Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Simon Turvey a prisoner at HMP Woodhill on 29 December 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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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 Simon Turvey was found hanged in his cell at HMP Woodhill on 29 December 2015. He was 27 years old. I offer my condolences to Mr Turvey's family and friends.

Mr Turvey had never been identified as at risk of suicide and his death came as a shock to staff and prisoners who knew him, as he gave little indication that he was at immediate risk. However, I am concerned that there had been little effective implementation of previous recommendation about identifying risk and little evidence of staff engagement with Mr Turvey in the six months he was at Woodhill. I know work is in hand to reinforce safer custody at the prison, but there also needs to be a restoration of a functioning personal officer scheme, at least to support prisoners at times of greatest vulnerability.

Although it would not have altered the outcome for Mr Turvey, there were also some continuing problems with the emergency response, which the prison needs to rectify. I also consider it took too long to notify his family of his death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2016**

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Summary

Events

1. On 2 July 2015, Mr Simon Turvey was remanded to HMP Woodhill charged with sexual offences. His initial health screen did not identify any physical or mental health issues apart from an overdose ten years earlier. Mr Turvey said that, because he now had children, he would not do anything to harm himself. He lived in Houseblock 4B, the vulnerable prisoners unit.

2. On 14 December, Mr Turvey was convicted and due to be sentenced on 7 January 2016. The day after his conviction, he seemed upset and told an officer that it had been difficult seeing his family in court but he would be okay. He told the officer that it was "not his way" to harm himself. The officer kept an eye on him for the rest of the day and she was reassured that he seemed okay.

3. On 17 December Mr Turvey became upset during a telephone call with his family. A member of staff, who was monitoring telephone calls that night, heard the call and alerted the night officer on Mr Turvey's houseblock. The officer noted the concern in the observation book but there is no evidence that staff followed this up the next morning. On 21 December, Mr Turvey's solicitor visited him to discuss his conviction and the sentencing process. The next day, his family visited him.

4. On Christmas Eve, Mr Turvey spoke to several family members, including his partner. This was the first time he had spoken to her since he had gone to prison, as there had been restrictions preventing contact until November and it had then taken some time to add her number to his telephone list. He was happy that he had been able to talk to his partner, but upset at hearing his children in the background.

5. A prisoner told us that he believed Mr Turvey might have taken some antidepressants, bought from another prisoner, on 27 December. The next day, Mr Turvey's cellmate moved to share with someone he knew, leaving Mr Turvey in the cell on his own. At 5.45am on 29 December, at a routine check, an officer found Mr Turvey hanged from the end of the bed and radioed an emergency. An officer and a nurse attempted to resuscitate him until paramedics arrived at 6.04am. After assessing him, at 6.12am, the paramedics recorded he had died. At 10.00am, prison staff informed his mother, who he had named as his next of kin, that he had died.

Findings

6. Mr Turvey had some risk factors for suicide detailed in Prison Service instructions for managing the risk of suicide and self-harm when he first arrived at the prison. While it is likely that the prison made a reasonable decision not to begin suicide and self-harm prevention procedures, the reason were not well documented. Some other opportunities to assess Mr Turvey's risk were missed. A nurse did not assess him after his court appearance and conviction on 14 December, as should have happened, although an officer spoke to him about his feelings the next day. Mr Turvey had been upset, but this seemed to be a normal

reaction to being convicted. Mr Turvey stressed he would come to terms with it and would not harm himself. No one, staff or prisoners, considered Mr Turvey was suicidal.

7. While we consider that it would have been difficult to foresee Mr Turvey's actions, the investigation found that the personal officer scheme at Woodhill was ineffective and did not offer meaningful support. Previous PPO recommendations about risk assessments had not been effectively implemented.

8. Although it would not have altered the outcome for Mr Turvey, we are concerned that the emergency response was not fully effective, matters we have raised with the prison before. No one took a defibrillator immediately to the scene in response to the emergency code and it took too long to get paramedics from the prison gate to the houseblock. Staff unnecessarily attempted resuscitation when it was clear that Mr Turvey had been dead for some time.

9. It took nearly four hours to notify Mr Turvey's family of his death, although his mother lived very near the prison. We do not consider that this was in line with the requirement in Prison Rules to inform families "at once" when a prisoner dies.

Recommendations

- The Deputy Director of Custody for High Security Prisons should ensure that Woodhill has effectively implemented all PPO recommendations made following self-inflicted deaths at the prison in the last five years and provide a report to the Ombudsman outlining progress within three months of receiving this report.
- The Governor should introduce an adapted personal officer scheme for Houseblock 4B so that prisoners in the early days of custody and other vulnerable periods of their time in prison have an assigned officer who gets to know and support them.
- The Governor should ensure that emergency response procedures enable paramedics to reach prisoners in a medical emergency without any unnecessary delay and that staff take relevant equipment to an emergency in line with the local instruction.
- The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate and when it can be stopped.
- The Governor should ensure that, in line with Prison Rule 22, when a prisoner dies, his next of kin are informed as soon as possible.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners contacted our office and the investigator interviewed them. We also received an anonymous letter from a prisoner about matters not directly related to Mr Turvey's death.

11. NHS England commissioned a clinical reviewer to review Mr Turvey's clinical care at the prison.

12. The investigator visited Woodhill on 4 January 2016. She obtained copies of relevant extracts from Mr Turvey's prison and medical records.

13. The investigator interviewed six members of staff and six prisoners at Woodhill in January 2016, and another member of staff by telephone.

14. We informed HM Coroner for Milton Keynes of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Turvey's brother-in-law, who represented his family, to explain the investigation. Mr Turvey's family wanted to know whether the prison had assessed and monitored him under suicide and self-harm prevention procedures and why Mr Turvey's cellmate had moved out of their shared cell. They asked if he had been given antidepressants and whether he had stored them in his cell.

16. Mr Turvey's family received a copy of the initial report. They had no further comments or questions about the report.

Background Information

HMP Woodhill

17. HMP Woodhill has a dual role of a local prison and a high security prison and can hold 727 men. Central and North West London NHS Foundation Trust provides health services at the prison.

18. There are three nurses on duty in the prison at night. One of the nurses, (usually based in the healthcare outpatient area) is designated to respond to emergency incidents.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Woodhill was in September 2015. Although staffing levels were better than they often found in other prisons, inspectors noted that the prison was heavily reliant on new recruits and officers from other prisons, temporarily working at Woodhill. Inspectors were very concerned about the high number of self-inflicted deaths at the prison (nine since 2012) and considered there was an insufficient whole-prison approach to understanding and addressing the contributory and preventative factors in prisoners' overall experience. Five of the deaths had occurred within the first two weeks of someone arriving at the prison. Inspectors commented that there were not enough Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) and some poor implementation of recommendations from the Ombudsman's investigations into previous deaths.

20. In their survey of prisoners, more prisoners than in comparator prisons said most staff treated them with respect, but prisoners told inspectors that the number of temporary staff from other prisoners had affected the quality of relationships. There was no personal officer scheme but 67% of prisoners surveyed said that they had a member of staff they could turn to for help, which was similar to comparator prisons. Officers' entries in prisoners' records mostly focused on institutional behaviour and showed little knowledge of prisoners' wider circumstances.

Independent Monitoring Board

21. 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 annual report for the year ending May 2015, the IMB commented that the stability of the prison was fragile. Severe staff shortages remained a concern and the IMB was concerned that the loss of experienced staff would impact on the mentoring and support of new staff joining the prison. The IMB said it was difficult for the prison to maintain sufficient numbers of Listeners, and some could be used only on certain units because of their security category or offence. The IMB commented that the personal officer scheme had all but been abandoned and considered this was a lost opportunity to help identify prisoners who might be at risk of suicide or self-harm.

Previous deaths at HMP Woodhill

22. Mr Turvey’s was the seventh self-inflicted death at Woodhill since the start of 2014. We have repeated some of the same issues in a number of our investigations, including concerns about the emergency procedures at the prison, which were not consistent with national instructions. However, these matters would not have prevented Mr Turvey’s death. Since Mr Turvey’s death, four more prisoners have apparently taken their own lives and the high level of deaths at the prison is a serious concern.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

24. After an initial assessment of the prisoner’s main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

25. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

26. On 2 July 2015, Mr Simon Turvey was remanded to HMP Woodhill, charged with sexual offences. Mr Turvey had not been in prison before. Mr Turvey's Person Escort Record (PER – which accompanies prisoners when they move between police custody, court and prison) noted that he was very emotional.

27. At his initial health screen, Mr Turvey told a nurse that he had taken an overdose of medication and alcohol ten years earlier, but he had no thoughts of suicide or self-harm and would not harm himself now that he had children. The nurse noted he had no other history of mental health problems or significant physical health issues and he appeared calm and relaxed.

28. A cell sharing risk assessment concluded Mr Turvey was standard risk and therefore able to share a cell. At a first night interview with an officer, Mr Turvey said he had a lot going on in his head and was quite shocked to find himself in prison because of alleged offences up to 13 years before. He said he had no personal or family history of suicide or self-harm and would speak to staff if he needed to. No one who assessed Mr Turvey when he arrived considered he was at risk of suicide or self-harm.

29. A nurse carried out a more detailed health assessment the next day and identified no concerns about Mr Turvey's thoughts or behaviour, or any suicidal intent or self-harm. During his induction, he said that he felt at risk because of the nature of his alleged offences and, at his request, he was moved to Houseblock 4B, the vulnerable prisoners unit on 14 July.

30. Because of Mr Turvey's alleged offences, his mail and telephone calls were monitored by Woodhill. (At that time, he was also prevented from contacting his partner.) On 28 July, an officer spoke to Mr Turvey as he had written in a letter that he did not want to be here anymore, could not take it any longer and wanted someone to look after his family. Mr Turvey said he had only meant he did not want to be in Woodhill anymore and that it was not a reference to harming himself. He said that he had grown up without a father and did not want his children to have to grow up the same way. Mr Turvey said he would speak to staff if he had thoughts of suicide or self-harm. The officer accepted his explanation and did not consider he needed to be monitored under ACCT suicide and self-harm prevention procedures.

31. On 12 October, Mr Turvey pleaded not guilty to the charges against him at a court appearance by video link. He was remanded in custody until his trial in December.

32. On Houseblock 4B, the weekday routine is that prisoners are allowed out of their cells during the morning to socialise, make telephone calls, have showers, attend medical appointments, and other domestic tasks. In the afternoon, they work between 2.00pm and 4.00pm. Prisoners who do not work are locked in their cells. From Monday to Thursday, there is an evening association period from 5.30pm until 7.00pm when prisoners have free time. Prisoners we spoke to said there was nothing unusual about Mr Turvey and he socialised with other prisoners.

33. For most of his time in Woodhill, Mr Turvey worked in the Waste Management Unit, four afternoons a week, sorting waste for recycling. The instructor described him as a hard worker who would always finish his tasks then offer to help others. Mr Turvey always seemed normal and quite jovial. He got along well with other prisoners and often talked about his family.

34. On 17 November, the restrictions on Mr Turvey contacting his partner were lifted, so she could visit him in prison and he could telephone her (once her details were added to Mr Turvey's list of approved telephone numbers).

35. Mr Turvey's trial took place during the first two weeks of December. On 11 December, an entry in the wing observation book noted that he had asked to speak to his closest friend at 9.40pm. As this was not possible, he asked to speak to a named Listener, although he had said he did not trust Listeners. Because it was night time and they were both in double cells (which would have caused a problem with their cellmates), staff offered Mr Turvey another Listener, but Mr Turvey said he did not want to speak to him. (At the time of our investigation, that Listener had been removed from the Listener scheme after he was suspected of breaching confidentiality.) Mr Turvey did not want to use the portable phone with a dedicated line to the Samaritans.

36. On 14 December, Mr Turvey was convicted of several offences of indecent assault and sexual assault. He was remanded until 7 January 2016, for sentencing. There were no concerns about his welfare noted in his escort record. When Mr Turvey returned to Woodhill that day, his status had changed from a remand prisoner to a convicted (but unsentenced) prisoner. Prisoners are considered to be more vulnerable after court appearances, or a change of status, but there is nothing in Mr Turvey's records to show that a nurse assessed him in reception when he got back from court, as should have happened.

37. On 15 December, Mr Turvey's cellmate told an officer working at Woodhill temporarily that Mr Turvey was upset and did not want his lunch. The officer went to speak to Mr Turvey in his cell and said it was clear he had been crying. Mr Turvey told her it had "broken his heart", seeing his family in court and then thinking about them, driving home without him. She asked what she could do to help. Mr Turvey told her he would get his head around it and that he would be okay. She (who has been an ACCT assessor for many years) asked him directly about suicide and self-harm and whether he felt like harming himself. She said Mr Turvey was offended that she asked this question and replied that she should know that this was "not his way". Mr Turvey said if he needed to talk to anyone, he would talk to his friend. He spent some time talking to him that afternoon,

38. The officer felt Mr Turvey was not suicidal at that time. She kept an eye on him during the rest of that day and checked to ensure that he went to work, collected his evening meal and socialised with other prisoners on the landing. She made an entry in his personal record and the wing observation book (so staff coming on duty would be aware that he had been low earlier that day). In her entry, she noted that Mr Mitchell had said he was a "broken man" but had assured her he would not harm himself. She then went on leave for three weeks.

39. During routine monitoring of Mr Turvey's telephone calls on the night of 17/18 December, a member of staff listened to a call he had made to a family member

earlier that day. Mr Turvey had been upset and tearful and said he was missing his partner and children. The phone monitor telephoned Houseblock 4B around 2.00am and told the night officer, who made a note in the wing observation book. There is no record that staff followed up the concerns, later in the day, to check how Mr Turvey was feeling.

40. Mr Turvey's solicitor told us that she visited him at 10.30am on 21 December to discuss his conviction and the sentencing process. Before the visit, staff had told her that Mr Turvey had made threats about her during a conversation with his sister. She had therefore first asked them to check that he wanted to see her. Initially, he had been clearly unhappy and had paced backwards and forwards in the room, but then calmed down. Mr Turvey said he was upset that he had been convicted. She discussed his next court hearing and said she could only advise him about an appeal after he had been sentenced.

41. Mr Turvey's mother, sister and brother-in-law visited him frequently and they often spoke on the telephone. On 22 December his sister and brother-in-law visited.

42. Mr Turvey's last session at work before the Christmas break was on 23 December. During a telephone call with his brother-in-law in the afternoon, he commented that staff were monitoring his cellmate under ACCT suicide and self-harm procedures and that it was a "nightmare" because they frequently shone a torch in the cell during the night. He said that he had just tried to call his partner, but her number had still not been added to his approved list. (Mr Turvey had asked for his partner's number to be added to his list of approved numbers on 3 December, shortly after the restriction on him contacting her had been lifted and the reasons for the delay are not clear.)

43. The next day, Christmas Eve, Mr Turvey made several phone calls to his family and spoke to his partner for the first time. The investigator listened to some of the phone calls. In the calls to his partner, they were both upset at times. Mr Turvey was concerned about their relationship and she reassured him. They talked about Christmas and the presents she had bought for the children. A child said, "Hello Daddy" and another child said they missed him and that Santa was coming. Mr Turvey said the worst part was not being there for the children and that he had to get through this time of year. He said he was not going to ring anyone on Christmas Day because he just wanted to get through it. After this call, Mr Turvey rang other family members. He said he felt "brilliant" after talking to her. Mr Turvey did not make any calls after 24 December.

44. Mr Turvey's friend said Mr Turvey did not particularly like socialising with other prisoners. He said that Mr Turvey had talked to him about his offence and the trial and was upset that he had been convicted. He was also concerned about the possibility that he might get a long sentence. However, he thought Mr Turvey had been very happy after the phone calls to his partner, although hearing his children's voices had upset him. Another prisoner told us the same and thought Mr Turvey was worried about the possible length of his sentence. The prisoner said that another prisoner had told him he would get a life sentence.

45. Another prisoner said that on Sunday 27 December he thought Mr Turvey might have taken some tablets of amitriptyline (an antidepressant) he had bought from another prisoner. He noticed his pupils were dilated and he seemed spaced out.

46. During the Christmas period, Mr Turvey told his friend that his cellmate had got hold of some mirtazapine tablets and asked what he thought might happen if his cellmate took them. With hindsight, he thought Mr Turvey was really talking about himself, not his cellmate, and wondered whether he had taken the tablets.

47. Monday 28 December was a Bank Holiday, so it was treated like the weekend. Prisoners did not go to work or have an evening association period. Mr Turvey's cellmate moved out of the cell that afternoon to share with someone he already knew. He said this was by mutual agreement, as he and Mr Turvey did not get along particularly well. An officer arranged the move at about 3.45pm. The cellmate said he did not notice that Mr Turvey was low or depressed while they were sharing. He said that they had had some long conversations some nights and Mr Turvey talked about his partner and children. The cellmate did not consider he appeared suicidal and said he always seemed positive.

48. At lock up time, which was approximately 5.00pm that day, the cellmate and another prisoner chatted to Mr Turvey on the landing and everything had seemed as normal. A prisoner spoke to Mr Turvey and he said he had talked about his children and that he planned to ring them on Thursday (when he would have had more phone credit). The prisoner noted nothing different about Mr Turvey. At 8.45pm, a member of staff did a routine count to check that all prisoners were in their cells and had no concerns about Mr Turvey.

49. Officer A did the morning count of prisoners on Houseblock 4B. CCTV shows that he got to Mr Turvey's cell at almost 5.45am. When he looked through the door observation panel, he saw Mr Turvey in a seated position, suspended from the end of the bed frame by a ligature made from a towel. He radioed a code blue medical emergency (which indicates circumstances such as when a prisoner is unconscious or not breathing) and tried to get a response from Mr Turvey. Thirty seconds later, an operational support grade (OSG) arrived. As the prison was still in night state (when staff do not carry standard prison keys), they used a cell key kept in a sealed pouch for use in an emergency and unlocked the door. At 5.46am, they went into the cell.

50. Officer A cut the ligature from around Mr Turvey's neck and they lowered him to the floor. The OSG found no pulse or signs of breathing and described Mr Turvey as cold and stiff. Within another minute, seven other staff arrived, including the night manager and Officer B. Officer B also said Mr Turvey's body was very cold and stiff, but he began chest compressions to try to resuscitate him, until the night manager took over.

51. A nurse arrived at Mr Turvey's cell at 5.51am, about six minutes after Officer A had called the emergency code. A minute later, she left to bring a defibrillator (which is kept in the central area between houseblock 4A and 4B). She said Mr Turvey looked pale, with blue lips and fingers, fixed pupils and that his body was rigid. She tried to insert an airway, but his jaw was locked. Officer C took over giving chest compressions and she attached the defibrillator, which found no

shockable heart rhythm. Staff continued to try and resuscitate Mr Turvey until the paramedics arrived.

52. The officer working in the control room noted on the emergency ambulance procedure form that the 999 call was made at 5.45am. Another log, the contingency plan for death in custody, records the call at 5.47am. A paramedic with the South Central Ambulance Service Trust logged the 999 call at 5.49am.

53. The ambulance arrived at Woodhill at 5.54am and a first response car, a minute later. CCTV confirms that the three ambulance staff got to Mr Turvey's side at 6.04am. They moved him to the landing (where there was more space) and attached their own defibrillator, but gave no shocks. At 6.12am, the paramedics decided Mr Turvey had died. At 7.35am, the on-call GP formally recorded Mr Turvey's death.

54. Mr Turvey left several notes in his cell to his family, his friend and the Governor, apologising and explaining his actions. He said he could not face life without his partner and children and maintained his innocence.

Contact with Mr Turvey's family

55. Operational support grade staff acted as the prison's family liaison officers. Mr Turvey's mother, who he had named as his next of kin, lived about 15 minutes from the prison. They arrived at her home at 10.00am and informed her that Mr Turvey had died. They offered condolences and support.

56. One family liaison officer kept in regular contact with Mr Turvey's brother-in-law, who was the main family contact. Woodhill offered help with the funeral arrangements and contributed to the costs, in line with national instructions. Several prison staff attended the funeral, which was held on 25 January.

Support for prisoners and staff

57. After Mr Turvey's death an operational manager debriefed the staff involved in the emergency response. She offered her support and that of the staff care team.

58. The prison posted notices informing other prisoners of Mr Turvey's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Turvey's death.

Information from Mr Turvey's solicitor

59. Mr Turvey's solicitor told the investigator that during legal visits Mr Turvey rarely spoke about his day-to-day life in Woodhill. He told her that his partner had attended court during the closing stages of his trial. It was the first time he had seen her since his remand and he had found it distressing. She said she had concerns about Mr Turvey's emotional wellbeing every time she saw him. He frequently referred to taking his own life, but would always follow it up with a comment such as, "But I'm not guilty so I won't give them the satisfaction". She said he mentioned it so frequently, that it was very difficult to assess whether he was serious or not.

60. The solicitor thought Mr Turvey had spoken about taking his own life at their meeting on 21 December, but said that he would not because he would rather his children knew that he was in prison than he was dead. At this meeting, she had intended to disclose a document from his barrister, which gave negative advice about his prospects of appeal. However, she decided against telling him because he was angry and upset and it was possible he would have fewer visits and not so much support over the Christmas period. She said her concerns were tempered in part because she knew that Mr Turvey shared a cell, so would rarely, if ever, be left alone. She said she would have been much more concerned about him if he no longer had a cellmate. She did not share any of this information with staff at the prison.

Information from prisoners after Mr Turvey's death

61. All the prisoners we spoke to were very shocked and surprised by Mr Turvey's death. They had not known he was feeling so low, or that he had any thoughts about ending his life. They told us they would have let staff know if they had been worried about him.

62. Some prisoners, including Mr Turvey's friend, suggested Mr Turvey was worried about getting a long sentence. There were also reports that other prisoners had worried him by suggesting that he would get a life sentence. His friend thought Mr Turvey was most worried about transferring to a London prison for sentencing. He said that there was a programme on television around the same time about hanging and wondered if this had had an impact on Mr Turvey's state of mind.

Post-mortem report

63. A post-mortem examination found Mr Turvey died from asphyxiation and hanging. Toxicology tests showed the presence of naproxen (an anti-inflammatory painkiller) in the range expected for a therapeutic dose. Mr Turvey had not been prescribed naproxen. It is possible that these were the tablets he had obtained shortly before his death. There was no trace of any antidepressants.

Findings

Assessing and managing the risk of suicide and self-harm

64. Prison Service Instruction (PSI) 64/2011 (Safer Custody), lists a number of risk factors and triggers that might increase prisoners' risk of suicide or self-harm. It says that after speaking to a prisoner, staff should use their judgement in combination with all available evidence to inform their decision about whether a prisoner poses a risk to himself.

65. There is no clear record of the risk factors staff took into account when they assessed Mr Turvey when he first arrived at Woodhill, or that they shared information with each other. This is a concern, as a number of recent self-inflicted deaths at Woodhill have been within the first two weeks of arrival and the prison has previously accepted recommendations that reception and first night staff should consider and *record* the factors they have taken into account when deciding whether or not to begin ACCT procedures. Recording known risks, helps make a balanced decision.

66. When he arrived at Woodhill in July 2015, this was Mr Turvey's first time in prison, he was facing serious charges, he had previously taken an overdose of drugs and alcohol in an apparent suicide attempt, and his escort record indicated that he was very emotional. He said he was shocked to be in prison. He was unable to contact his partner because of the charges he was facing and therefore was not able to speak to her for support (although he had the support of other family members). All of these are risk factors for suicide.

67. Although it is not clear that the staff considered all the risks, they noted that Mr Turvey's overdose had been ten years previously and he gave a convincing reason why he would no longer contemplate such an action, as his attitude and circumstances had changed since he had become a father. Assuming that the staff understood and considered his risks, we accept that it was probably reasonable not to begin ACCT procedures when Mr Turvey first arrived at the prison, as he had few additional risk factors. However, this was a finely balanced decision, which was not reflected in the records.

68. After his initial assessments, there was little further to indicate that Mr Turvey was a raised risk in his first few months at Woodhill, although an officer spoke to him about concerning comments he had written in a letter at the end of July. The letter indicated that Mr Turvey was feeling very low, but he reassured the officer that he was not suicidal.

69. The next potential trigger point was Mr Turvey's trial and conviction at the beginning of December 2015. There was some indication that he was finding this difficult to cope with, as he asked to speak to a friend and then a Listener on 11 December. There is no evidence that any member of staff spoke to Mr Turvey about whether he was finding the trial stressful.

70. Prison Service Order 3050 (PSO) Continuity of Healthcare indicates that events such as attending court, sentencing at court and being questioned by the police are factors that might increase an individual's risk of suicide and self-harm. It

says that for prisoners passing though reception, prisons must have protocols to screen them for any potential healthcare, suicide or self-harm issues.

71. There is nothing in Mr Turvey's records to show that a nurse assessed him in reception when he returned from court after being convicted of serious offences on 14 December. The Head of Healthcare said there is always a nurse based in reception, but prisoners often decide not to see the nurse so there is no note in the medical record. We do not consider that this is a reasonable process. Nurses should assess all newly convicted prisoners and if they do not comply this should be fully recorded, as this in itself might indicate increased risk. After our investigation into the death of a prisoner at Woodhill in 2013, the prison accepted a recommendation about the need for such assessments but it does not appear that the recommendation has been fully implemented.

72. To an extent, the lack of an assessment for risk of suicide and self-harm in reception was mitigated, as an officer spoke to Mr Turvey on 15 December, when his cellmate said he was very upset about his conviction. Mr Turvey assured her that he would come to terms with his conviction and would not do anything to harm himself. It is a natural reaction to be upset in these circumstances, but being upset and tearful does not necessarily mean someone is thinking of suicide. The officer is an experienced officer and an ACCT assessor and did not consider Mr Turvey was suicidal at that time. Although with hindsight, it might have been prudent to begin ACCT procedures and formally assess him, this was a judgement call and we are satisfied that the officer appropriately considered the options. She kept an eye on Mr Turvey for the rest of the day, and decided that ACCT monitoring was not necessary.

73. A few days later, a member of staff passed on a concern that Mr Turvey had been upset and tearful during a telephone call. This was noted in the observation book, but no one spoke to Mr Turvey the next day to ask how he was and decide whether he might need additional support. We listened to the phone call and while Mr Turvey spoke about not being able to cope, he went on to say that out of a funeral or prison sentence, he would take the prison sentence. While this suggested he was not intending suicide at the time, it indicated he had contemplated suicide. Someone should have spoken to Mr Turvey, checked how he was feeling and began ACCT procedures if they had any concerns.

74. On 21 December, Mr Turvey's solicitor seemed to have significant concerns about his state of mind, so much that she withheld information from him about his appeal prospects. It is most unfortunate that she did not pass any of her concerns to prison staff, but, as he had again mentioned his children as a reason why he would not kill himself, it seems likely that had she done so, prison staff would have again accepted his explanation.

75. These were missed opportunities to assess Mr Turvey's risk formally again and it does not appear that anyone recognised that he was at increased risk of suicide after his conviction or put together the various concerns. However, we recognise that there was little to indicate Mr Turvey was at high or imminent risk of suicide. Even if staff had begun ACCT procedures, it is unlikely that they would have recognised that his risk was very high and that monitoring would have been set

at such a level that it would have prevented his actions. However, he might not have been left in a cell on his own and should have had more support.

76. On Christmas Eve, Mr Turvey spoke to his partner and seemed happy about this. He also spoke to other family members and none of them identified any concerns about him. He seemed to everyone, including a work place supervisor (who saw him every weekday for a few hours) to be fine, sociable and hardworking. His closest friend at the prison knew Mr Turvey was worried about what sentence he might get and possibly moving prisons, he but did not think he was suicidal.

77. It is clear from the notes Mr Turvey left in his cell that he could not face being found guilty, the uncertainty of the sentence he might get and the fact he would not be with his partner and children. It seems that he had brooded on these matters over the Christmas period. Mr Turvey did not share these feelings with anyone in the prison, staff or prisoners.

78. While we consider that it would have been difficult for staff to have foreseen Mr Turvey's actions, the investigation identified some areas, such as recording risk factors when assessing new arrivals, and assessing risk after court appearances, about which we have made previous recommendations to the prison, which do not appear to have been implemented effectively. We also note that HM Inspectorate of Prisons at their inspection of Woodhill in September 2015 found poor implementation of PPO recommendations. Rather than repeat previous recommendations, we make the following recommendation:

The Deputy Director of Custody for High Security Prisons should assure himself that Woodhill has effectively implemented all PPO recommendations made following self-inflicted deaths at the prison in the last five years and provide a report to the Ombudsman outlining progress within three months of receiving this report.

Personal officer scheme

79. While we consider it would have been difficult for Woodhill to have foreseen Mr Turvey's actions, some of the information about his state of mind could have been more effectively coordinated and might have identified concerns. It seems there is little staff continuity in the houseblocks, which makes it difficult for staff to get to know prisoners or spot when there is a problem or a building pattern of concerns. Some staff said they might only work one or two shifts a week in the vulnerable prisoner unit. The Governor told us he was more than 40 officers short and used detached duty staff (staff from other prisons) to fill the gaps. There was also a lot of new and inexperienced staff.

80. The personal officer system at Woodhill was ineffective and none of the prisoners we spoke to, knew their personal officer. Personal officers are supposed to get to know the prisoners they are responsible for, help them with any problems and resettlement objectives and make regular entries in their case notes, outlining their progress and any concerns. Apart from the officer who was not a Woodhill officer, staff we spoke to knew little about Mr Turvey. Most prisoners thought it would be a positive thing if staff took more of an interest in them as a person. One prisoner commented that the only time prisoners had a more in depth

conversation with staff was when they were being monitored under ACCT procedures.

81. Mr Turvey had assigned personal officers but there were no entries by them in Mr Turvey's case notes and they told us they did not work on Houseblock 4B regularly. The officers said there was not enough time for personal officer work. One officer told us he had not done any personal officer work during the three years he had been at Woodhill. The other officer commented that there are 90 prisoners on Houseblock 4B and usually three or four officers. This meant that in practice officers only had time to talk to prisoners who approached them for something, or if it was obvious they were upset. Apart from a detailed case note entry by an officer in December, the entries in Mr Turvey's record are only administrative from August onwards.

82. The Ombudsman supports the concept of personal officer schemes which ensure that all prisoners have a named member of staff tasked to get to know their allocated prisoners, identify their risks and needs, and offer support. We therefore agree with the Independent Monitoring Board's view that the loss of the personal officer scheme ay Woodhill is a lost opportunity for staff to identify prisoners who might be at risk of suicide or self-harm.

83. We recognise that, currently, staffing levels and vacancies at Woodhill make it difficult to run a comprehensive personal officer scheme but a modified scheme at least for prisoners at known periods of higher risk, such as the early period in custody, during a trial, around sentencing and those recalled to prison should be achievable. In the short-term, this would restore the benefits of a personal officer scheme on a targeted basis, while a more comprehensive scheme is reintroduced. We make the following recommendation:

As part of a planned reintroduction of an effective personal officer scheme, the Governor should introduce an adapted scheme so that prisoners in the early days of custody and other vulnerable periods of their time in prison have an assigned officer who gets to know and support them.

Emergency response

84. The control room operator said she called 999 within a minute of receiving the code blue radio message. She wrote 5.45am in the ambulance log and said the time was taken from the electronic clock in the control room. Another form, completed by different person in the control room, recorded that the ambulance was called at 5.47am. South Central Ambulance Service record the time at 5.49am. She said she was certain she called an ambulance as soon as she heard the code blue message. According to the CCTV timings, the officer did not reach Mr Turvey's cell until two seconds before 5.45am so she would have had to be exceptionally quick to have called an ambulance at that time. It seems likely that there was a time discrepancy between the various systems used but we cannot be sure about this.

85. The ambulance arrived at Woodhill at 5.54am, and a first response car a minute later. It took paramedics another ten minutes to reach Mr Turvey's cell. We were told there is a perfunctory search of the vehicles and then quite some distance for the ambulance to travel once inside the prison gate to get to

Houseblock 4. Six internal gates have to be opened and closed. This was done by one dog handler escorting the paramedics.

86. Prison Service Instruction (PSI) 3/2013 sets out how a prison should respond to a medical emergency. It requires that every prison should develop a protocol with the local ambulance service, which ensures, among other things, that there is no unnecessary delay in escorting ambulances and paramedics to the patient and discharging them from the prison and that this must include procedures during the night state. In a report into a death at Woodhill in February 2015, we considered that 15 minutes was too long to get paramedics from the prison gate to a cell in a medical emergency and made a recommendation about ensuring there were no unnecessary delays.

87. While it would not have made a difference for Mr Turvey, we consider that ten minutes is still a little long for paramedics to reach a patient in an emergency, after they have arrived at the prison – longer than it had taken to get to the prison. At night, when all prisoners are locked in their cells, we consider it should be possible for more than one internal gate to be opened at the same time. To reduce the time, other staff could have assisted the dog handler by opening gates along the way, with the dog handler locking the gates behind them.

88. Once she had arrived at Mr Turvey's cell, the nurse left to collect and bring a defibrillator kept between the two sides of Houseblock 4. It had already taken her six minutes to reach Mr Turvey's cell after the code blue was called. Leaving the cell a minute later to fetch the defibrillator meant nearly nine minutes had passed before she was in a position to give medical assistance. In an investigation into another death at Woodhill, one month before Mr Turvey's death, we were critical that the nurse left officers at the emergency to collect a defibrillator. While it would not have made a difference to the outcome for Mr Turvey, time is of the essence in an emergency and the defibrillator should have been brought sooner by another member of staff so that it was in the cell when the nurse arrived. (In fact, an officer could have used it, as specialist training is not required.)

89. PSI 3/2013, says that emergency response procedures should ensure that staff called to the scene bring relevant emergency equipment. This should include a defibrillator when a code blue is called. Woodhill's own instruction about dealing with life threatening emergencies, Staff Information Notice 197/2015, issued on 16 September 2015, states that while waiting for healthcare assistance, staff must collect emergency equipment from the core area and initiate basic life support as needed. This did not happen. We make the following recommendation:

The Governor should ensure that emergency response procedures enable paramedics to reach prisoners in a medical emergency without any unnecessary delay and that staff take relevant equipment to an emergency in line with the local instruction.

Resuscitation

90. Prison staff attempted to resuscitate Mr Turvey. From the nurse's description of Mr Turvey, he had been dead for some time and his locked jaw and rigid body indicated rigor mortis had set in. The clinical reviewer said that attempts at resuscitation were therefore futile.

91. We understand the commendable wish to attempt and continue resuscitation until death has been formally recognised, but staff should understand that they are not required to carry out cardiopulmonary resuscitation in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased.

92. European Resuscitation Council Guidelines 2010 state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …" The guidelines define examples of futility as including the presence of rigor mortis. In October 2014, the British Medical Association, the Royal College of Nursing and the Resuscitation Council UK issued guidance about making appropriate decisions about resuscitation. The guidance says that every decision should be based on a careful assessment of each individual's situation. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

Clinical care

93. The clinical reviewer judged the healthcare Mr Turvey received to be comparable to the care expected in the community and in other secure environments. Mr Turvey saw the GP a few times when he was in Woodhill about back pain. The GP prescribed a four day supply of over the counter pain relief after the second appointment in September. Mr Turvey was not prescribed any antidepressant medication.

Notifying Mr Turvey's family

94. Prison Rule 22(1) states, "If a prisoner dies the governor shall, if he knows his or her address, at once inform the prisoner's next of kin…" PSI 64/2011 gives a mandatory instruction that, wherever possible, this must be done in person by a family liaison officer and another member of staff and that "time will be of the essence".

95. The family liaison officers arrived at Mr Turvey's mother's home at 10.00am and broke the news of his death. This was nearly four hours after he had died, although his mother lived just a short distance from the prison. We consider that this was too long and not in line with the requirements of the Prison Rule. We make the following recommendation:

    The Governor should ensure that, in line with Prison Rule 22, when a prisoner dies, his next of kin are informed as soon as possible.

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