

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jack Turner, a prisoner at HMP Haverigg, on 29 May 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Jack Turner died from lung cancer at Furness General Hospital, on 29 May 2015. He was 68 years old. I offer my condolences to those who knew him.

Mr Turner had been provisionally diagnosed with cancer less than two weeks before his death, which was very sudden. I am satisfied that there was nothing that healthcare staff at Haverigg could have done to predict or prevent his death and that he received a high standard of care at the prison, at least equivalent to that he could have expected to receive in the community. However, I consider that there were no security grounds to justify the use of restraints when Mr Turner was taken to hospital appointments during May.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

November 2015

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Summary

Events

1. Mr Jack Turner had been in prison since 1999 and was serving a life sentence. He had been at HMP Haverigg since 30 January 2014. He had a medical history of heart disease, high cholesterol, chronic obstructive pulmonary disease (COPD – the name for a collection of long-term progressive lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease) and asthma. He smoked and healthcare staff often encouraged him to stop.
2. Over several months from October 2014, Mr Turner reported a cough and chest pain. Repeated sputum sample tests and chest X-rays revealed no abnormalities until 29 April 2015, when an X-ray showed a partial collapse at the base of his left lung.
3. On 12 May, Mr Turner was admitted to hospital, with shortness of breath and pain in his rib and back. Tests suggested the possibility of cancer. On 15 May, the hospital carried out an urgent bronchoscopy, which identified a mass on his lung. On 18 May, a prison doctor told Mr Turner that the tests indicated a strong possibility he had lung cancer. On 23 May, Mr Turner had a biopsy and a hospital consultant discussed treatment options with him.
4. At around 4.50pm on 27 May, shortly after returning from a hospital appointment, Mr Turner collapsed in the prison grounds. Staff called an ambulance. Nurses attempted cardiopulmonary resuscitation and restarted his heart twice with a defibrillator. A paramedic arrived at 5.17pm and took over emergency treatment. An ambulance took Mr Turner to hospital. In hospital, Mr Turner's condition worsened and he died at 10.35am, on 29 May.

Findings

5. Mr Turner's health deteriorated very quickly and he died within two weeks of his provisional diagnosis, while he was still waiting for the outcome of a biopsy to establish the extent of his cancer. Healthcare staff managed his COPD and other conditions holistically, in line with National Institute for Health and Care Excellence (NICE) guidelines. After his diagnosis of lung cancer, they promptly assessed his needs and provided a special bed, relevant medication, a soft diet and nutritional supplements. We are satisfied that Mr Turner received a high standard of care at Haverigg, which was at least equivalent to that he could have expected in the community. Risk assessments when Mr Turner was taken to hospital for appointments in May, assessed him as a medium risk to the public, although he had been recategorised as a low risk. We therefore do not consider that the use of restraints was justified.

Recommendation

- The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Haverigg informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
7. The investigator obtained copies of relevant extracts from Mr Turner's prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr Turner clinical care at the prison.
9. We informed HM Coroner for Cumbria of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
10. Mr Turner had nominated a previous probation officer as his next of kin, who had transferred before his death. The prison was unable to trace any of Mr Turner's family.
11. The investigation has assessed the main issues involved in Mr Turner's care, including his diagnosis and treatment, whether appropriate care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
12. The initial report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been annexed to this report.

Background Information

HMP Haverigg

13. HMP Haverigg is a medium secure prison, which can hold 644 sentenced men. Cumbria Partnership NHS Foundation Trust provides healthcare services at the prison. The Gables Medical Practice provides GP services. Cumbria on-call medical service provides out-of-hours GP cover.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Haverigg was in January 2014. Inspectors found that health services were adequate. There was a good range of daily primary care clinics and well man checks for older patients. Care of patients with lifelong conditions, such as asthma, diabetes and heart disease, was good, through nurse-led clinics.

Independent Monitoring Board

15. 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 most recent annual report for the year to November 2014, the IMB reported that the healthcare premises were inadequate and staff shortages had affected attendance at outpatient hospital appointments.

Previous deaths at HMP Haverigg

16. Mr Turner was the second prisoner to die from natural causes at Haverigg since the start of 2014. There were no similarities between the circumstances of Mr Turner's death and previous deaths at the prison.

Findings

The diagnosis of Mr Turner's terminal illness and informing him of his condition

17. Mr Jack Turner had been in prison since 1999. He was serving a life sentence and had been at Haverigg since 30 January 2014. He had a history of heart disease, high cholesterol, COPD, and asthma. Despite his conditions, and against healthcare advice, he continued to smoke, although he had been given help to stop a number of times. Healthcare staff frequently reviewed his medical conditions and medication and persistently encouraged him to stop smoking.
18. On 6 October and 11 November 2014, Mr Turner reported a cough. Both times, healthcare staff sent sputum samples for analysis. The test results were normal. On 11 November, a prison GP, prescribed an antibiotic and Mr Turner's cough improved. He did not report any further new health issues until 28 January, when he said he had a tight and painful chest. The GP examined him and his chest sounded clear and he was not short of breath. Another sputum sample was tested and was again normal. The GP referred Mr Turner to the lead respiratory nurse.
19. The nurse reviewed Mr Turner on 26 February. His shortness of breath and chest wheeze had improved. He said he had stopped smoking and the nurse advised him how best to use his inhaler to improve the flow of medication to his lungs. Towards the end of March, the GP reviewed the results of several blood tests, taken at a Well Man check on 20 March, and they were all normal.
20. The nurse examined Mr Turner on 2 April as his chest felt tight and he had a notable wheeze. The nurse discussed Mr Turner with the GP, who prescribed an antibiotic and noted he would review Mr Turner in four days, after the Easter Bank Holiday, if his condition had not settled.
21. On 5 April, Easter Sunday, Mr Turner had chest pain and short of breath. He told the nurse that the antibiotics had not relieved his symptoms and he felt worse. The nurse telephoned the out-of-hours GP service and the GP visited the prison to examine Mr Turner. The GP found widespread abnormal lung sounds in both sides of the chest and prescribed prednisolone (a steroid medication). The next day, Mr Turner told the clinical manager at Haverigg, that he was feeling much better. His clinical observations were within the normal range.
22. On 7 April, a locum GP, ordered a routine chest X-ray for Mr Turner and prescribed further antibiotics. She noted that he had not coughed up blood and there was no clubbing of his fingernails or toenails, which are common signs of lung cancer. In the early hours of 10 April, Mr Turner was admitted to hospital with shortness of breath. A chest X-ray and blood tests were normal and the hospital discharged him on 12 April.
23. Staff at Haverigg took a further chest X-ray on 29 April. The results showed a partial collapse at the base of Mr Turner's left lung, which appeared to be the result of an inflammation. The GP told the nurse that as the X-ray had showed nothing remarkable, he did not need to review Mr Turner unless his condition worsened.

24. Between 29 April and 12 May, healthcare staff reviewed Mr Turner five times. On 12 May, the GP examined Mr Turner and suspected he might have a blockage in one of the arteries in his lung. He sent him to Furness General Hospital and he was admitted for 24 hours. A CT scan revealed abnormal lymph nodes in his lungs, possibly indicating lung cancer and a thickening of his gullet, suggestive of cancer of the oesophagus. The hospital requested an urgent bronchoscopy (a camera examination of the inside of the lungs) and a gastroscopy (a camera examination of the gullet).
25. On 15 May, Mr Turner went back to the hospital for the bronchoscopy. (Initially the prison said it was unable to provide staff to escort Mr Turner. Commendably, the GP and other healthcare staff challenged the decision, emphasising the urgency, and an escort was arranged.) The results of the bronchoscopy showed a lung mass on the left side and bleeding. The hospital referred him to the respiratory clinic, and asked for a follow-up in a week. When he returned to Haverigg the next day, a nurse discussed the follow up procedures with him and referred him to see the GP. On 18 May, the GP told Mr Turner that there was a strong possibility that he had lung cancer.
26. The clinical reviewer commented that Mr Turner had received exceptional care at Haverigg for his COPD, and that staff had followed NICE guidance for his treatment. We are satisfied that staff were responsive to Mr Turner's symptoms and promptly referred him for investigative tests. When the tests identified abnormalities, the prison GP saw him quickly to discuss his diagnosis.

Mr Turner's Medical Treatment

27. After Mr Turner's provisional diagnosis, the GP prescribed codeine (a painkiller) and a soft diet. A nursing care plan specified that staff should review Mr Turner daily in his cell.
28. A palliative care link nurse, visited Mr Turner on 19 May but he told her that he did not want to consider his future at that time. On 23 May, the nurse reviewed Mr Turner after a hospital appointment for a biopsy. Mr Turner said that his consultant had discussed treatment options with him, such as chemotherapy. He could no longer walk far and found it difficult to get to the healthcare centre daily to collect his nutritional supplement, so the nurse arranged for the supplement to be prescribed weekly and delivered to his cell.
29. On 27 May, Mr Turner went to hospital for a scan and arrived back at Haverigg shortly after 4.00pm. Around 4.50pm, Mr Turner collapsed in the prison grounds. An officer saw him fall and, as he appeared to be unconscious, he immediately radioed a code blue medical emergency. (A code blue indicates a prisoner is unconscious, not breathing or is having breathing difficulties.) The prison's communications room rang for an emergency ambulance at 4.54pm.
30. An officer and two nurses responded to the emergency call. Mr Turner briefly regained consciousness and they sat him up. A few seconds later, he lost consciousness and stopped breathing. The nurses began cardiopulmonary resuscitation and applied a defibrillator, which administered two shocks to restart his heart.

31. Around 5.17pm, a paramedic arrived and took control of Mr Turner's care. Two ambulances arrived at 5.22pm and 5.48pm. At 6.07pm, Mr Turner was taken by ambulance to Furness General Hospital. Mr Turner's condition did not improve and he died at 10.35am on 29 May. The cause of death was certified as widespread, inoperable squamous cell carcinoma. This had led to a heart attack at the time of his fall on 27 May.
32. The clinical reviewer found that healthcare staff assessed and met all Mr Turner's needs with care and compassion at all times. She commented that the holistic approach to Mr Turner's management and the level of continuity of care between medical and nursing staff was rarely found in the community. We are satisfied that Mr Turner's care was at least equivalent to that he could have expected to receive in the community.

Mr Turner's location

33. When the GP informed Mr Turner of his provisional diagnosis, Mr Turner said that his main problem was difficulty in sleeping because of coughing and being unable to swallow. The doctor ordered a new bed frame and three extra pillows so that he could sleep in an upright position. Medical reviews took place in his cell.
34. On 23 May, Mr Turner told the nurse that he had been recategorised to the lowest security category and wanted to move to an open prison while having treatment. The nurse agreed to speak to Mr Turner's offender supervisor about a suitable transfer. Medical records show that on 26 May, the officer confirmed that he would try to find an open prison with medical facilities. Mr Turner went to hospital the next day where he died. We are satisfied that Mr Turner was appropriately located at Haverigg with suitable facilities to meet his needs. .

Restraints, security and escorts

35. When prisoners have to travel outside prison, such as to a hospital, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility.
36. The risk assessments for Mr Turner's hospital visits from 12 May concluded that Mr Turner was a medium risk to the public, but low risk to hospital staff, of hostage taking and of escape. A medical assessment did not object to the use of restraints but did not comment on whether his condition affected his risk of escape. A manager authorised the use of single handcuffs, with an escort chain for visits to the toilet and medical treatments. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

37. On 25 May, the Governor reviewed the risk assessment and decided that restraints should not be used for any subsequent hospital visits. As a result, Mr Turner was not restrained when he went to Furness General Hospital on 27 May.
38. We are not satisfied that the risk assessments before 25 May properly considered Mr Turner's risk. They assessed Mr Turner as a medium risk to the public and authorised the use of restraints. However, on 6 May 2015, the officer noted in Mr Turner's prison record that he had been confirmed as security category D. This is the lowest security category and Mr Turner was waiting for a move to an open prison. Prison Service Instructions describe category D prisoners as, "Prisoners who present a low risk; can reasonably be trusted in open conditions and for whom open conditions are appropriate." While we are pleased to note that restraints were not used when Mr Turner was taken to hospital on 27 May, it is difficult to see how they were justified for appointments before that when he was a category D prisoner in poor health. We make the following recommendation:

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Turner's family

39. Mr Turner did not have any family contact and received support from the Roman Catholic chaplain. Mr Turner had listed his probation officer as his next of kin, but she had transferred to another job and the prison was unable to contact her. A new probation officer had been allocated Mr Turner's case. The Reverend, the managing chaplain at Haverigg, contacted Mr Turner's solicitor who knew that he had three sisters, but they were estranged and had not had any recent contact.
40. Further attempts to trace Mr Turner's family through the Probation Service and Greater Manchester Police were unsuccessful. The prison therefore arranged Mr Turner's funeral, which the chaplain conducted on 11 June.

Compassionate release

41. Prisoners can be released on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months. On 28 May, the officer began an application for a compassionate release. However, Mr Turner died before it was submitted.

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