to be allocated each day to each prisoner in segregation and should engage in purposeful dialogue with the prisoner and that at least three quality

entries must be recorded in the segregation history sheet. It is not clear from the history sheets that Personal Officers were allocated to WA in the segregation unit.

12.16 History sheet entries were regular and frequent, but on the whole they were formulaic and not informative. In some of the statements made by staff they have commented that the entries in history sheets understate the nature and quantity of conversations that go on routinely in the course of the day, for example, as prisoners make requests to staff, or meals are served, or they are unlocked for exercise.

12.17 We noted that the segregation officers were selected for that role and we considered this good practice. Segregation units tend to house prisoners who are exceptionally vulnerable and/or whose behaviour is exceptionally difficult. The skills and character of segregation staff, and their ability to interact appropriately with prisoners, are of the highest importance.

12.18 Staff complied with the requirements for a segregated prisoner to be visited each day by healthcare staff, a governor and a chaplain, but the entries in the history sheet do not show the quality or content of the interactions. We were not able to speak with the prison chaplain who visited WA in the segregation unit but we spoke to a current member of the Chaplaincy staff who was new to the prison in January 2012. He told us that it was always his practice to spend a little bit of time with prisoners in the 'Seg', to observe the condition of the cell and to probe a bit, and *'to get a feel'*. He said this was what he was taught and mentored to do at Ranby. He believed *'human contact was really important in these things'.* It was not a case of '*You OK today? Yeah, Fine, Gov, and close 'em back up*.' The chaplains recorded any issues of particular note in the Chaplain's Log. There was no reference there to WA.

<u>Conclusion</u>

12.19 The content of the health screen algorithm on both occasions calls into question whether the nursing staff who completed the form had properly considered healthcare records.

12.20 Nursing staff who completed the algorithm failed to identify that the records indicated an open referral for assessment to an NHS unit and that there was some history of self-harm.

12.21 The patient journal recording healthcare history at WA's previous prison was almost certainly accessible to staff at HMP Ranby when WA was placed in segregation~~,~~ but, if

this record was not accessible, then the system in place was inadequate to deliver reasonable continuity of care.

12.22 Careful examination of the patient journal entries since WA's transfer to Ranby would have identified that, apart from the reception screening, WA had not been interviewed by any member of the healthcare staff at Ranby and it should have prompted a more thorough investigation of his mental health history and its implications.

12.23 It was not unreasonable for the nurse who conducted the initial healthcare screening to take particular note of the reception screen and the decision that WA could hold medication in possession but we have had cause to question the adequacy of both these procedures.

12.24 There was compliance with the management checks, healthcare and chaplain's visits required under Prison Service Order 1700 Segregation but the content of the notes on checks by staff does not indicate whether these were quality interactions.

12.25 There is no evidence that Personal Officers were appointed as required by PSO 1700.

Chapter 13:

SHOULD STAFF HAVE IDENTIFIED A RISK OF SELF-HARM?

13.1 We have identified above that WA had some history of self-harm. It was not substantial and it was not recent. The instances he described on admission to Holme House seem to have been tentative and ambivalent. It is not clear that his excessive doses of medication at Lincoln were intended as self-harm rather than a means to sleep or of pain relief. He had been placed on an ACCT Plan briefly when he was worried about sentencing but was eager to be taken off the plan, possibly because he had difficulty sleeping and did not like to be disturbed by checks at night, or possibly because he did not want to lose 'face' – at Lincoln he said on occasions that he did not want to be on ACCT and at Ranby he is reported to have told the CARAT worker he did not want any other department to know he was engaging with CARAT's drug treatment.

13.2 Even if the nursing staff who screened WA for segregation had been aware of the previous incidents, or if wing staff had been aware of the history, I do not think, in the circumstances, that this knowledge alone ought to have prompted a decision that he was unsuitable for segregation on 16 or 18 February 2012, or that he should have been placed on an ACCT, though it might have prompted some extra vigilance.

Known risk factors

13.3 WA's history indicated a number of the historical and clinical factors which are known to indicate an increased risk of suicide or self-harm. He reported a troubled childhood, experience of abuse, and contact with mental health services; the nature of his offence and a diagnosis of personality disorder are also known risk factors. Unfortunately, these risk factors are prevalent across the prison population so it would be unreasonable to expect them to trigger a 'red light', singling WA out as at particular risk (see paragraphs 8.30 and 8.31 above).

13.4 There were circumstances in WA's personal life outside prison that may also have contributed to his state of mind. WA had been admonished for breach of a restraining order after writing to his former intimate partner and victim. In the letter he expressed regret and unhappiness about losing touch with his son and distress that he had heard that his former partner was pregnant. The act of self-harm occurred on the anniversary of WA's principal offence but staff had no reason to be aware of this.

13.5 Some staff were aware of the breach of the restraining order, but not the content of the letter, which was not received by Ranby until later. WA disclosed his fears of reprisals by other prisoners but staff believed they had dealt with these by placing WA in segregation until he could be moved out of the prison.

13.6 Mrs A has pointed out to the investigation, quite rightly, that significant anniversaries are known to be a risk factor for acts of self-harm and indeed that this is included in current guidance to staff about suicide and self-harm (see paragraph 8.33 above). Ranby's Safer Custody team now maintain a database of significant dates for prisoners on indeterminate sentences or ACCT plans. However, WA was not identified as at heightened risk in February 2012 so staff were not aware of the significance of 18 February 2012 as the anniversary of his offence. I do not think that I could reasonably have expected them to be aware.

OASys assessment

13.7 The OASys record is maintained by Offender Management staff in the prison and in the community. PSO 2205 states that the Risk of Harm section must be checked for every newly received prisoner and, if the risk of self-harm is positive, the Clerk must immediately notify the area where the prisoner is located.

13.8 There was a positive entry for a medium risk of self-harm in WA's OASys assessment. HMP Ranby did not comply with the requirement in PSO 2205. There was apparently no system in place for administrative staff to check OASys records for assessments of risk of harm when a prisoner was admitted to the prison. No meeting with the Offender Supervisor had been scheduled at the time of his self-harm even though the target time was two weeks from admission.

13.9 The Offender Manager who reviewed WA's OASys assessment in October 2011 said in a written statement that the rating of medium risk was based on WA's self-reported overdose in October 2010 and that there was no indication at the time of her assessment of any immediate or increased risk. But compliance with the requirement would have meant that WA's wing manager would have been alerted to his history.

The discipline staff's impressions of WA

13.10 The investigators asked the discipline staff at Ranby who encountered WA whether they had any reason before the event to consider that he was at risk of self-harm.

Without exception, they seem to have been genuinely shocked by what happened, though no member of staff had had very much contact with him.

13.11 There were 120 prisoners on G wing. The G wing manager, Senior Officer 1, said he had a vague memory of speaking to WA at the gate but otherwise it was only at the Incentives and Earned Privileges Board on Tuesday 14 February 2012, where WA had been adamant that he was not aware of any public protection restrictions. SO1 said he was sad to have to put him on Basic and would not have done so but for the hooch in his cell. He said WA was '*a nice lad, articulate and quite funny*'. He seemed '*quite level-headed with a dry sense of humour*', a '*bit of a bad lad but a lovable rogue and not a vulnerable type*'. SO1 said he felt annoyed that he had to put him on Basic. He '*didn't strike him as someone who would attempt suicide*'. He *'had no inkling this would happen and it was a real shock when I found out what he had done*.'

13.12 The Principal Officer who brought WA down from the roof (PO1), said he had no concern during the incident and had no thought in his mind that WA might self-harm. He told us that WA was frightened of others, not a risk to himself, but as soon as they said he would go to the segregation unit he was quite happy to go. PO1 said, '*It was a sad day and a sad, sad waste of a young man's life*.'

13.13 Prison Officer 8 who met WA in the segregation unit on 18 February 2012 said he seemed a coherent young man and did not seem to be in distress. He was shocked when he learned what had happened. He said WA had *'seemed so level-headed'*. Officer 4 said he didn't see any of the signs.

13.14 Prison Officer 8 did not recall any prior contact with WA until 18 February 2012 when he was working in the segregation unit, but he recalled him that day as being '*like a mischievous child*'.

13.15 RMN1 said he was probably a bit shocked when he heard what had happened, as WA had previously told him he felt good.

Were there lessons to be learned?

13.16 The investigation asked the staff if they were able to identify any lessons from what had happened.

13.17 Senior Officer 1, who has a background in nursing, said that he felt that prisoners who were known to be vulnerable, mentally unwell or identified as at risk of self-harm were managed very well but recent deaths he had been aware of were out of

the blue. Prisoners on ACCT care planning had a lot of specific input on a daily basis and were unlikely to take that step. Senior Officer 1 said he had left people with ACCT as a support mechanism until they decided they no longer needed it. But if someone was determined to take their own life staff would not know about it till it happened.

13.18 The Principal Officer replied to our question: *'Lessons? Try talking to people. Ask them if they have any issues.'* He said this had always been his practice.

13.19 The Chaplain said that in his view, '*Human contact is really important in these things*'. As a Chaplain he wanted to try to make the experience of incarceration '*less diminishing of humanity*'.

13.20 Prison Officer 8 said:

'*The difficult thing in WA's case was that he wasn't presenting anything unusual. It was a learning curve, maybe to look at people more closely.*

'In the segregation unit you're … confined in a cell for longer periods of time. So we appreciate that even … stronger character prisoners might have problems in that kind of environment. I mean it's made aware of when we start, then we get trained in there; so ... just to be more vigilant, I suppose, or as vigilant as we can be. And just appreciate the fact that just because someone's not, you know, showing those … the common signs of distress, that they might not be having those problems internally.'

13.21 A prison officer representing the Prison Officers' Association said he did not think that the current six-week training course for new prison officers did enough to deal with how to interact with prisoners, to talk to them and to read their signs and moods. In his view, this was something that could be learned in part in college and, in the past, one-third of the basic training, which was then a nine-week course, was about interpersonal skills and how to react to certain situations. He also thought that young officers, who might be aged not more than 18 or 19, lacked the experience to cope with a serious incident. There were often only two staff supervising 190 prisoners and violence against both staff and prisoners had increased.

Staff-prisoner relationships

13.22 PSI 64/2011, and its predecessor PSO 2700, both emphasise the importance of positive staff-prisoner relations in identifying risk and supporting prisoners. From this

investigation, I do not think that the information known to the discipline staff was such that they should have foreseen a risk of self-harm. However, I am left with an uncomfortable awareness of the contrast between both the healthcare records and case notes from Ranby as compared with those from Lincoln and, to some extent, from Holme House.

13.23 In Holme House and Lincoln, the two prisons where WA had been previously, there is a sense from the outset that healthcare and discipline staff knew WA as an individual and were taking notice of his history as well as his superficial presentation. While WA was at Lincoln there are frequent entries by Personal Officers and other staff in his case notes. Some refer to adverse behaviour and warnings but they generally indicate that WA was known by staff and that they took an interest in him. The patient journal also shows frequent interaction with healthcare staff throughout the 10 months he spent there, either by appointment or in passing on the wing. In the month he spent at Ranby there is minimal information recorded in the case notes and the staff we spoke to were able to recall only one or two encounters, if any. Neither in the records nor in what wing staff told us was there any evidence of significant interaction between WA and the staff on the wing until the IEP board on 14 February 2012.

13.24 Absence of recorded case notes may not necessarily indicate absence of interaction but records are important for staff to build up collectively, for the purposes of both care and prison management, a knowledge of prisoners as individuals and of the way that their behaviour changes over time.

13.25 WA had been transferred without notice to a prison which he apparently did not want to go to, when he had reason to expect he was on track for consideration for assessment for what he called a *'mental health prison'.* He applied to see the mental health team and we cannot assume that it was necessarily his neglect that caused him not to attend. Staff have referred to WA seeming '*in good spirits'* or presenting as *'well'*. WA was experienced in prison culture. He seems to have maintained a brash front and was unlikely to develop relationships of trust with staff readily. This was noted by the independent forensic psychiatrist commissioned by WA's defence solicitors to be an aspect of his disorder (see paragraph 7.27 above). WA is unlikely to have disclosed any distress in superficial encounters.

13.26 There is no reference to a Personal Officer and I have seen no record from Ranby which gives any indication that WA was given any opportunity - a safe space - to explain to a trusted member of staff how he was feeling, apart from his declared fear of other prisoners after the finding of hooch, which staff were confident they had dealt with by removing him from the wing. It is noteworthy that he felt the only way

to attain safety and a transfer was by the desperate measure of climbing onto the roof.

Conclusion

13.27 From the evidence obtained through this investigation, I do not think, on the balance of probability, that WA's act of self-harm could reasonably have been foreseen by discipline or healthcare staff from the information immediately before them.

13.28 We have established, however, that there was significant information in the healthcare records that, if examined at reception, or in a follow-up meeting with a health professional, or when WA was assessed for suitability for segregation, should have prompted concern, further enquiry, reinstatement of a mental healthcare pathway, and a dialogue with WA himself. These might have altered the course of events.

13.29 The OASys record also contained information about a history and risk of self-harm but no meeting with the Offender Supervisor had been scheduled at the time of WA's self-harm even though the target time was two weeks from admission.

13.30 There was apparently no system in place, as required by PSO 2205, for administrative staff to check OASys records for assessments of risk of harm when a prisoner was admitted to the prison and to notify their location of any recorded risks.

13.31 The absence of entries in case notes at Ranby, coupled with what we were told by staff, suggested an absence of constructive engagement with WA.

13.32 There was a series of faults in the management and care of WA. Healthcare staff at HMP Lincoln did not deal properly with the referral for assessment to the Oswin Unit and there were no satisfactory arrangements at Lincoln to secure continuity of mental healthcare. At Ranby there were missed opportunities that ought to have alerted staff to WA's vulnerability.

13.33 WA's superficial behaviour did not indicate that he was at risk of self-harm and there were circumstances in his personal life of which staff were unaware but which probably affected his state of mind. Procedures to protect against suicide and self-harm have to serve the whole prison population and to be embedded across the total culture and operation of establishments. Prisoners are removed from sources of social support that they could access in the community. Prisoner-staff interaction, and systems for recording and sharing information among staff, are key safeguards.

Chapter 14:

THE STAFF'S RESPONSE TO THE EMERGENCY

The life-saving actions of Prison Officer 7, Prison Officer 5 and Senior Officer 2

14.1 I agree with Senior Officer 2 that Prison Officer 7 and Prison Officer 5 should be commended for their prompt and skilled action, which undoubtedly saved WA's life. This is also the opinion of the investigation's clinical adviser. In addition, Senior Officer 2 deserves credit for managing the emergency decisively, with skill and authority.

14.2 At the time of the emergency, on a Saturday evening, there were no healthcare staff on duty in the prison. It was fortunate that Officer 5 was competent in administering first aid including CPR. Witnesses have told the investigation that staff are not given regular refresher training in first aid. The POA representative also noted that first aid was not part of the annual training plan. He thought there should be basic refresher training every year. Officer 7 said he was not first aid-trained and had only done a brief course at the training college since he joined the Prison Service.

14.3 I do not know what arrangements establishments make to ensure that skilled first aiders are available in the prison at all times within reasonable distance to respond to emergencies, but I see that this was a cause of concern to HM Inspectorate of Prisons as late as its inspection at Ranby in 2014. HMCIP's report said that the out-of-hours emergency provision was inadequate,, as too few discipline staff were trained in first aid, none was trained in defibrillation and there were no defibrillators on the house blocks. HM Chief Inspector of Prisons recommended:

'Prisoners requiring emergency first aid out of hours should have prompt access to appropriately trained staff and sufficient well-maintained equipment, including defibrillators, which receives regular documented checks'. (HMCIP: *Report on an unannounced inspection of HMP Ranby by HM Chief Inspector of Prisons* 10–21 March 2014, paragraph 2.76).

After WA was taken to hospital

14.4 The emergency occurred at the end of the evening shift before the handover to the night shift at 21:00. Indeed, if Officer 7 had not arrived early for his night shift there would have been a different outcome. However, the change of shift seems to have compromised the post-incident procedures. I was not able to discover significant information about the ligature, and the contents of the cell.

14.5 Governor F told the investigation that the 'simple inquiry' he conducted was confined to narrow terms of reference and he, as well as Mrs A, had expected that there would be a broader enquiry at a later stage. Mr F did not have access to healthcare records and the limited information available to him led him to the false conclusion that there was no history of previous self-harm.

14.6 Mrs A was not informed about WA's self-harm and life-threatening condition until Sunday morning when the local police called on her at home. She asked why she was not informed the previous evening, especially since the prison were aware of her phone number through the PIN phone system. Governor C told the investigation that the PIN phone records were held by administrative staff who would not have been at work at the weekend. He did not believe there was a central log that staff could access at the weekend. If WA gave next of kin details when he went into custody then these would have been available on the F2050 hard copy core record, including a telephone number if the prisoner gave one. The records would have been held in secure cabinets but would probably have been accessible.

14.7 We were not able to discover whether WA had given next of kin details. As a result of a Prisons and Probation Ombudsman investigation, Governor C, as Head of the Offender Management Unit, had led a project systematically to request next of kin details from prisoners for whom next of kin was not recorded, and details were now entered on the electronic information system so that they are available at all times.

Conclusion

14.8 The clinical adviser to the investigation states that, in his opinion, the attempts made at resuscitation were of a standard carried out by a reasonable body of professionals. In particular, paramedic support was called without delay, the response time was reasonable, and CPR was administered leading to WA starting to breathe with a palpable pulse.

14.9 The officers who attended WA and managed the emergency undoubtedly saved his life.

14.10 I note the concern expressed by HM Chief Inspector of Prisons in 2014 about insufficient provision for first aid. That was not an issue in the case of WA but I would expect the prison to have acted on HMCIP's recommendation.

14.11 Post-incident procedures were not satisfactorily recorded.

14.12 The scope of the simple inquiry by the prison was too narrow to examine adequately the circumstances of WA's self-harm, his care and management in the month he was at Ranby, or whether there were lessons to be learned. An inquiry into a death or an incident of serious self-harm should always include healthcare as well as the actions of the discipline staff.

14.13 The arrangements for notifying WA's mother were not satisfactory. It is also notable from Mrs A's evidence that she was left feeling that her contact with prison staff was terminated abruptly and that she was not given information and answers to her questions which prison staff had promised.

PART SEVEN: THE INVESTIGATION’S FINDINGS AND RECOMMENDATIONS

SUMMARY OF THE FINDINGS

Chapter 9: Allocation and transfer to Ranby

1 When WA was at Lincoln he told staff that he would prefer not to go to Ranby Prison because he did not think Ranby offered the courses or treatments he needed (9.20).

2 I have seen no evidence that WA gave prison staff at Lincoln any reason to believe that he would be at risk from other prisoners at Ranby, nor that they were, or should have been, aware of this from any other source (9.21).

3 WA was told he was being transferred to Ranby only in the morning of the move. Transfer without notice is disorienting for prisoners and undesirable unless there are overriding security reasons not to inform the prisoner in advance. There is no evidence that there were any such reasons in this case. If there were, they should have been documented (9.22).

Chapter 10: Assessment of fitness for transfer

4 The logistics of managing prison allocations may sometimes require last-minute decisions, but hasty arrangements for transfer make it more difficult to provide continuity of healthcare. In this case, the nurse assessing fitness for transfer on a Sunday afternoon would not have had time to review WA’s medical record before the prison was locked down at 5pm (10.9).

5 PSO 3050 requires that prison healthcare systems should ensure that the assessment of fitness for transfer includes arrangements for delivering continuity of healthcare. From the evidence of this investigation, no such systems were in place at Lincoln at the time. In particular, there was no system for informing the secondary mental health team of planned or actual transfers of patients in their care (10.10).

6 The secondary mental health team did not flag the pending referral for assessment by the Oswin Unit as a reason for ‘medical hold’~~,~~ - for WA to have been withheld from transfer while the assessment took place. PSO 3050 makes clear that there will sometimes be overriding operational reasons why a transfer cannot be deferred and, in those circumstances, I would expect there to be appropriate consultation between discipline and healthcare staff. The Oswin Unit was working to a 25-day target time for completion of assessments. Holding WA at Lincoln for the duration of the assessment would have been a reasonable and proportionate measure (10.11).

7 Medical hold would have been convenient, but it was not essential provided that Lincoln, the sending prison, and Ranby, the receiving prison, paid due attention to ensuring continuity of healthcare. In this case there were failings by both prisons (10.12).

Chapter 11: Continuity of Healthcare

8 In the opinion of the clinical adviser to the investigation, referral to the Oswin Unit was warranted and reasonable. We cannot be certain that WA would have been admitted to the Oswin Unit if the assessment had proceeded but, on the face of it, there is no evidence to indicate that he would not have been accepted. WA lost his chance of being assessed for admission to the Unit as a result of failings at Lincoln and Ranby Prisons (11.20).

9 The mental health team at HMP Lincoln did not deal satisfactorily with the referral to the Oswin Unit. There is evidence of delay in providing the information required for the assessment to proceed. It was quite wrong for Lincoln to instruct the Oswin Unit to close the referral and, doubly so, without informing Healthcare staff at Ranby of the position (11.21).

10 The transfer to Ranby would have been inconvenient while healthcare staff were liaising with the Oswin Unit, who had agreed to assess WA for a place there. But it would not have been an overwhelming impediment if there had been an effective handover from Lincoln to Ranby or if healthcare staff at Ranby had examined WA's history (11.22).

11 The healthcare assessment on reception at Ranby was by a member of staff who was not a qualified nurse. That was not appropriate (11.23).

12 If healthcare staff at HMP Ranby had examined the patient record, preferably at reception, or if not, at a prompt further screening shortly afterwards, they would have been aware of WA's history of contact with mental health services (11.24).

13 The references in the patient journal to the gatekeeping assessment by North East mental health services are brief, they do not give a full picture of the current status of the referral, but they were sufficient to prompt further enquiry (11.25).

14 WA may or may not have been responsible for missing two appointments but it was not satisfactory that he was at Ranby for a month without seeing a qualified clinician except to receive medication (11.26).

15 In spite of past cautions recorded in the patient journal, it was decided to give WA his medication in weekly batches without him having been assessed in person by a nurse or the GP. The patient record contains no checklist or other document showing how that decision was made (11.27).

16 The referral to the mental health team from reception was not recorded in the patient journal until after WA's self-harm. This meant that a significant item of information was not available to the staff who decided not to re-book healthcare appointments, to issue medication in possession, and that WA could safely be held in the segregation unit (11.28).

17 The failings in this case occurred through the acts or omissions of individuals in both prisons, but they flow from a lack of appropriate systems and management to ensure consistent delivery and continuity of healthcare to an acceptable standard (11.29).

18 I have been told that practice in providing information to ensure continuity of healthcare is now much improved. It is the responsibility of healthcare managers in both sending and receiving prisons to ensure that systems are in place to provide continuity of care and that there is rigorous adherence to these in practice (11.30).

19 In the case of prisoners in the care of the mental health team, good practice requires an explicit handover, in writing, or by telephone, or both, that is recorded in the patient journal (11.31).

20 As indicated by HMCIP, all prisoners should receive a full healthcare assessment by a qualified clinician, including review of previous history, within 72 hours of admission (11.32).

21 Clinical staff working in prisons require induction in understanding the particular requirements of healthcare in prison, and familiarity with the protocols and standards that govern procedures in prison that do not apply in community settings (11.33).

22 There is a diversity of healthcare providers operating in prisons so there is an overarching responsibility for NHS England and the National Offender Management Service (NOMS) to ensure that appropriate arrangements are in place and that consistent standards of information management and staff induction are achieved throughout the prison estate (11.34).

Chapter 12: Segregation

23 The content of the health screen algorithm on both occasions calls into question whether the nursing staff who completed the form had properly considered healthcare records (12.19).

24 Nursing staff who completed the algorithm failed to identify that the records indicated an open referral for assessment to an NHS unit and that there was some history of self-harm (12.20).

25 The patient journal recording healthcare history at WA's previous prison was almost certainly accessible to staff at HMP Ranby when WA was placed in segregation; but if this record was not accessible, then the system in place was inadequate to deliver reasonable continuity of care (12.21).

26 Careful examination of the patient journal entries since WA's transfer to Ranby would have identified that, apart from the reception screening, WA had not been interviewed by any member of the healthcare staff at Ranby and it should have prompted a more thorough investigation of his mental health history and its implications (12.22).

27 It was not unreasonable for the nurse who conducted the initial healthcare screening to take particular note of the reception screen and the decision that WA could hold in-possession medication but we have had cause to question the adequacy of both those procedures (12.23).

28 There was compliance with the management checks, healthcare and Chaplain's visits required under Prison Service Order 1700 Segregation, but the content of the notes on checks by staff does not indicate whether these were quality interactions (12.24).

29 There is no evidence that Personal Officers were appointed as required by PSO 1700 (12.25).

Chapter 13: Should staff have identified a risk of self-harm?

30 From the evidence obtained through this investigation, I do not think, on the balance of probability, that WA's act of self-harm could reasonably have been foreseen by discipline or healthcare staff from the information immediately before them (13.27).

31 We have established, however, that there was significant information in the healthcare records that, if examined at reception, or in a follow-up meeting with a health professional, or when WA was assessed for suitability for segregation, should have prompted concern, further enquiry, reinstatement of a mental healthcare pathway, and a dialogue with WA himself. These might have altered the course of events (13.28).

32 The OASys record also contained information about a history and risk of self-harm, but no meeting with the Offender Supervisor had been scheduled at the time of WA's self-harm even though the target time was two weeks from admission (13.29).

33 There was apparently no system in place, as required by PSO 2205, for administrative staff to check OASys records for assessments of risk of harm when a prisoner was admitted to the prison and to notify their location of any recorded risks (13.30).

34 The absence of entries in case notes at Ranby, coupled with what we were told by staff, suggested an absence of constructive engagement with WA (13.31).

35 There was a series of faults in the management and care of WA. Healthcare staff at HMP Lincoln did not deal properly with the referral for assessment to the Oswin Unit and there were no satisfactory arrangements at Lincoln to secure continuity of mental healthcare. At Ranby there were missed opportunities that ought to have alerted staff to WA's vulnerability (13.32).

36 WA's superficial behaviour did not indicate that he was at risk of self-harm and there were circumstances in his personal life of which staff were unaware but which probably affected his state of mind. Procedures to protect against suicide and self-harm, have to serve the whole prison population and to be embedded across the total culture and operation of establishments. Prisoners are removed from sources of social support that they could access in the community. Prisoner-staff interaction, and systems for recording and sharing information among staff, are key safeguards (13.33).

Chapter 14: The staff's response to the emergency

37 The clinical adviser to the investigation states that, in his opinion, the attempts made at resuscitation were of a standard carried out by a reasonable body of professionals. In particular, paramedic support was called without delay, the response time was reasonable, and CPR was administered leading to WA starting to breathe with a palpable pulse (14.8).

38 The officers who attended WA and managed the emergency undoubtedly saved his life (14.9).

39 I note the concern expressed by HMCIP in 2014 about insufficient provision for first aid. That was not an issue in the case of WA but I would expect the prison to have acted on HMCIP's recommendation (14.10).

40 Post-incident procedures were not satisfactorily recorded (14.11).

41 The scope of the simple inquiry by the prison was too narrow to examine adequately the circumstances of WA's self-harm, his care and management in the month he was at Ranby, or whether there were lessons to be learned. An inquiry into a death or an incident of serious self-harm should always include healthcare as well as the actions of the discipline staff (14.12).

42 The arrangements for notifying WA's mother were not satisfactory. It is also notable from Mrs A's evidence that she was left feeling that her contact with prison staff was terminated abruptly and that she was not given information and answers to her questions which prison staff had promised. (14.13).

THE INVESTIGATION'S RECOMMENDATIONS

1 The investigation has identified instances of non-compliance with Prison Service requirements and other poor practice. I am told that there have been significant improvements since the events related in this report. That does not mean that there are not still lessons to be drawn. My recommendations are designed to ensure that changes have been made, or will now be made, that specifically address the weaknesses the investigation has identified, and that changes are embedded and carried through into practice.

A. HEALTHCARE

2 The investigation has identified critical areas of poor practice that impaired the management and care of WA. I refer to Dr Wright's clinical review in Chapter 7 and the findings in Chapter 11 of the report.

3 To ensure that similar failings do not occur again,

Recommendation 1

4 **I recommend that, those responsible for healthcare governance at HMP Lincoln and HMP Ranby:**

- identify the requirements of good practice in the specific areas identified below, in the light of the problems that occurred in this case and taking account of NHS and NOMS policies

- review their current arrangements and amend them if necessary to meet the requirements of good practice

- check that effective processes are in place to ensure common expectations and compliance by all staff who undertake these procedures, including any temporary staff.

5 This will require dialogue with the prison management to ensure that prison and healthcare processes work in a way that is complementary, so that good practice in healthcare accommodates the legitimate needs of the prison but is not undermined by prison processes that are not compatible with good practice in healthcare.

6 At Lincoln, the areas for review are:

(a) making and monitoring referrals for assessment for NHS mental health units

(b) considering the circumstances in which to flag a patient for 'clinical hold'

(c) the scope of the assessment of fitness for transfer and the process to be followed

(d) handing over significant information to healthcare staff at the receiving prison when a patient is transferred, with particular but not exclusive reference to patients of the primary and secondary mental health teams.

7 At Ranby, the areas for review are:

(a) ensuring that healthcare screening in reception is always undertaken by clinically qualified staff

(b) defining requirements for the scope of the reception screening

(c) ensuring that all prisoners receive a full healthcare assessment by a qualified physician, including review of previous history, within 72 hours of admission as recommended by HMCIP

(d) defining requirements for the assessment and review of prisoners in segregation

Recommendation 2

8 **I recommend that NHS England and NOMS:**

- take note of the findings in Chapter 11, and consider jointly in the light of this investigation whether the lessons of this investigation have a wider application;

- in particular, that they consider whether they are satisfied that adequate arrangements are now in place to ensure that consistent standards of delivery are achieved by diverse healthcare providers throughout the prison estate in the following areas:

(a) continuity of care when prisoners are transferred between establishments, including the transfer of records, guidance on 'clinical hold', and the circumstances in which summary written or oral handover is required;

(b) induction of healthcare staff, including temporary staff, so that they are familiar with the protocols and standards that govern procedures in prison that do not apply in community settings: particular areas are reception, segregation, administration of medication, and the identification of, and support for, prisoners at risk of self-harm.

B. SENTENCE MANAGEMENT

9 The OASys assessment is a risk and needs management tool for both probation and prisons. In the case of WA, HMP Ranby did not comply with the requirement in PSO 2205 to inform his location of risk of harm identified in the OASys assessment.

Recommendation 3

10 **I recommend that the Governor of HMP Ranby establishes:**

- that the prison's current practice complies with the requirement to check the OASys risk assessment of newly admitted prisoners and to inform their location of any identified risk of harm to self or others; and

- that residential staff at Ranby are made aware of what is expected of them when sentence management staff notify them that low, medium or high risks of self-harm have been recorded in an OASys assessment.

Recommendation 4

11 **I recommend that NOMS**

look into whether the requirement for early checking of OASys assessments for new prisoners is consistently observed in other prisons and consider whether further measures are necessary to ensure that the system is used and understood.

C. RESIDENTIAL SERVICES

12 PSI 75/2011 about Residential Services emphasises the importance of good staff-prisoner relationships to the successful management of a decent prison, to the reduction of self-harm and violence and to the engagement of prisoners in activities designed to reduce re-offending (paragraph 2.1) and states at paragraph 2.3 that residential staff play a key role in spotting signs of distress, anxiety or anger which might lead to self-harm.

13 It is left largely to Governors' discretion as to how to cultivate positive interaction between staff and prisoners. Paragraph 1.3 says that the specification for residential services and PSI 75/2011:

'highlight the particular importance of staff in residential units building good relationships with prisoners, interacting with them regularly and providing positive role models. It is for Governors to decide the best way of achieving this locally. It is not (and never has been) mandatory to operate a Personal Officer Scheme …'

Recommendation 5

14 **I recommend that the Governor of HMP Ranby is asked**

- to note the absence of case notes or other evidence of constructive engagement with WA;
- to consider what practical arrangements are now in place at Ranby to cultivate positive interaction between staff and prisoners and whether more can be done; and
- to report to NOMS accordingly.

D. FIRST AID

15 Fortuitously in this case, a member of staff at the scene was competent in first aid. There might easily have been a different outcome.

16 HMCIP identified in 2014 that provision for first aid was inadequate at HMP Ranby.

Recommendation 6

17 **I recommend that NOMS**

checks whether provision and deployment of first aid staff and equipment at Ranby are now at an acceptable level.

E. INCIDENT MANAGEMENT

18 Significant information about the incident of self-harm was not recorded.

Recommendation 7

19 **I recommend that NOMS**

reviews the guidance to establishments about action following life-threatening incidents of self-harm to ensure that it makes clear that evidence must be preserved.

F. INTERNAL INVESTIGATION

20 The simple inquiry commissioned at HMP Ranby after the incident was too narrowly framed to constitute a sufficient investigation but no further inquiry was commissioned until the present investigation, more than two years after the event. I do not consider it sufficient for the prison and the healthcare provider to commission separate and parallel investigations. An investigation of serious self-harm should consider both aspects jointly.

Recommendation 8

21 **I recommend to NOMS that**

- An inquiry into an incident of life-threatening self-harm should always include an examination of healthcare as well as the actions of the discipline staff.

- Findings and conclusions should take account of both aspects considered jointly.

ANNEX:

THE INVESTIGATION PROCEDURE

Article 2 of the European Convention on Human Rights

1. Article 2 of the European Convention on Human Rights can require the state to mount an independent investigation when someone in prison suffers life-threatening harm. There must be an element of public scrutiny appropriate to the circumstances of the case.

2. In compliance with Article 2, this investigation will be independent, open, transparent and even-handed, and will provide an opportunity for WA, or those who can represent his interests, to participate in the investigation.

The investigation process in outline

3. The terms of reference and contact details for the investigation are in the notice accompanying this note on the investigation procedure.

4. The investigator will examine documents, establish relevant lines of inquiry, prepare a chronology, and identify relevant witnesses. Interviews with witnesses will be held in private. They will be recorded and transcribed. Documents and transcripts will be made available to the interested parties to enable them to participate in the investigation but are not for publication. Documents and interview transcripts may be quoted or referred to in the investigation report which will be a public document and will be made available on an appropriate website. Unless there are exceptional circumstances, individuals will not be named in the final investigation report.

5. The investigation will not consider any question of civil or criminal liability.

The interested parties

6. The interested parties known to the investigation are WA, through his mother and her representatives, the National Offender Management Service (NOMS) and NHS England. Any other person or body that wishes to be treated as an interested party should apply to the investigation giving reasons.[2]

Initial meetings

7. The investigation wishes to meet representatives of WA's family at an early stage and to consult them about how WA or his representatives may participate in the investigation.

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[2] Medacs and the Lincolnshire Partnership NHS Foundation Trust were subsequently added as interested parties, on 7 April 2015 and 5 August 2015, respectively.

8. A notice about the investigation will be distributed for the information of staff and prisoners at HMP Ranby.

Documentary evidence

9. The investigation requests interested parties and anyone who holds documents which may be relevant to supply those documents to the investigation. The investigation may request further documents from the interested parties or other persons whom it considers hold relevant material.

10. NOMS will make available to the investigation for examination such original documents as the investigation reasonably requires and will provide copies of such documents as are requested by the investigation.

11. The investigation will compile a set of documents relevant to the investigation which will be copied to the interested parties. Particular documents may be provided to persons and bodies who are not interested parties to the extent this is necessary for the conduct of the investigation.

12. The investigation makes a presumption that relevant documentary evidence will be shared, in confidence, with the interested parties and with others where necessary for the conduct of the investigation. However there are some circumstances in which, exceptionally, documentary evidence may be redacted or withheld.

13. The terms of the investigation's commission stipulate that the Secretary of State may require redaction of documents on the basis of security, relevance or other sensitive matters before onward transmission to interested parties or others.

14. Where a witness or any other person considers that any part of a document, transcript, statement or other material that they have provided should not be disclosed, he or she should inform the investigation of the reasons for this view when the document or statement is provided.

15. If any material which the investigation considers relevant is redacted by the Secretary of State, or withheld at the reasonable request of a witness, the investigation will disclose to the interested parties the fact that material has been redacted or withheld and the basis on which it has been redacted or withheld.

Chronology

16. The investigation will prepare a chronology of events early in the investigation. This will be shared with the interested parties as a working tool and may be amended as the investigation progresses.

Clinical Review

17. The investigation will be assisted by an appropriate independent practitioner who will conduct a clinical review of the evidence and provide the investigation with medical advice.

Witnesses

18. The investigation may undertake interviews with witnesses it considers relevant. Witnesses will be provided with a written explanation of the investigation, terms of reference and the purpose of the interview. The investigation will have regard to the need for witnesses to have the means and opportunity to obtain support and representation if necessary.

19. All the persons approached will be directed to the issues about which it is considered they may have relevant evidence. They will be supplied with copies of documents that are relevant.

Interviews

20. Interviews with witnesses will be recorded and transcribed. Witnesses will be asked to sign a copy of the transcript.

Draft report

21. The investigation report will be made available in draft to the interested parties in confidence so that any factual inaccuracies may be addressed and any comments considered before final publication.

22. Evidence referred to in the draft report will be attached as an annex to the report or made available to the interested parties in another form. A list of any documents considered but deemed by the investigation not to be relevant will also be provided to the interested parties.

23. Any person who may be criticised in the investigation report will be given advance disclosure of the criticisms and be given the opportunity to respond before the report is finalised.

Final report

24. The Investigation Report will be presented simultaneously to the parties subject to appropriate redaction if necessary. It will be a public document and will be published on the website of the Independent Advisory Panel on Deaths in Custody but without the documentary and witness evidence.

25. The final report will not contain the proper names of any persons unless the investigation considers that, exceptionally, any individuals need to be named for the purposes of Article 2, for example, because that person had been involved in serious wrongdoing. If I am minded to name any individual in the report for this or other reasons I am required to write to the Secretary of State in advance, giving reasons.

Barbara Stow
Lead investigator **28 October 2014**

[footnote added: 5 October 2015]