Investigation into the circumstances surrounding the death of a man at HMP Acklington in August 2007

Report by the Prisons and Probation Ombudsman for England and Wales

June 2008

This report considers the circumstances surrounding the death of a man. The man was found hanging in his cell at HMP Acklington at 9.20am on the morning of 29 August 2007, the day of a strike by the Prison Officers' Association. He had last been seen alive at 7.30am. The man was 39 years old.

The man had been released on licence from a four and half year sentence in March 2006. He was recalled for breaching the conditions of his licence in October 2006, but did not in fact return to prison until July 2007. The man was not typically a troubled or depressed man during his periods in custody. His death could not have been predicted and his actions are regarded as totally out of character. His death came as a great shock to the man's friends and family, to whom I would like to offer my sincere condolences.

My colleague led the investigation with an assistant. I would like to thank the Governors of HMP Acklington and Durham, and their staff for their cooperation. I am also grateful to the Northumberland Primary Care Trust who produced a clinical review of the care that the man received. I must apologise for the delay in issuing this report.

I have not been able to judge with any certainty whether the man's actions were a cry for help or if he intended to take his life. However, I am confident that staff in both Acklington and Durham acted appropriately in meeting his immediate needs. Nevertheless, I have found areas for improvement in the healthcare screening process and the G3 unit at Acklington. I have also made a recommendation regarding the transfer process from Durham (this has already been accepted and put in place by the Governor).

I have been particularly concerned whether the fact of the POA industrial action could in any way be related to the man's death. I cannot discount that possibility, but neither have I found any evidence to show that the two things were linked.

During 2007, the number of apparently self-inflicted deaths in prison custody increased by 37 per cent (92 deaths, compared to 67 in 2006). Thirteen prisons had three or more such deaths, one of them being Acklington, a category C training prison. Although self-inflicted deaths are more likely to occur in local prisons, it is simply not the case that training estate is immune. Deaths in category C prisons seem to be on the increase, a reminder of the title of a major study conducted by the former Chief Inspector of Prisons: suicide is everyone's concern.

Stephen Shaw CBE
Prisons and Probation Ombudsman **June 2008**

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SUMMARY

This man was released from custody in March 2006 after serving 22 months of a four and half year sentence. He was recalled to prison on 10 October 2006 for breaching the conditions of his licence. Despite his recall, the man absconded and was not brought back into custody until 7 July 2007. He was required to serve a further 19 months in custody.

On recall, the man was taken to HMP Durham. He was allocated a cell in C wing, one of the smaller residential wings at Durham, where prisoners benefit from an active regime and have up to eight hours out of their cells on weekdays. He quickly adjusted to being back in prison and mixed well with other prisoners.

After spending six weeks at Durham, the man was transferred to Acklington. He was told about his transfer the day before moving during a short assessment with a member of healthcare. During the assessment he told the nurse that he was "happy" to go.

As the man was a licence recall prisoner, the Observation, Categorisation and Allocations Unit (OCA Unit) did not directly inform him of the transfer. At this time it was not the policy to do so, whereas the OCA Unit would inform all other types of prisoner. As a result, licence recall prisoners did not have the opportunity to raise any security concerns about moving – unless they were aware that this could be done by submitting an application request form. My investigator discussed this with the Governor of Durham, his Deputy and the OCA Unit. During the meeting my investigator made a recommendation based on the OCA Unit's advice to revise the practice and routinely issue a paper slip to licence recall prisoners. The slip would inform the prisoner of the transfer and indicate that any concerns about moving for security reasons would be investigated by the safer custody or security departments. The Governor implemented this immediately. I commend his positive and speedy response to feedback.

On arrival at Acklington, the man appeared anxious and said he was unhappy to be at the prison. He said he was scared of unfounded rumours spread whilst he was at Durham that he was a sex offender. He was not clear where the rumour had started or of whom he was afraid.

The man only mentioned his anxieties once – during his initial assessment in reception. The officer noted his concerns but did not record them in detail. A member of healthcare recorded that the man was unhappy with his transfer, but no further comments were noted. I have recommended that the reception healthscreen assessment form be revised to make it mandatory for further comments to be provided when concerns are raised by prisoners. I also recommend that officers are reminded of the importance of keeping comprehensive and explicit records.

In acknowledgement of the man's concern for his safety, he was immediately allocated to the G3 unit. G3 unit is informally known as a 'poor copers' unit for prisoners who feel at risk in the main prison area. The unit is based on the third floor of G wing – a normal location wing. The unit has a very restricted regime and prisoners regularly spend up to 22 hours in their cells. Prisoners are not routinely

given a mental health screen on allocation to the wing despite being identified as 'poor copers'. I have made a recommendation about revising the regime to make it more purposeful and inclusive. I also recommend routinely giving prisoners new to G3 a mental heath screen.

New receptions to Acklington usually go to the induction wing on their first night. However, the man's level of anxiety and concern was such that he bypassed the induction wing and went straight to G3. He received his induction on the unit. Although staff on G3 were aware that the man was worried about "bother" they were unaware of the full extent of his concerns. The documentation completed by reception staff indicated a level of genuine concern and anxiety, but did not go into any further detail.

The man's anxiety was considered great enough to segregate him in a safe environment within the prison. Staff stressed to my investigator that the man did not appear depressed or at risk of self-harm at any point whilst on G3. I believe that staff on G3 cared for the man appropriately according to his presentation. Staff quickly recognised the man's wish to transfer and assured him that they would help with his application to do so. One officer in particular was very helpful and said that he would personally speak to the OCA Unit when he returned from four days of leave. The man had been allocated a personal officer, but there had been little interaction between them. I have commented on the ineffectiveness of the personal officer scheme at Acklington and recommended that it is revised so that officers are allocated to prisoners, and not cell numbers. Unfortunately, the man died before the Officer returned from leave.

The man's death occurred on the morning of the Prison Officers' Association (POA) strike. The impact of the strike on resources and the response has been taken into consideration in this report. I have found no evidence of a link between the man's actions and the strike. Although prisoners were unlocked considerably later that morning, it is not possible to say whether unlocking the man any earlier would have prevented his death. In the event, despite there being only a skeleton staff, there was an adequate number of people on the wing to respond to the situation.

I have not been able to say with any certainty whether the man's course of action was a cry for help or intentional. Staff acted appropriately in meeting his immediate needs on arrival at Acklington and they had no reason to believe that he would attempt to harm himself.

I conclude that the prison's response to the man's death was good, given the unusual circumstances. I have commended the actions of those staff who remained in the prison whilst the strike took place and who carried out their duties under extreme pressure and in unfamiliar circumstances.

THE INVESTIGATION PROCESS

1. The investigation was opened on 30 August 2007 by one of my investigators. She discussed the circumstances surrounding the man's death with the liaison officer at HMP Acklington. Due to the POA strike the previous day, only limited information was then available. My investigator agreed to return to the prison on 3 September to collect the papers relating to the man's time in custody and to receive a full briefing from the Governor.

2. The briefing on 3 September was attended by my investigator, the Governor, liaison officer, and a representative from the Independent Monitoring Board (IMB). Although invited, the POA did not attend. My investigator was given an overview of Mr the man's custodial history, the impact of the POA strike, and the events on the morning of 29 August.

3. Interviews were held at both HMP Acklington and HMP Durham. An assistant was with my investigator with her enquiries at HMP Acklington. The interviews at HMP Durham were carried out by my investigator only.

4. A clinical review of the man's care in custody was undertaken by Northumberland Primary Care Trust (PCT). An extensive review was not required as the man had minimal contact with healthcare, primary or secondary, whilst in custody. The clinical reviewer based this on documentation provided by the prison, transcripts of interviews carried out by my investigator, and his own telephone enquiries.

5. One of my family liaison officers contacted the man's family. She was directed to speak with the man's listed next of kin, a close family friend. Confirmation of the family's desire for the listed next of kin to be the primary point of contact was provided by her solicitors.

6. My investigator and family liaison officer met with the man's next of kin, her daughter, and a solicitor on 10 December 2007. The man's next of kin asked for the following questions to be answered:

    - What were the full conditions of the man's licence?
    - What were the circumstances of his return to prison?
    - Why was the man moved from Durham?
    - How soon would the man have been able to contact friends/family once he had arrived at Acklington?
    - Did he make any applications for visiting orders? How many prisoners were on G3? What is the prisoner/staff ratio on a normal shift?
    - Did the man have a personal officer?
    - Was the man seen by a doctor at Acklington?
    - How many hours a day would the man have been in his cell?

    All of these questions have been addressed within this report.

7. During the investigation process it was brought to my investigator's attention that another prisoner who had died in custody at HMP Frankland the previous year, was the man's second cousin. The family's solicitors questioned whether there was a link between the cases. The man had said he was concerned about (mistaken) rumours of being a sex offender. The man's second cousin had wrongly been placed in a vulnerable prisoner wing (used to accommodate sex offenders). When he was relocated to the correct wing the move was announced over the radio network and some prisoners in the vicinity heard what was happening. The solicitor questioned whether this resulted in the man's second cousin being labelled a sex offender by other prisoners. Such stigma can lead to bullying.

8. On reception to Acklington, the man told an officer that he was worried about rumours that he was a sex offender. He did not explain how the rumours originated, but did say that he felt it would cause him trouble with other prisoners at Acklington. The solicitors asked my investigator to explore the potential connection between the deaths of the two cousins.

9. My investigator spoke to her colleague, who had investigated the circumstances surrounding the man's second cousin death. This investigator provided the following summary:

> "This man was transferred from Durham to Frankland on 17 July 2006. On reception he was placed mistakenly on D wing (for vulnerable prisoners) for a matter of hours. The mistake was realised and he was moved from D to G wing on the same day. A message was broadcast over the radio system, not a tannoy or any other public address system, advising staff that the move was taking place. It was thought by a member of staff that prisoners had overheard the broadcast … recognising the potential of that mistake [they] reported the matter via a security incident report (SIR) to the Security Unit.
>
> "On the following day (18 July) as a result of the SIR an intelligence assessment was made and the Security Manager and the responsible Governor assessed the matter. There were no indications of any problem rising from or related to this incident.
>
> "On 2 August a Senior Officer from the Safer Custody Unit checked on this man and noted that no repercussions had taken place and that he was settled and remained on G wing.
>
> "This man died during the night of 7/8 September in a single cell by hanging. No mention was made during any of the interviews [this investigator] had with this man's friends, fellow prisoners or staff that knew him, that this incident had taken place or that it had affected this man in any way."

In light of this information, my investigator was satisfied that there was no way to determine whether the man's second cousin experience had impacted on the man's time at Acklington. There is one suggestion (see paragraph 45 below)

that the man was concerned because a member of his family had been (wrongly) identified as a sex offender. Beyond that, there is no known link between what happened to the man’s second cousin and the rumours about the man.

ESTABLISHMENTS

HMP Acklington

12. HMP Acklington opened in 1972 as a category C prison. The prison is situated on a former RAF station near Amble in Northumberland. It has the capacity to house 882 prisoners.

Accommodation

13. The prison is split into two sites – the main site and vulnerable prisoners unit (VPU). The VPU is separated from the main site by a natural fence line and is populated only by sex offenders. The main site comprises five wings:

    - D wing – induction
    - E wing – main residential unit
    - F wing – main residential unit, plus drug strategy wing
    - G wing – main residential unit, with a landing cordoned off for prisoners requiring protection (G3).
    - K wing – super enhanced

14. D, E, F and G have four enclosed landings each holding 28 prisoners. A senior officer and five officers are allocated to a wing. Each landing has one member of staff on duty. The staff to prisoner ratio is one officer to 28 prisoners.

15. G3 is a landing on G wing that is specifically cordoned off for prisoners who require protection from the main wing but do not fit into the criteria for the VPU, i.e. they are not sex offenders. It is unofficially referred to as the 'poor copers' wing. Reasons for seeking a safe environment away from the main prison include debts and bullying. If a prisoner asks to stay in G3 he is encouraged to apply for a transfer to another prison. However, pressures on the prison population often prevent a quick transfer. In some circumstances prisoners are content to remain in G3, but due to the restricted regime this is not ideal.

Healthcare

16. Northumberland Care Trust provides healthcare to the prison. Nurses and a medical officer are employed to deliver primary healthcare during the daytime, seven days a week. The healthcare team is also responsible for the administration of medication, either weekly or monthly, to prisoners who have been assessed as capable of keeping it in their own possession. Prisoners who require in-patient nursing care are transferred to an outside hospital or another prison with 24 hour healthcare facilities.

HM Chief Inspector of Prisons' report

17. HM Chief Inspector of Prisons carried out an announced inspection of Acklington in December 2006. The inspection found that the prison failed to provide sufficient purposeful activity and also struggled to sustain a safe and decent environment.

18. The Chief Inspector's report highlights that time out of cells is poor and there is insufficient purposeful activity for a training prison. During the inspection, less than half the prisoners were off the wings and engaged in activity. Limited training and education was available. What was on offer was of a satisfactory standard, but considered to be poorly managed.

19. The Governor of Acklington, was invited by my investigator to comment on the inspectorate's findings. I understand the prison is to be further expanded by 64 places from April 2008. The National Offender Management Service has also ensured that activity spaces are sufficient to at least meet the additional need. The expansion will also, for the first time, allow full-time access to learning and skills to both sides of the prison through one centre. A range of in-cell learning packs is available for prisoners who are unable to access learning and skills at any particular time.

20. An Adult Learning Inspectorate inspection in February 2008 graded the prison as "satisfactory". This was an improvement on the 2006 grading of "inadequate". The inspection found that the prison "[had] demonstrated that it is in a good position to make improvements. The early signs of improvements identified at the previous inspection have continued. Many effective actions have improved the quality and range of provision."

21. With regard to time out of cell, the above measures are an indication of increased and improved quality of provision. Further options are being explored to increase purposeful activity.

22. According to the Chief Inspector of Prisons' 2006 report, drugs and bullying were rife in the main prison. Since that report, Acklington's Violence Reduction Strategy has been re-launched, with a local Violence Reduction Information Report (VRIR) system introduced. This is linked to security intelligence and has enabled better identification and control of bullies. There have also been improvements in supply reduction of illegal drugs. Overall, for the last three years the prison has come within its target for mandatory drug testing. There is also an accredited drugs programme running three times a year, and a Counselling, Assessment, Referral, Advisory and Throughcare (CARATs) team in place.

23. The Chief Inspector's report found reception and first night arrangements to be weak. However there were few incidents of self-harm and some commendable examples of care for those at risk.

HMP Durham

24. HMP Durham was built in the early nineteenth century and has been undergoing a major refurbishment programme during the last ten years.

Accommodation

25. Durham is a category B local prison serving the courts in the area. Category C prisoners from the North East region are usually transferred from Durham to Acklington, although transfer is also dependent on population pressure and available spaces. Prisoners remain at Durham until a space at a training prison becomes available. The average stay for a new prisoner is two months. Prisoners on licence recall stay for approximately one month before moving to a training prison.

26. There are seven wings plus a segregation unit and healthcare. The operational capacity is 981 prisoners. The main residential wings (B and D) can accommodate 200 prisoners each and C wing holds an additional 93.

Regime

27. The prison has what it terms a non-collusive regime. This means that prisoners are not segregated from the main prison area due to the nature of their offence. For example, sex offenders are not housed separately and there is no vulnerable prisoner unit. All prisoners associate and work together.

KEY FINDINGS

HMP Durham

28. As noted, the man was recalled to prison on 10 October 2006 after breaching the conditions of his licence. He disappeared for a period of nine months, but was spotted in Newcastle in July 2007. He was taken into custody at HMP Durham on Friday 7 July 2007.

29. On arriving at Durham, the man was taken through the reception process. Every prisoner coming into custody, whether they are a new prisoner or on licence recall, is subject to a cell sharing risk assessment (CSRA) and health screen. This assessment uses a series of questions to determine whether a person is either at risk to themselves or others. The assessment is based on documentation accompanying the prisoner (prisoner escort forms or suicide and self-harm warning documents provided by the police), information given by the person themself, and staff observations. In the section for recording any observations, the CSRA referring to the man states "no immediate concerns". He was declared fit to be on a normal location and able to share a cell if required.

30. The second part of the reception process is the health screen. This was conducted by a reception nurse. During the screen this nurse asked the man about his physical and mental health. No concerns were raised and the man was declared "fit and well" with no further action required. He was taken from reception to the first night centre.

31. At the first night centre on the induction wing the man was given a telephone PIN number and sufficient credit to make a call. The prison regime was explained to him. Although this was not his first time in custody at Durham he underwent the same process as any new prisoner.

32. From Monday to Thursday each week, new receptions have an immediate needs assessment within 24 hours of coming into the prison. (If they arrive on a Friday, it takes place the following Monday.) The assessment determines any immediate needs or concerns regarding housing, benefits, family, employment or legal support. The man's immediate needs assessment took place on 9 July.

33. An officer conducted the man's assessment. She explained the assessment process to my investigator. As part of the assessment, the officer contacts the prisoner's offender manager (probation officer) to let them know which prison they are in. In the event that the prisoner is unsure why they have been recalled, the officer will, where possible, provide them with more information. In the comments and observations box at the foot of the assessment paperwork for the man, she has written "outside probation notified. Licence recall procedures explained."

34. My investigator asked this officer if she could remember her interview with the man. The officer could not and asked to see his photograph in case this

prompted any specific recollection. It did not. She explained that she conducts hundreds of interviews and, unless prisoners present as being particularly problematic or vulnerable, they do not stand out from the crowd. The officer went on to say that, had the man raised any concerns or if she herself had been worried about him, she would have noted it on the form and discussed her concerns with induction wing staff.

35. On 11 July 2007, the man was moved from the induction wing to C wing. This is a voluntary drug testing wing that is half the size of the other wings in the prison. At maximum capacity the wing holds 93 prisoners over four landings. Due to the smaller numbers, prisoners receive more staff attention. Prisoners go to this wing for three reasons:

- It is guaranteed to be free of any illegal substances.
- They have been identified as "good candidates" whilst on the induction wing (meaning not likely to cause any trouble for staff).
- They would fair better on a quieter and smaller wing.

36. Despite the vulnerability of some of the prisoners it would be unfair to label it a 'poor copers' wing (a term that, in any case, I dislike). It is not clear why the man came to the wing but, given no concerns or risks were raised, my investigator believes he might have been placed on this wing for good behaviour.

37. The regime on C wing is very structured. All prisoners are expected to take part in purposeful activity every day. This means employment in the workshops or wings, education, association or gym. An average week day allows for at least eight hours of activity and association. During the weekend, there are two periods of association, one in the morning and one in the afternoon. Prisoners attend one session each day and attendance is established by rota. Being based on C wing will have meant that, whilst at Durham, the man was in a safe environment with an acceptable amount of time out of his cell.

38. It is documented in the man's history sheet that he quickly settled in C wing and had no concerns or problems. An officer on this wing noted that the man is a "mature individual who keeps himself to himself". A second entry on 28 July by the same officer noted that the man had begun to mix with his peers, "but needs to be careful who he mixes with". It is not clear from the entry what this officer meant by this. My investigator was unable to interview the officer as he was on long term sick leave and none of the other officers interviewed knew what this officer meant. As far as staff were aware, the man was not involved in any trouble on the wing or was the victim of any bullying. There are no further entries in his history sheet to suggest that anything sinister was meant by the comment. My investigator did not speak to any prisoners at Durham. None had asked to speak to her about the investigation, and when she visited there were no prisoners on C wing who had been there at the same time as the man. However, my investigator was satisfied from talking to a cross-section of staff (including the chaplain) that there were no indications that the man had suffered any bullying.

39. On 16 August, the man was seen by a nurse from healthcare to ascertain whether he was "fit to transfer" to another prison. Transferring from a local prison to a training prison once a space becomes available is part of normal progression through the prison system. The "fit for transfer" interview with a member of healthcare is a pretty cursory assessment. It comprises a list of basic questions covering whether the person has any medical problems, or needs any medications dispensed to take with them on transferring. The man was noted to have no medical needs. He was also asked how he felt about transferring. The reply recorded was "happy".

HMP Acklington

40. The following day the man moved to HMP Acklington. On arrival he went through the same reception process as he had at Durham. However, on this occasion when he was asked how he felt about coming to Acklington, he appeared concerned and anxious. An officer completed the initial risk assessment interview with the man. The first question on the form is, "Have you any immediate concerns/worries about being at Acklington?" The man said he had. The officer wrote, "Knows for a fact that he will have 'bother' here. Unknown persons. Has requested G3."

41. As noted earlier, G3 is a landing in G wing that offers security for prisoners who feel they cannot cope in the main part of the prison. The vulnerable prisoners unit at Acklington is used solely for accommodating sex offenders. Any vulnerable prisoner who is not a sex offender can request a placement on G3.

42. The landing is split into two spurs. The regime on both spurs is limited as the prisoners are kept separate from both the rest of the wing and the main prison. There is no employment or education on offer, and association is limited to a couple of hours per day. There are two association periods of one half hour session in the morning and a couple of hours during the evening. Spurs take association periods in turn. As a result, on alternate days each prisoner only receives 30 minutes association time. The rest of the time (aside from collecting meals) is spent in their cells. Residing in G3 is a voluntary decision and prisoners can move back to the main prison on request. They can also be moved for negative behaviour.

43. The officer asked the man if he felt staff should be concerned about his well-being. He responded "yes", but no specific details were documented. In response to the question, "Do you feel depressed or suicidal in any way or have you previously committed any act of self-harm?" the officer ticked the 'yes' box. He wrote, "Very anxious ref above comments." Although it is not recorded on the form, the officer recalled in interview that the man said he felt unsafe as rumours were allegedly spread at HMP Durham that he or a member of his family was a sex offender. The man believed that this would cause him some trouble. The officer recorded part of this information in the man's history sheet:

> "Appears genuinely concerned for his safety. Rumours were being spread at Durham he knows there will be 'bother' here from unknown

persons. He appears very concerned about any abuse he will get from the 'windows'. G3 explained to him and offered."

44. The man appeared genuinely anxious. The officer felt that he was presenting as paranoid. The man did not provide any concrete information as to why he was so concerned. However, he did tell the officer that he believed an application for transfer from Durham had been submitted on his behalf under false pretences by another prisoner. My investigator did not find any substance to this claim. His transfer was a routine procedure and there was no evidence of bullying or rumour spreading found in Durham.

45. My investigator asked this officer about his interview with the man, particularly with regard to evidence of depression, self-harm or suicide. Although the man had admitted to self-harming in the past and appeared anxious and concerned for his safety, the officer did not feel that he presented as a risk to himself at that time. The officer stressed that, if he had thought the man's concern went beyond paranoid anxiety, and there had been signs of depression or risk of self-harm, he would have opened an Assessment, Care in Custody and Teamwork (ACCT) form. (ACCT is the Prison Service's process for monitoring and supporting prisoners believed to be at risk of suicide or self-harm.) Nevertheless, he treated the man's concern as genuine and allocated him a space in the G3 unit. He said that the man was very relieved and thanked him. It is important to note that this was the only time that the man mentioned his concerns about the sex offender rumour to anyone.

46. Before being moved to a wing, prisoners are routinely issued with a reception pack (containing tobacco, chocolate, drinks, breakfast items etc) and £2 telephone credit. The man did not make any telephone calls. A second officer escorted the man to G3. He knew that the man was going to G3 for his own protection, but no more than this. The assessment officer had not discussed the reason with him. The documents that went with the man to G3 contained a cursory reference to him being worried about "bother" but gave no further explanation.

47. An officer on G3 spoke to the man the next morning. The man explained that he was expecting trouble at Acklington, but did not go into any detail. This officer noted that the man was "very vague" about why he was on G3. Aside from saying he felt he should not be at Acklington, he would not elaborate. This officer told my investigator that every time he spoke to the man he would say, "I need to get away from this jail." He tried to reassure the man, telling him he was safe on G3. However, the man continued to talk about wanting to transfer out of the prison. He never referred to specific prisoners and never detailed any particular problems.

48. Apart from not wanting to be at Acklington, the man seemed fine. As the days passed he became more sociable and spent association periods out of his cell. Although settled he did not make any contact with his friends or family; neither did he send out any visiting orders. The personal officer scheme provides prisoners with a specific officer with whom they can raise issues or ask questions. At Acklington, personal officers are allocated seven cells each,

rather than specific prisoners. The cells allocated remain fixed, so if a prisoner moves cell (which can be a frequent occurrence) they also move personal officer. This makes building personal officer relations difficult. Personal officer interactions are recorded on a prisoner's history sheet.

49. The officer on G3 spoke to the man again on 23 August about a transfer. Prisoners are usually required to say which prison they would like to move to and the application is then processed by the OCA Unit. The officer asked the man where he would like to go. The man confirmed that he would be happy to move anywhere in the country. The officer told the man he would help him submit a transfer application, but that the two senior officers (SO) in the OCA unit were both off duty and he was himself due to go on leave for the next four days. He said if the man was happy to wait until 29 August, he would personally speak to a particular SO on his return. The officer also explained to the man that his willingness to go to any establishment would make the process quicker and easier, and that the SO would be able to advise which prisons had spaces available. My investigator asked this officer whether he felt the man was accepting of this help and willing to wait until his return. The officer confirmed that he was, and said that the man appeared calmer as a result of their discussion.

50. Approximately three days later, the man spoke to the same officer as previously about transferring to another prison but did not explain the reason. The officer gave him a transfer application form and offered to pass it to the OCA Unit once completed. Again, the man appeared content with this although he did not complete or submit the transfer application form.

51. At 6.00pm on 28 August, the man was out for evening association. One of the officers on duty, locked the spur gate (access to cells is restricted during association period) for an hour. At approximately 6.30pm, the man approached him and asked to be taken back to his cell early. He gave no reason for the request. This officer stressed to my investigator that the man did not appear troubled or distressed. On returning to his cell the man made no further requests. This officer last saw the man at approximately 7.20pm as he performed the evening roll check. (This is a procedure when officers look through the observation panel in the cell door to make sure that the right number of prisoners are present, located in the correct cell, and that there are no obvious problems.) At this time the man was sitting on his bed and appeared fine. This officer finished his shift at 8.30pm.

52. During the handover to night staff, no issues or concerns were flagged regarding any of the prisoners on G3. An operational support grade (OSG) came on duty at 8.45pm. At night, an OSG is responsible for patrolling all the prison wings and performing checks on prisoners. Night roll checks are performed at approximately 9.00pm, 10.30pm and 5.30am. During the night there is no requirement for verbal interaction, the checks are purely visual unless the prisoner is at risk of self harm or suicide. The OSG told my investigator that on all three roll checks the man appeared fine, and there was nothing noteworthy about his behaviour or appearance.

53. The following morning day staff arrived at the prison from 7.00am for a 7.30am start. Circumstances on the morning of 29 August were highly unusual. At 7.00am, the POA announced an unofficial countrywide strike. No prior warning had been given to governors. Acklington's Governor informed his managers of the situation at 7.15am and an emergency contingency plan was put into action. The Governor's office became a command suite and all governors arriving at the prison were called to the office for a briefing, to establish how many staff were remaining in the prison, and to assign roles. By 7.30am, day time operational staff were remaining outside the prison gate and not taking over from night staff. Simultaneously, night staff were leaving the prison and joining the picket line, leaving only a skeleton staff in the prison.

54. At 7.20am, an officer arrived at the gate and picked up his radio and a set of keys before heading to G3 at 7.25am to begin his shift. At this time the night staff were leaving the wing and one or two members of day staff were already present. After a handover, this officer performed a roll check on the landing. He checked all 28 cells, noted that everything appeared normal, and signed the log sheet. To his recollection, the man was lying on his bed. After signing the roll check log, the officer recalls being informed of the strike. All officers on the wing apart from the officer who had just arrived left to join the strike.

55. The remaining officer noted that the roll check for G4 landing had not taken place. He performed the roll check and gave the final figure for G wing to the control room. On return to the office he received a telephone call from a POA member who instructed him to tell a governor that he felt unsafe on the unit with depleted staff and wanted to join the others at the gate.

56. At approximately 8.15am, the deputy governor, three other governor grades, and two principal officers (PO) arrived on G wing to assist with unlocking for breakfast. The remaining told the deputy governor, that he was unhappy and wanted to leave the prison. The deputy governor sought advice from incident command at national level (called Gold Command). The response was that the officer should be given a direct order to remain in post.

57. The deputy governor told the officer to unlock two prison orderlies from F wing to assist with breakfast. The total number of staff on patrol for the wing was eight. The decision was taken to perform a controlled unlock. This meant unlocking a maximum of four prisoners at a time to retrieve their breakfast from the servery and return to their cells. Two cells from either side of the landing were unlocked at the same time. The process began on G1 landing. Two governors staffed the servery with the orderlies, whilst another two governors unlocked the cells. The officer stood downstairs at the end of the G4 landing watching the prisoners go to and from the servery. As soon as prisoners returned to their cells, the next four were unlocked.

58. At approximately 9.30am, prisoners in G3 were being unlocked. The man was in cell number six. It was around 9.40am when the first four prisoners from the landing had picked up their breakfast. One governor opened the observation panel on the man's door and saw him in a kneeling position with his head bent forward. A ligature made from a strip of bed sheet was tied around his neck

and suspended from the strip light fitting. This governor immediately shouted "Code blue, we've got a person hanging" to the second governor. ("Code blue" is the name given to an emergency situation involving hanging or breathing difficulties.) The first governor then opened the cell door and rushed in to support the man's body. The second governor ran into the cell and stood on the bed to try and pull down the ligature. Neither governor was carrying an anti-ligature knife, a piece of equipment that all frontline operational staff are required to carry on their belts.

59. The first governor loosened the ligature in a matter of seconds. The second governor lifted and supported the man's weight whilst the first governor tugged at the bed sheet by the light fighting until it snapped. They placed the man on the floor and loosened the sheet around his neck. The second governor then left the cell and made sure that the prisoners collecting breakfast went back to their cells.

60. The first governor's assessment was that the man had been dead for some time. His arms were blue and legs mottled (cyanosed), rigor mortis had started to set in, and he had urinated. Despite this, the governor placed the man in the recovery position and was about to commence cardio pulmonary resuscitation (CPR) when a nurse reached the cell. She had arrived very quickly as she was already on the wing having been instructed to help with general duties. She had heard the "code blue" call and rushed to the cell. The nurse did not bring the emergency response bag to the cell although it was easily accessible (the bag is located between F and G wing in the healthcare dispensary). Before the governor had the opportunity to start mouth to mouth resuscitation she told him to stop. The nurse told my investigator, "My initial reaction was to jump in and start CPR, but after stepping back and looking at the situation it seemed that would be a very futile exercise because it was very clear that the man was dead." She said that if she had required the emergency response bag, she would have started CPR, used the radio to call "code blue", and asked for the bag to be brought to the cell.

61. A prison doctor was asked to come to the cell and certify death. He arrived at approximately 9.50am. The governor and nurse then left the cell. Due to the exceptional circumstances of the day, it was impossible to implement the routine death in custody contingency plan. Instead, advice was sought from Gold Command on how to proceed.

62. The deputy governor spoke to Gold Command. He was told to block off the observation panel, close the cell and continue unlocking for breakfast. A Principal Officer (PO) remained outside the cell door. It was a delicate situation as staff had to complete the breakfast unlock without drawing attention to the fact there had been a death. As soon as breakfast was over, prisoners were properly informed. A notice was also distributed for those in other wings. The chaplain, who was already in the wing, provided immediate support and counselling to anyone who required it. All those prisoners with open ACCT forms were reviewed by the duty community psychiatric nurse (CPN).

Events after the man's death

63. Although some support was offered to the staff involved, the usual protocol for relieving staff of duties was not possible given the circumstances of the POA strike. There were also other incidents during the day that took precedence. However, counselling and support was offered the next day once the strike had ended and the normal regime resumed.

64. The man's next of kin was listed as a family friend and neighbour. The prison informed her of the man's death. The family friend relayed the news to the man's uncle and the prison chaplain, and the deputy governor later visited him. The prison chaplain told the man's uncle that the prison would assist with the funeral service and meet the expenses. The man's belongings were returned to his aunt to be passed on to his son. The prison chaplain provided continuing support to the man's family and friends for which she was grateful. The man's funeral took place on 7 September 2007. The prison chaplain conducted the service at the family's request. The liaison officer attended representing the Governor of Acklington, along with a SO, the prison's family liaison officer.

ISSUES

Clinical

65. Northumberland Primary Care Trust (PCT) undertook the clinical review.

Summary

66. The man was admitted to HMP Acklington on 17 August 2007 and died by hanging 12 days later. At no time was there any indication during routine healthcare assessment that he had current mental health problems.

Areas considered

Were mental health issues adequately screened in the initial healthcare assessment on 17 August 2007?

67. The clinical reviewer says the screening was carried out by an experienced and appropriately trained member of healthcare staff. On progressing through the screening no mental health issues, past or present, were identified. This reflected the results of many previous assessments conducted during the man's time in custody.

68. During the reception healthscreen, a nurse asked the man whether he was happy to be at Acklington. Although the nurse ticked the 'no' box, the adjacent box that could be used for further comments was not completed. The nurse told the clinical reviewer that the man did not want to discuss his reasons for not being happy and she thought his response to the question was typical of most new receptions. She concluded, therefore, that there was nothing untoward about his comment. The next set of questions related to mental health. The man told the nurse that he had no history of mental health problems, including depression or self-harm. Based on this information, the nurse decided that no further action or intervention was required.

69. The clinical reviewer concludes that the absence of follow up questions to elicit further information when prisoners say they are unhappy to be at the prison was inadequate. I agree. Further to this, the box adjacent to the question that could be used for comments is not clearly labeled. I suggest that the healthscreen form is amended to label the box clearly and indicate that it is mandatory to record further information in the event of a prisoner being unhappy. If the prisoner refuses to elaborate or discuss his concerns, it is equally important to note this. It would demonstrate that at least one follow-up question had been asked in relation to a negative answer.

    I recommend that the Head of Healthcare at HMP Acklington, with the Primary Care Trust, revises the initial reception healthscreen assessment form to make it mandatory for further information to be recorded if a prisoner expresses concerns about being transferred to the prison.

Was resuscitation appropriately withheld?

70. This content that, in the circumstances, the decision not to attempt resuscitation was correct. An experienced nurse and doctor separately concluded that attempts to resuscitate would be futile.

Was the unusual circumstance caused by the strike on that day of any relevance?

71. The clinical reviewer says the circumstances meant that the normal routine (for discipline and healthcare staff) was disrupted. As a result of the strike, prisoners were left locked in cells for longer than usual as staffing levels were critically reduced and a different strategy for unlock had to be employed. It is not possible to say with certainty that unlocking the man's cell at the earlier usual time would have prevented his death. The man had concealed any intention to take his life from staff and fellow prisoners.

Evidence of Good Practice

72. Under the Northumberland PCT verification of death policy, nurses are permitted to use their judgement in deciding if CPR is necessary. Where experienced clinical staff judge that attempts at resuscitation would be futile, this is both humane and respectful to the deceased person and to the staff themselves. In the man's case, the nurse at the time decided against CPR. However, she did not exercise the verification policy as she knew there was a doctor on site who could attend within minutes to pronounce death.

General

Impact of the POA Industrial Action

73. The POA held an unannounced strike on 29 August 2007. The High Court declared the industrial action unlawful, stating that any officer not returning to work would be in contempt of court. This was ignored by most officers belonging to the union. As a consequence, prisons all over England and Wales were left with only a skeleton staff, largely comprising governor grades. The aim was to provide prisoners with meals and emergency medical attention for as long as the strike lasted. Prisoners were made aware of the situation by staff as the morning unfolded and through watching or hearing the news on their radios and televisions.

74. The impact of the strike was felt at all prisons. The industrial action was called at 7.00am. Night staff left prisons and were not relieved by day staff. Governor grade staff were called upon to perform operational duties such as serving meals, with the help of the few officers not members of the POA or who declined to join the strike. Prison orderlies were also tasked to assist.

75. At Acklington, The Governor began informing his governor grade colleagues from 7.00am. He asked them to arrive for duty as soon as possible. After approximately 40 minutes the situation was under control with night staff relieved at around 8.15am. The governors and any staff who decided to stay

and help were allocated responsibilities in accordance with the contingency plan.

76. By this time, patrols had been assigned to wings and they had begun organising how to manage the day, starting with serving breakfast. This would normally have been served from 7.45am with whole landings being unlocked for prisoners to collect their breakfast from the servery. Given the very limited numbers of staff and the importance of maintaining security, this was not possible on 29 August. It was decided to unlock four to six prisoners at a time. This was a time consuming process and meant that serving breakfast took over two hours. It also meant that no prisoner was seen by a member of staff from the point of roll check (between 7.00-7.30am) until they were unlocked to collect their breakfast.

77. Given the exceptional circumstances, the fact that the man was not seen from approximately 7.30am until his cell was unlocked at 9.20am was not unreasonable. The man was not treated differently to any other prisoner and he had not presented as a risk to himself. The staff tasked to run the prison that morning worked hard and to the best of their ability given the difficulties. Despite the fact that they were working under pressure and performing tasks they would not usually do, the staff to prisoner ratio for each landing was higher than it would be on a normal day. The normal ratio is one officer to each landing (28 prisoners). On that morning there were eight members of staff managing the regime.

78. I have no evidence that the strike contributed directly to the man's death. His actions took staff and prisoners alike by surprise. I am unable to judge whether being unlocked earlier for breakfast would have made any difference to the outcome.

Contingency plan

79. The senior management team held an initial debrief followed by a contingency planning exercise a few days after the strike to reflect on the existing plan and incorporate lessons learned. The nurse who came to the man's cell was not aware of the debrief and was not invited to contribute retrospectively.

80. My investigator discussed the contingency plan for industrial action with another governor. She asked whether after the debrief any inadequacies in the plan had been identified. This governor said that with hindsight a less cautious approach could have been adopted in unlocking for breakfast on the vulnerable prisoners unit. The vulnerable prisoner population present fewer control problems, and the process could have been made quicker by unlocking more prisoners at a time. This would have left more resources for the main prison and meant unlock in other areas could have been slightly quicker. Another possible time saving measure identified was the use self-heating foods which could be distributed to cells and reduce the time taken to serve meals. It is impossible to say whether either approach would have made any difference to the man's situation.

81. A further lesson learned was that governors did not carry anti-ligature knives. The contingency plan has since been amended to read that governors carrying out operational duties should carry the same equipment as that which discipline staff are expected to carry. Whilst access to an anti-ligature knife would not have made any difference as the man had been dead for some time when he was discovered, it might be critical in the future.

82. I have been pleased to learn that the senior management team took the opportunity to reflect on the effectiveness of Acklington's contingency plan. This is good practice. However, I am disappointed that not all staff involved in the emergency were invited to the debrief. The nurse told my investigator that she would have found it useful to have attended and heard the discussion that took place.

Reception interviews and paperwork

83. During his reception interview at Acklington, the man told the assessment officer that he was worried about rumours originating from his time at Durham about being a sex offender. Although this officer had made reference to the man's concerns in the induction paperwork and on his history sheet, he did not record them explicitly. No other member of staff interviewed knew the precise nature of the man's concern. The reception interview and induction paperwork are intended to make sure that a prisoner is appropriately supported and managed, and that needs are met at the earliest point. Reception staff come into contact with prisoners only infrequently once they have moved into the main prison. For this reason, it is important that as much information as possible moves with a prisoner, particularly when the prisoner is identified as being vulnerable.

84. The man never spoke fully about his concerns after the reception interview. It would have been useful to staff on G3 to have had sight of all information that had been made available to the assessment officer. However, given my investigator was unable to find any evidence to explain why the man had expressed the concern he did, it is debatable whether it would have made any difference to the outcome. Despite this, I strongly recommend that when and where possible staff should provide a comprehensive record of issues and concerns in all paperwork. This is a recommendation that I have previously made to the Governor in the case of a prisoner who died at Acklington on 17 September 2004 and wish to restate.

The Governor of HMP Acklington should remind staff of the importance of comprehensive record keeping and information sharing.

Personal officer scheme

85. The personal officer scheme at Acklington was re-launched in 2006. However, during an inspection in 2006 HM Chief Inspector of Prisons found little evidence of active personal officer work. Staff received little or no training in personal officer duties and some had insufficient time to fulfil the role. Many prisoners did not know who their personal officer is as personal officers were allocated to

cells rather than to individual prisoners. My investigator found this remained the case.

86. I support the Chief Inspector's recommendation that:

"… personal officers should introduce themselves to prisoners, get to know their personal circumstances and record contact in wing files to build up an accurate chronological account of their time at Acklington and any significant events."

I would add to this by suggesting that personal officers be allocated to individual prisoners rather than to cell numbers. This would foster better continuity of care and make it easier for personal officers to keep track of a prisoner's progress.

I recommend that the Governor revises the personal officer scheme at Acklington to allocate officer responsibility by prisoner and not cell number.

Access to telephones

87. The man's next of kin asked whether he would have had access to a telephone on arriving at Acklington. She told my investigator that she found it odd that he had not made contact.

88. On reception into prison, prisoners are entitled to a free telephone call. All new arrivals at Acklington are given a £2.00 telephone credit, but not all receive a free telephone call during the first few days at prison. The man's credit was available from 20 August. He tried to make three telephone calls on 23 August. The first two were at 10.49am and 10.59am; however the PIN system was not switched on at this time. He tried again at 11.01am (when the system was on) but his called was disallowed as he had no active telephone numbers on his account. All three calls were to the same number. The prison has confirmed that the man had £3.36 on his PIN account at the time of his death. There is no evidence of any recorded approved telephone numbers.

89. The 2006 report by the Chief Inspector of Prisons noted that a number of prisoners complained about delays in activating the telephone numbers they wished to call and that the procedure could be lengthy. Prisoners record their telephone numbers in reception and the security department makes sure they are allowed to contact the people on the list. This can take a few days. Once cleared the numbers are registered on to the personal identification number (PIN) system.

90. G wing has five telephones for 112 prisoners. This is one extra phone compared to the similar sized wings (E and F). Prisoners on G3 have some difficulty in accessing the phones as they are locked in their cells during the day and only receive a short association period every other day. Morning association is between 10.45am and 11.15am and from 5.00pm to 7.00pm during the evening. There is also opportunity for prisoners to use the telephone

when collecting lunch. Under some circumstances staff on G3 will allow calls outside of these times.

I reiterate HM Chief Inspector of Prisons' recommendation that all prisoners should have daily access to a telephone.

G3 Unit regime

91. The HM Chief Inspector of Prisons report referred to G3 as offering an "impoverished regime" for prisoners who through debt or personality clashes needed protection from other prisoners. Lack of regime, in particular lack of access to education and courses to address offending behaviour, meant that prisoners on G3 stagnated. It made progression through the prison system difficult and prisoners on the wing either had to transfer out or move back to the main prison.

92. I agree that the regime on G3 unit is very limited. Prisoners spend an unhealthy amount of time on their own in their cells with little stimulating activity. Due to the positioning of the unit (a cordoned off unit in the middle of a normal functioning prison wing), it is difficult to provide a more purposeful regime. The prisoners in G3 need to be kept separate from other prisoners in the wing and the rest of the prison for their own safety. To manage this they are unlocked at different times for short intervals. Whilst this does mean that prisoners are safeguarded, it does not help address the reasons why they are in G3 in the first place. There appears to be little done to progress prisoners out of G3 aside from transferring them to another prison.

93. I am concerned about the lack of follow-up support that the man received on moving to G3. Although care had been taken to ensure he was situated in an area where he would feel safer, no structured support appears to have been provided beyond this. I appreciate that the man was not known to have any mental health or self-harm problems, but consideration could have been given to offering some support given his initial anxiety and his placement on a so-called 'poor copers' unit. For example, he could have been offered an initial session with the mental health in-reach team or, if available, another counselling service. Such intervention might have helped bring out any deep-rooted issues regarding his vulnerability that he might not have felt comfortable talking about to an officer or fellow prisoner. G3 is an isolated environment, and more needs to be done to foster an inclusive regime with a view to helping prisoners move on or cope better.

I recommend that all prisoners allocated to G3 at Acklington are routinely offered an initial session with the mental health in-reach team or another counselling service, regardless of their perceived self-harm or mental health problems.

94. Although G3 serves an important purpose, I consider that it compartmentalises problems rather than solving them. However, I accept that G3 needs to be sustained. What I would like to see is serious consideration taken to moving the unit and developing a more inclusive and purposeful regime.

I recommend that the Governor of HMP Acklington moves G3 unit to an area of the prison where a more inclusive and purposeful regime can be provided.

Transfer and application process at HMP Durham

95. During her interviews at Durham, my investigator asked a number of officers who work on C wing about the administration of applications for transfer. An officer was asked whether it would be possible for a prisoner to submit an application on behalf of another prisoner without their knowledge. He said that this would only be possible if officers were particularly busy or if a high number of applications was submitted on any one day. There is no limit to how many applications a prisoner can submit in one go. Applications are handed in once a day at a set time. If the officer who records the applications had a high number to process, he or she might have difficulty identifying which prisoner handed in a particular application. However, the officer stressed that if the application was for an important request, such as a prison transfer, then the prisoner would be approached by an officer to discuss it. Under no circumstances would a request for transfer be submitted and processed without the prisoner concerned being aware of what was happening. If an application was submitted under false pretences and was not of a trivial matter (particularly if the perpetrator was identifiable), a security information report (SIR) would be raised.

96. My investigator asked the officer how far in advance of transfer a prisoner would be told that they were moving. The officer replied that they would know the day before they leave as a member of the healthcare team would have to declare them "fit for transfer". He also said that night duty staff would be aware of any move as they would be required to prepare prisoners for leaving the following morning. However, it is unlikely that officers would be aware of which prison they would move to.

97. The transfer process is handled by the Observation, Categorisation and Allocations Unit (OCA Unit) in the prison. A senior officer (SO) in Durham's OCA Unit, explained the transfer process to my investigator. All prisoners with a long sentence can expect to be transferred from a local prison to a training prison. (A long sentence is regarded as more than 12 months.) Transfers can also be dictated by population pressures. A prisoner is transferred to a prison consistent with their security categorisation, i.e. category A, B, C or D. Acklington is a category C prison that holds some life sentence prisoners. Another training prison in the north east is Kirklevington Grange. This is a semi open prison. Reception to Kirklevington Grange follows an extensive application process for category C or D prisoners. All applicants must demonstrate the following:

    - Evidence of a desire to change
    - Evidence of need for resettlement
    - Evidence of ability to be granted temporary release on licence.

A prisoner on licence recall in the North East could not expect to be transferred from Durham to Kirklevington. They would transfer to Acklington.

98. The average stay for a prisoner at Durham is approximately two months after categorisation. A prisoner who is on licence recall would remain at Durham for at least a month before transferring to allow time to establish whether any new charges would be brought against them. Any additional charges would require a court appearance so they would not transfer until the hearing was over.

99. Like other licence recall prisoners, the man would have been placed on a waiting list to transfer to Acklington once the initial month had passed and a space became available. As mentioned above, before a transfer can occur a healthcare member must declare the prisoner 'fit' (meaning clinically well).

100. In addition to the healthcare assessment, all prisoners at Durham except for those on licence recall are personally informed by a member of staff from the OCA Unit. The member of staff explains that a transfer will happen and offers the opportunity to the prisoner to cite any security reasons for not going to a particular prison. Any such reason must be supported by evidence as well as the names of prisoners they might have trouble with. The SO explained that prisoners will often say that they do not want to go to a particular prison because it is far from home and difficult for visitors, rather than for security reasons. This is why sufficient reasons need to be given and confirmed prior to the transfer.

101. At the time that the man moved from Durham, a licence recall prisoner would not have received any contact from the OCA Unit. Licence recall prisoners would still have had the opportunity to appeal against the transfer (by submitting an application and statement to the OCA clearly stating the reason for appeal). It was assumed that licence recall prisoners were familiar with the process and therefore did not require a specific meeting/interview with the OCA Unit.

102. This means that the man would have had contact with healthcare, but not with the OCA Unit. The healthcare assessment records that he was "happy" to transfer. It was open to him to submit an application asking not to transfer to Acklington for security reasons, but he would have to have known about this procedure and have asked wing staff for an application. There is no record of the man submitting an application appealing against the move. The first mention of his concern is recorded during the reception process on arrival at Acklington. Either he did not consider the possibility of going to Acklington when he was asked if he was happy to transfer, or the reason he gave when he arrived was not genuine. It is impossible for me to comment with any certainty.

103. My investigator identified the disadvantage to licence recall prisoners and discussed it with this senior officer, and with the Governor and Deputy Governor of HMP Durham. She pointed out that, whilst licence recall prisoners might be familiar with the system, they were not given the opportunity to discuss any potential problems directly with the OCA Unit. The process heavily

relied on a prisoner being pro-active and more importantly knowing that they had to be pro-active.

104. My investigator asked the SO whether it would be problematic or time consuming for the OCA Unit to extend the 'transfer interview' to prisoners on licence recall. He said that, if they were instructed to do so by management, the OCA Unit could do this. However, he recommended that a more efficient and effective way (given that licence recall prisoners are likely to be familiar with transferring between establishments) would be to issue a simple slip to prisoners informing them that they could be transferred at short notice. The slip would highlight the opportunity for raising any concerns or submit a statement to the OCA Unit in time for consideration before a transfer. He showed my investigator an example of a slip already in use for new prisoners (except licence recall prisoners). The Governor and deputy governor were receptive to this idea, and said they would immediately implement a new system for advising licence recall prisoners of transfers. I welcome and commend this prompt response to feedback from my investigation.

Conclusion

108. It is not clear why this man took the actions he did on 29 August 2007. He left no note and gave no indication of vulnerability or risk to himself. It was very clear that he wanted to leave Acklington, but after his reception interview with the assessment officer he never discussed the reasons. My investigator found no evidence to suggest that the man was bullied at either Durham or Acklington. He rarely came to staff attention and was a relatively quiet prisoner who did not present as a cause for concern. He 'kept himself to himself' and was happy to spend time 'behind his door'.

109. The man's initial anxiety on coming to Acklington was noted and handled appropriately (and swiftly) by placing him on G3. The man was made aware of the implications of being in the G3 unit (the limited regime) and nevertheless appeared content to go there. His desire to transfer to another prison was also dealt with appropriately. The officer on G3 told the man that he would handle his transfer application as soon as he returned to work. Unfortunately, the man hanged himself the day that this officer was due back from leave.

110. Staff who remained in the prison on the morning of the strike were faced with the difficult task of maintaining security whilst trying to provide a limited regime. Good teamwork was demonstrated and problems were tackled head on with as little disruption as possible. The response to discovering the man was calm, quick and appropriate. The two governors on scene were faced with a difficult situation that neither would have encountered since working as officers. I commend them for their swift, professional and sensitive handling of the situation. It cannot have been easy for any of the staff involved, particularly as there was no opportunity for staff to be relieved of their duties due to the pressures caused by the strike.

111. I have been particularly concerned to see whether the fact of the POA industrial action could in any way be related to the man's death. I cannot discount that possibility, but neither have I found any evidence to show that the two things were connected in any way.

RESPONSE TO THE DRAFT REPORT

112. The man's family asked for clarification on the following points.

<u>Self-harm and suicide risk</u>

113. The man's family remain concerned about staff at Acklington not identifying his risk of self-harm. In their response to the draft report the family highlight:

- his change in attitude to transferring prisons, and ask why it was not further explored
- the fact that an ACCT document was not opened
- little support for the man

All of these issues have been dealt with during my investigation and explored at length.

114. It was noted by the assessment officer during the reception process that the man was unhappy and concerned to be at Acklington and he was moved straight to unit G3. The man did not discuss his concerns any further with the assessment officer. Despite the fact that the man said that he had self-harmed in the past, this officer did not find him to be a current risk to himself. Decisions to open an ACCT document are made by trained staff who consider a prisoner's presentation, recent events and information provided, i.e. police records, information given by the prisoners. The decision is a judgement call by staff. An ACCT form is not opened based on past events. If an ACCT document was opened for every prisoner who had self-harmed in the past there would be a danger of devaluing the process. The number of ACCT documents would be very high and the process would be difficult to manage with purpose.

115. As previously stated, this issue was considered during the course of the investigation and I have already highlighted my concerns. I remain content that the assessment officer acted appropriately given that the man did not actively present as a risk to himself. I have however recommended that all prisoners allocated to G3 are routinely offered an initial session with the mental health in-reach team or another counselling service, regardless of self-harm or mental health issues. This has been accepted by the Prison Service.

116. There is no evidence that the man did not have access to Listeners or the Samaritans telephone line. Both of these services should have been available to the man if he had requested them. I have already commented on the personal officer scheme and made a recommendation.

<u>The strike</u>

117. I have taken note of the fact that the family disagree with my statement that it was not unreasonable that given the exceptional circumstances on the day of the strike the man, along with all other prisoners on G unit were not seen until after 9.00am. As explained in my report, prisoners on G3 are informally labelled as 'poor copers'. 'Poor coper' does not mean that the prisoner is at

risk to themselves, it means that the prisoner requires protection from the main wing. Reasons for seeking a safer environment include debts and bullying. There is no reason why a prisoner would be checked more frequently if they are not on an open ACCT.

118. The regime on the day of the strike was extraordinary. Staff followed the prison's contingency plan for industrial action. It would be an unfair statement to say that staff were operating without a "well considered contingency plan". The events of the morning have been considered as part of the investigation and I conclude it is not possible to discount the possibility that the strike is related to the man's death, but neither has any evidence demonstrated that the two were linked.

Telephones

119. The man's family were concerned that he did not contact them whilst he was at Acklington. Specifically, they ask:

- whether he had access to a telephone
- whether he asked for any telephone numbers to be registered on the PIN system
- if so, when the numbers were added to the system
- where the telephones are located for G3 prisoners
- would the man have encountered any other prisoners not from G3 if he used the telephone.

120. On 18 August 2007, the man agreed and signed his PIN phone contract to indicate that he understood the system. The contract was returned to the PIN phone clerk. Any phone numbers that a prisoner wants approved and placed on the system would be attached to the contract for the clerk. Telephone calls cannot be made unless approved numbers are entered on to the system. A list of numbers was not submitted and so nothing was placed on the PIN system for him.

121. On 20 August, the standard £2.00 reception account was opened to allow the man access to the PIN phones. His account to date identifies that £3.36 remained in his account and there is no evidence of approved telephone numbers recorded.

122. A BT statement records that on 23 August, the man attempted to make two telephone calls at 10.49am and 10.59am. However, the PIN system was not switched on at this time so no outgoing calls could be made. He later tried to make a further call at 11.01am (when the system was on) however the number dialled was not allowed as it had not been approved and added to the system. Each of these calls was to the same number.

123. There are telephones located on G3 for use only by those prisoners on the unit. Prisoners have access to these between 10.45am and 11.15 each morning during association. They also have access whilst collecting lunch and between

5.00pm and 7.00pm each evening. Under certain circumstances unit staff will allow calls outside of these times.

Other

124. I have taken note of the family's disagreement with the assertion that the man concealed an intention to take his life from staff or prisoners. My investigator was unable to find any evidence that the man gave staff or prisoners any cause for concern that he was a risk to himself. He did make it clear that he did not want to be at Acklington and that he required a safe environment due to potential trouble. However, this did not translate as being at risk of self-harm.

RECOMMENDATIONS

I recommend that the Head of Healthcare at HMP Acklington, with the Primary Care Trust, revises the initial reception healthscreen assessment form to make it mandatory for further information to be recorded if a prisoner expresses concerns about being transferred to the prison.

The Prison Service has accepted the recommendation. The healthcare department at Acklington will revise the initial health screen assessment to take account of concerns raised by any prisoners on their first entry to the prison. Any concerns will be recorded and information passed to Induction staff. The target date for implementation is September 2008.

The Governor of HMP Acklington should remind staff of the importance of comprehensive record keeping and information sharing.

The Prison Service has accepted the recommendation. A "Governor's Order" will be issued reminding staff of the importance of recording information passed to induction staff. Target date for completion is September 2008.

I recommend that the Governor revises the personal officer scheme at Acklington to allocate officer responsibility by prisoner and not cell number.

The Prison Service has accepted the recommendation. A revised personal officer scheme has been written and will be implemented when the revised core day attendance patterns are in place. Target date for completion is July 2008.

I reiterate HM Chief Inspector of Prisons' recommendation that all prisoners should have daily access to a telephone.

The Prison Service accepts this recommendation.

I recommend that all prisoners allocated to G3 at Acklington are routinely offered an initial session with the mental health in-reach team or another counselling service, regardless of their perceived self-harm or mental health problems.

The Prison Service accepts this recommendation. Healthcare at Acklington will look at the possibility of providing routine mental health in-reach or other counselling services to prisoners located on G3 landing. Target date for implementation is August 2008.

I recommend that the Governor of HMP Acklington moves G3 unit to an area of the prison where a more inclusive and purposeful regime can be managed.

The Prison Service accepts this recommendation. The Governor of Acklington has commissioned a review of the regime and level of purposeful activity provided on G3 landing. The target date for completion is August 2008.