PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in July 2013 at HMP Northumberland

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man in July 2013, at HMP Northumberland. He was 50 years old and died from heart disease. I offer my condolences to his family and friends.

A clinical review of the medical care the man received was undertaken. HMP Northumberland cooperated fully with this investigation.

The man had been in prison since January 2006 and transferred to what was then HMP Acklington in April 2006 after receiving an indeterminate sentence for public protection. He suffered from mental illness, had a history of self-harm and had previously attempted suicide. He had extensive interaction with the prison's mental health team and the visiting consultant psychiatrist. From December 2011 to May 2012, he received psychiatric treatment at a medium secure hospital. In September 2012, he spent four days in hospital after he took an overdose of his medication. He had frequent mental health reviews but declined well-being physical health checks.

One morning in July 2013, the man was found unconscious in his cell. Staff responded immediately, but an ambulance was not called automatically as emergency procedures require. Appropriately, the experienced nurse who attended did not attempt to resuscitate him as it was clear that he had been dead for some time.

I am satisfied that the man received a good standard of healthcare at the prison and had very good access to mental health services. There is no evidence that his death was either foreseeable or preventable. However, the investigation does identify the need for HMP Northumberland to bring its emergency procedures in line with national instructions.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2014**

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SUMMARY

1. The man was remanded in custody at HMP Durham for robbery on 13 January 2006. He had a history of mental illness, alcohol abuse, self-harm and had previously attempted suicide. On 10 March, he was sentenced to an indeterminate sentence for public protection. On 1 April 2006, he transferred to HMP Acklington, which later became HMP Northumberland. During his time at the prison, he had extensive interventions with the mental health team and the visiting consultant psychiatrist.

2. On 14 December 2011, the man was transferred to a medium secure unit at a hospital in Newcastle-upon-Tyne for psychiatric treatment. He remained there until 4 April 2012, when he was discharged back to the prison when his treatment was completed.

3. On 13 September 2012, the man took an overdose of his medication and was in hospital for four days. He was monitored as a risk of suicide and self-harm for two weeks after he returned from hospital. He continued to have regular mental health reviews but declined physical well-being health checks.

4. One morning in July the man was found unresponsive and not breathing in his cell. The officer who found him immediately called an emergency on his radio but there was a delay in calling an ambulance. A nurse attended very quickly but decided not to attempt resuscitation as it was clear that he had been dead for some time. When the paramedics arrived they confirmed that he had died.

5. The investigation found that the man received a good standard of care at the prison and his sudden death could not have been predicted or prevented. Although it would not have made a difference for him, who had evidently been dead for some time when he was found unresponsive in his cell, there is a need for the prison to adhere to emergency procedures and call an ambulance immediately an emergency code is called. As in a previous investigation into a death at HMP Northumberland, we found that staff involved in the emergency did not all complete incident reports as they are required to do.

THE INVESTIGATION PROCESS

6. The investigator visited Northumberland on 10 July 2013 and obtained relevant records about the man. Notices were issued to staff and prisoners inviting anyone with information to contact the investigator. Two prisoners came forward as a result. He met the Governor and subsequently interviewed seven members of staff and two prisoners. On 14 August, he fed back his initial findings in person to the Governor.

7. NHS England appointed a clinical reviewer to review the man's clinical care at the prison.

8. The investigator contacted Her Majesty's Coroner to inform him of the investigation and request a copy of the post-mortem report. This investigation report has been sent to the Coroner.

9. One of our family liaison officers contacted the man's family to inform them about the investigation and to invite them to identify issues which they wanted the investigation to consider. The family had the following questions:

    - Should he have been in his cell between 1.30pm and 4.00pm on the day of his death without anyone seeing him?
    - What checks were done that afternoon?
    - Was he the victim of an assault?

    Details of what happened on the afternoon of his death are contained on the key events section of the report. The investigation found no evidence that he was the victim of an assault. The family received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP NORTHUMBERLAND

10. The merger of two separate prisons, HMP Acklington and HMYOI Castington was announced in 2010 and work began to integrate all of the functions in April 2011. On 31 October 2011, the merged prisons became known as HMP Northumberland. HMP Northumberland can accommodate more than 1,300 adult male prisoners. The man lived in the part of the prison which was formerly HMP Acklington. Care UK, a private company, provides health services at the prison.

Her Majesty's Inspectorate of Prisons

11. Her Majesty's Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Northumberland in June 2012. In their report, inspectors said that the amalgamation of the two prisons had gone well and were impressed with the energetic and committed management team. The report said that healthcare provision was reasonable and the care of patients with lifelong conditions such as asthma, diabetes and heart disease was good.

12. Inspectors found that most mental health referrals originated from uniformed officers and the prisoners referred were seen by a member of the mental health team within 48 hours. Assessments were discussed at a weekly mental health meeting. Patients with complex mental health problems were reviewed regularly by a visiting psychiatrist and those with long-term or enduring illnesses were managed using the care programme approach.

13. Inspectors found that the management of prisoners at risk of self-harm was reasonably good and that there were comprehensive investigations after incidents of serious self-harm.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its 2012 annual report, the IMB noted that prisoners had long waits before and after medical appointments, and that waiting rooms were crowded.

Previous deaths at Northumberland

15. The man's death was the first to occur at the prison in 2013. There were three deaths in 2012, two of which were self-inflicted. There are no similarities with the circumstances of his death, although we repeat previous concerns about checking prisoners when unlocking cells and the need for staff to complete incident reports after a death at the prison.

KEY EVENTS

16. The man was diagnosed with paranoid schizophrenia, had a history of alcohol and solvent abuse and a history of self-harm and attempted suicide. He had criminal convictions dating back to 1978.

17. On 13 January 2006, the man was remanded to custody at HMP Durham charged with robbery. On 14 January 2006, he was monitored as a risk of suicide and self-harm for two weeks after he took an overdose of his medication. On 10 March, he was given an indeterminate sentence for public protection, with a minimum period to serve of three years before he could be considered for release. (After the minimum period has been served the Parole Board can direct release only if it is satisfied that it is no longer necessary for the protection of the public for the prisoner to be detained.)

18. On 1 April 2006, the man transferred to what was then HMP Acklington. While at the prison, he had extensive input from the mental health team and the visiting psychiatrist.

19. On 14 December 2011, the psychiatrist arranged for the man to be admitted to the medium secure unit at a hospital under the Mental Health Act for further treatment and management of his condition. He stayed there until 4 May 2012. When he returned to the prison, he continued to receive extensive support from the mental health team and the psychiatrist. He was assessed as being unsuitable to undertake any work because of his mental illness and spent most of his time in his cell on Houseblock 7 or with the prisoner in the cell next door.

20. On 13 September 2012, the man took an overdose of his medication and spent four days in hospital. He was monitored under suicide and self-harm prevention procedures for two weeks after he returned to the prison. He was no longer allowed to keep his medication in possession and had to take it supervised by healthcare staff. At the time, he was prescribed a zuclopenthixol injection, given every two weeks (for schizophrenia), citalopram (for depression), orphenadrine (a muscle relaxant) and lansaprazole (for gastric conditions).

21. Between 29 September 2012 and 3 July 2013, the man continued to have regular interventions from the mental heath team. His medication remained unchanged. During this period, he was offered three appointments for a well-man check but he chose not to attend. He also declined to attend two appointments with the dentist and one optician’s appointment.

22. On 6 June 2013, a member of the mental health team began suicide and self-harm monitoring after the man threatened to kill himself when the decision of a Parole Board hearing, which was due to be received that month, was deferred until September. This was to allow time for a mental health plan to be devised that could facilitate his release back into the community. The monitoring ended four days later.

23. Prisoner A, a friend of the man's at the prison, told the investigator that he had last seen him on 3 July during the evening association period. He said that the man was stressed because of his position as an indeterminate sentenced prisoner and about having to waiting for a Parole Board hearing about his release. Otherwise, the prisoner said he was laughing and joking as usual.

24. On 4 July, the man was given his medication in the morning and afternoon at the treatment hatch. Prisoner B, who had the cell next to him, said that he saw him just after 12.00pm, when the man lit his cigarette for him. He told the investigator that he seemed fine at the time. During the afternoon, the man stayed in his cell. An officer conducted a roll check at 4.00pm that afternoon and did not record any issues about him. (Roll checks are conducted five times each day for security purposes when staff are required to account for all prisoners by checking that each prisoner is in his cell.)

25. Prisoners were unlocked for their evening meal later than usual that day, at 5.40pm rather than 5.15pm, due to an inaccurate roll count in another part of the prison. Two officers unlocked the cells on landings three and fours and then supervised the prisoners as they went to collect their meals. Officer A unlocked the man's cell.

26. Prisoner B said that after he was unlocked he went straight to the man's cell, but could not see him at first. He then saw him on the floor. He said that he did not seem to be breathing. He was wearing a tee-shirt and shorts and he noted that his legs and arms were blue.

27. Officer B told the investigator that Prisoner B was standing outside the man's cell when he asked him to come over. Both officers went straight to the cell and saw him lying face down on the floor. Officer B went into the cell, turned him over and found that his face was purple and arms rigid. Officer A radioed an emergency code blue. This should alert healthcare staff that a prisoner is unconscious or has breathing difficulties and should prompt the control room to call an emergency ambulance immediately. The control room log shows that the code blue call was made at 5.41pm but the 999 call for an ambulance was not made until 5.45pm.

28. A nurse was in the treatment room on Houseblock 7 when she heard the code blue call over the radio. She took the emergency response equipment, which was in the treatment room, and arrived at the man's cell in less than 60 seconds. She examined him and found he had no carotid pulse, his pupils were fixed and dilated and he was cold to touch. There were also signs of rigor mortis and post-mortem staining (both are physical signs that death has occurred).

29. The nurse told the investigator that based on her examination of the man, and her 25 years experience as a nurse, it was clear to her that he had been dead for some time and that a resuscitation attempt would be inappropriate. The paramedics arrived at 5.55pm and, at 6.03pm, confirmed that he had died.

Contact with the man's family

30. Later that evening, prison family liaison officers went to break the news of the man's death in person to his mother, who lived Sunderland. Over the following days the prison maintained contact with his family to provide ongoing support. Financial assistance towards the funeral expenses was offered in line with national guidance.

Support for staff and prisoners

31. A debrief was held on the evening of the man's death for staff involved in the emergency response to discuss what had happened and to offer support. The services of the care team were made available.

32. Officers and members of the chaplaincy were available to support prisoners affected by the incident. Both prisoners confirmed that they had been offered support. Prisoners subject to suicide and self-harm monitoring were reviewed in case they had been adversely affected by the death.

Post-mortem examination

33. A post-mortem examination carried out on 6 July 2013 showed that the man's cause of death was ischaemic heart disease caused by coronary artery atheroma (fatty deposits in the artery which supplies blood to the heart).

ISSUES

Clinical Care

34. The clinical reviewer found that the man received a standard of mental health care that was equivalent, if not better, than the standard those with similar mental health problems in the community could expect to receive. He reported that there was excellent continuity of care provided by the mental health team, especially given the complex nature of his mental illness. He chose not to accept general health assessment checks and appointments with the dentist and optician, but the opportunity was there.

Unlock procedures

35. The man had collected his lunch earlier on 4 July and was apparently well at that time. An afternoon roll count was completed at 4.00pm. Such checks are for security reasons to establish that the correct number of prisoners is present rather than to check on prisoners' welfare. Prison staff conducting roll checks are expected to check that the prisoner is in their cell and get a clear view of their face, but they are not required to get a response from prisoners unless they notice anything which causes them concern, for example that the prisoner does not appear to be breathing. Officers would be expected to note if there was anything untoward – such as if he had been lying on the floor at the time. The officer who completed the 4.00pm check did not identify any concerns.

36. The man was not discovered immediately when his cell was unlocked for the evening meal because the officer did not look into the cell or try to get a response from him. For their own safety, officers are supposed to make contact with a prisoner through the observation hatch before opening a locked cell door. At unlock they should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".

37. Northumberland's Local Security Strategy specifies that staff should interact with prisoners when unlocking cells but it is apparent that this was not done. This led to the man being found by another prisoner. While it was too late to save him, in other cases this could lead to a delay in treating a seriously ill prisoner. After his death, a Governor's Order was issued to remind staff of their responsibilities. We have previously made a recommendation to the prison about this matter in an investigation report issued in January 2013. We repeat the recommendation:

    The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Emergency response

38. The man was found unresponsive at approximately 5.40pm. A nurse responded immediately but did not attempt cardiopulmonary resuscitation (CPR) as she found evidence of rigor mortis and post-mortem staining which indicated that he had been dead for some time. He said in his report that the decision not to commence CPR was appropriate. We agree that the decision not to try to resuscitate was correct as to do so would have been futile. Staff treated him with dignity and respect.

39. The prison records show that there was a four minute delay between the code Blue radio message being made and the call made to request an emergency ambulance. Prison Service Instruction (PSI) 03/2013 (Medical Emergency Response Codes), which came into effect on 28 February 2013, gives instructions to staff about communicating the nature of a medical emergency and ensuring there are no delays in calling ambulances. Paragraph 5.4 requires the following mandatory action to be taken:

    "When the emergency is called over the radio network an ambulance must be called immediately."

40. The PSI is clear that an ambulance should be called immediately and that each prison should have a medical emergency response code based on the instruction. HMP Northumberland's guidance on dealing with a medical emergency rather surprisingly is contained in an instruction entitled "Death In Custody". The guidance was issued on 25 June 2013 and staff are instructed to raise the alarm immediately in an emergency, which Officer A did. The guidance then states that the communications officer should "call ambulance and inform gate to allow entry of ambulance/paramedics". This was not done automatically as the PSI requires and a delay of four minutes is too long. While in this case a delay in calling an ambulance for the man made no difference to the outcome, in other cases this could be crucial. We make the following recommendation:

    The Governor should ensure that, in line with PSI 03/2013, an ambulance is called automatically as soon as an emergency code is called.

Actions following a death in custody

41. PSI 64/2011 'Management of prisoners at risk of harm to self, to others and from others (Safer Custody)' sets out the actions that staff should undertake following a death in custody. Chapter 12 of the PSI specifically states (the italics mean that the action is mandatory):

    "Staff directly involved in the incident, particularly those who were first on scene, must complete Incident Report Forms as soon as is practicable."

42. After the man's death, staff involved in the emergency incident were not asked to complete an incident report form. This is not the first occasion where staff at Northumberland have not completed incident reports after a death at the prison.

We have previously made recommendations to the Governor to ensure that staff comply with the national instruction. We repeat the following recommendation:

The Governor must ensure that staff directly involved a death in custody complete incident report forms.

RECOMMENDATIONS

1. The Governor should ensure that an ambulance is called automatically when an emergency code is called.

2. The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

3. The Governor must ensure that staff directly involved a death in custody complete incident report forms.

ACTION PLAN: The Man – HMP Northumberland

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1.	The Governor should ensure that an ambulance is called automatically when an emergency code is called.	Accepted	Governors Order 04/2013 was issued on 29/11/2013 in Staff Bulletin 46/2013, highlighting the importance of following the instructions in PSI 03/2013 Medical Emergency Response Codes, and explaining the correct process for automatically calling for an ambulance when an emergency code is called.	Completed The Director	July 2014
2.	The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.	Accepted	Governors Order 04/2013 was issued on 29/11/2013 in Staff Bulletin 46/2013, explaining that when a cell door is unlocked, staff must satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention during unlock.	Completed The Director	July 2014
3.	The Governor must ensure that staff directly involved in a death in custody complete incident report forms.	Accepted	Governors Order 05/2013 was issued on 29/11/2013 in Staff Bulletin 46/2013, explaining the importance of submitting incident reports/statements after a 'Death in Custody' incident. Local contingencies now include a reminder to all managers of the importance of collating 'incident reports' after a Death in Custody.	Completed The Director	July 2014