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

January 2008

The man was 29 years old when he died in August 2007 in his cell at HMP Acklington. He was found hanging. My investigator and I offer our sincere condolences to the man's family and friends for their sad loss.

I wish to thank the Governor of Acklington for making the necessary facilities and information available to my investigator, and for the assistance of the Liaison Officer. In the course of the investigation, I also asked for a clinical review to be carried out into the care and treatment the man received in custody. I am grateful to the clinical reviewer for his assistance.

The man had been returned to prison earlier in 2007 after breaching his parole licence conditions. At the time of his death, he was being monitored under the Prison Service's suicide and self harm support and monitoring procedures. I believe these procedures were being operated properly and that, short of a one-to-one watch, all that could reasonably be done to support and monitor him was done. On what was known at the time, I do not judge that a one-to-one watch would have been justified

My report shows that the man had been treated for mental illness and had fabricated stories about the deaths of close relatives and a girlfriend. I make two recommendations to the prison authorities.

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Prisons and Probation Ombudsman **January 2007**

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SUMMARY

The man was released on licence from prison on 6 March 2007. Unfortunately, he breached the licence conditions and this resulted in him being taken back into custody on 4 May.

For the purposes of this report I have concentrated on the period from when he returned to prison. It had been recognised by the doctor assessing him following his reception back into custody that he appeared mentally stable but somewhat depressed.

On 29 July 2007, the man handed a note to a member of prison staff. He had written that he was suffering from anxiety and depression over the death of his brother, whom he said had killed himself in prison, and also his uncle's murder. He wrote that he felt suicidal. The member of staff opened a suicide and self harm monitoring and support document. Observations began immediately, followed by an assessment meeting. During the meeting the man said that his mother had died and that his family blamed him for her death. He also referred later to an ex-girlfriend, saying that she too had killed herself in prison.

Nine days later, on 7 August 2007, the man was meant to receive a visit from a friend but the visitor did not arrive. Recognising that this concerned him, a manager authorised a telephone call to find out why the visit had not gone ahead. After making the telephone call, he appeared much happier.

Later that evening, as part of the suicide and self harm monitoring procedure, an officer went to the man's cell to check on him. When he arrived, he saw the man hanging from the window bars. The officer immediately entered the cell and cut him down. He summoned assistance and began to administer first aid whilst waiting for assistance from other prison staff.

Shortly afterwards, ambulance staff arrived. After carrying out their own checks, they stopped any further attempt to resuscitate the man. The prison doctor arrived later and confirmed that the man had died.

Following the man's death, it became evident that he had fabricated the stories about the family deaths. In fact, his mother contacted the prison directly to find out if it were true that he had died. Sadly, she had first learned of her son's death from a friend.

THE INVESTIGATION PROCESS

1. Following notification from the Prison Service that the man had died in HMP Acklington, the investigation was allocated to one of my investigators. He contacted the prison's Liaison Officer and arranged to travel to the prison and open the investigation the following day.

2. On 9 August, the investigation into the man's death formally opened at the prison when the investigator chaired a meeting with prison managers and representatives of Northumberland Primary Care Trust. At the meeting was the Deputy Governor, an Officer representing the Prison Officers' Association, the Head of Care for Northumberland Care Trust), the prison's Clinical Team Leader, the Community Psychiatric Nurse and the prison's Liaison Officer.

3. The investigator was briefed about what had occurred. Following the meeting, he was shown the cell where the man had been found. From the information supplied, the investigator identified which staff he wished to interview and arranged to return to the prison at a later date. A number of interviews were recorded on tape, whilst others were carried out less formally and not taped.

4. On 23 August, my investigator returned to Acklington. He interviewed the officer who found the man hanging and also spoke to an offender supervisor who works at the prison. Before leaving the prison, the investigator met the Deputy Governor and fed back to him progress on the investigation. The Deputy Governor welcomed the feedback.

5. The investigator returned to the prison on 3 September to complete his interviews with staff.

6. The same day, one of my family liaison officers (FLO) telephoned the man's mother. The FLO explained my role and offered the man's family the opportunity to meet her and the investigator. The purpose of the meeting was for the family to contribute towards my report and ask any questions they would like me to examine. The mother decided that she did not require a visit. However, she did ask a few questions that I am pleased to say my report has been able to answer.

7. On 5 September, the investigator completed his interviews at Acklington. Before leaving the prison, the investigator met the Deputy Governor and fed back the findings of the investigation. These included one urgent finding. The Deputy Governor thanked the investigator and told him that the feedback would be dealt with.

HMP ACKLINGTON

8. 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. Additionally, about half the population are vulnerable prisoners and/or sex offenders. The prison can hold a maximum population of 871 prisoners. It provides employment in subjects such as farms and gardens, education and a variety of workshops. On 21 January 2006, the prison unlock roll was 849.

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. On Saturday, it is locked up at 7.15pm. On Sunday, the prison is locked up for the night at 5.20pm.

Anti-ligature knives

10. Staff in contact with prisoners are issued with specially designed knives, commonly known as fish knives. They are designed to be used in an emergency and assist the removal of a ligature. They have a concealed blade that is placed against a ligature and pushed forward to cut it without harming the prisoner.

Addressing Substance Related Offending (ASRO)

11. ASRO is a community based drug programme. The equivalent programme that runs in prisons is known as PASRO.

Code blue

12. Code blue is a local procedure at Acklington 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 correct emergency equipment.

Counselling, Assessment, Referral, Advice and Throughcare (CARATS)

13. The Counselling, Assessment, Referral, Advice and Throughcare (CARATS) service supports prisoners who have a history of drug or alcohol abuse. The CARATS service can be accessed by an intermediary service or by the prisoner referring himself.

Healthcare

14. Acklington does not have 24 hour medical cover on site. Outside of healthcare opening times, medical assistance is provided by an on call doctor, or the emergency service. The Healthcare opening times are weekdays from

7.30am to 7.45pm, Saturdays from 8.30am to 7.45pm, and Sundays 8.30am to 5.30pm.

Her Majesty's Chief Inspector of Prisons

15. In April 2003, Her Majesty's Chief Inspector of Prisons made an unannounced follow up inspection of the prison. The inspection found that Acklington was largely a safe prison. However, the Chief Inspector's report does comment on suicide prevention and anti-bullying training, highlighting the need for more extensive training especially for permanent night staff.

16. Three years later in December 2006, HMCIP carried out an announced inspection of the prison. In the introduction to her report, she says that she was disappointed to find that, despite raising concerns over three years earlier about extending the prison, those concerns had gone unheeded. The report states that the expanded prison had not only failed to provide sufficient purposeful activity places, but had struggled to sustain a safe and decent environment.

17. The report acknowledges that there were few incidents of self harm. It also describes commendable examples of care for those at risk.

18. The introduction to HM Chief Inspector's report acknowledges that a new group of senior managers had been transferred into the prison. She recommends that emergency resuscitation equipment and emergency assistance should be immediately available to all staff and prisoners.

Independent Monitoring Board (IMB)

19. Each prison has its own IMB made up of volunteers from the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State.

20. In their most recent annual report (covering the period to 30 June 2006), the Acklington IMB raised concern about the general condition of the prison with the exception of the newer accommodation. The Board did not identify any concerns relating to suicide and self harm. Their report said that, on the occasions when a death had occurred at the prison, the Board had been properly notified. They also reported that staff and prisoners had been supported.

Listeners

21. In common with most prisons, Acklington has a Listener scheme, under which the Samaritans train selected prisoners to offer support for any prisoner who is feeling vulnerable and at risk. The scheme is confidential and any prisoner can ask to speak to a Listener at any time of the day or night. Prisoners can access a Listener easily by speaking to a member of staff. During the hours

that prisoners are locked in their cells, anyone wishing to speak to a Listener can make the request from the staff on duty.

22. Also available to Listeners is a co-location suite, which is a cell that has been specially designed to accommodate two Listeners and a prisoner in crisis. It is not normally occupied and is ready for use at any time of day or night. The suite is available for any prisoner deemed to require support and allows them to speak in private to two Listeners.

Multi-Agency Public Protection Arrangements (MAPPA)

23. The MAPPA is a formal partnership between police, probation, prisons and other statutory and non-statutory agencies which assesses and manages offenders in order to minimise the risk of serious harm they may pose to the public. There are four core functions:

    - identification of offenders with the potential to commit serious violent and sexual offences
    - sharing relevant information between agencies
    - assessing the risk of serious harm
    - managing that risk.

24. Offenders who come within the MAPPA remit are classified according to the nature of the risk and its management. The higher the risk, the higher the level at which they are managed. Level one offenders are managed by one agency, usually the police or probation service. Level two offenders are managed jointly by all the MAPPA agencies, and level three offenders are managed by the Multi-Agency Public Protection Panel (MAPPP) which is made up of senior managers from the MAPPA agencies.

Night state 10.00pm – 6.00am

25. Night state is when the prison is fully locked up for the night and staffing levels are at a 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.

26. At night time, as well as officers and Operational Support Grades (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.

27. During night state, no one can gain entry to the prison or leave it without the night manager’s permission. The night manager has to override the in built security systems to allow anyone to enter or leave the prison before 6.00am

when the security systems disengage. It is only in exceptional circumstances, or when the duty governor requires entry, that night state would be broken.

28. During night state, it is not normal to unlock a cell unless the night manager has sufficient staff in place to deal with any situation. Night patrol officers do not carry security keys and are therefore unable to move freely around the prison. They do however carry a cell door key in a sealed pouch secured to their uniform belt. If it is felt necessary to enter a cell in the event of a life threatening situation, the night patrol officer breaks the pouch seal to obtain the key. However, in the first instance, the officer must summon assistance and only enter a cell on their own if safe to do so.

29. 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

30. Patrol state describes the arrangements when prisoners are locked into their cells during the day, 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. Additionally, patrol officers monitor the security of the wing, carry the normal prison security keys and, if necessary, access most parts of the prison including individual cells.

Police investigations of deaths in custody

31. With all deaths in prison 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 where the person is found as a potential crime scene and, as part of their investigation, note the names of everyone involved and those who have been in contact with the body. 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.

Previous deaths at Acklington

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

Prison staff

33. There are three levels of uniformed prison officer grades. Prison officers form the largest part of the uniformed staff. They are the front line supervisory staff with whom, in the majority of cases, prisoners have first and most contact.

34. Senior officers (SOs) are the first grade of managers and act as a reference point for prison officers. SOs are responsible for the day to day management of their area, supervising staff and dealing with issues raised by prisoners.

35. Principal Officers (POs) are the highest managerial rank of the uniformed staff. They supervise the uniformed staff and have operational responsibility for the prison.

36. Operational support grades are also 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 an officer.

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

37. 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 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.

Release on licence

38. All prisoners sentenced to more than 12 months' custody are considered for release on licence, which means they are supervised by the Probation Service until the expiry date of their sentence. There are standard conditions for all licences that include:

    - keep in touch with the probation officer in accordance with any instructions that may be given

    - receive visits from the probation officer at their place of residence

    - only undertake approved work

    - not travel outside the United Kingdom

    - be well behaved, not commit any offence and not do anything which could undermine the purposes of supervision, which are to protect the public, prevent re-offending and help successful resettlement into the community.

39. Further conditions can be added by the Secretary of State if they are deemed necessary for an individual.

40. If a licensee breaks any of their conditions, they are deemed to have breached their licence and the probation officer submits a report to the Secretary of State (in practice, the Ministry of Justice acts as the Secretary of State's agent) who has the authority to revoke it. When the licence is revoked, the person is subject to arrest by the police and return to the nearest prison.

Resuscitation equipment

41. Healthcare at Acklington has two emergency response bags. The bags contain the necessary equipment for suitably qualified staff to use to protect life.

42. There are five automatic defibrillators located around the prison. Four are situated in dispensary rooms situated in the accommodation units, whilst the fifth is held in healthcare. Defibrillators monitor the activity of the heart and inform the user on what action to take with the patient. As well as defibrillators, mouth to mouth facial masks are available and situated in unit offices.

Roll checks

43. 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 see the prisoner is in the cell but is not required to confirm that the prisoner is alive. Some roll checks are carried out very early in the morning when 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.

KEY FINDINGS

44. On 16 December 2005, the man was sentenced at the Crown Court to 30 months imprisonment. He had been found guilty of being involved in the supply of drugs. After receiving his prison sentence, he was taken to HMP Durham.

45. Durham is known as a local prison, which simply means that its main function is to serve the local courts. Once a prisoner has been remanded into custody or sentenced to imprisonment they are taken to a local prison. Following assessment, and subject to the security category, a convicted prisoner may be transferred to another establishment. On 1 February 2006, the man was transferred from Durham as a category C prisoner and taken to Acklington.

46. On 23 August, as part of his sentence plan, the man was transferred to HMP Haverigg where he stayed for two months. He returned to Durham on 10 October, remaining there until 6 March 2007 when he was released on licence.

47. Due to the nature of his offences, the man was being managed in the community under the MAPPP high risk arrangements. He went into supported accommodation provided by Northumbria Probation Area. (Supported accommodation is shared accommodation supported by the local drug treatment team.) The man's release was supervised by a probation officer of the Northumbria Probation Area.

48. The clinical reviewer notes correspondence in the man's medical record from the consultant psychiatrist of the district hospital. The doctor wrote about increased concern by the mental health team following the man's release from prison, and his own assessment of his condition on 1 May 2007. The assessment revealed increasing mental stress with marked suicidal thoughts. The doctor prescribed Olanzapine and Diazepam and planned to review him a week later.

49. In the meantime, whilst at the supported accommodation, the man was given Subutex (the active ingredient of which is buprenorphine, a drug prescribed to assist drug users overcome the effect of opiate withdrawal). Probation records show that, in the early days, the man co-operated with the Subutex programme and was regarded by his supervising officer as making a real effort to end his drug habit. He progressed so well that his supervising officer supported an application for him to be given a placement on the ASRO programme due to start later that month.

50. Unfortunately, the man's life style became chaotic when once again he returned to drugs. He got himself into debt and, on 3 May 2007, telephoned his probation officer to tell her he was being threatened because of the money he owed. He told her he had used cocaine on more than one occasion and owed £240. The man went on to say that he would kill himself if he was not given alternative accommodation.

51. His probation officer told him to inform the police about the threat, and to go to a local homeless persons unit as they could provide him with emergency accommodation. At that point, he became angry and threw a fire extinguisher through a window. Two police officers dealing with an unrelated matter saw what he had done. They arrested him and took him to the police station where he was charged with criminal damage.

52. As the man was still on licence and subject to MAPPP, an urgent referral was made by the Probation Service to the Early Release and Recall Section (then part of the Home Office, now part of the Ministry of Justice) which recommended an emergency recall to prison. The reason for recall was that the man had breached his licence conditions. Additionally, he was considered to be a risk to members of the public and to himself. The following day (4 May), the Home Office confirmed his licence had been revoked and he was returned to Durham prison.

53. The clinical reviewer notes that, whilst in Durham, the man was placed on a detoxification programme. He was also given an assessment for his ongoing asthma condition. The clinical reviewer notes that the man's suicidal thoughts and depression appeared to resolve when he began the detoxification programme, and there was no need for further psychiatric assessment. The man continued with a gradual reduction in the programme with reduced medication.

54. On 8 June, the man referred himself to the prison's CARATs team. Once again he was regarded by his supervising officer as making a determined effort to get away from drugs.

55. On 23 July 2007, the man telephoned his probation officer at her office. He had been told that he would not be able to join the PASRO programme at Durham because he was to be transferred to Acklington. The probation officer noted in the probation record that he was upset about being unable to join the programme.

56. Two days later, the man left Durham and transferred to Acklington. The clinical reviewer notes that assessment of his physical and mental health revealed that he had mild to moderate asthma which was disturbing his sleep. The man was required to continue using an inhaler and inhaled steroids. During the reception procedure at Acklington, he told the officer that he did not want to be located onto Foxtrot (F) or Golf (G) units due to previous problems. After completing the reception documentation, he was allocated to Delta (D) unit.

57. The duty SO spoke to the man after he arrived at Acklington. The SO had known the man from a previous sentence. He told my investigator that the man said he was unhappy at being recalled to prison. The man told him that he was having problems with his girlfriend, and he had been recalled for a trivial reason.

58. The duty SO told my investigator that he did not think that the man was depressed, but could see that he was unhappy. He added that the man was concerned about being back in prison as he thought his girlfriend would end their relationship. The man told the SO that he had a child. He asked the SO for writing paper, but did not say whom it was he wanted to write to. The duty SO presumed from the conversation that the man was going to write to his girlfriend.

59. The following day (26 July), the man was seen as part of the normal reception procedure by the prison's medical officer. The clinical review shows that the doctor assessed the man's physical and mental health. The doctor arranged for a routine asthma review which revealed ongoing mild to moderate asthma requiring inhaled steroids. His mental state appeared stable, although somewhat depressed. The detoxification programme continued with a gradual reduction in medication and sleeping tablets overseen by the doctor.

60. At some stage the man wrote a note asking to see the Principal Officer (PO). The note, which he handed to the prison officer on 29 July, said he suffered from anxiety and depression. He said he was having problems over the death of a brother and the murder of an uncle. The man went on to write that he had tried to talk to Listeners on a previous sentence, but implying that they told other prisoners of his problems. The man added that he felt suicidal and asked to move to another cell to be closer to someone he knew. Finally, he added that he wanted to see a doctor.

61. After reading the note, the first prison officer opened an ACCT document the same day. (the officer is a trained ACCT assessor.) She described the man as being low in mood. In the assessment section, the officer noted that the man's problems related to the death of his brother who he said had died in HMP Frankland. He also referred to an ongoing trial relating to the apparent murder of his uncle.

62. The man told the first prison officer that he had last harmed himself in April 2007, not intending to kill himself but instead to relieve pressure. He said that his previous attempts to kill himself were by hanging, but he had also cut his arms and throat not intending to end his life. The prison officer asked the man how depressed and suicidal he felt. She described him as shaking his hands to indicate that the decision was evenly balanced.

63. The officer noted that the man said he was taking medication because he had been hearing voices but said he had not heard them since. (The entry does not note what the voices were saying to the man.) The man also told the officer that his mother was dead. He said that his family did not support him as they blamed him for her death.

64. As soon as the ACCT assessment had been completed, the first prison officer, the wing SO, and the man met to discuss the action plan. The wing SO wrote the assessment and arranged an appointment with a community psychiatric nurse (CPN) on 2 August. He also asked probation staff to identify the date of the man's licence recall review. The wing SO arranged for the

man to remain in his current cell, which he occupied alone, so that he could speak freely to his cousin in a cell opposite his.

65. After completing the ACCT case review, the wing SO arranged a further case review for 2 August. Finally, the wing SO wrote on the front cover of the ACCT document noting his instructions regarding the level of observations. He wrote that the man should be seen three times during the night, with three conversations during the day, emphasising the need for staff to speak to him at least once in the morning, afternoon and evening.

66. As part of the investigation, my investigator met the PO and asked her how well she knew the man. She said that she had known him for about four years. She described him as depressed and said he once told her that he had often thought about suicide. The investigator asked if she had spoken to him about the note, and she said she had not. She added that she was not on duty when the note was received, and was satisfied that her staff had dealt with it correctly. However, she did speak to the SO who dealt with it in her absence.

67. The PO said the wing SO told her that the man had asked to move to another unit to be closer to a friend. The man told the SO that he did not trust the Listeners to respect the confidentiality of conversations with them. The PO said that the man had raised concern about Listeners on a previous sentence and believed it was paranoia on his part. The PO told the investigator that she had not discussed the man's concerns with the Listeners. She said that other staff had said he was happy to be back in prison. She added that her impression was that the man felt he had more support in prison than in the community.

68. One day later (30 July), the man was interviewed by a member of the probation team. He explained the recall process but told the man the review date had not been set. The officer noted in the ACCT document that the man had a good understanding about the process.

69. The ACCT document shows that the man had settled down and appeared in good spirits. However, on 31 July the ACCT document notes that the man was angry because his name was not on the medication list. The nurse dealing with treatments corrected the error and the man later apologised for his behaviour. The ACCT document shows that the man settled down again.

70. On 2 August, the man was seen by the CPN. After interviewing the man, the CPN wrote a summary of the meeting in the ACCT document. They discussed his personality disorder and alternatives to self harm behaviour. The CPN noted that the man did not have thoughts or plans of suicide at that time. They agreed that the man should ask to see a CPN whenever he was stressed rather than harm himself. The CPN also referred him for remedial gymnasium.

71. My investigator met the CPN and asked him to describe the man's mood. He said the man did not appear to be suffering from "clinical depression", but was

instead in low mood. The CPN explained that Acklington has a local policy of providing extra gymnasium activities for prisoners with mental health problems. He said it was the man who told him that he had a personality disorder, and not his own diagnosis. After ending the meeting with the man, the CPN arranged to see him again a week later on 9 August.

7 August

72. The first wing officer is a permanent member of D unit staff. He had known the man for some time during various prison sentences. Although unaware that the man had been released on licence, he did know that he had returned to the prison after breaching the conditions of his licence.

73. At interview, the wing officer described the man as someone who did not cause staff any problems. He said the man got on with most of the staff. The officer went on to say that the man would very rarely go to education classes or workshops, preferring instead to remain on the unit.

74. After arriving for duty at 1.30pm on 7 August, the officer went directly to D unit where he worked in the afternoon as an induction officer. He told the investigator that he did not see the man until approximately 5.00pm, when he was unlocked to collect his evening meal and medication.

75. During the afternoon, the man was meant to receive a visit from his girlfriend but she did not arrive. The wing officer said the unit SO asked him to allow the man to telephone her in order to find out why the visit did not take place. He added that the man had no money available to use the prisoners' telephone and, because he was on ACCT, the SO agreed to him being allowed to use one of the prison telephones.

76. The wing officer told the investigator that the man appeared to be in a low mood. He took him to an office and, before he was allowed to speak to his girlfriend, he explained who he was and asked if she would take the call. After she agreed to receive the call, the officer handed the telephone to the man. (Because he was using an office telephone, the officer was required to remain with him). The wing officer heard the man ask his girlfriend why she had not visited. Although the officer did not hear the reply, he said the man accepted her answer. The man went on to tell her that he had a parole hearing due. He also asked if she would book another visit for the following Saturday (11 August). Again, the wing officer did not hear the reply. After about two minutes, the man ended the call telling his girlfriend that he loved her.

77. The wing officer described the man as being much happier after he had spoken to his girlfriend. The man told the officer that she was going to try and visit him on the Saturday, and thanked him for allowing the call. Once he had left the office, the officer made an entry in the ACCT document noting the telephone call.

78. Although the officer was not present at the time, he knew that the man had had a disagreement with a nurse about his medication. The man had been prescribed sleeping tablets, but the prescription had expired which meant the nurse was unable to supply the tablets. At 6.45pm, the second wing officer, one of the unit staff, recorded in the ACCT document that the man had applied to healthcare for more tablets.

79. At 7.15pm, the wing officer made a further entry in the ACCT document noting that the man had been on association all evening. (Association periods allow prisoners to meet with other prisoners socially.) He added that the man was concerned at not being given sleeping tablets.

80. Five minutes later at 7.20pm, the wing officer began locking prisoners up for the night. In interview, he remembered that the man was the last person on the landing to be locked in his cell. After locking the prisoners, the wing officer completed his work by counting the landing roll. He recollected seeing the man lying on his bed, watching television. The wing officer returned to the unit office to record his landing roll and to wait for the arrival of another officer, who was coming on duty early that evening, to allow him to leave.

81. The duty officer arrived for duty at approximately 7.45pm. Although he was not due to be on duty until 8.45pm, he had agreed with the first wing officer to take over early so that he could leave the prison. The duty officer told my investigator that he went straight to D unit where he met the wing officer. He said the wing officer told him that the man was being monitored under ACCT and that he had spoken to him about 30 minutes earlier (7.15pm). The duty officer went on to say that the wing officer told him the man had been expecting a visit that afternoon from his girlfriend but she had not arrived. He also told him about the telephone call.

82. At approximately 8.40pm, the duty officer went to what he believed was the man's cell to check on him. He looked into the cell and saw a prisoner whom he thought was the man lying on his bed, watching television. The officer returned to the wing office and made an entry in the ACCT document, noting what he had seen. Once the duty officer had made the entry, he realised that he had been to the wrong cell. After checking the unit roll board to confirm the correct cell, he went straightaway to the right one, cell D1-7. I understand that the exact location of prisoners subject to ACCT is noted in the unit diary for the information of all staff.

83. When the duty officer arrived at the cell a few minutes later, he lifted the observation panel. After switching on the internal cell light, he saw the man hanging from the window bars. At interview, he said he could see his face which he described as being discoloured. He said he could see his eyes were wide open and that he looked to be seated. The officer said he saw that the ligature was secured to the window hinge.

84. The duty officer immediately unlocked the cell door, and at the same time removed his anti-ligature knife from its holder. He lifted the man up to take the pressure off his neck and cut the ligature using the knife. He then placed

the man onto the floor and loosened the ligature. The duty officer checked for any sign of breathing and a pulse, but did not detect anything. As he was the only member of staff in the D unit at that time, he then ran to the office to raise the alarm. Rather than use a prison radio, he used the emergency telephone number (222) to alert the communications room operator (the OSG) that there was a code blue emergency on D unit. After raising the alarm, the duty officer went straight back to the man and began to administer Cardio Pulmonary Resuscitation (CPR).

85. The prison radio communication log shows that, at approximately 8.45pm, the OSG received an emergency telephone call telling him of the code blue. He immediately informed the rest of the staff on duty via the prison radio, asking for all available staff to go to D unit. The OSG also telephoned for an ambulance via 999. Additionally, he sent a message to the on call Duty Governor via pager, asking him to contact the prison urgently. Unfortunately, the pager did not respond correctly so another OSG, who was also in the communications room, telephoned the Duty Governor.

86. In the meantime, the duty officer continued with CPR alone until he was joined by the third wing officer who had responded to the radio message. The duty officer told him to go back to the unit office to collect a resuscitation mask, while he continued with CPR. After collecting the mask, the third wing officer assisted the duty officer with CPR. Between them, they alternated the chest compressions and breathing until other staff arrived.

87. When the duty officer made the emergency call, the night manager (the duty SO) was also in the communications room. The duty SO issued a code blue message via the prison radio asking all available staff to go to D unit. He too went to D unit where he saw the duty officer and the third wing officer carrying out CPR. At interview, the duty SO described how he supervised what was happening, explaining that other staff arrived and assisted. He said mouth to mouth resuscitation was being administered via a plastic mask placed over the patient's face. (The mask has a tube in it, which the rescuer blows air through.) He said the officer was having difficulty getting any air into the man's lungs and that his chest was not rising. The duty SO described the man's skin colour as pale, his lips blue, and his eyes open.

88. The duty SO told my investigator that he did not know if a defibrillator was available in the prison, saying he presumed that if one were available it would be in healthcare.

89. Meanwhile, the second prison officer was in Bravo (B) unit, a short distance from D unit. She was relieved at approximately 8.55pm by a night patrol and went directly to D unit to offer assistance. When she arrived, she went to the man's cell and saw the officers carrying out CPR. She told my investigator that she took over CPR from the duty officer. She described the man's pupils as fixed and staring. She said his skin colour was becoming darker. The second prison officer checked the man's mouth for any sign of obstruction, as it was apparent to her that his mouth was full of liquid and air was not getting

into his lungs. As the staff were unable to see any blockage, they continued CPR until the ambulance staff arrived.

90. At 8.59pm, the ambulance arrived and was escorted to D unit. The second prison officer said the ambulance staff placed an oxygen mask over the man's mouth and attached an electrocardiograph (ECG) machine to his body. The ECG equipment did not show any sign of life. She said the ambulance staff then attached a defibrillator to the man to administer an electric shock, but it too was unsuccessful. As the man had not responded to the shock or CPR, the ambulance staff stopped any further attempt to resuscitate him and concluded that he had died.

91. When all attempts to resuscitate the man had been unsuccessful, the on call prison doctor was contacted at home at 9.10pm and asked to attend. The doctor was told what had occurred and asked to make his way to the prison to certify that the man had died.

92. In contrast to the recollections of the others interviewed, the duty SO believed CPR had continued until the doctor arrived. My investigator asked him if he was certain that his account was correct as other staff had told him CPR stopped soon after the ambulance staff gave the electric shock. The duty SO then doubted that his memory of events was correct. I am satisfied that CPR did stop once the ambulance staff said the man had died.

93. At 9.25pm, the on call Duty Governor arrived. Fifteen minutes later, the doctor telephoned the prison to tell them he was on his way. A few minutes later, the communications officer received a telephone call from a police officer telling him that the police were also on their way to the prison.

94. At 10.25pm, the prison doctor arrived and went directly to D wing. After carrying out his own checks, he confirmed that the man had died. The ambulance staff, having received confirmation that the man was dead, packed their equipment away and left the prison at 10.42pm. The doctor left a few minutes later.

After the man's death

95. Police officers arrived at about 11.30pm and initially treated the area where the man had died as a potential crime scene. After satisfying themselves that no one else was involved in the man's death, they left the prison shortly before midnight. During a search of the man's cell a handwritten note was found. The note simply said, "Phone [name withheld] my uncle I'm happy gone. Thanks."

96. At 1.47am the following morning, undertakers arrived at the prison and left with the man's body shortly afterwards at 2.20am. After meeting with his staff, the Governor and the Deputy Governor left the prison. Once they left, the prison was locked and placed in night state.

97. The first wing officer returned to the prison in the morning. When he arrived, he met the duty officer in the street who told him that the man had been found hanging during the night and had died. The wing officer did not believe the news, but when he went into the prison he realised it was true. The officer said that one of the governors took him to one side and told him what had happened. The governor arranged for the care team to offer support. The wing officer said the care team were helpful and was satisfied with the level of support available in the prison.

98. Following the man's death, the Deputy Governor arranged for the prison care team to be on hand and available to any member of staff. Additionally, managers at all levels made a conscious effort to speak to those directly involved and provide further support. All open ACCT documents were reviewed.

99. Managers and staff spoke to prisoners, telling them what had happened. Listeners were briefed and were asked to assist staff in supporting prisoners.

Contacting the man's next of kin

100. When any prisoner is received into prison they are asked to identify their next of kin. This is then recorded in the prisoner's record. Following the man's death, his prison record was checked. The record showed that he had first given the name of a woman who at the time was a prisoner at Low Newton. At some stage, the details were changed to another woman whom he described as his girlfriend. Having obtained her address, police officers in the area visited and asked her to telephone the Deputy Governor. The man's girlfriend telephoned at about 1.00am, and he broke the news to her. She told him that she had spoken earlier to the man, and he had not given any indication of what he was about to do.

101. Later that morning, the Deputy Governor received a telephone call from the police and was told that the man's girlfriend did not want to be regarded as the man's next of kin. This left the Deputy Governor in a quandary, as he had no further details of who could be contacted. The prison liaison officer decided to contact the man's probation officer to see if she knew of anyone who could be told of the death. Whilst trying to contact the probation officer, the Deputy Governor received a telephone call from the man's mother. She said she had been told by a friend that her son had died and she wanted to know if it was true.

102. The prison liaison officer had originally been told that the man's mother was dead. However, after confirming her identity, he told her what few facts he had available at that time. He arranged for the prison's family liaison officer, and the chaplain to visit her the following day.

ISSUES

Assessment, Care in Custody and Teamwork (ACCT)

103. Once the man handed a note to prison staff telling them that he was suicidal, an ACCT document was opened. He was assessed very quickly and a suitable support plan written. The case review shows that the decisions taken were acted on in a timely fashion. I am satisfied that the ACCT document was opened as quickly as possible and also that the man was monitored correctly.

Clinical care

104. The clinical review describes the man as a rather immature young man, with a long history of drug abuse. He had experienced frequent episodes of self-harm and shown previous suicidal intent, and this was immediately recognised at Acklington. The doctor adds that the man was placed appropriately on ACCT monitoring, with no significant depression or suicidal risk identified.

105. The clinical reviewer concludes that the standard of care was consistent with accepted NHS medical and prison practice. He adds that there were no clear organisational deficiencies that could have been implicated in the man's death. The doctor commends the ACCT procedure at Acklington for its person- centred approach. Although he does not make a recommendation, he believes that a comprehensive integrated healthcare IT system might make the assessment of health and prison care easier.

Resuscitation

106. In the eleven previous investigation reports into deaths at Acklington, I have not identified any similarities to this case other than staff training. I have previously said that consideration should be given to providing first aid training for all staff who have contact with prisoners. In the man's case, I extend the recommendation regarding first aid training to include the use of a defibrillator.

CPR

107. The duty SO gave a different account of the length of time CPR was carried out. Contrary to others, he said it continued until the doctor arrived. After being told that his account differed from other witnesses, he began to doubt that his recollection was correct. I am satisfied that CPR did continue until the ambulance staff took over, and it was they who stopped any further attempt to resuscitate the man after the electric shock failed. (I should emphasise that I am satisfied that the SO's account was a simple mistake and not intended to mislead. No criticism of him is intended or to be inferred.)

Face Masks

108. Whilst attempting to resuscitate the man, the staff used a face mask to blow air into his lungs. The mask is designed to allow the user to blow air in through a one way valve, whilst at the same time being protected from any liquid that may come from the patient's mouth. It is intended to be used in close contact.

109. In contrast to the face mask, the ambulance staff attending to the man used an Ambu bag. The equipment has a mask that fits firmly over the patient's mouth and air is pushed in by squeezing a bag. Unlike the face mask, it is not a close contact piece of equipment.

110. My investigator spoke to the healthcare manager about the face mask and the risk posed by body fluids being accidentally transmitted to the resuscitator. The manager immediately recognised the benefit of Ambu bags and placed an order for Laerdal masks to be supplied. (Laerdal masks are similar to Ambu bags and offer greater protection to the person using them.) I welcome and commend his action.

Defibrillator

111. My investigator asked staff involved in trying to resuscitate the man whether they had considered using a defibrillator. He was told that a defibrillator was available, but that it is locked in healthcare. Other than the night manager, no one else has access to it. The night manager said he did not know where it could be found.

112. When ambulance staff were trying to resuscitate the man, they connected their defibrillator to his body. The automated equipment told them to shock him, but this was unsuccessful. Although I cannot say with any certainty what the outcome might have been had a defibrillator been used by prison staff, I am bound to wonder if an earlier intervention might have had a positive effect.

113. After speaking to the healthcare manager, it was evident to my investigator that there are five defibrillators available across the prison, one of which is on D unit. However, I understand that it was generally believed that prison officers had no interest in learning how to use them and therefore they had not been made available to anyone other than medical staff. My investigator spoke to a member of the local Prison Officers' Association and asked if officers were reluctant to use the equipment. He said not, but went on to explain that no time had been made available to train the staff in their use.

114. Whatever the situation, I urge the Governor to find a way through the problem, which from my own investigations does not appear to be an issue in any other prison. I make the following recommendation:

    The Governor should consider training all staff in the use of defibrillators and make the equipment accessible. The Governor should

ensure that, at night, the night manager is not the only person trained to use the equipment.

Emergency Gate Override System

115. In an emergency, it is essential that the vehicle gates are capable of being opened to allow movement in and out of the prison. During the day, the gate staff can open and close the gates freely. However, in night state when the gate security systems have engaged, this is not possible without overriding the system.

116. In Acklington's case, the only person who can override the system during night state is the night manager. The night manager, who may be at the scene of an incident, must leave the area and first go the security department. After unlocking a safe, the night manager obtains the override key and breaks a seal to remove the key from its pouch. The night manager has then to leave the security department and go to the gatelodge where he or she can override the security systems.

117. The night manager told my investigator that he had five officers on duty at night, but none had access to the override key. The night manager was assisting with CPR when the ambulance arrived, but by the time it was leaving the automatic gate systems had engaged. Had the man been alive and requiring emergency transfer to hospital, the night manager would have had to leave him to override the gate security systems.

118. A further scenario to consider was what the situation would be if it were the night manager himself who collapsed. My investigator judged that this required urgent rectification and fed back his views to the prison liaison officer immediately.

The Governor should, as a matter of urgency, ensure that at least two people are on duty during the night who are trained and capable of overriding the gate security systems.

Family contact

119. Although quickly contacted, the person identified by the man as his next of kin did not want that responsibility. With no other family details available, efforts were made to speak to the man's probation officer.

120. In the meantime, the man's mother (whom he had said had died) rang the prison and spoke to the prison liaison officer. After confirming that he was indeed speaking to the man's mother, the liaison officer gave as much information as he had to hand.

121. I am satisfied that the prison did everything possible to ensure the next of kin was told as soon as possible about the man's death. They were not to know that the person listed as next of kin would withdraw. Neither were they to

know that the man had, for whatever reason, incorrectly told prison staff that his mother was dead.

122. I have been pleased to learn that the prison's family liaison officer and chaplain subsequently went to tell the mother what had occurred. Additionally, I am pleased that the prison has offered to assist the family with funeral costs.

123. My own family liaison officer has also contacted the man's mother. The mother told her that the prison have been extremely helpful and have returned the man's possessions to her.

Support for Staff and Prisoners

Prisoner Support

124. At a management meeting held the morning after the man's death, the Deputy Governor reminded all managers of the need to ensure prisoners were given the correct information. He asked for Listeners to be told about what had happened. In addition, he issued a notice to all prisoners telling them that the man had died. The PO and a governor spoke personally to a friend of the man. Additionally, all open ACCT documents were reviewed. Staff unlocking prisoners for the day ensured they were aware of what had happened. Not surprisingly, I understand that the prisoners were calm and subdued.

Staff Support

125. When my investigator arrived at Acklington on 9 August, it was evident that arrangements had been put in place by the Deputy Governor to support staff affected by the man's death. He found notices clearly displayed around the prison reminding them about the services of the local care team, and a separate notice telling staff when a member of the Prison Service Staff Care and Welfare would be present.

126. I also understand that, on the night the man died, the prison care team were contacted and quickly made support available to staff. Additionally, one member of the team arrived at the prison in the early hours of the following morning to relieve the care team who had been working through the night.

CONCLUSIONS

127. I conclude that, although the man was being monitored under the ACCT arrangements, he kept his true intentions very close to himself. He had often talked of suicide and clearly he had a number of mental health problems. However, unless a prisoner is subject to constant supervision (where a prisoner is supervised by a designated member of staff on a one to one basis, remaining within eyesight at all times and within a suitable distance to be able to physically intervene quickly), there will always be an opportunity for any prisoner to seriously harm themselves. I do not believe that the man warranted a one-to-one level of observations, and am satisfied that the prison did everything that was reasonable to protect him.

128. The evidence shows that ACCT monitoring was being carried out within the correct time scales. The man was monitored at 7.15pm, and it was as a result of an extra check that he was discovered hanging at 8.40pm. I am satisfied that ACCT monitoring was appropriately carried out.

129. It was only after his death that it became clear that the man had fabricated stories, telling prison staff that his brother had hanged himself in prison. He also told them that his girlfriend had committed suicide in prison. Additionally he told staff that his mother had died and his uncle had been murdered. All of these stories were untrue.

130. In the aftermath of the man's death, I judge that Acklington properly met all its responsibilities to the man's family, to its staff, and to other prisoners, so far as it was able.

131. My investigation has revealed some weaknesses in Acklington's night-time arrangements. However, I commend the speedy actions of the Healthcare Manager in recognising the benefits of Laerdal masks and placing an order for them to be supplied.

RECOMMENDATIONS

1. **The Governor should consider training all staff in the use of defibrillators and make the equipment accessible. The Governor should ensure that, at night, the night manager is not the only person trained to use the equipment.**

   The Governor has not accepted the recommendation

2. **The Governor should, as a matter of urgency, ensure that at least two people are on duty during the night who are trained and capable of overriding the gate security systems.**

   The Governor has accepted the recommendation.