INVESTIGATION INTO THE DEATH OF A MAN AT HMP ACKLINGTON IN OCTOBER 2005

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

JUNE 2006

This is the report of an investigation into the death of a man who died at HMP Acklington on in October 2005. He died of apparently natural causes. He was 65 years of age.

I would like to add my personal condolences to those already expressed to the family by my Family Liaison Officer.

The investigation has been undertaken by two of my colleagues. A clinical review was undertaken by a doctor from Northumberland Primary Care Trust. I am grateful to the doctor for his review and join my colleagues in thanking the then Governor of Acklington, and his staff for their full cooperation during this investigation.

Whilst I do not consider that anything could have been done to prevent this man's death, there were aspects of the prison's response to his being taken ill that were inadequate. Even though they do not appear to have had a significant impact on this occasion, it is important that lessons are learnt to prevent problems in the future.

The Northumberland Constabulary is currently investigating an allegation against a member of prison staff in relation to the man's death. I am issuing my report in draft before knowing the outcome of the police investigation to avoid unnecessary delay. Once the police investigation has concluded, I will issue an updated version should this be required.

Stephen Shaw CBE
Prisons and Probation Ombudsman **June 2006**

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Summary

The man was sentenced to 15 months imprisonment in October 2003. He was released in March 2004 on a two year licence, but was recalled to prison in May 2004. He came into the custody of HMP Acklington in June 2004.

He had a long history of heart disease and was being treated for angina following a heart attack in 1989. He received good chronic disease management and preventative care whilst in custody. He was fit enough to be employed at the prison's tailoring workshop, which is where he chose to work despite being of retirement age.

On the day that he died, the man went to work in the morning. At the end of his shift, he returned to C wing along with the other prisoners for lunch. He then spent the lunchtime period in his room. At 1:50pm, officers on the wing called for prisoners to return to work. At this time, an officer shouted down the landing to the man to tell him his afternoon probation interview had been cancelled. There was no response. It was at this point that a fellow prisoner, concerned that the man had not appeared, visited his room and saw him sprawled face down over the table.

Staff responded to the call for assistance and the healthcare team were alerted. Cardio Pulmonary Resuscitation was started and an ambulance called. Despite 25 minutes of resuscitation, including the use of a defibrillator and adrenalin, the man died before the ambulance arrived. The ambulance was cancelled and his death was pronounced at 3:35pm.

This report concludes that there was nothing staff could have done to prevent his death. However, it identifies some aspects of the response to his death that could have been handled better, and makes a number of recommendations.

Investigation Process

The investigation was opened at HMP Acklington on 2 November 2005. The liaison officer and his colleagues produced the man's prison, parole and medical records for examination. Notices were distributed around the prison informing staff and prisoners of the investigation.

A number of staff members, both prison and healthcare, were formally interviewed along with the prisoner who found the man collapsed in his room.

A doctor from Northumberland Care Trust undertook a clinical review of the medical care that the man received during his stay at Acklington.

My investigators contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, my report will be sent to the Coroner to assist him with his enquiries into the man's death.

One of my Family Liaison Officers spoke with the man's daughter and offered to meet with her. At this stage, she did not wish to meet but was grateful for the contact. She asked that we provide clarification of the medication that the man was prescribed for his heart condition.

The Northumberland Constabulary is undertaking a separate investigation (an allegation has been made against a member of prison staff about his conduct towards the man). Once the police investigation is concluded, and should it be required, I will issue an updated version of this report. It is hoped this will be concluded by the time the adjourned inquest is held in December 2006.

HMP Acklington opened in 1972 as a category C prison. The jail is situated on a former RAF station near Amble in Northumberland. It has the capacity to house 882 prisoners.

The man's room was situated on C wing in Residential block 1, which is a block for vulnerable prisoners. Prisoners on C wing have courtesy keys to access their rooms and they are free to move around their landing whenever they wish. Rooms can be locked from the inside, but the lock can be overridden by keys held by prison staff.

Northumberland Care Trust provides healthcare to the prison. Nurses are employed along with a medical officer to deliver primary healthcare during the daytime, seven days a week. The healthcare team is also responsible for the administration of medication, either weekly or monthly, to prisoners who have been assessed as capable of keeping it in their own possession. Prisoners who require in-patient nursing care are transferred to an outside hospital or another prison.

Her Majesty's Chief Inspector of Prisons (HMCIP) carried out an unannounced inspection of Acklington in April 2003. The Chief Inspector's report described a 'safe prison' stating that the '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. In June 2005 the clinical team leader began to address this by exploring the possibility of introducing clinics for specialist conditions, such as those experienced by older people.

Since August 2004, there have been seven deaths at Acklington including that of this man. Four of these were due to natural causes and three were apparently self-inflicted. Investigations into all seven deaths have been undertaken by my office or are in progress. Two previous recommendations made that are echoed in this report are:

- that staff should trained and equipped to recognise an emergency;
- consideration should be given to provide first aid training for staff who have contact with prisoners.

The prison has accepted that it should ensure that staff are trained and equipped to recognise an emergency. A target date of 31 March 2006 was set for discussions with the Head of Healthcare regarding suitable training. The recommendation for providing first aid training for all staff was not accepted by the prison. The prison's response was that officers receive basic training when they join the Prison Service and that refresher training is decided at a local level.

Events leading up the death of the man

The man was sentenced to 15 months imprisonment in October 2003. He began his sentence at HMP Woodhill, but transferred to HMP Lewes on 10 October 2003. He was released on 12 March 2004 on a two year licence, but was recalled to prison on 27 May 2004 for breaching its conditions. At the time of this recall he had no fixed abode having had his bail hostel accommodation withdrawn due to breach of his licence.

He first served the remainder of his sentence at HMP Durham and came into the custody of HMP Acklington on 11 June 2004. His extended sentence was reviewed in January 2005, but the Parole Board concluded that he still posed a risk to the public. He moved to C Wing and into a single room (C2-02) in May 2005.

He had a long history of heart disease. His medical records indicate that he had suffered a heart attack in 1989. Following this, he received treatment for angina. he also suffered from hypertension (high blood pressure). Whilst at Acklington he was prescribed a GTN spray, Aspirin, Atenolol and Symvastation. He received regular monitoring and well-organised chronic disease management and preventative care. He was last seen by healthcare staff on 3 October 2005 for a flu vaccination.

Despite being of retirement age, he wanted to continue working. He had a position in the tailoring workshop. On the morning that he died, he left his room as usual and went to work following breakfast at 7:50am. That morning he worked on the press in the workshop. The person in charge of his section in the workshop that morning told my investigators that there was nothing noteworthy about him that day. In her opinion, he appeared to be in normal health. At the end of the morning shift, he returned to his wing with the others for lunch at midday.

In line with the daily routine, a roll check was taken at 12:30pm and everyone returned to their rooms before the afternoon session of work or education. The second call for work would normally take place at around 1:40pm. However, on this particular afternoon the call was made five to ten minutes late. It is usual practice for prisoners who are not attending work to remain in their rooms until this movement is completed. The man was in his room at this time as he was expecting a meeting with probation. His door was locked from the inside.

Two officers were on C wing supervising the second movement of prisoners to work. They were the only officers on the wing. At 1:50pm, a prisoner in the room opposite the man heard one of the officers shouting. The officer was trying to tell the man that his scheduled probation interview had been cancelled. This was not an ideal way of delivering the message to him. It would have been more appropriate to wait until the end of the movement and inform him in person. Alternatively, he could have asked another member of staff to deliver the message as he was unable to leave his post at this time. A prisoner heard a second call for the man from the officer and thinking it

unusual that he had not appeared or responded to this call, went to knock on his door. He knocked several times but received no answer. The prisoner lifted the hatch on the door to look inside and saw that the man was sprawled on his table.

The prisoner immediately went to alert the officer that something was very wrong with the man and that he should come and check on him. The officer went to the man's room and opened the hatch to look inside. He saw that he was slumped on to his table and noticed that his ears had turned blue. His initial thoughts were that this was a prank and that his ears had been painted. He drew his keys and unlocked the door. On approaching him, he could see he was unwell and felt for a pulse. There was none, nor any signs of breathing, so he called for a prisoner on the landing to inform another officer and ask him to telephone healthcare for medical assistance. The first officer was not carrying a radio.

The second officer was in the office on the floor below at 1.55pm. The message he received did not highlight the severity of the situation. It was not clear who needed medical attention or the level of assistance required. This officer immediately informed the Communications Room but there was no request for emergency services at this stage. It was also not made clear that an emergency response bag or defibrillator might be needed. The Communications Room put a call out over the radio alerting healthcare staff to make their way to C Wing.

A senior officer (SO) was duty senior officer for Residential 1 (A, B and C wings) that afternoon. He was in the front office on B Wing when he heard the call over the radio for healthcare to attend C Wing. The SO felt they might benefit from additional help so he immediately made his way to the wing. B Wing neighbours C Wing and is also part of the Vulnerable Prisoners Block. The distance between them is short. The SO arrived at the man's room at 1:56pm.

On arrival, the SO met both officers. At this stage, there were still prisoners on the landing as it was mid movement time. One officer came down the stairs to the ground floor and led the SO to the man's room. The door had been shut and the second officer was standing outside. The SO entered the room. He found the man sitting on his chair and slumped over the table. His face had turned a grey/blue colour and he was unresponsive. Fluid had collected in his lower limbs. The SO has current first aid training so he lifted him to the floor to assess him further and start resuscitation. As he lifted him, he noticed that he had been incontinent. He began the first cycle of Cardio Pulmonary Resuscitation (CPR). During this time, an officer secured the landing to make way for the healthcare staff.

At 1:58pm, the Communications Room informed the orderly officer, and duty governor, of the situation. The duty governor made his way to C Wing.

As the healthcare team were making their way to the wing, they decided to collect the emergency response bag. A nurse went to fetch the bag from the

wing whilst a second nurse made her way to the man's room. At 2.00pm, the second nurse arrived at room C2-02. At this stage, she had still not been fully informed of the situation. The SO was continuing to administer CPR. He had completed six cycles. The second nurse quickly asked what had happened and checked for vital signs. He had fixed dilated pupils, no pulse and was not breathing. She immediately called for the defibrillation machine to be brought over and for an ambulance to be called. The ambulance was called at 2:00pm. The Gate was advised that an ambulance had been called for and they should be on stand-by. At this time, the first nurse arrived at the room with the emergency response bag. The second nurse asked the SO if he was happy to continue giving chest compressions and she took over managing the airway using a bag and mask from the response bag.

At 2:05pm, the defibrillator was brought from healthcare to the room by a third nurse. When this nurse arrived, the first nurse left the room to fetch a shot of adrenalin to aid the resuscitation. The adrenalin is kept on H Wing. Staff told my investigators that emergency equipment is spread across the prison so that is more readily accessible to healthcare staff. The third nurse took over airway management whilst the defibrillator was connected. One shock was delivered. The defibrillator indicated that no further shocks were needed and they should continue with CPR.

By 2:07pm, more staff had arrived. Two SO's from the Care Team, the chaplain, the orderly officer and a governor were all present. They all remained on the landing whilst the healthcare team continued with CPR.

At 2:10pm, the first nurse returned and took over chest compressions. The first SO went out onto the landing and began briefing the orderly officer. The second nurse administered one shot of adrenalin. The team continued with two to three further cycles of CPR until 2:17pm before reassessing the man's status. He had fixed and dilated pupils and there were no signs of a pulse or breathing after 25 minutes of CPR. The team decision was to stop CPR and the second nurse contacted a doctor who agreed with their decision. The ambulance had arrived at the establishment but the paramedics were no longer required.

Events after the death

The first SO secured the room and handed over to the security principal officer (PO), who continued to manage the scene. The PO left the landing to collect secure locks for the room from Security.

At 3:33pm, a doctor, the second nurse and the PO entered the room. The doctor pronounced the man's death at 3:35pm and the room was secured.

The prisoner who had the cell opposite was seen by the chaplain immediately after the man's death and was given thanks for his support by both the unit staff and healthcare.

A staff debrief with the deputy governor, was held in the board room at 4:20pm. Initial statements from some of staff present during the incident were given. The first officer did not attend because he was required elsewhere. The duty governor commented on the lack of a 'code blue' status and how this meant that healthcare staff were unaware of the situation before them. More information could have meant they would have brought the defibrillator with them to the man's room. However, it was not clear this would have had a significant impact upon the man's situation.

In addition, the deputy governor suggested that the ambulance protocol might need a review. For future situations, the emergency services should be called first, and cancelled if not eventually needed. The head of healthcare, agreed that the protocol should be revisited and that the policy should also change so that all staff working within the prison should be responsible for summoning an ambulance if needed, rather than waiting for healthcare to do this.

During the debrief it was noted that there had been a considerable delay in the verification of the man's death. The Northumberland Primary Care Trust policy states that community nurses are not permitted to verify an unexpected death. Therefore, they were required to wait for a doctor to arrive.

The man had named his daughter as his next of kin. She lives in Bedfordshire and there would have been a delay in informing her of her father's death should the Governor have delivered the sad news in person. The police were therefore asked to notify her. On finding the next of kin contact details Acklington's police liaison officer informed Bedfordshire police as requested they speak to his family. The police contacted his daughter at 11:20pm that evening.

Acklington's family liaison officer, made contact with the family offering condolences, assistance with the cost of the funeral and the opportunity to visit the prison. The offer of financial assistance was duly accepted, but the family declined the prison's offer of a representative attending the service. The funeral took place on Tuesday 1 November.

The following day, his daughter visited the prison and met with the Governor, who showed her father's room. She also spoke with a prisoner on C Wing who had known her father.

Clinical Review and Police Investigation

Clinical Review

A doctor from Northumberland Primary Care Trust (PCT) undertook the clinical review. The doctor analysed the medical records from both HMP Durham and Acklington. He concluded that the man had received "excellent chronic disease management" at Acklington. Regarding his collapse on the day he died, the initial examination by the second nurse indicated that he was likely to have already been dead when they started to resuscitate. The doctor said that, as staff had nevertheless started resuscitation, they were correct to continue doing so until it was clear that nothing further could be done. He also commented that the healthcare team were correct to discontinue resuscitation when it was obvious their efforts were ineffectual and he was clearly dead.

The PCT is undertaking a critical event analysis to examine existing procedural guidelines and address a range of governance issues. The doctor wrote that, whilst this case highlighted the need for such a review, his care was not in any way compromised.

Police Investigation

A letter from a prisoner on C Wing was sent to my investigators regarding the death. The letter makes an allegation against a member of staff who supposedly dismissed the man's complaints of chest pains before he went to work on the morning that he died. Allegedly, the prison officer told the man to "get in line and go to work".

The Northumberland Constabulary are undertaking a separate investigation into this allegation. It is hoped that this investigation will be concluded in time for the adjourned inquest scheduled to take place on 5 December 2006.

Findings and conclusions

I do not believe that healthcare or discipline staff could have done anything further to prevent this death. However, during the course of this investigation several issues have been brought to my attention that could adversely impact upon future incidents.

The prison has an emergency response protocol which requires staff, when raising the alarm, to identify the kind of emergency they are facing. If someone requires an emergency response that needs a defibrillator or breathing equipment, then a 'code blue' should be called. On alerting the Communications Room to the man's collapse, the second officer did not issue a 'code blue' warning. This meant the healthcare team were not fully prepared for the emergency when they arrived at the man's room. Fortunately, the nurses acted on their own initiative and one returned for the emergency response bag before arriving at the room. However, further trips were required to fetch the defibrillator and adrenalin. This could have been prevented if an adequate alert had been given.

The problem in this case seems to have been lack of communication between staff caused by poor equipment. Not all officers in Acklington carry radios. For those who do carry radios, there is an additional problem with the battery life of the radios and an apparent 'dead spot' on C Wing for radio communication. In addition, there are no alarm points on the wing landing. Alarm points are all located near the end of the corridors. The lack of radios and infrequent alarm points mean that staff, and prisoners, are currently relying on passing messages by shouting along landings, using prisoners to deliver messages. This point extends to how the first officer chose to inform the man of his cancelled appointment.

The officer, who was the first to enter the man's room, did not have a radio. He had to rely on a prisoner to take a message to a second officer; the only other officer on the wing. The second officer was in an office on the floor below. The message he received from the prisoner did not make the type of emergency clear. I think it is extremely bad practice to use a prisoner to relay details of an emergency. It leads to poorly informed and delayed communication, and to staff being ill prepared for an emergency. In this case, it may not have affected the outcome, but the prison needs to take urgent steps to avoid similar problems in the future.

The emergency services were not called until the second nurse arrived at the man's room. The current policy at Acklington is that the responsibility falls to healthcare staff when it comes to requesting an ambulance. However, Prison Service guidance makes it clear that time must not be wasted in summoning emergency assistance. Therefore, if discipline staff are first on the scene they should not wait for healthcare to arrive before deciding if an ambulance is required. The head of healthcare has already raised this issue within the prison and has redrafted the operational protocol lines to state:

> "The summoning of a '999' ambulance is not restricted to the Healthcare staff. All staff working within the prison who discover someone seriously ill or injured can and should summon a '999' ambulance without delay."

At present the PCT's Nursing Policy for the verification of death limits community nurses to verifying expected deaths alone. This means that a nurse cannot verify the death of someone who dies unexpectedly, for example of a heart attack. In such cases, a GP or on-call locum has the responsibility to refer the death to the Coroner. A review of this policy is currently being considered by the healthcare manager with the support of a doctor from the PCT.

Healthcare staff told my investigators that emergency equipment is spread across the prison grounds to make it more readily accessible when required. I am unsure of the logic behind this policy as staff still have to travel to more than one location if they need access to a defibrillator, adrenalin and an emergency response bag. This may hinder a quick healthcare response to an emergency situation.

Recommendations

1. The Governor should remind wing staff always to use emergency codes when summoning assistance to an emergency.

2 The Governor should consider revising the prison's policy to make discipline staff equally responsible for calling emergency services. An ambulance can always be cancelled if on arrival the healthcare team decide it is no longer necessary.

3 The Governor should consider increasing access to radios for all discipline staff and/or consider increasing the number of alarm points on the wings.

The clinical review also makes a number of recommendations, which I fully support:

4 The Primary Care Trust should examine how procedural guidance could be improved with particular reference to:

- **Group directions for nurses**
- **Nurse certification of death**

5 The Primary Care Trust and the Governor should review the need for more cardiac defibrillators and agree where they should be best situated.

6 The Primary Care Trust and the Governor should review the training needs of all staff, both clinical and discipline, who may be involved in resuscitation, with the aim of updating existing levels of training and increasing the numbers of staff with such skills.

7 The Governor should consider with the Head of Healthcare where emergency response equipment is kept in the prison. Equipment should be readily accessible to ensure the quickest possible response.

The clinical review notes that recommendations 4, 5 and 6 are already being addressed and will be taken forward via clinical governance activities or at the Prison Health Development Group.

Good Practice

The clinical review also identifies the following areas of good practice.

- **Excellent and well-organised chronic disease management and preventative care.**

- **Clear computerised medical records.**

Response to the report

The Prison Service has accepted the recommendations put forward in this report.

Actions to taken for each recommendation are:

1. The Governor will issue a notice to staff reminding them to always use emergency codes when summoning assistance to an emergency. All managers will be advised of this, as will Communications Room staff. Target date for completion - April 2006.

2. The Governor will issue a notice to staff and advise all managers that discipline staff are equally responsible for calling emergency services and this should not just fall to healthcare staff. Target date for completion - April 2006.

3. Head of Security at HMP Acklington will evaluate and advise the Governor on the cost and feasibility of:

- increasing access to radios for all discipline staff; and
- increasing the number of alarm points on the wing.

Target date for the evaluation – April 2006.

Clinical Recommendations

4. Group directions for nurses: Patient Group Directions are being considered by an NHS working party. Once complete they will be passed to Northumberland Care Trust to assess and approve. Target date for completion – September 2006.

Nurse verification of death: Working party from the Primary Care Trust and Clinical Director of Nursing will consider the need to amend the Northumberland Care Trust policy to allow nurses to verify death. Target date for completion – September 2006.

5. The issue of increased access to defibrillators will be discussed with the Prison Officer's Association (POA). These discussions will identify the way forward, including provision, location and staff training. Target date for completion – May 2006.

6. Meetings will be arranged between the Healthcare Manager, Head of Residence, Health and Safety Advisor and Training Manager to discuss

needs, method and delivery of appropriate first aid training. The aim will be to update existing levels of training in resuscitation and to increase the number of staff with such skills. Target date for completion – May 2006.

7. The Head of Healthcare and Head of Residence will identify suitable locations for emergency equipment to be kept in the prison. Once agreed, appropriate equipment and instructions will be provided and put in place. Target date for completion – May 2006.