Investigation into the death of a man whilst in the custody of HMP Acklington in November 2008

Report by the Prisons and Probation Ombudsman for England and Wales

December 2009

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Acklington, in November 2008. A post mortem showed that the cause of death was a heart attack.

The man's next of kin are his parents and his son. I offer them my sincere sympathy and condolences, as I do to all of the man's friends and acquaintances who have been affected by his passing.

The investigation was carried out on my behalf by my investigator. Both he and I would like to thank the Governor of HMP Acklington and all of his staff, in particular the second Governor, for their full and ready co-operation during the course of our enquiries. I also thank the local PCT for the appointment of the clinical reviewer reviewer. One of my Family Liaison Officers, liaised with the man's family during the investigation.

From the time the man arrived at Acklington in January 2007 until the day of his death, I believe he received a high standard of support from healthcare staff. His depression was reviewed at a total of 57 meetings with medical professionals and his blood pressure was monitored effectively. However, on the night he died there were serious lapses in his care. I am very critical of the management of the emergency, and the actions and inactions of the staff concerned.

I am also disappointed to have to repeat a recommendation about first aid training, which I draw to the attention of the Chief Operating Officer of the National Offender Management Service. I make a total of six recommendations.

The version of my report, published on my website, has been amended to remove the names of the woman/man who died and those of staff and prisoners involved in my investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **December 2009**

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SUMMARY

The man was remanded to HMP Holme House in November 2006 following conviction for sex offences. He was identified as a vulnerable prisoner as he had attempted suicide in 2005, and was suffering with chronic depression which was controlled by medication. He was a life long smoker.

The man remained at Holme House until his transfer to HMP Acklington in January 2007.

Following arrival at Acklington, a cell sharing risk assessment was completed and the man was allocated to a shared cell. However, by May 2007, his mood was very low and he was thinking of harming himself. From this date he had weekly reviews with a member of the Mental Health Inreach Team.

During June 2007, the man saw the prison doctor on three occasions with pains in his hip, knee and groin, and a rash to his feet. Cream was prescribed and he was referred for x-rays, the results of which were clear. An electrocardiograph (ECG) (monitoring the rhythms of the heart) was also carried out and the results were recorded as normal.

The man was seen by healthcare staff for pain in his abdomen, nausea and constipation during February 2008. He had four follow up reviews with the prison doctor. It was recorded that he did not suffer any weight loss nor any increase in heartburn. Regular blood pressure checks were completed, and a further ECG was conducted in May with the results again being normal.

The man began the Smoking Cessation Course in September 2008. He had five separate sessions with the smoking cessation adviser, but decided of his own accord to leave the programme in November.

The man used his cell bell to seek assistance. He told the Operational Support Grade (OSG) that he was experiencing pains in his chest and in his left arm. The OSG immediately contacted the SO, the night orderly officer (who was in charge of the prison at night) and relayed the message. The night orderly officer and two officers arrived at the man's cell at 3.17am. The man again explained that he had pains in his chest, back and left arm. All three officers left the man's cell and went to the office to ring the duty doctor (an out of hours service, not within the prison). The two officers and the OSG waited in the office for the doctor's call. The night orderly officer went to the security office to commence the emergency unlock procedure.

At 4.03am, the first officer on the scene and the OSG returned to the man's cell (the second officer on the scene joined them at 4.04am). They found the man collapsed and not breathing. The first officer on the scene used the radio to make an emergency call for assistance at 4.05am. The call for an emergency ambulance was made at 4.07am.

The second officer on the scene and the OSG commenced cardiopulmonary resuscitation (CPR) until the paramedics arrived at 4.28am. The paramedics took over CPR but pronounced the man's death at 4.40am.

Later that same morning, a second Governor and a liaison officer made a personal visit to the man's parents' to inform them of his death.

There are several important issues arising out of this investigation. The clinical reviewer has commented that the significant delay in calling the emergency services may have affected the outcome, and I am critical of the management and decision-making in response to the man's request for help. I am also concerned about the emergency response, emergency equipment and chest pain protocol.

THE INVESTIGATION PROCESS

1. The investigation was opened in November 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. No one came forward as a result.

2. My investigator visited HMP Acklington in December. During his visit he was given copies of all the documentation relating to the man. My investigator returned in January, assisted by another colleague and interviewed ten members of staff. In addition, he enjoyed excellent liaison with the clinical reviewer.

3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist his enquiries into the man's death.

4. One of my Family Liaison Officers has spoken to the man's parents to inform them of the investigation. His family had one issue that they wished the investigator to consider. They wished to know why he was left alone after telling staff that he was having pains in his chest and arm. This is an issue I explore in detail in my report.

HMP ACKLINGTON

5. 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 946 prisoners. It is a large site taking several minutes to walk from one block to another. In the wing where the man was located all cells are locked at night.

6. 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.

7. Her Majesty's Chief Inspector of Prisons last reported on Acklington following an announced inspection in December 2006. Her Majesty's Chief Inspector concluded that it did not provide a safe and decent environment. She did consider that healthcare had got better in recent years, but thought that there was still room for further improvement.

8. The Independent Monitoring Board Annual Report for 2006-07 strongly criticised the standard of accommodation on several wings at Acklington.

9. Since I was given responsibility for investigating all deaths in prison custody in April 2004, 16 prisoners have died at Acklington including the man. Of the 15 deaths that I have previously investigated, nine 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

10. The man lived alone. He had one son and six stepchildren, but was divorced from his wife.

11. Following an appearance at the Crown Court the man was remanded in custody at Holme House. He was due again in court for sentencing.

12. On arrival at prison the man had a First Health Screen Assessment. At this assessment he told staff that he was prescribed medication for depression. This medication was Mirtazapine (antidepressant) and Trazadone (antidepressant and sedative), but he was not keen to take it. He said that he was under the care of a psychiatrist. The man said that he was a smoker of 60 cigarettes a day, but did not use drugs. He also said that there was a history of diabetes and asthma in his family.

13. In December, the man saw the prison doctor because he had cough and pain in the left side of chest and back pain. The doctor prescribed a course of Erythromycin antibiotics and Ventolin Spray (relief medication for asthma or chronic obstructive pulmonary disease, COPD). He had a review with the doctor 11 days later, having completed the course of antibiotics and was advised to continue to use the Ventolin spray. A week later the man saw the doctor again for a review of his medication. He also expressed concerns about sleeping badly.

14. The man appeared at the Crown Court and was sentenced to eight years in custody. He returned to Holme House. The following day healthcare received written confirmation from the man's former doctor of the doses of medication he had been taking in the community.

15. A Registered Mental Health Nurse (RMN) saw the man in January 2007. The man said that he had fleeting thoughts of self harm but had no plan or intention to harm himself. The RMN referred him to the doctor, whom he saw three days later. He told the doctor that he felt depressed but was not keen to take any medication. The doctor prescribed Sertraline (antidepressant), in addition to continuing the Ventolin spray.

16. In January, the man transferred to HMP Acklington. On arrival he had another First Health Screen Assessment which confirmed the medication he was taking whilst at Holme House. He was deemed fit for both work and gym. Five days later he was seen by a nurse for an asthma review. The nurse recorded that the man had been first diagnosed in 2006. The asthma was disturbing his sleep but did not limit him from doing any activities. The man said that he had been smoking 60 cigarettes a day prior to his arrest, but had cut down although he had no intention of stopping.

17. Due to feeling low in mood the man was seen a prison doctor, in January. The man discussed the reasons for his mood and his frustration at being unable to see his children grow up. The prison doctor noted that he had been prescribed

high doses of Trazodone and Mirtazapine in the past. The doctor prescribed Sertraline 100mg.

18. In February, the man was seen by a second nurse from the Mental Health Inreach Team. He told the nurse that he felt very low and had thought of hurting himself. He said that he did not trust himself not to attempt anything. Based on her assessment, the nurse opened an Assessment, Care in Custody and Teamwork (ACCT) document. (ACCT is the Prison Service system used to monitor and support prisoners assessed at risk of self harm or suicide.)

19. The prison doctor conducted a review with the man in February. He said that he still felt low, and his mood could change quickly without cause. The doctor increased the prescription of Sertraline to 150mg. Six days later the second nurse from the Mental Health Inreach Team held a review with him. He still had suicidal thoughts and so the ACCT remained open, to be reviewed in three weeks time.

20. In March, the man saw another doctor. He felt generally unwell and had a cough which was producing sputum. The man told the doctor that he was using his inhaler six to eight times a day. The doctor prescribed Beclometasone (inhaler treatment for asthma), Prednisolone (treatment for asthma) and Amoxicillin (antibiotics).

21. A week later the man had a second review with the second nurse. He still reported having suicidal thoughts. The ACCT was to remain open and the nurse referred him to the doctor regarding his medication. The man saw the second doctor in March when his medication was changed from Sertraline to Citalopram (treatment of depression associated with mood disorders).

22. Between 14 and 26 March, the man had four more reviews with the second nurse. He still had suicidal thoughts and so the ACCT remained open.

23. In March, the man was seen by the first nurse and completed spirometry tests (which measure lung function). He saw the second doctor four days later to discuss the results of the tests. The doctor informed the man that the results indicated that he had mild COPD and prescribed Salmeterol Aerosol to treat the condition.

24. The man had an assessment with the visiting Consultant Forensic Psychiatrist, in April. He said that he felt better as a result of taking Citalopram and had started to work in the laundry which was also helping his mood. As a result, it was decided to close the ACCT. The man had four reviews with the second nurse and in May she recommended that he be allocated to a single cell.

25. The nurse saw him again in May and he told her that he had thought of taking his own life. As a result the nurse opened another ACCT. She saw him again the next day, and also on 27 May when he was moved to a single cell. The man had five further mental health reviews and was also seen by the consultant forensic psychiatrist in June. As a result of the consultation, the consultant forensic

psychiatrist changed the man's medication from Citalpram to Mirtazapine. The ACCT was discontinued due to his improved mood on 22 June.

26. Between June and November, the man had 21 mental health reviews with staff from the Mental Health Inreach Team. An ECG was also undertaken by a third nurse, the results of which were normal. He was referred to the doctor in November 2007 because he said he was having trouble sleeping. He was seen by a third doctor that day who prescribed Trazadone to replace the Mirtazapine.

27. A nurse from the Mental Health Inreach Team then saw him on nine separate occasions between 30 November and 8 February 2008. During this period it was recorded that there was an improvement in his mood. .

28. In February, he was seen by a fourth nurse because he was complaining of feeling dizzy. His blood pressure was recorded as being 148/88, and his pulse as 80. (The normal range for blood pressure is 100/70 to 140/90, although the pressure does vary throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.) The man was advised to stop smoking and to take up exercise. An appointment was made to see a nurse a week later to check his blood pressure.

29. The man was seen a week later by a fifth nurse. On this occasion his blood pressure was recorded as 137/104 in his left arm and 154/107 in his right arm. The nurse also recorded that he had seven small yellowing bruises across the left and centre of his abdomen which he could not explain. A test of his urine sample showed no abnormalities.

30. He had two more mental health reviews on 15 and 25 February when it was recorded that he was felt well and had no thoughts of harming himself. He had occasional disturbed sleep due to other prisoners on the landing making noises at night.

31. In February, the man was seen by a sixth nurse for a review of his blood pressure. It was recorded as being 152/95 on the right side and 157/103 on the left side. He told the nurse that he was still having abdominal pain and had been having stomach cramps. The nurse made an appointment for him to see the doctor.

32. The man was seen by the second doctor two days later. His blood pressure was recorded as being 140/95. The doctor asked that the man's blood pressure should be checked twice a month for the following three months. The man was seen on 6 March where his blood pressure was recorded as being 125/109. It was taken again on 14 March being recorded as 121/83. The doctor saw him on the same day because he was complaining about pain after he had eaten and that he suffered from constipation. The man recorded that the man had not suffered any weight loss and prescribed Ispaghula sachets (a high fibre drink), Docusate capsules (laxative and stool softener), and Omeprazole capsules (to reduce gastric acid produced in the stomach).

33. Four days later the man was seen by the nurse from the Mental Health Team Inreach for a mental health review. He said that he felt well, was motivated and settled. He had begun an educational course that he could study in his cell and also wanted to be considered for work outdoors in the summer months.

34. The man had three further blood pressure checks. The results were as follows:

Date	Reading
28 March	144/98
8 April	147/90
14 April	128/70

35. The same day (18 March 2008), the nurse from the Mental Health Inreach Team saw him to review his medication after liaising with the prison doctor. His mood was low and his Trazadone medication was increased. The man had two further reviews with the nurse on 17 and 24 April at which he said that he was irritable with others because of his low mood. This meant that he telephoned and wrote less frequently to his family.

36. On 2 May, the man was seen by the second doctor to review the problems of pain on eating and constipation. He said that he only had pain intermittently after eating and had no increase in heartburn so he had stopped taking the medication. He said that he experienced back pain. The doctor examined him and reassured him that it was muscular pain.

37. The man had a further blood pressure check taken on 13 May which was recorded as 131/88. He was seen the next day by the second nurse from the Mental Health Inreach Team. He was still feeling low with poor concentration and appetite. The nurse recorded that she had liaised with the prison doctor who had increased the Trazadone to 150mg and recorded that an ECG was required due to the high dosage.

38. The nurse had another review with the man on 28 May. His mood was much improved since the increase in medication. He said that his sleep was excellent and that he felt relaxed. As the ECG had not yet been completed, the nurse arranged it with another nurse. The other nurse saw him later that day and took his blood pressure, which was recorded as 128/80. The nurse booked the ECG for 30 May and recorded that the results were normal.

39. The man had two further mental health reviews with the second nurse from the Mental Health Inreach Team on 6 and 20 June. It was noted that he had been sleeping better than he had for months and was in a good mood with a positive attitude.

40. On 25 June 2008, the man was seen in healthcare by the fourth nurse because he had felt a click in his neck when he woke. He was issued with pain relief and an appointment was made for him to see the doctor the following day. The next day he was seen by the third doctor who, following examination, recommended rest and more pain relief.

41. Two days later the man was seen by a seventh nurse for an asthma review. Asthma was not limiting his activities but was affecting his sleep. He was still smoking and was given smoking cessation advice. He was to remain on his existing medication for asthma, and was referred to the smoking cessation clinic.

42. On 21 July, he hurt his neck whilst working in the laundry. He was seen by the fifth nurse who offered him Ibuprofen pain relief but he declined. He was seen the following day by a nurse as he still had neck pain. He was advised to rest and remain off work until he was fit enough to return. Three days later he was seen by another nurse to review the problems with his neck. He was still experiencing pain and discomfort and was given Voltarol cream (a non- steroidal anti-inflammatory cream used to reduce muscular inflammation and pain). The nurse reviewed his neck complaint on 19 August and, as there was no improvement, an appointment was made with the doctor.

43. The man had a mental health review with the second nurse from the Mental Health Inreach Team on 20 August and said that he was feeling agitated and frustrated. He said he was considering putting in an application to transfer to another prison. He was advised to think carefully because of the potential to be moved away from his family and the effect it might have on him.

44. On 26 August, he was seen by the third doctor regarding his persistent neck pain. He told the doctor that his mother had a type of arthritis but he did not know which type it was. The doctor made a referral for him to have physiotherapy.

45. The first physiotherapy session was on 2 September and the man was given advice about his posture and exercises to help him move more freely. He had a mental health review on the same day with the second nurse from the Mental Health Inreach Team. He was low in mood but looking forward to working in the officers canteen once he finished his course in the laundry.

46. The man had his second psysiotherapy session on 16 September where it was recorded that the mobility in his neck had significantly improved. He was advised how to avoid aggravating his neck in the future. He was discharged from physiotherapy at this second appointment, with a letter sent to the third doctor who saw him outlining the action taken.

47. On 17 September, the man began the Smoking Cessation Course by having an initial assessment with the sixth nurse who saw him. The nurse recorded his blood pressure as being 144/96, and prescribed 21mg nicotine replacement therapy patches. The aim was for him was to stop smoking tobacco on 19 September.

48. The nurse reviewed his progress on 30 September. At this review his blood pressure was recorded as 125/88. In addition to the smoking patches, nicotine replacement lozenges were also prescribed.

49. On 2 October, the man had a mental health review with the second nurse from he Mental Health Inreach Team and told the nurse that he felt his mood was stable. It was agreed that the nurse would review him again in one month.

50. Six days later the man had the influenza vaccination, and was next seen by the sixth nurse on 15 October. The man said that he was not smoking but still had slight cravings. He was advised to continue with the patches and lozenges. The nurse took his blood pressure and recorded that it was 137/95.

51. The man next saw the same nurse on 23 October. He said that he was struggling to continue the nicotine replacement therapy. These recognised the difficulties but encouraged him to continue. His blood pressure was recorded as 136/90. The next review was on 12 November. He was encouraged to continue with the replacement therapy for another two weeks. His blood pressure was recorded as 148/92.

52. Eight days later the man was seen by the eighth nurse. He said that he had been suffering from headaches for the past ten days and was getting increasing pain in his knee. The nurse made an appointment for him to see the doctor on 26 November.

53. On 24 November, the man was seen by the sixth nurse who saw him and said that he did not wish to continue with the smoking cessation course. The nurse discharged him, but made a note to discuss reapplying in six months time.

Events

54. Closed Circuit Television (CCTV) footage obtained from Acklington shows the activity that took place on the L wing corridor where the man's cell was located. The timings given in the sequence of events have been taken from the timing on the footage. It has been confirmed with the Governor that the clock may be two to five minutes inaccurate, but for the purposes of this investigation it provides unequivocal evidence of the time span between the responses by staff.

55. The OSG arrived at the man's cell door at 2.57am. The officer opened the cell door flap and looked into the cell. At interview, the OSG explained that he went to the cell to answer the cell bell and found the man holding his chest and saying he was experiencing chest pains. (the OSG commented in his interview that he did not look in distress.) The OSG then went to the wing office to contact the he night orderly officer in charge of the prison during the night. He told him what the man had said and the night orderly officer said he would come and see the man. At 3.06am, the OSG returned to the man's cell door to tell him that the night orderly officer was on his way. The OSG then returned to the wing office.

56. The night orderly officer and the first officer on the scene arrived at the man's cell at 3.17am and all three officers went into the cell. At interview, the night orderly officer told my investigator that the man said he had "pains in his chest, pains in his arms and a bit of pain in the back as well". (The night orderly officer went on to say that he was not healthcare trained but was aware if someone was in difficulty. He said that sometimes when making an assessment regarding chest

pains it turns out to be indigestion.) The man told the night orderly officer that he had no history of heart problems but did have COPD. At 3.20am, all three officers came out of the cell, the door was locked and they went to the wing office.

57. The night orderly officer told my investigator that when he arrived in the wing office he "rang the only facility available to me, the Northern Doctors Urgent Care". From the records held by Northern Doctors Urgent Care (NDUC), the night orderly officer made the call at 3.31am. From the recording of the call the night orderly officer told the call handler that the man was complaining of "having pains in his chest, pains down his left arm, and in his back". The call handler said to him, "Don't you think you should have an ambulance?" to which the night orderly officer replied, "I don't know that's what I'm ringing for." The call handler informed him that a doctor would be contacted.

58. The night orderly officer left the first and second officers on the scene and the OSG in the wing office to wait for the doctor to call. The night orderly officer said he then went to the security office with two other staff to start the emergency unlock procedure. (This is the procedure required at night to remove the double locks on gates to provide easy access for emergency vehicles.)

59. The on-call duty doctor that night who is one of the doctors who works in healthcare at Aclklington. The on-call doctor's telephone call record shows that he rang the prison at 3.43am and was on hold for five minutes. He rang off and called again at 3.49am and was on hold for 12 minutes. The doctor rang off again and rang at 4.02am and was on hold yet again for two minutes. Having failed to speak to anyone, he redialled again at 4.09am and was on hold for a further 17 minutes. He redialled yet again at 4.27am but was on hold again for another eight minutes. At this point the doctor rang NDUC to inform them of his attempts to speak to someone at the prison.

60. A second OSG was on duty in the communications room. At interview, the second OSG told my investigator that when on duty in the communications room at night he is locked in and can only leave in an emergency by breaking a sealed pouch to access the key to unlock the door. The OSG explained that the telephone has two distinctive ring tones to distinguish between internal and external calls. All external calls come into the communications room after the switchboard staff have left the establishment. He is able to contact other night duty staff by radio and telephone. The OSG could offer no explanation at interview why the on-call doctor could not get a response from the prison.

61. At 4.03am, the first officer on the scene and the first OSG returned and went into the man's cell. Within 49 seconds, the first OSG left the cell and returned to the wing office. At 4.04am, the second officer on the scene arrived and went straight into the cell. The second officer on the scene is a first aid instructor at Acklington. One minute later, the first officer on the scene came out of the cell and used the radio to make a Code Blue call (emergency response call for a prisoner found not breathing). The first OSG returned to the cell at this point. The second officer on the scene started CPR and was assisted by the OSG and

the first officer on the scene. No automated external defibrillator (AED) was available for staff to use.

62. An ambulance was called at 4.07am. During the following 20 minutes, five male officers came and went from the man's cell, including the night orderly officer who returned to the cell at 4.19am. The second officer on the scene is the only member of staff not to leave the cell once the Code Blue call had been made.

63. The CCTV footage shows the paramedics arriving at 4.28am. They took over CPR but pronounced the man dead at 4.40am. It was at this point that the second officer on the scene came out of the man's cell.

64. At 8.30am, the second Governor and the appointed Family Liaison Officer for the prison left Acklington to go directly to the man's parents home to inform them of his death. On arriving at the address only his mother was at home as his father was at work. The Family Liaison Officer remained with his mother whilst the Governor went to his father's place of work to bring him home to be with his wife. At the request of the man's mother, the liaison officer also rang the man's brother to tell him the sad news.

65. In the days following the man's death, the liaison officer kept in regular contact with the man's parents. Acklington offered assistance with the funeral, and the chaplaincy held a memorial service to allow fellow prisoners and staff to pay their respects. The man's fellow prisoners also held a collection to send a wreath to his family (this was co-ordinated by the Family Liaison Officer).

ISSUES

Clinical care

66. The clinical review has highlighted the following in respect of the man's care:

> "The man suffered from chronic depression which appears to have been well managed by the mental health team at Acklington. There is no recorded medical history to suggest he was suffering from coronary artery disease prior to the fatal attack. His smoking history and obesity are significant risk factors for the early development of coronary artery disease but he had not exhibited any symptoms. The quality of medical record keeping Acklington is first class."

67. Whilst at Acklington, he was noted to have raised blood pressure which was monitored and investigated with blood tests. An ECG was performed and reported as normal. His blood pressure settled to normal levels without requiring treatment.

68. The clinical reviewer also judges that his depression was well managed by the Mental Health Team at Acklington. During the period from 16 February 2007 and 2 October 2008, he had a total of 57 reviews with members of the team. The clinical reviewer concludes that the care he received prior to the morning of his death was entirely appropriate to his needs.

Emergency response on 25 November

69. Acklington does not have a 24 hour healthcare service. After 8.00pm, only uniformed staff are on duty managed by a senior officer. In the event of medical assistance being required or a medical emergency, the SO has an on-call doctor service available via NDUC or can request an emergency ambulance.

70. When the man raised the alarm it was responded to appropriately by the first OSG. However, the chain of events that followed was not acceptable.

Decisions and actions taken by the senior officer

71. The first OSG raised the alarm with the night orderly officer by contacting him from the wing office. The OSG said that the man was experiencing chest pain. The CCTV footage confirms that it took 15 minutes for the night orderly officer to arrive at the man's cell. At interview, the night orderly officer stated that once contacted he made his way from E wing to L wing where the man was located. My investigator believes this length of time was excessive given that the SO was responding to an emergency.

72. The second failure that, after discussion with the man, the night orderly officer told the officers to remain in the wing office rather than have someone stay at his cell door to monitor any deterioration. Once the night orderly officer and the first officer on the scene and the OSG left the man's cell, he was left alone and not checked for 43 minutes. On reading the draft report the man's family can not comprehend why he was left on his own in his cell for such a long time. They

believe that once the man had complained of these serious symptoms he should not have been left alone until his care was handed over to better qualified persons such as paramedics. They also can not understand why, as the first aid trainer, the second officer on the scene did not go to him at the same time as the night orderly officer. I share these concerns and indeed the second officer on the scene could have recommended someone stay with the man to monitor the situation. I have great sympathy with this view, the fact the man was left alone at the end of his life is deeply shocking. However, ultimately, it was the night orderly officer who was responsible for the management and deployment of staff that evening.

73. The night orderly officer chose to call the on-call doctor service rather than an ambulance. I appreciate that he is not clinically trained, however at interview he said, "I've rang the only facility available to me, the Northern Doctors Urgent Care." This clearly is not the case as an ambulance could have been called.

74. I am critical of the decision-making and management of this incident by the night orderly officer and consider that it warrants far closer assessment by the Governor

I recommend the Governor investigates the night orderly officer's handling of the emergency situation.

On-call doctor

75. As the on-call doctor was asked by NDUC to contact Acklington. He attempted to contact the prison on five occasions from 3.43am to 4.27am but each time was put on hold. The total amount of time that the on-call doctor was on hold was 44 minutes, which is evidenced by his telephone call log.

76. The second OSG was on duty in the communications room but, when interviewed, could offer no explanation for the on-call doctor's calls being unanswered. My investigator asked Acklington to interrogate the phone system for any faults on the telephone line from 00.01am to 5.00am on 25 November 2008. There is no evidence of any fault with the telephone system.

77. The second OSG could offer no explanation as to why the on-call doctor's calls went unanswered, despite my investigator's best efforts, questions regarding this matter are unresolved. I am aware that since the man's death an additional dedicated telephone line has been installed into the communications room.

I recommend the Governor investigates the second OSG's conduct on the night.

I recommend that the Governor reviews the procedures and protocols for outside bodies contacting the prison when in it is night state.

Emergency response

78. When the first officer on the scene and the first OSG returned to the man's cell at 4.03am, they found him collapsed on his bed and not breathing. The second officer on the scene arrived and started CPR, assisted by the OSG. There was no emergency bag or Automated External Defibrillator (AED) available for staff to use. (AEDs are simple to use and audibly advise the individuals performing first aid when to stop and recommence CPR.)

79. Emergency first aid equipment, including AEDs, should be placed at strategic points within the prison. I am very surprised that emergency first aid equipment is located in healthcare when no healthcare staff are on duty at night. However, as the Governor has assured my investigator that the prison is in the process of obtaining additional emergency equipment, I have decided not to make a formal recommendation in this regard.

80. Of the OSG's on duty in Acklington on the night the first OSG was the only one not trained in 'Heart start' which is basic first aid with emphasis placed on CPR. I am disappointed to have raised this issue in five previous investigations at Acklington, and draw this to the attention of the Chief Operating Officer of the National Offender Management Service.

    I recommend that the Governor ensures that all relevant staff, particularly those who work nights, receive CPR training and that their skills are regularly updated.

81. The first officer used the radio to contact the second OSG in the communications room to request an ambulance. The emergency call was made at 4.07am, which was more than an hour from the time the man had first raised the alarm. The clinical reviewer comments on the emergency response and has concluded:

    "There was a significant delay between the man asking for help and the arrival of an ambulance which may have affected the outcome."

82. National Health Service advice concerning chest pain in is that an individual experiencing pain in the middle of the chest or pain spreading from the chest to the upper back, neck, shoulder blades and arm, should seek emergency help immediately. Whilst it is not clear whether the immediate investigation by acute specialists would have made a positive difference to the outcome in the man's case, the failure to seek the guidance of emergency specialists or to apply best practice guidance is a serious lapse in care.

83. All prisoners who complain of chest pain should receive prompt attention with appropriate and timely referral to an acute specialist. As a matter of priority, a chest pain protocol should be implemented at Acklington to ensure that all staff are aware of the treatment options and need for prompt and appropriate action.

    I recommend that the Primary Care Trust and Healthcare Manager conduct an urgent review of the current policies and guidelines for the response to prisoners experiencing angina, chest pain, and cardiac events.

84. Overall, I regret to say that the management of the emergency situation was not remotely to the standard I have come to expect of the Prison Service.

The Governor should review the emergency response with specific attention to first on scene protocol and urgent requests for an ambulance.

Family Liaison

85. The man's family wished to thank the Family Liaison Officer for the sensitive manner with which she handled the breaking of the sad news of the man's death and her subsequent contacts. This was good practice and the Governor may wish to recognise formally the efforts made by the Family Liaison Officer.

RECOMMENDATIONS

1. I recommend the Governor investigates the night orderly officer's handling of the emergency situation.

2. I recommend the Governor investigates the second OSG's conduct on the night.

3. I recommend that the Governor reviews the procedures and protocols for outside bodies contacting the prison when in it is night state.

4. I recommend that the Governor ensures that all relevant staff, particularly those who work nights, receive CPR training and that their skills are regularly updated.

5. I recommend that the Primary Care Trust and Healthcare Manager conduct an urgent review of the current policies and guidelines for the response to prisoners experiencing angina, chest pain, and cardiac events.

6. The Governor should review the emergency response with specific attention to first on scene protocol and urgent requests for an ambulance.

It is very disappointing that at the time the final report has been issued there has been no response from the Prison Service to the recommendations.