INVESTIGATION INTO THE DEATH OF A MAN AT HMP ACKLINGTON ON 26 FEBRUARY 2005

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

JULY 2005

This is the report of an investigation into the death of a man, who died on 26 February 2005 having been taken ill at HMP Acklington. Because the cause of his death was unclear, my office carried out a full investigation into its circumstances.

I would like to take this opportunity to add my condolences to those already expressed by my Family Liaison Officer, to the sister of the deceased, and to those who knew him. They have lost a loyal and faithful brother and friend.

The man who is the subject of this report had a number of chronic health conditions, which appear to have been properly treated by the prison's healthcare department. There were occasions early in his time in custody when he experienced periods of depression. However, there were no indications that this was the case in February 2005, and I am satisfied with the prison's monitoring of his mental health. Similarly, although some arrangements for prisoners to hold their own medication were inadequate, there is no suggestion that the prison's practices should have been implemented any differently for the deceased.

Nevertheless, there were aspects of the prison's response to his being found unconscious that were inadequate. Whilst they do not appear to have been significant for this particular man, it is vital that the lessons are learnt.

I have been assisted greatly in this investigation by a doctor who carried out a prompt review of the man's healthcare whilst at the prison. I am pleased to see that the doctor makes no recommendations about the work of the healthcare centre. However, like most prisoners and indeed like people outside prison, the man held his own supplies of medication. Proper safeguards for prisoners in this position are not in place as they should be.

My thanks are due to the Governor of Acklington, and to his colleagues, for their assistance with the investigation. They have responded willingly to the changes brought about by my office's investigation arrangements and this is much appreciated.

Stephen Shaw CBE
Prison and Probation Ombudsman

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CONTENTS

SUMMARY

1. The man was 66 years old when he died at hospital on 26 February 2005. He had been found in his bed unconscious the same day at Acklington prison. He had suffered with several chronic medical conditions prior to his arrest and sentence.

2. The man's health conditions were stabilised by long term medication, which he kept in his own possession. The risks of keeping his own tablets were considered when he arrived at the prison and were deemed to be out-weighed by the benefits. He was a man who took positive steps to meet his own health needs and holding his own medication was a part of this.

3. Before transfer to Acklington in April 2004, the man had disclosed that he feared being bullied by other prisoners and had said that he was depressed. However, he appeared to have benefited from the transfer and there had been no more indications that he felt under pressure. Education and wing staff described him as a quiet man and the Sentence Planning Board set comprehensive and realistic objectives.

4. The man was allocated a single cell when he arrived at Acklington and kept it for eight months until December, when he was reduced to standard level on the Incentives and Earned Privileges Scheme because he refused to attend a treatment programme. He then shared his cell with his cell-mate until his death and there were no indications of any problems that the move might have caused.

5. When the man died it was thought by the hospital and prison that it was as a result of natural causes. However, the first post mortem found that he had consumed an excessive amount of medication and a second post mortem was ordered. The second post mortem has confirmed that his death was due to natural causes, and that the large number of tablets he had consumed were in an undigested state and so did not contribute to his death.

6. This report considers whether there were any indications that the man was at risk of harming himself which should have been noticed and responded to by staff. It also considers the treatment of his long term physical symptoms and whether any other actions should have been taken.

BACKGROUND

7. The man was born in 1938 and was 66 years old when he died on 26 February 2005 in hospital. He was a single man, and had cared for his mother until her death in the mid 1980s. He owned his own home, but it was sold when he was convicted and he had said that he would have no fixed abode on release. He worked until he was remanded in custody in January 2004. The Probation Service prepared a comprehensive assessment of the man before he was sentenced. He was described as suffering from angina and glaucoma, and had had a brief period of depression in 1984. He told Probation that he had no history of self harm, and confirmed this when he was first remanded in custody.

8. The man was subsequently convicted on 13 April and sentenced to five years imprisonment. On 1 July, the Appeal Court increased his term to six years. It was his first conviction and his first experience of prison life. Initially, he was held at Preston, but transferred to Durham where he was allocated a ground floor cell because of his angina. From Durham, he was moved almost immediately to Acklington. It was at Acklington that he was found unconscious in his bed on 26 February, transferred to hospital and died later that day.

HMP ACKLINGTON

9. HMP Acklington is a Category C prison for convicted adult male prisoners with an operational capacity of 882, which includes almost 400 spaces for vulnerable prisoners. The prison opened in 1972.

10. The man's cell was situated on the ground floor of C Wing which is in one of the wings for vulnerable prisoners. It has the capacity to hold 83 prisoners but, on the day he died, there were only 82 present. One of these prisoners was subject to the F2052SH monitoring procedures, which are put in place for prisoners who are considered to be at risk of suicide or harming themselves. The average age of prisoners on C Wing at the time of the man's death was 45 years. The man shared his cell with a prisoner who was a few years younger than he was but who was also in poor health.

11. Prisoners in the wing live in dormitory conditions and in double cells. There are 12 cells in the spur where the man lived. Each prisoner has a key to his 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 the corridor through the middle. Each prisoner has a single bed, table and wardrobe, together with a lockable bedside cupboard for the storage of valuables and medication.

12. The evening routine includes a regular roll call at 7.30pm to confirm that all prisoners have been seen, after which the prison goes into "patrol state" when C wing prisoners are locked in their spur and staff numbers are reduced. When the night staff arrive on the wing, they are given a hand over by the staff going off duty together with a sealed packet containing cell keys to be used in an emergency. In the morning, the day staff are also given a hand over and a further roll check is carried out before the night staff go off duty. The weekend routine is for prisoners to be unlocked from 8:40am and served breakfast. C wing prisoners are called to the spur gate, which is unlocked for them to collect their meal from the servery.

13. The prison's healthcare is provided by Northumberland Primary Care Trust, who employ nurses during the day, seven days a week. They work with a medical officer, providing out patient 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 to other prisoners, when either they are considered to be incapable of taking their medication without supervision or the medication itself is unsuitable to be held in their cell. Prisoners who require in patient nursing are transferred to outside hospital or to another establishment.

14. Her Majesty's Chief Inspector of Prisons (HMCIP) carried out an unannounced inspection of Acklington in April 2003. Her report described a 'safe prison' and went on to record that 'the low levels of

self harm and the absence of self inflicted deaths reflect well on the proactive approach taken by staff'. However, the Inspectorate highlighted concerns about the needs of older prisoners, and those with health conditions requiring a level of care that could not be provided at Acklington. 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.

15. The most recent audit of Acklington by HM Prison Service's Standards Audit Unit was in November 2004. It assessed four discrete areas: Decency and Health, Organisational Efficiency and Effectiveness, Regimes and Safety. The report identified concerns about the quality of support plans for prisoners who were considered to be at risk of suicide or self harm. The report also focussed on the management of medicines, and the Primary Care Trust plans to develop a policy for medication held in possession. At the time of this investigation, the work had yet to be completed.

CONDUCT OF THE INVESTIGATION

16. Initially, my office was advised that the man's death was likely to be due to natural causes. The subsequent results of the post mortem meant that interviews with staff and others were required and so the initial arrangements were altered. The investigation into the man's death began with a meeting with the Governor and a representative from the Independent Monitoring Board on 21 March 2005. Notices were displayed to announce the investigation and invite prisoners and staff to contact the investigator. One prisoner asked to speak to the investigator but later withdrew the request as he was moving to another prison.

17. Interviews were conducted with 11 staff, including those who knew the deceased, those involved when he was found ill on 26 February, and those responsible for the running of various aspects of prison life. A meeting was held with the Primary Care Trust's Clinical Team leader, who works full time at the prison, and two of her managers, together with the governor responsible for liaison between the prison and Trust. The man's cell-mate was also interviewed.

18. Informal conversations took place with the prison's chaplain, and with two members of staff in the art department where the man attended classes.

19. Prison records, including medical records, were also made available together with relevant prison policies and procedures.

20. One of my office's Family Liaison Officers has had telephone contact with the bereaved family and friends.

21. A Clinical Review was commissioned from Northumberland Primary Care Trust and was carried out by a doctor.

KEY FINDINGS

Events prior to 26 February

22. The man was remanded in custody to Preston prison in January 2004. He was charged with offences committed over many years. His legal advisors initiated the Poor Coper Risk Assessment because he was of pensionable age, not in good physical health and it was his first time in prison. At the time, the man expressed fears about his personal safety as he said that he was conspicuous amongst the other prisoners and was frightened of being attacked. He was given Vulnerable Prisoner (VP) status because of his age and the nature of his offences. This status continued throughout his time in prison.

23. A First Reception health screen was carried out on 17 January and this confirmed the earlier assessment of the man's physical and mental health. It was good practice that a Well Man assessment was carried out. The man had angina, glaucoma, diverticular disease and a hernia.

24. The man transferred to Durham in early February. On 8 February, he expressed concerns for his personal safety because of the nature of the charges and said that he was feeling low. It was arranged for him to see a Listener (a prisoner who has been trained to work by the Samaritans). Consideration was given to opening an F2052SH, but it was not thought to be necessary. Medical assessments that month described him as fit and well, but he later asked to see the Medical Officer because of his heart condition. On 10 March, he again asked to see the doctor because he felt unwell and his condition was further reviewed on 10 April.

25. On 20 April, the man was assessed as fit for transfer from Durham to Acklington. It was noted that he held his own medication for an ongoing heart condition. The same day, the Durham records note that he said he was being bullied because of his offences and that other prisoners were shouting at his door. The records state that action would be taken once the culprits were identified.

26. The man's home probation officer completed the OASys assessment on 21 April. This is the assessment tool used to describe all aspects of an individual's circumstances. It stated that there was no risk of self harm or of attempts at suicide. The man was described as an intelligent and eloquent man, but one who was manipulative.

27. The man transferred to Acklington on 23 April and the First Reception procedure was repeated. In response to questioning about self harm, he said that he had considered it in February that year and had felt depressed both inside and outside prison. He said that he had not recently considered suicide and neither had he received treatment for depression. He was referred to a Registered Mental Nurse for assessment. This was carried out the following week when he said

that he had previously mentioned suicide at court when he thought he was threatened with a lengthy sentence. There were no further occasions when suicide or self harm was mentioned by the man.

28. Prisoners at Acklington hold their own medication unless specific risks are identified, mainly for the individual prisoner but sometimes due to the type of medication. The arrangements are referred to as In Possession (IP). The arrangement has been in place for about two and a half years since prison healthcare providers were advised to replicate, as far as possible, the conditions in the community. In this case, the man signed the Medication Agreement the day that he arrived at the prison. Amongst other things, the Agreement stated that he agreed not to save up or hoard medication and to take it as prescribed for the prescribed duration. He held his own medication for the rest of his time at Acklington and there were no concerns about his safety. He collected it from healthcare staff each month and stored it in the lockable cupboard in his cell.

29. Throughout the time that prisoners at Acklington have held their own IP medication, the prison has not had a policy for its administration, although there are many implications for the day to day routine. IP medication has considerable benefits for prisoners like the man who died, who are able to take responsibility for their own health needs, particularly when they have a long term health condition. Correspondence from the man in his medical record suggests that he did just this. For example, he wrote to healthcare when he needed new glasses and to follow up medical tests. Holding his own medication also meant that he did not have to queue to collect it each time a dose was required, which might be time consuming and tiring.

30. However, there are also implications for procedures such as Cell Searches, Cell Sharing and Safer Custody and these should be considered jointly by discipline and healthcare staff. Policies for IP medication should take account of, and link with, other relevant prison healthcare and security policies, including national policies. It is good practice, when introducing any change to a service, that all resulting effects are monitored. This has not happened at Acklington and no information was available about whether any adverse incidents had taken place since IP medication was introduced. However, an additional cell search would be ordered if a member of staff suspected that a prisoner was stockpiling medication. In addition and where possible, a prisoner thought to be at risk of suicide or self harm would be located in wing where the access to medication was reduced.

The Governor and Primary Care Trust should develop a comprehensive policy for In Possession medication to include risk assessment for suitability, storage and compliance with treatment regimes. The policy should be audited on a regular basis to ensure its effectiveness.

31. On arrival at Acklington, the man was allocated to H wing. The wing has single cells and is the part of the prison used to accommodate new arrivals. He was given Enhanced Prisoner status under the Incentives and Earned Privileges Scheme (IEPS) on 13 May, meaning that he was entitled to additional association time with other prisoners each day and one more visit per week. H wing contains cells for enhanced prisoners and the man was able to remain on that wing. His medical record for the following month states that he was coping at the time, but was still melancholic about being in prison at his age.

32. Because of his age, the man was not employed at the prison, and he was eligible to use the Education department's classes. He attended art classes three times a week and the teachers in the department said that he enjoyed completing individual course work. He was not a man who asked for help with his work, but would wait for a teacher to approach him. The staff described him as a quiet and studious man, who worked hard and was a decent and fine artist. His art work improved considerably, but the teachers said that he never felt it was good enough.

33. A Sentence Planning Board took place on 3 December which identified objectives for the man's prison sentence. It also considered whether he was at risk of suicide or self harm and the judgement was that he presented as low risk. Although the man told the Board that he was unhappy about being in custody, he said that he would not harm himself. He had had issues when settling into prison life and had used a Listener, but he said that it had not been helpful to him. The prison's support network was explained to him, including the chaplaincy team and he said that he was coping without it. The Board recommended that the man undertake the Sex Offender Treatment Programme (SOTP) and continue with education classes. The Board's record was comprehensive and complete, and set realistic and achievable targets which were being delivered.

34. However, the man declined to attend the SOTP, as he said that his offences were committed many years ago and did not think he presented any risk of further offending. Because he refused to attend the programme, he was reduced to standard level on the IEPS. Consequently, on 9 December he was moved to C wing and allocated to a double cell, which he shared with his cell-mate and where he was subsequently taken ill.

35. Later that week, the man's medical record state that he said that he was feeling stressed and worried all the time. There are no more entries in the medical record until those of 26 February.

36. There are few entries relating to the man in the C wing observation book, but there is one for 24 January 2005 when he reported his cell-mate as having overdosed on his own medication. The records for this incident were requested by the investigators but were not available.

37. The two men continued to share a cell and it was the man's cell-mate who alerted staff to his condition on Saturday 26 February. He told the investigators that the man was unusually late going to bed on the Thursday beforehand as he was writing papers for many hours. However, he said that they went to bed as usual on 25 February and he did not hear anything during the night.

Events of Saturday 26 February

38. An Officer and an Officer Support Grade (OSG) carried out the routine roll check of C wing at 6:00 am on Saturday 26 February. This is done by opening the flap in the cell door to confirm that the prisoners are present.

39. At 7:30am, they handed over to a "guesting" officer, meaning that it was not his regular place of work in the prison. The guesting officer told the investigators that there was nothing of significance regarding the man in the night staff report. He repeated the roll check before the night staff left the wing, and rang the information through to the Detail office.

40. The guesting officer remained alone on the wing until 8:30am, when a second officer was to begin his shift. Of the two officers, the guesting officer was the more experienced but the second officer knew the wing better and there is no protocol that gives either responsibility over the other. Both were carrying keys, and the second officer carried cell keys, but neither carried a radio. A third officer was present as he was carrying out voluntary drug tests.

41. The man's cell-mate has given a statement to the police and to the investigators from the Ombudsman's office. This confirms that he was woken on the Saturday morning by the man's alarm clock. In interview with the investigation team, he described the deceased as a man of regular habits, who routinely set his alarm and got up quickly after it rang once or twice. He said that this routine did not vary at the weekend. On 26 February, the alarm rang as usual but the man did not silence it and his cell-mate said that he eventually reached to turn it off himself. Some time later he woke again and heard the man snoring. He said that he got out of his own bed and tried to rouse him by shaking his shoulder. He heard that his breathing was noisy and saw what he thought was blood coming from his mouth on to the pillow. He rang the cell bell and then went to the spur gate from where he could talk to staff.

42. The cell-mate confirmed that the second officer came to the gate and he told him that the man had been taken ill and that he could not wake him. In his statement for the prison, the second officer said that he arrived at the wing at about 8:25am in time to start his shift at 8:30am. He told the investigators that the cell call bell rang at the panel whilst

he was taking his jacket off. The panel indicated the cell bell that had rung. He went to the spur gate where he spoke to the cell-mate who expressed concern about the man and said that he could not wake him up. He returned to the office to collect a colleague, the guesting officer, as the prison was still in patrol state and officers are instructed to patrol in pairs. The two officers then went to the cell, and saw the man lying on his back in bed. In his police statement, the second officer said that there was what he thought was vomit on the pillow and blood by the man's mouth and nostril. He said that the man's breathing was laboured and the officers tried unsuccessfully to wake him. Neither the second officer nor the guesting officer had an up to date first aid qualification and neither officer was aware of whether the other was qualified. They did not attempt first aid.

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

42. The officers returned together to the office intending to ask for healthcare to be contacted. They left the man unaccompanied and the second officer said that another prisoner, a landing cleaner who could be trusted, was asked to wait at the cell door.

The officers should be instructed that a sick prisoner should not be left unaccompanied.

43. In his statement to the Ombudsman's investigators, the second officer said that when he and the guesting officer returned to the office, the voluntary drug-testing officer said that the Communications room had already been telephoned. However, in the second officer's statement to the police, made shortly after the incident, he said that he had actually asked the voluntary drug-testing officer to make contact, which is what the voluntary drug-testing officer says happened.

44. The second officer and the guesting officer returned to the cell, and the second officer said that the man remained on the bed and his breathing could be heard. He said that they tried to rouse him again but failed and again they returned together towards the office to see if healthcare staff were in sight. They then returned for the third time to the cell. The man was described as making a snoring noise, his breathing was noisy with his chest rising and falling. The second officer said that he thought that the matter was quite urgent.

45. In interview, he said he thought that he himself telephoned the Communications room the second time but did not consider using the radio to summon assistance even though he thought that there would be one in the office. Although the clinical review states that the time between the cell-mate alerting staff and medical assistance arriving was not significant to the man, it could be critical to another prisoner.

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.

46. At about 8:50 am, a Senior Officer (SO) completed his routine duties on A wing. He left to do the same on B wing, where the staff informed him that they thought that there was an incident on C wing. The SO went immediately to C wing and to the cell where he assessed the man's condition. He said that, although he does not have a medical background, he recognised that the man had medical needs and he was informed that healthcare staff were on their way. The Senior Officer said that he told the second officer to stay in the cell, whilst he ensured the smooth running of the wing. He ordered the other prisoners to return to their cells, allocated the cell-mate to another cell, ensured that those prisoners who were being monitored for suicide or self harm were checked and that breakfast was served. The cell-mate told the investigation team that his own medication was untouched and remained in his possession.

47. The voluntary drug-testing officer said in interview that there was a further telephone conversation between the wing and the Communications room. He recalled a Principal Officer (PO), who was the Orderly Officer in charge at the time, telephoning to ask if healthcare staff had arrived. The PO told the investigation team that the voluntary drug-testing officer then said that the man was coughing up blood, but he did not detect any urgency in the call and so was not surprised that the information came by telephone rather than radio. In interview, the voluntary drug-testing officer said that the fact that a second telephone call was made should have been an indication that he viewed the situation as urgent.

48. This call coincided with healthcare staff arriving on duty at the gate and collecting their radios. The first nurse, who arrived with the second nurse, told gate staff that they would see the man when they gave treatments at 9:30am, which is carried out either in the healthcare centre or the wing, depending on the numbers of staff on duty on the day. The routine for treatments is that prisoners make their own way there. The first nurse said that at this point the information she had been given led her to believe that the man was capable of walking to treatments independently. The Principal Officer was still on the telephone to the voluntary drug-testing officer and relayed the first nurse's decision to him. The voluntary drug-testing officer's response was that this would not be soon enough and that the man required urgent medical attention. The PO said that he informed the Communications room of the voluntary drug-testing officer's opinion and the radio was used to redirect the nurses to the wing. The PO told the investigation team that he then went to the wing as he realised that the situation was more serious than he had first thought.

49. The first nurse went first to B wing to collect the emergency response bag and the second nurse went straight to C wing, where she found the man lying on his back, with laboured breathing and dried blood around his nose. She placed him in the recovery position, checked that his airway was clear and requested wing staff to make an immediate request for an ambulance. The first nurse arrived with the bag, which contained resuscitation equipment, and oxygen was administered. The nurses said that he did not respond to stimuli but his pulse continued and they considered that he had suffered a massive stroke.

50. The PO stated that the ambulance arrived at about 9:00 am and the paramedics went to the cell to join the nurses. The man was placed on a stretcher and an electro cardio graph was carried out.

51. The PO remained on the wing after the ambulance arrived. As Orderly Officer, he was in charge of the running of the establishment and reported to the Duty Governor for the day. He was not involved in the arrangements for the other prisoners as he was aware that the SO had made arrangements for the wing's operation. The Duty Governor had arrived at the prison at about 9:00am to be informed of events and that an ambulance had been called. He carried out an assessment of any risks arising from man's departure from the prison and then went to the wing.

52. The man was placed in the ambulance at about 9:30am, but its departure was delayed for ten minutes whilst more treatment was given. Because he was so poorly, he was not strip searched and no restraints were in place. Two officers accompanied the man in the ambulance. At about 9:45am after the departure of the ambulance, the Duty Governor contacted the man's sister to inform her of his condition.

53. After the ambulance left the prison, The PO returned to the Detail office to arrange for staff to provide a bed watch at the hospital. He also spoke to the second officer and the guesting officer to inform them that they should have used the radio to summon assistance.

54. An officer who was assigned to the bedwatch has given a statement to the police to confirm that he was alone on the assignment because the severity of the man's condition meant that another officer was not required. He remained outside the room whilst hospital staff gave treatment. At 12:20pm he was informed of the man's death, and then telephoned the PO to let him know. The family were contacted by the Duty Governor and given the information soon after 1:00pm. It was only after the man died that the cell was isolated.

55. Initially, it was thought that the man had died due to natural causes and the prison put the appropriate procedures into place. A de-brief meeting was not held and no arrangements were made to monitor the well being of staff involved with caring for the man, although the Duty Governor spoke to them informally. The Duty Governor told the

investigation team that one of his duties was to evaluate the management of the incident and he said that the PO had advised him that, in his view, officers should have used the radio to summon assistance and used the Code Blue sign. The officers involved were informed of this at the time and the Duty Governor said that the matter would be considered further following completion of the Ombudsman's investigation.

56. A post mortem investigation took place and identified that significant quantities of medication had been consumed. A second post mortem was requested and has concluded that the man died from pneumonia. The report confirms that he had consumed excessive quantities of naproxen tablets, but that these were in an undigested state.

RECOMMENDATIONS

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

2 The Governor and Primary Care Trust should develop a comprehensive policy for In Possession medication to include risk assessment for suitability, storage and compliance with treatment regimes. The policy should be audited on a regular basis to ensure its effectiveness.

3 The second officer and the guesting officer should be instructed that a sick prisoner, such as the deceased, should not be left unaccompanied.

4 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.