

**Investigation into the death of a man, a prisoner at
HMP Acklington, on 8 June 2005**

**Report by the Prisons and Probation Ombudsman for
England and Wales**

January 2006

This is the report of an investigation into the death of a man who died from natural causes at HMP Acklington on 8 June 2005. He was 68 years of age.

The man was convicted in March 2005 and sentenced to seven years imprisonment. It was his first conviction and his first experience of prison life. He was initially held at HMP Holme House but later transferred to HMP Acklington, and it was there that he was taken ill and died.

The investigation has been undertaken by one of my investigators. I would like to thank the Governors at HMP Acklington and HMP Holme House and their staff for their help and co-operation during this investigation. A doctor at Northumberland Care Trust was commissioned to undertake a review of the man's clinical care, and I also appreciate his assistance.

The loss of a loved one is always distressing. I would like to add my personal condolences to those already expressed to the man's family by my Family Liaison Officer.

Whilst I do not feel that anything could have been done to prevent the man's death, there were aspects of the prison's response to his being taken ill that were inadequate. Whilst they do not appear to have been significant for the man, it is important that the lessons are learnt.

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ANNEXES

Summary

1. The man was born in 1937, and was 68 years old when he died.
2. He arrived at HMP Holme House on 4 April 2005. He was received into custody after being sentenced to seven years imprisonment. He was transferred to HMP Acklington on 26 May 2005.
3. At his first reception health screen at both prisons, it was noted that the man had a number of health problems including angina, asthma and circulatory problems.
4. Before his transfer to Acklington, the man had told his son that other prisoners were bullying him at Holme House, but the man did not draw this to the attention of prison staff.
5. After moving to Acklington the man volunteered to work and was allocated a position in the tailor's workshop. On 8 June around 8:20am the man entered Workshop 2 where he was employed as a tailor. The Instructional Officers quickly noted that the man was not very well. He then collapsed and one of the Instructional Officers left Workshop 2 to report this to the Workshop Manager. The other Instructional Officer remained in the workshop with the man and the other prisoners.
6. The Workshop Manager telephoned the healthcare centre at approximately 8:25am to request assistance. After five minutes, the radio was used to summon assistance, and medical staff arrived three minutes later. In Workshop 2, prisoners had already placed the man into the recovery position and were making him comfortable while awaiting medical assistance.
7. When medical staff arrived at Workshop 2, they quickly assessed the situation and requested that an ambulance be called. Cardio-pulmonary resuscitation (CPR) was immediately commenced. The prison doctor, a Senior Officer and the de-fibrillation equipment arrived just after CPR was started. The Senior Officer de-fibrillated the man and the doctor continued helping with the CPR. The man was pronounced dead at 8:43am after a prolonged period of resuscitation.
8. The clinical review noted that the man had suffered four previous heart attacks (the most recent in February 2004). The reviewer concludes that the man was in poor health with a life threatening illness, and that he would not be expected to survive a further myocardial infarction (heart attack). The reviewer also concludes that the man's care whilst in prison was appropriate and the attempted resuscitation was handled well by healthcare staff.

9. On 30 June 2005, one of my Family Liaison Officers contacted the man's family. They expressed their concern about his care and the treatment given to him both at Holme House and Acklington prisons. Their main concern was that the man lived in the community for 15 years with his heart condition, and yet died within a short time of entering prison. They felt that being located at Holme House caused additional stress. This was because it was in his home area, because he was allegedly bullied by other prisoners, because his cell was on an upstairs landing and because he had to wait outside for visits. His family think that all these factors exacerbated the man's condition. I hope this report provides answers to some of their questions.

10. I make three recommendations.

The investigation process

11. My investigator studied all relevant prison records relating to the man. These included his main prison record, Inmate Medical Record (IMR) and statements from both staff and prisoner witnesses.
12. A clinical review was commissioned from Northumberland Care Trust. I am grateful to the reviewer for undertaking this review in a most timely manner.
13. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him with his enquiries into the man's death.
14. One of my Family Liaison Officers and my investigator met with the man's family and were told their concerns about his care at Holme House and Acklington prisons.
15. My investigator visited Acklington and discussed aspects of the man's treatment with both staff and prisoners. My investigator also discussed with staff, at both Acklington and Holme House, the issues raised by the man's family about his care whilst in prison. The clinical review found that the man's clinical care was appropriately managed while he was in custody. However, I do have concerns that, in emergencies, assistance cannot be readily summoned by staff in the prison workshops.

Background

16. The man was born in a pit mining village in the north of England in 1937.
17. The man worked in the chemical industry and after he retired through ill health, his main interest was computers and he did voluntary work assisting with the set up of computer systems. The man had been married and had one son.
18. Before being arrested and sentenced, the man had suffered four heart attacks.
19. This was the man's first experience of prison life. Due to his age and ill health, he did not find it a very easy experience but had appeared to be overcoming these difficulties at Acklington shortly before his death.

HMP Holme House

20. Holme House is a purpose built prison, which opened in May 1992. It expanded in the late 1990s with the building of two further house blocks providing 235 additional places. It has an operational capacity of just under 1,000. The prison serves the communities of Tees Valley, South West Durham, East Durham and North Yorkshire. The accommodation consists of six self contained living units with integral sanitation, with a mixture of single and double cells.
21. Holme House holds convicted, sentenced and un-convicted male adults, and also a small number of un-sentenced young male adults for HMYOI Castington. The regime offers prisoners a variety of employment opportunities within its modern workshop complex. These are complemented and supported by a purpose built education department offering both part time and full time classes.
22. The prison healthcare is in a two storey, purpose built building. The top floor is used for primary care and outpatients services.
23. A first night centre has been established – a safer custody initiative that provides support to prisoners when they are first received into the establishment. A 'Listener' scheme operates on a 24 hour basis and is fully integrated into prison arrangements for those in need of support. (The scheme, which operates in almost all prisons, is a prisoner peer group support system, with each Listener receiving training from the Samaritans).
24. Her Majesty's Chief Inspector of Prisons (HMCIP) carried out an announced inspection of Holme House in April 2005. Her report described that the prison was carrying out 'good work in detoxification and healthcare, where uniformed and specialist staff were working together to produce excellent outcomes' and went on to say that 'more prisoners told us that they felt safe in Holme House than in comparable establishments'.

HMP Acklington

25. HMP Acklington opened as a prison in 1972 and is on the site of a former RAF station. It has an operational capacity of 882.
26. A man's cell was situated on the ground floor of A wing, which is in one of the wings for vulnerable prisoners. Prisoners in the wing share double cells and there are 12 cells in the spur where the man lived. Each prisoner has a key to their own cell and uses a shared bathing and toilet area within the spur. There is a locked metal gate at the end of the spur, with an office from which staff can see down the corridor through the middle. Each prisoner has a single bed, table and wardrobe, together with a lockable bedside cupboard for the storage of their valuables and medication.
27. The prison's healthcare is provided by Northumberland Care Trust, who employ nurses during the day, seven days a week. They work with a medical officer, providing primary health care and weekly or monthly administration of medication to prisoners who have been assessed as capable of keeping it in their own possession. They administer medication on a daily basis to other prisoners, when either they are considered to be at risk or the medication is unsuitable to be held in their cell. Prisoners who require in-patient nursing care are transferred to outside hospital or to another prison.
28. HMCIP carried out an unannounced inspection of Acklington in April 2003. Her report described a 'safe prison' and went on to say that 'the low levels of self harm and the absence of self inflicted deaths reflect well on the proactive approach taken by staff'.
29. However, the Inspectorate highlighted concerns about the needs of older prisoners, and those with health conditions requiring a level of care that could not be provided at Acklington. At the time of this investigation, the clinical team leader was exploring the possibility of introducing clinics for specialist conditions, such as those experienced by older people.

Key Findings

30. When the man first arrived at both Holme House and Acklington, it was decided that he should be given Vulnerable Prisoner status because of his age and the nature of his offence. The man had a number of health problems including angina, asthma and circulatory problems and he had previously suffered four heart attacks. It was good practice that a Well Man assessment was carried out by Acklington's healthcare team.
31. My investigator investigated the concerns raised by the man's family about his treatment at Holme House. The prison did locate the man in a cell on an upper floor for 11 days, before moving him to a cell on the ground floor. The man was initially located at Holme House as it is the local prison serving the court where he had appeared. The prison stated that the man would not have been made to wait outside whilst waiting for a visit as he would have been placed in a holding room which is in the middle of the visits building. Holme House could not find any records of complaints of bullying being made by the man and neither could my investigator substantiate this allegation.
32. After the man was convicted, he was moved at the earliest opportunity to Acklington, where he was allocated ground floor cells, initially in H wing. After his induction, he was moved to A wing.
33. Because of his age, the man did not have to work. However, the man volunteered to do sedentary work, and joined the tailor's workshop. A prisoner described meeting the man at the workshop and showing him how to complete their allotted tasks. The prisoner described the man as a likeable old gentleman and "a really nice lad" who got on with his work.
34. It was alleged in an interview with one of the prisoners that on 8 June 2005 before the man left his wing he told one of the officers that he did not feel well enough to attend work. The prisoner also alleged that this comment was ignored by the officer who still sent the man to work. When interviewed, the officer denied the allegation and pointed out how he been supportive to the man after he had moved to A wing. My investigator could not find any evidence to substantiate this accusation and an alleged witness identified by the prisoner, stated that he was not present at the time of the alleged comment.
35. At 8:20am on 8 June, the man entered Workshop 2 to commence work as a tailor. He sat down at a table near one of the Instructional Officers. A fellow prisoner was asked to collect the man's scissors from the tool store, as he did not look very well.

36. When the prisoner returned, another Instructional Officer was standing next to the man. The man told her that he wanted to work but he could not. One of the Instruction Officers stated that she thought that the man should return to his wing, but he was too out of breath to move at the current time. Both Instructional Officers carried keys, but neither carried a radio.
37. The prisoner returned with the scissors and asked the man if he wanted a drink. He then went to fetch him a glass of water. As the prisoner walked away, he heard one of the Instructional Officers shout and saw the man getting up from his chair and then falling, face first, onto the workshop floor.
38. The prisoner ran back to the man and turned him onto his right side. The man was unconscious and his face was badly damaged. He was bleeding very heavily from nose and mouth. One of the Instructional Officers immediately reported to the Workshop Manager and informed him that the man had collapsed. The Workshop Manager telephoned the healthcare centre and informed them of the situation. The other Instructional Officer, who was still in the workshop, was not involved in dealing with the emergency.
39. In his interview, the Workshop Manager said that he did not consider using the radio to summon assistance even though he carried one. Although the clinical review states that the time between the Workshop Manager alerting healthcare and medical assistance arriving was not significant to the man, it could be critical to another prisoner. The Workshop Manager also stated that instructional staff do not currently have to carry radios but he added that this is under review at the moment and that all new staff will now carry radios.

The Governor should review arrangements to ensure that staff are trained and equipped to recognise an emergency and call for immediate assistance using the standard prison emergency procedures.

40. Two other prisoners had come to help when the man collapsed. Together they put the man into the recovery position and put a cushion of towels under his head. Another prisoner also assisted. One prisoner held the man's head, another held his arms and another listened to his chest and checked his carotid artery for a pulse. One of the prisoners felt a weak pulse on the man's neck but believed that the man's heart was in arterial fibrillation (that is a very irregular rhythm and at time banging). By this time the Assistant Workshop Manager and Workshop Manager were present. The Workshop Manager informed the staff and prisoners that healthcare staff were on their way.

41. None of the staff who were present at this time had a first aid qualification, and they did not attempt first aid and were content for the prisoners to continue to assist the man. I commend the actions of the prisoners to assist the man, but believe staff working in the workshop should have appropriate training to enable them to manage emergency situations appropriately.

Consideration should be given to providing first aid training for all staff who have contact with prisoners.

42. At 8:30am, the Assistant Workshop Manager requested over his radio for urgent medical assistance from prison healthcare staff (a Code Blue). The Control Room informed healthcare of this request. At 8:33am, two members of healthcare staff arrived and an ambulance was called. Cardio-pulmonary-resuscitation (CPR) immediately commenced with the aid of an ambubag to blow air into the man's lungs.
43. At 8:36am, the prison doctor, a Senior Officer and the de-fibrillation equipment arrived. The Senior Officer defibrillated the man. At 8:43am, the prison doctor pronounced that the man was dead, just before the paramedics arrived. The paramedics and medical staff left the workshop at 8:55am.
44. The duty governor was immediately informed of the man's death. A member of the prison chaplaincy and another member of staff, representing the Governor, immediately contacted the family to offer their condolences and support to the man's family.
45. The prison maintained contact with the family and offered to assist with arranging the funeral and providing financial help. The man's funeral took place on in June 2005.
46. The post mortem report states that the cause of death was due to natural causes as a consequence of a coronary artery atheroma (a degenerative change in the inner and middle coats of the arteries in the heart).
47. The Clinical Reviewer concluded that the man's care while he was in prison was appropriate and that medical issues were dealt with in a timely manner. He drew attention to the fact that Holme House had obtained a summary of the man's General Practitioner's records. The Reviewer also drew attention to the fact that although there may have been a delay in summoning medical assistance, it was unlikely that the outcome was affected as the man received qualified assistance much sooner than he would in the community.

48. My investigator noted that Acklington does not have medical staff on duty 24 hours per day, and as the man's death occurred at the beginning of the working day, some medical staff were in the process of commencing their duties. Nevertheless, the use of a radio to summon assistance might have resulted in a more rapid response to the emergency. This would have been especially so in the case of prison medical staff who were already on duty and who could have been contacted via the radio. I acknowledge that this would not have made any difference to the outcome so far as the man was concerned.
49. Some of the prisoners who attended to the man complained that the staff in the workshop appeared content to allow them, the prisoners, to look after the man after he was taken ill. From interviews with staff and prisoners, it is doubtful whether the man's care could have been better managed with a more pro-active participation by staff in the workshop, as the prisoners who assisted had some first aid knowledge. However, I have already stated that I think that consideration should be given to providing first aid training for all staff who have contact with prisoners.
50. The man entered prison with very serious diagnosed physical health problems and had already suffered four heart attacks. The man's condition was being monitored and assessed regularly by the prison healthcare staff. As the man was taking a lot of medication related to his angina, asthma and circulatory problems, his dosages were carefully observed due to the relative complexity of the case and the potential for adverse reactions. Even with the limitations imposed by his health, the man was deemed fit enough to do sedentary work and was allocated work in the tailor's workshop.
51. The man did not have to work as he was over retirement age but he wanted to keep himself occupied. In his interview, one of the prisoners commented on how the man had taken to the work and seemed to enjoy it.
52. From comments made by staff and prisoners at Acklington, it seems that the man was a respected and well liked prisoner. It would have also appear that he had put behind him his experiences at Holme House and was starting to settle down into prison life.
53. I would like to commend the actions taken by the prisoners who went to the man's assistance when he was taken ill. Their actions meant that he was immediately being looked after and supported in what transpired to be his final moments.

The Governor should arrange for letters of commendation to be sent to those prisoners who assisted the man in his final moments.

Recommendations

Consideration should be given to providing first aid training for all staff who have contact with prisoners.

The Governor at Acklington should review arrangements to ensure that staff are trained and equipped to recognise an emergency and call for immediate assistance using the standard prison emergency procedures.

The Governor should arrange for letters of commendation to be sent to those prisoners who assisted the man in his final moments.