Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Keith Turner, a prisoner at HMP Humber, on 9 January 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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

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 Keith Turner died on 9 January 2020, after cutting his throat and wrist at HMP Humber. He was 50 years old. I offer my condolences to Mr Turner's family and friends.

In December 2019, Mr Turner told healthcare staff on four occasions that he was having suicidal thoughts. I am very concerned that healthcare staff did not start Prison Service suicide and self-harm monitoring or share this information with prison staff.

The clinical reviewer found that there were many missed opportunities for the mental health team to support Mr Turner's mental health.

On the morning of Mr Turner's death, around an hour before he was found, his wife called the prison's switchboard and asked if someone could check on her husband because she had not heard from him that morning. I am concerned that the switchboard operator did not refer Mr Turner's wife to the Safer Custody hotline. This was a missed opportunity for someone to check on Mr Turner.

I am also concerned that there was a delay in sending an emergency ambulance to treat Mr Turner, as prison staff initially gave insufficient information to the Ambulance Service for them to treat the call as an emergency.

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

Sue McAllister CB
Prisons and Probation Ombudsman **October 2020**

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Summary

Events

1. On 6 March 2019, Mr Keith Turner was sentenced to three years and nine months imprisonment for engaging in controlling or coercive behaviour in an intimate relationship. On 19 March, Mr Turner was moved to HMP Humber.

2. On 29 November, Mr Turner told a supervising officer and his offender supervisor that he was concerned about a new police investigation into a historical allegation from a former partner.

3. On 14 December, a senior nurse saw Mr Turner for a mental health review. She noted that Mr Turner said he was "terribly down and does not think he can get much lower", and that he had suicidal thoughts. The senior nurse did not start Prison Service suicide and self-harm monitoring (known as ACCT).

4. On 18 December, Mr Turner completed a mental health referral form and said he had suicidal thoughts daily, but that his wife and daughter stopped him from taking his life.

5. Two days later, a nurse saw Mr Turner for a mental health review. She noted that Mr Turner said he woke up every morning with thoughts of suicide but was adamant that he would not act on them. The nurse noted that she did not have any concerns about Mr Turner's risk of self-harm so did not start ACCT monitoring.

6. On 31 December, the senior nurse saw Mr Turner for a mental health review. She noted that Mr Turner said he had daily suicidal thoughts and "did not want to be here".

7. On 5 and 7 January 2020, two nurses saw Mr Turner, who said that he was really struggling. Both nurses referred Mr Turner to the mental health team, though the referrals were not reviewed until after his death.

8. At 8.08am on 9 January, an officer unlocked Mr Turner's cell but did not open the door or check on his welfare. At 8.28am, an officer looked through the observation panel into Mr Turner's cell and then walked to the next cell. He told the investigator that while he could not remember looking into Mr Turner's cell, he would have noticed anything untoward.

9. At 8.53am, Mr Turner's wife telephoned Humber's switchboard and asked if someone could check on her husband as she had not heard from him that morning. The operator told her that as Mr Turner had contacted her within the last seven days, they could not ask for an update. They did not refer Mr Turner's wife to the prison's Safer Custody hotline.

10. At approximately 9.55am, a prisoner found Mr Turner on the floor of his cell in a pool of blood. He shouted to staff. Two officers responded and found that Mr Turner had cut his throat. An officer called a code red emergency (which indicates that a prisoner has suffered a severe loss of blood). Healthcare staff quickly responded. They started cardiopulmonary resuscitation, inserted an airway, gave Mr Turner oxygen and attached a defibrillator.

11. The control room called for an ambulance at 9.58am. Paramedics reached Mr Turner at 10.10am but they were unable to resuscitate him and, at 10.34am, an air ambulance doctor declared that he had died.

Findings

Assessment of Mr Turner's risk of suicide and self-harm

12. In December 2019, Mr Turner made four statements to healthcare staff that he was having suicidal thoughts. We are very concerned that healthcare staff did not start ACCT monitoring or pass this information to prison staff.

Mental health

13. The clinical reviewer found that the mental health care Mr Turner received was not equivalent to that which he could have expected to receive in the community. There were missed opportunities to support Mr Turner as no one monitored his withdrawal from citalopram (an antidepressant), replaced his allocated nurse when he left, or checked on him after being tasked to do so by primary care colleagues.

Mr Turner's wife's call to Humber's switchboard

14. We are concerned that the prison's switchboard did not pass Mr Turner's wife's concerns to the Safer Custody hotline. Therefore, the prison missed an opportunity to check on him.

Unlock

15. Staff are supposed to check on a prisoner's welfare when unlocking their cell, either by getting a response or checking for movement. We are concerned that the officer who unlocked Mr Turner's cell did neither. While we acknowledge that it appears Mr Turner was still alive 20 minutes later, it is important that staff follow the correct unlock procedures.

Emergency response

16. We are concerned that, during the emergency response, an officer managed the emergency bag rather than one of the many healthcare staff standing outside the cell. Also, when staff initially called for an ambulance, they gave insufficient information for the Ambulance Service to treat the call as an emergency, which delayed the arrival of the ambulance by four minutes.

Staff support

17. We are concerned that one officer involved in the emergency response was not given a TRiM assessment and another was not given immediate support from senior prison managers.

Incident report forms

18. We are concerned that we only received one Incident Report Form from the prison staff involved in the emergency response.

Recommendations

- The Governor and the Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular understand:
    - the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated; and
    - the need to consider risk factors rather than simply relying on what the prisoner says or how he presents.
- The Head of Healthcare should share a copy of this report with Senior Nurse A and Nurse B and discuss the Ombudsman's findings with them.
- The Head of Healthcare should ensure that:
    - mental health tasks are checked daily, clearly actioned and allocated to appropriate members of the team;
    - mental health services are prioritised and reallocated when staff leave the service; and
    - all staff are trained in the use of the patient health questionnaire and the generalised anxiety disorder score and they feel competent to complete them.
- The Effective Practice and Service Improvement Group should liaise with SSCL to ensure that any calls raising credible concerns about a prisoner should be transferred to Humber's Safer Custody hotline.
- SSCL should provide refresher training to its switchboard staff to ensure that they know what to do when they receive calls raising concerns about a prisoner's wellbeing.
- The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.
- The Governor should share a copy of this report with Officer A and ensure that a senior manager discusses the Ombudsman's findings with him.
- The Governor and the Head of Healthcare should ensure that healthcare staff are responsible for managing emergency bags during medical emergencies, unless they are not available.
- The Governor should ensure that when staff call a medical emergency code, they promptly provide information about a prisoner's condition to the control room so that they can pass this information to the Ambulance Service.
- The Governor should ensure that staff are offered appropriate support, including access to TRiM practitioners, following a death in custody or other traumatic event.

- The Governor should ensure that all managers follow the national instructions for dealing with a death in custody or serious incident, including that all staff directly involved in an incident complete Incident Report Forms as soon as possible.

The Investigation Process

19. The investigator issued notices to staff and prisoners at HMP Humber informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded.

20. The investigator visited Humber on 16 January 2020. He obtained copies of relevant extracts from Mr Turner's prison and medical records.

21. NHS England commissioned an independent clinical reviewer to review Mr Turner's clinical care at the prison.

22. The investigator interviewed 15 members of staff and two prisoners at Humber on 16 January and 3, 4 and 5 March, and two members of staff by telephone on 28 February and 18 March. The clinical reviewer accompanied the investigator for the interviews on 3 and 4 March.

23. We informed HM Coroner for East Riding and Kingston Upon Hull of the investigation. He has not given us the results of the post-mortem examination, as they are not yet available. We have sent the coroner a copy of this report.

24. One of the Ombudsman's family liaison officers wrote to Mr Turner's wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not have any questions.

25. 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.

26. Mr Turner's wife received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

27. The clinical reviewer received a copy of the initial report. She pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly.

Background Information

HMP Humber

28. HMP Humber is a medium security prison in Yorkshire that holds approximately 1,000 men. It was created in 2014 by the merger of two previously separate prisons, HMP Wolds and HMP Everthorpe. City Health Care Partnership provides healthcare services. There are always healthcare staff on duty.

29. In August 2018, Humber was selected to be part of the '10 Prisons Project', which seeks to improve safety, security and decency in the prisons involved. The project was focused on reducing violence, improving living conditions, preventing drugs from entering the prison and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

30. The most recent inspection of HMP Humber was in December 2017. Inspectors reported a high number of self-harm incidents, though they found that ACCT management was multidisciplinary and many entries showed good care and interaction with prisoners.

31. Inspectors found that health services were reasonable, though they were unable to meet all mental health needs. The small mental health team provided immediate support for those prisoners with immediate needs but had high caseloads and were unable to meet longer term needs.

Independent Monitoring Board

32. 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 December 2019, the IMB reported that they had seen an overall improvement in the welfare and general safety of prisoners during the reporting year. The Board noted that staff showed professionalism, thoroughness and compassion when conducting ACCT reviews, which were of a very high quality.

33. The IMB reported that many prisoners had mental health issues, which placed the mental health team under considerable pressure. They reported that at times, the number of ACCTs the mental health team were dealing with interfered with their other work, particularly preventative treatment.

Previous deaths at HMP Humber

34. Mr Turner was the 10th prisoner to die at Humber since January 2018. Two of the previous deaths were self-inflicted, three were drug-related, two were from natural causes, one was due to an accidental fall and one is unascertained. We have previously made recommendations about properly assessing prisoners' risk of suicide and self-harm, checking on the wellbeing of a prisoner when unlocking cells and delays in providing information to the Ambulance Service.

Key Events

35. On 6 March 2019, Mr Keith Turner was sentenced to three years and nine months imprisonment for engaging in controlling or coercive behaviour in an intimate relationship. He was sent to HMP Hull.

36. When Mr Turner arrived at Hull, a nurse saw him for an initial health assessment. Mr Turner said that he suffered from anxiety and depression, which was treated with diazepam and citalopram, and he wanted to be referred to the mental health team. The nurse had no concerns about Mr Turner's risk of suicide or self-harm.

37. The following day, a prison GP saw Mr Turner and told him that there was no clinical justification for taking diazepam over a long period of time. Mr Turner said that he did not want to reduce his diazepam prescription but the prison GP decreased the dose from 10mg to 5mg.

38. On 19 March, Mr Turner was moved to HMP Humber. When Mr Turner arrived at Humber, a nurse saw him for an initial health assessment. Mr Turner told him that he suffered from depression, though he refused a referral to the mental health team. The nurse told Mr Turner how he could refer himself to the mental health team and he noted that he had no concerns about Mr Turner's mental state.

39. Five days later, a nurse saw Mr Turner, who was anxious that his diazepam prescription had run out and he thought it had been stopped. He said that he had taken it for seven years so the nurse referred Mr Turner to the prison GP.

40. On 12 April, a prison GP saw Mr Turner and told him that diazepam should not be taken long-term and that he would need to start a slow reduction. The prison GP decreased the dose to 4mg.

41. On 18 April, Mr Turner's offender supervisor saw him. Mr Turner said that he was struggling with his emotional wellbeing since his diazepam had been reduced, though he said that he was not having thoughts of suicide or self-harm. She noted that Mr Turner was tearful so she reminded him of the Listeners scheme (prisoners trained by the Samaritans to provide support to other prisoners) and suggested that he speak to his key worker and the mental health team.

42. The same day, Mr Turner completed a healthcare application and said that he had been "getting lower and lower" since prison GPs reduced his diazepam dose. Mr Turner said that he was not coping on a day-to-day basis so he needed help.

43. The next day, a nurse saw Mr Turner, who said that the reduction in his diazepam had caused him to suffer with anxiety, knots in his stomach and irritable bowel syndrome. The nurse referred Mr Turner to a prison GP.

44. On 29 April, an officer saw Mr Turner for a key worker session. Mr Turner said that the last week had been tough for him, which he put down to prison GPs changing his medication. Mr Turner said that he was over the worst of it and appreciated the support of staff, other prisoners and his family.

45. On 30 April, Mr Turner did not attend a mental health triage appointment. A nurse sent Mr Turner a letter reminding him that he had missed the appointment.

46. On 8 May, a prison GP saw Mr Turner and reiterated that diazepam should not be taken long-term. The prison GP advised Mr Turner that he needed to see the mental health team for a review and that the slow reduction of diazepam should continue.

47. On 20 May, Mr Turner did not attend a mental health triage appointment. A support worker sent Mr Turner a letter reminding him that he had missed the appointment. Four days later, Mr Turner declined a further appointment so the mental health team discharged him.

48. On 3 June, an offender supervisor saw Mr Turner, who said that he was struggling with post-traumatic stress disorder (PTSD) and suffered some concerning symptoms. She asked Mr Turner's key worker to contact the mental health team, though there is no record that this happened.

49. On 20 August, a pharmacist noted that Mr Turner was not taking his morning diazepam dose and referred him to a prison GP for a medication review. A week later, a prison GP saw Mr Turner and decided that Mr Turner could continue to take his diazepam when needed, as a long-term prescription. Mr Turner said that he did not want to consider distraction techniques for PTSD, as it was rare for him to suffer flashbacks.

50. Between 28 August and 21 November, an officer saw Mr Turner for 11 key worker sessions. On each occasion, she noted that Mr Turner appeared to be in good spirits and she did not record any concerns.

51. On 2 September, a probation officer completed Mr Turner's OASys Assessment and noted that she did not have any concerns about his risk of suicide or self-harm.

52. On 27 November, wing staff contacted a nurse because they were concerned that Mr Turner was struggling with his reduced medication. She referred Mr Turner to a prison GP for a medication review.

53. Two days later, a supervising officer (SO) saw Mr Turner, who said that he was struggling to sleep, eat or visit the gym and was lethargic. Mr Turner said that he had no thoughts of suicide or self-harm, as he had support from his wife and daughter, but that a new police investigation was causing him concern. The SO spoke with the healthcare department, who said that Mr Turner had a GP appointment on 20 December.

54. The same day, Mr Turner's probation officer saw Mr Turner. He said that the police investigation into a historical allegation from a former partner was making him feel very anxious and worried. He said that he did not have any thoughts of suicide or self-harm. His probation officer tried to make a referral to the mental health team for one-to-one support for Mr Turner but they said he had to apply himself.

55. On 4 December, a nurse noted that wing staff were concerned about Mr Turner's mental health and asked whether his GP appointment could be brought forward from 20 December.

56. On 9 December, Senior Nurse A sent Mr Turner a positive mental health pack, which held information about managing his mental health.

57. The same day, an officer saw Mr Turner for a key worker session. Mr Turner said that he was struggling with his mental health and had completed an application to the mental health team and was waiting to be seen.

58. On 10 December, a prison GP and a healthcare assistant saw Mr Turner, who said that he was suffering with stress and that his original 10mg dose of diazepam had helped with this, as well as his anxiety. The prison GP decreased the diazepam dose to 2mg, due to its addictive nature, though Mr Turner disagreed with this decision. Mr Turner said that his anxiety was getting worse but he refused any treatment except an increase in diazepam. The prison GP ended the appointment early, as Mr Turner allegedly began swearing and being argumentative, though the healthcare assistant noted that he had not been rude or sworn. The prison GP planned to review Mr Turner in two months or sooner if he experienced new or worsening symptoms and referred him to the mental health team.

59. On 14 December, Senior Nurse A saw Mr Turner for a mental health review. She noted that Mr Turner said he was "terribly down and does not think he can get much lower", and that he had suicidal thoughts but tried to get rid of them by reading or doing crosswords. He said that, since the reduction in his diazepam dose, he was not eating, felt constantly tearful, was not sleeping and had panic attacks. Senior Nurse A completed a patient health questionnaire (known as PHQ-9) and a generalised anxiety disorder (known as GAD7) score with Mr Turner, which showed that he had severe depression and severe anxiety disorder. Senior Nurse A planned to discuss Mr Turner's medication and asked another senior nurse to check his depression and anxiety scores. There is no record that the other senior nurse did this. Senior Nurse A did not start Prison Service suicide and self-harm monitoring (known as ACCT).

60. Two days later, a SO saw Mr Turner, who was upset that his legal visit had been cancelled and said that he was struggling to sleep. The SO confirmed that the police had cancelled their visit and she arranged for Mr Turner to move cells to aid his sleeping.

61. On 18 December, Mr Turner completed a mental health referral form and said that he had suicidal thoughts daily, but that his wife and daughter stopped him from taking his life.

62. Two days later, Nurse B saw Mr Turner for a mental health review. She noted that Mr Turner was increasingly unkempt and officers had noticed a severe change in his mood. Mr Turner said that he woke up every morning with thoughts of suicide but he was adamant that he would not act on them. Nurse B noted that she did not have any concerns about Mr Turner's risk of self-harm. She asked the mental health team to check on Mr Turner. She did not start ACCT monitoring.

63. On 21 December, a nurse saw Mr Turner for a welfare check and noted that he presented as a low risk of suicide. She noted that Mr Turner said he had no thoughts of or plans for suicide or self-harm and that his wife and daughter were protective factors. He said that he felt sick and anxious daily but that he was trying to occupy his time by colouring and talking to officers. She noted that Mr Turner presented as flat in mood and with tears in his eyes, though he kept good eye contact and was appropriate and polite throughout. The nurse reassured Mr Turner and discussed the extra support that the mental health team could provide him.

64. The same day, Mr Turner wrote a letter to his family and said that he was at his lowest point. Mr Turner said that he had begged for help but that doctors did not seem to want to help him, and that he "simply cannot do it anymore".

65. On 24 December, an officer saw Mr Turner for a key worker session, as his key worker had been off work. Mr Turner said that he felt at his lowest, as he wanted his medication sorted.

66. At 11.30am, a clinical manager saw Mr Turner for a mental health review and noted that he presented as a low risk of suicide. Mr Turner said that his mood had declined significantly since his diazepam dose had been decreased and that citalopram was not working. He decreased the citalopram dose to 20mg and prescribed a 50mg dose of sertraline (another antidepressant) from 3 January 2020. Mr Turner was not happy at the reduction but he explained this was needed before introducing sertraline. The clinical manager tasked Nurse C, an agency nurse, to monitor Mr Turner's medication withdrawal.

67. Later that day, another senior nurse reallocated the monitoring task to Senior Nurse A. There is no record that Senior Nurse A or any other nurse monitored Mr Turner's withdrawal.

68. On 31 December, Senior Nurse A saw Mr Turner for a mental health review. Mr Turner said that he needed a replacement for his diazepam prescription but Senior Nurse A said this could not happen. Mr Turner said that he had daily suicidal thoughts and that he did not "want to be here". Senior Nurse A suggested cognitive behavioural therapy (CBT – a talking therapy that can help you manage your problems by changing the way you think and behave) could help with Mr Turner's anxiety and he agreed to try it.

69. The same day, a mental health team meeting decided that Nurse C needed to monitor Mr Turner's withdrawal from citalopram as Senior Nurse A felt she did not have the right skills to support him. The meeting decided that once Mr Turner's medication stabilised, a nurse could see him for CBT. Later that day, a senior healthcare manager told Nurse C that his final shift at the prison would be on 7 January 2020, though Nurse C did not return. (A new nurse was not allocated to Mr Turner until 9 January.)

70. On 5 January 2020, Nurse B saw Mr Turner, who said that he was very low in mood, struggling and "only just coping". Nurse B referred Mr Turner to the mental health team, though the referral was not reviewed until after his death. There is no record that Nurse B recorded this information in Mr Turner's electronic medical record and it was only recorded on the referral to mental health.

71. On 7 January, Nurse D saw Mr Turner, who said he was "really struggling" so wanted something to help him sleep and to talk to someone in the mental health team. Nurse D referred Mr Turner to a prison GP and the mental health team, though the mental health referral was not reviewed until after his death.

72. The same day, Mr Turner wrote in his diary that it was "another feeling really low day".

73. On 8 January, Mr Turner met with his solicitor and they discussed the pre-interview disclosure provided by North Yorkshire Police. The police were investigating two

serious sexual offences and one false imprisonment offence and planned to interview Mr Turner on 10 January.

74. The same day, Mr Turner wrote in his diary that he was "absolutely gobsmacked at the allegations but guilty or not, it will change lives. I have never ever done anything FACT. Can't do this anymore. I love my family so so much."

Events on 9 January 2020

75. At 7.33am, Mr Turner pushed his cell bell. An officer responded and Mr Turner said he had pushed it by accident, as he had meant to turn on his cell light.

76. At 8.08am, Officer A started unlocking cells on Mr Turner's landing. Officer A unlocked Mr Turner's cell, but did not open the door, and then quickly moved onto the next cell.

77. At 8.28am, Officer B checked on Mr Turner's landing to see whether prisoners had gone to work. Officer B looked into the cell, through the observation panel, and then quickly moved onto the next cell.

78. At 8.53am, Mr Turner's wife telephoned Humber's switchboard and said she had not heard from him that morning. She said that Mr Turner had been "feeling really low" and she wanted to know whether the prison could check on him. The call handler, working for Shared Services Connected Ltd (SSCL) on behalf of HM Prison and Probation Service, said that she could not ask for an update because Mr Turner had contacted his wife in the last seven days and due to "data protection, security and safety reasons".

79. At approximately 9.55am, a prisoner went to Mr Turner's cell, as he had not seen him that morning, and found him on the floor in a pool of blood. He shouted to staff. Two officers responded and found that Mr Turner had cut his throat three times and his left wrist once with a razor blade. An officer placed a towel on Mr Turner's neck and the other officer called a code red emergency (which indicates that a prisoner has suffered a severe loss of blood).

80. Two nurses and two healthcare assistants quickly responded to the code red emergency. Initially, a nurse found that Mr Turner was breathing and had a faint pulse, though he quickly stopped breathing. They started cardiopulmonary resuscitation (CPR), inserted an airway (without lubricant, as an officer could not find it), gave Mr Turner oxygen and attached a defibrillator, which did not detect a shockable heart rhythm and advised to continue CPR. A nurse asked a healthcare assistant to apply pressure to Mr Turner's neck with his foot but he refused as he had a hamstring injury and did not think it was appropriate. Once he left the cell, the other healthcare assistant applied pressure to the right side of Mr Turner's neck with his foot.

81. At 9.58am, an operational support grade officer (OSG) called for an ambulance, though he was unable to immediately give the Yorkshire Ambulance Service sufficient information to determine the urgency of the call. He also named another prisoner as the patient rather than Mr Turner. Four minutes into the call, the OSG passed on information from the scene that Mr Turner did not have a pulse. At that point, the Ambulance Service sent two ambulances and an air ambulance, which reached Mr Turner at 10.10am, 10.23am and 10.29am respectively. They took over

the resuscitation attempt and gave Mr Turner adrenaline and sodium chloride. The paramedics were unable to resuscitate Mr Turner and, at 10.34am, an air ambulance doctor declared that he had died.

82. Mr Turner left two notes to his family in his cell and wrote an entry in his diary. The notes said he could not live with the allegations that he was facing and could not cope with the backlash they would cause. The diary entry said, "I cannot live with that, please understand I am so so sorry" and "I was intent on doing this".

Contact with Mr Turner's family

83. Following Mr Turner's death, the prison appointed a SO as the prison's family liaison officer (FLO). At 12.15pm, the FLO and the Deputy Governor visited the home address of Mr Turner's wife and broke the news of his death. They offered their condolences and support.

84. Later that day, Mr Turner's wife called the FLO and said that she had called the prison that morning to raise concerns about him but she was told that no action would be taken unless she had not heard from him for seven days.

85. On 10 January, Mr Turner's wife told the FLO that she wanted minimal contact from the prison and did not want any prison staff to attend Mr Turner's funeral. The FLO followed her wishes and had limited contact with Mr Turner's wife until his funeral, which was held on 30 January. The prison contributed towards the costs of the funeral in line with national instructions.

Support for prisoners and staff

86. After Mr Turner's death, senior prison managers spoke with most of the staff involved in the emergency response to offer support. The staff care team and TRiM practitioners (prison staff trained to deliver trauma risk management and ongoing support) offered support to most staff.

87. The prison posted notices informing other prisoners of Mr Turner'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 Turner's death and started ACCT monitoring for a prisoner to ensure that he received adequate support.

Post-mortem report

88. The coroner has not yet provided us with a copy of the post-mortem or toxicology reports.

Findings

Assessment of Mr Turner's risk of suicide and self-harm

89. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), provides a non-exhaustive list of a number of risk factors and potential triggers that might increase a prisoner's risk of suicide and self-harm. These require staff to take appropriate action, such as starting ACCT procedures or referring prisoners to the mental health team. Staff must identify prisoners at risk of self-harm and suicide, and that information should be shared between prison and healthcare staff.

90. We have considered whether staff at Humber should have recognised that Mr Turner was at risk of suicide and begun ACCT procedures to support him.

91. Mr Turner had some key risk factors: he was struggling with his mental health; he had been convicted of a violent offence against a former partner; and he was concerned that he could be facing further serious charges which could result in a lengthy prison sentence.

92. Between 14 and 31 December, Mr Turner made four statements that he had had suicidal thoughts, to Senior Nurse A, to Nurse B and on a mental health referral form. Despite making these statements, neither nurse started ACCT monitoring. Senior Nurse A told the investigator that she did not think Mr Turner's statement was sufficient to justify putting him on an ACCT, as "a thought is a thought", while Nurse B thought it was more chronic rather than him actively wanting to take his own life. Both nurses felt that the fact that Mr Turner had friends on the wing and was associating was an added reason not to do so.

93. While Senior Nurse A and Nurse B told the investigator why they decided not to start ACCT monitoring, they did not record their reasoning on Mr Turner's electronic medical record. Additionally, there is no record that Senior Nurse A or Nurse B made prison staff aware that Mr Turner had made these suicidal statements and that they had decided not to start ACCT monitoring. The prison staff interviewed by the investigator had no knowledge that Mr Turner had suicidal thoughts before his death and most expressed surprise that the nurses had not shared this information. Conversely, the healthcare staff interviewed by the investigator had no knowledge that Mr Turner was worried about another police investigation, which may have added context to his suicidal statements.

94. We are very concerned that Senior Nurse A and Nurse B did not put Mr Turner on an ACCT and that they placed too much emphasis on his statements that he would not act on his suicidal thoughts or that he could distract himself. We are also concerned that prison and healthcare staff did not share information about Mr Turner so no one recognised that his risk of suicide had markedly increased.

95. In a learning lessons thematic, Risk factors in self-inflicted deaths in prisons, published by the Prisons and Probation Ombudsman in April 2014, we identified that too often when risk is assessed, evidence of risk factors is not fully considered and that too great an emphasis is placed on staff perception of a prisoner's state of mind. We make the following recommendations:

The Governor and the Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, understand:

- **the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated; and**
- **the need to consider risk factors rather than simply relying on what the prisoner says or how he presents.**

The Head of Healthcare should share a copy of this report with Senior Nurse A and Nurse B and discuss the Ombudsman's findings with them.

Mental health

96. On 14 December, Mr Turner's PHQ-9 and GAD7 scores showed that he had severe depression and severe anxiety disorder. While these scores were only relevant on the day Senior Nurse A completed them, there is no record that they were repeated. Senior Nurse A also told the investigator that she asked her colleagues for their views on his scores because she was not used to completing the PHQ-9 or GAD7, though she never received a reply.

97. From 24 December, after the clinical manager decided that healthcare staff needed to monitor Mr Turner's withdrawal from citalopram, the mental health team chose Senior Nurse A to monitor his medication withdrawal. There are no entries on Mr Turner's electronic medical record between 24 and 31 December and it is not clear why Senior Nurse A or any other member of healthcare staff did not monitor Mr Turner's withdrawal or perform a simple welfare check.

98. On 31 December, Nurse C replaced Senior Nurse A as Mr Turner's mental health keyworker, though he stopped working at Humber that day. No one was allocated to Mr Turner until 9 January, which meant that a mental health nurse did not see Mr Turner before his death.

99. On 5 and 7 January, Nurse A and Nurse D, respectively, tasked the mental health team to check on Mr Turner, though a mental health nurse did not review these tasks until 9 January, the day of his death. During interviews with Senior Nurse A, the clinical manager and Nurse B, they told the investigator that there was an expectation that tasks were checked daily. It is not, therefore, clear why these tasks were not checked until 9 January.

100. We are concerned that there were missed opportunities to support Mr Turner, as no one monitored his medication withdrawal, promptly replaced Nurse C or checked on Mr Turner after being tasked to do so by their primary care colleagues. We are also concerned that there was a lack of peer support within the mental health team as Senior Nurse A's request for help with Mr Turner's PHQ-9 and GAD7 scores went unanswered.

101. The clinical reviewer concluded that the mental health care Mr Turner received was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that:

- **mental health tasks are checked daily, clearly actioned and allocated to appropriate members of the team;**
- **mental health services are prioritised and reallocated when staff leave the service; and**
- **all staff are trained in the use of the patient health questionnaire and the generalised anxiety disorder score and they feel competent to complete them.**

102. With regard to Mr Turner's diazepam prescription, the clinical reviewer considered that the prison GPs acted appropriately in decreasing his dosage. Mr Turner had been prescribed diazepam in the community for a lengthy period, which goes against the prescribing guidelines and can cause dependency.

Mr Turner's wife's call to Humber's switchboard

103. SSCL provided the investigator with an Important Reminder – Safer Custody document that sets out the processes to be followed if the switchboard receives a telephone call that raises concern that there has been no contact from a prisoner or that there is the threat of self-harm or suicide. The document says that the telephone call should be transferred to the prison's Safer Custody hotline if there is a credible concern about a prisoner but no immediate threat. The document does not make any reference to the length of time that the prisoner has been out of contact.

104. On the morning of Mr Turner's death, around an hour before he was found, his wife telephoned Humber's switchboard and asked if someone could check on her husband as she had not heard from him that morning. The operator told her, incorrectly, that as she had heard from him within the past seven days, they could not request an update. Although Mr Turner's wife had heard from Mr Turner on 8 January, we are concerned that the operator did not investigate how unusual Mr Turner's behaviour was and so failed to understand that he called his wife before 8.00am every weekday, except Bank Holidays.

105. We are also concerned that, although Mr Turner's wife raised a credible concern about Mr Turner's mood, the operator did not transfer her to Humber's Safer Custody hotline. Calls to the hotline are answered by Safer Custody staff between 9.00am and 5.00pm, and calls are diverted to the control room outside those times. We are concerned that the switchboard operator's failure to refer Mr Turner's wife to the Safer Custody hotline resulted in a missed opportunity for someone to check on Mr Turner.

106. We make the following recommendations:

The Effective Practice and Service Improvement Group should liaise with SSCL to ensure that any calls raising credible concerns about a prisoner should be transferred to Humber's Safer Custody hotline.

SSCL should provide refresher training to its switchboard staff to ensure that they know what to do when they receive calls raising concerns about a prisoner's wellbeing.

Unlock

107. PSI 75/2011, Residential Services, says that prison staff play a key role in spotting any signs of distress in prisoners and that systems need to be in place for staff to assure themselves of the wellbeing of prisoners during or shortly after being unlocked.

108. On 29 January 2019, Humber issued a Staff Information Notice that reminded staff that, when unlocking prisoners, they should get a verbal response or see physical movement before moving onto the next cell.

109. CCTV footage shows that on the morning of Mr Turner's death, Officer A unlocked Mr Turner's cell but did not open the door. He spent a matter of seconds outside Mr Turner's cell and could not have obtained a verbal response or seen any movement.

110. Twenty minutes later, at 8.28am, Officer B looked through Mr Turner's cell's observation panel. He told the investigator that he could not recall looking through the observation panel though he would have noticed if Mr Turner had been on the floor in a pool of blood.

111. While we recognise that Mr Turner appears to have been alive when Officer A unlocked his cell, we are concerned that he did not check on his wellbeing and that such an error could be vital in the future. We make the following recommendation:

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

The Governor should share a copy of this report with Officer A and ensure that a senior manager discusses the Ombudsman's findings with him.

Emergency response

Resuscitation attempt

112. After an officer called the code red emergency, many healthcare staff quickly responded. Although two nurses and two healthcare assistants entered Mr Turner's cell and tried to resuscitate him, we are concerned that no other healthcare staff took over management of the emergency bag from the officer. From reviewing body-worn camera footage, the officer could not easily find the correct equipment that the nurses wanted so there was a slight delay in locating the bag mask valve and a nurse had to insert the airway without lubrication. While this is unlikely to have affected the outcome for Mr Turner, it could be vital in the future. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that healthcare staff are responsible for managing emergency bags during medical emergencies, unless they are not available.

113. The body-worn camera footage and a witness statement from a healthcare assistant revealed that he felt uncomfortable being asked to use his foot to stem the bleeding from Mr Turner's throat. While we appreciate that placing a foot on a

wound is not standard procedure, we agree with the clinical reviewer that the nurses were working to save Mr Turner's life and that any criticism would be unfair.

Ambulance call

114. PSI 03/2013, Medical Emergency Response Codes, contains mandatory instructions that staff must use emergency codes to clearly convey the natural of the medical situation and that on hearing a code red or blue, control room staff must call an ambulance immediately.

115. Humber's Emergency Medical Response Codes protocol says the member of staff calling an emergency code must provide information on whether the prisoner is breathing, whether they are conscious and a brief summary of what is wrong with them, as this will allow the control room operator to relay the information to the Ambulance Service.

116. An officer called the code red at 9.58am and an OSG immediately called for an ambulance. However, due to delays in passing information about Mr Turner's condition from the scene to the control room, it took four minutes for the Yorkshire Ambulance Service to appreciate the severity of the incident and to send emergency ambulances. The officer told the investigator that he could only use his radio to call an emergency code and was not allowed to send additional information about what had happened.

117. While the officer met the requirements of PSI 03/2013, we are concerned that he did not follow Humber's local protocol by providing information about Mr Turner's condition. This caused a four-minute delay in sending emergency ambulances. While we cannot say whether providing this information would have changed the outcome for Mr Turner, it could be critical in other cases. We make the following recommendation:

The Governor should ensure that when staff call a medical emergency code, they promptly provide information about a prisoner's condition to the control room so that they can pass this information to the Ambulance Service.

Staff support

118. Following Mr Turner's death, senior prison managers and TRiM practitioners offered support to most of the staff involved in the emergency response. However, we are concerned that the officer, who found Mr Turner, told the investigator that he had not received a TRiM assessment and an officer, who was the third officer to enter Mr Turner's cell, told the investigator that he had not received immediate support from senior prison managers. While we appreciate that Humber did not intend to exclude both officers, we are concerned that both officers did not receive full support for such a traumatic incident. We make the following recommendation:

The Governor should ensure that staff are offered appropriate support, including access to TRiM practitioners, following a death in custody or other traumatic event.

Incident report forms

119. PSI 64/2011 sets out the actions that should be taken following a death in custody. This includes that all staff directly involved in an incident, particularly those first on scene, must complete Incident Report Forms as soon as possible.

120. As part of the investigation, Humber provided six statements from the healthcare staff involved in the emergency response and an officer gave one directly to the investigator. However, none of the other prison staff involved in the emergency response completed Incident Report Forms, despite being asked to do so by an officer on 15 January. We make the following recommendation:

The Governor should ensure that all managers follow the national instructions for dealing with a death in custody or serious incident, including that all staff directly involved in an incident complete Incident Report Forms as soon as possible.

Inquest

121. At the inquest, held from 16 to 23 September 2024, the jury concluded that Mr Turner died by suicide.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100