

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr James Turnbull a prisoner at HMP Durham on 23 December 2017

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

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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*

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**Fair:** *we are honest and act with integrity*

**OGL**

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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 James Turnbull was found hanged in his cell on 23 December 2017 at HMP Durham. He was 30 years old. I offer my condolences to Mr Turnbull's family and friends.

Mr Turnbull experienced a severe decline in his mental health in the weeks before he died. His transfer to a psychiatric hospital had been approved and he was awaiting a bed space when he died.

The investigation found there was a delay in arranging a psychiatric assessment for Mr Turnbull. If he had been assessed more promptly, it is possible he may have been transferred to hospital earlier where he could have received appropriate treatment.

Staff managed Mr Turnbull under suicide and self-harm prevention procedures (known as ACCT) when his mental health declined. Initially, they did this well. However, I am concerned that staff wrongly assessed his level of risk and stopped ACCT procedures prematurely. They restarted ACCT procedures on 20 December, after Mr Turnbull told them he had been thinking of ways to hang himself, but worryingly, stopped them just over 24 hours later.

I am concerned that despite Mr Turnbull's continued paranoid behaviour, his pending transfer to psychiatric hospital and a recent stated intention to take his life, he was not being monitored under ACCT procedures when he died.

Previous investigations at Durham have identified similar deficiencies in assessing prisoners' risk and managing ACCT procedures. The Prison Group Director needs to satisfy himself that staff at Durham are properly applying ACCT procedures to protect prisoners at risk of suicide and self-harm.

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**  
**Acting Prisons and Probation Ombudsman**

**September 2018**

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# Summary

## Events

1. Mr James Turnbull was remanded into custody at HMP Durham on 14 October 2017. He had a history of mental health issues and substance misuse, along with a history of attempted suicide and self-harm.
2. On 2 November, Mr Turnbull told a prison GP that he felt low, although not suicidal. The GP prescribed antidepressants and requested a mental health review, but this was not actioned.
3. On 4 December, Mr Turnbull appeared to have a psychotic episode. He said he was hearing voices and thought people were planning to kill him. A mental health nurse saw him and noted that he needed an urgent psychiatric assessment, but the nurse subsequently made a routine referral.
4. Staff started suicide and self-harm monitoring (known as ACCT procedures) on 8 December after Mr Turnbull's mother telephoned the prison to say that he had told her people were going to murder him and that he planned to end his life. He was moved to a wing for vulnerable prisoners the next day. On 11 December, Mr Turnbull was moved to the prison's Integrated Support Unit (ISU), a small unit that provides support to prisoners with severe mental health problems. On the same day, a psychiatrist assessed him and recommended a transfer to a medium secure psychiatric unit.
5. Staff stopped ACCT procedures on 18 December but restarted them on 20 December because Mr Turnbull told staff he had been thinking of ways to hang himself. Staff stopped them again on 21 December.
6. On 23 December, staff shortages meant that prisoners were not unlocked for association until early afternoon. At around 1.55pm, an officer arrived at Mr Turnbull's cell to find him hanging. The officer radioed for healthcare staff to attend, entered the cell and with the help of another officer, cut Mr Turnbull down. When healthcare staff arrived, they found no signs of life. A prison doctor certified Mr Turnbull's death at 2.33pm.

## Findings

7. Staff managed the ACCT procedures well initially but we are concerned that they stopped them prematurely on 18 December. Mr Turnbull was still having auditory hallucinations and maintaining that people were going to kill him when the decision to close the ACCT was made. We consider that staff wrongly assessed that he was no longer at risk.
8. We are also concerned that staff stopped ACCT procedures on 21 December, having opened them only 25 hours before when Mr Turnbull said he had been looking at ways he could hang himself in his cell. At his ACCT case review on 21 December, staff recorded that Mr Turnbull was in good spirits. We consider that they placed too much weight on his presentation, rather than considering his recent behaviour and risk factors, not least that he was awaiting a transfer to psychiatric hospital.

9. A television film crew filmed some of Mr Turnbull's ACCT reviews, with his consent. We question whether this created a suitable environment in which to have these important discussions and get an accurate picture of Mr Turnbull's risk.
10. We found that Mr Turnbull's mental health was not well managed. Despite a prison GP requesting a mental health review for Mr Turnbull on 2 November, this did not happen. When Mr Turnbull displayed psychotic behaviour on 4 December, an urgent psychiatric assessment should have been carried out but only a routine referral was made. It is possible that Mr Turnbull would have been transferred to hospital sooner if he had been assessed urgently.
11. The officer who discovered Mr Turnbull hanging did not use a medical emergency code in line with agreed protocol. Although this did not affect the outcome for Mr Turnbull, it could do in other cases.

## Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular, staff should:
  - assess the level of a prisoner's risk of suicide and self-harm based on all available information and known risk factors and not on a prisoner's own presentation;
  - set caremap actions designed to reduce a prisoner's risk of suicide and self-harm, review them at each case review and complete them all before closing an ACCT;
  - vary the times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked.
- The Prison Group Director for Tees and Wear Group should satisfy himself that staff at Durham are assessing risk appropriately and properly applying ACCT procedures to prisoners at risk of suicide and self-harm.
- The Governor should ensure that decisions to remove items from prisoners at risk of suicide and self-harm are properly recorded, as are the reasons for their return.
- The Head of Healthcare should ensure there is a system for urgent and routine mental health referrals, that staff know how to make these referrals and that referrals are followed up.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use their radio to communicate the nature of a medical emergency quickly and effectively.

## The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Durham, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator obtained copies of relevant extracts from Mr Turnbull's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Turnbull's clinical care at the prison.
15. The investigator and clinical reviewer jointly interviewed seven healthcare staff, and the investigator interviewed a further five members of staff at Durham on 12 and 13 February 2018, and the clinical reviewer interviewed a doctor and nurse by telephone.
16. We informed HM Coroner for Durham and South Darlington of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Turnbull's mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mrs Turnbull asked us to consider:
  - why Mr Turnbull had been taken off suicide and self-harm monitoring;
  - whether he was being treated for his mental health issues and what steps had been taken to transfer him to a secure mental health facility;
  - whether Mr Turnbull had self-harmed at Durham and how he was helped through those periods; and
  - whether Mr Turnbull was located appropriately within Durham.
18. Mr Turnbull's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
19. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and its action plan is annexed to this report.

## Background Information

### HMP Durham

20. HMP Durham, which holds up to 996 men, is a local prison serving the courts of Durham, Tyneside and Cumbria. G4S provides primary healthcare services, Spectrum CIC provides GP and pharmacy services, Change Grow Live (CGL) provides psychosocial DART (Drug and Alcohol Recovery Team) services and Tees, Esk and Wear Valley NHS Trust provide mental health services.

### HM Inspectorate of Prisons

21. The most recent inspection of HMP Durham was in October 2016. Inspectors reported that most prisoners they spoke to who were subject to ACCT procedures were positive about their care and said they valued the regular contact and support from staff. The quality of ACCT documents was improving but too many still lacked attention to detail. Personal factors and significant events that might have been a trigger for self-harm were identified in only some cases. Reviews were multidisciplinary and caremaps were completed in sufficient detail. Observational entries did not always record mood or interaction with staff but some included examples of positive engagement and regular contact.
22. Inspectors found the mental health provision at Durham remained excellent and was much better than they would usually see. Joint working between the prison and mental health staff was very good. Most of the 13 patients transferred under the Mental Health Act since January 2016 had experienced excessive waits for transfer. The average time was 14 weeks, principally because of external issues, including bed availability. To mitigate this, a prison unit [the Integrated Support Unit] was being developed to provide prisoners with intermediate therapeutic care while awaiting transfer or on return from mental health facilities.

### Independent Monitoring Board

23. 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 October 2017, the IMB reported that a case manager was allocated to every ACCT opened, and had responsibility for the case until its closure. The IMB found the prison held effective ACCT reviews which were audited for quality.
24. The IMB reported that mental healthcare was well integrated and waiting times and delays were monitored and addressed. The Board noted that the Integrated Support Unit (ISU) provided support to 11 prisoners with moderate to severe mental illness and prison staff allocated to the ISU had chosen to work there. There was a good relationship with regional NHS secure units and it was hoped that transfers to and from the units would run smoothly. The cells on the unit had not been upgraded to the standard of 'safer cells' but it was hoped that the standard of accommodation would improve. Waiting times for prisoners to be transferred to a secure mental health unit continued to be an issue, and, on average, took 61 days from the date of referral.

## Previous deaths at HMP Durham

25. Mr Turnbull was the 15<sup>th</sup> prisoner to die while a prisoner at Durham since December 2014 and the sixth to take his own life. Previous investigations identified deficiencies in the way staff managed ACCT procedures, concerns about mental health care and failure of staff to use medical emergency codes. Five prisoners have died at Durham since Mr Turnbull's death. Three took their own lives and two are awaiting classification.

## Assessment, Care in Custody and Teamwork (ACCT)

26. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. 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 of the caremap have been completed. 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.

## Transfer of prisoners to hospital under the Mental Health Act

27. PSI 50/2007 (Transfer of Prisoners to and from Hospital Under Sections 47 and 48 of the Mental Health Act 1983) and NHS England's 'Good Practice Guide – The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act' outline the process for transferring a prisoner to hospital under the Mental Health Act. The NHS guidance recommends that all such transfers take place within 14 days of the Secretary of State issuing a warrant for transfer. In October 2007, a revised version of 'Procedure for the Transfer of Prisoners to and from Hospital under Sections 47 and 48 of the Mental Health Act 1983' was issued. This document acknowledges there had been unacceptable delays in transferring prisoners, and provides a best practice flowchart for all key stakeholders.
28. Two independent reports by a medical practitioner, one of whom has to be approved under Section 12(2) of the Mental Health Act 1983, need to assess the same form of mental disorder and the need for inpatient treatment before the Secretary of State will issue a warrant for transfer. These assessments are valid for two months. The PSI and best practice flow-chart clearly state that the MoJ Mental Health Casework Section must be informed when a prisoner is first assessed as needing to transfer to a mental health unit.

## Key Events

29. Mr James Turnbull was remanded into custody at HMP Durham on 14 October 2017, charged with violent offences against his former partner. Mr Turnbull had been in prison before, with his last period in custody having ended in April 2017.
30. A healthcare support worker and a nurse saw Mr Turnbull in reception. Mr Turnbull said he used heroin and cocaine, and was concerned about withdrawing from drugs, but a urine sample tested negative for all substances. Mr Turnbull told a nurse that he had no thoughts of suicide and no history of self-harm. (This was untrue as he had self-harmed in the past.) He said he had previously been prescribed antidepressants but had not taken any recently, and had spent some time in a psychiatric hospital two years earlier. The nurse completed part of Mr Turnbull's Cell Sharing Risk Assessment (CSRA) which noted that he required a single cell because he suffered from anxiety. Mr Turnbull was given a cell on B Wing, the induction wing.
31. The nurse referred Mr Turnbull to see a prison GP the same day. At their consultation, Mr Turnbull told the GP that he had smoked heroin and cocaine two days before, but as he had tested negative for all drugs, the GP was reluctant to start Mr Turnbull on a methadone programme. He agreed to monitor Mr Turnbull for drug withdrawal and provide relief for any symptoms when necessary.
32. After a consultation with a prison GP on 16 October, Mr Turnbull began a methadone programme (10 mgs daily). This dosage was increased on 18 October, and again on 27 October (25mg). (Mr Turnbull continued to be monitored by the prison's substance misuse protocol until 5 December 2017, when he refused to take any medication.)
33. Mr Turnbull saw a prison GP on 2 November, and said he felt low, although not suicidal. The GP prescribed him mirtazapine 15mg (an antidepressant) and requested a mental health review. There is no record that a review took place.
34. On 4 December, a member of B Wing staff radioed for a member of the mental health team to see Mr Turnbull and a nurse responded. Mr Turnbull told him he was hearing the voices of a friend and his sister, who were calling him derogatory names, and said there was 'a £10,000 price on his head'. He said he had taken an overdose in 2014, and been admitted to the Ridgeway Unit at Roseberry Park hospital, a medium secure mental health unit. He said he felt paranoid so had isolated himself by not leaving his cell, but had no thoughts of suicide or self-harm. The nurse noted that Mr Turnbull needed an urgent psychiatric assessment and that he should remain on the mental health team's caseload. The nurse made a non-urgent referral the same day.
35. On 8 December, a prison officer started suicide and self-harm monitoring (known as ACCT procedures), after Mr Turnbull's mother telephoned the prison to say he had told her there was "a price on his head" and he was going to end his life. The officer noted that Mr Turnbull should be assessed hourly, but irregularly, until he had been assessed and had a case review.
36. During an assessment interview with the officer, Mr Turnbull told her that he believed he was going to be murdered in prison, and that false information was

being spread about him. Mr Turnbull had cut his left arm with a razor, but said he had not wanted to die. A supervising officer completed an immediate action plan noting Mr Turnbull should remain on hourly observations, be referred to the mental health team and have access to the Samaritans, Listeners and the Chaplaincy (Mr Turnbull had asked to speak to a chaplain).

37. Mr Turnbull attended a first ACCT case review later that day, with the supervising officer, the officer, a prison manager and a nurse. They discussed why Mr Turnbull felt at risk from staff and prisoners and whether he felt he was having a mental health crisis. They agreed he should move to a reduced risk cell (which has a Perspex door for better observation) prior to a mental health assessment. A manager completed a caremap as part of the review, noting that Mr Turnbull needed an urgent psychiatrist appointment and that he should be moved to a psychiatric unit after a period of assessment in the prison.
38. On 9 December, Mr Turnbull was moved to F Wing, a wing for vulnerable prisoners. A second ACCT case review was held on the same day. The supervising officer attended with a mental health nurse. It was agreed that Mr Turnbull's level of risk remained high, and his observations were increased to twice an hour, with a meaningful conversation four times a day.
39. A third case review was held on 11 December, with Mr Turnbull, the supervising officer and a nurse. It was noted that Mr Turnbull was still hearing voices and he believed he was going to be murdered. The nurse said he would make an appointment for Mr Turnbull to see a psychiatrist urgently and considered whether he should move to the Integrated Support Unit (ISU) on I Wing. Mr Turnbull said he had used the Samaritans telephone and continued to do so. He also said that he had attempted to cut off his ear to stop the voices in his head, although he said had no thoughts of suicide at that time.
40. A psychiatrist met Mr Turnbull that afternoon. Mr Turnbull said he believed there was a conspiracy to kill him and that staff, his family and prisoners were 'in on it'. He said he heard voices in his head that were telling him he was a bad person. Mr Turnbull said he had recently tried to cut off one of his ears with a razor blade to stop the voices. He added that he thought he was being poisoned and was refusing to eat or drink much, or take any medication (staff subsequently provided him with sealed food and drink). They spoke about previous suicide attempts and Mr Turnbull said he had previously been admitted to a psychiatric hospital. Mr Turnbull told the psychiatrist that he had smoked 'Spice' two weeks earlier and that is when the voices had started.
41. The psychiatrist diagnosed drug induced psychosis, and recommended that Mr Turnbull move to the ISU (Integrated Support Unit on I Wing) but he refused and became distressed. The psychiatrist recommended that Mr Turnbull should move to a medium security psychiatric hospital, that he should continue to meet mental health team staff; he should also be provided with sealed food and drink as he thought they were being contaminated, and he should be offered olanzapine, an antidepressant.
42. An ACCT case review was held on the afternoon of 11 December, because Mr Turnbull had moved to the ISU. The wing has 11 single cells and a higher ratio of staff to prisoners. Mr Turnbull said he was happy to be on the unit but still

seemed paranoid and believed he was being poisoned. He was assured that a hospital referral was being made for him to move to a psychiatric unit. Mr Turnbull's ACCT observations and interactions remained the same. Later that day, Mr Turnbull met with a nurse. They spoke about his auditory hallucinations.

43. A nurse met with Mr Turnbull the next day, 12 December. She noted his acute psychotic behaviour, that he believed he was being poisoned, that he had been prescribed olanzapine but was still unwilling to take any medication, and was suffering auditory hallucinations. Mr Turnbull was visibly distressed and appeared paranoid, believing the nurse was part of the conspiracy against him. It was agreed that staff would continue to monitor Mr Turnbull on the ISU until he transferred to hospital.
44. Later that afternoon, a nurse noted that Mr Turnbull had been shouting, "Help, they are going to kill me", from his cell. The nurse had a long discussion with Mr Turnbull during which he continued to display paranoid and delusional behaviour. Mr Turnbull agreed to take the prescribed olanzapine and was reassured that his referral to hospital was being processed.
45. On 13 December, Mr Turnbull was moved to a ground floor cell, which staff thought would be beneficial for him as it was nearer the ISU's office. He continued to voice paranoid and delusional ideas and again shouted from his cell that people were trying to kill him. Mental health nurses continued to monitor and tried to reassure him. He continued to take his food and drink in sealed containers, but only took his medication intermittently.
46. The psychiatrist completed Mr Turnbull's secure hospital referral paperwork on 14 December, which said he suspected Mr Turnbull had a 'first episode psychosis'.
47. A drug support worker reported that Mr Turnbull was not motivated or interested in continuing any substance misuse interventions. Mr Turnbull said he was not taking methadone or any prescribed medication. He spoke to her about his food and drink being poisoned, but did not mention hearing voices.
48. A fifth ACCT case review was held on 15 December. Mr Turnbull attended the meeting with a supervising officer, a mental health nurse and an officer from the ISU. Staff present agreed that Mr Turnbull's risk had reduced. He said he felt safer, had no immediate thoughts to harm himself and was pleased to be on the ISU. His diet and fluid intake had improved and his medication had helped his mood. However, he said he still heard voices and believed he was going to be killed. Mr Turnbull's observations were reduced to once every two hours and two conversations a day.
49. On 17 December, Mr Turnbull engaged in a morning group meeting on the ISU, and accepted his lunch and medication without any issue. He said he felt more settled and did not want to return to the main part of the prison. He asked to recommence mirtazapine and had a visit from his mother and grandmother.
50. The next day, 18 December, a nurse assessed Mr Turnbull. She noted that he spoke of a conspiracy to kill him, but accepted food from a sealed container and tap water. He said he was aware of staff support if he felt he needed it.

51. During the afternoon of 18 December, Mr Turnbull attended a sixth ACCT review with a manager, an ISU officer and a mental health nurse. They considered his risk remained low. He remained paranoid in his presentation but he had not self-harmed since arriving on the ISU and had not expressed any thoughts of self-harm. All present agreed that the staff ratio on the ISU allowed for more interactions and that he would receive support. They agreed to close the ACCT.
52. On 20 December, Mr Turnbull told a nurse that he had been thinking of suicide and looking for ligature points in his cell. He identified his bedsheet as a potential ligature. He said he did not want to be on an ACCT as he did not want to be 'caught in the act'. He then said he did not want to kill himself, but thought he should mention his thoughts to staff. The nurse opened an ACCT at 3.45pm and told officers, who removed Mr Turnbull's bedsheet and replaced it with an anti-rip blanket. (The investigator was told that his bedsheet was returned to him on 21 December when the ACCT was closed, but this was not recorded in the ACCT or elsewhere).
53. A nurse saw Mr Turnbull the next morning, 21 December. Mr Turnbull spoke again of his food and drink being contaminated, but was eating better now he received it in a sealed container. The nurse concluded that Mr Turnbull's physical health was generally good, but diagnosed tension headaches and prescribed him paracetamol.
54. During the afternoon, Mr Turnbull asked a nurse when he might be transferred to hospital. He seemed very anxious about this and wanted to move from the prison, saying that he felt well mentally but feared for his life in prison. The nurse said he would be transferred once a bed became available.
55. An ACCT review was held later that day at 4.45pm, which Mr Turnbull attended with a supervising officer, a member of the mental health team and an officer from the ISU. Staff recorded that Mr Turnbull seemed in good spirits and was planning his long-term future now that he had been accepted for a transfer to hospital (but was awaiting a bed to become available in the unit). His risk was assessed as low and the ACCT was closed.
56. A nurse carried out a mental health review for Mr Turnbull on 22 December. Mr Turnbull still seemed paranoid, but said he had no thoughts of suicide or self-harm. Mr Turnbull seemed concerned about transferring to hospital and when he would be released from the secure mental health unit. The nurse noted that Mr Turnbull remained on his caseload and awaited a hospital transfer date.
57. A psychiatrist met Mr Turnbull on 22 December. Mr Turnbull said he felt a little better, but still heard voices and believed there was a conspiracy to kill him. The psychiatrist noted that on the surface, Mr Turnbull displayed acute paranoid psychotic symptoms, but he wondered about their veracity and whether Mr Turnbull was looking for a way out of Durham. He said that Mr Turnbull should continue to take his medication and be monitored until he was transferred to hospital. The prison was waiting for a space to become available in the unit.
58. During the morning of 23 December, prisoners were not unlocked on the ISU. Because of staff shortages elsewhere in the prison, an ISU officer had been asked to work on D Wing, leaving a nurse alone on the ISU. The nurse saw Mr

Turnbull around mid-morning, through his door. He told her he felt okay but asked when he would be unlocked, and she replied she hoped it would be lunchtime. Mr Turnbull was unlocked for lunch and picked up a sealed packet of food, but asked for some additional hash browns, which were not sealed. He returned to his cell and later asked the nurse for some paracetamol because he had a headache. The nurse said she needed to wait for another member of staff to be present before he could be unlocked and given medication.

59. The ISU officer returned to the ISU at lunchtime. At 12.55pm, she heard a light tapping noise and, although she was not sure where it was coming from, suspected it was near Mr Turnbull's cell. The officer went to Mr Turnbull's cell where he was standing holding a plastic cup and she noticed his television was on. She asked if he was okay and whether he had been tapping. Mr Turnbull replied that he was fine and said he had not.
60. At 1.45pm, there were enough staff on the ISU to begin unlocking prisoners. A manager arrived at Mr Turnbull's cell at approximately 1.55pm. He looked into Mr Turnbull's cell before unlocking it, and saw Mr Turnbull facing the door. The manager opened the door and immediately saw Mr Turnbull was hanging from a ligature attached to a toilet curtain rail. The manager radioed for healthcare assistance in response to a ligature and shouted to the officer. (The control room log shows that the radio call was made at 1.55pm and an ambulance was called at 1.57pm.) The manager used his anti-ligature knife to cut the ligature while the officer supported Mr Turnbull's weight. They laid Mr Turnbull on the cell floor and checked for a pulse in his neck and wrist, but found none. Mr Turnbull's eyes were open and the manager thought that he had died. A supervising officer arrived in the cell, switched on his Body Worn Camera (BWC) and prepared to start cardiopulmonary resuscitation (CPR) when healthcare staff arrived.
61. Several nurses responded to the radio call. The first nurse arrived at Mr Turnbull's cell at 1.57pm, and immediately checked for signs of life, but found none. Another nurse subsequently carried out the checks as well, but similarly found no signs of life and verified that Mr Turnbull had died. The ambulance was stood down at 2pm. A prison GP certified the death at 2.33pm.

### **Contact with Mr Turnbull's family**

62. Mr Turnbull had given the prison the wrong address for his next of kin, but this was rectified and the prison's family liaison officer and a manager met Mr Turnbull's mother and broke the news of her son's death. The prison contributed to Mr Turnbull's funeral, in line with national guidance.

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

63. After Mr Turnbull's death, a prison manager 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.
64. The prison posted notices informing other prisoners of Mr Turnbull's death, and offering support. Staff spoke to all prisoners in the ISU to ask whether they had been adversely affected by Mr Turnbull's death.
65. Since Mr Turnbull's death, all curtain rails have been removed from ISU cells.

## Post-mortem report

66. The post-mortem examination determined Mr Turnbull's cause of death as hanging. A toxicology test showed that Mr Turnbull had taken only his prescribed medication.

# Findings

## Managing Mr Turnbull's risk of suicide and self-harm

67. Prison Service Instruction (PSI) 64/2011, which covers safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action. Mr Turnbull was remanded to Durham for violent offences against a former partner, had a history of mental health problems and substance misuse, and of attempted suicide and self-harm.
68. Staff started ACCT procedures on 8 December after Mr Turnbull's mother told prison staff that her son had said he intended to take his own life. The ACCT was managed well initially: case reviews were multidisciplinary, with a member of the mental health team present at each review, and the caremap was updated appropriately. Staff took steps to manage Mr Turnbull's risk by moving him to a wing for vulnerable prisoners on 9 December and then to the ISU on 11 December.
69. We are concerned, however, that staff downgraded Mr Turnbull's risk too quickly and closed the ACCT prematurely on 18 December. During the fifth case review, held on 15 December, Mr Turnbull's risk was assessed as low, despite him having told staff he still thought people were going to kill him and he still had auditory hallucinations. Furthermore, the caremap action that Mr Turnbull was awaiting a transfer to hospital was closed, as he had been accepted onto the waiting list. Mr Turnbull was clearly anxious about when he would transfer and we consider that this action, along with the ACCT, should have remained open as he was still awaiting a transfer and had not been given a transfer date.
70. Mr Turnbull's ACCT was closed during his sixth case review on 18 December. The rationale for closure was that Mr Turnbull's location on the ISU meant that he would have more interactions with staff and would receive support. While the ISU should normally have a high staff to prisoner ratio, staff were taken off the ISU when there were staff shortages elsewhere (which is what happened on 23 December). We consider it was short-sighted to close Mr Turnbull's ACCT based on him being in the ISU. Despite him not having self-harmed since arriving in the ISU or expressing any intent to self-harm, he still presented as paranoid and was still awaiting a transfer to hospital.
71. Two days later on 20 December, a new ACCT was opened when Mr Turnbull told staff he had been thinking of ways to hang himself and had been looking for ligature points in his cell. A caremap was not completed and the ACCT was closed the following day, just over 24 hours later. Staff decided to close the ACCT because Mr Turnbull seemed in good spirits and was talking about his long-term future after having been accepted to hospital (although he was still awaiting a bed and did not have a transfer date).
72. We consider that this ACCT was closed too soon, given Mr Turnbull had been considering how to end his life just over 24 hours before and was still awaiting his transfer to hospital. Staff placed too much weight on Mr Turnbull's presentation and failed to give proper consideration to his risk factors.

73. Although staff removed Mr Turnbull's bedsheet from him on 20 December, no other bedding, including pillowcases, was removed. We do not understand the rationale for this, given that pillowcases could have been ripped and used as a ligature. When staff closed the ACCT, they returned his bedsheet to him but this was not recorded anywhere, nor was the justification for doing so. As Mr Turnbull had identified his bedsheet as a potential ligature the day before, we consider that the reasoning for returning it should have been recorded.
74. We are also concerned that many of Mr Turnbull's observations were carried out at regular and predictable intervals, not least given his comments to staff about not wanting to be "caught in the act".
75. Previous investigations at Durham have identified similar findings on inadequate risk assessment, the premature closure of ACCT procedures and predictable observations. We make the following recommendations:

**The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular, staff should:**

- **assess the level of a prisoner's risk of suicide and self-harm based on all available information and known risk factors and not on a prisoner's own presentation;**
- **set caremap actions designed to reduce a prisoner's risk of suicide and self-harm, review them at each case review and complete them all before closing an ACCT;**
- **vary the times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked.**

**The Prison Group Director for Tees and Wear Group should satisfy himself that staff at Durham are assessing risk appropriately and properly applying ACCT procedures to prisoners at risk of suicide and self-harm.**

**The Governor should ensure that decisions to remove items from prisoners at risk of suicide and self-harm are properly recorded, as are the reasons for their return.**

76. During December 2017, a film crew was filming a documentary in Durham prison and they filmed a number of Mr Turnbull's ACCT reviews (with Mr Turnbull's permission). The investigator watched this footage. Although we have been critical of some aspects of the ACCT process, the reviews the investigator watched showed staff spent a lot of time trying to engage with Mr Turnbull and understand his concerns. However, staff commented that Mr Turnbull's behaviour was different when he was being filmed. We consider that careful consideration should be given to whether it is appropriate for television camera crews to film ACCT case reviews, even if the prisoner consents. The ACCT case review is supposed to be a way of establishing whether the prisoner continues to be at risk of suicide and self-harm, and how the prison can support them and manage their risk. We question whether having a television film crew present creates a suitable environment in which to have these discussions and get an accurate picture of the prisoner's risk.

## Mental health

77. Mr Turnbull should have been referred for a mental health review after seeing a prison GP on 2 November. There was no record this referral was ever made and nobody from the mental health team saw Mr Turnbull until 4 December, when they responded to a call from wing staff.
78. The initial mental health assessment on 4 December identified Mr Turnbull with acute mental health changes in line with a psychotic illness. A nurse noted that Mr Turnbull needed an urgent psychiatric assessment but only made a routine referral. The mental health team manager told the investigator that Mr Turnbull was not highlighted as an urgent referral at the daily meeting and so went onto the waiting list as a routine patient. She had addressed this with the nurse. She said that urgent appointments were usually seen within 72 hours and there was an on-call facility if required. Mr Turnbull was not seen for a week. It is possible that if he had been assessed earlier, he might have been transferred to hospital sooner (although we recognise that the availability of beds is outside the prison's control).
79. Mr Turnbull's mental health was monitored daily from 8 December, after an ACCT was opened. The clinical reviewer concluded there was evidence of continued assessments, regular reviews and Mr Turnbull was included in discussing his care and treatment. Mr Turnbull was eventually seen by a psychiatrist on 11 December. The clinical reviewer noted that there had been a delay in treating the onset of Mr Turnbull's mental health symptoms. We make the following recommendation:

**The Head of Healthcare should ensure there is a system for urgent and routine mental health referrals, that staff know how to make these referrals and that referrals are followed up.**

## Transfer to a secure mental health unit

80. In January 2016, we published a thematic review of lessons learned from our investigations into self-inflicted deaths in prisons where mental health issues were involved. We noted that where a secure hospital had been identified as the best environment to deliver appropriate care for acutely ill prisoners, we would expect all possible steps to be taken by the prison and the hospital to ensure this takes place within the 14-day target. We also noted that prisons need to be extra vigilant about the care of prisoners who are being considered for, or are awaiting transfer to a secure hospital.
81. Healthcare staff at Durham first identified that Mr Turnbull needed treatment in a secure hospital following his psychiatric assessment with the psychiatrist on 11 December. Mr Turnbull was accepted, but needed to wait until a bed became available for him. He was one place away from being given a bed in the unit, when he died.
82. Mr Turnbull frequently asked when he would transfer, but staff were unable to give him an exact date. They kept in touch with the hospital to find out where Mr Turnbull was on their list, but this was no indication of how long he would have to

wait. We note that Mr Turnbull died before the 14-day target for transfer to hospital was reached.

### Emergency response

83. PSI 03/2013 requires governors to have a two-code medical emergency response system that ensures an ambulance is called immediately when staff have serious concerns about the health of a prisoner. Durham's medical emergency response protocol requires staff to call either a code blue (when a prisoner is unconscious or having difficulty breathing) or a code red (when a prisoner has severe bleeding or burns), which should trigger the control room to call an ambulance immediately. When a manager discovered Mr Turnbull hanging, he immediately radioed for assistance from healthcare but he did not use an emergency response code as he should have done. An ambulance was still called and staff attended the incident quickly.
84. In the event, Mr Turnbull had already died and the ambulance was stood down. However, it is important that the correct medical emergency code is used in future so that all relevant staff are made aware of the nature of the incident and an ambulance is called immediately. We repeat a recommendation we have previously made to Durham:

**The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use their radio to communicate the nature of a medical emergency quickly and effectively.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations