

**Investigation into the circumstances surrounding the  
death of a man at HMP Acklington  
In September 2010**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**April 2011**

The man was found at 5.50am in his cell at HMP Acklington in September 2010, having hung himself with a bed sheet. He was 45 years old. I offer my sympathy and condolences to those touched by his death.

The investigation was carried out on my behalf by my colleague. A clinical review of the man's healthcare was undertaken by the clinical reviewer on behalf of the local Primary Care Trust (PCT). I am grateful for his timely review. I would also like to thank the Governor of Acklington and his staff for their co-operation and assistance.

The man was arrested on suspicion of a number of serious offences and came into custody in the wake of an attempt to take his life. Staff at HMP Holme House used suicide prevention measures to support him, and he recovered his stability. He transferred to HMP Acklington after a few months and appeared to settle in reasonably well. He complained of depression and post-traumatic stress disorder at various times and was supported by members of the mental health team. Despite this, staff were not concerned that he might harm himself and did not diagnose any enduring mental illness.

The man, although quite a private man, settled well at Acklington. My investigator was told that he had a close group of friends who he socialised with, and held a trusted job in the officers' mess. However, with the benefit of hindsight, it appears that he may well have struggled with a number of worries. The changeable level of contact with his family upset him, and I understand that his friends said that he was unhappy not knowing when he would be released. This uncertainty may have worsened in the weeks before his death when he was told that the police were considering further charges against him.

Although my report outlines a number of the man's concerns I am satisfied that he gave no indication to staff that he was at risk of harming himself. He was a private man and the friends who he confided in did not pass his concerns on to staff. He settled into life well at Acklington and had a responsible job that he enjoyed. I find no fault in the care provided by the prison and make no recommendations.

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**

**April 2011**

## **CONTENTS**

Summary

The investigation process

HMP Acklington

Key events

Issues

Conclusion

## SUMMARY

1. The man was born in March 1965. He was arrested on 21 January 2008 on suspicion of a number of serious sexual charges. When the police arrested him he told them that he had taken an overdose of paracetamol and citalopram (an anti-depressant). He was subsequently charged and remanded into custody at HMP Holme House.
2. When the man arrived at Holme House, he was assessed by a member of the healthcare team. He was judged to be at risk of harming himself and suicide prevention measures were initiated. He recovered, but was then subject to constant supervision in June 2009 after his cellmate told staff that he was worried about him. He was convicted of his offences later that month. He began to attend a mental health awareness group, and staff noted that his mood continued to improve.
3. The man moved to HMP Acklington on 29 September 2008. He was seen during reception by a nurse who recorded details of his diabetes and obesity, but he said that he was not considering harming himself. He was subsequently seen by the mental health team over the next few months in response to his complaints of low mood. He began the Sex Offender Treatment Programme (SOTP) in February and completed it in April 2009. He moved to L wing and began to work in the market gardens in the summer of that year. During this summer, his contact with his children was stopped and started a number of times.
4. An entry in the man's record at the end of the year showed that he had started work in the officers' mess. During the early months of 2010, he complained to healthcare staff of depression and post-traumatic stress disorder on a number of occasions. The mental health team assessed him but did not diagnose any serious mental illness. He was reviewed on a number of occasions when staff continued to have no concerns that he might harm himself.
5. In June, the indeterminate sentences for public protection (IPP) Parole Board began to consider whether it would be appropriate for the man to move to a less secure prison. However, the Board decided that he should remain at Acklington. The police visited him in late July and told him that they were investigating further allegations against him. On 14 September, he was spoken to regarding concerns that he had been harassing another prisoner. The allegation remained unproven, but he was warned about the impact such behaviour could have on his sentence progression.
6. At 5.50am several days later, the night patrol found the man hanging in his cell. He was cut down by staff but resuscitation was not attempted as it was clear that he had already died. His death was unexpected and I do not believe staff had any information to indicate that he was at risk of harming himself. I make no recommendations.

## THE INVESTIGATION PROCESS

7. One of my colleagues opened the investigation at HMP Acklington on 21 September 2010. He met senior prison managers and took copies of the documentation relating to the man. Notices of the investigation were issued to staff and prisoners, inviting those who wished to provide information regarding his death to make themselves known to the investigator. No-one came forward in response to the notices.
8. The investigator visited the prison on 5 and 6 October to interview nine staff and two prisoners. He spoke to the police regarding the investigation into the further alleged offences of the man. He also attempted to speak to the man's legal representatives, but was unable to speak to anyone who could provide him with further information on these matters.
9. The investigator wrote to the Chief Executive of the local Primary Care Trust (PCT) to commission a clinical review. They asked the clinical reviewer to carry out a review of the medical care received by the man whilst at Acklington. He received a copy of the man's medical record and the transcripts of the investigator's interviews upon which he based his findings.
10. One of my family liaison officers contacted the man's family at the beginning of the investigation. He explained the investigation process and offered them the opportunity to ask any questions or concerns they would like addressed during the investigation. They did not raise any issues that they wished to be investigated, but said that they want to see a copy of the draft report. I hope that my report provides them with further insight into the events leading up to his death.

## **HMP ACKLINGTON**

11. HMP Acklington is a Category C prison for convicted adult male prisoners. Prison Service Order (PSO) 0900 (Categorisation and Allocation) explains the reason for categorising prisoners:

“Prisoners must be categorised objectively according to the likelihood that they will seek to escape and the risk that they would pose should they do so.”

Category C prisoners are defined as: “Prisoners who cannot be trusted in open conditions, but who do not have the resources and will to make a determined escape attempt.”

12. The prison is on the site of a former RAF station and was opened in 1972. The prisoners are divided between sites within the prison, with one side dedicated to vulnerable prisoners. Within this section, L wing is the newest accommodation where enhanced prisoners live in 64 single cells. (Enhanced prisoners are those who have received extra privileges under the Incentives and Earned Privilege scheme, described below.) There is no in-patient healthcare facility in the prison.

### **Assessment, Care in Custody and Treatment**

13. Assessment, Care in Custody and Treatment (ACCT) is a care planning tool used by prisons to help support and monitor those prisoners identified as being at risk of suicide or self harm. ACCT is a multidisciplinary process as it encourages staff from different areas of the prison to work together to provide individual care to prisoners in distress and help to diffuse circumstances where self harm or suicide may occur.

### **Indeterminate sentence (IPP)**

14. An indeterminate sentence is a life sentence, where a minimum tariff is given. After the minimum tariff has been served, the prisoner must satisfy the Parole Board that they are fit for release and do not pose any threat to the community. A prisoner’s risk factors are identified by psychological assessments and they are required to complete prison courses to help reduce their risk of reoffending and improve their chances of being considered for parole.

### **Personal officer scheme**

15. Each prisoner is assigned a personal officer who acts as a point of contact should they need help. This officer is required to have regular conversations with the prisoner and record their interactions.

## **Incentives and earned privileges (IEP) scheme**

16. The IEP system is intended to encourage and reward good behaviour in prison. Prison Service Order (PSO) 4000 describes it as follows:

“The IEP scheme complements the discipline system by rewarding good behaviour. In addition to any local aims, it is intended to encourage prisoners and YOs [young offenders] to behave responsibly, to participate in constructive activity, and to progress through the system. This will foster a more disciplined and controlled, and therefore safer environment for prisoners and staff. It should also contribute to the reduction of re-offending by encouraging prisoners to lead law-abiding, productive and healthy lives.”

17. Prisoners are able to move up a level (basic, standard or enhanced) and earn various privileges. Poor behaviour can result in moving down a level or losing privileges. Privileges include association time (free social time) and extra visits.

## **Sex Offender Treatment Programme (SOTP)**

18. The prison provides programmes to help prisoners convicted of sexual offences address their offending behaviour. These include the SOTP which aims to increase prisoners’ motivation to avoid re-offending and help them to develop the self-management skills necessary to do so. The SOTP involves a lot of sessions and can be demanding for some prisoners because prisoners are asked to reflect on their offences and behaviour.

## **Her Majesty’s Chief Inspector of Prisons**

19. The Chief Inspector mentioned in the introduction to the report of the inspection of HMP Acklington in June 2009 that the prison had improved since the previous inspection. The report acknowledged some improvements in suicide prevention, but noted that not all ACCT case reviews were multi-disciplinary. The report also commented, with regard to relationships between staff and prisoners, that:

“We observed a considerable and welcome shift in the approach and attitudes of staff towards prisoners. The personal officer scheme had improved and some – but not all – history sheets reflected a more positive and proactive engagement. ... Many more prisoners than previously in our survey said most staff treated them with respect. There had also been a big improvement in the number of men who said they had a member of staff they could turn to for help. Prisoners said most staff were friendly, but there was still little active engagement and most officers continued to address prisoners by surname alone.”

## **Independent Monitoring Board**

20. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board’s role is to ensure that the prison is properly run

and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State. In its most recent report from July 2008 to June 2009, Acklington IMB noted that the prison was without an in-patients' centre, meaning that prisoners requiring further treatment had to go to hospital or another prison to receive it. The report also acknowledged the appointment of a dedicated safer custody lead in the prison.

### **Previous deaths at HMP Acklington**

21. Since the Ombudsman was given responsibility for investigating all deaths in prison custody for England and Wales in April 2004, there have been five other self inflicted deaths at HMP Acklington. The three most recent deaths were all in 2007. There are no significant similarities with the death of the man.

## KEY EVENTS

22. The man was known by another name until he legally changed his name in January 2010.
23. The man was arrested on 22 April 2008. When the police found him, he told them he had swallowed an overdose of paracetamol and citalopram. He was taken to hospital before being released back into police custody the following day. He was charged with a number of serious sexual offences and transferred into the custody of HMP Holme House on 24 April.
24. When prisoners arrive at a prison they go through the reception process. A number of interviews are undertaken to assess their physical and mental well-being, and immediate needs. A cell sharing risk assessment is undertaken by a prison officer to establish the level of risk the prisoner presents to a cellmate. The man's level of risk was judged to be low, although the form did indicate concern regarding self harm or suicide. He asked for Rule 45 status due to the nature of his offences. Rule 45 is a rule whereby prisoners who feel vulnerable either because of the nature of their offence or other reasons can be separated from the rest of the prison population.
25. The man also underwent a routine first reception healthscreen to assess his immediate health needs. The nurse noted that he had diabetes, excess weight and had recently taken an overdose. She referred him to the doctor and the mental health team. At 3.10pm, Assessment, Care-in-Custody and Teamwork (ACCT) procedures were begun as he said that he felt low, and his family did not want to visit him. He was placed in a cell in the healthcare department where he was continually observed via a video camera.
26. At 5.30pm, the ACCT assessment interview was undertaken. The man said that his wife no longer wanted to see him because of his offences. He explained that he had intended to die when he took the overdose on the day of his arrest, and had overdosed twice in the last 20 years due to money and relationship problems. He explained that thoughts of his children stopped him this time but he had no pride left and was ashamed of what he had done. He said that he was not eating and was not sure whether he would harm himself further.
27. The first ACCT case review was conducted immediately after the assessment interview. The man was told of the support available to him such as Listeners, Samaritans and the chaplaincy department. (Listeners are trained by the Samaritans to provide emotional support to fellow prisoners in distress.) It was agreed to keep him in the cell with a camera to monitor him closely until he was more settled. On the case review form his risk of self harm was recorded as 'raised'. My investigator only had access to part of the ACCT document and unfortunately has been unable to establish when the ACCT was closed.
28. The mental health team urgently reviewed the man on 29 May as he was tearful and told staff that he had lost everything. He was prescribed 30 milligrams (mg) of Paroxetine (an anti-depressant), and denied any thoughts of

harming himself. On 8 June, he was briefly transferred back to the cell with a camera in the healthcare unit as his cellmate had told staff that he was concerned that he was going to harm himself. He returned to the wing on 10 June. He was convicted of his offences on 27 June.

29. The man went to the mental health awareness group on 16 July and staff noted he interacted well with other prisoners. He was sentenced to an indeterminate sentence for public protection (IPP) with a minimum tariff of four years and six months on 25 July. It was noted in his medical file on 13 August that his mood had improved as he had seen his wife and daughter. On 24 September, he attended his final mental health awareness group. Staff said that he had worked well in the group. He was required to move to Acklington in order to complete the Sex Offenders Treatment Programme (SOTP) and was happy to transfer.
30. The man transferred to Acklington on 29 September. His initial healthscreen acknowledged his previous overdose and excess weight, but did not refer him further. He saw a nurse regarding his diabetes care on 10 October, and then saw the GP a week later to ask for help with his obesity.
31. A nurse visited the man on 31 October, and subsequently reviewed him every month until December. At the end of November, he was assessed by the programmes department as applicable to undertake the Sex Offender Treatment Programme (SOTP), and he began the course at the start of February 2009. Wing staff referred him to the community psychiatric team again in January 2009 as he complained of depression. He was given self-help literature to read. A prison doctor reviewed him on 4 February due to his feelings of depression. He was assessed as not being "profoundly depressed" but his medication was changed to Fluoxetine Hydrochloride (an anti-depressant) as he said his mood had lowered. The doctor noted that, as he had just started the SOTP, he was likely to be stressed anyway.
32. An officer completed a security information report on 11 February as the man said that another prisoner had threatened to "slash" him. He told the officer that he was targeted because the prisoner assaulted another man.
33. The following day, the man said that he had found the self-help material given to him by the mental health team to have been useful.
34. On 4 March, a note was made by the man's offender supervisor that the chaplain had visited her to discuss some problems within his family. His son was in hospital but his father was not allowed to contact him. She advised the chaplain that, due to these restrictions, he should not contact his family either.
35. The man moved to L wing at the end of month as an enhanced prisoner and worked on the market gardens. He finished the SOTP on 16 April. On 27 April, a letter was sent to the prison by his current partner requesting that contact was reinstated between them, but not their children. This was amended at the start of May when she wrote again to the prison asking for their children to be contactable by letter. Over the next few months, his

contact with his partner and their children was reinstated and withdrawn on a number of occasions at the request of his partner.

36. The man was recorded as a HOPE representative on 22 October 2009. (This meant that he spoke to other prisoners about the positive effect which he felt the SOTP had for him.) On 27 December, an officer wrote in his wing history that he was a “model prisoner” and was now working in the officers’ mess. My investigator spoke to a number of prisoners and staff about his employment. He was consistently told that the man greatly enjoyed his work, and was a hard and conscientious employee. A friend of the man said to the investigator that the man described the job as the best job he had in prison. He would start at approximately 8.30am and generally stayed in the mess until 5.15pm. My investigator was told that this was a trusted position, and he had to be cleared by security before he could take up the role. Despite settling into prison life, for the next few months his wing history contained a number of references to his frustration regarding his limited contact with his children.
37. On 12 January 2010, the man legally changed his name. A prison governor told my investigator that, when she asked him about it, he said that he was ashamed of his offences and did not want his family to be associated with them. At the end of January, it was noted once again in his wing history that he found it difficult to be prevented from having contact with his children. He received correspondence until 11 February but it noticeably stopped at that point.
38. The man saw a nurse in healthcare on 6 April having been referred by another nurse. (The nurse had attempted to see him on 29 March but had been unable to find him.) He said that he was suffering from post-traumatic stress disorder due to his experiences serving in the military in Northern Ireland. (Post-traumatic stress disorder is an anxiety disorder that can develop after a traumatic episode.) The nurse told the investigator that his mood appeared reasonably positive and she noted that he had stopped taking his anti-depressant medication. The nurse said that she was not entirely convinced by all of his claims as his accounts of his time in the military varied between conversations. She said that she did not see consistent evidence of post-traumatic stress disorder or depression, but decided to continue to monitor him. She wrote that she intended to discuss him with the psychologist, and was available if he wished to see her again.
39. Another note was made by an officer on 9 April explaining that child contact issues were continuing to frustrate the man. In mid-April, the prison received a letter from his partner requesting that all contact between them and his children was stopped. This is the last letter he is recorded to have received. His friends on L wing said that he found the lack of contact with his children very difficult, and he would frequently complain when access was denied. They also said that, when frustrated, he would sometimes talk of committing suicide. One of the man’s friend did not think he was serious, but another thought that he was sincere but could be talked around. His friend said that the man was very private, and did not want people to know about the issues in his personal life. He confirmed to the investigator that he did not tell staff that

the man spoke of committing suicide as he was afraid that it would risk ending their friendship.

40. On 29 June, the IPP Parole Board began to consider the man's suitability for open conditions. The mental health team confirmed in July that he was still waiting to see a consultant clinical psychologist. The sentence planning review report recommended that he should remain as a category C prisoner, and not be transferred to open conditions due to the level of risk he presented.
41. A security information report was written on 12 July by an officer explaining that the man claimed to have received two emails from his partner despite her saying that she wished to have no contact with him. On 16 July, he made what was to be his final telephone call. He spoke to his father and the call lasted for almost six minutes.
42. The man was visited by police officers on 21 July 2010. They told him that they were investigating further allegations against him. The man's friends said that this concerned him who was anxious about the effect it could have on future contact with his children. My investigator confirmed with the police officers that they had visited him. They said that he had not seemed noticeably distressed by the meeting.
43. On 17 August, the man's offender manager wrote in the Parole Assessment Report that he should remain as a Category C prisoner. On 4 September, he responded to the review on his participation in the Sex Offender Treatment Programme. He disagreed with some aspects of it but overall considered it fair. He wrote that the course enabled him to understand more about his life and also acknowledged the damage he had caused to his victims and family.
44. The man was seen by a nurse regarding his diabetes treatment on 11 September. He was described as cheerful and chatty during their conversation. According to his medical record, this was his last contact with healthcare staff before his death.
45. An Operational Support Grade (OSG) told the investigator that he saw the man on 13 September. The OSG recalled that, as he usually ate in the officers' mess, he knew him well enough to speak to when he saw him. However, on that particular day, the OSG saw him pushing another prisoner in a wheelchair (he had agreed to swap cells to allow this prisoner to be on the ground floor of the wing). The OSG recalled that he was very quiet, and did not respond properly to his greeting. Unusually, even though it was the morning, he did not volunteer any information about the lunch menu. It was not until after his death that the significance of his change of mood struck the OSG.
46. Another prisoner on L wing approached an officer on 13 September to say that he was being hassled and taunted by the man and his friend with regard to his index offence. The officer recalled that the prisoner had seemed troubled when relaying the allegation. The officer told him not to worry and said that it

would be looked into. The officer completed a security information report (SIR) and violence reduction information report (VRIR) with details of the allegations.

47. The following day, a Senior Officer (SO) began the investigation by interviewing the man and his friend. The SO told the investigator that the man said that he did not recall saying such things to the prisoner but, if he had, it would have been in a joking manner. As there was no evidence to support the allegation, the SO told him and his friend that their conduct would be monitored in the future. He also warned the man that such allegations could impact on his enhanced status and trusted job. (A proven bullying allegation could also impact on his sentence progression.) The SO recalled that he seemed rather shocked by how serious the consequences of negative behaviour could be. Both of the man's friends also said to the investigator that they felt that the allegation and investigation impacted on him.
48. One of the man's friends told the investigator that he last saw him at approximately 7.05pm when they were being locked in for the night on the evening of 16 September. He recalled that he said "see you in the morning", and he had replied in the affirmative. He said that, although he knew he had a tendency to consider suicide, he was not worried about him that night.
49. At the start and end of their shifts, night staff are required to conduct roll checks. (During the roll check staff look into each cell to ensure that the right number of prisoners are on the wing. Checks are conducted at 9.00pm, 10.30pm and a morning one that must be completed before 6.00am. The prisoners would not be checked at any other time during the night unless there was a particular reason to do so, such as ACCT requirements.) The man was in a single cell and had no such special requirements and so would not have been checked at any other time other than roll checks.
50. At 5.50am the next day, an OSG was conducting the morning roll check on L wing. When he looked through the door flap he could only see the man's arm as his body was mainly in the bathroom area of the cell. The OSG banged on the door before he radioed for help from the Night Orderly Officer (a SO). (The night orderly officer is in charge of the prison at night.)
51. The SO was in the next building along, the programmes bungalow, when the call came through. He reached the OSG in what he described as a minute or two. By the time he got to the cell, the OSG had gone into the cell. The man had hung himself with a bed sheet tied to the toilet door. The OSG cut him from the ligature. The OSG had taken the defibrillator into the cell but the SO assessed the man and judged him to be beyond resuscitation. (A defibrillator is a machine that can be used to restart the heart in certain situations.) There is no 24 hour healthcare cover at Acklington, but an ambulance was called for. The OSG recalled that the man was stiff and cold. The SO also told the investigator that there were no sign of life as he was cold and mottled. (The SO explained to my investigator that he came to this view from his experience as a combat medical technician in the Royal Medical Corps prior to joining the Prison Service.) The ambulance arrived at 6.15am and the paramedics confirmed at 6.20am that resuscitation would not be successful.

52. The duty governor was contacted and went straight to L wing when she got to the prison. She ensured that the death in custody protocols were being followed, that staff were coping and clarified that all prisoners subject to ACCT monitoring procedures would be checked. The care team was mobilised to support staff and the Listeners were briefed. A hot debrief was undertaken at 8.10am. (This is a meeting of all the staff who were involved in finding and possible attempted resuscitation of the prisoner.)
53. The chaplain offered support to the prisoners on the wing, and the man's friend told my investigator that the officers had specifically asked after him. The prison organised a memorial service for him and the mess was shut during this time to allow his colleagues and supervisors to attend.

### **Family liaison**

54. The prison was required to inform the man's family of his death, in accordance with the usual death in custody procedures. However, the governor explained to the investigator that this was complex because of his family circumstances. He had named his wife as next of kin when he came into prison. However, staff believed that the relationship was over. The relationship with his most recent partner had also ended and so the governor was not convinced that she was the appropriate person to be told of his death. She and the two family liaison officers decided to set off towards the area where the family lived. A governor at the prison spoke to the man's probation officer, who suggested that his parents might be the best people to receive the news. This was relayed to the governor.
55. The information that the man had died was given to his father at his home, and he agreed to tell the rest of the family. One of his brothers was in HMP Stocken and so the governor agreed to arrange for him to be told as well. The prison subsequently paid for the funeral and arranged for the property that the family wanted to be returned to them.

## ISSUES

### Clinical care

56. The man had some chronic health conditions but I do not think that they were a factor in his decision to take his life. He suffered from diabetes but received support for this throughout his time in prison. The clinical reviewer describes his overall medical care in his clinical review which is attached to the investigation report:

“He received timely and appropriate treatment for the physical health problems he presented with. His diabetic care was thorough and very well documented. He was given good support in managing his obesity.”

### Whether the man was at risk of suicide

57. The man told staff about his concerns for his mental health on a number of occasions, and appeared to be concerned by a number of other factors during his time in custody. However, after the early days at HMP Holme House, he was not thought to be at risk of harming himself or attempting suicide.

### *Mental health*

58. When the man first arrived at Holme House he was distressed and the ACCT procedures were used to support him. Staff were concerned about him, and appropriately used ACCT processes during this vulnerable time. He responded well to the support at Holme House and, by the time he transferred to Acklington, was thought by staff to be coping adequately. Once at Acklington, staff noted his previous overdose during the first reception healthscreen but did not deem it necessary to refer him further.
59. Despite this, the man had ongoing contact with the mental health team as he complained of depression and post-traumatic stress disorder. Staff engaged with him but did not diagnose any substantial degree of depression. The nurse thought that his concerns appeared to be natural stresses from being in prison and issues relating to the demands of the SOTP course. She said of his mood in early 2009, “I don’t think it was in the range of clinical depression”.
60. When the nurse saw him again in April 2009, she was not convinced that he was suffering from post-traumatic stress disorder. She explained this further and said of his mental health in the summer of 2009, “I didn’t have any concerns about his mental health”.
61. In his clinical review, the clinical reviewer comments on the approach taken to deal with the man’s mental health concerns:

“He had no known previous psychiatric history and at all times denied suicidal intent, he was therefore appropriate to be managed in a primary mental health care setting. The level and frequency of mental

health input is equivalent to that which would have been provided in a community setting outside of prison ... He was seen by two experienced mental health nurses who communicated well with the GP regarding prescription of anti-depressant medication. He was supplied with high quality self help written material in relation to depression and anxiety and post traumatic stress disorder (PTSD). He reported that he found this material to be helpful. He at times was troubled by past events and the nurse discussed relevant interventions with a Consultant Clinical Psychologist. In view of his lack of symptoms and high level of functioning the decision was to provide "watchful waiting". This treatment strategy is an accepted approach in PTSD and was appropriate given his presentation."

62. The man was regularly seen by mental health staff during his time at Acklington and they responded to his concerns. As the clinical reviewer explains, the treatment provided to him was appropriate and I find no fault in the care provided to him.

#### *Other risks*

63. A common theme in the man's prison records during his time at Acklington was his frustration about the limited access he had to his children due to the nature of his offences. There are multiple, short references to this in his record made by his personal officer and other staff but no indication that the frustration was anything other than a natural response to an unwelcome situation. During the investigation, he was consistently described by staff and prisoners that my investigator spoke to as a private man who would not ordinarily volunteer personal information. Unlike other prisoners, he had more opportunities to talk to staff as, as well as the usual personal officer arrangements, he had informal contact with staff in the course of his work in the officers' mess.
64. However, the prisoners who my investigator spoke to acknowledged that they knew how much the man was concerned about the restricted contact with his family. It is unfortunate that they do not appear to have shared their thoughts with staff. Neither prisoner said they were unable to approach staff, but they chose not to do so. One thought he was joking about committing suicide, and the other was worried about breaching his trust. Without any information that this issue might have increased the likelihood that he might harm himself, I think that it would be unreasonable to expect staff to have acted differently.
65. The prisoners who my investigator spoke to said that the police visited the man in the summer of 2010 regarding further allegations. My investigator spoke to one of the detectives who visited him. She said that they told him they were investigating further charges against him but she was not concerned by his reaction. His friends told the investigator that this meeting seemed to affect him, as he thought about the impact on his sentence and thus on his contact with his children.

66. The police regularly visit prisons to speak to prisoners, and prison officers are not expected to know when a prisoner has been interviewed by the police. However, it may be that further interviews by the police could affect a prisoner's state of mind. Unfortunately, as the man and his friends did not approach staff with information about the effect on him, it is hard to see what staff could have done differently. The police have their own duty of care to people who they are in contact with and I would expect them to have informed the prison if they were concerned about him.
67. A few days before the man's death, he was accused of harassing another prisoner. The allegation was unproven but he was warned about his future conduct and the potential consequences of proven offences. According to staff and prisoners, he was taken aback by the implications of such allegations. It is not possible to tell if this had any bearing on his apparent decision to take his life.
68. One of the man's close friends told the investigator that the man would openly and sincerely talk about committing suicide. He said that he did not tell staff about this, out of fear of upsetting him. Another of the man's friends did not take his talk of committing suicide seriously. None of the staff my investigator spoke to heard him talk about suicide.
69. Staff have a responsibility to note and act upon prisoner behaviour that indicates they are at risk of harming themselves. The prison has a responsibility to support those prisoners who they judge to be at risk of harming themselves. They did not identify the man as at risk of harming himself and therefore did not take any action. When there are no apparent warning signs, it is very hard for staff to put in place strategies to safeguard prisoners. With the benefit of hindsight, he was dealing with a number of issues that may have been difficult for him. However, given his private nature and the lack of knowledge staff had I do not think that the staff could realistically have foreseen the actions he would take.

### **Discovering the man**

70. When the man was found, I am satisfied that staff correctly judged that rigor mortis had set in. The SO assessed that he was beyond resuscitation. Annex 13A of PSO 2700 states:

“If not breathing and/ or no pulse is present, clear airway and attempt resuscitation, using a face mask with non-return valve, unless rigor mortis of the limbs has clearly set in.” (Emphasis in original)
71. Given the checks undertaken, and the existence of rigor mortis, I believe that the staff acted in accordance with the PSO. In such circumstances, any attempt at resuscitation would have been pointless. Worse still, it would not have been respectful either to the man's dignity or to the staff asked to carry out CPR.

## **Liaison with the man's family**

72. When the man died, the prison was initially unsure who to break the news to. He had named his wife as his next of kin but staff understood that she no longer had any contact with him. The prison was then unsure whether to contact his most recent partner, and sought the advice of his offender manager. It is disappointing that the prison did not review his next of kin details when his personal circumstances changed but they clearly went to some lengths to decide who to speak to. I am content that the decision to break the news to his father was the right one although this should act as a reminder to the prison of the importance of keeping next of kin contact details as up to date as possible.

## CONCLUSION

73. When the man came into custody, he was in a distressed and pessimistic mood. The staff at Holme House properly put the ACCT support procedures in place and he recovered well. He was in frequent contact with the mental health services in prison, but his symptoms and presentation never raised concerns that he might harm himself.
  
74. At Acklington, he had a close group of friends and a responsible job that he enjoyed. His death came as a great shock to all who knew him. It is clear that, at the time he took his life two matters in particular seemed to be playing on his mind. He did not like being out of contact with his children and he seems to have worried about the additional police investigations. He shared his worries with his friends but neither he nor they talked to staff about them. From his previous experiences, he knew that support would have been available for him and it is a shame that he did not ask for it in September. I am satisfied that staff at Acklington acted appropriately with the knowledge they had of him.