PSYCHOLOGICAL APPROACHES CIC

INDEPENDENT INVESTIGATION

THE CARE AND TREATMENT OF Mr A NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

MARCH 2022

Condolences

The investigation team wish to offer their condolences to the family of Mr B for their sudden and sad bereavement.

Acknowledgements

Thanks are due to the staff at Nottinghamshire Healthcare NHS Foundation Trust who assisted the investigators, and also to the staff at HMP Ranby who provided documentation and were interviewed for this investigation.

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Introduction: Events leading to this external investigation

1. Mr A, 38 at the time, was in prison for acquisitive offences, serving the last nine months of his sentence in HMP Ranby. During his imprisonment, he was under the care of both the inreach mental health team for monitoring of his mental health and also the substance misuse team. He was receiving methadone due to his long-standing substance misuse history.

2. Mr A had been prescribed olanzapine, an antipsychotic medication, for many years. This prescription ended in December 2018, while he was in HMP Ranby, for reasons that are unclear.

3. On 29/3/19 Mr A's behaviour deteriorated and following a disturbance on the wing he was transferred to the Segregation Unit where he was managed with enhanced care because he had said that he might harm himself. During the period until his release, prison officers and healthcare staff recorded a number of Mr A's statements and behaviours which suggested that he was becoming mentally unwell.

4. He was released on the 18/04/2019 and that afternoon he attended a brief post-release appointment at the community drug team accompanied by a member of his family.

5. On 18-19th April 2019 Mr A crashed a stolen vehicle, assaulted others, forced his way into a second vehicle containing a female driver, drove away with her, then let her go and crashed the second stolen vehicle. He forced his entry into a dwelling and stole the keys to a third vehicle, again assaulting others. While driving the third car he ran over Mr B, causing his death.

6. Immediately after his arrest, Mr A appeared to be psychotically ill (that is, he was out of touch with reality). However, the worker from the Liaison Team who assessed him in custody at that time, without access to the prison records, questioned how he could have become so psychotically ill so quickly: "[His] presentation is still under question with regards to it being substance related or onset of psychosis. However, psychosis does not happen overnight (Early psychosis rarely comes suddenly. Usually a person has gradual, non-specific changes on thoughts and perceptions but doesn't understand what's going on) and [he] was released from Prison one day before the offences were committed, presumably both medically and mentally well."

7. Subsequent psychiatric opinions, summarised in the pre-sentence report, agreed that Mr A had an enduring psychotic illness, either schizophrenia or schizoaffective disorder.

8. Mr A was found guilty of manslaughter by diminished responsibility and given a life sentence.

Brief biography of Mr A

9. Mr A was brought up by his maternal grandparents, who he referred to as his Mum and Dad. He was close to his aunt, who he regarded as a sister. He was of mixed race and suffered bullying because of this. He told the investigators that, as a schoolboy, he played chess for the county. He passed a number of exams at 16 and studied at college to work in the construction industry. He did not complete this because, as he described to the investigators, he started using drugs. This was a major problem in his life. He was first seen by community drug services in 2000.

10. He had been imprisoned many times for acquisitive offences. He was also involved in a prison riot in 2004 for which he served six years of an eight-year sentence.

11. In December 2014, age 34, Mr A was referred to a Derbyshire CMHT by his GP, who described that he had previously been under the care of another CMHT and he had a history of being prescribed olanzapine, an anti-psychotic. (No further details of this are available in the general practice records.) Mr A was described as feeling anxious and depressed, needing to lock all the doors and windows ("paranoid"), and struggling to be in crowded places. He appeared withdrawn and timid.

12. Mr A's documented contact with his local CMHT in Derbyshire was sporadic and punctuated by periods in prison. He was referred again to the CMHT by his Offender Manager in March 2017 as he was complaining of a mood disorder and hearing voices. Assessment in July 2017 showed that he had anxiety, paranoia, and auditory and visual hallucinations. This was the last appointment he attended, of a number that were offered. He was therefore discharged in November 2018. Throughout this time, he remained on olanzapine.

13. His contact with community drug services was more sustained because he was maintained on a methadone script; nonetheless, there are many occasions when he did not attend a booked appointment.

Analysis in relation to the Terms of Reference

1. Review the internal investigation

14. The internal investigation is dated 5/3/20. It covers an appropriate period of time - from Mr A's transfer to HMP Ranby on 18/7/18 to his release on 18/4/19. The authors acknowledge that their only information about Mr A's past psychiatric history was from his self-report. They describe these omissions by mental health care inreach in HMP Ranby:

    - Risk assessment appears to be incomplete (level 1 completed but not Level 2, as would have been expected).

- Failure to persist in seeking Mr A's consent to contact previous health care providers.
- Task allocated to Nurse 2 (in Nurse 2's absence) at the MDT (multi-disciplinary team meeting) seems not to have been conveyed to Nurse 2.
- Lack of clarity about how Mr A's olanzapine prescription (an antipsychotic medication) was stopped.
- A discharge summary for the GP should have been prepared.
- There was no evidence of liaison with the community mental health team on discharge.

15. These omissions are the basis of the five recommendations:

- Recommendation 1: The team should review its system for sharing tasks with identified professionals following MDT discussion to assure it is robust and this should be audited on a monthly basis for 3 months.
- Recommendation 2: All involved agencies on discharge should be documented in the healthcare record along with clear plans for communication with the same.
- Recommendation 3: The team should have a process included in their operational policy for seeking authorisation to access healthcare records, revisiting this at timely intervals if the request is declined and documenting this within the healthcare records.
- Recommendation 4: A full review of the prescribing, dispensing and discontinuation of medications including policies related to this should take place at HMP Ranby by the offender health service.
- Recommendation 5: An audit of discharge summary documentation should be completed to assure timely and full completion is now occurring in all cases.

16. These recommendations then formed part of a Quality Improvement Plan (QIP) produced by the Trust where they were translated into SMART[1] recommendations.

17. Additionally, the report includes a 'Lesson Learned' section referring to the need for the offender health service to ensure that all team members have regular access to clinical and managerial supervision and that regular healthcare records audits should be completed to demonstrate that full completion of required paperwork occurs within the team.

18. However, the report concludes that these omissions were unlikely to have influenced the outcome. The report acknowledges that the deterioration in Mr A's behaviour could be due to the cessation of his olanzapine prescription in December 2018 but it gives equal weight to his frustration with staying in

[1] Specific. Measurable. Realistic and Time-based. National standards for patient safety investigations March 2020 Report template - NHSI website (england.nhs.uk)

prison. The report also mentions that Mr A could have been refusing his olanzapine.

19. The authors identified two examples of good practice, specifically the robust liaison with substance misuse services at the time of Mr A's release, and the efforts made by mental health inreach services to monitor Mr A during his time in HMP Ranby.

Critique

20. In the opinion of the external independent investigators, the authors of the internal investigation did not give sufficient weight to multiple indications that Mr A was becoming psychotically unwell. There is nothing in the records to support the idea that he might have been refusing his olanzapine; on the contrary, on several occasions, he complained that his medication had been stopped. These are in the Chronology in Appendix 1. Examples occur in the ACCT[2] plan and the SystmOne record for 31/3/19. During the ACCT case reviews on 2nd, 9th, and 15th April 2019 there was an action for nursing staff to look into his complaint about his medication. There is no record that this enquiry was made.

21. Secondly, the authors of the internal investigation too readily accepted the diagnosis of personality disorder, despite the absence of any diagnostic clarity in the records. This lack of diagnostic clarity should have been highlighted as an omission by the mental health care team in the prison and should have been commented on in the report. A further diagnostic challenge was Mr A's use of mood-altering substances. This makes diagnosis more complex, but people can have both an enduring psychotic illness and a substance use disorder. The internal investigation too readily accepted that the use of street drugs was the cause of Mr A's psychotic state in the hours following his release.

22. Thirdly, Mr A had been received into HMP Ranby on a substantial dose of olanzapine, 15mg per day (BNF maximum 20mg per day). The authors of the internal investigation acknowledged that this had been a long-standing prescription. This dose and this duration suggest that it had been needed for the treatment of enduring psychotic illness. The time elapsed between the ending of his antipsychotic medication in December 2018 and the significant deterioration in his behaviour leading to his transfer to the segregation unit on 29/3/19 strongly suggests that Mr A was becoming psychotically unwell as a direct consequence of stopping his antipsychotic medication. The failure to recognise this was a critical omission by those who had charge of his care. Had this been addressed, Mr A, who had been asking about his medication, is likely to have willingly re-started his olanzapine and made a recovery. The authors of the internal report did not give sufficient importance to:

[2] ACCT - Assessment, Care in Custody and Teamwork - see Glossary

- this omission;
- Mr A’s concern that his medication had been stopped; and
- The lack of a care plan recording Mr A's olanzapine prescription and its management.

23. Fourthly, the internal report did not completely clarify the situation regarding seeking consent to obtain previous medical records. The internal report states:

> *“During the investigation the Investigators were made aware that there had been changes made to information sharing agreements nationally which meant that as [Mr A] dissented to allow his information to be shared the team were not allowed to access previous healthcare records, while not directly contributing to the incident in question this did mean that a full picture of [Mr A]’s mental health needs and risks related to the same was not able to be gathered.”*

24. This is factually incorrect in stating that they were not allowed to access Mr A's previous healthcare records without his consent. There is scope within national guidance for teams to access records if certain criteria are met, for example if there is a risk to safety, and whilst those particular criteria may not have been met in Mr A's case the external investigators found in records and at interview that there was no evidence that the risk of not obtaining the information had been considered and still some lack of understanding about local and national policy in this regard.

25. Fifthly, the internal investigators did not feel it was appropriate to speak to Mr A or his family. They therefore omitted important sources of information about Mr A's history and care in HMP Ranby.

26. The recommendations which were made in the ‘Lessons learned’ section of the report were not fully accounted for in the recommendations section or the subsequent Quality Improvement Plan. This meant that the Trust is unable to demonstrate that important lessons have been learned around ensuring adequate supervision and full completion of clinical records. However, at interviews with managerial staff, the investigators were told that clinical supervision was now regularly provided. This success will need to be maintained by the organisation to support this team who deliver services in a pressurised and challenging environment.

27. The five recommendations which were made are each addressed with a plan in the Quality Improvement Plan provided to the external investigators. All of these were rated as having been completed between the period May to September 2020. However, the information provided to the external investigators by both the healthcare team at HMP Ranby and the Trust Patient Safety Team did not adequately evidence completion and did not include ongoing actions to ensure changes are now embedded in practice. In particular:

- Recommendation 1. The audit on task completion provided to the external investigators showed that in December 2021, of the 425 tasks on SystmOne only 109 had been commenced and the oldest outstanding task was over 18 months old. This does not provide assurance that a robust system of task allocation and completion is in place.

- Recommendation 2: The evidence provided to the external investigators that 'All involved agencies on discharge should be documented in the healthcare record', showed the results from two audits on discharge planning that were apparently conducted in June and December 2021, though they were undated. Neither audit covered this recommendation.

- Recommendation 3: The team do not currently have a process included in their operational policy for seeking authorisation to access healthcare records as recommended. The Trust have amended the reception screening tool to remove the question about consent to access records, and regard this as evidence that this recommendation is implemented. However, this only covers access to prison clinical records on SystmOne. It does not cover access to health records in the community. Nor does this amendment address the recommendation that, if consent is refused, consent must be sought again at intervals to access community-held records; and that these requests should be documented within the healthcare records. At interview we also found that staff remained unclear about the circumstances in which they could access records without a patient's consent.

- Recommendation 4: The external investigators were shown evidence that a full review of the prescribing, dispensing and discontinuation of medications, including related policies, is underway, but not that it is completed. Nor were we shown any evidence of the outcomes of this review or how they will specifically address the omissions in the management of Mr A’s medication regime.

- Recommendation 5: The evidence provided to the external investigators that, 'an audit of discharge summary documentation should be completed to assure timely and full completion is now occurring in all cases', showed the results from two audits on discharge planning that were apparently conducted in June and December 2021, though they were undated. The June audit (conducted more than two years after the incident), showed that of a random sample of 20 patients on the mental health team caseload none had a discharge plan in place. The December audit appeared to show significant improvement with 18 out of 20 patients having a discharge plan in place. However, neither of the audits showed what standards they were being measured against, how the data was collected or what action for improvement was needed. We were also provided with the outcome data from the routine Health & Justice

Indicators of Performance (HJIPs) audit for January 2022. This showed that of the 24 men who were discharged from the mental health team at HMP Ranby in January 2022, 15 had a care plan in place. We were told that of the nine men who did not have a care plan all were 'internal discharges after initial assessment' and that ‘no prisoner left the prison in January without a care plan'.

28. In contrast to the written evidence, both custody and healthcare managers described at interview that there had been positive changes in the care of people in HMP Ranby who may have mental health vulnerabilities. Interviewees described the implementation of significant improvements in practice following these events. Examples included the adoption of wellbeing assessments which are developed collaboratively with the prisoner during their stay. These form the basis for discharge planning. Additionally, we were told that the Pharmacy team have implemented new procedures for the administration of medication, that there is clarity about the management of service users who do not collect their medication and that documentation is monitored.

2. Compile a comprehensive chronology

29. Please refer to Appendix 1.

3. Review the care, treatment and services provided by the inreach services, substance misuse services and primary care

30. This section covers the care and treatment provided to Mr A from his arrival at HMP Ranby in July 2018 until he left the prison in April 2019.

31. In the period from Mr A’s reception into HMP Ranby until his transfer to the segregation unit, there were omissions from the care provided by the mental health in reach services which caused them to be unprepared when Mr A’s mental state deteriorated. These omissions included:

- A failure to access previous records.
- Any formulation and diagnosis.
- A care plan.

32. These omissions caused the team to be unclear about Mr A’s vulnerabilities and treatment needs. In the opinion of the external investigators, this is at least part of the reason that the cessation of Mr A’s long term olanzapine prescription was overlooked by those who had care of him. It meant that the MDT meetings had only part of the information needed to make a fully informed management

decision. For example, the MDT review on 11th April clearly had no recognition of the urgency of his situation.

33. Similarly, during the critical period - from Mr A's removal to segregation on 29th March until his release on 18th April 2019 - when his mental state deteriorated and the prison officers' records documented actions and statements which suggest a psychotic illness - the in-reach staff did not have access to a care plan which would have alerted them to the fact that a long-term prescription for antipsychotic medication had stopped.

34. It is not clear that the prison officers' records were seen by the healthcare staff. The healthcare records demonstrate a reliance on brief assessments, often at the door of his cell, which focussed on his risk of self-harm. However, when healthcare staff spent more time with him, for example at the ACCT reviews, Mr A made multiple statements of a grandiose and paranoid nature which should have led to a detailed psychiatric assessment.

35. In the opinion of the external investigators, Mr A's records from this period contain overwhelming evidence of a psychotic illness. This was not recognised. It was not linked with his complaints of his medication having been stopped and his complaints about this were not investigated.

36. Substance misuse services demonstrated diligence in their follow-up of him, even though his attitude towards his worker was often critical because he wanted his methadone to be dispensed in the morning rather than the afternoon. Nonetheless, the worker maintained contact with him and documented essential health advice in relation to his release. They took all necessary steps to ensure he could access methadone and a community drug service after his release.

37. The records relating to primary care describe intermittent contact in response to incidents, for example Mr A's complaints on 6/4/19 of sustaining injury during his move to the segregation unit and his collapse on 17/4/19. These issues were managed in a timely and appropriate way.

38. Daily reviews of Mr A whilst he was in the segregation unit were undertaken by both primary care and mental health staff (as they are with all prisoners held there). We noted that there was a care plan in place on SystmOne for Mr A's period of detention in segregation. However, we were told that staff had no specific training either for undertaking reviews or about the potential impact of segregation on mental health.

4. Review the appropriateness of the treatment of Mr A's health and social care needs, identifying both areas of good practice and areas of concern

Mr A's health care needs	Good practice	Area of concern
Mr A arrived in HMP Ranby on a prescription for antipsychotic medication	-arrangements were made to do necessary blood tests on someone on a long-term prescription for antipsychotics	- failure to seek health care records so that the historical basis of this prescribing could be understood
He described symptoms of mental disorder	-allocated a key worker from the MH inreach team; he had an assessment with her, and he was seen by a psychiatrist -the key worker from mental health inreach made repeated and sustained attempts to keep in touch with Mr A	- When Mr A did not attend his follow-up appointment with the psychiatrist on 27/12/18, this was not robustly addressed. The psychiatrist offered a further appointment in three months' time
His long-term antipsychotic medication ceased for reasons that are unclear		- there was no recognition of this and so Mr A's mental state was not monitored for the emergence of a psychotic illness
Risk of self-harm	-Mr A was managed within the ACCT framework	Risk assessment undertaken was not in line with NICE guidance
Mr A's mental health deteriorated in the period before release while he was held in the segregation unit		-this was not recognised by the health care staff despite the observations of the prison officers and health care staff who recorded numerous examples of Mr A's speech and behaviour

		which suggested mental illness -no liaison with community mental health services and the GP about Mr A's release from prison
Receiving methadone substitution treatment for opiate dependence	-at Reception, Mr A was screened for alcohol misuse using the AUDIT questionnaire and he was offered testing for hepatitis B & C, and HIV -the key worker made repeated and sustained attempts to keep in touch with Mr A -his methadone dose was monitored, and he had a urine drug screen on 22/11/18 -Mr A attended Alcoholics Anonymous meetings in the prison -planning for release was comprehensive, with discussion of the risk of overdose, the provision of naloxone and liaison with community drug services	-no record of liaison between substance misuse services and the mental health in-reach team about Mr A's care plan
On 7/9/18, Mr A reported that he had had a fit	Mr A was reviewed by the GP on 27/9/18 and a plan was written in his SystmOne record	
Mr A reported feeling acutely unwell on 16/4/19 and 17/4/19 in the segregation unit	He was assessed promptly by primary care staff	

39. The external investigators did not identify any unmet social care needs.

5. Review the adequacy of risk assessments and risk management, including specifically the risk of Mr A harming himself or others.

40. NICE Guidance on the mental health of adults in contact with the criminal justice system[3] recommends that a risk assessment is undertaken for all people in contact with the criminal justice system when a mental health problem occurs or is suspected. It requires that both risk to self and risk to others is assessed and that the assessment takes into account: causal and maintaining factors; the likelihood, imminence, and severity of the risk; the impact of their social and physical environment; and protective factors that may reduce risk. This level of risk assessment was not undertaken for Mr A whilst at HMP Ranby.

41. We cannot say what would have been identified if the risk assessment had been undertaken but it was a missed opportunity to explore with Mr A how his mental health impacted on his behaviour towards others, and it may have assisted clinical staff to subsequently recognise his deterioration in behaviour, requiring removal to the segregation unit, as a possible indication of relapse in his mental health.

42. It should be noted that a risk assessment is used to develop a risk management plan for an individual. It is not a risk prediction tool and could not have predicted the incident.

43. Whilst in the segregation unit in March 2019 Mr A was appropriately placed on an ACCT due to concerns, he would harm himself. In the initial assessment interview on the 31st of March 2019, it was noted in the mental health section that Mr A was frustrated at still being in prison and that he was not getting his mental health medication. An action to review his medication was added to the care map section of the ACCT documentation. In the context of being held in the segregation unit due to risk to others it is our professional opinion that a review of Mr A's medication should have involved an assessment of his current mental state and an assessment of risk. This was not undertaken.

44. Mr A was discussed in the Mental health team meeting on the 11th of April 2019 where it was noted, 'Asking for medication. Discussed possibility of bringing appointment forward. Doctor not happy to prescribe anything for him until he has been seen'. At interview we were informed that at that point Mr A had a pending appointment with a psychiatrist booked for May 2019. There is no evidence that any attempt was made to bring this forward following Mr A's change in behaviour and subsequent segregation.

[3] National Institute for Health and Care Excellence: NG66 Mental health of adults in contact with the criminal justice system. This guideline covers assessing, diagnosing, and managing mental health problems in adults (aged 18 and over) who are in contact with the criminal justice system. www.nice.org.uk/guidance/ng66/chapter/Recommendations

45. Guidance for the ACCT process states that the case review team can decide to close the ACCT if they believe it is safe to do so and where all issues identified during the assessment interview have been resolved and the results of any referrals are known. Mr A's ACCT was closed on the 18th of April when he was released from HMP Ranby. Against the medication review action, it was noted that he had been referred to the community. It was unacceptable that an action which could have been dealt with promptly in prison when it was first noted in the ACCT was deferred to a community team in order to close the ACCT.

6. Review his mental health care in the lead up to his release and the release planning.

46. In the lead up to his release, Mr A's behaviour deteriorated abruptly and he assaulted staff. He was transferred to the segregation unit for the period from 29/3/19 until his release on 18/04/2019. The extracts from the records kept by healthcare and segregation unit staff in the Chronology at Appendix 1 contain multiple accounts of speech and behaviour which strongly suggest that Mr A was mentally ill, for example:

- 31/3/19: "stated "My sister will spend millions making sure staff responsible suffer" …has a plan to start own business and sell alarm ideas to Apple etc"
- 2/4/19: "Talking to himself"
- 4/4/19: (Mr A) had tried to burn a pile of newspaper pages, when asked why, replied "You know"
- After 6/4/19, multiple entries relate to Mr A writing his life story.
- 9/4/19: "Currently educating the residents of the segregation unit about the earths positive energy"
- 9/4/19: "Believes he changed everyones views on the ethnic minority in his home town. Stating that he was a scientist. Accusing prison staff of being racist. Stated that he is currently writing a book where he will be naming…prison officers…would not elaborate further on this. Believes the book will most definitely be made into a film…"
- 14/4/19: "Been telling staff about the future of the planet and how it will change".
- 15/4/19: "He is occupying himself in his cell with writing and mathematics. Some of his statements were random and perhaps grandiose - having brilliant ideas to carry out on release but no description…"
- 17/4/19: "Asked me for some water because in his opinion water in his tap is poisoned and we trying to kill him. Showed me food he is collecting to take it with him on release to test it so he have a proof that we want to poison him."

47. These examples are very typical of psychotic illness (ie, being out of touch with reality). They demonstrate that Mr A was in the grip of grandiose and paranoid

delusions (false beliefs). In the opinion of the external investigators, Mr A suffered a relapse of the enduring psychotic illness which had caused him to be first prescribed olanzapine.

48. The development of this level of mental and behavioural disturbance would be a major risk for someone who has stopped their long-term antipsychotic medication. The time interval of three months before relapse is to be expected because antipsychotic medication is stored in the body and so blood levels decrease slowly.

49. The risk of relapse after stopping olanzapine is well recognised and described explicitly in national prescribing guidelines:

> *"There is a high risk of relapse if medication is stopped after 1–2 years. Withdrawal of antipsychotic drugs after long-term therapy should always be gradual and closely monitored to avoid the risk of acute withdrawal syndromes or rapid relapse. Patients should be monitored for 2 years after withdrawal of antipsychotic medication for signs and symptoms of relapse."*[4]

50. Mr A was not monitored after the abrupt cessation of his olanzapine. These signs and symptoms of psychosis were missed and Mr A was released with no liaison with community mental health services or his GP. This is a further important omission because there was no handover of the management of his medications while in HMP Ranby and no arrangements with services to continue the care of his mental health, despite the fact that he had been under the care of the mental health inreach team during the months prior to his release.

7. Review his medicine management throughout his prison stay

51. When Mr A transferred into HMP Ranby, he was on three regular medications:

- Gabapentin 900mg three times daily (a treatment for epilepsy and pain due to nerve damage; it has an anti-anxiety effect. This is about the middle of the dosage range).
- Olanzapine 15mg once daily (a treatment for psychotic illness. Olanzapine can also be used in other mental disorders, in which case, typically, a smaller dose would be prescribed).
- Methadone liquid 60mg once daily (opiate substitution, used in the treatment of opiate addiction; 60mg is a typical dose).

52. Mr A remained on this dose of methadone throughout his stay in HMP Ranby. It was appropriately monitored and robust arrangements were made to continue it

[4] https://bnf.nice.org.uk/drug/olanzapine.html

after his release. It was administered by nursing staff once a day; it was not in Mr A's possession.

53. The gabapentin and the olanzapine were dispensed weekly to Mr A. This continued unchanged for the following four months until 30/11/18, when a cell check demonstrated that Mr A could not account for 42 gabapentin tablets. Gabapentin is a powerful anti-anxiety medication, known to alter mood, and so it is at risk of being diverted to others.

54. In view of the missing 42 tablets, Mr A's dose of gabapentin was reduced from 900mg to 300mg three times daily, still in his possession.

55. On 3/12/18, it seems that two prescriptions were dispensed, one for gabapentin 300mg three times daily (21 tablets) and one for gabapentin 900mg three times daily (63 tablets).

56. The entry in the healthcare record states: "[Mr A] collected 63 gabapentin tablets @ 8.45 and at 10.0'clock he did not have any, said that they were stolen when questioned about his olanzapine that he also collected at the same time they had not been touched. Informed him that they may be stopped he said "Oh well... I am out in March."

57. There is a record that the gabapentin was stopped on 4/12/18, but no specific record that the olanzapine was stopped. Nonetheless, there is no record of olanzapine being dispensed for Mr A from then until his release.

58. Sertraline (an antidepressant and anti-anxiety drug) 50mg daily was prescribed by the psychiatrist on 15/11/18, but there is no record of it being dispensed and Mr A does not seem to have started this medication. He did not attend the follow-up appointment with the psychiatrist to assess the impact of the sertraline. A further appointment was arranged but by this time, Mr A had left the prison.

59. In summary, there was a failure to record the change in olanzapine so that it is not clear why Mr A was no longer taking it. It appears to have been overlooked and was not brought to the attention of his key worker. Similarly, it is not clear from the records why Mr A was not started on sertraline after the psychiatrist had prescribed it. Again, this may have been overlooked.

60. Mr A was also able to access anti-inflammatory analgesics and other "homely remedies". These were dispensed on an 'as required' basis without a specific prescription under a Patient Group Directive. His use of this facility was not excessive.

8. Review compliance with local policies, national guidance, and statutory obligations

61. Divergence from local and national guidance has already been noted specifically in each section of this report where it was found. This section summarises the most significant deviations in order to assist the reader in seeing the broader view of the standard of care provided to Mr A.

62. The standards for mental health care provided to people in prison are set out by NHS England[5]. In addition, there are clinical guidelines both specifically for prison health and for mental health conditions in any setting, drawn up by the National Institute for Health and Care Excellence (NICE). Since 2015 the Royal College of Psychiatrists has led a quality improvement programme, The Quality Network for Prison Mental Health Services (QNPMHS). The programme supports prison mental health teams to deliver the best quality services in line with National standards and all prison healthcare services in England are expected to be part of the network. The QNPMHS publish and updated a set of quality standards against which teams are assessed. In evaluating the care of Mr A, the external investigators referred to the 4th Edition of these standards, published in September 2018[6].

63. The mental health care provided to Mr A did not meet a number of these standards. For the purposes of this report, the investigators have confined themselves to solely reviewing the standards described as 'essential', because, in the words of the document, failure to meet them results in a significant threat to patient safety, rights or dignity and/or would breach the law. A number of standards relating to care planning were not met (Standards 9, 10, 19, 20 & 21); among those relating to discharge planning a number were breached (Standards 37, 38 & 40) and certain standards relating to medication management were not met (Standards 52, 53 & 54).

64. With reference to the management of Mr A's substance misuse disorder, the external investigators evaluated his care against the intervention described in the service specification for substance misuse treatment services in England, published in April 2018[7].

65. This is the basis for describing the multiple examples of good practice by the substance misuse team at ToR 4. In terms of areas for development, the external investigators noted that there was no written record of liaison between substance misuse services and the mental health in-reach team about Mr A's

[5] Service Specification for Integrated Mental Health Services for Prisons www.england.nhs.uk/wp-content/uploads/2018/10/service-specification-mental-health-for-prisons-in-england-2.pdf

[6] https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2

[7] https://www.england.nhs.uk/wp-content/uploads/2018/05/service-specification-integrated-substance-misuse-treatment-service-in-prisons.pdf

care. However, both services could read each other’s entries as they shared the same clinical record in SystmOne. Which provided for an acceptable level of cross referencing.

Interview with Mr A

66. The external investigators met with Mr A, supported by his keyworker, in November 2021. He told us about his current medication, which includes olanzapine for psychosis. He said that olanzapine stops him hearing the voice he had previously heard where a woman tells him he is God, and he feels a lot calmer. He said he cannot remember his first psychotic experience but that it was a long time ago and he had often hallucinated but had found it difficult to confide in anybody about it.

67. When asked about his experiences at HMP Ranby in the months leading up to his release, Mr A said that he thought people were trying to kill him by poisoning his methadone. This was an intermittent thought and led him to not take his methadone sometimes. He thought that his mental health deteriorated in HMP Ranby following his olanzapine being stopped. He said that initially after it had been stopped, he bought olanzapine from other prisoners but that when he was sent to the segregation unit, he could no longer do this.

68. When asked if he was having psychotic symptoms whilst in the segregation unit, he described a female voice of God telling him to harm himself and that he was Jesus. This made him feel panicky. He described how he thought it should have been obvious to staff that he was unwell because he was attacking officers, setting himself on fire and telling people he was being poisoned and not eating for days on end. He also told us whilst in the segregation unit he repeatedly asked visiting healthcare staff for his medication to be restarted but they had not done so. He went on to say that the voice said his son was in danger and he believed this and so planned to go and check on his son as soon as he was released from prison. On the day after he was released from prison Mr A described that he had taken a neighbour's car in order to travel to Nottingham to check his son was alive. He said he had not taken any illicit drugs that day.

69. On the day of the offence Mr A remembers talking to his dead father and brother and them responding clearly and believing that he was the son of God. When asked he again reiterated that he had not used any illicit substances that day. He described how he had used 'spice' sometimes at HMP Ranby and this usually made him feel 'chilled'. Mr A told us that when he went to HMP Manchester after the offence he initially thought that everyone there was against him but a particular nurse persisted with him and got him to take his medication.

70. We asked Mr A what he thought may be learned from his experience at HMP Ranby and he said that he thought if people (healthcare staff) were more friendly and encouraging and listened to you, it helped you to work with them: "staff should persevere with people with mental health problems".

Partnership Working

71. The Independent Monitoring Board published their latest annual report on HMP Ranby in November 2021[8]. At page 6, the report draws attention to the need to repeat that the placement of mentally ill prisoners in the segregation unit is inappropriate:

> *"Will the Minister explain what is being done to reduce the need to house prisoners with mental health problems in the segregation unit of HMP Ranby? The Minister responded to the same question in the past with a comprehensive list of reports, audits, programmes being compiled/developed by specialised health and justice commissioners, mental health teams in NHS England, the Royal College of Psychiatrists, and a Select Committee. Regrettably, it appears that no actual action to deal with this problem has been planned or taken and the segregation unit, as well as a cell in house block four, is being used to monitor prisoners who should, in the Board's opinion, be elsewhere."*

72. This issue has been commented on adversely in the IMB's annual reports on HMP Ranby for some years. While the external investigators acknowledge that Mr A was not recognised to be mentally ill, they did seek to understand why his grandiose and paranoid presentation was not brought to the attention of healthcare staff. They hypothesised whether the experience of housing mentally ill prisoners over the years had made this level of disorder seem unremarkable. However, this issue is outside the scope of their enquiry.

73. The investigators were informed by clinicians that during the period of this investigation services in HMP Ranby were commissioned for and set up to meet the health needs of longer-term prisoners but a recent change in the group of prisoners served by the prison has led to shorter stays, faster turnovers, and more acute health needs. Clinical teams told us that at the time Mr A was at HMP Ranby this meant that clinical services were not structured to meet the needs of the new prison population. Whilst these issues were not within the scope of this investigation, we felt they were sufficiently important to highlight it in this report. The external investigators understand that NHS commissioners and the leadership teams in Healthcare and HMP Ranby are working together to make sure that the provision of health care is informed by the current needs of prisoners, including prisoners housed in the segregation unit. We therefore make no recommendation on this matter.

[8] https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2021/11/Ranby-2020-21-annual-report-for-circulation-.pdf

Findings

Finding 1

74. Mr A's previous history, his vulnerabilities and his protestations about medication being stopped were not given sufficient importance throughout his time in HMP Ranby. The investigators found that the mental health in-reach workers focussed on Mr A's presentation solely at the time of seeing him, rather than looking back at his presentation over recent days and weeks. They lacked professional curiosity about the inter-relationship between mental illness, substance misuse and anti-social behaviour. They too readily attributed disturbed behaviour to personality difficulty or substance misuse, or to an expression of anger at the establishment. MDT meetings as recorded in SystmOne did not address these points or the fact that his olanzapine had stopped. These omissions contributed to a failure to recognise his deteriorating mental state.

75. Some improvements in the provision of clinical supervision have been made. This success will need to be maintained by the organisation and developed to ensure that it supports staff working with complex presentations in a pressurised and challenging environment.

Finding 2

76. There was a lack of diagnostic clarity for a prisoner on a robust dose of antipsychotic medication. Among the contributions to this lack of clarity were the following:

    - A failure to seek his previous records either from the community or from his most recent prison.
    - Mr A was accepted onto the MHIT caseload and understanding the contribution made by his medication should have been a core task.
    - The repetition of the description of Mr A as having a personality disorder, in the opinion of the external investigators, served to reduce enquiry by mental health staff about the nature and severity of his mental disorder.

77. The Trust has not fully implemented its own action to ensure that their operational policy guides staff on access to health records in the community and what actions to take if consent is refused. At interview we also found that staff remained unclear about the about the circumstances in which they could access records without a patient's consent.

78. Mr A was difficult to engage but this does not remove the responsibility to accurately diagnose and manage mental disorder. We conclude that his antisocial behaviour got in the way of assessment and treatment. Staff had a limited understanding of the co-morbidity due to personality vulnerability and

substance misuse, and no recognition of the possibility that Mr A's problems were related to enduring mental illness.

Finding 3

79. The quality of written documentation did not support continuity of care, an understanding of the thought involved in decision-making, or clarity in care planning. There was a lack of detailed recordings of the decision making at MDT meetings. The only care plan in SystmOne is a standard care plan for people in segregation.

Finding 4

80. The communication between the custody staff and the healthcare staff did not ensure that observations suggestive of mental disorder made by officers in the ACCT 'on-going record' were routinely seen by healthcare staff.

81. The daily healthcare reviews in the segregation unit did not take this information into account either. The purpose of these reviews was to ensure that the prisoner was well enough to be housed in the segregation unit. They seemed to solely focus on Mr A's risk of self-harm.

Finding 5

82. The process for planning the discharge of Mr A was inadequate. There was no record of liaison with CMHT services despite the fact he had been on the MHIT's caseload. The following issues were not taken into account in any risk assessment in the period before discharge:

    - The lack of diagnostic clarity.
    - Mr A's statements that he was being poisoned by his methadone the day before release (necessitating reviews by primary care), and on the day of his release.

83. The Trust did not provide evidence of their own action that all agencies involved with a patient at discharge should be recorded in the healthcare record.

Recommendations

Due to time and logistical constraints the Trust did not co produce these recommendations though they have had an opportunity to comment on them.

Recommendation 1

84. Within six months, the healthcare team should provide ring-fenced time for clinically driven supervision to all clinical staff. Uptake should be supported by a programme of audit undertaken at least monthly.

Recommendation 2

85. Within six months the healthcare team should ensure that clinical supervision is based on a model which supports professional curiosity, complex case management of people with co-morbidity and working with those who are difficult to engage.

Recommendation 3

86. Within six months the healthcare team should review its operational policy and processes in relation to information sharing to ensure that care planning and risk assessment are routinely informed by all available information within the constraints of the patient's right to privacy. This must include ensuring staff understand when they do, and do not, require the patient's consent to gain information.

Recommendation 4

87. Within six months the healthcare team should use a recognised quality improvement methodology to undertake a full review of: task allocation, care planning, documentation of MDT decisions and discharge planning. The review should ensure that practice meets local and national professional standards. Once completed the standards should be supported by a programme of audit undertaken at least annually.

Recommendation 5

88. Within six months the healthcare team should implement a system which ensures that the daily healthcare review for prisoners held in segregation takes into account observations and records made by both prison and healthcare staff and that the review assesses both risk to self and risk to others.

APPENDIX I Chronology of Mr A's time in HMP Ranby

source	date	time	entry
SystmOne record	18/7/18	14.56	Received into HMP Ranby. Daily medication recorded as olanzapine 15mg, gabapentin 1,200mg and methadone 60ml. Referred to mental health team and substance abuse clinic. 48 hours later the gabapentin dose was altered by the GP in the prison to 900mg three times daily.
SystmOne record	24/7/18	09.26	Mental health assessment: "suitable for secondary mental health care…to be placed on waiting list to be allocated a keyworker…notes to be requested…reports that he engages with the CMHT
SystmOne record	25/7/18	11.59	DNA substance misuse clinic - houseblock (H/B) confirmed had been unable to attend as had gone to induction
SystmOne record	30/7/18	12.28	DNA substance misuse clinic - staff attended H/B. (Mr A) was aware of appt but staff unable to find him
SystmOne record	2/8/18	12.49	Multidisciplinary meeting including psychiatrist: On waiting list to be allocated keyworker.
SystmOne record	3/8/18	08.55 and 12.09	DNA substance misuse casework appointment and clinic. Appointment to be re-scheduled.
SystmOne record	7/9/18	08.42 And 11.49 And 12.15	Substance misuse assessment. "Engages with drug services in the community… MH [mental health] appears in deterioration. Requesting to change back to am [morning] meds
SystmOne record	7/9/18	14.28	Mental health in-reach team review: "Asked to see today due to recent [bereavement]…reported he had a seizure last night. States he is on gabapentin for epilepsy. Will put him down for review with GP…"
SystmOne record	18/9/18	15.24	Substance misuse team: "tried to see for UDS [urine drug screen]. Attended cell with wing officer, unaware of whereabouts of pt. Will try again tomorrow."
SystmOne record	20/9/18	09.55	DNA substance misuse casework appointment [Attending funeral]
SystmOne record	20/9/18	14.00	DNA mental health review. Advised he had been to a funeral… I will rebook.
SystmOne record	27/9/18	10.44	General Practitioner review: "[Bereaved] this week. I feel we should just leave him as is at present"

SystmOne record	1/10/18	10.14	Mental health assessment declined, rearranged for tomorrow.
SystmOne record	2/10/18	09.40	Mental health appointment. Further appointment allocated where we will look at care planning… PHQ-9=14, GAD-7=9… H/O psychosis. Reading previous notes seems there is nil evidence of epilepsy…aware of how to contact healthcare for further advice.
SystmOne record	16/10/18	11.15 And 15.02	"DNA substance misuse Casework appointment… DNA 13-week review, I have tasked his keyworker to ask for this to be completed."
SystmOne record	22/10/18	10.53	"DNA mental health review…call made to wing. Due to writer being unwell it was not possible to attend the wing to see him"
SystmOne record	29/10/18	10.35	Mental health in-reach team review: "Attended the wing to see…not present - arrange further appointment"
SystmOne record	31/10/18	15.06	Mental health in-reach team review:" …Talked very little about 'the voices but states these are heightened at times…would like to start reducing methadone…follow-up appointment booked…Has appointment booked with psychiatrist"
SystmOne record	14/11/18	10.20	Follow-up substance misuse assessment: Discussed timing of methadone dispensing. "Agreed to complete a UDS..."
SystmOne record	14/11/18	11.30	"Attempted to do a UDS but working in the servery"
SystmOne record	15/11/18	09.36	Psychiatric assessment:"…prescribed olanzapine for a 20 year history of hearing abnormal voices but it is not clear to me that any diagnosis of psychotic mental illness has ever been made…seemed quite abrupt or even a little hostile with increased eye contact that made me feel somewhat uncomfortable to begin with…Objectively a little lowered in mood…presenting complaint anxiety…We left it today that I would restart him on sertraline and get his antipsychotic monitoring/baseline investigations before considering any other changes.. I would like to review him in 6 weeks"
SystmOne record	16/11/18	11.18	Substance misuse team - attempted to collect UDS but he has already started work. Discussed and agreed to have a UDS the following week.
SystmOne record	21/11/18	11.43	Failed medication check - 42 gabapentin missing.

SystmOne record	22/11/18	11.01	Substance misuse team - UDS positive for methadone, nothing else. “Still reports to be struggling with PM methadone”.
SystmOne record	26/11/18	11.17	“DNA mental health review, unable to ascertain reason due to no answer on the wing”
SystmOne record	29/11/18	09.35	“DNA substance misuse Casework appointment… This will be re-scheduled”
SystmOne record	30/11/18	09.28	Doctor review: failed cell check - 42 tablets short. Dose of gabapentin reduced.
SystmOne record	3/12/18	10.58 And 14.55	“Unable to return 63 tablets of 300mg gabapentin that was issued in error…” “…when questioned about his olanzapine that had also been collected at the same time they had not been touched.”
SystmOne record	4/12/18	12.40	Doctor review: “Stop gabapentin given 2 x failed cell checks…”
From this point on there is no record of further regular medication except for methadone, so it appears that the olanzapine was stopped, too, even though there was no evidence that Mr A had been unreliable with his olanzapine medication.			
SystmOne record	6/12/18	08.45	DNA Nurse clinic appointment
SystmOne record	7/12/18	10.04	Substance misuse team. Appeared irritable and frustrated about the time of dispensing his methadone.
SystmOne record	27/12/18	10.58	DNA psychiatric review, no explanation: “I started him on antidepressant medication. There seem to be few entries that reveal acute mental health problems in recent times…another appointment in 3 months.”
SystmOne record	8/1/19	13.58	DNA mental health review: “Seems bloods have not been done. I will need to see on the wing due to his poor attendance. Currently unable to due to attending the allocations meeting”
SystmOne record	10/1/19	16.24	DNA mental health review: “Due to other commitments and ACCT I could not see on the wing. Re book”
SystmOne record	14/1/19	11.53	DNA substance misuse appointment: “This will be re-scheduled”
SystmOne record	17/1/19	09.32	DNA mental health review: “I went to the wing to see him. He was happy to speak to me but just to inform me that he did not want anything to do with healthcare/mental health…To discuss in MDT with psychiatrist”

SystmOne record	17/1/19	13.07	Discussed in MDT with psychiatrist…appointment with psychiatrist to remain unchanged.”
SystmOne record	21/1/19	10.35	DNA substance misuse appointment
SystmOne record	12/2/19	09.19	Blood test declined, signed disclaimer
SystmOne record	18/2/19	12.38	Mental health review - staff member attended the wing, but he had attended healthcare - appointment missed and another will be allocated
SystmOne record	28/2/19	16.12	DNA Mental health review
SystmOne record	1/3/19	15.22	Mental health review: seen on wing, still does not want anything from mental health…reports he could be going home next week…seemed to be in good spirits… writer to complete GP letter for release… not on any secondary mental health medication… … methadone only”
SystmOne record	6/3/19	13.45	DNA appointment with healthcare Support Worker.
SystmOne record	25/3/19	16.21	Mental health review: “Went to see on the wing but was at work. ”
SystmOne record	27/3/19	09.38	Attended mental health checks this morning…Replied “I am not interested in this as you have not been interested in my care for over a year”…walked out of clinic
SystmOne record	28/3/19	12.46	MDT discussion with psychiatrist - no current action required. RMN to proceed with agreed plan on release
SystmOne record	29/3/19	18.05	“Prison segregation unit risk assessment… planned removal from H/B to the segregation unit… Aware a nurse visits segregation daily.”
SystmOne record	30/3/19	12.17	Seen by nurse to review admission to the segregation unit. No concerns. Patient contact: 1 minute.
Inside front page of ACCT Plan	31/3/19	08.50 or 18.50	Under Warning signs and triggers: “Meds 4 his Mental Health Problems”
Assessment interview Page 14 of 70	31/3/19	11.30	“Not getting his meds for mental health problems”
SystmOne record	31/3/19	11.39	Seen by nurse in segregation unit: “Patient not happy stating that his medications have been stopped: Citalopram, Olanzapine and Gabapentin. Discussed with his RMN - states

			he is not on these and has not been on these for a while."
SystmOne record	31/3/19	15.35	Initial ACCT review in segregation. Removed to segregation due to disturbance and assault on staff. Some signs of possible grandiosity in speech content. Had been seen earlier for healthcare round "annoyed as medication stopped" stated to nurse "and you thought it would be a good idea to stop my medication".
Letter to mother (Separate file)	1/4/19		Mr A writes letter to a family member complaining (among other things) that his medication has been stopped: "They drove me to this … by 1. Stopped my meds"
On-going record p45	1/4/19	19.45	(Mr A) alleged that he had taken a paracetamol O/D on a background of anger that he had not been released on HDC
SystmOne record	1/4/19	20.24	Nurse review in segregation as stated he had taken 16 paracetamol. Refused to show blister packs or evidence. Staff to keep an eye on him.
On-going record, p47	2/4/19	06.30	"Talking to himself"
ACCT Case review in On-going record p27	2/4/19	10.30	Mr A described issues with his medication…being stopped. Mental health nurse who attended said he would look into his medication.
SystmOne record	2/4/18	14.41	Record of ACCT review in SystmOne. Mr A irritable and angry: "his main issue is prison related and concerns his perception that he should have had his HDC approved and then released 3 weeks ago"
SystmOne record	4/4/19	13.50	Seen at the door by nurse with governor for segregation review. "Raised no issues about having to remain in the seg. No thoughts of deliberate self harm."
On-going record, p48	2/4/19	15.00	Concern was noted that Mr A felt staff were, "stitching him up"
SystmOne record	4/4/19	18.15	Seen by nurse. No suicidal thoughts.
On-going record, p51	4/4/19	19.15	(Mr A) had tried to burn a pile of newspaper pages, when asked why, replied "You know" Subsequently assaulted officer while being moved to a different cell.
On-going record, p53	5/4/19	08.20	Argumentative, shouting aggressively
SystmOne record	5/4/19	09.58	Seen by nurse. "Reports of flooding his cell last night and being disruptive. No healthcare concerns…raised by staff. No thoughts of deliberate self-harm."

SystmOne record	6/4/19	11.30	Seen by Health Professional. “No thoughts of deliberate self harm.” Mr A alleged that he had been injured during his removal to the segregation unit.
SystmOne record	6/4/19	12.01	Above-mentioned physical injuries sustained by Mr A documented.
On-going record, p55	6/4/19	19.00	“Demanding to see healthcare but would not state why”
After 6/4/19, multiple entries relate to Mr A writing his life story.			
SystmOne record	7/4/19	14.49	Seen by nurse. No suicidal thoughts.
SystmOne record	8/4/19	08.43	Seen by nurse at the door with officer present. No thoughts of deliberate self-harm.
SystmOne record	8/4/19	14.13	Seen by nurse. “Pleasant when seen.”
SystmOne record	9/4/19	09.16	Daily segregation healthcare review: No healthcare issues.
On-going record, p59	9/4/16 (sic)	15.30	“Talking to others about conspiracy theories”
On-going record, p59	9/4/16 (sic)	16.30	Possible signs of grandiosity noted in the clinical record.
ACCT Case review, in On-going record p30	9/4/19	17.00	‘Caremap reviewed’ - “Nurse checking with doctor regarding meds”. “Spoke about his medication which the nurse said she would look into for him.”
SystmOne record	9/2/19	17.26	Nursing record of the above ACCT review. Possible signs of grandiosity noted in the clinical record. Stated that he was no risk to himself. “Task sent to discuss his request for medication in MDT”
On-going record, p59	10/4/19	03.00 and 04.00	“Talking out aloud to self”
SystmOne record	10/4/19	10.52	Seen by nurse. No healthcare concerns…raised by staff. No thoughts of deliberate self-harm.
SystmOne record	11/4/19	08.38	Seen by nurse. No thoughts of deliberate self-harm.
SystmOne record	12/4/19	08.33	Seen by nurse. No thoughts of deliberate self-harm.
ACCT Case review, in On-going record p31	12/4/19	14.15	Attended by Health care worker and a CPN. “No further care map issues have been completed”
SystmOne record	12/4/19	16.02	Nurse record of the above ACCT review. Possible signs of grandiosity noted in the clinical record. “No indication of mental health

			concerns today. No indication of psychosis or thought disorder but did objectively appear narcissistic .“(sic).
SystmOne record	13/4/19	10.55	Seen by nurse. No thoughts of deliberate self-harm.
On-going record, p62	14/4/19	10.00	Possible signs of grandiosity noted in the clinical record.
SystmOne record	14/4/19	10.49	Seen by nurse. No healthcare concerns…raised by staff. No thoughts of deliberate self-harm.
On-going record, p63	14/4/19	22.30	Possible signs of grandiosity noted in the clinical record.
SystmOne record	15/4/19	08.35	Nursing review of admission to segregation unit: No thoughts of deliberate self-harm.
ACCT Case review, in On-going record p33	15/4/19	14.30	“He is occupying himself in his cell with writing and mathematics. Some of his statements were random and perhaps grandiose” “A caremap action re medication is still incomplete…”
Caremap p24	15/4/19		Medication stopped - action required: “medication review by nurse in the MH Team”
SystmOne record	15/4/19	16.19	Nursing record of attendance at above ACCT review. “Reports is doing OK in segregation. Remains grandiose in perception of self to others. Denies any thoughts of current self harm…. Keyworker to report back around alleged (sic) missing medication.”
On-going record p64	16/4/19	00.00	Mr A was shouting and woke other prisoners. When an officer spoke to him, he talked about his substance misuse and mental health as a child. The officer noted that. “That was very random and out of character.”
SystmOne record	16/4/19	08.36	Seen by nurse at door along with officers: “...nil concerns raised today. No thoughts of deliberate self-harm.”
On-going record p64	16/4/19	11.00	“Had a chat with (Mr A)… Appears a bit lost as talking about all sorts of stuff…”
On-going record p66	16/4/19	18.00	Pressed cell bell saying he is ‘dying’. States he is sweating, feeling sick, palpitating…
SystmOne record	16/4/19	19.07	Reviewed by healthcare. ? viral infection, for reassessment tomorrow.
On-going record p66	16/4/19	22.30	“Put on his cell bell told me he wants to speak to Oscar, didn’t want to tell me why”
On-going record p66	17/4/19	00.00	Clear evidence of psychotic paranoid beliefs noted by an officer.
SystmOne record	17/4/19	08.56	Substance misuse team - release plan faxed to community drug team.
On-going record p66	17/4/19	09.35	Possible signs of grandiosity noted in the clinical record.

On-going record p65	17/4/19	11.30	Clear evidence of psychotic paranoid beliefs noted by an officer
On-going record p65	17/4/19	12.15	Clear evidence of psychotic paranoid beliefs noted by an officer
SystmOne record	17/4/19	12.42	Nursing record: "Seen on the segregation exercise yard following reports of collapsing…face down on the concrete… (possible psychotic paranoid beliefs noted by nurse) …escorted back to his cell…due for release tomorrow and appears very anxious…I will review later…"
On-going record p65	17/4/19	13.10	Clear evidence of psychotic paranoid beliefs noted by an officer
SystmOne record	17/4/19	14.58	Seen by substance misuse team - spoke to him through the door - discussed prescribing arrangements for methadone following his release the next day.
On-going record p65	17/4/19	16.50	"Declined tea meal…states he is fasting."
SystmOne record	17/4/19	17.02	Nursing record: "Reviewed this afternoon in the segregation unit - appears well."
ACCT Case review, in On-going record p35	18/4/19	08.50	"(Mr A) is being discharged today following all outstanding issues being dealt with."
SystmOne record	18/4/19	09.48	"[Mr A] refusing methadone stating it makes him ill."
SystmOne record	18/4/19	10.29	Nursing record of attending ACCT review: "There was no evidence which would suggest the presence of acute mental illness". Released this morning and he reported to be looking forward to leaving prison…no thoughts of self harm…"
SystmOne record	18/4/19	11.21	Substance misuse worker: "..released today…declined today's dose of methadone, reporting he didn't need it. I spoke to him twice and on both occasions he declined. He has a community drug team appointment today."
Page 172 in drug & alcohol pdf	18/4/19	15.55	Mr A was due to have a 90-minute appointment with the community drug team on release but this clashed with his probation appointments that day so he was offered a brief appointment with an alternative team close to his probation appointment. This focused on ensuring he had his methadone script. Mr A attended this brief appointment with a relative. There is no description of his mental state.

			Methadone prescribing and follow-up appointment arranged. Harm reduction advice given.

APPENDIX II Terms of Reference

1. Review the internal investigation and assess the adequacy of its findings, recommendations and action plan.
2. Compile a comprehensive chronology of events leading up to the incident.
3. Review the care, treatment and services provided by the inreach services, substance misuse services and primary care from Mr A's first contact with services to his release from HMP Ranby.
4. Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
5. Review the adequacy of risk assessments and risk management, including specifically the risk of Mr A harming himself or others.
6. Review his mental health care in the lead up to his release and the release planning.
7. Review his medicine management throughout his prison stay.
8. Review and assess compliance with local policies, national guidance, and relevant statutory obligations.
9. Provide a written report to NHS England & Improvement that includes measurable SMART and sustainable recommendations that have been co-produced with the affected organisations.
10. Create a learning document with the key learning points for wider dissemination.
11. Undertake an assurance follow up review six months after the report has been published, to assure that the report's recommendations have been fully implemented.
12. Produce a short report that may be made public.

APPENDIX III Documentation read and interviews held

Documentation

- Community Mental Health Team (CMHT) records, December 2014 to Mr A's discharge in November 2018.
- Community Drug Team records dating from 2012 to 2019.
- Prison health care records, including entries from mental health in-reach service, relating to Mr A's period in HMP Ranby from 18/7/18 to his release on 18/4/19.
- Liaison and Diversion Team records starting from Mr A's arrest on 19th April 2019.
- Nottinghamshire Healthcare NHS Foundation Trust Level 2 Investigation and subsequent Quality Improvement Plan.
- Pre-sentence psychiatric report on Mr A dated 13th March 2020.
- On-going records kept by custody staff from Mr A's period in the segregation unit, 29/3/19 until his release.
- HM Coroner Prevention of Future Deaths Notice following the inquest into the death of Mr B, dated 18th January 2022.

Interviews

The investigators conducted interviews with Mr A in prison on 18/11/2021 and, during the period 21st - 27th January 2022, with several members of healthcare staff from HMP Ranby: the Head of Healthcare, the Modern Matron for Mental Health, Nurses 1 and 2 who worked with Mr A and the Lead Pharmacist for Offender Health. The investigators also met with two members of prison staff who provided information about the liaison between prison officers and healthcare in the segregation Unit in HMP Ranby, both in April 2019 and at present.

The lead investigator had a discussion with the senior partner at Mr A's GPs' surgery.

APPENDIX IV: Glossary

Term	Description
ACCT	Assessment, Care in Custody and Teamwork
BNF	British National Formulary, the authoritative guide to prescribing medication and dose ranges
DIP	South Derbyshire community substance misuse team
DNA	Did not attend an appointment
gabapentin	A drug used for epilepsy and for pain due to nerve damage. It is a powerful anti-anxiety drug
GAD-7	see PHQ-9, below
GP	general practitioner
H/B	Houseblock, referring to locations within the prison
HDC	Home Detention Curfew, the scheme by which a prisoner can be released 'early' subject to an electronically monitored curfew
IMB	Independent Monitoring Boards monitor the treatment received by those detained in custody to confirm it is fair, just, and humane
MDT	Multi-disciplinary team
methadone	A prescribed opiate substitute for street opiate use
MHIT	Mental health inreach team, also called the MDT in the context of this investigation
naloxone	A medication to reverse the effects of opioids, for example, following an overdose
olanzapine	A medication usually prescribed for the treatment of serious and enduring mental illness
On-going record (in Chronology)	Information extracted from the “Defensible decision to segregate a prisoner on an open ACCT” records dated 29/3/19 to Mr A’s release on 18/4/19
PHQ-9 GAD-7	The PHQ-9 and the GAD-7 are questionnaires which are widely used in primary care to assess the severity of depression and anxiety, respectively.
RMN	Registered Mental Nurse
schizophrenia and schizoaffective disorder	Schizophrenia is an enduring mental illness characterised by delusions (false beliefs) and hallucination (false perceptions). Schizoaffective disorder has similar symptoms but there is a more prominent element of mood disorder in addition, such as depression or elevation of mood
‘spice’	Synthetic cannabinoid compounds
SystmOne	Electronic database for healthcare records used in prisons

APPENDIX V: Psychological Approaches CIC

Psychological Approaches is a community interest company delivering a range of consultancy in collaboration with mental health and criminal justice agencies; our focus is on the public and voluntary sector, enabling services to develop a workforce that is confident and competent in supporting individuals with complex mental health and behaviour (often offending) that challenges services. We have a stable team of six serious incident investigators, and offer a whole team approach to each investigation, regardless of the specific individual or panel chosen to lead on the investigation. Our ethos is one of collaborative solution-seeking, with a focus on achieving recommendations that are demonstrably lean – that is, achieving the maximum impact by means of the efficient deployment of limited resources.

Investigators

Dr Deborah Brooke, Consultant Psychiatrist, was the lead investigator for this report. Deborah's co-investigator was Ms Lisa Dakin, Mental Health & Learning Disability Nurse Consultant and specialist in secure inpatient and prison healthcare.