

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Andrew Wilson a prisoner at HMP Northumberland on 21 September 2017

**A report by the Prisons and Probation Ombudsman**

PO Box 70769  
London, SE1P 4XY

Email: [mail@ppo.gsi.gov.uk](mailto:mail@ppo.gsi.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100  
F | 020 7633 4141

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Andrew Wilson died on 21 September 2017 of a heart attack and coronary artery disease (a narrowing of the arteries to the heart) at HMP Northumberland. He was 33 years old. We offer our condolences to his family and friends.

We are satisfied that healthcare staff could not have predicted or prevented Mr Wilson's death and that the care that Mr Wilson received at Northumberland was equivalent to that which he could have expected to receive in the community. Prison staff were with Mr Wilson when he collapsed, healthcare staff arrived promptly, used a defibrillator and appropriately performed cardiopulmonary resuscitation.

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

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**March 2018**

**Contents**

Summary ..... 1  
The Investigation Process ..... 3  
Background Information ..... 4  
Key Events ..... 5  
Findings..... 9

# Summary

## Events

1. On 5 February 2016, Mr Andrew Wilson was remanded in custody and was sent to HMP Holme House. On 15 June, he was sentenced to seven years and three months in prison for robbery and attempted robbery. On 23 December, he was transferred to HMP Northumberland. Mr Wilson's brother, was also serving a prison sentence and was transferred to Northumberland on the same day.
2. At his initial health assessment, Mr Andrew Wilson told a nurse that he had a history of substance misuse and had problems with anxiety and low mood. On 22 May 2017, he completed a substance misuse programme and declined further methadone.

## Emergency response

3. At 4.30pm on 21 September, Mr Wilson collapsed in the association area of Houseblock 2. He was struggling to breathe and became unconscious. An officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing) and the control room called for an ambulance.footer
4. Nurses arrived promptly with an emergency bag and oxygen. They applied a defibrillator, which said that there was no shockable heart rhythm. The nurses started cardiopulmonary resuscitation.
5. Nurses and officers gave first aid, continued cardiopulmonary resuscitation and to use the defibrillator, which on each occasion advised that there was no shockable rhythm.
6. At 5.01pm, paramedics arrived and took over resuscitation efforts. They stopped at 5.49pm, and pronounced that Mr Wilson had died.

## Findings

### Clinical care

7. The clinical reviewer was satisfied that the care Mr Wilson received at Northumberland was equivalent to that which he could have expected to receive in the community. The clinical reviewer was also satisfied that healthcare staff could not have predicted or prevented Mr Wilson's death.

### Emergency response

8. Prison staff were with Mr Wilson when he collapsed. A medical emergency was called immediately and the control room rang the ambulance service. Healthcare staff arrived promptly, and supported by prison staff, appropriately used a defibrillator and started cardiopulmonary resuscitation.

## Supporting Mr Andrew Wilson's Brother

9. Northumberland started suicide and self-harm prevention measures, known as ACCT, for him as a precautionary measure after his brother died. After an ACCT review the next day, monitoring was stopped and Mr Wilson was transferred to HMP Holme House on 23 September. While it would have been better if Northumberland had told Holme House that he had been subject to ACCT monitoring, we are satisfied that he received appropriate care and support at Holme House.
10. We make no recommendations.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and asking anyone with relevant information to contact him. No one responded
12. The investigator obtained copies of relevant extracts from Mr Wilson's prison and medical records.
13. The investigator interviewed Mr Wilson's brother, who was also a prisoner at HMP Holme House, on 23 October 2017, and six members of staff at HMP Northumberland on 24 October.
14. NHS England commissioned a clinical reviewer to review Mr Wilson's clinical care at the prison. On 26 October, the clinical reviewer emailed Nurse W for information about her role in the emergency response.
15. We informed HM Coroner for Northumberland of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
16. The investigator wrote to Mr Wilson's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
17. We shared the initial report with the Prison Service. There were six factual inaccuracies and this report has been amended accordingly.

# Background Information

## HMP Northumberland

18. HMP Northumberland holds up to 1,348 men. Sodexo Justice Services manage the prison and G4S provide the healthcare services. Healthcare staff are on duty from 7.30am to 7.30pm from Monday to Thursday and from 7.30am to 6.00pm on Friday. At weekends and on bank holidays, healthcare staff are on duty from 8.00am to 6.00pm. Northern Doctors Urgent Care provide an out of hours service at other times.

## HM Inspectorate of Prisons

19. The most recent inspection of HMP Northumberland was in August 2017. Inspectors criticised many aspects of the prison but noted the Director's determination and leadership in making improvements. They said that agency staff were regularly used in the healthcare department to cover vacancies and the nursing team struggled to achieve their core functions. Despite this, inspectors found that most healthcare needs were met. They said that medical incidents occurred regularly, many in connection with the use of new psychoactive substances (NPS). Inspectors said that most prison officers had received appropriate first aid training and had access to defibrillators.

## Independent Monitoring Board

20. 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 recently published report for the year to 31 December 2016, the IMB noted that direct prisoner feedback about healthcare services was generally positive. They also noted that while waiting times for urgent care were not of concern, waiting times for routine care had deteriorated.

## Previous deaths at HMP Northumberland

21. Mr Wilson was the third prisoner to die from natural causes at Northumberland since September 2016. There were no significant similarities with our previous investigations.

## Assessment, Care in Custody and Teamwork (ACCT)

22. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key Events

23. On 5 February 2016, Mr Andrew Wilson was remanded in custody and was sent to HMP Holme House. On 15 June, he was sentenced to seven years and three months in prison for robbery and attempted robbery. On 23 December, he was transferred to HMP Northumberland.
24. Mr Wilson's brother, was also serving a prison sentence and was transferred to Northumberland on the same day, where they both lived in Houseblock 2, but in separate cells. Both had jobs working at the servery.
25. On 23 December, Nurse W completed an initial health assessment for Mr Andrew Wilson who told her that he had a history of substance misuse, anxiety and low mood. He said that he was a smoker. Nurse W noted that he had been on a substance misuse programme at Holme House, where he had been prescribed methadone. He remained on the substance misuse programme at Northumberland.
26. On 27 December, a nurse saw Mr Wilson for a second stage health assessment. He told her that he wanted to stop taking methadone. She discussed the risks of reducing the dose quickly. She said that he should keep a stable level of methadone until a prison GP reviewed him. Mr Wilson told her that he had chronic pain in his knees, shoulder and neck after falling from a roof in 2000. She advised him to make an appointment to see a physiotherapist.
27. On 31 January, Mr Wilson tested positive for methadone and a new psychoactive substance (NPS). On 9 February, officers found five litres of hooch (an illicitly brewed alcoholic drink) in his cell. Prison staff gave him a warning on both occasions. He completed the substance misuse programme on 22 May when he declined further methadone.
28. On 15 February 2017, Mr Wilson saw a therapist from the mental health team. He agreed to undertake cognitive behavioural therapy to manage his anxiety. She referred Mr Wilson to Rethink, a local charity offering psychological support to prisoners.
29. Prison GPs monitored Mr Wilson's chronic pain and referred him to a physiotherapist who gave him exercises. On 13 September, a prison GP referred Mr Wilson for a Magnetic Resonance Imaging (MRI) scan (which produces images of the body structure).
30. Before going to the servery to serve tea on 21 September 2017, Mr Wilson told his brother that he could not breathe properly. He told him that he had not felt well all day and had flu symptoms. When they went to the servery, he again told his brother that he did not feel well and asked him to find someone to cover for him.

## Emergency response

31. At 4.30pm, Mr Wilson went to the association area of the houseblock to prepare the food. He came out of the servery and told prison custody officer S that he felt like he had flu. Mr Wilson stood by a window in the association area before

slumping onto the snooker table. Prison custody officer Q went over to Mr Wilson. She said that he was grey in colour, was sweating and his pupils were dilated. He was struggling to breathe.

32. Prison custody officer Q called her colleagues. Prison custody officer S and prison custody officer Q lowered Mr Wilson to the floor and placed him in the recovery position. Prison custody officer Q said that he was not conscious.
33. Immediately, at 4.39pm, a senior prison custody officer radioed a medical emergency code blue. The control room called for an ambulance promptly.
34. His brother came to check him. Prison custody officer Q asked if his brother had any medical conditions. He said that he wanted to stay with his brother but Prison Custody Officer S took him to a bench in the same room, where a nurse stayed with him and supported him.
35. Nurse W and Nurse T arrived with an emergency bag and oxygen and assessed Mr Wilson. They asked for the defibrillator, which is kept in the wing office nearby. The nurses turned Mr Wilson onto his back and applied a defibrillator which found no shockable rhythm. The nurses started cardiopulmonary resuscitation.
36. Nurse W and Nurse T inserted a tube into Mr Wilson's mouth. A senior prison custody officer and Prison Custody Officer Q used a bag to give him oxygen between chest compressions. The nurses, and two senior prison custody officers continued cardiopulmonary resuscitation and used the defibrillator, which continued to advise that there was no shockable rhythm.
37. At 5.01pm, paramedics arrived and took over resuscitation efforts. A second ambulance arrived. At 5.49pm Mr Wilson was pronounced dead.
38. The two senior prison custody officers, and two paramedics put Mr Wilson on a stretcher and moved him to a side office. His brother wanted to see Andrew so they took him to the office.

### **Contact with Mr Wilson's family**

39. At 5.20pm, The Deputy Head of Residence spoke to Andrew's brother. He did not want to leave while staff treated his brother. She said that she was the family liaison officer (FLO). He asked her to tell his mother that his brother was ill.
40. At 5.30pm, The Head of Regimes and The Duty Manager, asked The Deputy Head of Residence, to speak to Mr Wilson's next of kin, his mother, because of his condition. At 5.34pm, she telephoned Mr Wilson's mother but there was no response.
41. At 5.36pm, the Deputy Head of Residence, spoke to Mr Wilson's father by telephone and told him of his condition. When the Deputy Head of Residence called again minutes later, he told her that he had spoken to Mr Wilson's mother who was now expecting a telephone call from the prison.

42. At 5.56pm, after Mr Wilson died, his brother told The Deputy Head of Residence, that he wanted to tell his mother. The Head of Regimes telephoned Mr Wilson's mother and told her that Mr Wilson had died and offered his condolences and passed the telephone to Andrew Wilson's brother to speak to his mother. At the same time, The Deputy Head of Residence telephoned Mr Wilson's father and told him that Mr Wilson had died. She offered her condolences.
43. At 9.55pm, the Head of Regimes and The Deputy Head of Residence, visited Mr Wilson's mother. His stepfather was also present. They again told them that Mr Wilson had died and offered their support and condolences.
44. On 29 September, Mr Wilson's family went to Northumberland, visited his cell and went to his memorial service. Mr Wilson's funeral took place on 20 October, and Northumberland contributed to the cost in line with national guidelines.

### **Support for prisoners and staff**

45. After Mr Wilson's death, The Head of Regimes debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
46. Staff at Northumberland posted notices informing other prisoners of Mr Wilson's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Wilson's death.

### **Supporting Mr Andrew Wilson's Brother**

47. ACCT procedures are used to assess, monitor and manage prisoners considered at risk of suicide or self-harm. They can be initiated by any member of staff.
48. At 6.35pm on 21 September, a senior prison custody officer saw Andrew Wilson's brother. Although he said that he did not want to self-harm, the senior prison custody officer started ACCT monitoring as a precautionary measure, and asked officers to monitor him twice an hour. He also arranged for him to have access to the Samaritans if he wanted to speak to them. On 22 September, after the first case review, the senior prison custody officer stopped ACCT monitoring.
49. On 23 September, he was transferred to Holme House to be nearer to his family. An officer spoke to him when he arrived. While she told the investigator that he received £2.00 in telephone credit on arrival, he said that because he arrived on a Saturday, he was given no telephone credit. He said that he asked for emergency credit which did not arrive for three weeks.
50. At 4.48pm, he visited the chaplain. Later that day, he was allowed to telephone his mother. An officer told staff on the wing what had happened to him at Northumberland. She offered him support from Listeners (prisoners trained by the Samaritans to support other prisoners) and the Samaritans.

51. Officers at Holme House assessed him as fit to share a cell. He told staff that it was difficult to grieve in a shared cell and it was awkward for his cellmate. He asked to be moved to a single cell but remained in a shared cell.
52. On 24 September, his mother and family visited him and an officer used the legal visits' boardroom for privacy. He said that staff at Northumberland supported him after the death but that at Holme House, staff had supported him for a couple of days but then had forgotten about him.

### **Post-mortem report**

53. A post-mortem examination found that the cause of Mr Wilson's death was a heart attack (myocardial infarction) and a narrowing of the arteries to the heart (ischaemic heart disease). Toxicology tests detected no illicit substances in Mr Wilson's bloodstream when he died.

# Findings

## Clinical care

54. The clinical reviewer was satisfied that the care that Mr Wilson received at Northumberland was equivalent to that which he could have expected to receive in the community. Mr Wilson completed a methadone detoxification programme, and after his death, the toxicology report confirmed that there were no illicit substances in his body. He was appropriately referred to a therapist from the mental health team and had physiotherapy for his chronic knee, shoulder and neck injuries.
55. The clinical reviewer said that there were no major factors in Mr Wilson's medical records to suggest that he was unwell and would have a heart attack. She was satisfied that healthcare staff could not have predicted or prevented Mr Wilson's death.

## Emergency response

56. The emergency response was timely and appropriate. Prison staff were with Mr Wilson when he collapsed and placed him in the recovery position. Staff immediately radioed a medical emergency code blue and the control room promptly called for an ambulance. Healthcare staff arrived promptly, used a defibrillator and supported by prison staff, started cardiopulmonary resuscitation. Staff ensured that the two ambulances had quick access through the prison gates. Paramedics were with Mr Wilson within 22 minutes.

## Supporting Mr Andrew Wilson's Brother

57. After Mr Wilson's death, a senior prison custody officer started ACCT monitoring for Andrew Wilson's brother as a precautionary measure, which he stopped the next day. Although Prison Service Instruction (PSI) 64/2011 on safer custody says that ACCT monitoring must not be stopped within 72 hours of a planned transfer, we consider it reasonable that he was transferred to be closer to his family after his brother's death.
58. In line with the PSI, Holme House should nevertheless have been told that he had very recently been monitored under ACCT procedures, albeit for a very short time. There is no evidence that this happened and this meant that a post-closure ACCT review, which should have been scheduled for 29 September, did not take place. Despite this, we appreciate that ACCT monitoring had been started as a precautionary measure and he said that he did not wish to self-harm.
59. Officers at Northumberland supported him well until he was transferred to Holme House. An officer at Holme House organised his immediate care and support which included a compassionate telephone call, a visit to the chaplain and a compassionate visit from his family. We are satisfied that it was an appropriate decision for him to share a cell at Holme House and that his care was reasonable and appropriate.



**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations