National Offender
Management Service

Equality, Rights and Decency Group
National Offender Management Service
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Email:

Andrew McNamara
Assistant Coroner for Nottinghamshire

11 May I 2016

Dear Mr McNamara,

Inquest into the death of Mr Steven James May on 25 May 2015 at HMP Ranby

Thank you for your Regulation 28 Report of 16 March 2016. Your report has been passed to Equality, Rights and Decency (ERD) Group in the National Offender Management Service, as we are responsible for sharing learning from deaths in prison custody. I am responding on behalf of the Secretary of State for Justice, NOMS and the Governor of HMP Ranby.

You will be aware that healthcare at HMP Ranby is commissioned by NHS England and provided by Nottinghamshire Healthcare NHS Foundation Trust, and I understand that the matters of concern that you have raised at points 1, 2 and 10 have been addressed separately by the Chief Executive of the Trust in a letter dated 13 April 2016, and by the Clinical Quality Manager at NHS England in a letter dated 5 May 2016. This response therefore addresses the matters of concern at points 3 to 9.

(3) The failure of prison staff when preparing the ACCT document to prepare as full a note as possible. For example, to follow the subject areas suggested in the narrative accompanying sections 1-8 of the Assessment interview.

As you know, Prison Service Instruction (PSI) 64/2011 Safer Custody sets out the policy position, and the importance of fully recording and sharing information about risk is clear throughout, and particularly in chapter 2 on information sharing. Chapter 5 describes the Assessment, Care in Custody and Teamwork (ACCT) process, making reference to the need for effective record-keeping and requiring that the assessor record the outcome of the assessment interview on the ACCT plan.

Staff at HMP Ranby were reminded of the need to make comprehensive records of all such interviews at a briefing on 23 March 2016. All ACCT documents at the prison are now being monitored by the Head of Safer Custody and the quality assurance check that is conducted addresses this point.

At national level a review of the ACCT process was conducted in 2015 and NOMS is taking forward work on the recommendations, including issuing improved operational guidance for staff, developing a shorter and clearer ACCT plan and improving the content and delivery of safer custody training.

(4) Reliance by prison staff on verbal and/or oral handovers of information, rather than written records, regarding the deceased.

PSI 64/2011 states that "it is vital that the on-going record contains sufficient information about the progress and well-being of the prisoner. This information is critical to ensure that the risk is being managed appropriately and the CAREMAP remains relevant".

At HMP Ranby a notice was issued in February 2016 reminding staff that those responsible for a prisoner on an open ACCT must record all relevant information in the ACCT document, the wing observation book and on the P-NOMIS system. Both the prison and the healthcare provider have recently reviewed their procedures to ensure that systems are in place for information to be shared between prison and healthcare staff and recorded appropriately. In order further to improve information sharing, meetings of the multi-disciplinary team for prisoners identified as being vulnerable or at risk of harm are held every two weeks, and any ongoing concerns are discussed and recorded.

(5) The involvement in the ACCT process of prison staff possessing neither relevant training nor the appropriate rank.

PSI 64/2011 states that all staff in contact with prisoners must receive the foundation level 'Introduction to Safer Custody' training, and specific training is available for the roles of assessor and case manager. It also requires governors to provide ACCT refresher training according to local needs.

At HMP Ranby there are currently 30 trained assessors, 50 case managers and 464 staff of various grades who have received the foundation level training, and the Governor keeps these numbers under review.

One of the recommendations of the national review of the ACCT process referred to above was for further work to clarify the band/grade requirements for staff in assessor and case manager roles and work on this is being taken forward during 2016.

(6) The failure of prison staff to ensure the attendance of a medical professional at the First Care Review.

It is a mandatory requirement of PSI 64/2011 that the first case review is attended by a member of healthcare staff.

All case managers at HMP Ranby have been reminded that the initial case review must be attended by a member of healthcare staff, and the healthcare provider has adjusted its delivery model to make this possible.

(7) The selective training of prison staff in emergency First Aid (namely the first member of prison staff on the scene of the death was not trained in the administration of CPR and was ignorant of the location of and method of use of defibrillators).

PSI 29/2015 First Aid requires governors of public sector prisons to ensure that at all times such numbers of suitably trained first aiders as is sufficient and appropriate for the circumstances are available. These numbers must be determined by conducting a first aid risk assessment. First aiders must be trained to levels which are appropriate for the circumstances – to either First Aid at Work (FAW) level or Emergency First Aid at Work (EFAW) level.

The PSI becomes effective on 16 May 2016, and in preparation for its implementation, the Governor of HMP Ranby is reviewing the band/grade and numbers of staff who need to be trained in first aid. The prison currently has 61 staff trained in FAW and 73 in EFAW. 86 staff have received training in the use of defibrillators, and all staff have been provided with information on the location and use of defibrillators through a staff information notice issued on 16 July 2015.

(8) The hesitancy of the first member of prison staff on the scene to enter the deceased's cell in apparent adherence to an instruction not to enter cells alone.

PSI 24/2011 Management and Security of Nights sets out the policy on how incidents should be managed during the night state when prisoners are locked in their cells. Night operating procedures must be agreed by the Governor and the Deputy Director of Custody and set out in the prison's Local Security Strategy (LSS), which must include the local procedures to be followed in a potentially life threatening situation where there are no other staff in the immediate vicinity. Where there appears to be an immediate danger to life, cells can be opened by an individual member of staff: in such circumstances, the staff member must make every effort to obtain a response from the prisoner and then make a dynamic risk assessment of the situation based on what they can see through the observation panel and on what they know of the prisoner.

HMP Ranby has reinforced the relevant elements of its LSS, and issued a staff notice to this effect on 9 September 2015. All staff have been given access to the LSS and their knowledge of it will be tested annually.

(9) The inadequacy of First Aid training provided to prison staff in any event (namely, the administration of CPR by prison staff whilst the deceased was lying on a bed).

PSI 29/2015 is clear that all training provided to NOMS staff must be delivered by competent instructors, either by external providers from an approved list or trained and currently certificated NOMS trainers.

HMP Ranby is currently taking steps to ensure compliance with this element of the instruction in preparation for its implementation on 16 May 2016, alongside the review of the number of trained staff described in the response to point 7 above.

Thank you for bringing these matters of concern to our attention. I hope that the contents of this letter have been helpful in providing some national context and an assurance that the concerns that you have raised have been, or are being, addressed locally at HMP Ranby.

Yours sincerely

NOMS Equality, Rights and Decency Group