

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Culverhouse, a prisoner at HMP Woodhill, on 24 April 2019

A report by the Prisons and Probation Ombudsman

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



© Crown copyright 2018

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

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

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

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 Mark Culverhouse was found unresponsive with a ligature around his neck in the segregation unit at HMP Woodhill on 23 April 2019. He died in hospital the next day. He was 29 years old. I offer my condolences to Mr Culverhouse's family and friends.

Mr Culverhouse arrived at Woodhill on 18 April after being recalled to custody. The previous day he had threatened to jump from a building. He had self-harmed while on the roof and also while in the court cells awaiting hearing. When he arrived at Woodhill, staff started suicide and self-harm monitoring (known as ACCT) immediately. He was monitored under ACCT throughout his time at Woodhill and at times was placed on constant supervision due to his high risk of suicide and self-harm.

On 23 April, Mr Culverhouse was taken to the segregation unit after fighting with another prisoner. Less than an hour later, he was found unresponsive. He was resuscitated and taken to hospital but he died the next day.

The investigation found that staff at Woodhill provided a good level of support to Mr Culverhouse in challenging circumstances, although we found some of his ACCT reviews were not multidisciplinary as they should have been. The clinical reviewer identified some weaknesses in healthcare staff's assessments, record keeping and involvement in the emergency response, although these did not affect the outcome for Mr Culverhouse.

Mr Culverhouse was recalled to prison custody on Maundy Thursday, just before the Easter bank holiday weekend. When his sentence was recalculated on the next working day, Tuesday 23 April, it was found that he had been eligible for immediate release on 18 April because of the time he had previously served on remand.

Although the decision to recall him was lawful, Mr Culverhouse was therefore unlawfully detained between 18 and 23 April. This meant that Mr Culverhouse took his life at a time when he should not have been in prison custody. We are concerned that this was able to happen even though those involved followed the relevant policies correctly.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

February 2021

Contents

Summary	1
The Investigation Process.....	4
Background Information	5
Key Events.....	7
Findings	14

Summary

Events

1. Mr Mark Culverhouse arrived at HMP Woodhill on 18 April 2019. He had been released on licence from HMP Peterborough on 12 April. He was recalled to prison after climbing onto scaffolding and threatening to throw himself from the roof of a building. Prior to arriving at Woodhill, Mr Culverhouse had been taken to hospital after knocking himself unconscious in the court cells. He had been assessed by community mental health services, a forensic psychiatrist and the court's liaison and diversion team. All considered him suitable to be detained.
2. Mr Culverhouse arrived at Woodhill with a suicide and self-harm warning form. Staff started suicide and self-harm monitoring (known as ACCT) and placed him on constant supervision. Later that evening, staff stopped constant supervision but continued to observe Mr Culverhouse three times an hour.
3. On the morning of 19 April, Mr Culverhouse damaged his cell and was taken to the segregation unit under restraint. Staff increased his level of observations to five times an hour. He was later found unresponsive in his cell and was taken to hospital. Staff suspected he had taken illicit drugs but he did not say what he had taken. He refused to be treated at the hospital and was returned to the prison later that day and was located on a standard wing. Staff placed him on constant supervision again.
4. On 20 April, Mr Culverhouse had an early days in custody mental health screening. The nurse noted that he would be offered a full mental health assessment. She recorded that he said he had no current thoughts of suicide and self-harm.
5. On 23 April, Mr Culverhouse had a mental health assessment. The nurse noted that he was struggling to deal with traumatic issues from his childhood and the death of his father. Mr Culverhouse had an ACCT review later that morning. Staff agreed that his risk had reduced sufficiently to take him off constant supervision and set observations at three an hour.
6. At around 1.50pm, Mr Culverhouse had a fight with another prisoner. Staff restrained him and took him to the segregation unit where they set observations at five an hour.
7. At 2.49pm, a nurse went to Mr Culverhouse's cell to carry out the Initial Segregation Health Screen (which includes completing an algorithm to assess whether a prisoner is fit for segregation). Mr Culverhouse was lying on the floor under a blanket, and did not respond to her. Staff had last checked him nine minutes before.
8. Staff opened the door and found that Mr Culverhouse had tied one end of a ripped piece of sheet to his foot and the other end around his neck. He had used the sheet to strangle himself by pulling it with his foot. Staff called an emergency code blue and cut the ligature. Prison officers started cardiopulmonary resuscitation (CPR) while the nurse went to get the emergency bag. Other

healthcare staff arrived and took over CPR. A prison GP administered adrenalin and was able to resuscitate Mr Culverhouse.

9. Paramedics arrived shortly afterwards and took Mr Culverhouse to hospital. However, he never regained consciousness and died the next day.
10. A prison manager authorised Mr Culverhouse's release from custody on 23 April, shortly before his death, following a recalculation of his sentence after his recall.

Findings

Sentence calculation

11. Mr Culverhouse's recall to custody on 18 April was lawful but he was detained unlawfully between 18 and 23 April.
12. Mr Culverhouse arrived at Woodhill on the evening of Maundy Thursday, the start of the Easter bank holiday weekend. Staff in the Offender Management Unit (OMU), who have responsibility for calculating the sentences of newly arrived prisoners, do not work evenings, weekends or bank holidays. Due to previously unused remand days, the calculation of Mr Culverhouse's sentence after his recall meant that he should have been immediately released from custody on 18 April. However, the sentence calculation was not done until OMU staff returned to work on Tuesday 23 April, which meant that he was not released until after he had been taken to hospital.

Risk assessment and management

13. We found that staff acted promptly to provide Mr Culverhouse with appropriate mental health support and to reduce his risk of suicide and self-harm. However, we found that some of the ACCT reviews were not carried out in accordance with PSI 64/2011 in that they were not multidisciplinary and some records were inaccurate.

Healthcare

14. Two nurses refused to carry out the Initial Segregation Health Screen when Mr Culverhouse was segregated on 23 April, because they were concerned about his mental health. This was not acceptable. By the time a nurse did attend to carry out the health screen, Mr Culverhouse was unresponsive.
15. Mr Culverhouse was not assessed by a qualified medical practitioner after he banged his head on 23 April.
16. We found that the nurse who was present at the start of the emergency response did not take an active role in the resuscitation. Prison staff started cardiopulmonary resuscitation (CPR) while the nurse went to get the emergency bag.
17. The clinical reviewer found some weaknesses in the accuracy and clarity of healthcare records.

Recommendations

- HMPPS's Director General of Prisons should consider whether sentence calculations for prisoners who may be eligible for immediate release could be completed within one working day of their arrival into prison.
- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that staff:
 - hold multidisciplinary ACCT reviews, with healthcare staff in attendance at first case reviews; and
 - complete the relevant paperwork fully and accurately at all stages of the ACCT process, including the names and roles of those attending or providing input to case reviews.
- The Head of Healthcare should:
 - review the incident when clinical staff did not complete the algorithm for Mr Culverhouse on 23 April;
 - ensure that all staff are aware of their responsibilities for completing an algorithm for prisoners in the segregation unit;
 - complete these actions within one month of receiving this report.
- The Head of Healthcare should:
 - review the process for staff dealing with potential head injuries suffered by prisoners; and
 - develop a clear pathway for reporting and actioning those injuries in line with NHS guidelines for head injury and concussion.
- The Head of Healthcare should remind all clinical staff of their responsibilities to lead and direct resuscitation attempts.
- The Head of Healthcare should ensure that:
 - staff enter all interactions with prisoners in the clinical notes in an accurately and timely manner;
 - staff make an entry in the clinical notes when they have attended or provided input into an ACCT review; and
 - regular checks are made of clinical notes to maintain standards.

The Investigation Process

18. 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. No one responded.
19. The investigator obtained copies of relevant extracts from Mr Culverhouse's prison and medical records.
20. NHS England commissioned an independent clinical reviewer to review Mr Culverhouse's clinical care at the prison.
21. The investigator and clinical reviewer jointly interviewed nine members of staff at Woodhill. The investigator separately interviewed one prisoner and two members of staff. The interviews took place between May 2019 and February 2020.
22. We informed HM Coroner for Milton Keynes of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
23. We wrote to Mr Culverhouse's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Culverhouse's mother appointed a solicitor to act on her behalf but the solicitor did not raise any specific questions.
24. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.
25. We sent a copy of our initial report to Mr Culverhouse's mother via her solicitor. She pointed out several factual inaccuracies which have been amended in this report.

Background Information

HMP Woodhill

26. HMP Woodhill in Milton Keynes is a complex institution known as a 'core local' prison. It provides a local prison function for just over 600 men, and also holds a small number of category A prisoners, most of whom are going through the court process or have been recently convicted. In addition, the prison operates a close supervision centre (CSC), a specialist facility for some of the country's most disruptive prisoners.
27. Central and North-West London NHS Foundation Trust provides health services at the prison. There is an inpatient unit with 12 beds, which provides mental and physical healthcare, including end of life and palliative care.
28. As part of HM Prison and Probation Service's estate transformation, HMP Woodhill was due to become a category B training prison in 2018. At the time of writing (March 2020) this has not yet happened.

HM Inspectorate of Prisons

29. The most recent inspection of HMP Woodhill was in February 2018. Inspectors found that incidents of self-harm remained high and they were concerned about the high number of self-inflicted deaths. They noted that there had been some improvement in the way prisoners at risk of suicide and self-harm were supported but felt that more needed to be done to improve safety and reduce self-harm.
30. Inspectors found that the mental health team was well-integrated with the rest of the prison and regularly involved in ACCT reviews and prison-wide meetings to support prisoners with complex needs. They found that referrals were received to a dedicated email box, reviewed and actioned appropriately.
31. Inspectors reported that over half of respondents to their survey said that illicit drugs were easily available at Woodhill. The mandatory drug testing positive rate was lower than at other local prisons and mostly concerned tradeable medication and psychoactive substances (PS), but the prison's supply reduction strategy and action plan were weak and out of date.

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 31 May 2018, the IMB reported that the proportion of prisoners being managed under ACCT remained high. While some innovative work had been done in developing safer custody strategies, the management of ACCTs was inconsistent. The use of PS had been controlled with front end and targeted searching but remained a disruptive force when accessed by prisoners. Levels of violence remained high. Healthcare services had performed well against challenging staffing problems.

Previous deaths at HMP Woodhill

33. Mr Culverhouse was the ninth prisoner to die at Woodhill since April 2017. Of the previous deaths, two were self-inflicted, four were from natural causes, one was drug-related, and one was a homicide. There have been two deaths since, both self-inflicted.
34. Previous PPO investigations identified concerns with the management of ACCT procedures at Woodhill.

Assessment, Care in Custody and Teamwork (ACCT)

35. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system 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 risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions on the caremap have been completed.
36. 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, Management of prisoners at risk of harm to self, to others and from others (Safer Custody).

Key Events

Events leading to recall

37. Mr Mark Culverhouse was released on licence from HMP Peterborough on 12 April 2019. On 17 April, he drove his mother's van to a nearby building where he climbed onto scaffolding and threatened to throw himself from the roof. He also made cuts to his arms and body while on the roof.
38. A nurse from the community mental health team observed Mr Culverhouse while he was on the roof. He noted that he observed Mr Culverhouse for two hours and saw no evidence of delusional behaviour. He considered Mr Culverhouse was "playing to the crowd". He considered that Mr Culverhouse was fit for detention and interview.
39. Mr Culverhouse was taken to the police station where he was assessed by a forensic psychiatrist. The psychiatrist noted that Mr Culverhouse had mental health, substance misuse and self-harm issues. He assessed that Mr Culverhouse was fit to be detained. The police charged Mr Culverhouse with criminal damage and remanded him to attend court the following day.
40. On 18 April, Mr Culverhouse was taken to Northampton Magistrates Court where he was assessed in the cells by someone from the Liaison and Diversion Service (who identify people in contact with the criminal justice system who have mental health, learning disability or substance misuse vulnerabilities). She noted that she could initially see no obvious mental health issues with Mr Culverhouse although self-harm marks were visible on his arms. She noted that his behaviour changed suddenly during their interview and he began banging his head off the door until he knocked himself unconscious. Staff called an ambulance and Mr Culverhouse was taken to hospital. He did not appear before the court for the further charges.
41. The police had already alerted the probation service to Mr Culverhouse's further charges. As Mr Culverhouse was a high-risk offender and had been charged with a further offence, the probation service made a decision to recall him to prison. Mr Culverhouse's offender manager visited him at the hospital. She was concerned by his behaviour and presentation and discussed her concerns with the hospital doctor. However, as the decision had already been made to recall him, he was taken to HMP Woodhill.

Arrival at HMP Woodhill - 18 April

42. Mr Culverhouse arrived at Woodhill on the evening of 18 April with a suicide and self-harm warning form. Reception staff noted a history of mental health and substance misuse issues as well as his recent self-harm and suicidal thoughts. Staff started suicide and self-harm procedures (known as ACCT). CCTV shows Mr Culverhouse arriving in reception. He can be heard expressing disbelief at being recalled to prison for trying to take his life and saying that he needed to be in a mental health hospital rather than prison.
43. A Supervising Officer (SO) completed a Concern and Keep Safe form with Mr Culverhouse shortly after he arrived in reception. The SO knew Mr Culverhouse

from previous sentences over the years but noted that his presentation was different this time. The SO recorded that Mr Culverhouse told him he intended to kill himself as his “head has gone”. Staff placed Mr Culverhouse on constant supervision.

44. A nurse carried out Mr Culverhouse’s reception healthcare screening. He noted that Mr Culverhouse was being supported by the ACCT process. He referred Mr Culverhouse to the mental health team and the prison doctor.
45. A prison GP saw Mr Culverhouse as part of the reception process. The GP knew Mr Culverhouse from previous sentences and he noted that his presentation had changed. He was particularly concerned that he had been cutting himself, which he considered to be unusual behaviour for him. Mr Culverhouse told the GP that he had not been misusing drugs or alcohol, but he was angry and felt that he needed something to calm him down. The GP noted that Mr Culverhouse was struggling to deal with the death of his father but he said he had no further thoughts of taking his life or self-harming. The GP prescribed a short course of chlordiazepoxide (Librium, a sedative) to help reduce his levels of stress and anxiety. The GP also reviewed the results from the hospital in relation to Mr Culverhouse’s earlier head injury. He noted no concerns.
46. Later that evening, staff stopped constant supervision but observed Mr Culverhouse three times an hour. No concerns were noted through the night.

19 April

47. At 7.30am, staff told Mr Culverhouse that he would be moving to a different wing. Mr Culverhouse was under threat from another prisoner and, for this reason, he was not allowed to leave his cell until a manager gave authority for this to happen. It is not clear if this information was communicated to Mr Culverhouse. Although the manager gave authority for Mr Culverhouse to be unlocked at 10.25am, he still remained in his cell by 12.00pm. He, became agitated, shouted at staff and said he did not want to move. Mr Culverhouse later damaged his television and broke the observation panel on his cell door. He told staff that his father did it and said he would soon be joining his father in heaven. Staff restrained Mr Culverhouse and took him to the segregation unit. They increased his observations to five an hour.
48. At around 12.40pm, Mr Culverhouse blocked his observation panel and staff found him unresponsive in his cell. Staff called a code blue (an emergency code which tells the control room that a prisoner is unresponsive or not breathing and an ambulance should be called immediately). Staff found evidence of crushed white tablets next to the toilet, suggesting that Mr Culverhouse may have taken an illicit substance.
49. A healthcare manager told the investigator and the clinical reviewer that she responded to the code blue with a healthcare assistant. She found Mr Culverhouse struggling with officers and making growling noises. She said that he resisted while she was trying to treat him, he was agitated, trying to bite staff, and was banging his head on the floor. Although she was able to carry out some observations on Mr Culverhouse, she said she was not sure if she was treating him for the use of an illicit substance or a head injury so she felt it was better for

him to go to hospital for further assessment. The ambulance arrived and Mr Culverhouse was taken to hospital under restraint.

50. At the hospital, Mr Culverhouse told doctors that he wanted to speak to someone about his mental health but not in the presence of prison staff. Due to his level of aggression and his risk, prison staff were unable to leave him alone with hospital staff so, although he was seen by the mental health team at the hospital, he refused to engage with them. He indicated that he had taken something, but he would not say what it was and refused treatment. He also said that he had more pills and some glass “plugged” in his rectum and that he would try to harm himself again.
51. A healthcare manager told us that she spoke to the hospital consultant who told her that Mr Culverhouse had been assessed as having capacity to refuse treatment and to discharge himself from hospital. She said she tried to make it clear to the consultant that Mr Culverhouse would not be returning to a clinical facility at the prison and, as it was a bank holiday weekend, he would not immediately receive a mental health assessment. Mr Culverhouse was returned to Woodhill around 5.00pm that evening.
52. Mr Culverhouse had an urgent ACCT review on his return from hospital. The review was chaired by a prison manager and was also attended by a Custodial Manager (CM). Healthcare staff did not attend. The ACCT review documentation recorded that healthcare provided verbal input but we found no evidence of this. Staff discussed Mr Culverhouse’s recent self-harm and hospitalisation. They agreed his risk to himself was high and put him on constant supervision.
53. Healthcare staff monitored Mr Culverhouse at regular intervals throughout the night.

20 April

54. At 9.30am, Mr Culverhouse had an ACCT assessment interview with a prison GP and an SO from the safer custody team. Mr Culverhouse told them that he had not recovered from the death of his father and was keen to have bereavement counselling and contact with the mental health team. Mr Culverhouse also said that he wanted to continue with the chlordiazepoxide medication which had helped him. The GP agreed to prescribe the medication. Mr Culverhouse was keen to come off constant supervision, but the GP said it would continue for now.
55. Around 9.40am, a nurse carried out an early days in custody mental health screening with Mr Culverhouse. She recorded that he engaged well with her. He told her he had depression and had engaged with mental health services in previous establishments. Mr Culverhouse said that his sleep, appetite and energy levels were okay and he had no current thoughts of suicide or self-harm. The nurse referred him for a full mental health assessment.
56. At 10.45am, a prison manager chaired Mr Culverhouse’s second ACCT review. Two CMs attended. The ACCT review paperwork showed that someone from healthcare attended but we could not establish who this was. There is no record in Mr Culverhouse’s medical records that anyone from healthcare attended. Mr

Culverhouse said he had seen the doctor. He admitted that he was unwell and needed mental health support. Staff noted that Mr Culverhouse had not self-harmed but said he still had suicidal thoughts. Staff assessed that his risk remained high.

57. At 4.00pm, Mr Culverhouse spoke to his mother on the phone. Staff recorded in the ACCT observation record that he was initially upset but said he felt better after speaking to her.

21 April

58. At 9.50am, Mr Culverhouse had a constant supervision review with a prison GP. The GP reported that Mr Culverhouse seemed more upbeat and there had been no further incidents of concern. Mr Culverhouse was keen to be taken off constant supervision and the GP said he would support it.
59. At 10.30am, Mr Culverhouse attended his third ACCT review. The review was chaired by a prison manager. It was also attended by an SO and a nurse. Mr Culverhouse said he felt better after speaking to his mother. He said he felt supported by her and his stepfather and staff noted that his three children were a protective factor. Staff assessed that his risk was high and he should remain on constant supervision until after his mental health assessment. They also added a caremap action to refer him to the substance misuse service.
60. During the afternoon, Mr Culverhouse complained of headaches and neck pain which were caused by banging his head. Healthcare staff provided him with paracetamol and ibuprofen on two separate occasions during the day. Mr Culverhouse had a settled night.

22 April

61. At 10.30am, Mr Culverhouse attended the healthcare unit to request more pain relief for his head and neck pain. A nurse gave him paracetamol and placed him on the waiting list to see the doctor.
62. At 11.20am, a prison GP saw Mr Culverhouse for a constant supervision review and to discuss his head and neck pain. The GP noted that Mr Culverhouse engaged well with the review and said that he had no thoughts of suicide or self-harm. Mr Culverhouse said that he was getting pains due to banging his head on the walls and the GP prescribed a stronger painkiller, naproxen, and advised to continue with pain relief when needed.
63. At 11.35am, the prison chaplain met with Mr Culverhouse. They spoke about Mr Culverhouse's father and agreed that Mr Culverhouse could go to light a candle at the chapel for his father, with the agreement of prison staff.
64. At 3.00pm, a CM chaired Mr Culverhouse's fourth ACCT review. Two SOs and an officer attended. Staff agreed that Mr Culverhouse seemed more positive and engaged well with the review. He was glad that a mental health assessment was due to take place the following day and he told staff he had spoken to his mother. Staff agreed that Mr Culverhouse was at high risk of suicide or self-harm and that he should remain on constant supervision until after his mental health assessment.

23 April

65. Mr Culverhouse had a settled night and staff reported that he was in a positive mood first thing in the morning. An officer noted in the ACCT observation record that he told her he was feeling very positive about the day. At 9.00am, an officer made an entry which said that Mr Culverhouse was looking forward to going to light a candle in the chapel for his father.
66. At 9.55am, Mr Culverhouse had a mental health assessment with a nurse. The nurse noted that he was struggling to deal with traumatic issues from his childhood and the death of his father. She noted that most of his previous mental health support had come from prison and probation services due to his frequent sentences. She noted that he said he felt depressed and he struggled to adapt when in the community. She noted that there was a suggestion of a personality disorder but queried if it had been diagnosed.
67. The nurse told the investigator and the clinical reviewer that Mr Culverhouse presented well during the assessment and appeared keen to engage with the mental health team. The nurse recorded in Mr Culverhouse's medical record that no further intervention would be required by the mental health team, but she could not explain at interview what she meant by this. She said she had every intention of taking him onto her caseload and setting up a care plan to support him. His medical records show that the nurse did discuss him at a multidisciplinary team meeting shortly after she met with him and that it was agreed that he would be taken onto her caseload.
68. Later that morning, a CM chaired Mr Culverhouse's fifth ACCT review. An SO, a nurse, and two members of OMU attended. (The CM incorrectly recorded the name of another nurse on the list of attendees rather than the nurse who did attend. He said at interview that he got the two nurses mixed up as they look similar.) Staff recorded that Mr Culverhouse appeared positive. He spoke about his mental health assessment and probation staff agreed to help him to plan for release, including maintain family ties. Staff agreed that his risk had reduced sufficiently to take him off constant supervision. They set observations at three an hour.
69. At around 1.50pm, Mr Culverhouse was on his way to the chapel to light a candle for his father when he saw a prisoner he knew from the community, and they got into a fight at the muster point. The prisoner told the investigator that he and Mr Culverhouse had an ongoing feud in the community and he had not known Mr Culverhouse was in the prison. He said that he had been on his way to education when Mr Culverhouse rushed towards him and started attacking him. He said he knew Mr Culverhouse to be a violent person, but he was shocked by his appearance and the level of his aggression towards him. Staff pressed the general alarm to break up the fight. The prisoner said that staff pulled them apart but Mr Culverhouse would not calm down so they had to restrain him and take him to the segregation unit.
70. A healthcare assistant responded to the emergency alarm and was present throughout the restraint. He told the investigator and the clinical reviewer that Mr Culverhouse was being actively resistant. He described him as swearing and lashing out at officers. This can also be seen from body-worn video camera

footage of the incident. During the restraint, Mr Culverhouse fell to the floor and hit his head. The healthcare assistant said Mr Culverhouse was briefly unconscious. He assessed him and said that he spat out some blood and he was shaking, but he did not consider he was having a fit. Staff took Mr Culverhouse to the segregation unit.

71. When Mr Culverhouse arrived at the segregation unit at approximately 2.00pm, he was searched and put into a cell. He continued to behave aggressively towards staff and he banged his head against the cell door, causing him to fall to the floor. The healthcare assistant assessed him again. He said that Mr Culverhouse was not opening his eyes but he carried out a reflex test which indicated that he was conscious. Due to his aggressive behaviour, staff left the cell around 2.15pm and agreed that Mr Culverhouse should not be unlocked unless there were four officers present. Staff set observations at five an hour.
72. Prisoners in segregation should have an Initial Segregation Health Screen (which includes an algorithm to assess whether they are fit for segregation) completed within two hours. Nurse A and Nurse B were available to complete the health screen but did not do so. Nurse A wrote in Mr Culverhouse's medical record that he saw Mr Culverhouse in the segregation unit but was unable to assess him due to his behaviour. He wrote that he was aware that Mr Culverhouse had recently come off constant supervision so asked for the health screen to be completed by someone from the mental health team.
73. Nurse B wrote in the medical record that she saw Nurse A in the segregation unit but he did not tell her which prisoner needed to be reviewed. She said he then went off to do something else. It is not clear from Nurse B's entry why she did not complete the healthscreen when she became aware that it was for Mr Culverhouse. Instead, she contacted Nurse C and asked her to complete it. Nurse C said she was in the middle of a clinic and was not sure why she was called away to do something that two other qualified nurses could have done. The healthcare manager said that Nurse A and Nurse B were both capable of completing the health screen and there was an expectation that any available qualified nurse should do it.
74. Staff in the segregation unit checked Mr Culverhouse at 2.30pm and 2.40pm. An officer recorded in the ACCT observation book that he was covered with a sheet. She noted that there was movement in his foot and he was singing.
75. Nurse C attended to complete the health screen at 2.49pm and saw Mr Culverhouse covered by a sheet. She said he was not moving and he did not respond to her when she called him. She asked staff to open the door and they found that Mr Culverhouse had tied one end of a piece of ripped sheet to his foot and the other end around his neck. He had used the sheet to strangle himself by pulling it with his foot. Staff called an emergency code blue and cut the ligature. Staff noticed crushed white powder by the toilet.
76. Staff cut the ligature and an officer started cardiopulmonary resuscitation (CPR). A CM called an emergency code blue and Nurse C went to get the emergency bag. Other prison officers assisted with CPR and staff moved Mr Culverhouse out of the cell so they had more space to treat him. Healthcare staff arrived and took over CPR, although prison staff continued to assist. A prison GP

administered adrenalin and staff were successful in resuscitating Mr Culverhouse before the paramedics arrived.

77. Paramedics arrived and transferred Mr Culverhouse to hospital around 4.00pm. Mr Culverhouse did not regain consciousness and died in hospital the next day.
78. Before Mr Culverhouse self-harmed in the segregation unit, staff in the Offender Management Unit (OMU) had started recalculating his sentence following his recall. They found that, due to unused remand time, he should have been released immediately on the day he was recalled. Mr Culverhouse had already been taken to hospital when the duty governor ordered his release from custody on 23 April.

Contact with Mr Culverhouse's family

79. The prison's family liaison officer contacted Mr Culverhouse's mother by phone to let her know that her son had been taken to the hospital. Mr Culverhouse's family were with him at the hospital when he died the following day. The prison contributed to the cost of Mr Culverhouse's funeral in line with national guidance.

Support for prisoners and staff

80. The Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
81. The prison posted notices informing other prisoners of Mr Culverhouse'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 Culverhouse's death.

Post-mortem report

82. The post-mortem report concluded that Mr Culverhouse's death was caused by brain hypoxia (lack of oxygen to the brain) and pneumonia, caused by a cardiac arrest due to ligature compression of the neck.
83. The pathologist found no evidence that trauma, violence or third-party assault caused or contributed to Mr Culverhouse's death and concluded that this was a case of self-strangulation. He commented that although cases of self-asphyxiation are relatively rare, they do occur and said that if the ligature is tied so that it does not loosen when unconsciousness occurs, it will remain in place and fatal asphyxia will occur.
84. The toxicology tests showed that Mr Culverhouse had recently used chlordiazepoxide (which he had been prescribed) at therapeutic levels, and had previously used cannabis (although the toxicologist was unable to say how recent this was or whether Mr Culverhouse would have been experiencing the effects at the time of the incident). No synthetic cannabinoids ('Spice') were detected but, because of the delay before the sample was taken, the toxicologist could not completely rule out the possibility that they were present at the time of the incident. The pathologist said, however, that drugs had not directly caused Mr Culverhouse's death.

Findings

Mr Culverhouse's recall to prison

85. Mr Culverhouse was released on licence from HMP Peterborough on 12 April and was recalled to custody on 18 April, following his arrest for further offences. We are satisfied that the decision to recall Mr Culverhouse was lawful. However, he was unlawfully detained between 18 and 23 April. This is because when his sentence was recalculated after he had returned to prison custody, it showed that he was eligible for immediate release on 18 April due to the time he had previously served on remand.
86. Staff in the prison's Offender Management Unit (OMU) are responsible for recalculating sentences. OMU staff work standard office hours, Monday to Friday, and do not work weekends or bank holidays. As Mr Culverhouse arrived at Woodhill on the evening of Maundy Thursday, OMU staff did not calculate his sentence until Tuesday 23 April, the first working day after the Easter bank holiday weekend. He was released that day, but by that time he was in hospital.
87. The *Recall, Review and Re-Release of Recalled Prisoners Policy Framework*, dated 1 April 2019, is a joint Ministry of Justice (MoJ) and HM Prison & Probation Service (HMPPS) document. Part II of the document provides detailed guidance on what prisons should do when a recalled prisoner arrives. However, it does not provide any detail about recalculating the prisoner's sentence or the timescale for doing this.
88. PSI 03/2015, *Sentence Calculation – Determinate Sentenced Prisoners*, states as a desired outcome "that determinate sentenced prisoners have their sentences calculated in accordance with the legislation and policy as it applies following commencement of the Offender Rehabilitation Act 2014, are lawfully detained in custody and are released on the correct date". The PSI includes a mandatory action that release dates must be calculated within five working days of the prisoner's reception. Para 6.3 of the PSI deals specifically with licence recalls but states that it "does not go into detail about the re-release arrangements for recalls", stating that this specific detail can be found in the Framework document. The PSI does not give a specific timescale for the sentence calculation to be completed for recalled prisoners but concludes that, until all information has been received and checked, "prisons cannot confirm that the prisoner is being held lawfully to the correct re-release date".
89. We accept that OMU staff calculated Mr Culverhouse's sentence on the first working day after he arrived at Woodhill and that this was in line with PSI 03/2015. However, this meant that he was not released on 18 April as he should have been, and that he spent the next four days, between 18 and 23 April, unlawfully detained. During that time, he ligatured and was taken to hospital, where he died.
90. We are very concerned that Mr Culverhouse was in prison when he should not have been, and that he ligatured during that time. We consider that the policy on sentence calculation needs to be reviewed so that prisoners eligible for

immediate release are identified when they arrive at prison and are not unlawfully detained. We make the following recommendation:

HMPPS's Director General of Prisons should consider whether sentence calculations for prisoners who may be eligible for immediate release could be completed within one working day of their arrival into prison.

Management of Mr Culverhouse's risk of suicide and self-harm

91. PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, gives guidance to staff on how to identify, manage and support prisoners who are at risk of harm to themselves or others. It sets out the procedures (known as ACCT) that must be followed whenever staff assess that a prisoner is at risk of suicide or self-harm. The instruction highlights the need for ACCT reviews to be multidisciplinary and for healthcare staff to attend the first review. The PSI states that a detailed and accurate record of the review should be made.
92. Mr Culverhouse arrived at Woodhill with a suicide and self-harm warning form. We found that staff correctly identified his level of risk and immediately started ACCT procedures. Overall, we found that staff provided a good level of support to Mr Culverhouse in challenging circumstances and worked together to achieve this. We found that staff appropriately assessed and managed his level of risk, including putting him on constant supervision when his risk was heightened.
93. We found that the ACCT assessment and the first review after assessment were not completed within 24 hours. We also found that the decision to take Mr Culverhouse off constant supervision on 18 April was not made by a prison manager or a doctor and it was not clearly documented. While these actions were not in accordance with PSI 64/2011, we do not consider that they had a direct impact on the eventual outcome for Mr Culverhouse.
94. Although staff held five ACCT reviews, we found that only two were multidisciplinary and healthcare staff did not attend the first ACCT review. We also found that the list of attendees at some of the reviews was inaccurate or incomplete. As a result, healthcare input at two of the reviews was not clearly evident. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that staff:

- **hold multidisciplinary ACCT reviews, with healthcare staff in attendance at first case reviews; and**
 - **complete the relevant paperwork fully and accurately at all stages of the ACCT process, including the names and roles of those attending or providing input to case reviews.**
95. When Mr Culverhouse was taken to the segregation unit on the afternoon of 23 April, his ACCT observations were raised to five an hour. We have considered whether he should have been put under constant supervision instead.

96. PSI 64/2011 says that constant supervision can be de-humanising and may therefore increase risk. For this reason, the PSI says that “constant supervision must only be used at times of acute crisis and for the shortest time possible”, and must be authorised by the Operational Manager or the Senior Clinical Manager after discussion with each other. The PSI gives examples of “an acute suicidal crisis” which could justify constant supervision: serious attempts or preparations for suicide; credible expression of a wish to die; and a recent and credible attempt by a prisoner to take his own life.
97. Staff told us that Mr Culverhouse would have had an ACCT review within an hour or so of being segregated and that the need for constant supervision would have been considered then, in the light of the Initial Segregation Health Screen. In the event, this did not happen because he was only in the segregation unit for 50 minutes. He was on a high level of observations and had been checked only nine minutes before he was found unresponsive.
98. We have concluded that the decision to place him on five observations an hour was not an unreasonable one in the circumstances.

Mental health

99. Mr Culverhouse had a history of mental health problems. He told staff that he had depression and anxiety but he did not take any regular medication. Mr Culverhouse engaged with mental health services both in prison and in the community, but his level of engagement was poor. Records show that he had had several assessments over the years and, although there is mention of anxiety, depression, paranoia, and personality disorders, he did not have a formal mental health diagnosis and was never under the care of a psychiatrist. Although Mr Culverhouse was known to have problems controlling his anger, he did not have a history of self-harm or suicide attempts.
100. It seems likely that Mr Culverhouse suffered a breakdown in his mental health at the time of his recall to prison. He began self-harming and threatening to take his life, which was out of character for him. At the time of his arrest, he was on top of a building threatening to jump and had made cuts to his arms and torso. He also banged his head while in police and court custody to the point that he lost consciousness and had to be taken to hospital.
101. Mr Culverhouse was assessed by community and forensic mental health professionals who agreed that he was fit for detention. Despite being concerned for his mental health, the probation service decided to recall him to prison.
102. Mr Culverhouse arrived at Woodhill on the evening of 18 April. He received a mental health screening on 20 April and a full mental health assessment on 23 April. Following the assessment, a nurse wrote in his medical record that no further intervention was required by the mental health team. However, we are satisfied that the nurse made an error in Mr Culverhouse’s record when she recorded that no further intervention was required. We found evidence in his medical record that he had been discussed at a multidisciplinary meeting following the assessment with the nurse and he had been taken onto her caseload. Although errors were made in the record keeping, we do not consider that these affected the outcome for Mr Culverhouse. We found nothing to

suggest that the mental health team would not have provided appropriate support to Mr Culverhouse following the assessment.

103. When Mr Culverhouse was taken to the segregation unit on 23 April, Nurse A and Nurse B had concerns about his mental health so refused to complete the Initial Segregation Health Screen. We heard from the healthcare manager that the expectation is that any qualified nurse should complete the health screen. Nurse C attended to complete it within 45 minutes of Mr Culverhouse arriving in the segregation unit, which was within the timeframe allowed. However, it could have been completed sooner by Nurse A or Nurse B and we are concerned that both refused to do it, despite being qualified to do so. We make the following recommendation:

The Head of Healthcare should:

- **review the incident when clinical staff did not complete the algorithm for Mr Culverhouse on 23 April;**
- **ensure that all staff are aware of their responsibilities for completing an algorithm for prisoners in the segregation unit;**
- **complete these actions within one month of receiving this report.**

Physical healthcare

104. A healthcare assistant assessed Mr Culverhouse after he banged his head on two occasions on 23 April. First, when Mr Culverhouse fell and hit his head on a kerb during the restraint incident and, secondly, when he collapsed to the floor of the segregation cell after banging his head against the door. The healthcare assistant should have asked a qualified member of healthcare staff to check Mr Culverhouse for any possible head injury. The clinical reviewer was concerned that this did not happen. While we accept that Mr Culverhouse's death was not caused by a head injury, we consider that the correct process should be followed to ensure that prisoners are properly assessed following a potential head injury. We therefore make the following recommendation:

The Head of Healthcare should:

- **review the process for staff dealing with potential head injuries suffered by prisoners; and**
- **develop a clear pathway for reporting and actioning those injuries in line with NHS guidelines for head injury and concussion.**

Emergency response

105. Nurse C was the only member of healthcare staff on the scene when Mr Culverhouse was found unresponsive in his cell. Rather than taking a lead role in the resuscitation, she went to get the emergency bag while prison staff started CPR. We make the following recommendation:

The Head of Healthcare should remind all clinical staff of their responsibilities to lead and direct resuscitation attempts.

Healthcare record keeping

106. The clinical reviewer noted that record keeping by some members of staff was not of the expected standard. A nurse incorrectly recorded in Mr Culverhouse's medical records that no further intervention was required after his mental health assessment. A healthcare assistant did not accurately record his interactions with Mr Culverhouse on 19 and 23 April.
107. We found two instances where healthcare staff were recorded as being involved in ACCT reviews but nothing was noted on Mr Culverhouse's medical record. We cannot be sure if this was an error on the ACCT record keeping or if healthcare staff failed to put a note on Mr Culverhouse's clinical record.
108. We make the following recommendation:

The Head of Healthcare should ensure that:

- **staff enter all interactions with prisoners in the clinical notes in an accurately and timely manner;**
- **staff are reminded of the need to make an entry in the clinical notes when they have attended or provided input into an ACCT review; and**
- **regular checks are made of clinical notes to maintain standards.**

**Prisons &
Probation**

Ombudsman
Independent Investigations