Circumstances surrounding the death of a man at Wansbeck Hospital, Northumberland, in October 2006, whilst a prisoner at HMP Acklington

Report by the Prisons and Probation Ombudsman for England and Wales

June 2007

This is the report into the death of a man at Wansbeck General Hospital on in October 2006. The man, who was a prisoner at HMP Acklington, died after being admitted to hospital following concerns about reduced oxygen levels in his blood and his persistent problems with chest pain. He was 76 years old.

The man was at Acklington having been recalled to prison in July 2006. Prior to his recall, he had been residing in an Approved Premises in Middlesbrough. The placement had broken down due to his behaviour towards hostel staff and his refusal to cooperate with police and probation services.

One of my Family Liaison Officers contacted the man's daughter and son-in-law to inform them of my investigation and to offer the opportunity to raise any concerns. I know that they are worried about the circumstances surrounding the man's recall to prison and the care he received whilst in custody. They are also unhappy about not being told that he had been moved to hospital. I hope this report goes some way towards addressing their concerns, and I offer them my sincere condolences for their loss.

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

Northumberland Care Trust conducted a review of the care the man whilst in prison and I appreciate its invaluable contribution to the investigation.

This report deals not only with the care the man received whilst in prison, but also with the circumstances that surrounded his recall. I was pleased to learn that the revocation of his licence was a last resort. It came after he had been properly warned on more than one occasion about his behaviour and the consequences of failing to comply with his supervision.

I make one recommendation. This concerns the unsatisfactory manner in which the news of the man's death was broken to his family.

This version of the report has been anonymised in preparation for publication on the PPO website. This has required some amendment to the text of the final report.

Stephen Shaw CBE
Prisons and Probation Ombudsman **June 2007**

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SUMMARY

On 5 July 2004, the man appeared at Teesside Magistrates' Court and was remanded into the custody of HMP Holme House. Upon his reception, he was assessed by healthcare and a family history of heart disease and mobility problems were identified. He was initially held on the healthcare unit so that his mobility could be assessed. This and subsequent assessments showed that he was able to move adequately with the aid of two elbow crutches.

In September and October, the man claimed that he had been assaulted. He was seen by healthcare staff who noted minor injuries. On 25 October, he said that he had suffered a "stroke". When he was examined by a nurse, he said he was fine and had no health problems other than earache.

On 24 January 2005, the man appeared at Teesside Crown Court and was sentenced to three years' imprisonment with three years' extended supervision. On 18 February, he was transferred from Holme House to Acklington where he would remain until he was released.

A month later, he again claimed that he had been assaulted. He was assessed by a doctor who could find no obvious signs of injury. He was seen by another doctor the following day. This doctor too could detect no injuries.

In May 2005, the man who later died was referred for an x-ray of his pelvis, hips and knees. The results were received on 8 June. Osteoarthritis in both knees and mild degeneration of the left hip were noted.

The man was released from Acklington on 3 January 2006 on licence. He was supervised by Teesside Probation and, as a condition of his release, he had to reside at an Approved Premises in Middlesbrough. Prior to moving there he signed the Approved Premises 'Core Rules'. By doing so, he agreed to refrain from abusive, aggressive and violent behaviour whilst resident in the hostel.

In late January, he was formally warned by his probation officer for being aggressive towards his keyworker at the hostel. In June, he made threats of violence in writing and was issued with a further warning.

Whilst in the community, the man made concerted efforts to find independent accommodation. Unfortunately, he failed to keep the police and probation services informed of his plans which he was required to do as a condition of his release.
On 28 July 2006, his licence was revoked and he was recalled to prison by the Home Office because of his threatening behaviour towards hostel staff and his refusal to cooperate with police and probation. He was returned to Holme House on 31 July and was transferred to Acklington on 10 August.

During the morning of 22 September 2006, the man complained of pains in his chest. An ambulance was called but he refused to be examined by the paramedics. He was seen later in the morning by a nurse who conducted

basic observations and found him to be satisfactory. He was given some painkillers to combat what he described as a sharp pain.

On 25 September, he again suffered from an episode of severe pain in his chest. He was transferred to the healthcare centre where an electrocardiogram (ECG) was conducted. He was seen by a doctor who diagnosed the problem as having a gastric origin. The man was prescribed an antacid which apparently alleviated the pain temporarily.

Later in the day, the pain returned and he was seen by a nurse. She also found that the pain originated in the man's abdomen, and therefore chose not to transfer him to outside hospital. The following morning, he did not report any pain.

On 5 October, the man reported that he was short of breath. The nurse who attended to him noticed that he was talking a lot, and this led her to suspect that his claims about being short of breath were exaggerated. The next day, he again claimed to be experiencing shortness of breath. Basic observations were carried out and his vital signs were found to be within the normal range.

During the morning of 9 October, the man reported pain and feeling short of breath. His basic signs were tested and were found to be within the normal range. However, as a precautionary measure, the nurse decided to examine him again later that day. She visited at lunchtime when he did not report any particular problems. However, the nurse found out that the oxygen levels in his blood were lower than they should have been, and she admitted him to the healthcare centre for further tests. In the afternoon, he was moved to the healthcare centre in a wheelchair. By this time, his physical appearance had changed significantly and he looked unwell. The nurse decided to transfer him to Wansbeck General Hospital and he was admitted later that day. A number of tests were carried out over the next two days which established that he had suffered a heart attack at some point in the recent past.

Just after 4.00pm on 11 October, the man's condition suddenly deteriorated. A crash team of medical staff was called but was unable to revive him. He was pronounced dead at 4.22pm. His next of kin was informed of his death shortly after 9.00pm.

THE INVESTIGATION PROCESS

1. My investigator considered the man's prison documentation, including his clinical records, before formally opening the investigation on 9 January 2007.

2. Prior to my investigator arriving at Acklington, notices were issued to staff and prisoners announcing the investigation and inviting anyone who had information relevant to the death to make themself known to the investigator. One prisoner came forward and six members of prison staff were interviewed by prior arrangement. The man's supervising probation officer was interviewed, and his solicitor was also spoken to on the telephone.

3. One of my Family Liaison Officers contacted the man's daughter and son-in-law to offer them the opportunity to participate in the investigation process. They raised concerns about the circumstances of the man's recall to prison and the way he was cared for after returning to custody. They said they believed prison healthcare ignored his family history of heart problems and the low levels of oxygen in his blood, and that the professionalism of the healthcare staff left a lot to be desired. Finally, they were unhappy that the prison failed to tell them that the man had been transferred to hospital and about the way in which the news of his death was broken to them. I hope this report goes some way towards addressing their concerns.

4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist him with his enquiries.

5. Northumberland Care Trust conducted a review of the clinical care the man received whilst in custody.

HMP ACKLINGTON

6. HMP Acklington opened in 1972 as a category C prison. The jail is situated on a former Royal Air Force base near Amble in Northumberland. It has the capacity to hold 882 prisoners.

7. One of the wings is H Wing which accommodates 120 prisoners. Cells on H Wing are single occupancy and include full in-cell sanitation. Cells on the ground floor are allocated to prisoners with mobility problems.

8. Northumberland Care Trust provides healthcare to the prison. Nurses are employed to deliver primary healthcare during the daytime, seven days a week. Prisoners who require 24 hour nursing care are transferred to an outside hospital or another prison as there is no inpatient unit.

9. Her Majesty's Chief Inspector of Prisons carried out an unannounced inspection of Acklington in April 2003. The Chief Inspector, Ms Anne Owers, found Acklington to be a safe prison and commented that "low levels of self-harm and the absence of self-inflicted deaths reflect well on the proactive approach taken by staff". However, the inspectorate highlighted concerns about the needs of older prisoners, and those with health conditions requiring a level of care that could not be provided at Acklington.

10. Prior to the man's death, seven prisoners had died at Acklington since I assumed responsibility for investigating all deaths in custody in April 2004. Since then, three more prisoners have died. Seven of these deaths have been through natural causes. The other four have been self-inflicted.

Release on Licence

14. All prisoners sentenced to more than 12 months' imprisonment are released on licence, which means they are supervised by the Probation Service until the licence expiry date. In general terms, the expiry date falls three quarters of the way through a released prisoner's sentence. There are standard conditions for all licences, which 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.

Further conditions can be added by the Secretary of State if they are deemed necessary to manage a person's risk.

15. If a licencee 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 Home Office 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.

16. Since the Powers of Criminal Courts (Sentencing) Act 2000 was implemented, courts in England and Wales have had the power to extend the period a released prisoner is subject to probation supervision.

Multi-Agency Public Protection Arrangements (MAPPA)

17. 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.

18. 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.

KEY FINDINGS

19. On 5 July 2004, the man appeared at Teesside Magistrates' Court and was remanded into the custody of HMP Holme House. Upon reception, he was assessed by a member of healthcare staff. He disclosed a family history of heart disease and complained of back pain, poor mobility and hay fever. It was noted that he took prescribed medication for his health problems, including painkillers, sedatives and an antihistamine.

20. Later that day, the man was admitted to the healthcare unit so that his mobility could be assessed. It was noticed that he was significantly more mobile when he thought he was not being observed by staff, and could carry a cup without walking aids and make his bed. This contrasted with his presentation when he arrived on the healthcare unit, when he only managed to get round by using two elbow crutches. He was discharged from healthcare on 6 July, and was located with the general prisoner population.

21. A further assessment of his mobility was made by a physiotherapist on 11 August. The physiotherapist also noted that his ability to move about deteriorated when he became aware the staff were observing him, and also concluded that he did not require additional walking aids. He was not deemed to require relocation to another wing or prison with disabled access as his mobility was assessed as being satisfactory.

22. On 12 September, the man alleged that he had been assaulted by another prisoner. He was seen by healthcare staff who noted minor lacerations to his mouth and the top of his head. No serious injuries were observed and he was prescribed a painkiller for the soreness.

23. The following month, on 16 October, the man alleged that he had been struck in the face with a glass jar. He was taken to the healthcare centre and assessed, but no signs of trauma were identified.

24. On 25 October, the man was examined in his cell by a nurse in response to a letter he had submitted to the prison claiming he had suffered a stroke. When questioned, he said that he was fine and had no complaints apart from earache in his right ear. He then proceeded to walk across his cell from his bed to a chair. The nurse checked his pulse and blood pressure and concluded that he displayed no signs of weakness. He was advised to report sick because of his earache. The following day, the man fell over when his knee gave way. He was again

seen by a member of the healthcare staff who could not find any signs of injury.

25. Six weeks later, on 11 December 2004, a physiotherapist attempted to assess the man's mobility needs. However, he refused to be seen and the assessment did not take place.

26. On 24 January 2005, the man appeared at Teesside Crown Court and was sentenced to three years' imprisonment with three years' extended supervision for a total of nine offences. He was returned to Holme House to commence his sentence. Three weeks later, on 18 February, his suitability for transfer to another prison was assessed by a doctor. The doctor noted that his mobility had been assessed on numerous occasions, and it was thought that he was more physically capable than he claimed. He was therefore deemed fit for transfer, and moved to HMP Acklington later that day.

27. The following month, on 18 March, the man was seen by a doctor at Acklington and claimed that he had been punched by a prison officer. The doctor noted that no bruising was evident. Later in the day, the man was seen by a specialist nurse who has specific responsibilities for Acklington's elderly and disabled prisoners. Again he claimed that he had been the victim of an assault. She too noted that he had no obvious injuries.

28. The next day, on 19 March, the man was assessed by another doctor who conducted a full assessment of his basic functions in light of his claims that he had been assaulted. The doctor could find no injuries and the man denied that he was suffering from double vision or any other sign indicative of concussion.

29. The same day, the man was seen by the specialist older persons nurse in order to assess whether he needed a wheelchair to move about. She concluded that he was able to walk with the use of one walking stick, and therefore did not need a wheelchair.

30. Two months later, on 17 May 2005, the man was referred for a chest x-ray as he was found to have had close contact with a tuberculosis sufferer whilst detained in Holme House. The results came back on 19 May. He was given the all clear.

31. Four days later, on 23 May, he was referred for another x-ray, this time of his pelvis, hips and knees. The results were received on 8 June. Osteoarthritis in both knees and mild degeneration of the left hip were noted.

32. In December, the man's supervising probation officer visited him at Acklington on two occasions. The purpose of the meetings was to start advance arrangements for his release from prison, which would take place on 3 January 2006. During her first visit, the supervising officer

told the man what would be expected of him upon his release. She also told him that Teesside Probation would be seeking additional licence conditions in order to manage the risk he posed to the public. The man was reportedly unhappy with many of these conditions, but he agreed to abide by them when he was released. He also signed the Approved Premises 'Core Rules'. By doing so, he agreed to refrain from using abusive language or aggressive behaviour in the hostel.

33. The man was managed at level two of the Multi-Agency Public Protection Arrangements (MAPPA) as a result of the offences of which he had been convicted. This meant that numerous agencies were involved in his case. An example of how this worked in practice was illustrated later in December when he was interviewed jointly by his supervising officer and a detective from Cleveland Police.

34. On 2 January 2006, he was examined by a nurse, who assessed him as being fit for discharge. During the course of the assessment, the man claimed he was suffering from dysentery, although nothing about his presentation indicated that this was the case.

35. The following day (3 January), the man was released. The extended supervision imposed by Teesside Crown Court meant he would be managed by the probation service until 4 October 2009. His supervising officer collected him from prison and transported him to a police station in Middlesbrough. After he signed some necessary forms, his supervising officer took him to the Approved Premises where he was formally inducted by hostel staff.

36. On 19 January, the man refused to sign his Approved Premises supervision contract or his licence supervision plan, saying he refused to address his offending behaviour because he had not committed any offences. He was subsequently formally warned by his supervising officer for a separate incident of being aggressive towards his keyworker at the hostel and using abusive language. This was in contravention of both the Core Rules of the Approved Premises and condition 5 (vi) of his prison licence, both of which he signed prior to his release. Condition 5 (vi) specifies that those released from prison on licence must 'be well behaved, not commit any offence and not do anything which would undermine the objectives of [their] supervision …'

37. In March, the man started to complain that living in the hostel was having a negative effect on his mental health. His supervising officer and the hostel arranged for him to be assessed by mental health professionals from the Custody Diversion Team. However, he refused to be interviewed and the assessment did not take place.

38. By this time it was evident to both hostel staff and his supervising officer that the man was unhappy about living at the hostel. He repeatedly expressed a wish to leave and live independently. However, he was prohibited from doing so without first obtaining the permission of his

supervising officer who had the authority to veto any accommodation that she deemed unsuitable. On 10 April, the man arranged to travel to Scarborough to view properties. He failed to provide his supervising officer with the addresses of the properties, and did not supply the contact details of the landlords. He was therefore asked to provide the details of the vehicle in which he was going to be travelling to Scarborough so that North Yorkshire Police could be informed. The details he supplied were of a vehicle that was neither registered nor licensed, and as a result permission to travel to Scarborough was denied. When the man attempted to make the journey, he was actively prevented from doing so by Cleveland Police and returned to the Approved Premises.

39. In June, the man once again told probation staff that living at the hostel was damaging his mental health. He said that he felt as though he might attack someone and expressed a view that he would not be responsible for his actions. On 23 June, he was interviewed by a community psychiatric nurse, and was not assessed to be suffering from any significant mental health problems. When the nurse suggested to the man that he was more aggrieved or frustrated than mentally ill, he threatened to physically harm the female staff working at the hostel. He also handed the nurse some handwritten notes in which he made explicit his threats of violence to the female staff. He was issued with a further (and final) warning by his supervising officer for his behaviour.

40. According to the supervising officer, the man persisted in his attempts to move to the coast, despite being told that the MAPPA would not allow it. He responded by saying that he would rather go back to prison than live where the police and probation told him.

41. On 28 July, the man's case was discussed at a level two MAPPA meeting. The meeting was told that his behaviour in the hostel, particularly towards female members of staff, was becoming increasingly difficult to manage, and that his failure to co-operate with police and probation over his housing was undermining the objectives of his supervision. Those present, including representatives from housing, health, police and probation, unanimously agreed that he could no longer be safely managed in the community. The meeting directed that the man's licence be revoked immediately, and the supervising officer completed the necessary paperwork. The Home Office authorised the recall to custody later that day and he was arrested and taken to Holme House on 31 July.

42. Upon his arrival at Holme House, the man was assessed by a member of healthcare staff in accordance with reception procedures. He told the nurse that he had an appointment scheduled with the James Cook University Hospital for a hernia operation. Otherwise, no changes in his health from his previous period in custody were noted.

43. On 3 August, he collapsed with severe abdominal pain. He was seen by a doctor, and an ECG was carried out which revealed that he was suffering from a heart block and extra heartbeats. The doctor noted an irregular pulse and the right-sided hernia. The man was made comfortable by healthcare staff and advised to rest. Subsequent tests failed to add anything to the initial findings of the doctor and ECG.

44. The next week (10 August), the man was transferred back to Acklington. He underwent reception procedures which again identified the presence of a hernia. He was referred to the chronic disease management clinic which it was hoped would help him to manage his symptoms.

45. On 21 August, the man had a General Practitioner appointment. He did not attend, although it was subsequently discovered that the reason he failed to turn up was because there were no wheelchairs available to take him from his wing to the healthcare centre. He was seen the following day by a nurse and again on 23 August by a doctor. After examining the man, the doctor wrote in the clinical notes that the man was experiencing 'nil of a serious nature'.

46. During the morning of 22 September, the man complained of chest pain. As there are no healthcare staff in the establishment between the hours of 7.45pm and 7.30am on a weeknight, wing staff immediately called for an ambulance. North East Ambulance Service has confirmed that it received a call-out at 6.46am and that the ambulance arrived at the prison at 6.55am. The paramedics then went to H Wing, but the man refused to be seen by them. It is reported that he was verbally abusive towards them, and they left the prison without examining him.

47. At around 7.20am, the specialist older persons nurse arrived at Acklington to start her shift. As she was passing through the front gate, a prison officer who had worked the night shift told her that an ambulance had been called out to see the man but he had refused to be examined. She went to his cell where she found him lying on his bed. She examined him and observed that his colour was good, he did not look distressed, and no signs of sweating were evident. The man also denied that he was feeling nauseous. When the nurse asked him to describe the pain, he replied by saying it felt sharp. The nurse told my investigator that pain associated with cardiac arrest is usually described as crushing, and she therefore concluded that his complaint was more likely to be respiratory rather than cardiac. When she asked him why he had not spoken to the ambulance crew, he swore at her and became verbally abusive. The specialist nurse therefore left the cell and could not conduct any further examinations to check whether the man was experiencing respiratory problems.

48. Later that morning, the specialist older persons nurse went to see the man again. On this occasion, he was not abusive and merely requested more painkillers. As he was scheduled to receive his prescribed painkillers at that time anyway, he was given the medication. The nurse

told my investigator that he looked fine at this point and she had no concerns about his presentation.

49. Just before 7.45am on 25 September, the man complained to the staff on H Wing that he was suffering from chest pain. A nurse attended to him and found him to be sweating and writhing in pain. She arranged for him to be transferred to the healthcare centre where an electrocardiogram (ECG) was carried out. The ECG showed that the electrical activity in his heart was abnormal and suggestive of ischaemic heart disease (meaning the blood supply to heart was reduced). However, having read the ECG print-outs, the prison doctor concluded that the ischaemia was of historical origin. In the man's clinical notes, the doctor has identified that an ECG carried out in August 2005 found the same problem. He therefore suspected the man's pain on 25 September to be of gastric origin. The man was prescribed Omeprazole, which suppresses the secretion of acid in the stomach, and this apparently had the effect of alleviating his pain. The doctor made a referral to the consultant cardiologist at Wansbeck Hospital to deal with the bigger problem of insufficient blood being supplied to the heart. Meanwhile, the man returned to H Wing.

50. Later in the day, the specialist older persons nurse was called to H Wing where the man was once again complaining of chest pain. After conducting observations of his blood pressure, pulse and respiration, which were all found to be normal, the nurse determined that the origin of his pain was in his abdomen. As he had a longstanding problem with a hernia, this did not unduly concern the nurse and she refused the man's demands that he be taken to hospital. Early the following morning, the nurse saw the man at the medication dispensary on H Wing. He did not report any pain.

51. On 5 October, the man reported to wing staff that he was short of breath. A nurse was called from healthcare, and he told her that he had been short of breath for three nights in a row and had not slept as a result. However, the nurse observed that he was talking a lot, apparently without great exertion, and this led her to suspect that his claims about being short of breath were exaggerated. She continued her examinations and found that he had a good colour, and blood pressure, pulse and respiration were normal. At one point during the examination, the man became verbally aggressive towards the nurse, but she managed to calm him down and reassure him that he was alright.

52. The following day, the man again complained of shortness of breath. On this occasion, he was seen by the specialist older persons nurse who found his basic observations to be within the normal range. The man told the nurse that he had been vomiting and not eating for the previous eight or nine days, although the nurse could find no obvious signs of weight loss or dehydration to substantiate his claims. However, she did make a non-urgent appointment for him to see the prison doctor.

53. During the morning of 9 October, wing staff asked the Deputy Clinical Team Leader, a qualified nurse, to see the man as he had rung his cell bell on numerous occasions through the previous night. He told the Deputy Clinical Team Leader that he had been suffering from pain and shortness of breath throughout the night. He demanded to go to hospital, but the Deputy Clinical Team Leader could find no reason to transfer him out; his colour was good and no shortness of breath was observed. Indeed, when asked by the Deputy Clinical Team Leader to describe the pain, he said it was coming from his stomach rather than from his chest. As the man already had a non-urgent appointment to see the doctor, the Deputy Clinical Team Leader took no further action although she did ask him whether he would like to come to healthcare. He replied in the negative and said he was fine. The Deputy Clinical Team Leader told the man that she would come and see him again at lunchtime to see how he was doing.

54. At lunchtime, the Deputy Clinical Team Leader returned to H Wing and carried out a series of basic checks on the man. His blood was fine, but the Deputy Clinical Team Leader found that he seemed to be struggling to catch his breath. She told my investigator that he appeared a little bit panicky and, when she tested the amount of oxygen in the blood, she found his reading to be 10per cent less than it should have been. However, he looked satisfactory and he said he was alright so the Deputy Clinical Team Leader said she would move him to healthcare for observation when prisoner movements started after 1.30pm.

55. When the prisoners were unlocked at 1.30pm, the man was transferred to the healthcare centre in a wheelchair. The Deputy Clinical Team Leader again tested his blood pressure and conducted basic observations which showed that his condition was deteriorating. His pulse was in the region of 126-140 beats per minute, which is too fast and meant his heart was not functioning properly. After testing his blood again, the Deputy Clinical Team Leader decided to transfer the man to Wansbeck General Hospital. An ambulance was called and he left Acklington accompanied by two prison officers. He arrived at the hospital shortly afterwards, and was admitted as an in-patient later in the day. In accordance with the bedwatch guidance, the man would continue to be guarded by two members of prison staff until he died on 11 October.

56. At 7.30am on 11 October, two prison officers commenced the bedwatch duty. One of them told my investigator that the man was asleep when she arrived, but over the course of the day he readily engaged in conversation with both herself and her colleague. At 8.55am, the man was seen by a doctor, and later in the morning healthcare staff at the prison telephoned the hospital to check on his progress. The nurse who made the call was told that the hospital had confirmed that the man had had a heart attack and that there were no plans to discharge him.

57. Just after 4.00pm, the man’s condition suddenly deteriorated. One of the bedwatch officer’s told my investigator that he was lying on his back when he abruptly turned on to his side and the colour in his face rapidly drained away. She alerted nursing staff by calling out to them, and they arrived at the bedside within a matter of seconds. Moments later a crash team arrived, and the two prison officers were moved out of the way. The curtains were closed and the medical staff worked on the man. Sadly, the crash team was unable to revive him and he was pronounced dead at 4.22pm.

58. One of the bedwatch officers subsequently telephoned the prison to report the man’s death. Acklington activated its contingency plans for responding to a death in custody, and at 5.16pm the Deputy Governor telephoned the man’s daughter to tell her the sad news. Unfortunately, the call went unanswered so the Deputy Governor left a message on the answering machine asking her to call him at the prison as a matter of urgency. At 6.00pm, the man’s daughter telephoned Acklington but was told that the Deputy Governor had left for the day. Nobody else at the prison was able to help or provide her with any information, and she therefore had no choice other than to wait for the Deputy Governor to call back, which he did at 9.00pm.

59. Staff at Acklington subsequently contacted the man’s daughter to offer her and her husband the opportunity to visit the man’s cell. They also discussed the arrangements for the funeral, the costs of which were met by the prison.

ISSUES

Circumstances surrounding the man's recall to prison

60. One question my investigator has sought to answer is whether the man's recall to custody was justified. It is documented in his prison and probation records that he believed he had been recalled unjustly, and his family has expressed concerns about the way he was treated whilst in the community. Indeed, they told my Family Liaison Officer and the investigator that they thought the criminal justice agencies treated the man in a discriminatory manner because of the nature of his offences.

61. As detailed above, the man was released on licence from Acklington on 3 January 2006. Due to the nature of his offences, the fact he denied committing them, and his failure to engage in any offending behaviour work whilst in prison, he was assessed as posing a high risk of reoffending. Consequently, a number of additional conditions were attached to the standard licence so that his risk could be managed and his behaviour monitored. One of these was a requirement that he live at an Approved Premises. He was not allowed to live elsewhere without obtaining the permission of his supervising officer.

62. The supervising officer told my investigator that, throughout his licence period, the man made concerted efforts to secure accommodation independently. Whilst the probation service and the other MAPPA agencies did not oppose this in principle, the man's refusal to provide the addresses of the properties or the contact details of the landlords meant that probation could not grant him permission to move. In addition, the supervising officer reported that she became aware that the man was providing false information to housing providers: in one housing application, he failed to disclose any of his convictions. In another, he stated that he was currently living in a homeless hostel, whereas he was actually living in a hostel approved by the Home Office to house offenders. It is for these reasons that the supervising officer wrote on the revocation paperwork she sent to the Home Office that the man had been uncooperative with regard to his housing, and that this was serving to undermine the purposes of his supervision.

63. Prior to moving in to the hostel, the man signed the Approved Premises 'Core Rules'. By doing so, he agreed to refrain from using abusive language or aggressive behaviour in the hostel. Over the course of his tenancy he was formally warned on two occasions by his supervising officer, once for being verbally abusive and aggressive towards a female member of staff, and once for threatening violence against female staff in writing.

64. In my view, the formal warnings the man received were entirely proportionate to the seriousness of his behaviour. It was made explicit to him before he arrived at the Approved Premises that aggressive or

abusive behaviour would not be tolerated, and this was reinforced in the warning letters. Approved Premises staff have the right to go about their duties without fear or intimidation.

65. In my opinion, the probation service and other MAPPA agencies were right to look at these incidents as part of a pattern of deteriorating behaviour, rather than in isolation. Given this, the man's on-going refusal to cooperate with the police and probation services about his housing, and the assessment that he posed a high risk of harm to the public, I do not question the decision of the MAPPA to recall him to prison. Clearly his behaviour was worrying, and the agencies that make up the MAPPA could not be sure that he could be managed safely in the community.

The man's access to services and entitlements

66. One of the main concerns of the man's family concerned his inability to access services whilst in custody. His daughter told my investigator and Family Liaison Officer that, whilst in the community, the man was classified as disabled and entitled to relevant benefits. When in prison, he was not given the same status, and his daughter felt that this was tantamount to discrimination.

67. There is no documentation in the man's clinical records to show that he was classified as disabled when living in the community. Indeed, prior to being remanded into custody, he was observed by police officers riding a bicycle. Upon his reception into custody, he was seen to require the use of two elbow crutches. A number of assessments completed by nurses, doctors and physiotherapists, carried out independently of each other, found that these walking aids were adequate for his needs. The clinical review has found that 'when [the man was] not aware that he was being observed, [he] was noted to be reasonably mobile'.

68. After his recall to custody in July 2006, the man who later died was observed to be less mobile. However, my investigator was told that this only affected him when he had to move relatively long distances in the prison, such as from the wing to the healthcare centre. On these occasions, he would be pushed in a wheelchair. I note that, on 21 August, he was unable to attend an appointment with the prison doctor because there were no wheelchairs available. This is clearly unacceptable, and my investigator spoke to the Head of Healthcare to raise his concerns. The Head of Healthcare confirmed that there had been a problem with wheelchairs that had been specifically acquired to transfer prisoners to healthcare being misused to take them to education classes. He assured my investigator that the problem of misappropriation of wheelchairs has been resolved, and I therefore refrain from making a formal recommendation.

69. The man's daughter told my Family Liaison Officer and investigator that the man had sent her numerous letters from prison in which he said he

was missing out on meals because he could not collect them from the hatch on the wing. My investigator looked into this matter and spoke to the Principal Officer who is in charge of day-to-day operations on H Wing, and a prisoner on H Wing. The Principal Officer confirmed that, after the man was recalled to prison in July 2006, his ability to get round was noticeably worse than when he had been in prison previously. To overcome this, wing staff commissioned a prisoner on H Wing to collect the man's meals from the hatch every day and take them to his cell. The prisoner told my investigator that he has carried out tasks of this kind for some time. At the time he was interviewed, he was collecting meals for two other prisoners with mobility problems. By way of reward for helping his fellow prisoners in this way, the prisoner receives the television in his cell for free – equivalent to £1 a week.

70. Over the course of his sentence, the man submitted a series of complaints to Acklington about the fact that, one evening every week, he had to make a choice between queuing for his canteen (cigarettes, sweets, soft drinks and so forth) and going outside for fresh air. The regime on H Wing is that, on the day the canteen is delivered, the hour (6.00pm - 7.00pm) given over to exercise for the rest of the week is split into two half-hour sessions. Prisoners have the choice of either taking half an hour's outside exercise first before collecting their canteen, or vice versa. In his complaints, which have been examined by my investigator, the man says that his mobility problems prevented him from doing both activities and, if he wanted to collect his canteen, he necessarily missed out on outside exercise. He said that this violated his right to one hour's exercise in the open air each day.

71. Prison Service Order (PSO) 4275 says that, ideally, 'prisoners should have the opportunity to spend at least an hour in the open air each day and that the period allowed should not normally be less than half an hour'. It is therefore clear that the man was wrong to believe he was entitled to one hour's exercise every day, as the minimum period is 30 minutes.

72. That said, my investigator sought to establish whether the man would have been able to go out into the fresh air on the day the canteen was delivered, given his mobility difficulties. H Wing is laid out in such a way that there is a relatively short distance, no more than ten metres, between the end of the ground floor landing and the gate to the exercise compound. Given that the canteen is distributed from the end of the landing nearest the gate, my investigator believes that the man would have been able to go outside into the exercise compound if he had wanted to.

73. The H Wing prisoner told my investigator that the man never mentioned anything to him about missing out on aspects of wing life. He reported that the man would go out on exercise every evening and sit on the bench, and he expressed the view that he was not disadvantaged because of his mobility problems. My investigator could find no

evidence that the man was discriminated against, and it would seem he received all his meals and other entitlements.

The quality of the man's care

74. The man's family also expressed concerns about the quality of care the man received whilst in custody. They told my Family Liaison Officer they thought the Prison Service ignored his family history of heart problems and the low levels of oxygen in his blood. Furthermore, they said that the judgment of the healthcare staff was clouded by the fact that they thought he was exaggerating his ailments and they questioned the professionalism of the healthcare team.

75. As part of the investigation, three nursing staff directly involved in the man's care were formally interviewed. My investigator was impressed by their knowledge of the man's health needs and could find no evidence that would support the view that they were unprofessional. Indeed, the available evidence suggests that they continued to engage with him in spite of his challenging behaviour, which included incidents of verbal abuse.

76. The clinical review carried out by Northumberland Care Trust concludes that "all clinical staff did their best to manage a very difficult case and I have no criticism of the decisions that were made". As such I cannot endorse the family's opinion that the man's health needs were ignored.

The events of 22 September

77. During the morning of 22 September, the man who died complained to wing staff that he was experiencing pains in his chest. As there is no healthcare cover at Acklington at night, the emergency services were called. When the paramedics arrived at the prison and attempted to examine him, he responded with verbal abuse and refused to be treated. The paramedics therefore left the prison without examining him.

78. The man's family have pointed out that one of the symptoms associated with a heart attack is agitation. They told my Family Liaison Officer that they think the paramedics should have realised this and insisted on examining him.

79. My terms of reference preclude me from investigating complaints about the conduct of staff from the emergency services. However, it is the case that patients who are not otherwise mentally incapacitated have the right to refuse treatment. Whilst there is an expectation that all medical personnel give patients all the information necessary to make an informed decision, they cannot examine them against their will. As there is no evidence to suggest that the man was unable to make an informed decision, it would be hard for me to justify criticising the paramedics involved or referring the matter the appropriate disciplinary body.

Informing the man's next-of-kin of his transfer to hospital

80. The man's daughter told my investigator and Family Liaison Officer that she was extremely unhappy that the first she heard of her father's transfer to hospital was when the news of his death was being broken at 9.00pm on 11 October. She said that the prison had had ample opportunity to inform her between the time her father went to hospital during the afternoon of 9 October and his death two days later.

81. Acklington has said that it does not routinely contact next-of-kin when prisoners are transferred to outside hospital. The main reason for this is that there are security implications of doing so. I accept that there are such implications, although Acklington is a category C prison and I would expect security to be tempered by common sense in the case of a 76 year old man with no known contact with organised crime. Moreover, in all instances where it looks as though a prisoner is likely to die (rather than being sent to hospital because of a broken limb, or something of that nature), my expectation is that the family are informed so that they have the opportunity to see them. That said, in this case, there was little reason to suspect that he would not be returning to the prison – the Deputy Clinical Team Leader told my investigator that she thought the hospital would be able to conduct some extra tests and stabilise him. One of the bedwatch officers similarly reported that the man was happily engaging in conversation shortly before he died, and that the deterioration in his health was sudden.

82. In this case, I am persuaded that Acklington believed right up until the man's death that he would in all likelihood be returning to the establishment. His rapid deterioration was not predicted by prison staff, or by Wansbeck General Hospital. However, I draw my comments in para 82 to the attention of the Governor and Area Manager.

Informing the man's next-of-kin of his death

83. After Acklington was informed of the man's death, the prison activated its contingency plan for responding to a death in custody. As part of this plan, the Deputy Governor telephoned the man's daughter to pass on the sad news shortly after 5.15pm. This was timely and shows that the prison appropriately prioritised this sensitive task. Unfortunately, the call went unanswered and he left a somewhat ambiguous message (to the effect of "please call me urgently") on the answering machine.

84. When the man's daughter called the prison 45 minutes later, the Deputy Governor had left for the day and nobody else at the prison was able to tell her what was going on. Entirely understandably, this left her and her family feeling extremely anxious.

85. My investigator has found out that, after leaving the message on the answering machine, the Deputy Governor contacted the man's daughter's local police force to ask them to visit her in person to break

the news. This is common practice when prisons are located some distance from the home of the next-of-kin. However, it would appear that the police only turned up at the house after 11.00pm. In the meantime, the Deputy Governor had telephoned the man's daughter again (around 9.00pm) to tell her what had happened. This was some four and a half hours after the man had died and three hours after she had telephoned the prison.

86. I was extremely disappointed to learn that the man's daughter could not find out any information when she called the prison as directed. As a minimum, I would have expected her call to have been directed to a senior member of staff such as another governor or a principal officer who had been briefed on the circumstances of the man's death. If this was not deemed to be appropriate, the man's daughter should have been provided with an alternative number on which to contact the Deputy Governor.

87. On this occasion, it would appear that a number of relatively minor shortcomings culminated in there being an unnecessary delay in informing the man's next-of-kin of his death. I urge Acklington to look into what went wrong on this occasion and to develop a more robust system for informing next-of-kin when a prisoner dies.

Acklington should review the system currently in place for informing next of kin of a prisoner's death, and implement any changes as necessary.

RECOMMENDATIONS

To the Governor

1. **Acklington should review the system currently in place for informing next of kin of a prisoner's death, and implement any changes as necessary.**