Circumstances surrounding the death of a man in HMP Acklington in August 2004

Report by the Prisons and Probation Ombudsman for England and Wales

December 2005

This is a report into the circumstances surrounding the death of a man on 26 August 2004 in HMP Acklington. He bled to death as a result of a deep wound to his right arm that he had apparently inflicted himself.

A further sad aspect of this story is that the man had not been in contact with his family for many years. Nor, in the months leading up to his death, was he in contact with any friends. Despite the best efforts of the police, none of his relatives has been traced after his death. I have had no opportunity, therefore, to involve his family in this investigation.

Under transitional arrangements agreed with the Prison Service at the time, a Senior Investigating Officer (SIO) was appointed to conduct the investigation. The SIO worked to me for the duration of the investigation and submitted a draft report that I have reviewed and amended as necessary. This final report is my independent examination of the circumstances leading to this man's death. I regret the delay in its completion.

A clinical review was commissioned from Northumberland Primary Care Trust (PCT).

I am grateful for the assistance offered to the investigation team by the staff and prisoners at Acklington.

This version of my report, published on my website, has been amended to remove the name of the deceased and the names of staff and prisoners who were involved in my investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **December 2005**

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Summary

1. The man was a life sentence prisoner, originally from Scotland. He bled to death from an apparently self-inflicted wound in his cell in HMP Acklington on 26 August 2004, two days after his 44th birthday. He had been released on life licence in 2001 but recalled to custody. He had spent over half his life in prison.

2. The man had taken an overdose of paracetamol in February 2004 while still at liberty. On being taken to HMP Edinburgh on 26 February, he was put on suicide watch. He told staff he had returned to Scotland to kill himself.

3. He was transferred to HMP Durham on 30 March 2004 and to HMP Acklington on 25 August. At Durham, he was regarded as a quiet prisoner. He received no visits and made no telephone calls. Following his death, the police have been unable to trace any of his relations.

4. On reception at Acklington he was not identified as being at risk of suicide or self-harm. Two prisoners who spoke to him told the investigation team that he did not present any obvious signs of distress. In contrast, two members of the Insiders (a peer support group) said they had perceived that he might be a problem. They did not share their concerns with staff, however, because he "made all the right noises".

5. The man's body was discovered at about 7.20am the following morning. It seems likely he had been dead for some time.

6. I conclude that there were no reasons for staff in Acklington to anticipate that the man was at risk of taking his own life. However, I draw attention to gaps in the risk assessment process at both Durham and Acklington.

7. The report identifies two examples of good practice.

1. Background

(i) The man

In 1980, aged 19, the man was convicted of murder and sentenced to life imprisonment with a tariff (minimum time to serve) of ten years. In 1990, the Home Secretary accepted a recommendation from the Parole Board that he be released. He was given a provisional release date of 2 April 1990 but this was cancelled in February that year after he was convicted of assaulting a young woman. In 1994, while he was in Ford open prison, the Parole Board again recommended his release but this time the Home Secretary rejected it. He later absconded from Ford and was returned to Wandsworth prison in April 1996.

In November 2001, he was released on life licence and moved to Brighton where he enrolled for a social science degree at Brighton University. He lived initially in a hostel before moving to a rented flat in July 2002. Like many students, he found it hard to support himself financially and took on street cleaning work to help to make ends meet. His studies were going well and he impressed his landlord sufficiently for his rent arrears to be treated sympathetically.

On 10 January 2004, the man was involved in an incident with a female neighbour which resulted in the police being called. He head butted one of the attending officers and was arrested. He was given bail but then left his flat leaving the keys on a neighbour's door with a note which said, "I'm gone, I'm not coming back, take my things." On 19 February 2004, he was admitted to intensive care in Edinburgh Royal Infirmary having taken an overdose of paracetamol. He was transferred to Edinburgh prison on 26 February 2004 and then to HMP Durham on 30 March 2004. He arrived at HMP Acklington on 25 August 2004.

(ii) HMP Acklington

HMP Acklington is a category C training prison for adult male prisoners in Northumberland. It was formerly the site of an RAF station and opened as a prison in 1972. Acklington has a Certified Normal Accommodation (CNA - maximum uncrowded capacity) of 882, which is also its Operational Capacity (maximum operating capacity).

HM Chief Inspector of Prisons last inspected Acklington in April 2003. Her subsequent report was largely positive, concluding that much progress had been made since the previous inspection in 2001.

In the 13 months prior to this death, there were four deaths at Acklington of which three were from natural causes.

2. The events leading up to the man's death

(i) *HMP Edinburgh*

The man was arrested at Edinburgh Royal Infirmary on 26 February 2004 and taken to Edinburgh prison. He went through reception procedures and was designated a 'high risk' prisoner because of his recent overdose. He was put on suicide watch and made subject to observations every 15 minutes. In the first two days he told staff he had constant thoughts of suicide and that he had come to Edinburgh to kill himself. On 28 February, he told staff that he no longer had thoughts of suicide or self-harm. Reports show staff were sceptical about this and thought that his change of heart had more to do with a forthcoming court appearance for his assault on a police officer.

On 3 March 2004, the observations on him were reduced from 15 minutes to once every hour. Staff described him as "much improved" with no thoughts of self-harm. He demonstrated improvement in three further reviews and, on 23 March, staff were satisfied that he posed "no apparent risk" and he was taken off the suicide/self-harm procedures.

(ii) *HMP Durham*

The man was transferred to Durham prison on 30 March 2004. His first night centre reception interview shows that he told staff that he had taken an overdose of paracetamol four weeks previously. He said he was not expecting to have problems coping in prison and that he had no worries or concerns.

He was also the subject of a cell sharing risk assessment (CSRA) form. He told staff he was on an open F2052SH (self-harm monitoring form) because he had taken an overdose while on release (in fact it had been closed on 23 March). The CSRA form notes that he "states he feels fine". He was deemed to present a 'low' risk for sharing a cell by the reception officer. Section three of the form was completed by a member of the healthcare team. The form indicates that there was "insufficient evidence to give an opinion" and he is rated as a 'low risk' for cell sharing purposes. A F2052SH form was not opened.

He appears to have been a quiet prisoner at Durham. He received no visits and made no telephone calls. The F2052A Record of Events booklet in his prison record is quite bare of detail. It shows that on 28 April his cellmate accused him of assaulting him. He was not charged with a disciplinary offence following this allegation. On 21 May, however, he received a caution at adjudication for refusing to work. A week later he received further punishments including stoppage of earnings and loss of canteen for the same offence. There is no evidence that he gave staff any other cause for concern while in Durham. An entry dated 13 July records, "No concerns/issues, keeps himself to himself."

On 3 June, he received notification from Lifer Recall and Review Section in Prison Service Headquarters that he was to remain in prison until at least May 2005 when his case would be considered by the Parole Board. On 24 August, he was 'fitted' for transfer. The Fit for Transfer document records that he said he had "no problems" with the transfer when asked by healthcare staff.

(iii) HMP Acklington

The man left Durham for Acklington at 10.30am on 25 August 2004. His Prisoner Escort Record (PER) form indicated that he was not known to be a medical or suicide/self-harm risk. The box was ticked to indicate that he did pose a risk of violence. The explanation appended to this stated, "Violence current long term prisoner."

He arrived at Acklington at 11.45am. He and the other new arrivals waited in a holding cell in Reception before going through standard reception procedures. A Registered General Nurse (RGN) undertook his initial healthcare assessment. She said that the man told her that he had been the subject of F2052SH procedures about five months previously. She thought this was as a result of cutting himself while in police custody. She said he admitted to having self-harmed in the past. When she asked him if he had recently considered suicide he replied, "Well I wouldn't sit here and tell you if I had, but no I haven't." The RGN said he appeared to be in good spirits and his eye contact and body language was good. She did not refer him to the mental health nurse.

The RGN said she completed a CSRA form on the man and remembered assessing him as medium risk. Unfortunately, my investigator was not able to trace this document. The RGN said that, although prisoners arrive in reception with a medical record, there is no time to read through it before interviewing the prisoner for risk assessment purposes. Risk assessment is therefore largely based on the prisoner's response to the questions asked. She said that her practice is to check through the medical record at a later point to make sure the prisoner has told the truth. In this case, she said she checked his medical record and found that, "He told me the truth that he had self-harmed in the past, but was feeling fine." The RGN said she had seen "a bit of" the information from Edinburgh prison but it did not give her cause for concern. She said she "ran it past" the mental health nurse and "she seemed fine with it". The RGN said that in her opinion there was no reason to regard the man as at risk of committing suicide.

An Officer interviewed the man and completed the New Reception Checklist. He described him as "quite happy" and said he did not detect anything out of the ordinary in his demeanour. He said that only healthcare staff complete CSRA forms at this stage. Wing staff complete the first part of the form when the prisoner arrives on the wing. The Officer said that he was unaware of the man's previous history of self-harm. He said that if a prisoner has been on a F2052SH form in the month before he is transferred then this is highlighted on the transfer documents.

The man was taken to his cell on D wing at about 3.30pm. All cells on D wing are single occupancy and no prisoners share cells. Together with the other new arrivals, he attended an induction talk. At the end of the talk, an Officer gave him the Lifer Handbook and explained about specific aspects of the regime relevant to life sentence prisoners. The Officer said that he was unaware at the beginning of the talk that the man was a lifer. He said he routinely asked at the end of such talks whether there were any lifers present, but was quite surprised to find one. The Officer said the man seemed very "level headed". He said that, because he and the other new arrivals did not arrive on the wing until 3.30pm, there was no time to complete the CSRA forms that afternoon.

Also in the late afternoon, the man attended a presentation given by two 'Insiders' (members of a peer support scheme designed to welcome new prisoners and identify any concerns they may have). Both Insiders formed the opinion that the man might be a

“problem” and went to his cell after the meeting to ask if he was alright. The first Insider said he appeared “detached” and “not there” during the presentation, and the second Insider said he had an exaggerated “jauntiness” about him when they spoke at his cell. The man told them he was ok. The Insiders decided not to tell staff about their concerns because he had “made all the right noises”. They remained concerned about him but could not identify any particular reason why. They decided that the first Insider would talk to him, on a one to one basis, the next day.

Another wing Officer saw all of the new arrivals on D wing at about 4.10pm in the wing office. He said he asked all of the prisoners whether they had any problems or concerns but none said they had. The Officer said the man appeared fine. He said the prisoners were locked up between 4.20pm and 5.00pm when they were given their evening meal. They then had association until about 6.00pm. The Officer said he was responsible for locking the cells that evening and doing the roll check. He said he last saw the man at about 7.20pm. He was sitting on his bed watching television.

An Operational Support Grade (OSG) was the night patrol officer on 25 August. He carried out three roll checks at 8.45pm, 11.00pm and 5.30am. In each case he used either his torch or the cell night light to check that prisoners were in their cells. He did not notice anything untoward when checking the man’s cell.

An Officer who arrived on duty on D wing at about 7.15am said he spoke to the OSG who told him that everything was fine. The Officer then began his roll check. He said he got to the man’s cell at about 7.20am. He looked through the flap and his first impression was that everything was fine. He said that as he looked away he noticed a big pool of shiny liquid under the bed. He said he did not realise what it was at first, but as he looked closer he realised it was blood. The Officer said he kicked the cell door and shouted the man’s name but got no response. He moved to the end of the landing out of earshot of the other prisoners and used his radio to raise the alarm. He said he returned to the cell and opened the flap again. He said he banged the door and shouted again and then other staff arrived at the cell.

The Officer said he entered the cell and shook the man. He said he was very cold and stiff, there was no pulse and he was not breathing. The Officer said it was “pretty clear he had been gone a while”.

The post mortem report showed that the man had made a deep incision into his right upper arm which caused him to bleed to death. When staff found him he was lying in bed on his right hand side with his right arm under the covers and his left arm on top of the blanket.

3. The prison's immediate response

Several staff responded within two minutes of the alarm being raised. A Principal Officer (PO) kept a log from 7.22am when he arrived at the man's cell. A Nurse arrived within three minutes of the alarm being raised, but no resuscitation was attempted as it was obvious that the man was dead. The cell was sealed at 7.35am and the prison doctor attended at 8.23am and pronounced death.

The contingency plans for a death in custody were activated. All the necessary authorities were promptly informed. The prisoners on D wing were unlocked for breakfast as normal at 7.47am. A notice to staff and prisoners was issued at 8.00am and members of the Care Team were present on the wing and available to staff and prisoners. A hot debrief was held at 11.30am.

At this stage, the prison was awaiting confirmation from police in Scotland that the information on the man's next of kin was correct. Unfortunately, his family was never traced.

4. What other prisoners said

A prisoner who was transferred to Acklington at the same time as the man said he spoke to him in Reception in Durham on the morning of 25 August and described him as, “pretty laid back”, ”polite” and “well mannered.” He said that the man did not give him any reason to think he was depressed or was thinking of killing himself. He said he thought he was looking forward to his review in May 2005, and said he had told him that he was pleased to be in a prison near to Scotland because it would be easier for his family to visit.

The prisoner said that following their transfer to Acklington, at about 4.15pm shortly before they were locked up before tea, the man gave him his PIN number so that he could use the PIN phone system. The prisoner said the man simply told him that he was not going to use the number and asked if he would like it. The prisoner said he was surprised by this but did not think it was an indication that the man was going to kill himself.

Another prisoner said he had a brief conversation with the man in a holding cell in Acklington’s Reception. He described him as “normal” and a “general guy”.

The prisoner in the cell next door to the man said he did not speak to him but had heard him asking the prisoners in the cells below for tobacco after lock up. He said he heard nothing out of the ordinary during the night.

The prisoner in the cell opposite said that he did not speak to the man but remembered him and thought he had looked depressed.

5. Consideration

The man took an overdose of paracetamol in February 2004. He told staff in Edinburgh prison that he had journeyed to Scotland with the intention of killing himself. The clinical review [not published] shows that, on admittance to Edinburgh Royal Infirmary after the overdose, he requested to be treated with supportive measures only and did not wish for active intervention in the event of life-threatening complications.

During reception procedures at Edinburgh prison, he told staff that he had spent half his life in custody and did not wish to be in prison any more.

Two days after he arrived at Edinburgh prison, he tried to convince staff that he no longer harboured thoughts of suicide. Staff were (properly) sceptical about this. Thereafter, in the months leading up to his death, he did nothing to draw attention to himself. Despite being asked on several occasions by both staff and prisoners during his brief time in Acklington, he stated that he was ok and had no problems.

The manner and timing of his death may be indicative of a deliberate act and a determination not to be discovered until it was too late. I note the opinion expressed in the clinical review, that he, "remained determined to commit suicide and made a calculated decision to deny risk in order to ensure a lower level of surveillance which would make any further attempt more likely to succeed". I note too that he shared a cell while in Durham and therefore his allocation to Acklington represented the first time since his recall that he was alone for a significant period of time.

I conclude that there were no reasons for staff at Acklington to anticipate that he was at risk of taking his own life. He had presented no self-harming behaviour in prison. Nevertheless, I would like to draw attention to some aspects of the risk assessment process in this case.

1. I am concerned at the apparent lack of information available to medical staff at Durham when completing the cell sharing risk assessment form. The man arrived from Edinburgh four weeks after a very determined attempt to kill himself and only one week after being removed from suicide monitoring procedures. Staff appear to have accepted his assurances that he felt "fine" and little or no investigation appears to have taken place. The clinical review notes that his overdose is recorded as self-harm rather than as a suicide attempt on his medical record and the details are wrong. I am unclear as to what information travelled with him, but – as the clinical review notes – his Edinburgh medical record shows that he viewed the prospect of a further period of custody with some dread. It was in Durham, on 3 June, that he would receive confirmation that he had been recalled from licence.

2. I am also concerned that the PER form accompanying the man to Acklington recorded that he was not a known suicide risk. I accept that he had not shown overt evidence of risk while in Durham. However, his history of attempted suicide/self-harm was more recent than his history of violence (yet the PER records him as being at risk of violence). I also find the explanation for the indicator of violence ("current long term prisoner") unclear and inadequate.

3. I have been struck by how little the staff who were expected to care for this man knew about his circumstances. The nurse in Acklington had not had time to read his medical

record before interviewing him on reception, and subsequently only read “a bit about” his suicide attempt in Edinburgh. Wing staff were not immediately aware that he was a life sentence prisoner and not at all aware that he had been recalled after some two and a half years on licence and had attempted to kill himself (an act one can reasonably speculate was linked to the prospect of going back to prison). It may be that this knowledge would not have changed the course of events, but staff have little hope of identifying potential risk when important information is not shared effectively.

The prison’s immediate response to his death appears to have been good. I am aware that two minor problems were identified – the difficulty in accessing the contingency plans and an incorrect phone number – but both these have since been rectified.

I end by drawing attention to points of good practice.

1. I note that at Acklington it is wing staff who are responsible for completing the first part of the cell sharing risk assessment form. In my experience this is work usually undertaken by overstretched reception staff. If Acklington’s practice results in a more thorough assessment by the staff who will have day to day contact with the prisoner then this is to be commended. I know that the Prison Service is soon to bring in new procedures for risk assessment and draw attention to Acklington’s approach as an example of good practice.

2. I note also that Acklington appears to have a thriving Insider scheme which has the confidence of both staff and prisoners.

6. Good Practice

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