Investigation into the circumstances surrounding the death of a man at HMP Acklington on 17 September 2004

Report by the Prisons and Probation Ombudsman for England and Wales

June 2005

This is a report into the death of a man that occurred at HMP Acklington on 17 September 2004.

The investigation was carried out under the terms of transitional arrangements agreed between my office and the Prison Service. The Senior Investigating Officer at the time is now Governor of HMP Wakefield. The investigation was overseen by a member of my staff from the PPO Manchester office. I am most grateful to the Senior Investigating Officer for his work. The report that follows is his, save for some minor editing.

Like the Senior Investigating Officer, I offer my sincere condolence to the man's family.

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

SENIOR INVESTIGATING OFFICER'S INTRODUCTION

This report has been commissioned by Stephen Shaw, Prisons and Probation Ombudsman, in an attempt to find out why the death of a man in custody occurred and what could be done to prevent such a tragedy in the future.

I send my heartfelt condolences to his family and friends.

I am grateful to all those concerned who have contributed to this investigation and assisted me with my enquiries. I pay special tribute to the his family and friends for being tolerant, understanding and most helpful to the investigation in what must be a most distressing period of their lives. Special thanks are due to his brother, who afforded us his valuable time and hospitality.

I am grateful to the Governor of HMP Acklington for arranging access, consideration and hospitality to the investigation team.

Senior Investigating Officer

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HMP ACKLINGTON

1. Acklington is a Category C Training Prison for adult male prisoners. Approximately half of the population are vulnerable prisoners, mainly sex offenders. It is also a stage 2 Lifer Centre taking up to 40 life sentenced prisoners. The prison is on the site of a former RAF station, about 10 miles north east of Morpeth, Northumberland. The site was acquired by the Prison Service in 1971 and opened as a Category C training prison one year later. Acklington has developed into a large prison that has held up to 842 prisoners since the summer of 2003.

2. The number of prisoners held on 17 September 2004 was 839.

3. C Wing, where the man died, is a converted former RAF personnel barracks unit, holding up to 83 Vulnerable Prisoners (VP's). On 17 September 2004, it held 77 prisoners, one of whom was subject to F2052SH (suicide and self-harm) procedures.

4. HM Chief Inspector of Prisons carried out an unannounced inspection in April 2003. Her report described a 'safe prison' and went on to say that 'the low levels of self harm and absence of self inflicted deaths reflect well on the proactive approach taken by staff.'

5. A Prison Service Audit was carried out between October and November 2002. An action plan, undertaken to rectify the findings from that report, does not contain any matters which relate to this investigation.

THE MAN'S BACKGROUND

Prison No:	XXXXXX
Age:	50 years old
Ethnicity:	White - British
Status:	Convicted
Category:	Adult Category C
Date/Place of Last Court Appearance:	16/06/2004 Lancashire Magistrates' Court (Recall from Licence)
Date of Conviction:	09/07/2002
Date of Sentence:	09/08/2002
Sentence	Three years
Release Dates:	02/01/2004 (on licence) 05/07/2005
Cell Sharing Risk Assessment:	Low Risk of harm to others
Current F2052SH:	No
Previous F2052SH:	None known
Known Previous Custody Dates:	1975 – 1985

CONDUCT OF THE INVESTIGATION

6. The investigation commenced on 27 September 2004. The investigation team conducted interviews and collated documentation in preparation for compiling this report. We have examined the detail of the incident, why the man was in custody at Acklington, and the circumstances surrounding his recall to custody.

7. The investigator and Family liaison officer from the prison met with the man's brother. He gave valuable assistance and I am very grateful for his hospitality and assistance.

8. The investigation team met with a member of the local police to compare findings.

INCIDENTS AND EVENTS LEADING UP TO THE DISCOVERY OF THE DEATH

9. On 9 July 2002, the man was convicted at Mold Crown Court on two charges and sentenced to three years imprisonment. On 2 January 2004, he was released from HMP Wymott under the provisions of Section 33 (1) (b) of the Criminal Justice Act 1991.

10. He was deemed by the supervising authority to have failed to comply with the licence conditions by entering Kirkham, an area from which his licence conditions excluded him because of victim issues, and by failing to engage with the Sex Offender Treatment Programme (SOTP). On 16 June 2004, Lancashire Magistrates' Court ordered his recall to prison.

11. The man was initially taken to HMP Preston, this being the local prison to the court. On 7 July 2004, he transferred to HMP Acklington. This allocation was not the recommended establishment when an OASys (sentence planning assessment) was undertaken. However, because of population pressures it was the next nearest suitable establishment to HMP Wymott, an establishment much closer to his home area. The man's licence and sentence expiry date was 5 July 2005.

12. A Cell Sharing Risk Assessment was carried out at HMP Preston on 16 June 2004 and assessed the risk of harm to others as being low. The prison and healthcare staff who interviewed the man recorded no other areas of concern. On 8 July at Acklington the process was repeated. Again a low risk to others was recorded. The only comment referred to him requesting that he share accommodation with someone of his own age. However, it is not always possible to facilitate a specific request and is dependent upon available space, etc. The locating officer should complete Section 4 of the Cell Sharing Risk Assessment – the purpose of this requirement is to ensure that high-risk prisoners are not located with other prisoners. On this occasion it would have informed locating staff that he had specifically requested that he share a room with someone of his age. No entry was made by a locating officer and so he shared a room with an elderly man.

13. Whilst at Preston on 27 June, the OSG raised a Security Information Report (SIR) stating that, when monitoring a telephone conversation, she had heard the man's partner saying that "she had to finish their relationship or she would lose her child". He had replied, "Its all right I'll just top myself". This information was relayed to a senior officer who spoke to the man. The senior officer recalls that the man told him, "There was nothing in what he said, it was merely the manner in which they engaged in conversation." The senior officer described the man's mood as jolly and could recall being satisfied that he did not give any cause for concern. The senior officer did not make any entry on file of this conversation.

14. On arrival at Acklington, the man received an Induction to the establishment. A prisoner compact was issued and signed by him on 8 July. He was located onto H Wing and remained there until 17 July when he was located on C Wing.

15. A comment was recorded in his record of events file (F2052A) on 29 August by an officer. This stated, “No problems or concerns at this time.” This comment was echoed by the staff and prisoners interviewed by the investigation team who knew him. It was evident that he was a person who did not share his thoughts with staff and only confided in a select band of prisoners.

16. When received back into custody on 16 June, he had described his partner at the time as his next of kin. They also communicated regularly until 28 July when he wrote complaining that he had not heard from her and wanted to know ‘how they stand’. On 16 August, he wrote again to say that he thought she had found someone else and asked “why won’t you tell me?” On 19 August, he received a reply from her saying, “I don’t want to spoil what I have with my kids as I have realised that they come before my man”. He replied the next day saying that he would always love her.

17. On 27 August, he wrote saying that he believed his partner was seeing someone else, giving some details about him, and ending by saying that he felt he was doing two sentences now that she had dumped him. On 29 August, he wrote again expressing concerns about their relationship. He wrote again the following day stating that his actions could end up with him coming back to prison because of his temper and state of mind. On 9 September, he again wrote and stated that his temper would mean him returning to prison. No letters were noted as being received from his partner since that dated 19 August 2004.

18. On 3 September, he saw the prison GP and was prescribed medication for athlete’s foot and depression.

19. On 7 September, his brother visited him. The next day he was visited by his sister and two sisters-in-law. This was the last recorded social visit at HMP Acklington.

20. From recordings of the telephone conversations between 24 August and 14 September (the last known telephone call), it is clear that he was struggling to come to terms with the breakdown of the relationship with his partner. It has proved difficult to ascertain the exact dates and times of these calls due to technical difficulties.

21. Another prisoner states that during the morning of 17 September he went to the man’s cell. Not knowing whether he was inside, the prisoner knocked and then looked through the door aperture and says that the man was standing on a chair behind the door. He asked what he was doing and he replied “Nothing”. The prisoner asked whether he was trying “to top himself” to which the man replied “No, don’t be stupid”. This exchange was not reported to any member of staff.

22. In the afternoon of the same day, staff on C Wing were dealing with another prisoner who they had to move from the wing to the Segregation Unit. At

approximately 3.45pm the man's cell mate tried to enter his room but could not open the door. Another prisoner, who has not been identified, helped and they discovered that the man was suspended from a ligature behind the door.

23. The man's cell mate immediately sought the assistance of a prison officer. The officer noted that the man was hanging from a ligature made from bed sheeting and was suspended from a conduit pipe at high level. He immediately returned to the office to raise the alarm, but unfortunately the radio battery was flat. Instead he dialled 222, which is the emergency number in the internal telephone system, and said that there was a serious Code Blue, which means an urgent response requiring resuscitation. He also shouted to another officer for assistance and returned to the scene with the anti-ligature kit. He cut down the ligature and checked the man for signs of life but found none apparent. He was then joined by a colleague who also confirmed there did not seem to be any sign of life and that the man's skin was discoloured. One of the officers did not feel confident or capable of attempting resuscitation and a few minutes later a Nurse arrived at the scene and commenced resuscitation. He was soon joined by another nurse. It was when both the nurses arrived that the man was lifted on to a hard flat surface. They then attempted resuscitation for approximately 25 minutes before the paramedics arrived and took over. They ended their attempt at resuscitation after approximately 20 minutes and at 5.15pm a doctor attended the scene and certified that the man was dead.

24. The staff involved with the incident were seen by a representative from the prison's management team and the prison's care team before going off duty.

25. Attempts to contact the man's family were hampered by their distance from the prison and because his ex partner had been identified as the next of kin when he was received into custody. The police became involved and it seems that communication flowed through a number of channels before the immediate family were informed. It was then difficult for the family to ascertain details from the establishment directly.

26. A letter addressed to the man's ex partner was found in his cell. The letter makes it clear that he intended to take his own life because of their break-up.

27. Another prisoner wrote to a prisoner at a different establishment in which he said that he knew from the previous week that the man was intending to take his life. The prisoner did not confirm this when interviewed as part of this investigation.

LEVEL OF COMPLIANCE WITH AUTHORISED PROCEDURES

28. Information recorded on a Security Information Report on 27 June 2004 whilst the man was at HMP Preston noted that he told his former partner that he would "top himself". Staff at the prison state that he was asked about it, but did not record the conversation.

29. The investigation team obtained significant information about him from examination of correspondence relating to child protection arrangements, particularly relating to difficulties he was experiencing. This information does not appear to have been communicated to wing staff who were oblivious to his problems.

30. A high level conduit pipe in the cell was used by the man as a ligature point. It is now a number of years since Prison Service Headquarters advised that such potential ligature points should be removed.

31. When he was discovered, staff responded appropriately to the situation but were hampered by the batteries in the radio used by the officer who found him being flat. According to him, this was a regular occurrence. The officer did not attempt resuscitation or move the man onto his back on a hard, flat surface as required by the establishment contingency plans.

32. The prison's contingency plans for handling an apparent death in custody were activated, except that a hot de-brief was not carried out immediately after the incident.

33. There were difficulties contacting the man's family and the task was handed over to the police at Kirkham. The family continued to have difficulty getting information from the prison.

34. Although the prison's family liaison officer initially communicated with his family, their attentions lessened after his brother visited the prison. The family liaison officer went on annual leave and no one else from the prison asked about attendance at the funeral, sending flowers, holding a local memorial service or keeping in contact with the family.

35. The man's family identified some issues regarding the handling of the incident and I have investigated those which are outlined as follows:

- it was said that one of his brothers telephoned the prison a couple of weeks before his death to raise concerns about his well being and that they thought he was suicidal. I have not been able to trace the recipient or find evidence of the concerns being raised. Families and visitors need to know how to report their concerns and staff need to know how to respond to them.

- it was also said that various matters were on his mind as well as the termination of the relationship and this investigation has confirmed that he found it hard to manage the breakdown of the relationship.

- his family said that he was also concerned about his cell TV being broken, but I have established that the fault had not been reported and it was working properly when I saw it.

- the family reported that he was worried that he had not received a postal order but I have found out that it was received into his account on 23 August.

- his family also said that he was unable to see a doctor. I asked a group of prisoners on the wing about these arrangements. They said they had no difficulties. He saw the doctor on 3 September when he was referred from the wing.

- the family had difficulty obtaining information after they finally were notified of his death. It would have been helpful if the switchboard operator was instructed to forward all such calls to the prison's family liaison officer. They also considered that the prison did not continue to support them after their visit to the prison a few days later.

CONCLUSIONS

36. The man was appropriately recalled to prison after breaching the conditions of his licence.

37. HMP Preston knew of concerns that he had threatened his former partner that he would take his own life, but it is claimed that he stated that this was not a real threat. The conversation was not recorded in the wing observation book or the history sheets. I believe this explanation but it is regrettable that the conversation was not appropriately documented.

38. The reception procedures were followed at HMP Preston and HMP Acklington except that his request to share a cell with someone of his own age was not followed up and was not included in the Cell Sharing Risk Assessment.

39. Monitored correspondence outline the breakdown of his relationship with his partner and indicated that he was vulnerable, but the information was not shared with wing staff.

40. There is no evidence to suggest that he was denied access to medical treatment and this is repeated in the clinical review.

41. There appear to have been difficulties with the batteries for the radio holding their required charge and going flat quickly.

42. High level conduit piping provided a convenient ligature point and no efforts had been made to eradicate them. Establishments have been advised about the risk they present and efforts should be made to remove as many ligature points as possible.

43. Staff responded promptly and appropriately to the emergency call, code named “Code Blue”.

44. The officers who were first on the scene did not immediately begin resuscitation as prescribed in the contingency plans because they did not feel confident or competent and this led to a short delay in commencing resuscitation. From the interviews with the officers and nurses, I do not believe that this short delay affected the outcome of the incident. No formal arrangements for training in resuscitation techniques were available within the Prison Service at local or national level. Two trained nurses commenced cardio pulmonary resuscitation (CPR) and were relieved by paramedics who were called to the establishment. At no time did any of them identify any signs of life.

45. Although a member of the establishment Care Team attended the scene and spoke to most members of staff involved with the incident, no “hot de-brief” took place as required by the establishment contingency plans.

46. The task of communicating news of the death to the next of kin was passed to the police at Kirkham because of the distance from the establishment.

However the nominated next of kin was not a direct relation, but was his ex-partner. The information was subsequently passed to members of his immediate family, who then had difficulty ascertaining events with the establishment. There does not seem to have been any continuing communication with the police who were asked to inform the next of kin.

47. The man left a letter behind addressed to his former partner indicating that he would take his life.

48. The role of the establishment family liaison officer was not consistent, as the first liaison officer appointed went on holiday and was replaced by another manager. Once he returned from holiday the original liaison officer took over responsibility for the family. The prison did not send a representative to the funeral. The liaison officer wrote to the family expressing his sympathy, but unfortunately the Governor did not. There was no formal system to allow family and loved ones to communicate their concern, nor were there adequate arrangements for dealing with such communication.

49. It was evident that the staff on C Wing demonstrated care and empathy for the prisoners under their care and this was also repeated by the prisoners we spoke to.

RECOMMENDATIONS

National

50. There should be mandatory training for prison officers in resuscitation techniques to ensure that staff who discover prisoners asphyxiated by ligature are able to offer immediate assistance.

Local

51. Staff should be reminded to enter in the prisoner's history sheet (F2052a) all concerns. This recommendation is also directed to the Governor of HMP Preston.

52. Staff should be reminded to complete Section 4 of the Cell Sharing Risk Assessment when locating prisoners.

53. The Governor should consider communicating confidential information from post and telephone monitoring to wing management staff to promote successful case management.

54. The condition of UHF radio batteries should be reviewed and a battery management protocol should be implemented.

55. There should be a survey of all accommodation areas to eliminate all high level ligature points.

56. Senior managers should familiarise themselves with the role of family liaison officers for deaths in custody. Senior managers should undertake the family liaison training co-ordinated by Safer Custody Group. The family liaison officer should deal with all enquiries regarding deaths in custody and respond to all enquiries.

57. An annual check of next of kin details should be incorporated into the sentence planning process.

GOOD PRACTICE

58. The efforts to revive the man by both the Nurses should be formally recognised by a letter of thanks.

GLOSSARY OF TERMS

CNA	Certified Normal Accommodation (the certified normal level of occupancy for a prison)
ECR	Emergency Control Room
F2050	Main Core Record
F2052SH	Self Harm at Risk Form
F213	Injury Report Form
FLO	Family Liaison Officer
GOV	Governor Grade (of which there are 6, [A-F] 'A' being the highest)
History Sheet	Prisoners Record of information and events (Wing based)
HMCIP	Her Majesty's Chief Inspector of Prisons
HMP	Her Majesty's Prison
IMSU	Incident Management Support Unit
IMB	Independent Monitoring Board – formerly Board of Visitors (visiting lay observers)
IMR	Inmate Medical Record
IRS	Incident Reporting System
ISS	Investigation Support Section
LIDS	Local Inmate Database
MAPPA	Multi Agency Public Protection Arrangements
OP CAP	Operational Capacity (the agreed maximum level of accommodation per cell/room)
PER	Prisoners Escort Record
PO	Principal Officer
POA	Prison Officers' Association
PSO	Prison Service Order
Remand	Period held in custody before conviction
SIO	Senior Investigating Officer
SO	Senior Officer
YOI	Young Offenders' Institution