

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Colin Green, a prisoner at HMP Northumberland, on 24 May 2022**

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

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## OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

## WHAT WE DO



## WHAT WE VALUE



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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.

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

Mr Colin Green died of heart disease on 24 May 2022 at HMP Northumberland. He was 58 years old. I offer my condolences to Mr Green's family and friends.

Mr Green was found unresponsive in his cell on the morning of 24 May. Prison staff and ambulance paramedics tried to resuscitate him but were unsuccessful.

The clinical reviewer found that the care that Mr Green received was equivalent to that which he could have expected to receive in the community.

I make no recommendations.

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

**Kimberley Bingham**  
**Acting Prisons and Probation Ombudsman**

**November 2022**

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# Summary

## Events

1. On 9 May 2022, Mr Colin Green was convicted of violent disorder and sentenced to two years and five months imprisonment. On 16 May, Mr Green was moved to HMP Northumberland.
2. Mr Green had hypertension (high blood pressure) for which he was prescribed medication.
3. At approximately 9.00am on 24 May, during morning unlock, a prison custody officer (PCO) found Mr Green unresponsive. She called to a colleague who started CPR on Mr Green as soon as he arrived at the cell. The PCO called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Staff in the prison's control room called for an ambulance.
4. A few minutes later, further prison staff and healthcare staff arrived at Mr Green's cell and assisted in giving CPR and first aid.
5. At approximately 9.25am, paramedics arrived and assisted in the resuscitation efforts.
6. At 9.49am, healthcare staff and paramedics agreed CPR should be stopped and Mr Green was pronounced dead.
7. The post-mortem report concluded that Mr Green died from heart disease.

## Findings

8. The clinical reviewer found that the care that Mr Green received was equivalent to that which he could have expected to receive in the community.
9. We found that there was a prompt emergency response when Mr Green was found unresponsive in his cell.
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. NHS England commissioned an independent clinical reviewer to review Mr Green's clinical care at the prison. The investigator and clinical reviewer interviewed three members of staff at Northumberland on 15 July. All interviews were completed by video conference.
13. We informed HM Coroner for Northumberland of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.
14. The Ombudsman's family liaison officer contacted Mr Green's next of kin, his partner, to explain the investigation and to ask if she had any matters she wanted us to consider. She asked whether healthcare staff had followed the relevant codes of conduct when managing Mr Green's care. This has been addressed in this report and the clinical review.
15. Mr Green's family received a copy of the draft report. They did not make any comments.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

## **Background Information**

### **HMP Northumberland**

17. HMP Northumberland is a Category C prison, with capacity to hold approximately 1300 adult men. The prison is located near Morpeth and is operated by Sodexo Justice Services under contract from the Ministry of Justice. Healthcare services are provided by Spectrum Community Health.

### **HM Inspectorate of Prisons**

18. The most recent inspection of HMP Northumberland was in August 2017. Inspectors reported that the majority of prisoners felt staff treated them with respect. They also reported that there were appropriate plans in place to deal with medical incidents and resuscitation equipment was checked and reviewed regularly. Inspectors also conducted a scrutiny visit of Northumberland in September 2020. They found that contingency arrangements were in place during the COVID-19 pandemic to ensure that healthcare continued to be delivered and that medical appointments continued to be facilitated.

### **Independent Monitoring Board**

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 December 2021, the IMB reported that the prison was a safe environment, where prisoners were treated fairly and humanely. The IMB noted that the prison healthcare system had recently been taken over by Spectrum Community Health which had caused staffing issues, but they were committed to addressing these.

### **Previous deaths at HMP Northumberland**

20. Mr Green was the twelfth prisoner to die at HMP Northumberland since May 2020. Of the previous deaths, seven were from natural causes, three were self-inflicted and one remains unclassified.

## Key Events

21. On 9 May 2022, Mr Colin Green was convicted of violent disorder and sentenced to 29 months imprisonment. He was sent to HMP Durham.
22. Mr Green had hypertension (high blood pressure). He was prescribed medication for this condition.
23. On 16 May, Mr Green was moved to HMP Northumberland. A nurse completed a reception health screen. The nurse noted that Mr Green arrived with his hypertension medication and that his blood pressure was within normal range. The nurse referred Mr Green to the long-term conditions' clinic for his hypertension.
24. On 22 May, a healthcare assistant completed observations on Mr Green and recorded that he had high blood pressure. She contacted the prison GP and asked for Mr Green's prescription to be renewed to ensure he had continued access to his hypertension medication.
25. On 23 May, a nurse completed observations on Mr Green and recorded that his blood pressure was still high. She completed a National Early Warning Score (NEWS2, a tool used to assess a patient's degree of illness) and calculated a score of zero, which meant that no further action was required. She noted that Mr Green had one tablet left for his hypertension and she chased up the prescription.
26. At approximately 5.30am on 24 May, the night operation support officer checked on Mr Green during the morning roll check (a count of prisoners). She had no concerns.
27. Shortly after 9.00am, a prison custody officer (PCO) unlocked Mr Green's cell. She called out to him but got no response. She then noticed his chest was not moving.
28. The PCO called to another PCO, who was two cells away from her. The second PCO immediately entered Mr Green's cell and started CPR on him. The first PCO called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Staff in the prison's control room called for an ambulance. The first PCO went to get the defibrillator.
29. At approximately 9.05am, the first PCO returned with a third PCO and the defibrillator. They applied the pads to Mr Green's chest.
30. A minute later, further prison and healthcare staff arrived at Mr Green's cell and helped with providing CPR and first aid.
31. At approximately 9.25am, paramedics arrived and assisted in giving Mr Green CPR and first aid.
32. At 9.49am, healthcare staff and paramedics agreed that CPR should be stopped, and Mr Green was pronounced dead.

## Contact with Mr Green's family

33. The prison appointed a PCO as the family liaison officer (FLO).

34. At approximately 11.45am on 24 May, the FLO and his colleague visited Mr Green's next of kin, his partner, at her home and told her of his death.
35. The prison offered to contribute to the costs of Mr Green's funeral in line with national policy and is currently arranging payment.

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

36. After Mr Green's death, the Head of Performance and Delivery debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
37. The prison posted notices informing other prisoners of Mr Green'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 Green's death.

### **Post-mortem report**

38. The post-mortem report concluded that Mr Green died from heart disease.

# Findings

## Clinical care

39. The clinical reviewer concluded that the care that Mr Green received was equivalent to that which he could have expected to receive in the community. He was satisfied that healthcare professionals had followed the relevant codes of conduct in managing Mr Green's care and that they had managed his hypertension appropriately.
40. We are satisfied that staff responded quickly when they found Mr Green unresponsive and provided appropriate emergency care.

## Inquest

41. The inquest, held on 6 November 2023, concluded that Mr Green died from natural causes.

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