A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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

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, who was found hanging in his cell at HMP Northumberland in August 2013. He was 52 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at the prison was conducted. The prison cooperated fully with the investigation.

The man was sentenced to life imprisonment in 2004. He had previously been treated for mental health problems and had a chronic back condition for which he was prescribed pain killers. Although he had a history of depression and self-harm, he had not attempted to harm himself since 2010 and had never shown any symptoms of mental distress at Northumberland.

In August an officer unlocked the man's cell but did not check on his wellbeing. Shortly afterwards, a prisoner discovered him with a ligature around his neck, formed from the cable of a vacuum cleaner. He was a wing cleaner and had kept the vacuum cleaner in his cell for some months. Prison and healthcare staff responded quickly, but did not attempt resuscitation as it was apparent that he had been dead for some time.

While it is regrettable that the man appears to have been allowed to store a vacuum cleaner in his cell, the significance of this should not be overstated as staff did not regard him as at risk of suicide and, in any case, other items in his cell could have been used as a ligature. We do not know the reasons for his actions, although he had disclosed to another prisoner that he was worried about a forthcoming parole review and that he was being coerced by other prisoners into giving away his medication. While he had not disclosed this suggestion of bullying to staff, he was worried that a check on his medication the day before he died had found that some was missing and that there might be disciplinary consequences. Nonetheless, he did not appear particularly distressed to staff or other prisoners who saw him the day before he died and it would have been difficult for staff to have predicted or prevented his actions.

Finally, I must express particular concern that once again I have had to criticise the adequacy of unlocking procedures for prisoners at HMP Northumberland. Officers are evidently still not checking prisoners for signs of life when opening their cells, a matter I have raised with the prison twice before in the last year and which must now be addressed as a matter of urgency.

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 **September 2014**

CONTENTS

Summary

The investigation process

HMP Northumberland

Key events

Issues

Recommendation

SUMMARY

1. The man was sentenced to life imprisonment for murder on 31 March 2004. He had a history of mental health problems, including post-traumatic stress, depression and anxiety. He had previously attempted to take his own life several times. He had a chronic back problem for which he had been prescribed strong pain relief.

2. The man transferred to HMP Northumberland in November 2010. He later moved to house block 8, a unit for prisoners on an enhanced regime. He worked as a landing cleaner and kept the wing vacuum cleaner in his cell. Other prisoners said that an officer had given him permission for this. However, officers said that they were unaware of this practice and that they had not noticed the vacuum cleaner in his cell, despite carrying out daily checks.

3. In May 2013, the man had a difficult interview with his offender supervisor about a parole review. Afterwards, he told another prisoner that he believed he would 'never get out of prison' and that this had played on his mind.

4. The man was reliant on pain relief for his chronic back pain and he was allowed to keep his medication in his cell. During the investigation, one of his friends alleged that he had been being bullied for his medication by other prisoners and he had been stressed and anxious about this. On 24 August, a member of the healthcare department conducted a medication check and found that some of his tablets were missing. He told other prisoners that he was worried about the implications of this for him.

5. At 4.20pm, around an hour after the medication check and just before he was locked in his cell for the night, the man spoke to other prisoners who noticed nothing unusual about him. He told the officer who locked his cell that he would see him in the morning. The officer who checked prisoners between 5.30am and 6.00am the next morning noticed nothing untoward.

6. At around 8.15am, an officer unlocked prisoners for breakfast. He did not see the man and assumed he was in the shower area of the cell. A few minutes later, a prisoner discovered that he had hanged himself in his cell. He had used the cable from a vacuum cleaner as a ligature, secured between the shower door and the wall. Prison officers and a nurse responded quickly, but did not attempt resuscitation as it was clear that he was dead. As there were signs of rigor mortis, we are satisfied this was appropriate.

7. The man was able to store a vacuum cleaner in his cell contrary to the proper arrangements. While it is a concern that he was then able to use the vacuum cleaner cable as a ligature, we recognise that he had access to many other items which he could have used to hang

himself. We consider it would have been difficult for prison staff to have predicted and prevented his actions. We repeat a recommendation that we have made to Northumberland twice previously about the need for staff to ensure the safety and wellbeing of prisoners when they unlock cells.

THE INVESTIGATION PROCESS

8. Notices were issued to staff and prisoners at HMP Northumberland, informing them of the investigation and inviting anyone who had relevant information to contact the investigator. Two prisoners responded.

9. The investigator visited HMP Northumberland on 3 September and spoke to one prisoner. She obtained copies of the man's prison and medical records and visited house block 8. She interviewed staff and a prisoner at HMP Northumberland and briefed the Deputy Governor about her initial findings.

10. North East Offender Health commissioned a clinical reviewer to review the man's clinical care at the prison.

11. HM Coroner for Northumberland was informed of the investigation and provided the results of the post-mortem examination. This report has been sent to the Coroner.

12. One of the Ombudsman's family liaison officers contacted the man's sister and daughter to explain the investigation process. His family raised the following concerns:

    - The man had written to his sister about being upset after a meeting with his offender supervisor, in which he had been given information that made him believe that he was not going to get parole. He felt his questions had not really been answered

    - His sister said it was quite common for him to have down periods during his time in prison, and then he would bounce back again. She had spoken to her brother on 18 August and he had seemed happier as was his usual pattern. She asked if something had happened before his death which had affected his mental health

    - His daughter asked if her father had left any letters in his cell

13. The man's family received a copy of the draft report. They raised some questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

14. The service also received a copy of the draft report. They did not raise any factual inaccuracies and an action plan in respect of the recommendation is attached.

HMP NORTHUMBERLAND

15. HMP Northumberland was formed in 2011 by the merger of two separate prisons, HMP Acklington and HMYOI Castington. The prison can accommodate more than 1,300 adult male prisoners. The man lived in the part of the prison which was formerly HMP Acklington. Since 1 December 2013, the prison has been managed by Sodexo Justice Services and another private company, Care UK, provides health services at the prison.

Her Majesty's Inspectorate of Prisons

16. The most recent inspection at HMP Northumberland was in June 2012. Inspectors found that the amalgamation of the two prisons had gone well. They assessed the healthcare provision as reasonable and the care of patients with lifelong conditions such as asthma, diabetes and heart disease was good. 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.

17. The Inspectorate concluded that the management of prisoners at risk of suicide and self-harm was reasonably good and that there were comprehensive investigations after incidents of serious self-harm.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for 2012, the IMB noted that prisoners waited a long time before and after medical appointments and waiting rooms were crowded.

Previous deaths

19. The man's death was the second of three at Northumberland in 2013. There had also been three deaths in 2012, of which two were self-inflicted. We repeat previous concerns about checking prisoners when unlocking cells.

KEY EVENTS

20. The man was convicted of murder on 31 March 2004. He was sentenced to life imprisonment with a minimum period to serve of ten years before he could be considered for release. He had previously served in the armed forces and had been diagnosed with post-traumatic stress, migraines and depression. He had attempted to take his own life several times by various methods. He also had a history of violence. In 2001, he was seriously assaulted and sustained severe head injuries. This had impacted on his mental and physical health.

21. The man spent time in HMP Holme House and HMP Liverpool before transferring to HMP Garth in February 2007. He was under the care of the mental health team at Garth and he was prescribed mirtazapine (an anti-depressant with a sedative effect) and co-codamol (strong pain relief), for chronic back pain.

22. On 15 March 2010, the man took an overdose of anti-depressants. He said he was being bullied on the wing and that he had been upset that his transfer to a prison nearer his family had been delayed. He was monitored under suicide and self-harm prevention procedures until 30 March and spent eight days as a patient in the healthcare unit. When he returned to his residential wing, the mental health team continued to support him.

23. The man transferred to HMP Acklington (which later became HMP Northumberland) on 17 November 2010. At his reception health screen, it was noted that he had a history of depression and self-harm, but had no current thoughts of self-harm or suicide. He was not referred to the mental health team and received no further mental health input. The prison GP reviewed his prescription of mirtazapine and reduced it over a period of time.

24. In September 2012, after a reorganisation of accommodation, the man moved to cell 4 on the second landing of house block 8. This block was for prisoners on the enhanced level of the prison's incentives and earned privileges scheme (a system to reward good behaviour). He had a single cell with his own shower and sanitation facilities. He had psoriasis and routinely had a shower at around 9.30am each day after he had finished his morning duties as a landing cleaner. He had a few close friends, but mostly preferred to keep his own company and often remained in his cell.

25. Every morning after breakfast, the man cleaned the landing using the wing vacuum cleaner. This equipment should be collected from a locked store cupboard on the first floor landing. However, prisoners said that an officer had given him permission to keep the vacuum cleaner in his cell. Prisoner A, who lived in the cell opposite him, said that he had done so for at least five months. The man had told him

that he used to collect it from the cupboard on another floor, but because of his bad back an officer had given him permission to keep it in his cell. Other officers had accepted this when they conducted fabric checks.

26. On 17 January 2013, a doctor reviewed the man's medication and reduced the dose of mirtazapine and kept co-codamol the same at two 500mg tablets four times a day. He asked to stop taking mirtazapine in February 2013 and the doctor advised him to inform healthcare staff if his depressive symptoms returned. He continued to take co-codamol for his back pain. His medication was issued weekly and he was allowed to keep it in his cell.

27. The man was due to have a Parole Board hearing in February 2014 to determine his suitability for release. An independent psychiatric assessment was required before the parole process for this review could begin at the end of August 2013. In 2010, the Parole Board had been unable to consider a progressive move as there had been no psychiatric report and he became concerned about the continued delay in arranging his psychiatric assessment. His offender supervisor told the investigator that the man had submitted three written complaints. His offender supervisor had replied to explain that the delay had been caused by funding issues and sending medical information to the psychiatrist, but assured him that the psychiatric report would be completed in time for consideration by the Parole Board.

28. On 17 May 2013, the man met his offender supervisor. She described the interview as difficult as he was unwilling to accept responsibility for a previous offence and had been aggravated by their discussion.

29. The man told Prisoner A about his meeting with his offender supervisor. The prisoner said that the man had gained the impression at the meeting that if he did not admit an offence of assaulting a family member, it was unlikely that he would ever get out of prison. Owing to memory problems, he said he could not remember committing the assault.

30. A consultant forensic psychiatrist conducted the man's psychiatric review on 10 June 2013. His report indicated that he had no mental health problems and required no mental health input at that time. His also concluded that there was no evidence of post-traumatic stress. It is unclear if this report was shared with him directly, but a copy was sent to his solicitor.

31. The man had had a personal officer since 6 October 2012. His role was to be his first point of contact to support him with any difficulties and help him meet his sentence plan targets. The officer recorded his contact with him in his case notes. In the seven weeks before his death, there were three recorded interactions between them. The

entries were brief, but showed no obvious problems or concerns. When interviewed, the officer said that he had not indicated to him any concerns about bullying.

32. On 22 August, the man received 56 co-codamol tablets. As this medication is often traded in prison, prisoners who are prescribed it have random medication checks. At about 3.15pm on Saturday 24 August, a healthcare support worker (HCA) went to his cell to carry out a medication check. She noted that 22 tablets remained in the original packaging. This indicated that at least 10 tablets were unaccounted for.

33. Prisoner A said that during the medication check he had heard the man asking the HCA whether he was getting into trouble for this and why she was taking his medication from him. Afterwards he saw him standing in the doorway of his cell. He said he was visibly shaken and stressed. He later told him that a few tablets had been missing during the check and he was concerned he was going to get into trouble. The prisoner described him as obsessed with his medication and a stickler for taking them at the correct time each day. He had told him that he was ‘addicted to his meds’ and was convinced that if he did not take them at the same time each day he would become ill. He was worried that he would face disciplinary action because of the missing tablets. The prisoner described him as agitated, anxious and stressed about this.

34. Prisoner A told the investigator that two prisoners on the wing had been pestering the man for his pain relief medication and that this had made him worried and anxious. He had told him that he sometimes gave them one or two tablets to avoid the stress of being badgered by them. He said he had not personally witnessed him giving the other prisoners medication, but had frequently seen them go into his cell. When they left, he would tell him what they had asked and whether he had given the tablets to them. There is no evidence to suggest that staff were aware of prisoners bullying him for his medication.

35. Prisoner A also said that an officer went to the man’s cell three or four times a day to smoke and sometimes asked for information about other prisoners. The man had told the prisoner that he felt uncomfortable about this and was concerned that other prisoners would think he was passing on information. However, he did not feel able to challenge the officer as he was responsible for managing the wing cleaners. When the investigator asked the officer about this, he denied it.

36. About an hour after the medication check, the man spoke to Prisoner A about the noise a prisoner was making in the next cell. Ten minutes later, Prisoner B went to see the man in his cell. He said they had discussed the missing medication. The man told him that he was looking forward to watching the motor racing the next day. Prisoner B

said that the man seemed his usual self and did not seem upset about anything.

37. An officer locked the man in his cell for the night at around 4.30pm on 24 August. He told the investigator that when he said goodnight, he had replied, "I'll see you in the morning Mr P". A roll check (count of prisoners) was carried out at 4.29pm.

38. An operational support grade (OSG) conducted the next roll check at about 5.45am the next morning. He explained that during the check he would open the observation hatch of each cell and either shine his torch through or switch on the light to check the prisoner was present. If he could not see him or there was no response, he would then contact the officer in charge. He said that he did not know the man and could not specifically remember checking his cell, but assumed he must have been in bed when he checked as he had reported no untoward incidents that morning.

39. Officer A began to unlock the cells at about 8.15am. He said that when he unlocked the man's cell, he opened it a few inches and said, 'good morning. He said he looked into the cell and noted that his bed had been slept in, his cell and shower lights were on and the shower door was open. The officer assumed he was in the shower area but did not look in the observation mirror above the bed to check. He said he did not think that he was having a shower because he could not hear running water, but thought he might be cleaning his teeth. He pulled the door closed and continued unlocking cells.

40. Prisoner B, who lived in cell 5, next to the man, told the investigator that it was unusual that he had not seen him when he went to collect his breakfast. On his way back, at around 8.20am, he noticed the cell door was ajar, so he pushed it open and saw the man's feet on the floor by the shower door. He went into the cell and found him with the cable from a vacuum cleaner around his neck, tied around the hinge to the shower door. The shower door was closed and he was sat on the floor with his back to the door. His head was tilted towards the bed and he looked pale. Prisoner B believed the man was dead and went to inform the officer.

41. The officer told the investigator that he was still unlocking the cells and had reached cell 20, when Prisoner B called to him, indicating urgently that there was something wrong. He went to the cell and found the man as the prisoner had described.

42. The officer said that the man was cold to the touch and his tongue was protruding and discoloured. He called an emergency code blue (indicating a prisoner is unconscious or has breathing difficulties) at 8.33am and cut the cable from around his neck. The control room requested an ambulance immediately. Two officers then arrived. The three officers believed that it was apparent that he was dead as there

were signs of rigor mortis. They therefore did not attempt to resuscitate him. A nurse arrived two minutes later at 8.35am. She also found obvious signs of rigor mortis. Paramedics arrived at the cell at 8.50am and at 8.55am pronounced him dead.

43. The man had left a handwritten note in his cell, addressed to his sister. The note contained an extract from his diary:

> "I know I keep saying that I never wanted to become a burden but that's how I feel – sorry. If you can send whatever savings I've got left then that'll take care of the ashes…"

44. Prison managers held a debrief for staff involved in the emergency response to discuss what had happened and to offer support and the services of the care team. Officers and members of the chaplaincy supported prisoners affected by the incident.

45. The prison's family liaison officer visited the man's family at their home and informed them of his death. Over the following days the prison maintained contact with the family to provide support and they offered financial assistance towards the funeral expenses, in line with national guidance.

Post-mortem examination

46. A pathologist carried out a post-mortem examination on 28 August 2013, which showed that the cause of death was hanging.

ISSUES

Clinical care

47. The clinical reviewer found that the man had regular physical health checks at Northumberland and that the standard of monitoring was good and clearly documented. Nevertheless, he makes some recommendations for improvement which are not repeated in this report as they are not directly related to his death.

The man's mental health and risk of suicide and self-harm

48. The man had a history of depression and self-harm before he went to prison. After his imprisonment in 2004, he continued to take anti-depressants and he received mental health input and support after he had harmed himself at HMP Garth in 2010. During his reception health screen at HMP Northumberland in November 2010, it was noted that there were no current symptoms of depression or other mental health concerns. Despite his history of mental illness and previous care by Garth's mental health team, he was not referred to the mental health services when he arrived at Northumberland and there was no further mental health input.

49. HMP Northumberland's reception medical risk assessment document states that the mental health team should be consulted if a prisoner has a history of mental illness. The clinical reviewer clarified that this applies only to more complex mental health problems, such as psychosis. He explained that in the community it is common for mental health issues, such as depression, not to be referred to mental health services unless there is a risk of suicide. He therefore concluded that the approach taken with the man was equivalent to the practice in the community. This was some years before his death so we do not consider that a referral at that stage would have made a difference to the outcome. We note that a psychiatric report in June 2013 found no evidence that he had any mental health problems at that time.

50. Neither healthcare nor wing staff saw any signs of mental distress during the man's time at Northumberland prison. Although he had mentioned some worries to friends, those who last saw him before his death had no concerns about his immediate welfare and considered he was his normal self. We are therefore satisfied that staff at the prison could not have predicted or prevented his actions.

The man's medication

51. The man was allowed to keep his medication, stored securely in a personal locker in his cell. He was issued 56 co-codamol tablets each week and took two, four times a day. The last batch was dispensed on 22 August.

52. On 24 August, the day before the man's death, a medication check took place. A healthcare assistant noted on the relevant form that there were only 22 tablets, rather than the 32, there should have been. The guidance on the form states that the doctor on call should be informed immediately of an incorrect count. The clinical reviewer was told that in practice this process is never followed and, instead, the forms are passed to the pharmacy for the prison GP to take action the next working day.

The possibility of bullying and trading medication

53. The man had confided to Prisoner A that other prisoners had frequently asked him for his medication and he had given some away to them. He said that this had caused him stress and anxiety. He mentioned the shortfall in his medication, which was discovered on 24 August, to two of his friends on the wing and was anxious that disciplinary action would be taken against him.

54. The missing medication suggests that the man was being pressured by other prisoners for his pain relief tablets. However, prison officers stated at interview that they were not aware of any bullying or trading of medication on the wing. There is no evidence that he ever reported the matter and there is no security intelligence to indicate this was a general problem on the wing. While the evidence suggests that he might have been coerced to trade his medication, we have been unable to confirm this or assess the impact this might have had on his wellbeing.

55. Prisoner A also alleged that the man was anxious about an officer placing pressure on him to divulge information about other prisoners. The officer denies that he did so and we have found no other evidence to support the claims.

Access to cleaning equipment

56. The man was a cleaner on house block 8, responsible for maintaining landing 2. It appears his usual routine was to clean the landing after prisoners were unlocked in the morning and then have a shower at about 9.30am.

57. All cleaning supplies and equipment, including two vacuum cleaners, for house block 8 should be kept in a locked storage cupboard on landing 1 (the ground floor). Staff on duty are responsible for locking and unlocking the storage cupboard and monitoring the issue of equipment. However, an officer explained that the storage cupboard usually remains open at night, as night staff do not have access to the keys. He said that he did not think prisoners were permitted to keep vacuum cleaners in their cells but that it was possible that a cleaner or an orderly might have one.

58. Prisoners A and B said that the man had kept a vacuum cleaner in his cell permanently for over five months and that this was widely known by prison staff. Prisoner A believed that an officer had approved this. Three officers all denied that they had given him permission to keep the vacuum cleaner in his cell or that they were aware of it.

59. As the cells are subject to daily fabric checks, staff would have seen that the man kept the vacuum cleaner in his cell. We therefore believe it is likely that officers had given tacit approval. Although he used the electrical cable attached to the vacuum cleaner to hang himself there were a number of other items in his cell that he could have used. While the staff appear to have been lax about the arrangements for storing cleaning equipment, we do not consider that this in itself was a significant contributory factor to his death, particularly as there was no indication that he had any thoughts of self-harm or suicide and other items in his cell could have been used to make a ligature.

Unlock procedures

60. An officer unlocked prisoners' cells at about 8.20am, but did not discover the man immediately because he did not go into the cell or wait to get a response from him. For their own safety, officers are supposed to look through the observation hatch before unlocking a cell door. When they unlock cells, they should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states:

> "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."

61. Northumberland's Local Security Strategy specifies that staff should interact with prisoners when unlocking cells. As this was not done, another prisoner found the man dead which is wholly inappropriate. While it is clear that he had evidently been dead for some time and a more effective check would have made no difference to the outcome, in another case such poor unlock procedures could lead to a delay in treating a seriously ill prisoner. We have made two previous recommendations to HMP Northumberland about this matter in investigation reports issued in January and November 2013. It is a serious concern that this practice does not appear to have changed. 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

62. When the man was found hanging in his cell, the officer acted quickly. He followed the procedures for reporting an emergency and the control room called an ambulance immediately. It was clear to both wing staff and the nurse who attended that he was already dead and we are satisfied that they were correct in not attempting resuscitation in these circumstances.

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