Investigation into the circumstances surrounding the death of a man at HMP Acklington in March 2010

Report by the Prisons and Probation Ombudsman for England and Wales

January 2011

This report considers the circumstances surrounding the death of a man at HMP Acklington in March 2010. The man was found collapsed in his cell at around 7.25am. He was 64 years old. A subsequent post-mortem examination found that the man died from ischaemic heart disease (reduced blood supply to the heart) caused by coronary artery atheroma (swelling in the artery walls which reduces blood flow).

I offer my sincere condolences to the man's family and all those who knew him.

The investigation was conducted by one of my investigators on my behalf. I would like to thank the governing Governor for his co-operation. I also extend thanks to the liaison for the Ombudsman's office. In addition, I thank the clinical reviewer who conducted a review of the man's clinical care.

The man was remanded to HMP Durham after appearing in court in February 2009. He reported experiencing frequent fits and, despite various tests being conducted, no diagnosis was reached as to their cause. He also received ongoing support from the mental health team. In late August, he transferred to HMP Acklington and remained there until his death.

This is the 14th death from natural causes at Acklington since 2004, when the Ombudsman's office began investigating all deaths in custody. Before this man's death, the last such death occurred in 2009. Four weeks after this man's death, another prisoner died from natural causes at Acklington.

I have looked into the man's clinical care, including the lack of information which accompanied him to Acklington and the processes relating to keeping him safe. I make four recommendations and endorse a further three recommendations made by the clinical reviewer. As some of the recommendations relate to the man's care at Durham, I will also send my report to the Governor for his consideration.

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

Jane Webb
Acting Prisons and Probation Ombudsman **January 2011**

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SUMMARY

The man appeared in court on 16 February 2009 and was remanded to HMP Durham. He attended a medical appointment, a substance misuse assessment, and a mental health assessment. He told staff that he had fits once per week. The man undertook a week long alcohol detoxification programme in the healthcare unit.

Although he appeared to settle well, there were some concerns about the man's memory. In early March, he suffered what was described as a "funny turn" and he was discharged to a residential wing on 8 March.

The man saw a consultant psychiatrist on 23 March, who confirmed that he had very poor memory. The psychiatrist believed that this was due to alcohol consumption. He saw the doctor in April who thought that his fits, which were now four or five times per day, were panic attacks. She prescribed diazepam and referred the man to the community psychiatric nurse (CPN).

In May, the man said he was still having fits two or three times daily. The psychiatrist noted that he was depressed and suggested anti-depressants and an electroencephalogram (EEG).

On 20 May, the man was convicted at a crown court. He returned to Durham to await sentencing. He was taken to hospital on 14 June after falling from his bed and suffering a head injury. When he returned to prison the next day, he was admitted to the healthcare unit but discharged on 16 June. An EEG showed that his brain activity was within normal limits.

The man was sentenced to a nine-year extended sentence. He saw the psychiatrist, who thought he was chronically depressed and changed his medication. The Assessment, Care in Custody and Teamwork (ACCT) process was put in place as the man was judged to be at risk of harming himself. He transferred to HMP Acklington on 28 August and the ACCT remained open until 8 September.

The man continued to have regular fits which remained undiagnosed despite hospital tests. He refused any more treatment from 27 January 2010 onwards.
The man was found collapsed in his cell at 7.25am on a day in March and officers started cardio-pulmonary resuscitation (CPR). Paramedics arrived within 15 minutes, but there were no signs of life. The paramedics declared that life was extinct at 7.57am, and a prison doctor pronounced the man's death at 8.40am. A post-mortem found that he died from ischaemic heart disease (reduced blood supply to the heart) caused by coronary artery atheroma (swelling in the artery walls which reduces blood flow).

I have investigated issues around clinical care, including handing over information between prisons and the ACCT process. I make four recommendations and endorse a further three recommendations made by the clinical reviewer.

THE INVESTIGATION PROCESS

1. One of my senior investigators opened the investigation on 16 March 2010. He visited HMP Acklington on 25 March and met the following people:

   - The PPO's liaison officer
   - A Governor
   - Two family liaison officers
   - The Chair of Acklington's Independent Monitoring Board (IMB)
   - The representative for the Prison Officers' Association

2. The various people present at the meeting explained the background to the man's imprisonment, his time at Acklington and the circumstances of his death. The two family liaison officers discussed family liaison issues, and the Governor explained that she had attended the man's funeral.

3. The liaison for the Ombudsman's office provided my investigator with all of the records relating to the man's time in custody.

4. One of my family liaison officers (FLOs) spoke to the man's daughter by telephone on 31 March. She asked whether her father had tried to summon help in the hours before he was discovered by members of staff on the morning of his death. I have tried to answer this question as part of the report, which I hope will help the man's family to better understand the events leading to his death.

5. My investigator returned to Acklington in May 2010 and conducted recorded interviews with five members of staff. My investigator also spoke informally to three prisoners who were living in cells near to the man at the time of his death. The content of those conversations is summarised in this report.

6. Northumberland Primary Care Trust (PCT) appointed Custodial Care Innovative Solutions (CCIS) to conduct a review of the man's clinical care whilst in custody. (The purpose of a clinical review is to examine the medical care that a prisoner received whilst in custody, which should be of an equivalent standard to what might have been expected in the community.) The clinical reviewer from CCIS consulted the man's medical records from HMP Durham and Acklington, as well as receiving information from his community general practitioner (GP). Her findings are summarised in this report.

HMP ACKLINGTON

7. Acklington is a category C prison for convicted adult male prisoners. On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. Category C prisoners are defined as those who cannot be trusted in open prison conditions but who would not have the ability or resources to make a determined escape.

8. Located near the town of Amble in Northumberland, and built on a former Royal Air Force base, it is the northernmost prison in England. Acklington has an operational capacity of 946 and has 11 residential units.

9. Healthcare at Acklington is provided by Northumberland Primary Care Trust (PCT) and offers general health provision, mental health support and dentistry. Primary healthcare is provided by a doctor and nurses during the daytime, seven days a week. There is no out of hours medical cover, although a doctor can be contacted by telephone after 6.00pm. All healthcare is provided on an outpatient basis as there are no inpatient facilities at Acklington. Prisoners requiring inpatient care are transferred to an outside hospital or to another prison.

Performance

10. The Ministry of Justice produces quarterly performance figures for all prisons in England and Wales. Every establishment is given a rating between 1 and 4 based on 34 agreed performance indicators. The most recent figures available at the time of writing are for quarter 4 of 2009-2010 (January, February and March 2010). For this period, Acklington received a rating of 3, indicating good performance.

11. HM Chief Inspector of Prisons inspected Acklington in June 2009. Although the prison had previously received a critical report in 2006, inspectors found "a greatly energised and much better managed prison" during their visit in 2009. Although progress had been made in all areas, HM Chief Inspector of Prisons' report noted that some of the older buildings remained unfit for purpose, many prisoners spent too much time in their cells, work with older prisoners was underdeveloped, and mental health provision was insufficient.

12. An Independent Monitoring Board (IMB) is made up of volunteers from the community in which a prison is located. IMBs must satisfy themselves as to the humane and just treatment of people held in custody, and they report to the Justice Secretary annually. At the time of writing, the most recently available IMB report for Acklington covered the period July 2008 to June 2009.

13. Regarding healthcare, the IMB noted that there was an increasing need to manage prisoners with illnesses associated with aging, whilst acknowledging that Acklington had no inpatient facilities. The Board also reported that "the actual ability of staff to deliver healthcare interventions is currently hampered

by lack of space”. They went on to report that staff struggled to find appropriate consultation space within healthcare, and that access to consultation rooms on the residential units was very poor with little opportunity for confidential consultation. However, the IMB also reported that the healthcare team “work in difficult and challenging conditions [and] always offer their best efforts to those seeking their support”.

Previous deaths at Acklington

14. The Ombudsman’s office has been responsible for investigating all deaths in custody since April 2004. Prior to this man’s death, 13 prisoners have died from natural causes whilst at Acklington. One of these deaths occurred in 2004, four in 2005, two in 2006, one in 2007, four in 2008, and one in 2009. Four weeks after this man’s death, another prisoner died from natural causes at Acklington.

HMP DURHAM

15. HMP Durham holds a maximum of 981 prisoners and serves courts from its local area. It accommodates remand, unsentenced and convicted prisoners over 21 years of age. There are seven residential units that include medical treatment rooms for outpatients. A separate inpatient unit accommodates prisoners with more complex medical requirements.

KEY EVENTS

HMP Durham

16. The man was born in 1945 in Bradford, West Yorkshire. He was 64 years old at the time of his death, and was serving a nine-year extended sentence for arson. He had previously been sentenced to two years in custody, also for an offence of arson, in 2005.

17. The man was remanded to HMP Durham on 16 February 2009 whilst awaiting trial for arson. A first reception health screening was completed upon his arrival. (This is a short medical assessment completed for all prisoners.) In this man's case, alcohol consumption was identified as a problem and he was referred for a substance misuse assessment. He was also referred for a mental health assessment and a review of his medication. Additionally, the man completed a consent form so that the prison could access his previous medical records.

18. On the same day, the man had a substance misuse assessment. He disclosed that he drank half a litre of gin daily and had done so for several years. A week-long detoxification programme was recommended, and the man was prescribed Haloperidol (a medication used for the treatment of alcohol withdrawal). He also saw a general practitioner (GP) and was prescribed paracetamol to relieve back pain.

19. Also on the day of the man's arrival, a Community Psychiatric Nurse (CPN) made an entry in his clinical record, noting a telephone call from the community mental health team in Newcastle-upon-Tyne. The CPN was told that the man had alcohol-related mental health problems, and was possibly in the early stages of dementia. He was due to be assessed by a CPN but had been remanded into custody. The man was admitted to the prison's healthcare unit (cell M2-09) for further assessment of his cognitive functioning.

20. The next day, 17 February, the man spoke with a nurse about his alcohol consumption, again saying he drank half a litre of gin daily. The nurse noted in the clinical record that a seven-day detoxification regime was in place and he would be monitored on the unit. The man also saw a medical student working at Durham, after suffering a fit. The man reported that the fits had started around four months earlier and that he experienced them approximately once per week. The medical student wrote in the clinical record that the man was vague in his description of the fits, and attributed them to a reduction in alcohol consumption.

21. The man seemed to find the healthcare unit agreeable for the next few days. An entry in his clinical record on 19 February reported that he had a "settled day … and joined in all activities". The next day, an administrator in Durham's healthcare unit noted that, as a result of his referral to the mental health team, an appointment had been made with the man for 26 February.

22. Over the next few days there were no recorded healthcare concerns about the man. Entries in his clinical record consistently described him as “settled” and participating in activities such as education, exercise and association (the time prisoners spend out of their cell with others from the same unit).

23. On 25 February, a doctor wrote in the clinical record that he had seen the man and whilst he appeared “cognitively intact” on a superficial level (that is, he was able to think, respond and behave appropriately in everyday situations), he also gave an inconsistent account of owning a house and swimming pool in Australia. The next day, a nurse wrote in the clinical record that the man was due for an assessment by a registered mental health nurse (RMN). The original referral had been completed on the day of his arrival (16 February) but the nurse noted that as he was now in the healthcare unit, she would refer him to the inpatient manager in view of his possible cognitive impairment. There is no indication that a mental health assessment took place on 26 February as originally planned.

24. No health concerns were recorded over the next few days. The man left the prison for a court appearance on 3 March, and the next day a note was made in his clinical record that an appointment had been made for 23 March with a consultant psychiatrist. (This appointment was a result of the original referral rather than anything arising from the court appearance.) On 6 March, a nurse noted that the man’s cell mate had witnessed him having what was described as a “funny turn”, although he could not recall feeling unwell. There was no further explanation given about what characterised this incident.

25. On 8 March, the man was discharged from the healthcare unit. A note in the clinical record explained that this was a temporary measure due to the urgent needs of other prisoners, and the possibility remained to re-admit him when a bed became available again. He moved to B wing, in cell B2-15.

26. There are no entries in the man’s wing history record between 18 March and 17 June, and little is known about his experiences on B wing. However, he did attend a number of medical appointments during this time. On 23 March, he saw a consultant psychiatrist for a mental health assessment. The doctor described him as “self-assured, friendly and sophisticated”. He referred to assessments in 2004 and 2005, noting that whilst the man had “a substantial cognitive deficit especially in terms of poor memory”, there had been little change and “certainly no ongoing deterioration in the interim”.

27. The consultant psychiatrist thought it likely that the man’s alcohol consumption had led to Wernicke’s encephalopathy. (This is a syndrome characterised by, amongst other things, confusion and impairment of short-term memory and commonly associated with prolonged alcohol consumption.) The consultant psychiatrist asked the court to consider hospitalisation under Section 37 of the Mental Health Act. (This is a treatment order that can be used as an alternative to imprisonment for people with a mental illness.) At this point, the man was maintaining his innocence and had not yet been convicted.

28. On 9 April, a nurse wrote in the clinical record that the man's cell mate had approached her at the teatime clinic to say he was worried about him. He said the man had looked unwell at lunchtime, though he had not reported it at the time. When the nurse spoke to the man, she did not think that he looked unwell but suffered chronic pain and "absent episodes". A GP appointment was made for 20 April when he saw a doctor. He had felt unwell whilst waiting for his appointment. The episodes that he complained of were described by the doctor as panic attacks, occurring four or five times per day since his admission to prison. She prescribed diazepam, a medication commonly used for treating anxiety, and also referred the man to the CPN. In addition, the doctor asked for an electrocardiogram (ECG) to be performed. This involves connecting electrodes to the skin to obtain a reading of the electrical activity of the heart.

29. On the referral form to the mental health team, the doctor indicated that the man's referral was 'urgent', meaning that he should have been seen within 48 hours. One week later, however, on 27 April, an entry was made in the man's clinical record to say that, due to the number of referrals received by the mental health team, his referral had been re-graded to 'routine'. This meant he should have been seen within seven working days.

30. On 29 April, a number of tests (blood count, thyroid function, plasma glucose level, liver function, urea and electrolytes, lipoprotein electrophoresis) were conducted from a single blood sample, and all the results were found to be normal. An ECG was also performed. The following day, an administrator in Durham's healthcare unit noted in the clinical record that an appointment had been made for the man with a nurse (the CPN) for 18 May.

31. The man submitted a formal complaint about healthcare on 1 May. (The formal complaints procedure involves prisoners completing a form and leaving it in a box on the unit. Complaints are responded to by an appropriate member of staff.) He wrote on the form that, although he had been prescribed paracetamol and diazepam, he was unable to obtain more of this medication from the nurses on the unit.

32. A nurse saw the man on 5 May when she attended B wing to see his cell mate. He told her that he was still having what were described as panic or anxiety attacks two or three times daily. This was confirmed by his cell mate. He asked for more paracetamol, but a nurse on B wing advised the nurse that this was being addressed. The next day, the primary care co-ordinator at Durham wrote to the man about his complaint. She explained that, whilst his paracetamol was on repeat prescription and could be obtained from nurses on the unit, his diazepam was not. She advised the man to make an appointment with a doctor so that this could be reviewed.

33. On 7 May, the man had an appointment with a nurse. This was listed as a physical care pathway appointment, which is used for prisoners taking anti-psychotic medication (which the man was not prescribed). The nurse wrote in the clinical record:

> “Confused as to why he had been called up. Explained the purpose of the appointment which confused him further, as he is not taking anti-psychotic medication at the present time. It appears he was prescribed a course of haloperidol in February for his alcoholism, which has now expired.”

34. The man told the nurse that, other than an episode of depression due to family problems in the past, he did not suffer from any mental illness and did not require or want anti-psychotic medication. He was, however, keen to have a new prescription for diazepam, and the nurse advised him to arrange a review appointment with a doctor.

35. Four days later, the man had an appointment with a GP at Durham who noted that he had seen the result of the ECG and it suggested the absence of P-waves. (P-waves are formed on the ECG as part of the heart’s normal beating process. Their absence can indicate atrial fibrillation, a type of abnormal heart rhythm.) The GP was not convinced that the P-waves were genuinely absent and, believing that this may have been an error, suggested that the ECG was repeated. He also speculated that the episodes described as panic attacks could be due to tachycardia (an accelerated heartbeat).

36. On the same day, the man attended a second appointment with the consultant psychiatrist. He spoke more about the episodes that had previously been described as panic attacks, and told the consultant psychiatrist that he seemed to go into a different world five or six times per day, for two or three minutes each time. The consultant psychiatrist wrote:

> “He claimed to have some warning that these episodes were about to occur because he notices that he starts sweating. He then enters into this disassociated state when he is not really aware of what is going on around him.”

37. Regarding depression, the consultant psychiatrist wrote:

> “He agreed that he is quite depressed. He agreed that his alcohol abuse, for which he offers no apology and about which he expresses no regret, is motivated by a desire to blot everything out. I recalled with him that he had used the word ‘depressed’ to me the last time and that he had used it again today. I advised him that, in view of his depressed state, he should be taking anti-depressants and certainly in preference to medicating himself with alcohol. He agreed that he would take a medication if it were prescribed.”

38. In conclusion, the consultant psychiatrist’s recommendation about the man was “essentially unchanged”. He suggested 20mg of fluoxetine (an anti-depressant) daily, and also recommended an electroencephalogram (EEG). This monitors electrical activity in the brain (sometimes called brainwaves) using electrodes placed on the scalp. There had been a suggestion in 2005 that the man’s fits might be caused by temporal lobe epilepsy (a type of epilepsy characterised by seizures).

39. On 14 May, a prison GP prescribed fluoxetine for the man as recommended by the consultant psychiatrist. He also referred the man to the EEG department at outside hospital and described his symptoms. On the same day, the man saw another GP at Durham and told her that he had suffered a head injury around one year earlier but could not recall the details.

40. The man saw the CPN on 18 May, 19 working days after the referral form was received by Durham's mental health team. The CPN wrote in the clinical record that he presented as a "generally pleasant and co-operative man". He described his 'panic attacks' and said they happened at any time, rather than in particular situations. The man said his mood was low but this was due to being in prison. There were no problems with appetite, sleep, concentration or communication skills. The CPN planned to see him again in five or six weeks, but would offer some support if necessary following his court appearance on 20 May.

41. Two days after this meeting, the man was convicted at a crown court. He returned to Durham to await sentencing. On 5 June, he again saw the CPN, who described him as pleasant and amiable with no thoughts of self-harm or suicide. She wrote in the clinical record that he would be reviewed again in five or six weeks.

42. At 11.55pm on 14 June, a nurse was called to B wing. The man's cell mate had alerted wing staff that the man had fallen from the top bunk and was having a fit. The nurse wrote in the clinical record that when she arrived, the man was lying on the floor of the cell with "copious amounts of blood coming from an injury he had sustained to his head".

43. As the nurse was unable to get a response from the man, who appeared to be unconscious and was breathing heavily, she asked for an ambulance to be called. The man remained in a semi-conscious state for around 15 minutes, becoming quite agitated at times. The nurse reported that he would not tolerate an oxygen mask on his face. By the time the ambulance arrived, the man was more alert and able to respond to verbal commands, but had lost blood from two cuts to his head. He was taken by ambulance to outside hospital.

44. The man arrived at the hospital at 12.41am on 15 June, less than an hour after the nurse examined him. He had a tender bruise to the right side of his head, redness over his right shoulder, a bruise and abrasion to his right elbow, and tenderness in his right ankle. X-rays were performed on his skull and right ankle, and no injuries to the bone were found. The cuts to his head were surgically glued.

45. Returning to the prison at 3.15am, the man was admitted to the healthcare unit for observation. The nurse who was called to B wing to see the man a few hours' earlier wrote in the clinical record that regular monitoring of brain functioning would take place and he would see a doctor in the morning regarding the episode that had led to his fall. The subsequent observations did not indicate any immediate cause for alarm.

46. The man saw a GP at Durham, that morning. He felt better although he was sore in various places due to the fall. The bleeding from his head had stopped. The GP recommended that the man was observed in the healthcare unit, with a follow-up appointment one week later. He slept for much of the day and told a nurse that he wanted to be discharged from the healthcare unit due to the noise. The nurse said she would discuss his request with the doctor the next day.

47. Also on 15 June, an appointment was received from outside hospital for the man to attend for an EEG on 2 July.

48. The next day, the man saw a prison doctor. He said he felt well and wanted to return to B wing. He was unable to remember anything about falling from his bed until he awoke on the floor. The man also said that he was not keen to go to hospital whilst a prisoner. The doctor agreed to discharge the man from the healthcare unit and suggested that he should have a lower bunk, but he wanted to return to the same cell because he was friendly with his cell mate. Given that there was no clear indication what caused the fits or how often they might occur, the doctor allowed this.

49. On 17 June, a senior officer wrote an entry in the man's wing history record. This was the first such entry for three months. The senior officer wrote that there were no concerns, other than the man injuring himself as a result of the fall. One week later, the man discussed the EEG with a doctor and said he did not want to attend and so the appointment was cancelled. However, after a further conversation with a GP at Durham, the man agreed to go to hospital and a new appointment was made for 21 July.

50. No medical issues were recorded during the latter half of June, and no entries were made in the man's wing history record either. On 4 July, a nurse was asked to attend B wing because the man was having difficulties with balance when walking out of his cell. He told the nurse that he had experienced such episodes before but could not explain them. He said he had eaten breakfast but the officers on the unit did not think this was the case. A prison GP saw the man and, although there was nothing new to report, decided to admit him to the healthcare unit for observation.

51. The next day, 5 July, the same prison GP saw the man and wrote in the clinical record that he seemed better, although he reported having two fits since being admitted to healthcare. Two days later, his cell mate alerted staff as the man was having a fit in his cell. On 8 July, the prison GP noted that the cause of the episodes remained unclear, but there was no reason not to allow him to return to B wing.

52. The CPN saw the man on 10 July and reported that he presented quite well. He was preoccupied by the episodes and believed there was an organic cause. He said he spent most of his time in his cell and had a good relationship with his cell mate. The man did not see the purpose of trying to

associate with prisoners who were mostly much younger than him. The CPN planned to see him again in five to six weeks.

53. On 17 July, an entry was made in the man's wing history record saying that there were no concerns to report, other than him being somewhat quiet at times. Four days later, the man attended outside hospital for his EEG. The graph produced was within normal limits, with no focal or epilepiform abnormalities (which, if present, can indicate epilepsy). He did not experience any fits or seizures during the process. On 23 July, the man saw a prison doctor and said he was still experiencing up to four fits per day.

54. The man attended a crown court on 24 July and received a nine-year extended sentence. (This meant that he would spend four years in prison and a further five years in the community on licence.) Three days later, a note in the clinical record explained that the man's pre-sentence report (written by a probation officer to aid the sentencing decision) warned of deteriorating mental health and a risk of suicide. A prison doctor wrote in the clinical record that, as the man had an appointment arranged with the consultant psychiatrist for 10 August, he would await the outcome before taking any further action.

55. On 2 August, the man was described in his wing history record as "a model prisoner" who had good relations with staff and other prisoners and who was always polite.

56. Sentenced prisoners are categorised from A to D (A being the highest) based on their offence and the risk they would pose if they were to escape. The man was categorised as C on 5 August. Category C prisoners are defined as those who cannot be trusted in open prison conditions but who would not have the ability or resources to make a determined escape.

57. The man did not attend his scheduled appointment with the consultant psychiatrist on 10 August. He saw the CPN three days later and they discussed the missed appointment. The man said he did not know about it but could not see the purpose of the appointment either. The CPN suggested that it would be a good opportunity to discuss the results of his recent tests, as he was still complaining of fits. She noted that he was unwilling to look at ways of coping with them, instead spending "virtually all of his time in his cell".

58. On 17 August, the man saw the consultant psychiatrist (the appointment having been rearranged from 10 August). They discussed the man's fits, and the consultant psychiatrist wrote in a follow-up letter that he had little doubt they were not caused by epilepsy, but by "a phenomenon of his custody and his rather chronically depressed state". The man also told the consultant psychiatrist that he would not survive until his release date of February 2011. When asked, he confirmed that he was referring to the prospect of taking his own life. The consultant psychiatrist recommended a prescription for an anti-depressant and suggested mirtazapine. (At this point, the man was already prescribed fluoxetine, though the consultant psychiatrist did not mention this in his follow-up letter to the prison GP.)

59. The next day, an administrator in Durham's healthcare unit wrote that she had received the consultant psychiatrist's letter to the prison GP, and was concerned that the man might pose a risk of suicide. As the information had not been passed to anyone the previous day, the administrator spoke to two nurses who suggested that she contact a senior officer on B wing. She asked a senior officer (SO) to speak to the man, who would also be reviewed by the CPN the following day. There is nothing in the man's wing history sheet to indicate whether or not the staff spoke to him.

60. The CPN saw the man on the morning of 19 August. She wrote in his clinical record that "he was reluctant to discuss with me his thoughts around suicide, but eventually admitted he had made plans, but would not say how or when". The man felt that he had no future and could not imagine spending years in prison. The CPN discussed the possibility of starting the Assessment, Care in Custody and Teamwork (ACCT) process. (The ACCT process is used by all prisons to provide additional support and monitoring to people considered to be at increased risk of self-harm or suicide.)

61. At 11.40am the same day, the CPN completed a Concern and Keep Safe form, which is the first part of the ACCT process. She was concerned because the man had expressed thoughts about killing himself, felt that he had no future and would struggle to cope with a long sentence.

62. An Immediate Action Plan was formed at midday. (Immediate actions are those which are necessary to keep the prisoner safe over the next 24 hours.) A senior officer completed the form, saying that the man should be located in a double cell for support, and have access to the telephone and to a Listener (a prisoner trained by the Samaritans) as required. Unit staff were required to have at least one conversation per day with the man, and also observe him (and record their observations) twice during the day. Staff would also talk with the man at the start of night duty, and observe him at least twice during the night.

63. At 3.00pm, the man attended an assessment interview with a psychologist who was also an ACCT assessor. (Prisoners subject to the ACCT process must be interviewed by a trained ACCT assessor within 24 hours of the initial concern being raised.) He described his main problem as being in prison, and said that nothing would help apart from being released as he did not think he could cope with the length of his sentence.

64. Although he had not harmed himself, the man said he thought about killing himself every day and talked about the idea of cutting his wrists. He said he did not want to die but wanted to be out of prison and saw killing himself as a way out. He also talked about his fits and feeling depressed. The man said he did not have any contact with his family. He enjoyed making things with his hands but did not want to go to work or education classes in prison. It was agreed that he would continue to see the CPN and apply for an art and design course. He would also find something that he enjoyed doing that could occupy his time, whilst remaining subject to ACCT.

65. After the assessment interview, the first ACCT review took place. The man, a senior officer and an officer discussed his situation. The senior officer noted on the review form that the man appeared distraught and, due to his “strange behaviour” would remain subject to the ACCT process. A further review meeting was arranged for 26 August, and a note made to invite the CPN.

66. A Caremap was produced the same day. This document lists the issues experienced by the prisoner, as well as the goals and actions required to overcome the issues. The senior officer wrote that the man was having trouble accepting his sentence. He would receive support from the unit staff and the CPN in order to try and come to terms with his situation. His fits were mentioned, though the cause had not yet been ascertained. It was noted that the man was thinking about harming himself, and was awaiting a further appointment with the consultant psychiatrist.

67. Conversations with and observations of the man were recorded in the ongoing record section of his ACCT document over the next two days, although there was nothing of particular note. On 21 August, a prison GP noted in the clinical record that he had read the letter from the consultant psychiatrist (arising from the man’s appointment on 17 August) in which he had recommended an anti-depressant. The prison GP noted that, whilst the man was already prescribed fluoxetine, it might be reasonable to withdraw this and prescribe mirtazapine instead. Four days later, a prison doctor did this.

68. On 26 August, a second ACCT review took place. The man, a senior officer and an officer discussed his circumstances. The senior officer wrote on the review form that the man continued to protest his innocence and did not accept his situation. He was not planning for the future, other than saying he might have to hurt himself to get out of prison. The senior officer noted that he was “incoherent and rambling at times”. The ACCT remained in place and a further review was arranged for 1 September. Again, a note was made to invite the CPN.

69. No mention was made in the man’s wing history record or clinical record about a discussion regarding transfer to HMP Acklington. However, at 5.40pm on 27 August, an entry was made in the ongoing ACCT record of a conversation with an officer. The man had mentioned that he was being transferred to Acklington the following day. It is unclear how this issue was first raised and whether there was any discussion about how such a move might affect him.

70. On 28 August, a ‘prisoner fit for transfer’ form was completed by a member of staff in Durham’s healthcare unit. (It is unclear who filled in this form because it required only a signature from the member of staff, which is illegible.) The person noted that the man was subject to the ACCT process, but was not suffering from any physical or mental illness that would prevent him from being transferred and cared for safely in the receiving prison. The person completing the form also wrote that there was no need to communicate healthcare information to the receiving prison. The man was assessed as fit for transfer and he left Durham at 7.30am the same day.

71. On the same morning, an officer spoke to the Safer Custody office (the department responsible for suicide prevention and the management of the ACCT process) at Acklington to explain that the man was subject to the ACCT process. He was advised that an ACCT review would be conducted upon the man's arrival at Acklington.

HMP Acklington

72. When the man arrived at Acklington, an initial reception healthcare assessment was completed by a nurse. His current medication was listed, as well as the fact that he was subject to the ACCT process. However, there was no mention of his fits or his involvement with the mental health team at Durham. The man was not referred to a doctor or nurse for further assessment.

73. An ACCT review was conducted at 3.30pm on D wing, where the man had been accommodated. He was present at the review, with a senior officer, an officer, a nurse and a Salvation Army chaplain. The senior officer noted that the man was happy to be at Acklington and in a single cell. He maintained good eye contact throughout the review and understood what was said, his main concern being his insistence that he was innocent and should not be in prison. He was not permitted to have medication or razors in his cell, although he claimed that his thoughts of self-harm had reduced. He remained subject to the ACCT process, with a further review arranged for 1 September. A note was made to invite a representative from the mental health in-reach team, as well as the man's offender supervisor.

74. The next day, 29 August, an officer wrote in the man's wing history record that he was very depressed about the length of his sentence, had no family support, suffered from fits and memory loss, used a walking stick, and was to remain on the ground floor as it was more accessible. He described the man as "extremely vulnerable".

75. The fourth ACCT review took place on 1 September. The man was present, as were a senior officer, an officer and the chaplain. The senior officer reported that the man remained in a very low mood and could not accept his situation. He claimed to have no thoughts about harming himself, but might do so if he had the means and his mood was low. He remained subject to the ACCT process and a review was arranged for 8 September, with the CPN and chaplain invited.

76. The next day, the man's offender supervisor wrote a long entry in the man's offender management unit (OMU) record. (The OMU risk assesses prisoners, helps them to use their sentence constructively and liaises with community offender managers, previously known as probation officers.) The man's offender supervisor's entry was an overview of their induction meeting. He noted that the man was very bitter about the length of his sentence and continued to maintain his innocence. He had applied to start working in the engineering workshop, which he thought was a positive move.

77. On 2 September, a senior officer wrote in the ongoing record section of the ACCT document that he had seen the man standing in the association area of D wing, appearing disorientated. He escorted the man to his cell but was unsure if he had genuinely been taken ill or simply wanted attention. The senior officer wrote that he got the feeling the man was laughing at being asked questions and that he was "not quite sure what to make" of him.

78. An ACCT review (the fifth) took place on 8 September. In addition to the man, a senior officer, an officer and the chaplain attended. The senior officer wrote that the man was feeling much better and had no thoughts of self-harm. Everyone present agreed that it was appropriate to close the ACCT document. The senior officer explained that support was still available if he required it. A post-closure ACCT review meeting was arranged for 16 September.

79. An officer wrote in the wing history record on the morning of 12 September that the man had told him about a bad fit he had experienced the previous night. He said he saw flashing lights for around five minutes and was unsteady on his feet. As a result, the man saw a nurse and described the periodic episodes that he had experienced for the past seven months. He said he often saw flashing white lights for around five minutes but had experienced these symptoms for a number of hours during the previous night. The nurse noted that it was difficult to assess the man because of the possibility that he had dementia. On the same day, a further nurse wrote that the man had told her that investigations had been carried out into the cause of his episodes whilst he was in Durham. She noted that he had an appointment with a GP.

80. On 14 September, a nurse wrote in the clinical record that another nurse had completed an elderly assessment for the man. He was not forthcoming during the interview and seemed low in mood. She was unsure if he was being obstructive or suffering from memory loss. The nurse wrote that the man had a GP appointment and asked the doctor to assess any memory loss. However, there is nothing in the clinical record to suggest that this appointment took place.

81. The man's offender manager from the community visited Acklington on 16 September and met him and his current offender supervisor. He agreed to attend an alcohol awareness course and be assessed for a thinking skills programme (a group programme focusing on offending behaviour and avoiding it in the future). He also expressed an interest in going to education classes to spend more time out of his cell. Regarding his offence, the man continued to maintain his innocence.

82. On the same day, a senior officer, an officer and the man attended the ACCT post-closure review. The purpose of such a review is to examine what has happened since the closure of the ACCT, and to decide whether it should remain closed or be re-opened. The senior officer wrote that, although the

man was in a generally low mood, he had no thoughts of self-harm. The ACCT remained closed.

83. On 25 September, a nurse wrote in the clinical record that the man had refused to swallow his paracetamol tablets when the nurse gave them to him. Instead he had walked away from the treatment area with the tablets in his mouth. Unit officers searched his mouth and pockets but found nothing.

84. Three days later, 28 September, a nurse wrote in the clinical record that she was called to see the man after unit officers witnessed him having a fit. During interview with my investigator, the nurse explained that she had not witnessed the episode herself, and she conducted some simple tests (blood pressure, blood sugar level etc.) when she arrived. She thought that the man's blood pressure was slightly high, and that one of his pupils was slow to respond to light. She therefore asked for an ambulance to be called, and the man was admitted to outside hospital.

85. The next day, the nurse spoke to one of the officers who had accompanied the man to hospital. She was told that he was awaiting tests and would be discharged depending on the results. The man returned to Acklington that evening. A consultant physician at outside hospital wrote to the prison and explained that the results of the tests had been normal. They included a computerised tomography (CT) scan, which involves scanning a patient's head or body and producing an image that can be used to help diagnosis illnesses and conditions. The consultant physician suggested that there could be a cardiovascular cause to the man's symptoms and arranged an appointment for a 24-hour ECG.

86. The man attended an appointment with a doctor at Acklington on 30 September, who noted that he had not experienced any previous fits. (This was, of course, not the case.) She also noted that the man would soon have a CT head scan and tilt table testing. (Tilt table testing involves the patient lying on a special table whilst connected to an ECG. The table is then tilted so that the patient is in an upright position, and changes in blood pressure and heart rhythms are monitored.)

87. Two days later, a nurse saw the man at the request of unit officers. He reported having a couple of fits and an officer had seen him clutching his stomach as if in pain. The nurse noted that, whilst she was talking with the man, he seemed to have vacant episodes and admitted having memory problems. She wrote that he would need his elderly assessment reviewed and she would see him again the next week. The following day, 3 October, a nurse saw the man at the request of unit staff after he had what was described in the clinical record as a "funny turn". He was sitting on the floor of his cell, but declined healthcare input.

88. An entry was made in the man's clinical record about him failing to attend an appointment on 6 October, though there were no details about the nature of the appointment. The same day, the outside hospital the man was attending

sent a letter to Acklington asking the man to attend the cardiology department for 24-hour ECG monitoring on 15 October.

89. On 8 October, a nurse wrote that the man had been seen at the medication dispensing hatch, where he asked for paracetamol. He was told that it had been stopped and an appointment was made for him to see the doctor. One week later, a prison doctor noted in the clinical record that paracetamol had been restarted for general aches and pains, though did not specify why it had previously been stopped.

90. Although the man's hospital appointment on 15 October was registered on his clinical record, there is no indication whether or not he attended. However, on 21 October, the consultant physician at outside hospital wrote to the prison, saying he understood that the man had declined to attend. (The only mention of this in the clinical record was an entry almost a month later, which simply noted that the letter from the consultant physician had arrived.)

91. A nurse wrote in the man's clinical record on 21 October that she went to see him the previous night as unit officers reported that he had collapsed when sitting on his bed watching television. He told her that these episodes were happening four or five times per day. At the time of the assessment he looked well, although his blood pressure was slightly high. The nurse told the investigator that she made an appointment for the man to see a doctor the next day, although there is no evidence of this in the clinical record.

92. The next recorded appointment was on 26 October, when the man saw a prison doctor. He wrote about the man's "bizarre history" of brief but frequent episodes of going into what he described as "another world". He told the prison doctor that the episodes had only started since his arrival at Acklington and had not happened at Durham (though again, this was not the case, as he had complained of similar episodes throughout his time at Durham).

93. The next entry of any significance in the man's clinical record was some 19 days later, on 14 November. A nurse wrote that there was some question as to whether the man was being bullied for his medication. The man said this was not the case and would tell officers if it happened. No further context was given in the clinical record about how these concerns had come to light, and there is no corresponding entry in the wing history record.

94. On 19 December, an officer wrote in the wing history record that the man had settled well, spent most of his association time on the landing playing pool, and was treated with respect by other prisoners due to his age. On 2 January 2010, he wrote that the man "still plods on to every challenge daily life sets" and was always polite.

95. A nurse noted in the clinical record on 13 January that the man was given paracetamol for "general aches and pains". (This was the first entry in his clinical record for almost two months, the previous entry having been written on 14 November.) Four days later, an officer noted in the wing history record that the man looked "a bit down" but did not have any particular problems.

96. The man reported more fits on 27 January. He was seen by a nurse who wrote in the clinical record, in reference to the recent fits, that "nobody has seen him have one". (Previous fits had been witnessed; the nurse herself had reported on 28 September 2009 that unit officers had witnessed him experiencing a fit.) The nurse checked the man's blood pressure and pupil response. He asked for sleeping tablets and the nurse arranged a review with the GP. However, there is no evidence in the clinical record of such a review taking place.

97. The next day, the man moved to E wing as he had gained enhanced prisoner status and had additional privileges. On 31 January, an officer wrote in the wing history record:

> "Having been approached by one or two prisoners on the landing, who have said that [the man] had taken a funny turn and also they thought he might be depressed, I have spoken at length to him. He said (and this has been confirmed by healthcare) that he has been taking turns for a number of years now and despite a lot of medical tests they can find nothing wrong with him. Healthcare have also confirmed that he has a history of depression, but not of self-harm. [The man] has stated he has no thoughts of self-harm and does not want to talk to prison Listeners but I have asked landing staff to keep an eye on him. Unit manager informed."

98. A corresponding entry in the man's clinical record was made by a nurse. As he did not want any healthcare intervention, none was given, though unit staff were advised to contact the healthcare unit if they were concerned about him. This was the last entry in the man's clinical record until the day of his death, six weeks later.

99. During interview with my investigator, an officer spoke about his general impressions of the man. He said the man was significantly older than most of the other prisoners and, because of his age, the younger prisoners tended to treat him well and look after him. The officer said the man was generally quiet and kept himself to himself.

100. A senior officer described the man in similar terms. He said:

> "He was no problem on the unit. Everybody tended to treat him like a father figure, all the prisoners tended to just leave him alone and he just got on with his own thing. He sat a lot … in his cell, watching TV."

101. On 7 February, an officer wrote in the man's wing history record that he had settled well and was "keeping himself very much to himself up to now and rarely coming to the attention of staff". This was the last entry in his wing history record.

The eve of the man's death and the day of the man's death

102. After the man's death, an officer support grade (OSG) wrote a statement about his overnight shift on E wing on the eve/the day of the man's death. The OSG explained that he had carried out roll checks (counting all prisoners on the unit to check that they are present) at 9.00pm and 10.30pm on the eve of the man's death and at 5.30am on the day of his death. The OSG wrote:

> "This would mean that the last time I saw [the man] would have been around 5.30am and although regretfully I cannot recall exactly what [he] was doing at this time, I can assure you that if I had seen him in any form of pain, distress or anything else out of the ordinary, I would have taken appropriate action."

103. My investigator spoke to the three prisoners who were in the two cells adjacent to the man and the cell opposite, and asked if they had seen or heard anything untoward on the morning of the man's death. An inmate from the cell opposite the man did not see or hear anything, but had noticed that the man was often short of breath. Similarly a further inmate, from one of the adjacent cells, said the man frequently made noises, almost as if he were shouting, during the day and night. However, he did not hear anything that gave him cause for concern on the morning of the man's death. A further inmate, who was in the other adjacent cell, said the man suffered from frequent fits and made lots of noise. He went on to explain that at around 7.00am on the day of the man's death, he heard the man making a different noise which he described as "yelping". The inmate said that, although he had not heard the man make such a noise before, he often made other noises and so he did not alert members of staff to the situation.

104. During his interview with my investigator, an officer said he arrived at Acklington shortly after 7.00am on the day of the man's death and made his way to E wing to take over from the night staff. Having arrived on the unit at around 7.10am, he received a handover report from an OSG and then began to conduct a roll check of his own, to confirm that the number of prisoners was consistent with the earlier count. The officer explained that he started with one of the two ground floor landings, went upstairs to one of the first floor landings, across to the other first floor landing, and then downstairs to the second ground floor landing. The man was in cell E1-11, on the last landing to be checked.

105. When he reached the man's cell, the officer opened the observation flap and saw him "lying face down, fully clothed, over his bed … his legs were trailing the floor and his arms were straight down by his side, his hands were in a fist". This immediately struck the officer as something out of the ordinary, and he did not think it was a natural sleeping position. He tried to get the man's attention by calling out to him and kicking the cell door, but there was no response. He then shouted to a senior officer who was in the unit office approximately 30 feet away.

106. In his written statement and during his interview with my investigator, the senior officer explained that he arrived on E wing around 7.20am. As the senior officer, he was in charge of the wing for the duration of his shift. He was in the office whilst the officer was completing the roll check, and said that after a few minutes, he heard the officer shouting his name. The senior officer said he immediately thought something was wrong because it was unusual to be shouted in such a way during the roll count. He left the office immediately and arrived outside the man's cell around ten seconds later.

107. The senior officer looked through the observation panel and saw the man in the cell. He said it was not a comfortable or usual position for sleep, but he thought the man might have fainted or fallen asleep on the floor. He tried to raise a response but was unable to do so, and so opened the cell door and went into the cell. The senior officer felt the man's neck but did not detect a pulse. Due to restricted space in the cell, he and the officer moved the man into the corridor of E wing. (All other prisoners remained locked in their cells at this time.)

108. The senior officer and officer continued to check for signs of life. They could not find a pulse and the man did not appear to be breathing. The senior officer asked an officer who had just arrived on the unit to begin his shift, to call a 'code blue' using his radio. (This is the radio call sign that alerts the communications room to a serious, life-threatening situation, and usually indicates that someone has stopped breathing. When receiving a 'code blue' message, the communications room will ordinarily contact healthcare staff via the radio system to inform them of the need for medical assistance. In addition, a specific alert noise is sent to every radio in the prison to alert the staff to the situation.)

109. When they could not get a response from the man, the senior officer and officer began cardio-pulmonary resuscitation (CPR). The senior officer performed chest compressions whilst the officer administered mouth-to-mouth breathing. Both officers had received relevant training and felt confident in their ability to perform CPR effectively.

110. The officer said that, as he was performing CPR, he noticed that the man was still warm. Other members of staff began to arrive, and the senior officer asked them to stay back so that CPR could be carried out effectively and without distraction. The officer recalled that a defibrillator (a piece of medical equipment which is attached to a patient's chest and administers an electric shock if necessary) arrived but as nobody present was trained to use it, manual CPR continued.

111. Three nurses were all in the healthcare unit, discussing their work for the day ahead, when they received a message over their radios at approximately 7.30am, alerting them to the situation on E wing. The nurses immediately left the healthcare unit to attend, taking with them an oxygen cylinder and a bag containing emergency equipment. On their way to E wing, a further message was received over the radio, advising that a defibrillator was required. Although the nurses did not have this equipment with them at the time, all

three spoke during interviews with my investigator about the defibrillators in the treatment rooms of each residential unit, and so they would have access to one when they arrived at E wing. The radio message about the defibrillator made it clear to the nurses that they were responding to a very serious situation.

112. According to all three nurses, it took around four or five minutes for them to get from the healthcare unit to E wing. Upon arrival, they found the senior officer and officer performing CPR. One of the nurses attached the defibrillator to the man's chest and inserted a tube into his mouth to open his airway. The oxygen cylinder was attached to a squeezable bag which the nurse then used to artificially 'breathe' oxygen into the man's lungs using the tube that had been inserted.

113. The other two nurses performed chest compressions. The defibrillator attempted to find a heart rhythm (an electric shock can only work if there is electrical activity in the heart in a particular rhythm) but advised that this was not present and that manual chest compressions should continue. The nurses continued their efforts with CPR until paramedics arrived.

114. A report completed by the paramedics from the North East Ambulance Service Trust recorded the time of the 999 call as 7.35am. They arrived at the prison at 7.43am and were with the man two minutes later. He showed no signs of life, his pupils were fixed and dilated and he was not breathing. An ECG was attached to the man which showed that there was no heartbeat. CPR was discontinued at 7.57am when the paramedics declared that his "life was extinct". The man was moved back into his cell and the door was locked. A prison doctor pronounced his death at 8.40am.

115. The prison Governor ensured that representatives from the staff care and welfare team were in the prison. She spoke to and debriefed the members of staff who had been involved. This was done on an individual rather than group basis as the nurses had returned to the healthcare department and the officer who had carried out CPR went home.

116. At 8.40am, the prison Governor spoke to two prison family liaison officers about the man's death. There was no readily available information about his next of kin, although they were able to use the prison's old computer system to retrieve a name and address for his daughter. This had been supplied at the time of the man's previous term of imprisonment (he had been sentenced to two years for arson in 2005). One of the family liaison officers spent the next two hours contacting various people, such as police officers, healthcare, and the offender manager, in an attempt to verify the address for the man's daughter.

117. At 10.30am, the family liaison officers left the prison, arriving at the address at 1.00pm to find the property empty. After some investigation in the local area, they were able to find the new address for the man's daughter, and delivered the news of his death at 2.00pm. The family liaison officers remained in

contact with the man’s family for some time after his death, and the prison contributed to the funeral expenses.

118. A post-mortem examination found that the man died from ischaemic heart disease (reduced blood supply to the heart) caused by coronary artery atheroma (swelling in the artery walls which reduces blood flow).

119. The man’s funeral took place on 24 March and was attended by the prison Governor, a prison family liaison officer and the prison chaplain.

ISSUES

Clinical care

120. A review of the man's clinical care was carried out by a clinical reviewer from CCIS. She assessed the care he was given whilst he was at HMP Durham as well as at Acklington, where he died. The clinical reviewer concluded that the man's physical and mental health needs were met by the healthcare staff at Durham and Acklington and, when necessary, by referral to outside hospital.

Healthcare support at Durham

121. From the time of his reception into Durham, the man attended numerous appointments regarding his physical and mental health needs. Many related to his frequent collapses (see below for further information) and the various but unsuccessful attempts made to diagnose them. The clinical record was comprehensive and it was easy to see when the man had attended appointments, who he had seen, and the reasons for them.

122. The man was first referred to the mental health team in February 2009, shortly after he was remanded to Durham. However, due to various delays, he was not seen by a CPN until 18 May. After the original referral, an appointment was made for 26 February, though this only resulted in a further referral. The second referral was initially marked 'urgent', indicating that the appointment should take place within 48 hours, but was downgraded to 'routine', allowing seven working days for an appointment. This timescale was not met, and the man was actually seen 19 working days after the referral. However, the man did have two appointments with a consultant psychiatrist in the interim. Although the man himself received appropriate mental health support by way of his appointments with the consultant psychiatrist, Durham should ensure that referrals for CPN support are followed up promptly and within the published timescales. Although I do not make a recommendation in this regard, the healthcare manager will wish to assess the referral processes to ensure that delays like this do not occur.

123. Despite the man's ongoing medical treatment and uncertainty about the cause of his fits, it appears that healthcare staff at Durham did not provide a handover to their colleagues at Acklington. The man had been assessed by hospital specialists as well as prison healthcare staff. He may well have been 'fit for transfer' and his clinical record contained copious information, but the attempts to diagnose his fits should have been communicated directly to Acklington. Noting that there was no need to communicate any healthcare information to the receiving prison was, in my view, inaccurate and insufficient.

    The head of healthcare at Durham should ensure that up to date healthcare information is sent to each receiving prison, particularly regarding prisoners who are having continuing treatment or have undiagnosed symptoms.

Continuity of care at Acklington

124. Not surprisingly given the absence of handover information, the man's involvement with the healthcare team at Acklington was not nearly as extensive as had been the case at Durham. In particular, there was no evidence of ongoing mental health support following his transfer. He saw a psychiatrist at Durham twice, and had regular support from a CPN. This did not continue after his transfer, nor was there any assessment of what ongoing support, if any, might be required. This is particularly significant given that the man transferred to Acklington whilst subject to the ACCT process (the issue is covered in more detail below).

125. Although there was no handover, the man's extensive clinical record was available to staff at Acklington. There is little evidence, however, that it was read. With regard to the man's fits in particular, it sometimes seemed that Acklington staff were re-treading ground already covered at Durham. It also meant that information from the man, such as his statement that the fits started since he came to Acklington, were taken at face value even though they were well documented in the clinical record.

126. The clinical record at Acklington was not always particularly clear. After the man was taken to hospital on 28 September, he returned to the prison and attended an appointment with a doctor on 30 September. It was noted that the man would undergo a CT scan and tilt table testing, but there was nothing in the clinical record stating whether or not these tests took place. Additionally, a hospital appointment was made for 15 October for a 24-hour ECG, which the man apparently declined. The appointment itself was recorded, and more than a month later, when a letter from the hospital was scanned into the clinical record, a note was made that he had not attended. However, no mention was made at the time of the man's failure to attend the appointment and the reasons behind this, and neither was an alternative arranged.

Undiagnosed symptoms

127. It is clear that the man's reported fits were both puzzling and troubling to healthcare staff at Durham and Acklington, as well as to hospital specialists. The fits remained undiagnosed at the time of his death, and there was no real consensus about whether the cause was physiological or psychological.

128. The man complained of fits from the time he arrived at Durham. They were initially thought to be alcohol-related, and were later described as panic attacks. In searching for a physiological cause, both an ECG and EEG were carried out, but neither test provided any illumination.

129. Although no diagnosis was made, the fits certainly had the potential to cause injury. In June 2009, the man was taken to hospital after he fell from the top bunk whilst suffering from a fit. He was not seriously injured, and although it was recommended that he should be moved to a lower bunk, he eventually

returned to the same cell and bed. The clinical reviewer made the following recommendation, which I endorse.

The healthcare manager at Durham should ensure that risk assessments are undertaken and documented in a timelier manner for individuals with a history of seizures, to ensure that they are not placed at additional risk of injury.

130. After he transferred to Acklington, the man continued to suffer from fits, and efforts were again made to diagnose them. After an ECG in September 2009, an appointment was made for 24-hour ECG monitoring, though the man did not attend to have the device fitted. It is unclear whether or not a CT scan and tilt table tests were undertaken.

131. Members of healthcare staff treated the man as and when required. This was usually in response to concerns raised by other prisoners or members of staff. Their interventions, however, were limited because of the lack of a medical diagnosis.

132. In relation to this undiagnosed condition, the clinical reviewer made the following recommendation, which I endorse.

The healthcare managers at Durham and Acklington should ensure that staff undertake more robust care planning and adopt an assessment tool for individuals who have a history of seizures (including frequency, type, duration and warning signs).

133. The appointment for a 24-hour ECG was part of the attempt to diagnose the man's condition. However, this was impeded because he did not attend the appointment, having previously expressed concerns about attending hospital as a prisoner. I endorse the clinical reviewer's recommendation in this area.

The healthcare manager at Acklington should consider training members of staff to complete ECG recordings within the prison rather than using an outside hospital.

Assessment, Care in Custody and Teamwork (ACCT)

134. The ACCT process is intended to provide additional support and monitoring for prisoners who are considered to be at risk from self-harm or suicide. The process was started for this man at Durham on 19 August 2009 after an appointment with a CPN.

135. An assessment interview was conducted, and a plan was made to keep the man safe. His first ACCT review took place on the afternoon of 19 August. Although the officer who had completed his detailed assessment interview was present, the CPN was not. A note was made on the review form to invite her to the next review. This took place on 26 August, but again nobody was present from the mental health team. Again, a note was made to invite the CPN to the next review.

136. The man was transferred to Acklington on 28 August. There was no evidence in the ACCT document of the move being discussed with him beforehand. He was certainly aware of the impending transfer on 27 August, because he mentioned it to a member of staff, but the way in which he was initially told was not recorded.

137. Prison Service Orders (PSOs) provide instructions to prisons about procedures that must be followed. PSO 2700 relates to suicide prevention and self-harm management. In terms of transferring prisoners who are subject to the ACCT process, paragraph 15.7.3 states that "the proposed transfer, and issues arising from it, must be discussed at a case review with the prisoner". Paragraph 15.7.4 goes on to say that "the prisoner should be given information about the regime and facilities of the new environment". The man had an ACCT review on 26 August, two days before his transfer, but there was no mention of the transfer on the review form and therefore no indication that it was discussed. Although he was told about the transfer in advance of it happening, there was nothing in the ACCT document to indicate when he was told and whether he was made aware of Acklington's regime and facilities.

The Safer Custody manager at Durham should ensure that, in accordance with PSO 2700, transfers are discussed with prisoners during ACCT reviews.

138. Paragraph 15.7.2 of the same PSO covers the actions that prisons should take in advance of prisoners being transferred. It states:

> "The intention to transfer a prisoner on an open ACCT Plan … must be discussed with the receiving establishment, a record must be retained in the sending establishment to show this has been done (as well a record [sic] made in the ACCT Plan), and relevant information must be conveyed either with or ahead of the prisoner."

139. On 27 August, an email was sent from a member of staff at Durham to a member of staff at Acklington. The member of staff at Durham explained that the man would be transferring to Acklington the next day, and that he was subject to ACCT. On 28 August, an officer (at Durham) wrote in the ongoing record of the man's ACCT document that he had spoken to the Safer Custody office at Acklington and confirmed that an ACCT review would be carried out upon the man's arrival. However, at this point the man had already left Durham and was on his way to Acklington. There was no evidence of any other discussion between staff at Durham and Acklington about the man's transfer.

The Safer Custody manager at Durham should ensure that, in accordance with PSO 2700, discussions about transferring prisoners subject to the ACCT process take place with the receiving establishment in advance of the transfer.

140. An ACCT review took place at Acklington on the day of the man's arrival. In addition to unit staff, it was attended by a member of the healthcare team and one of the prison chaplains. Further reviews took place on 1 and 8 September. Both reviews noted that a CPN should be invited to the next review, although this did not seem to happen.

141. On 8 September, the man's ACCT document was closed. A post-closure review took place eight days later. Based on the reviews that had taken place, and the post-closure review form, there is no reason to conclude that this decision was anything other than reasonable.

142. The ACCT review forms at both Durham and Acklington included notes about inviting mental health staff, although this did not happen. I therefore make the following recommendation to both establishments:

The Safer Custody managers at Durham and Acklington should ensure that ACCT reviews are multi-disciplinary wherever possible, and that mental health professionals attend particularly when the prisoner is being treated by their team.

Emergency response

143. When an officer saw the man on the morning of his death, he immediately alerted the senior officer. The response was swift; the officer and senior officer started CPR, and three nurses from the healthcare unit reached the man within a few minutes. Attempts at CPR continued uninterrupted until the paramedics arrived.

144. A defibrillator arrived before the nurses, but was not used initially because nobody present was trained in its use. When the nurses arrived, they attached the defibrillator to the man. It did not find a suitable heart rhythm and so did not administer a shock. During interview with my investigator, one of the nurses who performed chest compressions on the man emphasised the importance of using a defibrillator as early as possible to maximise the chance of resuscitation.

145. It is good practice for Acklington to have defibrillators on the residential units where they can be accessed by prison officers as well as medical staff. However, if the equipment is to be useful, members of staff need to be trained in how to use them. I am pleased that, on 17 May 2010, the liaison for the Ombudsman's office told my investigator that 35 members of staff of various grades were trained to use defibrillators. A further 37 had also expressed interest in undertaking such training. The liaison for the Ombudsman's office intends to arrange further training, to be delivered by the North East Ambulance Service, and so I do not make a recommendation on the matter.

146. Overall, the emergency response on the day of the man's death was quick and professional. Despite sustained and valiant efforts by the members of staff involved, resuscitation was not successful.

Issues raised by the man's family

147. At 7.25am on the morning of his death, the man was found fully dressed and lying in an unusual position in his cell. His daughter asked if he had tried to summon help earlier in the morning.

148. All cells have an alarm bell which prisoners can use to alert members of staff that they require attention. The alarm bells are linked to a computer system which automatically records the date and time at which they are activated. My investigator obtained the records for the man's cell, which showed that he did not activate his cell alarm bell on the morning of his death. My investigator also looked at the records for the cells adjacent to the man's cell, and found that none of these alarm bells were activated either

149. An inmate who was in one of the adjacent cells said he heard the man making noises around 7.00am on the morning of his death. He said that although he had not heard these particular noises before, it was not unusual for the man to make noises during the day and night. He did not attempt to contact anyone at the time of hearing the noises, but told members of staff what he had heard after he learned of the man's death.

CONCLUSION

150. The man appeared in court in February 2009 and was remanded to HMP Durham. He attended numerous healthcare appointments for both physical and mental health issues, and had ongoing support from a CPN and a consultant psychiatrist. The clinical reviewer concluded that the man's physical and mental health needs were met by the healthcare staff at Durham and Acklington and, when necessary, by referral to outside hospital.

151. In terms of his physical health issues, the man regularly told staff that he experienced fits several times a day. Despite numerous tests being carried out, the cause of the fits remained undiagnosed. Whilst both prisons took his complaints seriously, Acklington staff would have benefited from a handover from Durham and from paying closer attention to the healthcare records which accompanied him.

152. In August 2009, the ACCT process was started after the man said he felt like harming or killing himself. On 28 August, he was transferred to HMP Acklington whilst remaining subject to the ACCT process. This was discontinued on 8 September after a review meeting. Although I am pleased that the man remained safe throughout, I am concerned that the transfer between prisons seems to have happened without sufficient joint planning beforehand.

153. The man was found collapsed in his cell on the morning of his death. Despite sustained attempts at resuscitation, he could not be revived. A post-mortem examination found that he died from ischaemic heart disease (reduced blood supply to the heart) caused by coronary artery atheroma (swelling in the artery walls which reduces blood flow). The man was 64 years old at the time of his death.

RECOMMENDATIONS

Healthcare:

1. The head of healthcare at Durham should ensure that up to date healthcare information is sent to each receiving prison, particularly regarding prisoners who are having continuing treatment or have undiagnosed symptoms.

   The recommendation was accepted. Durham stated that current practice was to provide medical records for each transferring prisoner.

2. The healthcare manager at Durham should ensure that risk assessments are undertaken and documented in a timelier manner for individuals with a history of seizures, to ensure that they are not placed at additional risk of injury.

   The recommendation was accepted. Healthcare staff will be reminded of the potential injury risks associated with seizures. Such medical information will be gathered at initial health screenings, and members of staff will clearly identify prisoners who should be located on the ground floor and/or in a lower bunk.

3. The healthcare managers at Durham and Acklington should ensure that staff undertake more robust care planning and adopt an assessment tool for individuals who have a history of seizures (including frequency, type, duration and warning signs).

   The recommendation was accepted by both Durham and Acklington. Durham will liaise with specialist services regarding existing assessment tools for prisoners who experience seizures. Acklington has developed an assessment tool for prisoners presenting with clinical symptoms that require further assessment and monitoring. Care plans will be introduced where warranted by a prisoner's condition.

4. The healthcare manager at Acklington should consider training members of staff to complete ECG recordings within the prison rather than using an outside hospital.

   The recommendation was accepted. Acklington's medical staff are trained in performing ECGs, although this will be updated through training.

Assessment, Care in Custody and Teamwork (ACCT):

5. The Safer Custody manager at Durham should ensure that, in accordance with PSO 2700, transfers are discussed with prisoners during ACCT reviews.

   The recommendation was accepted. Prisoners subject to ACCT who are pending transfer to another establishment will have a review in the 24 hours before the transfer. During this review, the prisoner will be provided with all relevant information about the transfer.

6. The Safer Custody manager at Durham should ensure that, in accordance with PSO 2700, discussions about transferring prisoners subject to the ACCT process take place with the receiving establishment in advance of the transfer.

   The recommendation was accepted. All Safer Custody staff are aware of the issue and will ensure that receiving establishments have, in advance of transfers, relevant information about prisoners subject to ACCT.

7. The Safer Custody managers at Durham and Acklington should ensure that ACCT reviews are multi-disciplinary wherever possible, and that mental health professionals attend particularly when the prisoner is being treated by their team.

   The recommendation was accepted by Durham. All members of staff there were informed of the correct procedures of management and support for prisoners subject to ACCT. It will also be reiterated at all ACCT foundation and case manager training events.

   At the time of issuing this final report, a response from Acklington regarding this recommendation had not been received.