

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent Investigation into the death of Mr Harold Turner a prisoner at HMP Whatton on 7 September 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 Harold Turner died of widespread cancer while a prisoner at HMP Whatton, on 7 September 2015. He was 78 years old. I offer my condolences to Mr Turner's family and friends.

I am satisfied that Mr Turner received an excellent standard of clinical care at Whatton for his range of medical conditions and that there was a humane approach to security, which allowed him to die with dignity in a hospice.

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

March 2016

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Summary

Events

1. Mr Harold Turner was serving an eight-year sentence, and had been at HMP Whatton since 10 February 2012.
2. Mr Turner was generally frail; a stroke in 2010 had left him with left-sided weakness and he had a number of other health problems. Healthcare staff reviewed his conditions frequently and ensured he attended hospital appointments as required.
3. In June 2015, Mr Turner experienced pain in his hip and an X-ray identified some changes in his lower back, apparently from old age. On 21 July 2015, a nurse noted that Mr Turner had some bowel problems, poor appetite, dehydration, mild anaemia and urinary incontinence. The nurse referred him to a GP who took a blood test the next day. On 23 July, the results of the blood test showed high levels of calcium in his blood, which can be an indication of bone cancer. The GP referred Mr Turner to Queen's Medical Centre, Nottingham for further investigations. He was admitted the same day.
4. On 29 July, hospital doctors told Mr Turner that tests indicated that he was likely to have an incurable form of bone cancer. A biopsy confirmed this on 6 August. Doctors told Mr Turner that he would receive radiotherapy treatment for the pain but no active treatment was possible.
5. On 17 August, Mr Turner began a five-day course of radiotherapy treatment. Prison nurses liaised with the hospital to plan Mr Turner's discharge to the palliative care unit at Whatton, but it was decided that he needed hospice care. On 1 September, Mr Turner transferred to Hayward House Hospice, Nottingham. He died at the hospice on 7 September 2015.

Findings

6. The clinical reviewer considered that Mr Turner received an excellent standard of care at the prison for his range of medical conditions and we are satisfied that his care was equivalent to that he could have expected to receive in the community. Appropriate risk assessments ensured that he was not restrained when he was taken to hospital and was able to die with dignity, in a caring environment.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Whatton informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Turner's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Turner's clinical care at the prison. He interviewed two members of healthcare staff by telephone on 2 October 2015.
10. We informed HM Coroner for Nottinghamshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted Mr Turner's son, to explain the investigation. He did not have any specific issues he wanted the investigation to consider.
12. The investigation has assessed the main issues involved in Mr Turner's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
13. The initial report was shared with the prison service. There was one factual inaccuracy and the report has been amended accordingly.
14. Mr Turner's son was informed the initial report was available, but did not wish to receive a copy or make any comment.

Background Information

HMP Whatton

15. HMP Whatton in Nottinghamshire is a medium security category prison holding up to 841 men convicted of sex offences.
16. Nottinghamshire Healthcare Foundation Trust provides healthcare services at the prison. The healthcare centre is open seven days a week. GPs from a local practice provide specialist clinics for older prisoners and those with chronic conditions and there is an out-of-hours service. There are no inpatient beds, but there is a palliative care suite in the healthcare centre, for end of life care.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Whatton was in February 2012. Inspectors reported that the quality of healthcare was good, and relationships between healthcare and prison staff were effective. They noted that the prison's palliative services were impressive.

Independent Monitoring Board

18. 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 May 2015, the IMB reported that the number of daily escorts to hospital affected the operation of the prison. The Board noted an increasing demand for healthcare services, the result of a higher proportion of elderly prisoners.

Previous deaths at HMP Whatton

19. Mr Turner was the tenth prisoner to die from natural causes at Whatton since July 2014. Generally, our investigations have found a high standard of end of life healthcare at the prison.

Findings

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

20. On 13 June 2011, Mr Harold Turner was sentenced to eight years in prison for sexual offences. He had been at HMP Whatton since February 2012 and had a number of medical conditions when he arrived, including left-sided weakness from a stroke in 2010, high blood pressure, nocturia (a need to pass water during the night), a hernia and pain in his right hip.
21. Mr Turner subsequently developed chronic kidney disease, venous leg ulcers, and angina and had some gastrointestinal bleeding. Healthcare staff saw him frequently to review his medical conditions and he attended a number of hospital appointments for X-rays of his hip and chest, and treatment for his leg ulcers. He was frail with limited mobility, but prison staff encouraged him to remain active.
22. On 18 June 2015, Mr Turner told a nurse that he could not put any weight on his right leg and his right hip was painful. The nurse referred him to the prison GP. On 22 June, Dr A examined Mr Turner and referred him for an X-ray, which he had on 26 June. This identified some changes in his lower back, possibly due to old age.
23. On 21 July, a nurse examined Mr Turner and noted he had bowel problems, a poor appetite, dehydration, mild anaemia, and urinary incontinence. He referred him to the GP. On 22 July, Dr B reviewed Mr Turner and took a blood sample.
24. On 23 July, Dr B noted that the blood tests showed high levels of calcium, an indicator of bone cancer. The doctor arranged for Mr Turner to be admitted to Queen's Medical Centre, Nottingham, that day for further investigations.
25. Mr Turner remained in hospital and, on 29 July, after X-rays and CT scans, a hospital doctor told him that he had bone metastases (where the cancer has spread from one organ to another part of the body). The doctor said that a biopsy on 31 July would determine the appropriate treatment.
26. On 6 August, a doctor told Mr Turner that the biopsy had confirmed he had cancer (squamous cell carcinoma). A prison nurse and a prison chaplain visited Mr Turner in hospital to support him.
27. We are satisfied that healthcare staff at Whatton reviewed Mr Turner frequently, and considered his symptoms appropriately. A doctor referred him to a specialist promptly when he identified concerns that might indicate cancer and there was no delay in his diagnosis.

Mr Turner's clinical care

28. The doctor, who informed Mr Turner of his diagnosis, told him that radiotherapy at City Hospital, Nottingham, might be possible and Mr Turner was transferred there on 11 August. On 12 August, an oncologist told him that the cancer was incurable and that he would receive radiotherapy only to alleviate pain. Mr Turner began a five-day course of radiotherapy on 17 August.

29. On 24 August, hospital doctors considered that Mr Turner had only about two weeks to live. On 1 September, Mr Turner transferred to Hayward House Hospice. Staff managed Mr Turner's pain, but his condition continued to decline. Mr Turner died at 5.00pm on 7 September.
30. A post-mortem examination found that Mr Turner had died from metastatic squamous carcinoma (cancer that had spread) but did not find a primary site.
31. All of Mr Turner's clinical care after his diagnosis was in an NHS hospital and a specialist palliative care unit in the grounds of the hospital, which is outside the remit of this investigation. We are satisfied that Mr Turner received a good standard of healthcare at the prison, before his diagnosis.

Mr Turner's location

32. Mr Turner was in Queen's Medical Centre at the time of his diagnosis and then moved to City Hospital on 11 August. On 20 August, Nurse A, spoke to nurse at City Hospital about Mr Turner's end-of-life care plan and whether the hospital would discharge him back to Whatton. They discussed the care package and arrangements Whatton would need before Mr Turner could be discharged back to the prison's care. On 27 August, hospital staff decided that Hayward House Hospice, within the grounds of City Hospital, would be the best option for Mr Turner's end of life care.
33. We are satisfied that Mr Turner was appropriately located throughout his final illness.

Restraints, security and escorts

34. When prisoners have to travel outside prison for any purpose, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints.
35. On 23 July, custodial manager, Ms A, completed a risk assessment and concluded that Mr Turner was a low risk to the public, hospital staff and of escape and did not need restraints. Two officers accompanied Mr Turner to Queen's Medical Centre. Later that day, duty governor, Mr A, reviewed the risk assessment and reduced the number of escorting officers to one.
36. We are satisfied that Whatton took Mr Turner's health and mobility into account when assessing the security arrangements and concluded that restraints were not necessary. We consider this was an appropriate and humane decision.

Liaison with Mr Turner's family

37. On 24 August, hospital doctors said Mr Turner had approximately two weeks to live and the prison appointed Officer A as their family liaison officer. Mr Turner was estranged from his family, but had named his godson as his next of kin. He had had not been in contact with his godson either and he could not be traced on the telephone number or at the address in Mr Turner's records. The police were unable to find him and the officer was therefore unable to let him know that Mr Turner was ill. The officer contacted a friend from Mr Turner's phone list but he had no further information about family members.
38. Officer A made further enquiries with Mr Turner's offender manager, the police and his legal representative in an attempt to trace any family members. On 17 September, the police traced Mr Turner's son and informed him that Mr Turner had died on 7 September. The prison arranged the funeral.
39. While we consider that it would have been preferable to appoint a family liaison officer earlier, as soon as it became apparent that Mr Turner had a terminal illness, we are satisfied that the prison made good and appropriate efforts to contact Mr Turner's family to let them know of his illness and subsequently, his death.

Compassionate release

40. Prisoners can be released before their sentence has expired, 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.
41. Mr Turner had been in prison for several years and considered it his home. He was estranged from his family and was comfortable with prison staff. While in hospital and the hospice, he indicated he did not wish to be released. Because of this Whatton did not start an application for compassionate release. We are satisfied that this was appropriate.

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