In re. the death of Steven James May.

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. The Secretary of State for Justice, Michael Gove MP** **2. The Secretary of State for Health, Jeremy Hunt MP** **3. The National Offender Management Service** **4. The Governor, HMP Ranby** **5. [redacted], Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust** **6. [redacted], Clinical Quality Manager, NHS England** **7. The Prisons and Probation Ombudsman** **8. The Care Quality Commission**
1	**CORONER** I am Andrew McNamara, Assistant Coroner, for the coronial area of Nottinghamshire.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 15 June 2015 I commenced an investigation into the death of Steven James May who was born on 31 September 1986. The investigation concluded at the end of the inquest on 22 January 2016 The conclusion of the jury after the inquest was: Medical cause of death: *Hanging* How, when, where and in what circumstances the deceased came by his death: *By hanging on 25 May 2015 at 01:45 at HMP Ranby. There were systemic failings in the application of the reception and ACCT process that if fully implemented may have prevented his death.*
4	**CIRCUMSTANCES OF THE DEATH** On 6/9/14 the deceased was remanded in custody to HMP Hull pending trial. Whilst on remand, on 11/9/14, he cut his own wrists and expressed that he had intended to take his own life in doing so. He was placed on the Assessment, Care in Custody and Teamwork (ACCT) programme; underwent a mental health assessment; and was treated with medication for depression. In November 2014 the deceased was sentenced to a term of imprisonment of 35 months. His sentence began at HMP Hull. He subsequently transferred to HMP Humber where he began to be concerned of reprisals: the deceased understood a fellow inmate had been offered money to assault him. The deceased experienced increasing concern for his well-being. Subsequently, the deceased obtained a transfer to HMP Ranby which occurred on 21/5/15. Upon arrival at HMP Ranby, the deceased underwent a reception health screen where he responded to various questions put to him by a member of nursing staff. No reference was made to the deceased's historical notes but his answers to various questions were recorded. By 23/5/15 he was concerned that the risk of reprisal had followed him and he requested a move to segregation. Instead he was given a move to a different house block. During the move he expressed to the prison officers accompanying him that if he were not moved to segregation he would hang himself. He was placed on a new ACCT and

	observed hourly through the night of the 23-24/5/15. The ACCT review on 24/5/15 was conducted by a single prison officer during which the deceased expressed the view that he did not want to die. His observations were reduced to 3 conversations during the day and 3 random observations overnight. On 24/5/15, the deceased was seen alive at 20.00 and again at 22.00. When next observed at approximately 01.16 on 25/5/15 he was seen to be hanging from the wall with what turned out to be a ligature that he had fashioned from torn bed linen around his neck. The first officer in attendance did not enter the cell but did radio for assistance. Officers attended within 3 minutes, cut down the deceased and commenced CPR but to no avail. The deceased was pronounced dead at 01:45 by the paramedic in attendance.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) The failure of reception nursing staff, by reason of lack of training and/or instruction or lack of staff and/or time, to consult the deceased's historical medical notes prior to or during the reception interview; (2) The lack of experience and/or training of reception nursing staff in the field of mental health; (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; (4) Reliance by prison staff on verbal and/or oral handovers of information, rather than written records, regarding the deceased; (5) The involvement in the ACCT process of prison staff possessing neither relevant training nor the appropriate rank; (6) The failure of prison staff to ensure the attendance of a medical professional at the First Care Review; (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); (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; (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); (10) The accessibility of health and/or mental health care to inmates at weekends and during Bank Holidays.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 May 2016. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION**

	I have sent a copy of my report to the Chief Coroner and to the following Interested Parties/Persons: 1. The National Offender Management Service/Governor Nottingham Prison; 2. Nottinghamshire Healthcare NHS Foundation Trust; 3. [redacted] I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**16 March 2016** **Andrew McNamara**