

**Investigation into the circumstances surrounding the
death of a prisoner
at HMP Acklington in October 2006**

**Report by the Prisons and Probation Ombudsman for
England and Wales**

June 2007

This is the report into the death of a prisoner at HMP Acklington in October 2006. He died in his cell, apparently of natural causes. He was 52 years old. The man had been a prisoner at Acklington since 11 October 2004, shortly after he was sentenced to seven years' imprisonment by Teesside Crown Court.

I offer my sincere condolences to all those touched by his passing, especially his wife.

This investigation has been undertaken by a member of my team. I would like to thank the Governor of Acklington and his staff for their co-operation and active participation. Special thanks go to the Ombudsman's liaison officer for making the arrangements for my investigator's visit.

Northumberland Care Trust conducted a review of the care the man received whilst in prison. My thanks go to the clinical reviewer for his invaluable contribution.

One of my Family Liaison Officers contacted the man's wife to inform her of my investigation and to offer her the opportunity to raise any concerns. I hope this report answers any questions she or any other family member may have about the circumstances surrounding the man's death.

As well as suggesting that the Governor may wish to review a particular aspect of his contingency plan following a death in custody, I make two formal recommendations in this report. One concerns the apparent unreliability of the radios currently being used at the prison. Whilst there is no suggestion that this would have helped to save the man's life, I am conscious that I made a similar recommendation to Acklington following the death of a prisoner in 2004.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man who is the subject of this report was remanded into custody by Teesside Crown Court on 9 August 2004. He was taken to HMP Holme House, where he was given a full health screening. He disclosed to the nurse who assessed him that he suffered from high blood pressure, epilepsy and depression, for which he took prescribed medication. The nurse subsequently found out that he also received medication for gout and alcohol misuse.

On 1 October, he returned to Teesside Crown Court and was sentenced to seven years' imprisonment. He went back to Holme House, where he remained until he was transferred to HMP Acklington on 11 October.

The man adjusted well to life at Acklington and enjoyed positive relationships with both staff and fellow prisoners. Having proved that he was willing to make the most of his time in prison, he successfully applied to be relocated to J Wing where prisoners are encouraged to manage their own lives.

Around 12.00pm on 31 October 2006, the man collected his lunch as usual before returning to his cell. At 1.40pm, all the prisoners who worked were told to go to their workplaces. He failed to report, so one of his fellow prisoners went to his cell to investigate. A few seconds later, the prisoner came running to a member of staff and said that the man was on the floor and he thought he was dead.

The member of staff accompanied the prisoner to the cell, went in and observed the man lying prone on the floor. He was not breathing and, when checked, no pulse could be found. The officer went to the wing office and raised the alarm, summoning others including medical staff to help. Sadly, no signs of life could be detected. Emergency resuscitation was not initiated because rigor mortis had already started to set in.

The man was formally pronounced dead at 2.55pm. His family was informed of the sad news later that day.

THE INVESTIGATION PROCESS

1. My investigator considered the man's prison documentation, including his clinical records, before formally opening the investigation on 9 January 2007.
2. Prior to my investigator arriving at Acklington, notices were issued to staff and prisoners announcing the investigation and inviting anyone who had information relevant to the man's death to make themselves known to the investigator. One prisoner came forward and five members of staff were interviewed by prior arrangement.
3. One of my Family Liaison Officers contacted the man's wife to offer her the opportunity to participate in the investigation process. I hope this report addresses any concerns that she and other family members have about the circumstances surrounding her husband's death.
4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries.
5. Northumberland Care Trust conducted a review of the clinical care the man received whilst in custody.

HMP ACKLINGTON

6. HMP Acklington opened in 1972 as a category C prison. The jail is situated on a former Royal Air Force base near Amble in Northumberland. It has the capacity to hold 882 prisoners.
7. One of the wings is J wing, which is a unit for non-smoking prisoners who have shown that they can comply with the prison regime without constant staff supervision. Prisoners on the wing are granted a degree of freedom within the physical confines of the unit, on the understanding that they will be returned to the main prison if they break the rules.
8. Northumberland Care Trust provides healthcare to the prison. Nurses are employed to deliver primary healthcare during the daytime, seven days a week. Prisoners who require in-patient nursing care are transferred to an outside hospital or another prison.
9. Her Majesty's Chief Inspector of Prisons carried out an unannounced inspection of Acklington in April 2003. The Chief Inspector, Ms Anne Owers, found Acklington to be a safe prison and commented that "low levels of self-harm and the absence of self-inflicted deaths reflect well on the proactive approach taken by staff". However, the inspectorate highlighted concerns about the needs of older prisoners, and those with health conditions requiring a level of care that could not be provided at Acklington.
10. Since August 2004, there have been nine deaths at Acklington, including that of the man who is the subject of this report. Six of these were due to natural causes and three were apparently self-inflicted. Investigations into all nine deaths have been carried out by my office. One previous investigation has highlighted problems with the prison radios. I was disappointed to learn that this issue does not appear to have been resolved.

KEY FINDINGS

11. On 9 August 2004, the man who later died appeared at Teesside Crown Court and was remanded into custody. He was taken to Holme House, where he underwent a full health screening. He disclosed that he suffered from hypertension (also known as high blood pressure), epilepsy and depression. The nurse who assessed him contacted his General Practitioner (GP) and found out that he received a combination of medications for his health problems. These were Atenolol, Bendrofluazide and Nifedipine for his hypertension, Epanatin for his epilepsy and Paroxetine for his depression. The GP also told the nurse that the man was in receipt of a Vitamin B supplement for alcohol misuse and Alluplurnol for gout.
12. On 1 October, the man appeared again at Teesside Crown Court and was sentenced to seven years' imprisonment. He was returned to Holme House, where he remained for ten days before being transferred to Acklington on 11 October.
13. Upon his arrival at Acklington, he was subject to another health screening. No further issues were identified by the nurse who reviewed him, although it was documented that his blood pressure should be regularly monitored.
14. On 15 September 2005, the man was admitted to Wansbeck General Hospital for an operation to strip a varicose vein in his right leg. He remained at the hospital overnight and was discharged back to Acklington, as planned, the following day. In the days after his discharge, his progress was systematically followed up by healthcare staff who noted that the wounds were clean and dry, and healing well. The man experienced no further problems with varicose veins after the operation.
15. Over the next 12 months, the man's contact with healthcare staff was limited to collecting his prescribed medication and routine checks related to his hypertension and epilepsy. At the same time, he made positive progress through the prison and secured himself a cell on J Wing.
16. At around 12.00pm on 31 October 2006, the man joined the lunch queue on J Wing. He chatted with his fellow prisoners before collecting his meal and making his way to his cell on the first floor. One of the prisoners told my investigator that the man climbed the stairs in his usual brisk manner, taking two steps at a time. He turned to the prisoner and said he would see him later, then continued on to his cell, J2-17.
17. Around 1.40pm, staff on J Wing started labour movements, which is when the gates inside the prison are opened to enable prisoners to attend work and education classes. After about ten minutes, an officer, who was one of two officers on the wing at the time, noticed that the man had failed to come down from his cell for work. He mentioned this to one of the prisoners on the wing, with whom he was conversing at the time. The prisoner offered to go up to the man's cell to check on him. He made his way up to the first floor landing,

pushed the door ajar (the cell doors on the wing do not have conventional prison locks) and looked inside. He came running back down the stairs to the officer, and said that the man was on the floor and appeared to be dead.

18. The officer and the prisoner quickly made their way to the man's cell, followed shortly afterwards by another officer, who was guarding the gate that separates the wing from the outdoor compound. The first officer went into the cell and saw the man lying prone on the floor. He did not respond to any verbal commands, and so the officer checked for a pulse. He could not find one and promptly left the cell to return to the wing office. The officer who first went to the man's cell telephoned the communications centre, and asked them to put out an emergency call over the prison's radio network. The officer told my investigator that he had a radio in his possession, but it was not working properly because the battery was going flat, and so he had to go to the wing office to make the call.
19. According to Acklington's Incident Log, a code blue call was transmitted over the radio network at 1.50pm. (Most prisons in England and Wales now use a code system for indicating different types of emergencies. Code blue is the call sign used to signify that a prisoner's breathing may be compromised, and this helps staff attending to the emergency to decide what equipment might be needed to deal with it.)
20. Whilst the first officer went to the wing office, the officer who was previously guarding the gate went into the cell. He saw that the man's lunch lay untouched on the bed, and that he was lying on the floor in an unnatural, uncomfortable looking position. He called out to the man, asking whether he was okay, but did not receive any response, verbal or otherwise. He saw that the man's eyes were wide open, his skin had a greyish/white hue, and that he had apparently urinated and wet himself. The office believed that the man was dead, and he briefly left the cell before returning to check for a pulse. The officer is trained in first aid, albeit not recently, and he told my investigator that he would expect to be able to find a pulse. He said that he could not detect any sign of a pulse, and then left the cell and stood outside.
21. Two minutes after the code blue call, at around 1.52pm, a senior officer and another prison officer arrived at the cell from their normal location on H Wing, next to J Wing. They asked the officer who had been previously guarding the gate what he had found, and the senior officer asked him whether he was alright.
22. At the same time, another senior officer arrived at the cell, and also asked the officer who had earlier been guarding the gate what had happened. The senior officer went into the cell to check the man's vital signs. Like the officer who had been guarding the gate before the man was found in his cell, he could find no signs of life.
23. At some point between 1.55pm and 2.00pm, two nurses arrived from the healthcare centre. They brought with them a range of emergency resuscitation

equipment including a defibrillator. As they arrived on the wing, and prior to going to the man's cell, they asked a member of the wing staff (my investigator has been unable to establish whom) to telephone 999 and request an ambulance.

24. The two nurses went to the cell on the first floor landing and conducted checks for signs of life. Despite not being able to find any signs, they attached the defibrillator machine to the man in order to establish whether his heart was emitting any electrical signals. The defibrillator recorded that an electrical shock should not be administered, and recommended that they administer Cardio Pulmonary Resuscitation (CPR). However, as the man's left arm was stiff, and rigor mortis had clearly already set in, the nurses decided not to commence CPR.
25. At 2.20pm, the ambulance arrived and the paramedics confirmed death. A local GP arrived at Acklington shortly afterwards and formally pronounced the man dead at 2.55pm.
26. The prison subsequently activated its contingency plan for dealing with a death in custody. The other prisoners on the wing were asked to return to their cells. The officer who had been guarding the gate prior to the man being found was stationed outside cell J2-17 to ensure that only authorised personnel, specifically those involved in removing the man's body, entered. He told my investigator that he did not consider it appropriate for him to be assigned this duty as he had been involved in checking the man's vital signs after he was found. Acklington has accepted that allocating this task to this officer was not best practice and has decided to implement a policy so that staff who are directly involved in fatal incidents are not required to remain at the scene any longer than necessary. I welcome this initiative.
27. A memorial service took place on the wing later in the day, and prisoners sent a card to the man's widow. Support was offered to the prisoners, and most of the officers said that they were also offered support.
28. As part of the contingency plan, and because of the distance to the man's family home, North Yorkshire Police were contacted and asked to inform his next of kin of his death. This did not happen until 8.10pm, and unfortunately the police officer did not give the relative the name or contact details of the person to contact at Acklington.

ISSUES

Management of the man's health problems

29. It is the opinion of the clinical reviewer that the man's chronic diseases, namely epilepsy and hypertension, were well managed by Acklington. I therefore make no recommendations about Acklington's management of his health problems.

Prediction of the man's death

30. My investigator found no evidence to suggest that the man's death could have been predicted. Just minutes before it is likely he collapsed in his cell, he was engaged in conversation with a fellow prisoner who then observed him dashing up the stairs to the first floor landing taking two steps at a time. He had had no contact with the healthcare department for two weeks, and this was for nothing more than a routine blood test.

Response to the man's collapse

31. Given that the man's lunchtime meal, which he collected around 12.00pm, was found untouched on his bed, it is probable that he collapsed shortly after returning to his cell. By the time he was discovered, more than an hour and a half later, it is highly unlikely that CPR or any other form of emergency intervention would have made any impact whatsoever. Indeed, members of staff who went to the cell after the man was found told my investigator that his limbs had started to go stiff, indicating that rigor mortis had set in. Initiating CPR at this stage would have been futile. Indeed, it would have been disrespectful both to the man's memory and to the staff expected to carry it out.
32. I therefore have no recommendations to make in relation to how Acklington managed the man's health problems or how his collapse was dealt with by the staff who attended to him in the minutes after he was found.

Failure of the officer's radio

33. Despite the fact that the man was sadly beyond resuscitation when he was discovered in his cell, I am concerned that the first member of staff to arrive was unable to summon help over the radio network because his radio failed. The officer told my investigator that this is a persistent problem. Whilst there is no evidence to indicate that faster assistance would have saved the man's life, there might very well be instances in the future when prisoners' lives can be saved through a rapid response.
34. A previous investigation conducted by my office into the death of a prisoner at Acklington made a recommendation that the condition of UHF radio batteries should be reviewed and a battery protocol should be implemented. Whilst there now exists a written procedure for the management of UHF radio batteries at Acklington, it would appear there are still problems. I therefore urge Acklington

to revisit its written protocol to check whether it is sufficiently robust to eliminate problems on the frontline.

The Governor should review whether further steps are necessary to ensure that the prison radios work effectively.

Informing the man's next of kin of his death

35. My office believes strongly that it is more respectful for the families of prisoners who die in custody to be informed of the death in person. Ideally this should be done by a senior member of prison staff who is knowledgeable about the circumstances of the death. Where this is not possible, for instance when the prison is too far away from the next of kin's home, it is reasonable for a prison to contact the local police to pass on the news (although best practice would be to ask the staff of another prison). As Acklington is more than 80 miles away from the man's family home, I think it was understandable that the prison chose to ask the North Yorkshire Police to inform his family.
36. However, I am concerned that the family was not told until more than six hours after he was found. I am also worried because the police officer did not provide either a name or contact details for the prison. It is beyond my remit to make recommendations to the police. However, the Governor may wish to review this aspect of his contingency plan. Following any future death, I think it would be far better if Acklington itself, or another prison, takes responsibility for informing the bereaved family. If for one reason or another this is not possible, then every effort should be made to ensure the police have all relevant details and are impressed with the need for the news to be delivered without delay.

Returning the man's possessions to his family

37. For reasons that my investigator has been unable to establish, the man's possessions were only returned to his wife in late December, some seven weeks after he died. I know that this delay caused the man's wife considerable distress. This should have been avoided.

Acklington should review its policy on dealing with deaths in custody to ensure that the personal possessions of prisoners are returned promptly to their next of kin.

RECOMMENDATIONS

To the Governor

1. The Governor should review whether further steps are necessary to ensure that the prison radios work effectively.
2. Acklington should review its policy on dealing with deaths in custody to ensure that the personal possessions of prisoners are returned promptly to their next of kin.