Case No: CO/5343/2016

Neutral Citation Number: [2017] EWHC 1194 (Admin)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
DIVISIONAL COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 23/05/2017

Before:

Lord Justice Irwin

and

Mr Justice Garnham

- -

Between:

The Queen (on the application of MRS PEARL SCARFE, JULIE BARBER and JAMIE BLYDE)	**Claimants**
- and -	
(1) Governor of HMP Woodhill (2) The Secretary of State for Justice	**Defendants**
INQUEST	**Intervener**

- -

Heather Williams QC & Adam Straw (instructed by **Deighton Peirce Glynn**) for the **Claimant**

James Strachan QC & Emma Price (instructed by **Government Legal Department**) for the **Defendant**

Written intervention by Heather Williams QC & Jesse Nicholls (instructed by **Hickman & Rose)** for **INQUEST**

Hearing dates: 7th April 2017

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Judgment

Mr Justice Garnham:

Introduction

1. This is a judgment of the Court to which we have both contributed.

2. By these judicial review proceedings, the Claimants seek to challenge what they describe as "*the Defendants' failures to comply with their public law, common law and article 2 ECHR duties to protect prisoners at HMP Woodhill from suicide*", failures which they contend are "*ongoing*". The relief they seek is a declaration that the Defendants have breached those duties and an order requiring them to comply with the mandatory provisions of national prison policy.

3. The context for this challenge is what is agreed to be the very high rate of self-inflicted death at HMP Woodhill. The Claimants are three persons with a close interest in the arrangements for suicide prevention at that prison. Pearl Scarfe is the mother of Ian Brown, a prisoner who committed suicide in his cell in HMP Woodhill on 19 July 2016. Julie Barber is the sister of Ian Brown. Jamie Blyde is the brother of Daniel Dunkley who was found suspended by ligature in his cell at the prison on 29 July 2016, and who died on 2 August 2016 as a result of the injuries he sustained. Mr Blyde was himself detained at HMP Woodhill until recently and could be returned there in the future. He has been placed under observation due to concerns about his risk of suicide or self-harm. It is accepted that all three claimants have sufficient interest to bring these proceedings.

4. We have received helpful written submissions from an intervener, the organisation "Inquest". Inquest is a small, independent charity which, amongst other things, provides free advice to people bereaved by a death in detention or custody. Those submissions were prepared by Heather Williams QC and Jesse Nicholls. When leading counsel originally instructed by the Claimants was unable to conduct the case, Ms Williams took over that role. It has been accepted by all concerned that that was entirely appropriate. We are grateful for Ms Williams' assistance, in both her capacities, and for that of counsel for the two Defendants, James Strachan QC.

5. In addition to the declaratory relief to which we have referred, the Claimants seek an order under CPR 54.20 transferring the civil claim for damages relating to Ian Brown's death to the Queen's Bench Division. We do not understand that application to be disputed and, subject to further submissions that may be made when this judgment is handed down, we are minded to make an order in those terms.

The Common Ground and the Issues

6. A remarkable feature of this case is the extent of the agreement between the parties. There is agreement as to the essential factual background, the circumstances of the deaths at HMP Woodhill, and the obligations on the Defendants. There is a considerable measure of agreement between the parties as to the applicable legal principles.

7. Also agreed are the national policies which apply. We set out below the relevant parts of Prison Service Instruction ("PSI") 64/2011 entitled "*Management of Prisoners at*

risk of harm to self, to others and from others (Safer Custody)" and PSI 03/2001 relating to responses to medical emergencies.

8. It is possible, in addition, to set out in relatively short compass the applicable legal principles because the difference between the parties is largely on matters of emphasis.

9. The substantive differences between the parties relate to whether the deficiencies identified in the various reports to which we have referred below amount to "systemic" failings by the prison authorities, and the extent to which the identified problems at HMP Woodhill are capable of solution by means of an order of this Court.

The Investigations

10. It is common ground that there have been eighteen self-inflicted deaths in HMP Woodhill since 2013. There were five self-inflicted deaths at the prison in 2015 and seven in 2016. These represent both the highest rate, and the highest number, of self-inflicted deaths in any prison in the entire prison estate.

11. At the time of the hearing of this claim, 11 of the deaths had been subject to an inquest. Inquests in respect of the other deaths were yet to take place. Because they all occurred at the same prison, all the inquests were conducted by the same Coroner, HM Senior Coroner for Milton Keynes, (with the exception of one inquest which was conducted by an assistant coroner for that region). In each case, as required by The Coroners and Justice Act 2009, the Coroner sat with a jury. Each jury has produced determinations in which they have answered questions posed by the Coroner. Following a number of the inquests, the Coroner produced a "*report to prevent future deaths*" (or "PFD report"), pursuant to paragraph 7 of Schedule 5 of the Act.

12. Subsequently, reports have been produced by the Prisons and Probation Ombudsman for England and Wales ("the PPO") in respect of each of the deaths. The PPO frequently conducts investigations and produces reports on deaths in prison. The reports are detailed, independent and authoritative. They provide descriptions of the circumstances of the relevant death and make relevant recommendations to the prison authorities. We have seen reports in respect of 13 recent self-inflicted deaths.

13. The Prison has, without exception, accepted all the recommendations made by the Coroner and the PPO about the need for compliance with Prison Service Instructions relevant to suicide prevention

14. Based on those reports, we set out below, by way of example only, a short summary of the circumstances of six of the deaths at HMP Woodhill. None of this is in dispute.

The Circumstances of the Deaths

15. Inevitably, the detailed circumstance of each death at HMP Woodhill prison are different. However there are significant similarities between many of them. The following five cases all occurred in 2015 or 2016.

16. **Daniel Byrne** died on 27 February 2015 after hanging himself in his cell the previous day. The inquest jury concluded that there had been a failure by both healthcare staff and prison officers to carry out an adequate risk assessment for self-harm and suicide, and a failure to carry out the first "ACCT" case review adequately. (Some of the requirements of "ACCT" or "Assessment, Care in Custody and Teamwork" are considered further below).

17. The PPO found there was a failure to assess and manage Mr Byrne in accordance with the requirements of PSI 64/2011. Staff had failed to consider a number of risk factors identified in the instruction, and had wrongly based their assessment of Mr Byrne substantially on his presentation. It was said the ACCT Assessor failed to review Mr Byrne's records, that the 'care-map' contained inadequate measures to reduce risk and that the response to finding Mr Byrne hanging was too slow. The PPO noted

> "*we are concerned that many of the same issues have been repeated in a number of our investigations including this one. In six cases investigated in 2013 and 2014 we found that staff had failed to identify or properly assess the risk of suicide and self-harm in newly arrived prisoners*".

18. The PPO recommended that the Governor should ensure that there were effective operating procedures in the prison reception and that all staff understood the procedures for identifying prisoners at risk of suicide and self-harm, and for managing and supporting them.

19. **Ian Brown** committed suicide by hanging in his cell on 19 July 2015. The jury at the inquest concluded there was a failure to carry out the ACCT procedures and reviews. The PPO found there were shortcomings in the ACCT process, including the fact that his ACCT had been closed without a multi-disciplinary review.

20. **Simon Turvey** died by hanging on 29 December 2015. The coroner's PFD report indicated that

> "*the family of Mr Turvey was not aware of the arrangements for the family to notify the prison if they had concerns as to his welfare. If they had known of the telephone line to report concerns they would have used it*."

21. The PPO noted that, during a telephone call overheard by staff, Mr Turvey had been upset and tearful, had indicated he had contemplated suicide and had spoken about being unable to cope.

22. **Thomas Morris** died by hanging on 26 June 2016. The PPO expressed concern that the timings of checks made on Mr Morris by staff were predictable, and about the adequacy of ACCT care-maps. He said that the Governor

> "*should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including setting levels of observations which are appropriately adjusted as the perceived risk changes and these changes are irregular to prevent the prisoner anticipating that they will occur and*

> *setting care-map actions which are specific and meaningful, aimed at reducing prisoner's risks and are actively followed up*".

23. As noted above **Daniel Dunkley** died from hanging on 29 July 2016. The jury at the inquest into his death concluded that there was a failure to carry out appropriately the ACCT procedures and reviews, and in particular that there was an inadequate understanding of the importance of the ACCT document. The jury said it was an error for inexperienced officers to be working on the wing alone, and that there was no apparent system in place to ensure timely observations were carried out.

24. An initial PPO report concluded that "*there were serious deficiencies in the way [the prison] operated suicide and self-harm prevention procedures*". In particular, case reviews failed to address Mr Dunkley's needs and level of risk effectively, observation levels were not performed appropriately and care-maps were ineffective. The PPO concluded "*staff did not interact effectively to identify Mr Dunkley's risks, needs and issues in the days leading up to his death…..*"

The Adequacy of the Prison's Response

25. The Defendants have produced reports and action plans in response to the recommendations. The Claimants allege that, despite accepting these recommendations and preparing such plans in response, "similar failings" are repeated in successive cases. The Claimants refer, for example, to the Coroner's PFD report in the case of Daniel Byrne. The Coroner wrote:

> "*my concern is that reports and recommendations of the Ombudsman and indeed my own Preventing Future Deaths Reports have not been implemented by Woodhill prison and there needs to be an urgent review as to why the necessary measures to prevent suicides from recently admitted prisoners have not been implemented*".

26. To similar effect in the same case, the PPO said:

> *"We are concerned that many of the same issues have been repeated in a number of investigations including this one……I have raised most of these matters with Woodhill before."*

27. In Mr Dunkley's case the PPO report noted that "*There were serious deficiencies in the way [the prison] operated suicide and self-harm prevention procedures"* and concluded *"we are bound to repeat our findings about the short-comings of those procedures"*

The National Policies

28. Two national policies are relied on in this case, ("PSI") 64/2011 and PSI 03/201.

29. PSI 64/2011 sets out the National Offender Management Service ("NOMS") "*framework for delivering safer custody procedures and practices to ensure that prisons are safe places for all those who live and work there.*" It came into force on 1

April 2012 and applies to all public and private prisons. It aims, amongst other objectives, to "*identify, manage and support prisoners and detainees who are at risk of harm to self, others, and from others*" and "*to reduce incidents of self-harm and deaths in custody*." The policy identifies a number of mandatory actions and provides, at paragraph 9 of the executive summary, that prison governors must ensure "*that the outcomes set out in the Management of prisoners at risk of harm to self, to others and from others (Safer Custody) specification are delivered."*

30. Those requirements include the following (taken from the executive summary):

- Governors must have procedures in place to identify, manage and support prisoners and detainees who are at risk of harm to self, others, and from others, and to reduce that risk (paragraph 11).
- Staff must identify prisoners at risk of self-harm and/or suicide based on the risks and triggers outlined in Chapter 3 of the PSI. They must check relevant documents for evidence of risk (paragraph 17).
- Governors must ensure that staff who have contact with prisoners are aware of the procedures by which prisoners' risk of harm to self is identified, assessed and managed (paragraph 18).
- All visitors must be provided with information that outlines the procedures in place for the identification, assessment and management of prisoners at risk of harm to self (paragraph 18).
- The most effective way to assess and manage risk is through a multi-disciplinary process, in which the prisoner is involved (paragraph 21).
- Prisoners identified as at risk of harm to self must be assessed using Assessment, Care in Custody and Teamwork (ACCT) procedures (paragraph 22).
- Prisons must have procedures in place to facilitate learning from incidents of self-harm and deaths in custody to prevent future occurrences and improve local delivery of safer custody (paragraph 31).

31. There are additional requirements in subsequent chapters of the PSI. Of particular relevance are the following:

- All staff in contact with prisoners must be trained to at least ACCT Foundation level. From January 2012 ACCT Foundation was to be replaced by Introduction to Safer Custody and new staff were to be trained in this. ACCT refresher training must be provided according to local training needs (chapter 1)
- Any prisoner identified as at risk of suicide or self-harm must be managed using the ACCT procedures. The ACCT process is necessarily prescriptive and it is vital that all stages are followed in the timescales prescribed (chapter 5).

- Staff are to agree the frequency, and recording, of conversations, observations and support, day and night, as the night requirements may be different...Observations must be at unpredictable times, e.g. twice an hour as opposed to every 30 minutes (chapter 5).

32. PSI 03/2013 sets out "*the framework for calling a medical emergency consistently over the establishment radio network in all prisons*". It came into force on 28 February 2013. It aims to ensure "*timely, appropriate and effective response to medical emergencies and thereby to maximise the likelihood of a positive outcome for the patient*." It is said that "NOMS *wishes to learn from PPO investigations into deaths in custody and we are consequently introducing a standard approach to how medical emergencies are responded to in prisons*".

33. Paragraph 3.2 of 03/2013 provides that "*All prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies."*

34. Paragraph 5.7 provides that as a minimum, local protocols must:

- Inform staff that if they are in any doubt about the nature of the injury, they must call an ambulance.
- Define the nature of codes being used. This must be sufficiently prescriptive to describe the incident and trigger automatic contingencies.
- Define what must be done when there is not a nurse or doctor on duty, or if the nurses are not first aid trained.
- Prevent any unnecessary delay in escorting ambulances and paramedics to the patient and discharging them from the prison.
- Minimise delays to staff accessing cells during patrol state and the night state.

35. It is also of note that Woodhill's local suicide prevention policy states:

> "*All staff that have contact with prisoners must be trained to at least ACCT Foundation Level*."

<u>The Detail of the Claimants' Complaints</u>

36. At the conclusion of the hearing of this application, we were concerned to understand, by reference to the detailed circumstances of the cases to which the Claimants referred, the precise nature of the systemic faults about which complaint was made. Accordingly, we directed the parties to produce a Scott Schedule, identifying the precise faults or error on the part of the prison authority identified in the various reports compiled on the relevant death, and the Defendants' response to each. We are grateful to the parties for their assistance in producing that schedule. It has proved very useful.

37. In respect of PSI 64/2011, the Claimants indicate in the schedule that their primary complaint "*is that there was a systematic failure by the Defendants to put in place general measures to ensure staff understand and comply with*" those instructions in that PSI. It was said to be sufficient for the purpose of the Claimants' case that the various reviews had concluded that there were many individual failures by staff to comply with the requirements of the PSI.

38. The Claimants particularise that allegation by pointing to the following six breaches of PSI 64/2011. First, staff did not identify all relevant factors, or the prisoner's underlying needs, contrary to paragraph 17. Second, staff did not identify appropriate measures to protect the prisoner or address the underlying cause of the prisoner's risk, contrary to paragraph 22. Third, there was a failure to hold multi-disciplinary reviews contrary to paragraph 21.

39. Fourth, it was alleged that ACCT documents were not completed properly. Fifth, the standard of observations and conversations noted in the ACCT documents was said to be inadequate. Sixth, observations were alleged to have been conducted at predictable, rather than unpredictable, intervals. These last three failures were said to be contrary to requirements set out in chapter 5.

40. Next, the Claimants alleged that a number of reviews indicated that staff had not received sufficient training or did not have enough time to perform their duties, contrary to chapter 1 of PSI 64/2011 and the local HMP Woodhill policy referred to at paragraph 35 above.

41. Finally, the Claimants identify eight cases in which there was a failure to comply with the provisions of PSI 03/2013 on emergency response. They refer to failures to use the correct emergency response code, delays in calling ambulances, failures to bring appropriate equipment to the emergency and failure to understand the circumstances in which they should enter a cell in an emergency.

The Legal Principles

42. As we have said, there is a good deal of agreement as to the applicable legal principles.

43. First, as a matter of domestic public law, it is agreed that a decision maker must comply consistently with his published policy (see for example R (Lumba) v Secretary of State for the Home Department [2011] UKSC 12). A failure to comply with a mandatory provision of the policy may justify a finding of breach of public law duty (R (Gill) v Secretary of State for Justice [2010] EWHC 364.)

44. Second, as a result of the Human Rights Act 1998 and Article 2 ECHR, it is agreed that the Defendants are subject to both negative and positive obligations to protect life. The positive obligations involve a general duty to put in place appropriate systems to protect life and an operational duty to protect those individuals to whom a responsibility is owed or assumed.

45. It is agreed, however, that only the former of those two positive obligations is relevant in the present proceedings. As the Claimants put it (at paragraph 35 of their skeleton argument)

"*there is a distinct 'operational duty' within article 2….This focuses on one off, isolated, operational failures by individual members of staff, as opposed to system or general measures. The operational duty is not in issue in the Divisional Court part of this claim*."

46. Third, it is agreed that the precise extent and nature of the general duty depends on the relationship between the individual concerned and the State. In Mitchell v Glasgow City Council [2009] 1 AC 874 Lord Rogers said (at paragraph 66):

> *"where a state has assumed responsibility for an individual, whether by taking him into custody, by imprisoning him, detaining him under mental health legislation, or conscripting him into the armed forces, the state assumes responsibility for that individual's safety. So in these circumstances police authorities, prison authorities, health authorities and the armed forces are all subject to positive obligations to protect the lives of those in their care. The authorities must therefore take general measures to employ and train competent staff and to adopt appropriate systems of work that will protect the lives of the people for whose welfare they have made themselves responsible. These are general obligations, not directed at any particular individual, but designed to protect all those in the authorities' care. If, however, an authority fails to fulfil one of these obligations and someone in their care dies as a result, there will be a violation of his or her article 2 Convention rights. Authorities which are under these general obligations to persons in their care may also come under a distinct, additional, "operational" obligation to take special preventive measures to protect a particular individual in their care. That operational obligation arises only where the authority knows, or ought to know, of a "real and immediate risk" to the life of the particular individual."*

47. In Savage v South Essex Partnership NHS Foundation Trust [2009] 1 AC 681 Lord Rodger said;

> *"30…So far as the risk of suicide itself is concerned, under article 2 there is a general duty on the prison authorities to take measures and precautions which can diminish the opportunities for self-harm, without infringing the prisoner's personal autonomy: Keenan's case 33 EHRR 913, 958, para 91; Renolde v France (2008) 48 EHRR 969 , para 83. The practical example of that duty given in Tanribilir v Turkey given 16 November 2000 , para 74, and Akdogdu v Turkey given 18 October 2005 , para 47, is removing things, such as sharp objects, belts or laces, which prisoners could use to harm themselves. A rather more elaborate general precaution of this kind is the wire netting which, for well over a century, has been stretched between the first floor landings of*

traditional British prisons to catch prisoners who might try to commit suicide by jumping from an upper landing.

31 If the authorities failed to put in place appropriate general measures to prevent suicides among the prisoners in a particular prison and, as a result, a prisoner was able to commit suicide, there would be a breach of article 2. If, on the other hand, the authorities had employed properly trained staff and taken all the relevant general precautions, but a prisoner none the less succeeded in committing suicide because of the casual negligence of a member of the prison staff, the prison authorities would be vicariously liable for that negligence, but there would be no violation of article 2."

Discussion

48. It follows from that short review of the authorities that the critical question for us in the present case is whether the Claimants have established that the suicides at HMP Woodhill, or some of them, were the result of a systemic failure by the prison. It was not suggested that there was a deliberate decision not to comply with the relevant policies. While a single operational failure, or even a series of operational failures, may justify an award of damages in the particular circumstances of an individual case, such would not justify a declaration of the sort sought by the Claimants in these proceedings.

49. The distinction between operational and systemic failures is discussed in the authorities cited above but, for our purposes, perhaps the best explanation of the difference is that provided by Lord Dyson MR in R (Long) v Secretary of State for Defence [2015] EWCA Civ 770.

50. Long was an appeal by the mother of a British soldier, unlawfully killed in Iraq in 2003, against a decision that the Secretary of State had not breached his duty to investigate the killing. The son had been one of six soldiers in a military police patrol who had been murdered. A month before their deaths, a communications order had stipulated that all patrols should be equipped with an iridium satellite phone. However, a practice had developed of ignoring the order. The six soldiers had, as a result, not been equipped with such a phone. If they had been, their lives might have been saved.

51. The Court of Appeal held that art.2 would not be engaged in a case involving no more than an allegation of negligent conduct by an individual, or a combination of events over which the state had no control and could not be held responsible. However, a case involving dangerous activities undertaken, organised or authorised by the state, might engage art.2, if it was arguable that the death was caused by insufficient state systems, regulations or control. In Long, it was clear that the failure to comply with the order to provide soldiers with iridium phones was a failure of system or control. It was the result of the introduction, or routine acceptance, of a different practice somewhere in the chain of command from that required by the order. That practice was not occasional or sporadic. It was a system failure by the military authorities to permit soldiers routinely to disregard the order.

52. At paragraphs 11-12 Lord Dyson said:

> *11 It is common ground that the failure to provide the soldiers with iridium phones on 24 June 2003 was not the result of a decision about "training, procurement or the conduct of operations ... at a high level of command and closely linked to the exercise of political judgment and issues of policy": see the Susan Smith case [2014] AC 52 , para 76. Nor was it a decision relating to "things done or not done when those who might be thought to be responsible for avoiding the risk of death or injury to others were actively engaged in direct contact with the enemy" [2014] AC 52, para 76. That is why, for the purposes of these proceedings, it is common ground that the Divisional Court was right to analyse the allegations in the present case as falling within what Lord Hope DPSC described in the Susan Smith case, at para 76 as the "middle ground".*
>
> *12. Whether a case which falls within the middle ground engages or comes within the scope of article 2 is, as Lord Hope DPSC said, "much more difficult" (than deciding whether it falls within the middle ground at all). In saying that (i) no hard and fast rules can be laid down, (ii) it requires the exercise of judgment and (iii) this can only be done in the light of the facts of each case, Lord Hope DPSC provided little assistance as to how this difficult exercise is to be performed."*

53. At paragraph 25 Lord Dyson went on:

> "*The distinction between (i) system or framework failures or failures of state control and (ii) individual human error is not always easy to apply. All errors which fall within (i) are "human" in the sense that they are made by human beings. In general terms, the distinction is clear enough. A case falls within Lord Hope's middle ground where there has been an arguable failure of a systematic nature, i.e. a failure to provide an effective system of rules, guidance and control within which individuals are to operate in a particular context. A case does not fall within the middle ground where the death is due to an individual's failure to operate properly within the system provided by the state. In the military context, I see no reason to limit individual failure to operational error by the service men and women on the ground. It may include individual error by those who are responsible for supervising or giving instructions to such men and women. An isolated lapse by a supervisor is just as much beyond the reach of article 2 as an isolated operational lapse by a man or woman on the ground."*

54. Applying this approach to the present case, the crucial legal issue, in our judgment, is whether the suicide of prisoners is a result of failure in the operation of the system,

whether that be a failure by a prison officer or an administrator, or a failure of the system itself. In our judgment, that analysis is not determined by whether there is one operational error or a series of such errors. What matters is not the number of errors, but their character. Where there are identical, or very similar errors, of practice, that may point to a systemic fault in the design or supervision of the system; where there are repeated, but different, operational errors, it may be impossible fairly to characterise that as a system fault.

55. We fully recognise that such distinctions may seem artificial, or even unimportant, to the families of those who have died. However, this distinction is of genuine importance legally, since it helps to determine the legal consequences where there is said to be a failure or breach of duty which caused or contributed to a death.

56. It is argued by the Claimants that there were "*systemic failings*" at HMP Woodhill to ensure that staff understood and complied with the requirements of PSI 64/2011. The fact that the complaint can be expressed at that level of generality, however, does not establish a systemic fault. On the contrary, in our view, it may simply be that the evidence demonstrates individual failings of understanding and individual failings of compliance.

57. Four further examples illustrate the point. First, it is alleged that staff did not identify all relevant risk factors. But that is simply to describe compendiously a series of individual failures by particular members of staff to identify the relevant risk factors in individual prisoners. Second, it is said that staff failed to identify appropriate measures to protect prisoners. But that says nothing about what the particular members of staff failed to do on the occasion in question. Third, it is argued that ACCT documents were not completed properly. But the errors in the documents are different in each case, and the fact that they can be described as a failure to complete documents properly does not demonstrate an error of system. Fourth, it is said that there were repeated failures to comply with the instructions for emergency response. But the evidence does not support a suggestion that it was the same mistake being made repeatedly, merely that there were a number of different errors in applying detailed procedure in different circumstances. The evidence does not show a failure of procedure, or of training in the procedure.

58. Viewed analytically, the Scott Schedule demonstrates, in our judgment, a series of distinct but separate operational mistakes in suicide prevention at HMP Woodhill. Their frequency does not, of itself, demonstrate a failure of the system but instead, that this is a system prone to operational error. That, in our judgment, is unsurprising, given that the "system" concerns the inter-relationship between prison officers and prisoners. Where there are human beings involved on both sides of the arrangement, in situations of some stress and complexity, and where there are inevitably numerous distractions from the performance of what are often important but routine tasks, the scope for mistake is substantial.

59. Overall, the evidence does not suggest to us that the same mistake was made time and time again. Instead, it demonstrates that different mistakes were made in specific factual circumstances.

60. The two areas where the claimants' case is at its strongest, in our judgment, are in respect of training, and irregular inspections of prisoners in their cells.

61. It is said by the Claimants that a number of reviews indicated that staff had not received enough training, or did not have enough time to perform their duties. In fact, however, as the Defendants assert, only two PPO reports deal with such issues, and the respects in which complaints about training are made are different. In the report into Mr Scarlett's death it is said that officers were unaware of whose responsibility it was to place a prisoner in a safer cell. In Mr White's case there were a number of different allegations about inadequate training. None of this points to systemic failure in the sense we have identified. Moreover, the findings relate to deaths prior to the commencement of work by a task force that is seeking to address this issue.

62. It is said that there was a failure to ensure all staff are subject to proper "refresher" training. This is inevitably a continuing process related to local requirements. We have seen no convincing evidence of a deficiency in the programme for training. We are not satisfied that there was, in fact, any breach of the obligation, referred to at paragraph 31 above, to provide ACCT refresher training "*according to local training needs*".

63. The second critical area relates to the need to ensure that observations of prisoners are conducted at unpredictable times, as required by chapter 5 of PSI 64/2011 (paragraph 31 above). In the case of Mr Latham, the PPO report records (at paragraph 132) that in a four-hour period on 27 November "*all the checks were recorded either on the hour or half past the hour*." In the PPO report on Mr Morris it is said that "*the timing of the staff checks was predictable to the point that Mr Morris was, in all probability, able to anticipate when staff would next check him*." In the PPO report on Mr Dunkley it was noted at paragraph 69 "*many of the checks on Mr Dunkley were carried out at predictable intervals contrary to PSI 64/2001 which says that ACCT observations must be conducted at unpredictable intervals*."

64. But even here, in our judgment, the faults are more fairly characterised as individual errors, rather than the outcome of systemic failure. The instruction is perfectly clear: inspections should be at unpredictable times. There is no evidence that the prison failed to make the instruction known to its staff or that a practice of making only regular inspections was tolerated or encouraged by the prison. This does not seem to us the equivalent of the practice of not issuing servicemen with iridium satellite phones, the failure criticised in Long.

65. In those circumstances, in our view, the Claimants have failed to establish a systemic failing of the sort which, on their case, would be amenable to the type of relief they seek in these proceedings.

66. We repeat the point made earlier: the distinction here is of legal importance, principally because it determines the legal consequences where fault is alleged to have contributed to death by suicide. Such cases can be, and often are, pursued on the basis that prison staff failed to act as they should have done. That is entirely appropriate. The families of those who have died, who face the very sad loss of the life of a loved one, are not without legal remedy.

67. Moreover, they would not gain a legal remedy which would be conclusive in relation to any individual death from a declaration such as that sought here. Even were such a declaration made, it would be of limited, and often no, impact in a given case. If hypothetically, a Court were to declare that the training programme of a given prison

was deficient in relation to the need for irregular (and thus unpredictable) observations, it would still be necessary in each individual case to establish whether the training of the individual officers concerned had been deficient and whether more irregular observations would or may have prevented the death in question. No doubt a declaration would enhance the focus on that issue, but it could not normally be decisive for the individual.

Discretion

68. Even if we had been persuaded that there was a systemic error, we are doubtful whether we would have concluded that an injunction, or a mandatory order, or a declaration would have been appropriate.

69. Relief in judicial review proceedings is a matter for the discretion of the Court. The Defendants have made it clear that they share the great concern of the Claimants and the Intervenor, this Court and other commentators, about the rate of suicides in prisons generally, and HMP Woodhill in particular. They have in place sensible and satisfactory policies. It is important to stress that the contents of the policies are not criticised by the Claimants. They specify the right sort of training. The Defendants have acknowledged that, on occasions, operational errors have been made by their staff in dealing with those at risk of suicide and have sought to prevent those mistakes being repeated. The Defendants have accepted the reports of both the Coroner and the PPO and have sought to take steps to address the deficiencies identified.

70. In those circumstances, it is not obvious precisely what else it is said should be done to address the problem. The Claimants' submissions came close to an argument that "*something must be done*", without identifying what it is that could be done. In our view, a remedy of the sort proposed by the Claimants would serve little purpose.

71. The Courts can and do provide a remedy for specific failures in specific cases. However the reality, we suspect, is that this is not a problem with which the Courts are equipped to deal in generality. Suicides in prison raise complex societal issues. The solution to those problems, acute as they are, lies not with judges applying principles of public law but with those who have the unenviable task of managing prisons.

Conclusion

72. For all those reasons, this claim must fail.