Investigation into the circumstances surrounding the death of a man at HMP Acklington in January 2007

Report by the Prisons and Probation Ombudsman for England and Wales

August 2007

This is the report into the death of a man at HMP Acklington in January 2007. The man died in his cell, apparently of natural causes, and was found around 11.10am that morning. He was 40 years old and had been at Acklington since April 2006, having transferred from HMP Durham. He was serving a sentence of two years and six months imprisonment.

I offer my sincere condolences to all those touched by this man's passing, especially his partner and his family.

This investigation has been undertaken by two members of my team. I would like to thank the Governor of Acklington, and his staff for their co-operation and active participation.

A doctor of Northumberland Care Trust conducted a review of the clinical care the man received whilst in prison. I thank him for his report and contribution to the investigation.

One of my Family Liaison Officers contacted the man's partner to inform her of my investigation and to offer her the opportunity to raise any concerns. I hope this report answers any questions she or any other family member may have about the circumstances surrounding his death.

As well as suggesting that the Governor may wish to review one particular aspect of his contingency plans following a death in custody, I make two further formal recommendations in this report. I should add that this is not the first occasion on which I have made recommendations about Acklington's death in custody contingency plans. I hope steps are already underway to address the concerns I have raised.

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

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SUMMARY

A man was sentenced to two years and six months imprisonment by a Crown Court on 5 April 2006. He was taken to HMP Durham where he was given a full health screening. Following a review of his security categorisation, he was transferred to a category C prison, HMP Acklington, in April. At the time, he had no medical or mental health problems. He settled into the prison regime very quickly and enjoyed positive relationships with staff and fellow prisoners. He was soon upgraded from standard to enhanced regime status, and located on the second landing on F Wing.

At the beginning of January 2007, the man complained of chest pains and was seen by staff in the healthcare unit. Tests were carried out, but his complaint was not assessed as serious and he was prescribed paracetamol followed by some anti-inflammatory medication. The man made no further mention to staff that he was experiencing any pains.

On 28 January, the man did not come down for breakfast and had not been seen by 11.00am. Another prisoner went to his cell to look for him, found him in bed and thought that he had died. He ran to the office to tell staff what he had seen.

Two officers went immediately to the man's cell, where they saw him lying in bed as if he were sleeping. They checked for any signs of life but the man was not breathing, was cold and no pulse could be found. The officers raised the alarm, summoning others including medical staff to help. However, emergency resuscitation was not initiated because rigor mortis had already started to set in.

The man was formally pronounced dead at 11.45am.

THE INVESTIGATION PROCESS

1. My investigators, considered the man's prison documentation, including his clinical records, before formally opening the investigation on 2 April 2007.

2. Prior to my investigators going to the prison, notices were issued to staff and prisoners announcing the investigation and inviting anyone who had information relevant to the man's death to make themselves known. One prisoner came forward and eight members of staff were interviewed by prior arrangement.

3. One of my Family Liaison Officers (FLOs) contacted his partner to offer her the opportunity to participate in the investigation process. She said that the man had been complaining of chest pain since before Christmas, but was only given pain killers. She was aware that an electrocardiogram (ECG) was carried out which showed an irregular heartbeat, but did not believe that any further action was taken. She felt that more should have been done to investigate and treat the cause of the pain. I hope this report addresses any concerns that she and other family members have about the man's care and the circumstances surrounding his death.

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 in his enquiries.

5. A doctor from 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. F wing is one of four main wings where all the cells are single occupancy. The wing holds around 112 prisoners serving various sentences. The wing office is on the ground floor, as is the servery. The man's was situated at the very end of the wing on the second landing, with no through access after this point.

8. F wing is a unit for prisoners who have shown that they can comply with the prison regime without constant staff supervision. It mainly holds prisoners within the basic and standard levels of the Incentives and Earned Privileges scheme **(**IEP). There are also a few prisoners on enhanced level because of good behaviour and their type of employment. Adrian was an enhanced prisoner, who preferred to remain on F unit rather than move to E unit.

9. On weekdays the prisoners are locked in their cells after breakfast. At weekends those on the second landing are allowed to have their cell doors unlocked for the day. Prisoners on the landing have responsible jobs such as cleaners and kitchen workers.

10. At the weekend one officer comes on duty at 7.30am and the rest commence their duty at 8.30am. Usually there are five officers and one senior officer on duty. The breakfast trolley also arrives at 8.30am and staff set the food out on the hot plates. When the meal is ready, staff unlock the landings at approximately 8.45am and prisoners collect their meal.

11. After breakfast, prisoners on the second landing are left to their own devices for the morning. One officer works between the ground floor office and the landing, carrying out various jobs. At 12.00 noon, staff ensure that all prisoners return to the landing for a roll check before lunch is served.

Healthcare

12. 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 in-patient nursing care are transferred to an outside hospital or another prison with 24 hour healthcare provision.

13. The initial reception screening process for all prisoners includes a Well Man assessment by healthcare staff. The prison also offers smoking cessation clinics for prisoners who wish give up smoking. Healthy eating advice is also available.

14. Her Majesty's Chief Inspector of Prisons carried out an unannounced inspection of Acklington in April 2003. The Chief Inspector, 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 Chief Inspector 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.

15. Since August 2004, there have been ten deaths at Acklington, including that of the man. Seven were due to natural causes and three were apparently self-inflicted. Investigations into all the deaths have been carried out by my office.

Mandatory drug testing (MDT)

16. Mandatory drug testing is carried out in every prison in England and Wales. The tests are used to tackle drug misuse in prison and are part of the Prison Service strategy "Tackling Drugs in Prison".

Roll check

17. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur at a number of specified times during the day, and staff must sign that they are correct. Acklington's local instruction states -

Roll checks will take place at the following times:

06.00 before morning unlock by night duty staff
07.30 on commencement of day duty staff
12.30 following the serving of prisoners' lunch meal
16.30 following the return of prisoners from labour
19.30 following evening association
21.30 by night staff on commencement of duty
23.00 by night staff.

Incentives and Earned Privileges scheme (IEP)

18. Prisoners are placed first on the standard level of the Incentives and Earned Privileges scheme, unless they have transferred from another establishment at the enhanced level. Prisoners may apply to upgrade from standard to enhanced on condition that they comply with Prison Rules.

Home Detention Curfew (HDC)

19. The Home Detention Curfew (HDC) scheme applies to prisoners who are serving sentences of between three months and under four years. It is designed to help prisoners prepare for life after they complete their sentence, and allows them early release from custody subject to electronic monitoring and providing they do not breach the rules of their curfew.

Category D conditions

20. Category D prisons are open establishments where prisoners are allowed more freedom and encouraged to manage their own time, for example, by attending a further education college or employment during the working day. Home visits can also be granted.

Assessment, Care in Custody and Teamwork (ACCT)

21. In common with all prisons, Acklington has implemented the Assessment, Care in Custody and Teamwork (ACCT) approach to helping and monitoring prisoners at risk of harming themselves. The key aims of ACCT are to create a safe and caring environment, to identify prisoners' individual needs and to offer individualised care and support before, during and after a crisis.

Offender Assessment System (OASys)

22. An OASys assessment is carried out by the probation department, and summarises the factors identified as contributing to a person's risk of conviction.

Adjudication hearings

23. All prisons conduct adjudications - disciplinary hearings - against prisoners charged with a breach of Prison Rules. The prisoner is notified before the hearing and is allowed to present their own evidence. Hearings of the less serious offences take place before a governor and are usually held in the segregation unit. The governor hears that evidence, decides whether the rules have been breached and imposes a punishment.

KEY FINDINGS

April – December 2006

24. The man appeared at Crown Court in April 2006 and was convicted of drug offences. He was sentenced to two years and six months imprisonment. He was escorted from court to HMP Durham, arriving at 1.15pm.

25. The man went through the prison reception and induction process and no concerns were noted, including no health problems. He was assessed as a low risk of self harm to himself and others. Over the next week, he completed the full induction programme, which included meeting chaplaincy, probation and detoxification staff, Counselling Assessment Referral Advice and Through care (CARAT), healthcare, Citizens Advice Bureau, the anti bullying team and being given an introduction to suicide awareness.

26. On 10 April, as part of his post-sentence planning, he was assessed for recategorisation. Staff use an algorithm to consider a range of information, such as security, patterns of behaviour and the circumstances of the offence. They assess whether the category of prison is correct or whether it should be higher or lower. Durham is a category B prison. The assessment was that the man's pattern of offending and the seriousness of his current offence made him unsuitable for open conditions, and he was allocated to category C.

27. The next day (11 April), staff wrote in the man's wing history sheet that he had settled back into prison life and no problems were noted. As a result of his recategorisation, the man transferred to HMP Acklington on 20 April after the Durham healthcare team assessed him as fit for transfer.

28. The man arrived at Acklington at 11.00am, and went through a similar reception process. He said that he had no concerns about the transfer. He also said that he did not feel depressed or suicidal. He admitted being a daily user of cannabis in the community, but was not suffering from any withdrawal symptoms at the time. The officer concluded his interview with the man by noting that he was polite, cooperative and cheerful.

29. The man was also interviewed by a Registered General Nurse. She asked him a number of questions about his health and he said he was fit and well. No concerns were noted, except that he said he was allergic to penicillin. Medically, he was assessed as fit for "labour and gym", and his medical records were noted accordingly.

30. The man's Incentives and Earned Privilege (IEP) level was standard. The cell sharing risk assessment (CSRA) recorded a low risk and no concerns. After completing the reception process, he was located on D wing (the induction wing).

31. On 8 May, staff had reason to suspect the man was under the influence of drugs. A mandatory drug test (MDT) was conducted which found that he

tested positive for cannabis. He was subject to a governor's adjudication hearing which took place on 12 May. He pleaded guilty and provided written representations saying that he had taken the drugs because he was experiencing problems sleeping. His penalty was loss of half of his earnings as a cleaner and loss of his television, both for 14 days.

32. On 1 June, the man moved to F wing, on the fourth landing. Through good work and behaviour, he was later relocated to the second landing on 17 July where an officer was assigned as his personal officer. She quickly made herself known to the man and noted in his wing history sheet that he was in cell 2-21. Later she referred to him settling in very quickly on the wing. He seemed quite popular with the other prisoners, was always prompt at roll checks and kept himself clean and tidy. The personal officer said she would see the man on most occasions that she was on duty and he would always speak to her. He did not cause any concern to staff, and raised no concerns with her. He never mentioned any health difficulties, although the personal officer said that prisoners rarely told officers such information.

33. Two months later, the man applied for enhanced IEP. Staff noted that his conduct and behaviour was exemplary and his application was approved. However, two weeks later the personal officer submitted a security information report (SIR) because it appeared that the man was keeping look-out for two other prisoners who were suspected of having a mobile phone. The personal officer said that he displayed a sharp tongue and temper when she spoke to him about it.

34. On 1 September, the man was seen by the healthcare doctor and complained of severe frontal headaches the previous week, accompanied by numbness to the left arm, fingers and lips. He also experienced flashing in the eyes. He was prescribed propranolol hydrochloride tablets 40g, which is generally an effective treatment for migraines.

35. On 25 October, another SIR was submitted because the man and a fellow prisoner appeared to be under the influence of alcohol or drugs. Their eyes were glazed; they had small pupils, flushed faces and were swaying and staggering. A request for an MDT was carried out, but the test result was negative.

36. The man's personal officer submitted an application for him to be considered for Home Detention Curfew (HDC) on 5 November. She reported that he worked well on the landing, and had become the wing orderly officer in charge of the cleaners. He was always prompt, polite and kept his cell tidy. Around 17 November, the man applied to be re-categorised to an open prison in category D conditions.

January 2007

37. On Friday 5 January 2007, the man went to the wing medical hatch during treatment time and spoke to a nurse. He complained of having chest pains and said he was worried about them. The nurse decided that the symptoms did not require immediate attention, and referred him to healthcare the following day.

38. The man went to healthcare the next morning (Saturday 6 January), where a RGN carried out an ECG test. (An ECG is a trace of the heart to see if there is any evidence of problems, whether there has been a heart attack or if there are any unusual rhythms.) The ECG result showed that he had an unusual heart rhythm but there was no evidence of risk of a heart attack. The man described the pain as being like heartburn which resulted with him sweating a little. He was not experiencing any nausea or vomiting, but said the pain had been constant for the past few days.

39. The RGN also checked the man's blood pressure which was found to be high. The nurse was concerned about his condition. When questioned, he said that he had chest pains for a few weeks, on and off, but had not told anyone until then. He was not particularly distressed about the pain and the nurse told my investigators that he did not describe it as unbearable. Had he done so, the nurse said she would have taken immediate action and called for an ambulance to take him to outside hospital. She described the man as a 40 year old, who was overweight, had high blood pressure, and was a smoker. Because of these factors, and his unusual heart rhythm, she assessed him as a high risk and so telephoned the prison clinical director, who was a doctor, straight away.

40. The RGN explained the man's symptoms and the test results to the doctor. The doctor was content that, because of the length of time the man had had the pain; it was not a heart condition. The nurse wanted to monitor him further and referred him to the doctor on Monday 8 January. She told the man to contact staff if his symptoms worsened or he had any problems in the meantime.

41. Later that evening at around 6.20pm, he saw another nurse. This was the first time she had seen him since when he arrived in reception at Acklington. He told her that he was experiencing pains across both sides of his chest. The nurse said she was not alarmed by the pain the man described, which she thought was consistent with muscular pain. She said that if the man had described the pain as being in his central chest area, with any pain down his left arm, she would have telephoned the doctor immediately. The nurse prescribed paracetamol.

42. On the morning of Monday 8 January, the man went to his appointment in healthcare and was examined by the duty doctor. The doctor noted that the chest pains persisted and had not been helped by the painkillers. The doctor

prescribed anti-inflammatory medication used to treat muscular pain.

43. The next day (Tuesday 9 January), the man returned to healthcare saying that he wanted to lose weight. A letter was prepared to refer him to the gym's weight loss programme. He did not return to healthcare again.

44. On 15 January, a decision was made about his application for recategorisation. A reallocation assessment was completed which recognised that he had long term drug and alcohol problems. The man's OASys report said that he needed to address his drug and alcohol misuse and improve his thinking skills. His personal officer endorsed the application, subject to the availability of relevant offence focused programmes. However, recategorisation to category D was refused on the grounds that the man had a history of dishonesty and could not be trusted. Although his application was supported by wing management, he had not completed any offence-focused or drug-related work.

45. The Discipline Officer on F wing was also the landing officer on the second landing where the man's cell was located. The officer told my investigators that he did not know the man very well, but knew when he became a cleaner. He said he was slightly older than most other prisoners on the wing, and gave no problems or cause for concern. He generally kept himself to himself, and had a small circle of friends. The officer said that, although he saw the man whenever he was on duty, he had not heard him complain of chest pains.

46. On 20 January, the man gave up his job as a wing cleaner. This was recorded as being, his own choice. He had applied for other jobs, but nothing had come up yet.

47. The prisoner who was located in the cell next door to the man, and had been so for about eight months, had known the man for about 12 years. They had been at Durham around the same time and then transferred to Acklington. He described the man as a happy go lucky person who was a good friend of his. He thought that the man first complained to him of chest pains in November. He said that some time later the man told him he had been to healthcare a few times and had some tests, but he still complained of chest pain. The man in the next cell was also aware that the man had changed his diet and decided to start eating healthily. He advised the man to return to healthcare and inform them, but as far as he was aware he did not follow the advice. He said that normally the man would hold his chest as if something was wrong, and would only mention the pain if asked. The man in the next cell told the man that if he was ever having any problems to bang on the cell wall and he would raise the alarm. The man never did this.

48. The man in the next cell said that, during the day of Saturday 27 January, the man seemed his usual self and he recalled no concerns about him. They spoke together around 7.30pm, just before their cells were locked for the evening. Although he thought the man seemed okay, he looked very pale. The man in the next cell told him that he was as white as a sheet and asked if he was alright, to which he replied that he was. His response did not surprise

him. He described the man as someone who would not necessarily say if he was in pain.

Sunday 28 January

49. An officer came on duty at 7.30am and for the next hour was the only member of staff on the wing. He told my investigators that he carried out the roll check of the wing by going to every cell to open the observation panel and see that there was a prisoner in the cell. He recalled looking into the man's cell and seeing him lying in his usual sleeping position on his left hand side. Afterwards he collated the roll for each landing, wrote the figures into the book, added them together and rang them through to the communications room.

50. The officer who was the Discipline Officer on F wing came on duty at 8.30am. He spoke to other staff before beginning to unlock prisoners for breakfast at 8.45am so they could make their way to collect their breakfast. On arriving at the man's cell, the officer said he had a quick look through the observation panel and saw the man lying in bed. The officer said that he appeared to be sleeping in his usual position, lying with his arm out.

51. The officer opened the man's cell door slightly, and continued to unlock the remainder of the cells on the landing. He did not notice if the man came downstairs to collect his breakfast and said that there was no log to check who had breakfast. At the weekend prisoners often had a lie in and the man also sometimes stayed in bed.

52. His cell, like the others on the landing, was left open for the remainder of the morning. After the Discipline Officer had unlocked the prisoners for breakfast, he continued his normal Sunday wing duties, including completing paperwork in the ground floor office. He said that there were no events or concerns during the morning.

53. The man in the next cell said he collected his breakfast as usual at around 9.00am. Although he said the man was someone who tended to always get up for breakfast, neither the man in the next cell nor anyone else realised that he had not been seen. The man in the next cell returned to his cell, and a little later was joined by another prisoner. They played a PlayStation computer game on his television. It was not until about 11.00am that he realised he had not seen the man all morning. He said he would have expected him to have knocked on his door and acknowledged his presence.

54. The man in the next cell went to look for the man. When he went into the cell he saw that the curtains were drawn and, unusually, the television was on. As far as he could tell, the man appeared to be asleep. The man in the next cell looked at the man's face and noticed that it was white and discoloured. He was lying on his side and it appeared as if his blood had been drained. The man in the cell next door believed that the man was dead and quickly left the cell to raise the alarm.

55. The man in the next cell and another prisoner quickly made their way to the ground floor wing office to inform staff. It was about 11.05am when he told the Discipline Officer what he had seen and said that he should go to the cell as he thought that the man had died. The Discipline Officer and a Senior Officer (SO) immediately made their way to the man's cell. He was lying in his bed in the same position that the officer remembered from when he had unlocked the cell earlier in the morning.

56. The Discipline Officer said that, when he entered the cell, he immediately realised that something was wrong. He touched the man, who was very cold, and checked for signs of life. He looked for a pulse in his neck and any breathing from his mouth. He said that the man's arm was stiff, and his skin was discoloured with a blue tint. The colour on his face was also darker on the side that was lying on the bed. The Discipline Officer believed that the man was dead and that rigor mortis had set in. The SO also checked for signs of life and concurred with the Discipline Officer. The SO said that the television and the light in the cell were on and the man's cell looked normal. There were no signs of a struggle or a fight having taken place, and he looked as if he was lying in his bed watching television.

57. My investigators asked the Discipline Officer why they did not try to resuscitate the man. The officer said that, although he had not had resuscitation training for about seven years, he believed that he was already dead. He had checked his vital signs, there was discolouration and the body was cold. The officer also said that something had come out of his mouth on to the sheet that looked like blood or vomit. The Discipline Officer said that, if he had felt resuscitation would have saved the man's life, he would have attempted it although he added he would not have felt totally competent to do so.

58. The SO immediately raised the alarm to call healthcare and the principal officer and the governor of the day to come to the wing. The Discipline Officer stood guard at the entrance of the cell to ensure that no one entered and he directed any prisoners back to their cells.

59. The nurse, who was in healthcare, received a telephone call from the SO at approximately 11.10am. He said that a prisoner had been found dead in their bed. The nurse and her colleague immediately made their way to F wing and the man's cell. They brought from their office the blue emergency medical bag which contained airways and face masks, together with oxygen and the defibrillating machine.

60. The nurses arrived at the cell in approximately one to two minutes. They saw the man lying curled up on his bed on his left hand side with his arm sticking out. He appeared to be asleep. The nurses tried to turn him on his back to assess him. One of the nurses lifted his arm and it was clear to her that rigor mortis had set in as it was very stiff. His colour was grey and mottled. One of the nurses checked the man's pulse and breathing, but found neither. The other nurse also checked for signs of life and concurred with her colleague that he was dead. She told my investigators that they realised he had actually

been dead some time, and so did not attempt resuscitation.

61. A Principal Officer (PO) and a Governor arrived shortly after the nurses. One of the nurses telephoned the on-call doctor to come to the prison to certify the man's death. She asked whether staff had noticed anything wrong with him the night before, but all responses were negative. She left the cell to return to healthcare and the 2nd nurse went to the prison gate to meet the doctor who arrived after approximately 20 minutes. The man was pronounced dead at 11.45am.

After the man's death

62. The prison activated its contingency plan for dealing with a death in custody. The Discipline Officer remained outside the cell to ensure no unauthorised entry was made, and cleared the landing of any prisoners. He was later relieved by a log keeper who kept a record of all events in and outside the man's cell. The police and the coroner were informed and subsequently arrived at the prison.

63. Staff had difficulty ascertaining the man's next of kin as the computer system identified a different next of kin to that found on his OASys. The man's partner subsequently told my Family Liaison Officer that she was informed of his death by a friend, which she was unhappy about, and then had to contact the prison to confirm the news. The death in custody contingency plans record that the next of kin was informed at 1.00pm. The man's partner said she was later visited by staff from the prison around 3.00pm, and arrangements were made for her to visit the prison. The man's mother, who was also listed as a next of kin, was visited afterwards.

64. After the police concluded their investigations at around 4.55pm, the man's body was moved from the prison. The chaplaincy, Independent Monitoring Board (IMB), staff care team and the Samaritans were all informed of his death. Support was offered to prisoners, and most of the officers said that they were also offered support. The man in the next cell asked to move to another cell, but this was not possible at the time because of a shortage of spaces and he had to return to his cell. The Discipline Officer and SO had to remain on duty for some time afterwards because of staff shortages. A hot debrief was also carried out by a PO the following morning. The man's personal officer was on leave at the time of his death and on her return was not offered support.

65. The post mortem results confirmed that the man had significant abnormalities of the heart. It appeared that he died as a result of ischaemic heart disease (reduced blood supply to the heart) due to coronary artery atheroma. The report says that such deaths often occur very unexpectedly and extremely rapidly.

ISSUES RAISED IN THE INVESTIGATION

Clinical care

66. It is the opinion of the clinical reviewer that the man's healthcare was managed appropriately by the prison. My investigator found no evidence to suggest that the man's death could have been predicted. There was a three week gap between his last complaint of chest pains and his death. Healthcare nurses are accessible as they attend the wings every day. It would appear therefore, that he kept to himself any further pains he may have felt and did not report them to wing or healthcare staff. The evening before he died, Adrian and another prisoner were in conversation and he looked pale but said he was fine.

67. Staff responded swiftly once they were alerted to the emergency. They told my investigators that when they found the man rigor mortis had already set in. The clinical review concurs that attempts to resuscitate him would not have been appropriate, and would have been disrespectful to the man's memory and to the staff expected to carry it out.

68. However, it is a concern that neither officer who discovered him had up to date first aid training, and one said he would not have felt confident in attempting resuscitation.

The Governor should review the first aid and life support training for front line staff.

Discovery of the man's death

69. It is not known whether the man was actually alive at the morning roll check or at breakfast. He appeared to be asleep when the roll check was carried out, and the next opportunity staff had to engage with him was when his cell was unlocked for breakfast. The officer who unlocked his cell only opened it a few inches, and he too believed that the man was asleep and so did not speak to him. During the course of the morning, staff periodically passed through the landing carrying out their duties, but did not go into his cell. The man was not discovered until two hours later. I appreciate that staffing levels are not generous and that prisoners in low security prisons are permitted to lie in at the weekends. However, it would be good practice for staff to ensure that all prisoners who do not attend for breakfast are checked for their wellbeing.

70. Whilst I could find no written requirement in Acklington's local roll check procedures that staff should check prisoners for signs of life when they unlock the cell, I believe that they should ensure the wellbeing of prisoners when they do so. The Prison Officer Entry Level Training (POELT) manual states:

> "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open

the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

The Governor should review the procedures for unlocking prisoners.

Support for staff and prisoners

71. Although support was offered to staff and prisoners, there were omissions which left some individuals feeling that their needs had not been met. The neighbouring prisoner who discovered the man was distressed and wished to move to another cell, but it was not possible as there was no available space. As fewer staff are on duty at the weekend, those who discovered the man had to remain at work despite, in one particular case, feeling affected by what they had seen. The man's personal officer was on leave at time of his death and was not offered support on her return to duty.

72. I cannot know what impact his death had on staff and prisoners, and I am pleased that the care team were available to offer assistance on the day. However, when possible, consideration should be given to relieving staff of their immediate duties, and where feasible, affected prisoners should be relocated. Arrangements should also be made for staff who are absent, where there is a likelihood that they may subsequently be affected by the news.

The Governor should review the prison's policy for dealing with deaths in custody to ensure that provision for staff and prisoners meets their individual circumstances.

Informing the man's next of kin

73. The prison has informed me that it automatically reviews its death in custody contingency plans after any death, and includes consideration of the contact with the bereaved family. I believe that it is respectful for the families of prisoners who die in custody to be informed of the death in person. Ideally, this should be done by a senior member of prison staff who knows the circumstances. When this is not possible, for instance because the prison is too far away from the next of kin's home, it is reasonable for a prison to contact the local police to pass on the news (although best practice would be to ask the staff of another prison). As Acklington is more than 50 miles away from the home of the man's next of kin, and it was a Sunday, I accept that a visit could not have been carried out quickly.

74. I am very concerned that the family found out about the man's death from a third party. This must have caused a great deal of distress. It is unfortunate that the prison were unaware that the man's neighbouring prisoner was a family friend who had contact telephone numbers. It seems that this prisoner made a telephone call and, via an intermediary, the news was passed on to his partner.

75. There was an additional issue about who actually was the man's next of kin, as

two different names were given in separate prison records. I have mentioned in a previous report on a death at Acklington that the Governor may wish to review the issue of contacting family members in his contingency plans, and repeat that suggestion here. That review may wish to include consideration of temporarily restricting prisoners' access to telephones following a death in custody, although I appreciate that there are strong counter-arguments.

76. Nevertheless, following any future death I stress again that it would be preferable for Acklington or another prison to inform the bereaved family as quickly as possible. If this is not possible, every effort should be made to ensure that information is not passed on by a third party without the Governor's authority. It is also essential that accurate next of kin details are obtained.

RECOMMENDATIONS

1. The Governor should review the first aid and life support training for front line staff.

2. The Governor should review the procedures for unlocking prisoners.

3. The Governor should review the prison's policy for dealing with deaths in custody to ensure that provision for staff and prisoners meets their individual circumstances.