

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

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

January 2008

This version of my report has been anonymised for publication on my website. The man died in January 2007, after hanging himself in his cell on H wing at HMP Acklington. He was 23 years old.

My colleagues and I offer our sincere condolences to the man's family and friends.

Two colleagues from my office carried out the investigation. I wish to thank the Governor of Acklington for making the necessary facilities and information available to my investigators, and for the assistance of the prison's Liaison Officer.

In the course of the investigation, I asked for a clinical review to be carried out into the care and treatment received by the man whilst in custody. I am grateful to the clinical reviewer for his assistance.

I conclude that the man kept his intentions very close to himself and gave no indication of what he was planning to do. The evidence is of a man who had settled reasonably well to the prison regime and was making plans for his future release. However, he had made an application for transfer a month before his death. He was also aware that he was to be deported at the end of his sentence and had begun an appeal process against the decision. The appeal hearing was to have taken place two weeks after the man's death.

I have been concerned to learn that the night manager did not go into the cell or carry out his own checks of the man's vital signs, but relied on those of junior staff who were not qualified first aiders. My report makes eight recommendations.

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SUMMARY

The man was serving a four year prison sentence imposed at the Crown Court in January 2006. Although he was only 23, prison was not a new experience for him and he had previously served four custodial sentences. However, what was new was the intention to deport him back to his home country at the end of this latest sentence. He was appealing against the decision.

In August 2006, the man transferred to HMP Acklington from HMP Manchester. The transfer did not go smoothly. At first he refused to leave his cell, and for a short period of time he prevented prison staff from entering by erecting a barricade against the cell door. However, he removed the barricade and the transfer to Acklington then went normally.

Due to the nature of his offence, the man was allocated to the vulnerable prisoner wing. He appears in the main to have settled in reasonably well, although he did have a fight with one other prisoner and had made an application for a transfer. Additionally, an allegation of racial abuse was made against him, and he too made a similar claim against a prisoner. Neither allegation could be substantiated by the prison, but they were recorded as racial incidents.

On the day of his death, a night patrol officer carrying out his normal roll check duty at 5.35am looked into the man's cell and saw part of his face against the cell observation panel. Believing him to be hiding, the staff member went to seek assistance from his colleagues. They responded very quickly. When they entered the cell, found the man hanging by a ligature secured to the door hinge. The officers had great difficulty in cutting the ligature away from his neck and, as they did so, his body fell heavily to the floor.

Sadly, it would appear that it was much too late to attempt resuscitation and, after staff received confirmation from paramedics that the man had died, the cell was locked pending the arrival of police. After the police were satisfied that the death was not suspicious, the man was taken later that morning to the mortuary.

I conclude that the man took his own life. I make eight recommendations.

THE INVESTIGATION PROCESS

1. Following notification from the Prison Service that the man had died in Acklington, the investigation was allocated to one of my investigators. He contacted the Governor on 22 January, and arranged to travel to the prison and open the investigation on 25 January. An initial meeting was attended by the Governor, the Independent Monitoring Board Chairman, a representative of the Prison Officers' Association, the prison's Clinical Team Leader and the prison's Liaison Officer.
2. The investigator was briefed about what had occurred. Following the meeting, he was shown the cell where the man had been found. The investigator identified from the briefing those staff he wished to interview, and arranged to return to the prison at a later date to commence the investigation in detail.
3. The clinical reviewer received a brief from the clinical team leader regarding the man's medical history and was given a copy of his medical records. The clinical reviewer was asked to identify any history of mental health problems in the past and to comment on the overall appropriateness of the treatment the man received whilst in custody. On 8 February, the clinical reviewer submitted his report to my investigator and made two recommendations for the prison.
4. On 20 February, the investigator and one of my family liaison officers visited the man's mother at her home address. The mother made my staff very welcome and asked them to look at a number of issues and concerns that she had in relation to her son's custody. Unfortunately, some of these questions were outside my terms of reference. However, my report has dealt with the questions that I am able to answer.
5. I am aware that the man's mother believes that a third party was involved in her son's death, but I am satisfied that both the police and my own investigation has found no evidence to suggest a third party was involved. Additionally, as part of the normal service that my office offers, and at her request, the mother was given a redacted copy of the man's prison records.
6. The investigation reopened on 2 April. Seven prison staff were interviewed and their interviews recorded on tape. Unfortunately, the recording quality of one interview was not as good as I would wish. However, I am satisfied that the person interviewed was not involved with the man at the time of his death, and was providing background information only about his arrival at Acklington. Additionally, the investigators spoke to the prison chaplain and one prisoner (neither discussion was formally recorded as the participants were providing background information). The investigators identified two prisoners who were in cells either side of the man's cell on the night he died, but were unable to speak to either. One had been discharged and the other man declined to be interviewed. The investigators completed their interviews on 4 April and, before leaving the prison, fed back their initial findings to the Governor, including the two recommendations made by the clinical reviewer.

HMP ACKLINGTON

7. Acklington prison is a category C establishment situated near the village of Acklington, close to Morpeth in Northumberland. It was built on the site of a former RAF base and accommodates convicted adult male prisoners with a mixture of prisoners including men serving life sentences. About half the population are vulnerable and/or sex offender prisoners. The prison can accommodate a maximum of 871 prisoners. It provides employment in farms and gardens, education and a variety of workshops. On 21 January 2006, the prison unlock roll was 849.
8. H wing is divided into four landings each with 30 cells and, in total, can accommodate up to 120 prisoners. The wing accommodates vulnerable prisoners who, because of the nature of their offences or for other reasons, cannot be placed into what is known as "normal location". The ground and second landings are reserved for prisoners on induction or waiting to be transferred into one of the other vulnerable prisoner wings. Wing facilities include showers, telephones, laundry, as well as a pool and football table.
9. Between Monday and Friday, prisoners are unlocked in the morning at 7.55am. They are locked up for the night at 7.15pm. At weekends, the prison is unlocked at 8.30am and on Saturday is locked up at 7.15pm. On Sunday the prison is locked up for the night at 5.20pm.
10. The most recent inspection carried out by the HM Chief Inspector of Prisons was in April 2003 when an unannounced follow up inspection was undertaken. The inspection found that Acklington was largely a safe prison. However, the report commented on suicide prevention and anti-bullying training, highlighting the need for more extensive training especially for permanent night staff.

Healthcare

11. The prison does not have 24 hour medical cover. Outside the normal operating hours, the prison relies on the services of an on call doctor, or if necessary on the emergency services.

Night Manager

12. At night time, as well as officers and OSGs there is a senior officer (SO) on duty. The SO is responsible for the prison and, in the event of an incident, staff refer to the SO for advice and instructions. If necessary, the SO in turn will refer to the on call Duty Governor for advice

Operational Support Grades (OSG's)

13. Operational support grades are uniformed members of staff. They are issued with security keys and carry out a number of tasks, but not the full range of duties given to a prison officer.

Anti Ligature Knives

14. Staff in contact with prisoners are issued with specially designed knives, known as fish knives, to use in an emergency to remove a ligature. The knives have a concealed blade which is placed against a ligature and which can be pushed forward to cut it without harming the prisoner.

Night State 10.00pm – 6.00am

15. Night state is when the prison is fully locked up for the night and staffing levels are at the minimum. There is often just one night patrol officer per wing or, on occasions, between two wings. Their role is to monitor the security of the wing and prisoners.
16. In night state no one can gain entry to the prison or leave it without the night manager's permission. To allow anyone to enter or leave the prison before 6.00am when the security systems disengage, the night manager would have to override the in-built security systems which engage from 10.00pm. It is only in exceptional circumstance or when the Duty Governor requires entry that night state would be broken.
17. During night state it is not normal to unlock a cell unless the night manager has sufficient staff resources in place to deal with the situation. Night patrol officers do not carry security keys and are therefore unable to move freely around the prison. However, they do carry a cell door key in a sealed pouch which is secured to their uniform belt. In the event of a life threatening situation, or if it is felt necessary to enter a cell, the night patrol officer has first to break the pouch seal to obtain the key. In the first instance, the officer must summon assistance and should only enter a cell on their own if safe to do so.
18. Unlike the night patrol officers, the night manager does carry security keys and is able to move freely about the prison. The manager will usually visit each of the wings during the night and check on the welfare of the staff and ensure they are carrying out their duties correctly

Patrol State

19. Patrol state is the name given to other times when prisoners are locked into their cells, for example during staff meal times. In patrol state, it is only the prisoners' cells that are locked, whilst other parts of the prison may be functioning normally. There may be at least one officer patrolling the wing and quite often two. The patrol officer deals with any cell call bells, and checks those prisoners on Assessment, Care in Custody and Teamwork (ACCT) documents (documents for those prisoners =judged at special risk of suicide or self harm). Additionally, patrol officers monitor the security of the wing. They carry the normal prison security keys and, if necessary, can access most parts of the prison including individual cells.

Roll checks

20. Roll checks are carried out to confirm the individual wing totals correspond to the prison total. Whenever a roll check is done, the officer has to physically see the prisoner is in the cell but they are not required to confirm the prisoner is alive. The reason for this is that some roll checks are carried out very early in the morning, and it would be inappropriate to wake the prisoner to check if he or she is alive. However, if the prisoner is subject to ACCT monitoring, the officer must confirm that the prisoner is alive. During normal observations, if the officer has any doubt about the condition of the prisoner, or is unable to see the occupant, they must seek assistance immediately and if necessary, enter the cell. Roll checks are carried out at midnight, 6.00am, 7.30am, lunchtime, 4.00pm and 9.00pm.

PSO 2700 Assessment, Care in Custody and Teamwork (ACCT)

21. ACCT requires staff to identify any concerns, take action, and document those actions for prisoners identified as at risk of suicide or self-harm. The ACCT document should be available to all the staff where the prisoner is located. Within 24 hours of the document being opened, the at-risk prisoner will be seen by an assessor and have a case review meeting. The meeting draws up a care and management plan, known as a CAREMAP, and a member of staff is nominated as the case manager. Wing managers take on the role of case manager, oversee the management of the ACCT document and attend case reviews.

Race Equality Officer

22. The Race Equality Officer is responsible for co-ordinating and supporting the work of the prison's Race Equality Action Team and Diversity Management Team. It is a full time position managed by a principal officer.

Code Blue

23. Code blue is a local procedure used to alert the communications room staff that someone is experiencing breathing difficulty. The radio operator in turn alerts healthcare staff and they attend carrying the emergency equipment.

Previous Deaths at Acklington

24. Since my office took over the responsibility for investigating all deaths in prison custody on 1 April 2004, there have been three apparently self inflicted deaths (including the death of the man who is the subject of this report) at Acklington and eight due to natural causes.

Police Investigation

25. With all deaths in custody, the police are notified by the prison as soon as the death has been discovered. In the first instance the police treat the area as a potential crime scene. As part of their investigation, they note the names of

everyone involved, and those who have been in contact with the person who has died. Additionally, they note the identity of all those entering and leaving the cordoned area. It is only when the police are satisfied that the death is not suspicious that my investigators are allowed to begin their own investigations.

KEY FINDINGS

26. The clinical review has identified that in September 2005 the man suffered from eczema and, although not connected, was thought to be suffering from paranoid psychosis. He was referred for a mental health assessment. The assessment concluded that his paranoid ideas and auditory hallucinations were probably related to the use of cannabis and did not believe that he needed ongoing supervision. It went on to say that his problems settled once imprisoned, and the clinical review suggests the assessment diagnosis was correct.
27. In January 2006, the man was sentenced at the Crown Court to four years' imprisonment. Although the prison records do not make it clear, it would appear he had been to HMP Forest Bank and HMP Manchester before transferring to Acklington.
28. At about 8.30am on 8 August 2006, whilst at Manchester, the man barricaded himself into his cell and placed a razor blade into his mouth. He was protesting about being transferred to Acklington and refused to go to the prison reception to prepare for the journey. After a short while, he gave up his protest and transferred to Acklington without further incident.
29. When the man arrived at Acklington he went through the normal reception procedures and was interviewed by the reception officer. In one of the records, the officer noted that the man had complained about the transfer, saying he would be unable to have visits. She made a note to show that he was allocated to the prison induction wing, H1 (a vulnerable prisoner wing). She noted that he had been polite and respectful and had been offered the support of the chaplain.
30. The earlier history of auditory hallucinations was identified by healthcare staff at Acklington, but no follow was required in view of the diagnosis. The man's use of cannabis and the eczema were also noted.
31. Six days later (24 August 2006), the reception officer made a further entry in the man's record, noting that he had settled in to the prison and was happy to be at Acklington. The officer told my investigator that she was satisfied that her entry was a true reflection on how he was at the time. She explained that any prisoner can request a transfer to a different establishment after they have been at Acklington for three months, unless there are compassionate reasons for an earlier transfer. The officer said that the man would have been aware of the transfer procedure as it is explained to every prisoner during induction. She confirmed that the man did not make a transfer request on compassionate grounds during the three month period.
32. On 28 October, the man's mother wrote to the Governor asking for him to be transferred nearer home, as she was unable to visit at Acklington. Although the letter is dated 28 October, the prison has recorded the letter as received on 4 December.

33. Eleven days later (15 December 2006), the principal officer (PO) wrote to tell the man's mother that the man had not at that stage applied for a transfer. Unfortunately, the letter does not appear to have ever been posted and due to an internal mistake the prison wrongly closed the file.
34. On 26 December, the man submitted a request to transfer to another prison. I understand that it normally takes about three months from an application being made to a transfer taking place. However, any transfer is subject to the receiving prison having the available space so it can take much longer. At the time of the man's death, the application process had not been completed and no arrangements for transfer had been made.
35. My investigators found that two racial incident reports were raised in relation to the man. The first was opened on 15 November 2006 after a prisoner was found to have a cut to his face and bruising, and alleged that the man had assaulted him. Another prisoner, who was apparently in the area at the time, reported to staff that he heard the man make a racist comment and this was the reason for the form being raised.
36. The prison's Race Equality Officer (REO), who is a principal officer, told the investigator that the man and the other prisoner were reported to the Governor for fighting and dealt with under the prison disciplinary system. It was during a disciplinary hearing that the man told a senior manager (SO) at the prison, that the other prisoner had called him a monkey. The SO opened a racial incident report on 18 December as the man believed the comment to be racist.
37. The REO said that, due to both prisoners making counter claims about what was said, the racist incident investigations could not be proved. However, both were recorded as racist incidents.
38. The man was given an additional 28 days in prison for fighting, but the punishment was suspended. (This meant that the 28 days would not be activated at that time, but could be activated if the man was found guilty of another breach of prison rules.) However, he was moved to H wing as a precautionary measure to get him away from an area where he had problems.
39. On 8 January 2007, the Asylum and Immigration Tribunal office wrote to the man in relation to his appeal against deportation. The letter told him that his appeal would be heard on 2 February at the Magistrates' Court. At the same time, the Governor was notified of the appeal date and asked to arrange for the man to be taken to the court.
40. Contained within the documents handed to my investigators was a copy of a letter written by the man and dated 18 January 2007. The letter, which apparently had not been posted, was addressed to one of his friends. There is nothing contained in the letter to suggest anything about what the man was about to do. In fact, he talked about being released from prison.
41. One of wing officers based on H wing had been on duty in the wing during the evening of 20 January. At interview, he said that he did not know the man well,

but felt that he would have asked the officer for anything that he might have wanted. The wing officer added that he was aware of the man contesting his deportation.

42. My investigator spoke to the wing officer to establish if he had locked the man up for the evening on 20 January, to determine his mood, and whether the officer had any concerns about his safety. He said that he locked the man into his cell at about 7.20pm, after first of all checking that he was in it. Once he had completed locking up the landing and verifying the correct number of prisoners, he confirmed to the wing manager that his landing roll was correct. He went on to say that he had no concerns about the man's safety. Having completed his work for that day, the officer left the prison at about 7.30pm.
43. The Operational Support Grade (OSG) works on a regular basis as a night patrol. He told my investigators that he had been employed at the prison for about four years and had received specific training related to his work when he first joined the Prison Service. He confirmed that he had received no training in first aid, and that his training mainly concerned security.
44. At interview, the OSG said he started his duty at about 8.10pm on 20 January. When he arrived at the prison, he collected the equipment that he would need to carry out his work. This included a prison radio, anti ligature knife and a cell door key, which is held in a sealed leather pouch and carried by the OSG at all times. He then made his way to the wing, where he arrived at approximately 8.45pm.
45. In addition to the OSG, there were two prison officers based in the wing for the night. The OSG said the officers were not required to patrol the wing or assist him with his work. I understand the officers' duty at night is to respond to incidents when required. They also carry out some searching duties outside the cells, but after searching they are free to relax. The OSG told the investigators that the officers normally sit watching television.
46. The OSG told the investigators that, when he arrived on the wing, he received a briefing from the wing manager. He was told about prisoners being monitored under the ACCT procedure. He told the investigators that the man was not on the list of ACCT prisoners.
47. At about 9.05pm, after receiving the briefing, the OSG began a full roll count of the prisoners on the wing. He told the investigators that it took him about 15 to 20 minutes to complete, after which he confirmed the wing roll was correct.
48. My investigators asked the OSG if he remembered seeing the man that evening when he carried out the roll check. He said yes, and was satisfied that the man was alive when he looked into the cell. At about 10.30pm, he carried out a further roll check and, as previously, he confirmed the wing roll was correct.
49. At around midnight, the OSG spoke to another prisoner in the wing who was complaining about loud noise. The OSG went to a cell on the landing below where the man lived and spoke to a prisoner who was deaf and had turned his

television volume up. The prisoner turned down the volume, but there was still a lot of noise coming from another cell. The OSG investigated where the noise was coming from and found that it was from the man's cell.

50. When the OSG looked into the cell he saw the man with his back to the cell door, dancing and singing. At interview, the OSG described him as happy and in a good mood. He tapped on the observation glass and asked him to turn the music down, which he did. My investigators asked if it was unusual for the man to be singing and dancing at night and whether the OSG had had to speak to him previously about excessive noise. The OSG said he did not know the man and had not spoken to him previously.
51. The investigators asked the OSG if he entered the cell to speak to the man and he said he did not. The OSG did not call the night manager and no one entered the cell before the time when the man was found hanging. The investigators asked the OSG if he could recall what the man was wearing at the time. He said that he was only wearing a pair of track suit bottoms, and confirmed that no one entered the cell.
52. The senior officer on duty that night told the investigators that he had been an SO for 16 years. Prior to this he had been a prison officer for 12 years. He said that SOs are not permanently employed to work on nights; they work approximately two sets of nights per year, each lasting one week.
53. The investigators asked the duty SO if he had received any specific training to work on nights. He said there was no specific training other than being given what he referred to as a manual. The SO clarified that the manual was actually the prison's contingency plans which would guide him through any particular incident. There was no specific training for night managers, and they each learned what to do from each other by "handing things down". The SO told the investigators that he had not received training in first aid. My investigators asked if he had ever received training in dealing with a death in custody. He said not, but added that he had read the death in custody contingency plan about two nights before the man's death.
54. The duty SO told the investigators that, as part of his normal night manager duties, he is based in the prison's staff facility area which is central to the rest of the prison. He told the investigators that he goes around the prison three times during the night and speaks to the OSG wing patrol staff. He ensures they are okay and there are no problems for him to deal with. He said that the visits are irregular and staff would not know when he was due. The SO said that, whilst he sees every OSG, he does not necessarily see the officers as they "can be dotted about". He added that the officers must remain in contact with him by radio. He said that on the night of the man's death there were two officers on H wing, one covering A, B, and C wing, and the remaining two officers stayed with him. The SO said that he last saw the two officers on H wing at about 10.00pm on 20 January.

21 January

55. At around 5.35am, the OSG began the morning roll check, starting on landing one followed by landing two. He told my investigators that, when he arrived at the man's cell (2-18), he looked into the cell using his torch and saw that the bed was empty. He said the sheets were folded back and there was a roll of bed clothing neatly folded on the foot of the bed. At first he thought that the man was in the toilet and tapped on the observation glass to obtain a response.
56. The OSG was unable to obtain a response and began to call out the man's surname. At the same time, he looked in the right hand side of the cell. He thought he could see the tip of the man's nose and lips and also a silhouette. He tried calling to the man again, but did not obtain any reply. Although he had a cell door key in his sealed pouch, the OSG did not open the door as he thought the man was hiding. He also had a prison radio, but did not use it. Instead, he returned to the wing office to alert the two officers in the television room.
57. My investigators asked the OSG if he suspected that the man was hanging. He said not, believing that the bars or bed are normally used. He added that he did not think the man was hanging due to the position he was in. However, at interview, he said that when he went to speak to the officers he told them that he thought the man was hanging, but could not give a clear explanation as to what had changed his mind other than the man was at normal height when he looked into the cell.
58. The OSG said the two officers went straight to the cell, opened the door and cut the man down. He said the officers told him to continue with his roll check, but to first of all contact the night manager and tell him they had a code blue on H wing.
59. At interview, the OSG said he telephoned the prison communications room and the call was answered immediately. He told the officer answering the telephone call that there was a code blue on H wing and gave the name and cell location. He heard the officer telling the night manager and the rest of the prison about the code blue over the prison radio.
60. After alerting the communications room, the OSG continued with the wing roll check and, after confirming the roll, he completed his paperwork. In addition, he carried out a further precautionary check of the three prisoners in the wing who were being monitored under ACCT.
61. The prison officer has been at the prison for over eight years and normally works on K wing during the day. He told my investigators that, at the time of the man's death, he was working on nights, something he does about every six months. Although he was due to start work at 8.45pm, he arrived early at approximately 7.30pm and went directly to K wing to allow a member of staff to go home.

62. At about 10.45pm, after completing his work, the prison officer and the duty officer went to K wing staff rest room. He said they carried out a roll check in another wing at about midnight, after which they both returned to K wing where they remained until the OSG approached them at about 5.35am to tell them that the man was hanging.
63. The prison officer said that he and the duty officer ran to the cell, which he estimated to be about 80 to 100 feet away. The prison officer was the first to arrive at the cell, and, before unlocking the door, he looked in to see if the OSG could be mistaken. He said he looked into the cell and saw what looked like someone standing behind the door on the right, looking into the cell. He tried to gain a response by calling the man's name and tapping on the observation glass, but was unsuccessful.
64. The prison officer unlocked the cell door. He told my investigators it was difficult to open as the body was wedged against the corner of the cell door and wall. He managed to open the door sufficiently for him and the other officer to squeeze through the gap and enter the cell.
65. When the prison officer went into the cell he saw a ligature, believed to be a piece of torn bed linen, around the man's neck. The ligature was leading up to the top corner of the door where the hinge is. The officer was carrying an anti ligature knife, which he removed from its holder and tried to place between the ligature and the man's neck. He was initially unsuccessful as the ligature was too tight. The enclosed space inside the cell prevented the duty officer from holding the man up to relieve the pressure on his neck. Eventually, the duty officer managed to place the knife under the ligature and cut it free. At that point, the man fell heavily to the floor as the officer could not support the weight.
66. I understand from the duty governor that the ligature had been secured to the top door hinge by a piece of wire. This had apparently been placed around the hinge before the ligature was attached to it.
67. Due to the way the body fell, the officers had difficulty laying him flat on the floor. However, they succeeded and the prison officer checked for any signs of life. He tried to find a pulse and listened for any sound of breathing, but due to the man's tongue being so swollen he doubted that he was breathing and did not detect anything. The prison doctor said the man had defecated. He said the man's tongue was protruding and recalled that his skin was dull and felt like rubber. The officer also thought that the body might have been warm, adding that he did not remember it being cold to touch.
68. My investigators asked the prison officer if he was first aid trained. He said he had not received any training since leaving the Prison Service College, although added that local training at the prison was available. He said that a few years previously he had asked to attend a number of training courses but attendance was restricted. However, it is not clear whether one of the training events was in first aid.

69. The investigators asked the prison officer if he attempted cardio pulmonary resuscitation (CPR) on the man. The officer said that, as well as not being first aid trained, he was not trained in CPR. He said there was no space in the man's mouth to perform CPR, due to the swelling of the tongue. He added that, in other circumstances, he would have felt compelled to try CPR but did not know the ratio for chest compressions and breaths.
70. Shortly afterwards, additional staff began to arrive and the prison officer left the cell. He told my investigators that, before leaving, he looked around the cell for any sign of a suicide note but did not find one. He found two pieces of paper, one a certificate and the other a canteen order form.
71. My investigators asked the prison officer if he had noticed anything else. He remembered that the television was switched off, the bed was not made, and the man's clothes were folded at the end of the bed. He added that the man was wearing boxer shorts and described the sheet as being strewn across the bed. The officer said he remembered the cell was very warm.
72. The investigators asked the prison officer if he knew what rigor mortis was. He said he had a "rough understanding" and explained that the man's body was not stiff, and again described it as rubbery and moveable.
73. The duty SO was in the prison restaurant area and heard the code blue radio message over his prison radio. He said that he and the two officers who had been with him went to H wing, which he estimated took him about six minutes. When he arrived he met the prison officer who told him that he and the duty officer had cut the man down as he had been found hanging and, in their opinion, had died. The SO asked the officer if he had tried to resuscitate the man, and the prison officer told him that he did not feel this was appropriate.
74. The prison officer told the investigators that, when he left the cell, the duty SO was outside and did not enter the cell but instead left to deal with the contingency plans. The prison officer and the duty officer went back into the cell to move the man's body as it was obstructing the door. Having moved the man to the centre of the cell, the officers left and closed the door behind them. Soon after they left the cell, the paramedics arrived and began to check for signs of life. After connecting electrocardiograph equipment to his body, the paramedics told the officers that the man was dead.
75. As the prison officer was no longer required at the cell, he left the area and went to an office where he met a police officer, the Governor and Duty Governor. He said that the second prison officer took him into a separate room to ask him how he was feeling and make sure that he was okay. He said the Governor was very supportive, which he appreciated. In addition, the local care team and managers had been very supportive throughout.
76. The OSG told the investigators that he escorted the paramedics to the cell. He saw the man lying on the floor with his head towards the cell door. After taking the paramedics to the cell he returned to the wing office to continue with his

wing patrol duties. He later accompanied two police officers to the cell, but did not remain with them as the area was restricted.

77. The investigators asked the duty SO if he entered the cell and he said that he had not done so. He told an officer to remain at the cell and keep a log of what happened, adding that he did not know of any reason why he would go inside. He said the officer had described what he had seen and told him that the man appeared dead and had been so for some time.
78. My investigators told the duty SO that the two officers who had been at the cell were not first aid trained, which he was unaware of. The investigators suggested that, as the night manager, he ought to have checked for himself what the condition was inside the cell and whether he could detect any signs of life. The SO told the investigators that it would have been a waste of time because he too had no first aid training. He went on to say that once an officer has checked, he is mindful of the time factor for requesting emergency medical assistance and has to accept what the officer has told him.
79. The duty SO said he contacted the prison communications room to ensure the contingency plans were in place and, as the prison does not have 24 hour medical cover, he wanted to ensure the emergency services were called. At about 5.55am, the duty SO had to go to the security department to obtain two keys which were locked in the office safe in order for the main gates to be opened to allow the ambulance in. The keys are used to override the prison security systems and allow the gates to be opened during night state. The SO deployed his staff to escort the ambulance crew and police officers who had also been asked to attend the prison.
80. After overriding the security systems, and while the paramedics and police were in the prison, the duty SO continued with the normal unlocking of the remainder of the prison. As a consequence, staff unconnected with the man's death had normal access to the prison which would otherwise have been inaccessible.
81. My investigators spoke to Physical Education Instructor (PEI). He told them that the man had been selected to join an NVQ Level 1 course in sport and recreation. He said the course ran for three mornings each week and participants were required to complete home work. The PEI said that the man had progressed well on the course, and could have gone on to level 2 and beyond had his offence not precluded him. The PEI described the man as bright and articulate, but someone who would display high and low moods. He last saw him on 17 January and stressed that he did not show any signs of being suicidal. The PEI told the investigators that he remembered writing a report and telling the man that "he could be the star of the show if he put his mind to it".

After the man's death

82. At about 7.00am on 21 January, the prison doctor arrived and confirmed that the man had died. The Governor and a few of his senior management team spoke to staff involved and offered them support. As well as this, the local care team was made available to any member of staff requiring additional support.
83. The Governor wrote to all prisoners telling them that the man had died and that the death would be investigated. He briefed his managers and reminded them about the need to support prisoners.
84. The prison's contact with the man's family is described later in this report.

ISSUES

Night managers

85. The role of a night manager is to take overall control of the prison and deal with any incident they are faced with. Unlike during the day when a senior prison manager is in overall charge of the prison, night managers have to make their own decisions, occasionally in isolation, until the on call Duty Governor can be contacted.
86. Acklington is no different to any other prison in that, although the grade may vary, the night manager is in charge of the prison. The Duty Governor is off duty, but on call and contactable by telephone or pager. Additionally, governor grades receive specific training in the management of incidents and their own local contingency plans. This should equip them to deal with most incidents they are likely to face.
87. The duty SO told the investigators that he had not been given any specific training in managing at night. At interview, he said to read the manual that is given to night managers would take approximately ten years. Whilst I accept that the comment was exaggerated, it does raise issues about training for night managers.
88. Because the SOs do not work as night manager more than twice a year, it is very likely they will not remember everything required of them from six months previously. It may not be safe to assume, therefore, that they will pass on the correct information to each other. In any event, those taking over responsibility for the prison must have sufficient training to enable them confidently to carry out their duties. The training needs of night managers is an issue locally but may affect the wider Prison Service too.

The Prison Service should consider whether there is a specific need for training night managers in incident management.

The Governor should consider whether there is a specific need for training night managers and whether the night instructions are user friendly.

The Duty Senior Officer

89. When the duty SO arrived at the cell, he was told by the prison officer that the man had been found hanging and had died. He asked the prison officer if he had tried to resuscitate the man and was told that he had not.
90. When my investigators asked the duty SO if he had entered the cell and checked the man's condition for himself, he told my investigators he had not and did not know of any reason why he should have done so. He went on to say that the prison officer had checked and he had to accept what he had been told and so instead left to deal with the local contingency plans.

91. I accept that contingency plans have to be dealt with quickly and that the duty SO was apparently the only person with access to the safe containing the override keys. However, not checking for himself what he had been told left the duty SO vulnerable to criticism.
92. Additionally, the duty SO did not check to see if he could detect any signs of life and told the investigators it would have been a waste of time as he had had no first aid training. This also causes me some concern, as all prison officers are trained in first aid when they first join the Prison Service. It may well have been some time since the SO's training took place, but not to enter the cell and check for basic signs such as breathing or pulse was questionable practice. Although I make no formal recommendation, this may be something the Governor will wish to examine further at a local level.

First Aid and Cardio Pulmonary Resuscitation Training

93. HMP Acklington is situated in an isolated part of the country and does not have emergency medical services on its doorstep, nor healthcare staff employed at night. The absence of medical staff at night, the distance to the nearest hospital and the likelihood that paramedic assistance in an emergency will not be available rapidly, leaves everyone in the prison vulnerable unless proper first aid is administered as soon as possible. It is therefore very important that staff working on nights are competent to administer first aid and CPR sufficient to support a patient until trained specialists can attend. (However, I accept that in the man's case, it was probably too late to attempt resuscitation.)
94. In his clinical review, the doctor says that from the man's appearance he was clearly dead. The report confirms that no signs of life were detected.

The Governor should review the training for all staff employed on nights and ensure sufficient first aid and CPR trained staff are on duty during the night and at any other time when healthcare is closed.

The OSG

95. Following any death in custody, the ACCT guidance states that the prison should review all open ACCT documents to check those prisoners who are being monitored. As a member of staff working permanently on nights, I am not certain that the OSG would have been trained to know the procedure. However, using his own initiative, he decided that he should ensure that the three prisoners in his care were safe. At what was an extremely difficult time, he kept his head, taking positive steps to protect three vulnerable prisoners. This is professionalism that should be formally recognised.

The OSG should be commended for his decisive action in ensuring the safety of three vulnerable prisoners being monitored under ACCT.

96. At interview, the OSG told the investigators he had carried a prison radio, but had not used it to raise the alarm as he had not thought to do so. Instead, he went to the television room to alert the two officers. Clearly, there is a need in

such circumstances to obtain assistance by the quickest and most appropriate method and it is for this reason that the Prison Service provides radio communication, alarm bells, telephones and whistles to attract attention. I accept that there may have been little anyone could do for the man, but in another case it could mean the difference between life or death. It should be an automatic response by prison staff to use the emergency equipment provided.

The Governor should remind all staff how to obtain prompt emergency assistance.

The ligature

97. It would appear that the ligature had been tied to a piece of wire which had first of all been secured to the top hinge of the cell door. It is not known where the wire came from or how the man obtained it. Neither is it known when the wire was secured to the hinge. It could have been done whilst the door was open, or later when closed by bending it into the shape of a hook, passing it through the gap in the door and then pulling it back around the hinge. Whatever the method used, it was certainly a deliberate act. The clinical review supports the view that the man's actions were premeditated.

Deportation

98. The man had appealed against the decision to deport him at the end of his sentence and was aware that the appeal date had been arranged for 2 February 2007. Although known to him and the prison, the information had not been passed to healthcare (or, if it was, the details were not recorded in his medical record). The clinical review notes that the deportation may have been a risk factor, although it is not certain what the outcome of the appeal hearing was likely to be. However, the clinical reviewer judges that the risk would have been more significant if the decision to deport had been confirmed. In contrast, the mother told my investigators that the prospect of being deported did not concern her son.
99. The clinical reviewer says in his report: "In view of his behaviour and general demeanour, even if healthcare had been informed, it is by no means certain that a mental health risk assessment would have identified the intent to self harm or suicide. [The man] skilfully concealed his intentions from everyone". Because it cannot be certain whether healthcare is routinely informed about deportation decisions, the clinical review makes the following recommendations.

The Governor should ensure that healthcare are informed when prisoners are to be considered for deportation.

Healthcare should ensure that such prisoners are carefully assessed to eliminate, as far as possible, the risk of suicide.

Family contact

100. The man's mother asked if I could explain why she was not informed of her son's death until 3.50pm on 21 January. I understand that due to the distance from the prison to her home address, the police officers who went to the prison following her son's death were asked at the same time to assist in contacting her. An officer agreed to contact Greater Manchester Police on the prison's behalf, but unfortunately I do not know when this happened.
101. After being told of her son's death, the mother telephoned the prison and spoke to the Duty Governor. He told her about the circumstances and arranged to telephone back the following day at 10.00am. The mother told my investigators that she did not receive the planned call. One of the investigators spoke to the Duty Governor about the arrangement. He said that he did make the call at 10.00am, but unfortunately the telephone kept redirecting to an answerphone facility. He said the man's mother telephoned him late that day and gave a different telephone number to the one provided previously.
102. Whenever anyone dies in prison custody, the family of the prisoner should be invited to visit the prison and offered the opportunity to see the area where the person was found. To ensure arrangements happen as smoothly as possible, the prison has a family liaison officer whose role is to organise and facilitate the visit. I am pleased to learn that the prison offered the man's mother the opportunity to visit Acklington.
103. The mother met the Duty Governor before going to the cell where the man died. The mother told my investigators that, before her visit, she had asked for the cell to remain exactly as it was when the man was found, and she was assured that this would happen.
104. When she went to the cell, she saw that her son's bed was neatly made, with no signs that anyone had been on it, and his shoes were alongside and not at the foot of the bed as was his usual routine. In addition, on the pillow were a set of wooden rosary beads, which she believed had been placed there by someone else as the man was not a Catholic. My investigators have examined the prison records and, although I cannot account for the beads on the pillow, it would appear that the man had been allowed to have them in his possession since he was in HMP Manchester.
105. As with any serious incident it is easy to give out information which, although well intended, may not necessarily be fact. The mother said she asked that the cell be left exactly as it was when the man was found hanging and was apparently assured it would be. In fact, it is clear that the cell had been tidied up. I am satisfied that it was cleaned out of respect for her visit and that no one intended to mislead or cause additional stress at what was an extremely difficult time. And obviously there has to be a balance between decency and health and safety which will need to be handled very sensitively. But wherever possible, the wishes of the family should be accommodated. If they cannot be followed, an explanation should be given.

106. Following a death at Acklington an information leaflet is usually given to the bereaved family. It refers to the inquest and post mortem and explains that the family are allowed to have an independent person present at the post mortem. The mother said she was not told this by the prison or the coroner's office, and only learnt of it after the post mortem was carried out when the leaflet arrived from the prison. She said the funeral was delayed as she then waited for a second post mortem to be conducted.
107. The mother said that the prison did not return her son's clothing to her in time for his funeral, and this resulted in her having to purchase new clothes for him. An investigator spoke to the Duty Governor about this and he said the clothing was sent by courier and it was the company's responsibility to deliver the package on time.
108. In addition, the mother said that after her son's death she was given a number of names and telephone numbers at the prison to call if she wanted anything. She explained to the investigators that, prior to his death, she had telephoned the prison and, in order to speak to anyone about the man, she had to go via the switchboard. It was only after the death that the prison gave out names and telephone numbers of staff who could be contacted.
109. I understand that on the back of every visiting order sent from the prison is the telephone number of the 'Critical Incident Line', which is available 24 hours a day. Any visitor who has a concern about any prisoner can telephone the number and leave a message. The messages are checked daily and any necessary action taken.
110. I welcome the dedicated telephone number, but am unclear how people like the man's mother who do not visit the prison would know of its existence. Although I make no formal recommendation, the Governor may wish to consider the point.
111. More generally, I believe there is a need for Acklington to consider how the prison communicates with bereaved relatives in light of the mother's concerns listed above.

The Governor should review how best to meet the needs of bereaved relatives in light of the concerns raised by the man's mother.

Bullying

112. The mother told my investigators that during a telephone call with the man he told her he was being bullied within the prison. Additionally she said that he was being called a "black bastard" and "paedo" by officers and they were encouraging prisoners to do the same.
113. One of my investigators met the prison's Race Equality Officer. He told her that he had been at Acklington for four years and a Principal Officer for one year. He said that he was responsible for answering queries from prisoners and dealing with the monitoring procedures. In addition, he supported the

implementation of the Race Equality Action Plan, answering complaints and applications from prisoners and staff of a racist nature.

114. The Race Equality Officer said that there were approximately 50 racist complaints made during 2006. (At the time when my investigator spoke to him in 2007, the number of complaints was about 25 for the year.) He added that this was an increase on the previous year. He explained that he personally does not investigate every complaint, but oversees them before they are passed to the Race Equality Action Team leader and Deputy Governor who check the quality of the investigation reports.
115. At interview, the REO said that approximately 20 per cent of the prison's staff had been trained in race equality. He added that the figure was mainly non-uniformed staff, which means the majority of those trained are not front line prison officer grades.
116. As noted earlier, the REO told the investigators that there had been two racial incident reports raised in relation to the man. Due to both prisoners making counter claims, the investigations could not be proved.
117. The REO went on to say that prison staff at Acklington were reluctant to report prisoners who make racist comments. In his opinion, they do not feel confident to report such behaviour. He added that he had brought it to the attention of the prison Race Equality Action Team, and that it was being addressed by additional training. The Governor will wish to ensure that this is indeed the case.

Recommendations arising from previous deaths in custody

118. There are similarities between the recommendations in this report and those I have made in previous investigations at Acklington, especially those relating to training. In previous investigations at Acklington, I have made the following recommendations and regrettably they have arisen again here:
 - There should be mandatory training for prison officers in resuscitation techniques to ensure that staff who discover prisoners asphyxiated by ligature are able to offer immediate assistance.
 - Consideration should be given to providing first aid training for all staff who have contact with prisoners.
 - The Governor should review arrangements to ensure that staff are trained and equipped to recognise an emergency and call for immediate assistance using the standard prison emergency procedures.

I urge the Governor and wider Prison Service once more to give due consideration to these matters.

Staff Support

119. It would appear from what my investigators were told that staff felt supported by the prison's management and the appropriate care mechanisms were in place.

CONCLUSION

120. I am satisfied that no one else was involved in the man's sad death. I am also satisfied that no one could reasonably have suspected what he was planning to do. He appears to have hidden his true intentions very well. He had indeed written about his future on leaving prison.
121. It is uncertain what effect the deportation issue may have had on his mind. (As noted, his mother has said this was not a concern.)
122. The man had not wanted to be transferred to Acklington and was not receiving visits from his mother. He made an application for transfer a month before his death. However, the other evidence suggests that he had settled reasonably well at the prison.

RECOMMENDATIONS

1. The Prison Service should consider whether there is a specific need for training night managers in incident management.

The Prison Service have accepted the recommendation.

2. The Governor should consider whether there is a specific need for training night managers and whether the night instructions are user friendly.

The Governor has accepted the recommendation.

3. The Governor should review the training for all staff employed on nights and ensure sufficient first aid and CPR trained staff are on duty during the night and at any other time when healthcare is closed.

The Governor has partially accepted the recommendation.

4. The OSG should be commended for his decisive action in ensuring the safety of three vulnerable prisoners being monitored under ACCT.

The Governor has accepted the recommendation.

5. The Governor should remind all staff how to obtain prompt emergency assistance.

The Governor has accepted the recommendation.

6. The Governor should ensure that healthcare is informed if prisoners are to be considered for deportation.

The Governor has accepted the recommendation.

7. Healthcare should ensure that such prisoners are carefully assessed to eliminate, as far as possible, the risk of suicide.

The Governor has accepted the recommendation.

8. The Governor should review how best to meet the needs of bereaved relatives in light of the concerns raised by the man's mother.

The Governor has accepted the recommendation.