

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Turner a prisoner at HMP Wymott on 17 October 2016

**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.

The 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 Turner died on 17 October 2016 of heart disease while a prisoner at HMP Wymott. He was 60 years old. I offer my condolences to Mr Turner's family and friends.

I am satisfied that Mr Turner received a good standard of clinical care at Wymott. Mr Turner was a heavy smoker with a history of high alcohol consumption. I am satisfied there was nothing healthcare or prison staff could have done to predict or prevent his death. I am also satisfied that staff acted appropriately during the emergency response.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

May 2017

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Summary

Events

1. On 30 October 2013, Mr James Turner was sentenced to 13 years 4 months in prison for attempted murder. He was transferred from HMP Liverpool to HMP Wymott on 16 January 2015.
2. Six months before he moved to Wymott, a prison GP referred Mr Turner for an echocardiogram (a scan used to look at the heart and nearby blood vessels) which produced a normal result. He was prescribed simvastatin to lower his cholesterol, which he no longer required by the time he moved to Wymott.
3. At his initial health screen at Wymott, a nurse noted that Mr Turner was slightly overweight and his blood pressure was within the normal range. She noted that he smoked 20 cigarettes per day and consumed 100 units of alcohol per week before he entered custody (current UK government guidelines recommend a maximum of 21 units per week for men). Mr Turner declined smoking cessation advice and substance misuse treatment.
4. Mr Turner missed appointments with a prison nurse and GP in October 2015 and February 2016, respectively. The nature of the appointments was not recorded. He attended one appointment with a prison GP on 27 January 2016 in relation to a sore shoulder, for which he was prescribed ibuprofen gel.
5. On 17 October, Mr Turner attended work as normal and returned to his cell at lunchtime. During the lunchtime roll-check, an officer found Mr Turner in his cell suffering with chest pains. He was able to talk. The officer made an emergency code blue call at 12.08pm. Mr Turner then lay down on his bed and became blue in the face. The officer called for a colleague who transmitted another radio call at 12.09pm for urgent medical assistance. Healthcare nurses arrived at 12.13pm and Mr Turner stopped breathing. Nurses carried out cardiopulmonary resuscitation (CPR) and applied a defibrillator to administer shocks.
6. Paramedics arrived at the scene at 12.29pm and continued CPR. They detected a faint pulse and, at 1.00pm, decided to transfer Mr Turner to hospital. They continued CPR in the ambulance and left the prison at 1.30pm. Mr Turner died at 1.47pm on the way to hospital.

Findings

7. We are satisfied that Mr Turner received a good standard of healthcare at Wymott, equivalent to that he could have expected to receive in the community. Mr Turner was a heavy smoker with a history of high alcohol consumption. He was appropriately assessed when he arrived at Wymott and did not require further check-ups. We are also satisfied with the actions taken by staff during the emergency response. Mr Turner's death was sudden and unforeseen and healthcare staff at Wymott could not have done anything to prevent it.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator visited Wymott on 22 November 2016. She obtained copies of relevant extracts from Mr Turner's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Turner's clinical care at the prison.
11. The investigator and clinical reviewer interviewed six members of staff at Wymott on 22 November.
12. We informed HM Coroner for Preston and West Lancashire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Turner's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not have any specific issues he wanted considered.
14. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Wymott

15. HMP Wymott is a medium secure prison holding over 1,100 adult men. Lancashire Care NHS Foundation Trust provides the majority of healthcare services at the prison. Indigo Primary Care Services provides GP services and GTD Healthcare provides out of hours GP services. There are no inpatient beds, but there is 24-hour nursing cover.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Wymott was in October 2016. Inspectors reported that upon arrival, prisoners were offered a prompt, full health assessment, appropriate referrals were made and prisoners received information about health services. Prisoners who were acutely unwell had access to a daily nurse triage clinic. For routine services, appointment slips were received the day before the appointment, which caused frustration and missed appointments.

Independent Monitoring Board

17. 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 2016, the IMB reported the service provided by the Lancashire Care NHS Trust fell far below the standard of care required from the Secretary of State for Health and the duty of care placed on the Secretary of State for Justice. However, it also noted that healthcare improved during the reporting period and there had been significant improvements in the overall situation, due in large part to the active involvement of the Governing Governor.

Previous deaths at HMP Wymott

18. Mr Turner was the seventh prisoner to die from natural causes at Wymott since January 2015. There has been one subsequent death. There were no similarities between the circumstances of Mr Turner's death and previous deaths at the prison.

Key Events

19. On 30 October 2013, Mr James Turner was sentenced to 13 years 4 months in prison for attempted murder. He transferred from HMP Liverpool to HMP Wymott on 16 January 2015.
20. In June 2014, while at Liverpool, a prison GP identified raised potassium levels and white cell count in Mr Turner's blood, and referred him to hospital for an echocardiogram (a scan used to look at the heart and nearby blood vessels). The echocardiogram produced a normal result and a prison GP prescribed Mr Turner simvastatin, to lower his cholesterol. Mr Turner no longer required simvastatin by the time he was transferred to Wymott.
21. At his initial health screen at Wymott, a nurse noted that Mr Turner had a body mass index (BMI) of 26.09 (a BMI of 25 to 29.9 classifies a person as overweight) and a blood pressure reading of 137/82. A blood pressure reading greater than 140/90 is considered high. The nurse noted Mr Turner smoked 20 cigarettes per day and was an ex-problem drinker having consumed 100 units of alcohol per week before he entered custody (current UK government guidelines recommend a maximum of 21 units per week for men). Mr Turner declined substance misuse treatment and smoking cessation advice. The nurse assessed him as fit for normal location. He did not require any prescription medication or any routine check-ups.
22. After his initial health screen, Mr Turner attended healthcare once, although he failed to attend appointments with a prison nurse and a prison GP on 20 October 2015 and 24 February 2016 respectively. The nature of the missed appointments was not recorded on Mr Turner's medical record.
23. On 27 January 2016, Mr Turner attended an appointment with a prison GP, as he was suffering with a sore shoulder. The GP diagnosed 'golfers elbow' and prescribed ibuprofen gel.

Events of 17 October 2016

24. On 17 October, Mr Turner went to work in the prison workshop as normal. A workshop supervisor had no concerns about Mr Turner's health that morning. At the end of his morning shift, Mr Turner returned to his cell.
25. At approximately 12.00pm, an officer carried out the lunchtime roll-check. When he arrived at Mr Turner's cell, Mr Turner was standing in his cell clasping his chest. He told the officer he was experiencing pains in his chest and had been doing so for the last few hours. Mr Turner said that he had not reported his chest pain to anyone that morning.
26. The officer called a code blue emergency (which indicates that a prisoner is having difficulty breathing) over the radio at 12.08pm. Mr Turner was able to speak and he remained with him and reassured him. Mr Turner then lay down on his bed and became blue in the face. The officer called for assistance from another officer. At 12.09pm, the other officer requested urgent medical assistance over the radio. The control room had already requested an ambulance at 12.09pm before the officer's radio call.

27. A nurse was administering medication on a wing at the other end of the prison when she heard the code blue. She immediately made her way to Mr Turner's wing with a colleague. They arrived at 12.13pm. The nurse entered Mr Turner's cell while her colleague collected the medical bag located on the wing. At 12.14pm, Mr Turner stopped breathing and was placed on the floor to enable both nurses to commence cardiopulmonary resuscitation (CPR).
28. Another nurse and a healthcare assistant arrived and took over CPR. They applied defibrillator pads to Mr Turner, and the device advised no shock on the first attempt. At the second and third attempt, the defibrillator administered one shock. They continued CPR between the shocks.
29. Paramedics arrived at the scene at 12.29pm and continued CPR, and a second ambulance crew arrived at 12.50pm. At 1.00pm, paramedics detected that Mr Turner had a faint pulse and decided to take him to hospital. They placed him in an EVAC chair (a chair that allows wheelchair users or less able-bodied people to be evacuated quickly and safely down stairs in the event of an emergency) and carried Mr Turner down three flights of stairs to the ambulance. The paramedics stopped CPR while they went down the stairs but continued it in the ambulance. They left the prison at 1.30pm. Mr Turner died on the way to hospital at 1.47pm.

Contact with Mr Turner's family

30. On 17 October, the prison appointed an officer as the family liaison officer. Mr Turner's son was his next of kin.
31. At 3.30pm, the officer and a senior manager visited the address of Mr Turner's son, but he no longer lived there. A neighbour provided them with the address of Mr Turner's estranged wife and mother of his son.
32. At 4.00pm, the officer and the senior manager told Mr Turner's estranged wife of his death. She gave them her son's address and they arrived at 4.30pm, by which time his mother had told him of his father's death. They offered their condolences and ongoing support.
33. Mr Turner's funeral was held on 9 November. The prison service contributed towards the costs of the funeral in line with national policy.

Support for prisoners and staff

34. After Mr Turner's death, a senior 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.
35. The prison posted notices informing other prisoners of Mr Turner's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Turner's death.

Post-mortem report

36. The post mortem concluded that Mr Turner died of ischaemic heart disease caused by severe coronary atheroma (degeneration of the walls of the arteries).

Findings

Clinical care

37. When Mr Turner arrived at Wymott, he was a heavy smoker, had a history of significant alcohol consumption and was slightly overweight. His blood pressure was within normal range and he did not have any other health concerns. Mr Turner declined smoking cessation advice and substance misuse treatment. He attended one prison GP appointment in January 2016 for a sore shoulder and missed two other appointments with a prison nurse and a GP. The nature of those appointments was not recorded.
38. We agree with the clinical reviewer that Mr Turner's care was equivalent to that he could have expected to receive in the community.

Emergency response

39. We are satisfied that, when Mr Turner collapsed, prison officers responded immediately, and appropriately called a code blue. Nurses responded as soon as possible and quickly obtained the necessary emergency equipment.
40. We note that paramedics used an EVAC chair to move Mr Turner from his cell to the ground floor rather than using a lift located in a nearby wing. While this decision meant that paramedics had to stop CPR to carry Mr Turner down the stairs, this decision avoided a delay in moving him to the lift. We are therefore satisfied that this decision was reasonable, but note that the clinical reviewer has made several recommendations relating to such situations, which the Head of Healthcare will need to address.

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