Investigation into the circumstances surrounding the death of a prisoner at HMP Acklington in January 2008

Report by the Prisons and Probation Ombudsman for England and Wales

December 2008

This is the report of an investigation into the death of a man, who was a prisoner at HMP Acklington. The man died on 25 January 2008, at a local hospital, having been taken ill in his cell two hours earlier.

The cause of death, established after a post mortem, was given as ischaemic heart disease (reduced blood supply to the heart) due to a coronary artery atheroma (fatty patches developing in the arteries) and a left ventricular hypertrophy (enlargement of the left ventricle). I offer my sincere sympathy and condolences to the man's partner and family, and to all of those affected by his loss. The man's family had a number of concerns regarding the circumstances of his death. I hope that my investigation helps relieve those anxieties. I must, however, apologise for the delay in issuing this report.

The investigation was carried out on my behalf by my colleague. A review of the man's medical care in prison was carried out on behalf of the Northumberland Care Trust. I am most grateful to the clinical reviewer for his assistance.

I would also like to thank the Governor and staff of Acklington for their full and ready co-operation during the course of the investigation. My particular thanks go to the Deputy Governor for his work in liaising with my investigator.

In previous investigations at Acklington I have recommended that the first aid training needs of staff are reviewed. Despite this, the man was initially resuscitated by an untrained member of staff. I have therefore strengthened my previous recommendations. I make two further recommendations and highlight one example of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman **December 2008**

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SUMMARY

The man arrived at HMP Durham on 31 August 2007, having been sentenced to three years imprisonment on the same day. Other than indigestion, he reported no health problems when he was seen by a nurse on the day of his reception.

The man settled well into prison life at Durham and received good reports from staff on his wing and his place of work. He transferred to Acklington on 3 January 2008. The man saw a prison doctor on 9 January after complaining of pain in his knee and pins and needles in his arm, for which he was prescribed painkillers. He had no further contact with healthcare staff during his remaining three weeks at the prison.

At around 10.13pm on 24 January, the man called the Operational Support Grade (OSG) who was on night patrol to his cell. The man said that he was experiencing heavy pains in his chest. He then slumped forward onto the floor. The OSG went to request assistance, and he and another officer then entered the man's cell. They found the man lying on the floor with mucus around his mouth. The man's breathing was laboured and so, after putting him in the recovery position, the staff called for an ambulance.

Around a minute later, the man stopped breathing. The OSG and a second officer immediately commenced cardio-pulmonary resuscitation (CPR). As this officer is not CPR trained, he struggled to do the breaths correctly. He was replaced by another officer, who is trained, when she arrived a few minutes later. No clinical staff work overnight at Acklington.

The paramedics arrived at around 10.40pm. One of them took over the breaths from the CPR trained officer, although the night patrol OSG continued to administer chest compressions. At around 11.55pm, the paramedics left the prison to take the man to a local hospital. Sadly, he died at 12.18am, shortly after his arrival at hospital. A post mortem report gave the cause of death as ischaemic heart disease due to a coronary artery atheroma and a left ventricular hypertrophy.

The man's death was sudden and unexpected. In a number of previous investigations into deaths at Acklington, I have recommended that the Governor review the first aid training needs of staff. I consider this to be particularly important in a prison with no healthcare cover overnight. However, the first few minutes of the man's resuscitation was partly administered by an untrained member of staff.

THE INVESTIGATION PROCESS

1. The investigation was opened on 30 January 2008 when my investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. One prisoner came forward as a result.

2. My investigator was given access to the man's prison files, including the medical record. He visited Acklington on 17-18 April 2008, and interviewed five members of staff during the course of the investigation. My investigator also spoke to the prisoner who had come forward during his visit, as well as to two other prisoners. An independent clinical review of the man's health needs whilst he was in custody was carried out on behalf of the Northumberland Care Trust.

3. A copy of the post mortem report was kindly supplied to my investigator by HM Coroner. The pathologist who carried out the post mortem concluded that the man died from ischaemic heart disease (reduced blood supply to the heart) due to a coronary artery atheroma (fatty patches developing in the arteries) and a left ventricular hypertrophy (enlargement of the left ventricle). The pathologist also found that the man had two fractured ribs and abrasions on his face and upper leg. These injuries were considered likely to be due to resuscitation attempts and the terminal collapse respectively.

4. My senior family liaison officer telephoned the man's partner and wrote to his sister to inform them of the investigation. The man's partner made the following comments:

    - That the treatment she had received from Acklington had been "really excellent".

    - That she had visited the man on the day that he died and that he was grey and was complaining of pain in his legs and that he was cold.

5. My family liaison officer and my investigator later met the man's sister, and other members of his family, on 30 April 2008. At the meeting, the man's sister raised the following issues that she wanted the investigation to address:

    - She had heard from the man's partner that he had not been receiving his medication for indigestion in October.

    - The man's family had heard a rumour that the man had been beaten up by two prison officers on the night that he died. Another rumour was that the man had been passed drugs on his visit that afternoon and that the packet had burst after he swallowed it. The family were therefore concerned that "something untoward" might have happened.

- The man's sister had also heard that the man had fallen and banged his head on a wall whilst on association on the day he died.

- The man's sister asked why it took so long to get the man to hospital after he collapsed.

- She had heard that when the man was dying he was crying for his son and wanted to know why prison staff had not called him.

- Her contact with Acklington had been poor.

6. My report was sent in draft form to the man's partner, his sister and her family, and his ex-wife and eldest son. Their comments have been incorporated into this final report, along with those made by the Prison Service.

HMP ACKLINGTON

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

8. Healthcare is provided by the Northumberland Care Trust. Nurses and a prison doctor (provided through a local practice) deliver primary healthcare during the daytime, seven days a week. There is no out of hours medical cover at the prison, although a doctor can be contacted by prison staff over the telephone after 6.00pm. Prisoners who require inpatient nursing care are transferred to an outside hospital or another prison.

9. Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, last reported on Acklington following an announced inspection in December 2006. Ms Owers was disappointed at what she found at Acklington, and concluded that it did not provide a safe and decent environment. She did, however, consider that healthcare had improved in recent years, but thought that there was still room for further improvement.

10. The Independent Monitoring Board Annual Report for 2006-07 strongly criticised the standard of accommodation on several wings at Acklington, including E wing, where the man lived.

11. This is the 14th death to have occurred at Acklington since April 2004 when I began investigating all deaths in custody in England and Wales. (Another prisoner died later on the same day as the man.) Of the 13 previous cases that I have investigated, eight were due to natural causes. In five of my previous investigations I recommended that the Governor review the first aid training needs of staff.

KEY FINDINGS

12. The man was sentenced to three years imprisonment on 31 August 2007, and arrived at HMP Durham the same day. A first reception health screen (a routine health screen for all new arrivals into prison) was carried out following his arrival at the prison. At his reception screen, the man said that he was taking lansoprazole (medication for indigestion) and that he drank a lot of alcohol. On account of this, an appointment was made with a prison doctor. The health screen requires the member of staff who completes it to ask the prisoner if they have problems with a number of specific diseases, including angina and heart disease. The man replied in the negative to each of these.

13. Later that afternoon the man saw a prison doctor. The prison doctor noted the man's history of indigestion and that he was a heavy drinker. He recommended that the man undertake an alcohol detoxification programme and that he continue to take lansoprazole.

14. The man initially lived on B wing at Durham and settled in well. On 6 September, his medication was reviewed by a prison doctor, and he was prescribed a course of omeprazole (an alternative to lansoprazole). Later in the month, the man reported that he was having trouble sleeping. He was advised to record his sleep in a sleep diary and was given some herbal tea bags to help him relax.

15. On 4 October, the man moved to F wing. Again, he settled in well there. The man's personal officer wrote in his wing record that he was a "mature prisoner who causes no concern for wing staff". After further good reports from staff, including from the workshop where the man worked, he was made an enhanced prisoner (enhanced is the highest level on the 'Incentives and Earned Privileges Scheme' used to encourage and reward good behaviour in prisons) on 15 November.

16. Despite the provision of herbal teas, the man continued to have trouble sleeping. He was therefore prescribed a course of zopiclone (a sleeping tablet) on 16 November. He was assessed and considered as fit for transfer to Acklington on 2 January 2008, and moved there the following day.

17. On his arrival at Acklington, the man was subject to another reception health screen. The man said that he had problems sleeping and had been taking medication for heartburn. He was again asked if he had any heart problems, and said that he did not. The man was routinely referred to the prison doctor on account of his history of heartburn and sleeping problems. Shortly after his arrival the man moved to E wing, which is for enhanced prisoners.

18. The man saw a prison doctor, on 9 January after complaining of pain in his knee. He also complained of pins and needles in his left arm. The prison doctor therefore prescribed some painkillers. The man had no

further contact with healthcare staff during his time at Acklington. As part of this investigation, the clinical reviewer spoke to the prison doctor about this consultation. The prison doctor said that the pain in the man's arm was muscular. He added that it was not related to exertion and there were no other features to suggest possible heart problems.

19. On the afternoon of 24 January, the man was visited by his partner and his son. When she spoke to my senior family liaison officer after the man's death, his partner said that he looked grey to her and was complaining of pain in his legs and being cold. However, the man's son said that he looked well that afternoon but had said that he had been cold in the night and had worn his coat to bed.

20. That evening the man spent time with the prisoner in the cell opposite to his own, with whom he had developed a friendship. The prisoner subsequently said that the man seemed to be fine and he did not complain of feeling unwell. At around 8.00pm, after the prisoners were locked in their cells for the night, the man spent some time shouting through his window to a prisoner on an opposite wing. The man and the other prisoner were having a conversation, rather than arguing, and were shouting due to the distance between wings. The prisoner later recalled that the man looked alright and said that he did not appear to be unwell.

21. During the night, an Operational Support Grade (OSG) works on each wing. In addition there is a Senior Officer (SO), who is in overall charge of the prison, and five officers who support the SO. Only the SO carries an open cell key at night. The OSGs carry a cell key in a sealed pouch. If an OSG believes there is a danger to life, the sealed pouch may be broken, the cell entered and the appropriate emergency call made over the radio. If there is no immediate danger to life then the OSG must ask the SO's permission to break the pouch and enter the cell.

22. On the night of 24 January, a night patrol OSG was on duty on E wing. His shift began at around 8.45pm and he carried out a roll check (where each prisoner is counted to ensure that the correct number is present on the wing) shortly after his arrival. The OSG did not remember seeing the man on his roll check.

23. At 10.13pm (according to the record of cell call system), the man pressed his call bell. The man was in cell E2-003, a single cell. The records show that the OSG reset the call bell, which can only be done at the cell, 51 seconds later. On his arrival, the OSG found the man sitting on his bed. He spoke to the man from outside the door. The man said that he had heavy pains in his chest. The OSG asked him if he had been feeling well through the day, and the man said that he had been fine. The OSG thought that the man's breathing seemed to be "okay" at that time and recalled that he was able to hold a conversation.

24. The OSG told the man that he was going to return to the wing office to ask the senior officer to come over and see him. As he was about to leave the

cell door, the man fell forward. He was now kneeling on the floor with his head on his knees. The man was moaning, but the OSG could see that he was breathing.

25. As an officer was on E wing at the time, the OSG asked him to watch the man while he telephoned the senior officer. At 10.16pm (according to the communications room log), the OSG telephoned the communications room and requested that they ask the senior officer to attend E wing.

26. Shortly afterwards, the officer arrived at the man's cell. He found the man lying face down on the floor making a noise that sounded like snoring. The officer therefore radioed the senior officer to ask for permission to break the sealed pouch and enter the cell. This was given. The officer and OSG entered the cell at around 10.18pm, just as the senior officer and another prison officer arrived on the landing.

27. On entering the man's cell, the staff found him lying face down on the floor with his legs under the bed and head under his chair. The man was making a noise that sounded like snoring and had mucus around his mouth. His breathing was deep and laboured. The senior officer tried to get a verbal response from the man, but heard nothing. He and an officer therefore put the man into the recovery position. They continued to try to get a response, but none was forthcoming.

28. The senior officer then radioed the communications room at around 10.24pm to request that an ambulance be called. Following this, he went to the main gate to let the ambulance in (as only the SO carries a gatelodge key at night). At 10.25pm, the man stopped breathing. A third officer, who had subsequently arrived at the cell, and the OSG therefore began cardio-pulmonary resuscitation (CPR). Although the third officer was not first aid trained, he administered the breaths. The OSG, who is trained, administered the chest compressions.

29. A few minutes later, a CPR trained officer arrived at the cell and took over the breaths. The paramedics arrived at around 10.40pm. One of them took over the breaths from the officer, but the OSG carried on with chest compressions. A defibrillator machine was not used by the staff. Prison officers have not been trained in its use and there have been concerns expressed about the safety in them doing so.

30. Around an hour later, the paramedics decided to transfer the man to hospital. The ambulance left at 11.55pm, with two officers accompanying it. The paramedics continued to work on the man in the ambulance and following his arrival at a local hospital. Sadly, their efforts were unsuccessful. The man was pronounced dead at 12.18am on 25 January. A post mortem report later gave the cause of death as ischaemic heart disease (reduced blood supply to the heart) due to a coronary artery atheroma (fatty patches developing in the arteries) and a left ventricular hypertrophy (enlargement of the left ventricle).

31. The man's next of kin was recorded as being his partner. She was informed of his death by the local police in the of the morning of 25 January 2008. The man's funeral took place on 9 February. My investigator found that the prison's contribution to the funeral arrangements was in accordance with PSO 2710, the Prison Service Order that sets out the actions to be taken following a death in custody.

ISSUES

The man did not receive his medication in October 2007

32. The man's sister said that she had been told by his partner that he had not been receiving his medication for indigestion in October 2007. When he was first received at Durham on 31 August 2007, the man told a prison doctor that he was taking lansoprazole for his indigestion. The prison doctor prescribed a further course of lansoprazole.

33. On 6 September, the man's medication was reviewed by the prison doctor. He was prescribed omeprazole for his indigestion, as an alternative to lansoprazole. It is unclear how long a course the man was prescribed as the prescription chart is missing. However, on 16 November he was prescribed a further 56 day course.

34. If the man had been prescribed a 56 day course on 6 September, this would last until 31 October. There is no evidence that he made a formal or informal complaint to healthcare staff regarding his medication. It is also unclear whether the man took his medication each day or only if he felt it was needed. Whilst it would be disappointing if the man had gone some time without his medication, I do not consider that this would have had any bearing on his death.

The man was unwell during his visit on 24 January 2008

35. The man's partner told my senior family liaison officer that he looked grey during her visit on the afternoon of 24 January 2008. He had also complained of pain in his legs and that he was cold.

36. The man was also visited by his son that afternoon. After reading my draft report, the man's son passed his memories of the visit to my senior family liaison officer, via his mother. He said that the man looked well that day, but told him that he had been cold in the night and had to wear his coat to bed.

37. Two prisoners who spent time with the man that evening also told my investigator that he seemed fine and had not complained of ill health. However, the OSG said that the man told him that he had been feeling well throughout the day when he attended his cell at 10.13pm.

38. Whilst it is uncertain whether the man was feeling unwell or not on 24 January, there is no evidence to suggest that he asked for healthcare assistance at any time. When he did request help, at 10.13pm, he was attended to promptly.

Prisoner concerns

39. My investigator was contacted by a prisoner on another wing during the course of his investigation. The prisoner said that he had heard through

other prisoners that the man had pressed his call bell at around 9.00pm on the evening of 24 January 2008 and reported having chest pains. He said that the man was told by the member of staff who attended that he could see the nurse in the morning. The prisoner thought that more should have been done at this time given that the man died just a few hours later.

40. The call bell records clearly show that the only time that the man pressed his call bell on 24 January was at 10.13pm. This was confirmed by the OSG at interview. In addition, the two prisoners who were named as people who could support this prisoner's claim both said that the man appeared to be well that evening. I am therefore satisfied that there is no evidence to support the claim that the man first reported chest pains at around 9.00pm.

Rumours surrounding 24 January 2008

41. The man's family told my investigator that they had heard several rumours regarding the events of 24 January. First, they had heard from the prisoner with whom he was sharing a cell that the man had been beaten up by two prison officers. Secondly, that the man had been passed drugs during his visit and that the packet had burst after he had swallowed it. On account of these rumours, the man's family were concerned that his death may have been suspicious.

42. A further rumour was that the man had fallen and banged his head on a wall during association. Finally, the man's sister had heard that he had been crying for his son when he collapsed. She felt that, if this was the case, staff should have contacted the man's son.

43. On the night that he died, the man was in a single cell on E wing. He was not therefore sharing a cell with another prisoner. No prisoners or staff have come forward to say that the man had been assaulted. The post mortem report noted that the man had fractured two ribs and had abrasions to his face and upper leg. However, the pathologist concluded that the man's fractured ribs were most likely as a result of resuscitation attempts and that the abrasions were likely to be related to his collapse. I do not therefore consider that there is any evidence to support the claim that the man was attacked by prison staff.

44. During his time in prison, two Security Information Reports (SIRs, the main system for collecting and collating security information on prisoners) were submitted relating to the man's involvement with drugs in prison. First, during a monitored telephone call on 14 October 2007, another prisoner was heard to ask his mother to send in £40 to the man. Secondly, on 23 November, a prisoner said that the man was being passed subutex (a heroin substitute) on visits. However, no additional evidence was forthcoming in either case and no further action was taken.

45. The toxicology report revealed no drugs or alcohol in the man's blood. I am therefore satisfied that his death was not related to the misuse of drugs. Moreover, the post mortem report notes that the man died of ischaemic heart disease, caused by symptoms that may "lead to collapse and sudden death at virtually any time". I am therefore satisfied that there are no suspicious circumstances surrounding the man's death.

46. The man's sister had also heard that he had fallen during association on 24 January and banged his head on a wall. As I have already noted, the post mortem reports that the man had some recent injuries but that these were most likely caused by his collapse and subsequent treatment. There is no evidence in his records to suggest that the man reported a fall to discipline staff or that he was seen by healthcare for any injuries.

47. The final rumour that the man's family had heard was that he had been calling out for his son as he was dying. They thought that, if this was the case, prison staff should have contacted the man's son.

48. None of the staff who were present when the man was being treated made any mention in their statements or at interview of his calling out for his son. During the short period between his collapse and his breathing stopping, the man was described as "moaning" and "making a noise like snoring". No staff were able to get a conscious response from the man.

49. I do not therefore have any evidence to confirm the rumour that the man was calling out for his son when he collapsed. I do, however, later raise concerns about how the news of the man's death was given to his next of kin.

Response to the man's collapse

50. When the man pressed his call bell on the night of 24 January 2008 to request help, the OSG responded in good time and attended the cell in less than one minute. Once it became clear that the man had collapsed, the cell was entered promptly. However, there was a gap of around six minutes between staff entering the man's cell and an ambulance being requested. I accept that the staff present spent this time checking for signs of life and trying to get a response from the man. However, it would have been prudent to have called for an ambulance immediately.

51. Cardio-pulmonary resuscitation (CPR) was administered as soon as the man stopped breathing. Of those staff who were present at the time, only the night patrol OSG was trained in CPR. He had also previously been a first aid instructor in the army and was therefore confident in what he was doing. The officer who initially administered breaths is not CPR trained. At interview, he said that he struggled to use the facemask that is recommended for administering breaths. The officer who took over a few minutes later is CPR trained and was able to use the facemask correctly.

52. As I have pointed out in many of my investigation reports following a death in custody, speedy intervention by properly trained and qualified staff can be the difference between life and death. I think it is essential that discipline staff have the knowledge and confidence to carry out CPR effectively. This is especially the case at a prison like Acklington, where night staff do not enjoy the support of healthcare staff out of hours.

53. In five previous reports I have recommended that the Governor of Acklington should review the first aid training needs of staff. A summary of my previous recommendations, and the prison's response, can be found at Annex 11. In particular, in my report into the death of a prisoner in January 2007 I made the following recommendation:

> "The Governor should review the training needs for all staff employed on nights and ensure sufficient first aid and CPR trained staff are on duty during the night and at any other time when healthcare is closed."

54. This recommendation was partially accepted by the Governor. The six month progress report following the recommendation reported that "all night patrols have received training in heartstart".

55. However, this has still led to a situation in which an untrained member of staff has struggled to administer CPR for several minutes. In his clinical review, The clinical reviewer makes the following recommendation which I support:

The Governor should consider a rolling programme of CPR training updates for all prison officers and operational support grades so that should another sudden collapse occur in the prison outside of healthcare operating hours then resuscitation can be initiated immediately by trained staff.

56. The clinical reviewer also considers the defibrillator machine at Acklington. He notes that:

> "At the present time it is not used by prison officers as they have not been trained in its use. There have been concerns about the safety in doing so and any liabilities that may incur to prison staff if used incorrectly … Modern defibrillator machines are designed to be used by members of the public with no training. It is not possible to cause harm but may on occasions save life."

57. The clinical reviewer goes on to make the following recommendation, which I again support:

The Governor and Healthcare Manager should work together to establish the use of the defibrillator machine by prison staff.

58. The OSG administered chest compressions for around one hour and 20 minutes, until the man was taken to hospital. He was offered a rest on a number of occasions, but was happy to carry on. His efforts are worthy of praise:

    The Governor should commend the OSG for his efforts in attempting to resuscitate the man.

Transferring the man to hospital

59. The man's sister queried the length of time that it took for him to be taken to hospital after his collapse. An ambulance was called at around 10.24pm on 24 January, shortly after staff entered the man's cell and found him collapsed. The paramedics arrived at the cell at around 10.40pm, at which time staff had been attempting to resuscitate the man for around 15 minutes. The decision to transfer the man to hospital was made by the paramedics at around 11.45pm, and he left the prison in the ambulance around ten minutes later.

60. Once the paramedics arrived at the man's cell, the decision regarding when to transfer the man to hospital was entirely theirs. In this case, they decided that their time would be more effectively spent attempting to resuscitate the man in his cell rather than transferring him to hospital immediately.

Prison contact with the man's family

61. Prison Service Order (PSO) 2710, which provides instructions for the aftermath of a death in custody, says that Governors must:

    > "Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner, giving an accurate factual account of what has happened."

62. The accompanying Family Liaison Officer Guidance recommends that:

    > "The family should be informed face to face as soon as possible after the death. Wherever possible this should be done by a dedicated Family Liaison Officer working alongside the Chaplain, or Governor or most senior individual available together with the Chaplain."

63. Acklington's death in custody contingency plans say on page 5 that:

    > "The family should be notified … in person by Governor grade and another eg Family Liaison Officer or Chaplain. Only if distance is too great should the family be either telephoned or police notified and asked to visit."

64. The contingency plans later say, on page 16:

> "The decision on how to inform the next of kin should take into account individual circumstances, especially the distance from the establishment … Domestic circumstances and any anticipated reaction from the neighbourhood must be taken into consideration … in some instances notification via the police will be preferable."

65. The man had notified the prison that his next of kin was his partner. She lives around 30 miles from Acklington. She was informed of his death by the police in the early hours of the morning of 25 January. The police were apparently asked to inform her because of the time of night.

66. Neither the PSO nor Acklington's local policy make any reference to the time of night being a factor in determining how to inform the next of kin of a death in custody. Whilst the man's partner was pleased with the contact that she had had with the prison, it is best if first contact is made in person by an informed member of prison staff. As well as being better qualified to answer the family's questions than a police officer, such an approach also helps to show that a death in custody is a matter of proper concern to the establishment in question. The Governor should bear this in mind should there be a future death in custody at Acklington.

67. After reading my draft report, the man's ex-wife spoke to my senior family liaison officer. She said that the man's eldest son had heard that when the police visited the man's partner to break the news of his death, they could get no response. My senior family liaison officer was told that the police therefore left a note for the man's partner asking her to call them.

68. Unfortunately I have been unable to confirm this account of events with the man's partner. Nevertheless, it re-emphasises the importance of prison staff breaking the news of a death in custody in person as soon as practically possible after the event.

    The Governor should ensure that, where possible, the news of a death in custody is broken to the next of kin by a member of prison staff, face to face, in accordance with local and national instructions.

69. The man's sister said that her contact with Acklington had not been good. Whilst she understood that she was not the man's listed next of kin, his sister said that she did not find out that he had died until 26 January. The man's sister added that she had received a telephone call from the prison's family liaison officer. The prison family liaison officer offered the man's family the opportunity to visit the prison and see where he was living, but, at the time of meeting with the family on 30 April 2008, they had not heard from him again.

70. The extract from PSO 2710 paragraph 57 confirms that prison staff are only required to inform the prisoner's nominated next of kin of a death in custody. The man had nominated his partner to be his next of kin and it was she who was told of his death. I am very sorry that the man's sister

did not find out about her brother's death until 26 January. However, I am satisfied that Acklington fulfilled all of the required duties in this respect.

71. The family liaison officer's contact log contains an entry on 27 January 2008 which says that he has spoken to the man's sister and that she does not wish to visit the prison. It would therefore appear that there has been a breakdown in communication between the man's sister and the prison's family liaison officer. This is most unfortunate. In future, the prison's family liaison officer might want to write to the deceased's family in follow-up to conversations in which such decisions are made.

RECOMMENDATIONS

1. The Governor should consider a rolling programme of CPR training updates for all prison officers and operational support grades so that should another sudden collapse occur in the prison outside of healthcare operating hours then resuscitation can be initiated immediately by trained staff.

   Accepted – Northumbria PCT currently provides healthcare services to HMP Acklington throughout the core day. During those hours when healthcare staff are not on duty HMP Acklington have staff who are trained in first aid. The number currently trained exceeds the minimum required. All Night Patrols receive training in 'heartstart' which incorporates CPR, first aid and dealing with blood.

2. The Governor and Healthcare Manager should work together to establish the use of the defibrillator machine by prison staff.

   Partially accepted – Northumbria PCT are working with HMP Acklington to look at providing additional defibrillators for use across the establishment and subject to negotiations with staff implement a programme of staff training.

3. The Governor should ensure that, where possible, the news of a death in custody is broken to the next of kin by a member of prison staff, face to face, in accordance with local and national instructions.

   Accepted – HMP Acklington will ensure that, where appropriate and safe, a Family Liaison Officer will be deployed to inform the next of kin in the event of a death of a relative in custody.

GOOD PRACTICE

1. The Governor should commend the OSG for his efforts in attempting to resuscitate the man.

   Accepted – commendation letter to be sent to the OSG in recognition of his actions on the night of 24 January 2008.