Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dennis Turner a prisoner at HMP Whatton on 25 February 2019

A report by the Prisons and Probation Ombudsman

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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*

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 I oversee can improve their work in the future.

Mr Dennis Turner died on 25 February 2019 of liver cancer at HMP Whatton. He was 78 years old. I offer my condolences to Mr Turner's family and friends.

I am satisfied that Mr Turner received excellent clinical care at Whatton, which was at least equivalent to that which he could have expected in the community.

However, I am concerned that the prison continued to restrain Mr Turner, despite his frailty and limited mobility. I have made a recommendation about this before and the Governor must now ensure that changes are made and embedded.

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

Sue McAllister CB
Prisons and Probation Ombudsman **September 2019**

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Summary

Events

1. Mr Dennis Turner was serving a life sentence and had been at HMP Whatton since 31 October 2012.

2. Mr Turner had a number of health concerns on his arrival at Whatton. A prison GP noted that he declined to have a hospital review, despite knowing that he could have undiagnosed conditions including cancer. Mr Turner declined most hospital reviews during his time at Whatton.

3. In July 2015, Mr Turner was successfully treated for bladder cancer. In autumn 2018, a prison GP referred Mr Turner to hospital with suspected lower gastro-intestinal cancer. On 27 August, he was admitted to hospital with internal bleeding. The cancer referral was cancelled at the request of the specialist. Four days later, Mr Turner was discharged back to Whatton, where he received additional clinical and social care.

4. Mr Turner also suffered with several other health concerns, including heart disease, respiratory problems and cardiovascular disease. During the next few months, his condition continued to deteriorate. On 10 January 2019, nursing staff discussed his end of life wishes with him. From 22 February he was provided with 24-hour care.

5. On the morning of 25 February, Mr Turner was with his care worker when he died. A prison GP pronounced him dead at 12.40pm.

Findings

Mr Turner's clinical care

6. We agree with the clinical reviewer that the care Mr Turner received at Whatton was equivalent to that which he could have expected in the community. He was appropriately cared for and monitored for his many health concerns, and referred to specialists as necessary.

7. We would also like to share the clinical reviewer's praise for the care and compassion demonstrated by healthcare staff at Whatton.

Restraints, security and escorts

8. We are concerned that the prison continued to restrain Mr Turner during his escorted trips to hospital in the community. This continued long after he became too frail to pose an unmanageable risk.

Liaison with Mr Turner's family

9. We are satisfied that the prison conducted its contact with Mr Turner's family appropriately. Despite living some distance from Whatton, the prison informed Mr Turner's family in person with the assistance of staff from HMP Usk.

Compassionate release

10. We are satisfied that the prison considered Mr Turner's application for compassionate release appropriately.

Recommendations

- The Governor should ensure that:
    - all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints;
    - assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time; and
    - measures taken in response to the PPO's previous recommendation on this subject are embedded.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Whatton informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Turner's prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Turner's clinical care at the prison.

14. We informed HM Coroner for Nottinghamshire of the investigation. She gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Turner's brother, to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He did not respond to her letter.

16. 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.

17. We shared our initial report with HM Prison and Probation Service (HMPPS). HMPPS did not identify any factual inaccuracies. They provided an action plan which is annexed to this report.

Background Information

HM Prison Whatton

18. HMP Whatton, in Nottinghamshire, is a medium security prison holding up to 841 men convicted of sex offences. Since 1 April 2017, MITIE Care and Custody Health have provided healthcare services. The healthcare centre is open from 7.30am to 6.30pm Monday to Friday and from 8.00am to 1.30pm on weekends and bank holidays. There is an out-of-hours service at other times. 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

19. The most recent inspection of HMP Whatton was conducted in August 2016. Inspectors reported that the quality of health and social care was good, and waiting times for treatment were reasonable. Inspectors found that a mix of appropriately-skilled staff, in well-integrated teams, provided health services. They provided polite and professional interactions with their patients. There was high demand for routine hospital appointments but an increase in the number of available escort officers had significantly reduced the number of cancellations.

Independent Monitoring Board

20. 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 2018, the board reported that healthcare remained a major concern. In January 2018, NHS England issued a rectification notice and increased funding to ensure additional nursing and administrative staff could be recruited. At the end of the reporting year, this notice was still live. The Board reported that healthcare staff had worked hard to deliver a quality service, and the GPs, in particular, received high praise from prisoners and staff. It was evident from conversations with healthcare, however, that the contract did not adequately take into account the needs of HMP Whatton's population, including a high proportion of older prisoners and those with complex health conditions. The Board considered that this had resulted in a substandard provision of care.

Previous deaths at HMP Whatton

21. Mr Turner was the thirteenth prisoner to die of natural causes at Whatton since January 2017. We have previously made a recommendation about the inappropriate use of restraints. The prison told us in response that they would amend their escort risk assessment form and remind all staff of the legal position on the use of restraints by 31 January 2019.

Findings

22. Mr Dennis Turner was serving a life sentence and had been at HMP Whatton since 31 October 2012. (He was sentenced as Dennis Kelly but in November 2016, he changed his name to Dennis Turner.)

23. At his reception health screen, a nurse recorded that he had a history of stroke, heart attack, angina and asthma. Four days later, a prison GP reviewed him. She noted that he refused to go to hospital and was aware that he could have undiagnosed conditions, including cancer.

Mr Turner's clinical care

24. Mr Turner's general health steadily deteriorated during his time at Whatton, and he was subject to several health concerns.

Cancer concerns

25. In November 2013, a prison GP advised Mr Turner that he needed investigations into his persistent urinary infections. He declined. In December, a prison GP examined Mr Turner and observed that he had an enlarged prostate. Mr Turner declined a hospital review. In September 2014, a prison GP persuaded Mr Turner of the need for further investigations. She made an urgent referral to a urologist under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks.

26. On 26 September, Mr Turner attended his urology appointment at hospital where he was diagnosed with bladder cancer. Mr Turner initially declined treatment and further investigations of his prostate but healthcare staff persuaded him to undergo treatment. In July 2015, Mr Turner had surgery to remove the tumour, and in January 2016, tests confirmed that he was clear of bladder cancer.

27. On 14 August 2018, a prison GP referred Mr Turner to hospital under the NHS urgent two-week pathway for suspected lower gastro-intestinal cancer. On 27 August, a nurse recorded that Mr Turner was observed vomiting blood, and was sent to hospital as an emergency. The hospital diagnosed Mr Turner with internal bleeding and performed surgery to resolve this. An administrator noted that Mr Turner's two-week cancer referral was cancelled at the request of the lower gastro-intestinal surgeon after this surgery had been performed.

28. On 31 August, the hospital discharged Mr Turner back to Whatton. Healthcare staff monitored him and he was assisted with personal care. On 10 October, Mr Turner underwent a follow-up review at the hospital, which found that his surgery was holding and that there was no abnormal lesion.

Respiratory problems

29. Chronic obstructive pulmonary disease (COPD) is a term used to cover a wide range of respiratory problems, causing breathlessness. Mr Turner had been diagnosed with asthma on his arrival at Whatton. Healthcare staff monitored his condition with a COPD care plan, and adapted his medication where necessary. Mr Turner consistently declined specialist referrals to establish the underlying cause of his respiratory problems, against the advice of healthcare staff.

30. In August 2018, clinical investigations into an unrelated matter revealed that Mr Turner had a left lower lobe pulmonary nodule (a growth in his lung). On 24 September, a consultant respiratory physician informed him that cancer was a possibility and offered him a bronchoscopy to investigate further. Mr Turner declined this, along with further investigations, despite healthcare staff encouraging him to accept.

Heart disease

31. Shortly after Mr Turner arrived at Whatton, a prison GP suspected he had heart disease and offered to refer him for an echocardiogram. (An echocardiogram is a scan which uses soundwaves to build up a detailed image of the heart.) Mr Turner declined to attend hospital for this. In June 2014, a prison GP requested an ambulance after Mr Turner complained of chest pain and shortage of breath. He declined to go to hospital and signed a disclaimer to this effect. In February 2015, a prison GP advised Mr Turner to have an echocardiogram and chest X-ray but he again refused. Mr Turner continued to refuse hospital interventions.

32. On 5 May 2018, Mr Turner was taken to hospital with suspected heart failure. He was given a chest X-ray which indicated pulmonary (lung) congestion. At his request, he was discharged the same day although the hospital advised a cardiology referral and monitoring. On 13 July, Mr Turner was again sent to hospital with suspected heart failure. He had an echocardiogram but the results were inconclusive. On 29 October, Mr Turner had a chest X-ray which revealed that he had pulmonary congestion. The hospital advised medication including a glyceryl trinitrate (GTN) spray to relax the blood vessels in his heart.

Cardiovascular conditions

33. In October 2015, Mr Turner underwent routine abnormal aortic aneurysm (AAA) screening. His AAA was enlarged and he was prescribed medication to reduce cholesterol and prevent blood clots. Specialists at the vascular clinic reviewed Mr Turner annually, but did not deem surgery necessary. When they reviewed him in November 2018, they considered him to be too frail for treatment.

The management of Mr Turner's end of life care

34. Mr Turner was never diagnosed with a terminal condition but by the autumn of 2018, it was clear that he was nearing the end of his life. His health was rapidly deteriorating and he was becoming increasingly frail.

35. A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided. On 21 August 2018, Mr Turner signed a DNACPR form. A prison GP noted that he had the capacity to do this. Officers on his wing were informed of the DNACPR.

36. During October, healthcare staff became concerned about Mr Turner not complying with his medication. On 3 October, a healthcare assistant created a medication care plan to monitor his medication regime and to ensure that he took his medication as directed. Healthcare staff also created a number of care plans for Mr Turner, including for his mobility, skin care and nutritional needs. Staff

reviewed his complex care needs at multidisciplinary team meetings. He was also granted social care to assist with his personal care.

37. Early in 2019, Mr Turner's health declined further. On 10 January, a nurse reviewed him as part of an advanced palliative care plan. They discussed his end of life wishes, and the nurse noted that he consistently refused clinical investigations to establish a definitive prognosis. She offered Mr Turner the opportunity to relocate to the palliative care suite at the prison but noted that his wish was to remain on the wing. The nurse also noted that Mr Turner was "surprised but not shocked" to hear that he was still subject to a DNACPR.

38. On 28 January, Mr Turner told a prison GP that he would like to be resuscitated if he collapsed. The GP advised him to think about this because many of his conditions were life-ending. A nurse later noted that prison staff had been informed that Mr Turner was no longer subject to a DNACPR. On 31 January, Mr Turner told a nurse that he wanted to be resuscitated so that he had a chance of survival. On 7 February, the nurse recorded that Mr Turner still wished to be resuscitated.

39. On 19 February, a prison GP reviewed Mr Turner after reports that he was jaundiced. She offered him a hospital review which he declined. On 22 February, a nurse reviewed Mr Turner and noted that his NEWS score was 8. (The National Early Warning Score, or NEWS, is a predictive tool used to gauge the medical condition of a patient – 8 equates to a high risk which should prompt an emergency medical assessment.) The nurse advised Mr Turner to go to hospital but he declined. She recorded that he still wanted to be resuscitated and had the mental capacity to make this decision. She noted that an open-door policy had been started and that Mr Turner would be receiving 24-hour care. (An open-door policy is where a prisoner's door is left unlocked at all times to enable healthcare or social care staff to have unrestricted access.)

40. On 24 February, a nurse recorded that Mr Turner was aware of his prognosis and wanted to remain on the wing. She noted that he still wanted to be resuscitated but was willing to discuss this with the GP the next day. A prison GP discussed Mr Turner's resuscitation position with the Head of Healthcare. They decided that, given his indication that he wished to discuss DNACPR again, and his rapidly deteriorating health, resuscitation should not be attempted.

41. During the morning of 25 February, a healthcare support worker was with Mr Turner as part of his 24-hour social care. At 11.50am, he was present when Mr Turner died. At 12.40pm, a prison GP attended and formally pronounced Mr Turner dead.

Post-mortem report

42. The post-mortem concluded that the primary causes of Mr Turner's death were: upper gastro intestinal bleeding; hepatocellular carcinoma (liver cancer) and left ventricular hypertrophy (thickening of the heart wall). Secondary causes were listed as: haemorrhagic gastritis (gastrointestinal bleeding) and cholestatic hepatitis and cirrhosis (a form of liver disease). COPD was noted as being a further contributory factor.

43. We agree with the clinical reviewer that the care Mr Turner received at Whatton was equivalent to that which he could have expected in the community. He was appropriately treated and monitored for his numerous healthcare and social care needs. Healthcare staff encouraged him to have specialist clinical investigations but respected his wishes when he chose not to. The clinical reviewer observed that Mr Turner's medical records provided clear evidence of the care he received, and were: "well written, legible and contemporaneous".

44. We would like to share the clinical reviewer's praise for the care, compassion and sound clinical judgement that healthcare staff demonstrated in their dealings with Mr Turner. She recognised the excellent team work and communication between healthcare staff at Whatton, and we endorse this sentiment.

Mr Turner's location

45. On 2 October 2018, a multidisciplinary team meeting discussed the possibility of relocating Mr Turner to a nursing home. They concluded that he met the clinical criteria for this. On 31 October, Mr Turner's offender supervisor discussed a potential move to a nursing home in Cardiff with him, if the Parole Board granted his application for release. On 29 November, the Parole Board heard his application but rejected it on the grounds that his risk could not be managed in the community.

46. Mr Turner was located on a standard wing but one that was reserved for elderly and frail men. Healthcare staff were on hand during the day, and carers could be provided with 24-hour access where necessary.

47. On 10 January, a nurse offered Mr Turner a room in the palliative care suite within the prison but Mr Turner said he would prefer to remain on his wing. On 22 February, when Mr Turner's condition deteriorated, he was provided with 24-hour social care and an open-door policy.

48. We are satisfied that the prison located Mr Turner appropriately, and respected his wishes by allowing him to remain on a standard wing and accommodating him well there.

Restraints, security and escorts

49. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

50. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

51. During his early days at Whatton, Mr Turner had declined to attend hospital appointments on occasions because he did not want to be seen in restraints. He did not subsequently raise this as an issue.

52. 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. On 12 November 2018, Mr Turner's escort risk assessment recorded that he had a heart condition, had limited mobility and was wheelchair-bound. It assessed him as posing a very high risk to children and instructed that he be restrained with an escort chain. This risk assessment remained active for the rest of the year.

53. On 14 January 2019, Mr Turner's risk assessment recorded that his medical condition did not affect his ability to escape and that his mobility remained unchanged. The security assessment again recorded that he posed a very high risk to children. A nurse recorded that Mr Turner used a wheelchair and had a known cardiac history but there were no other healthcare concerns. The risk assessment again authorised the use of an escort chain. This was Mr Turner's last escort.

54. We acknowledge that Mr Turner was assessed as being a very high risk to children and that healthcare staff made no medical objections to him being restrained. However, we consider that given Mr Turner's frail condition and lack of mobility, any risk he posed could have been adequately managed by the two prison officers who were escorting him, especially on his last trip to hospital. We recommend:

The Governor should ensure that:

- **all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints;**
- **assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time; and**
- **measures taken in response to the PPO's previous recommendation on this subject are embedded.**

Liaison with Mr Turner's family

55. On 27 August 2018, when Mr Turner went to hospital, the prison appointed two officers as his family liaison officers (FLOs). Mr Turner did not have a nominated next of kin, so the prison called his brother who agreed to be updated about his brother's condition.

56. On 1 September, following Mr Turner's return from hospital, one of the FLOs spoke to him and they agreed that he could liaise with his brother. On 4 September, the FLO called Mr Turner's brother to introduce himself and explain his role. On 18 January 2019, the FLO informed Mr Turner's brother that Mr Turner had been to hospital and was refusing further treatment.

57. On 22 February, an officer called Mr Turner's brother to inform him that his brother's health had declined and that he was weak and frail. The officer told him that a nurse had advised that Mr Turner could die within 7-10 days. Mr Turner's

brother asked to be informed in person when his brother died. The officer recorded that a family liaison officer at HMP Usk would deliver this message.

58. At 12 noon on 25 February, the second FLO recorded that she spoke to the duty Governor at Usk to ask if they could inform Mr Turner's brother of Mr Turner's death. At 3.15pm, she recorded that the chaplain had informed Mr Turner's brother of Mr Turner's death in person.

59. Mr Turner's funeral was held on 9 April 2019. The prison contributed to the costs in line with national guidance.

60. We are satisfied that the prison conducted its contact with Mr Turner's family appropriately.

Compassionate release

61. Prisoners can be released from custody 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.

62. On 29 November 2018, The Parole Board considered Mr Turner's application for release and took account of his health issues. The Board rejected Mr Turner's request to be released to a nursing home because they found no evidence of any reduction in the risk he posed. They concluded that Mr Turner's risks were imminent and unmanageable either in open prison conditions or in the community.

63. On 10 January 2019, a nurse recorded that healthcare staff were unaware of Mr Turner's prognosis because he had declined all investigations to establish an exact diagnosis for his condition.

64. On 14 February, a prison GP completed the relevant section of Mr Turner's compassionate release form. She made no reference to his life expectancy, but noted that he was extremely frail with poor mobility and was largely wheelchair-bound. A prison GP observed that he was reliant on care for daily living which would make reoffending very unlikely. A probation officer noted that Mr Turner had no resettlement plan in place and that the Parole Board had previously rejected his release when he had applied the previous autumn.

65. The following day, the Governor recorded that she did not consider Mr Turner suitable for compassionate release. The Governor noted that given the Parole Board's concerns about the risk Mr Turner still posed, and his lack of social support in the community, she could not support his application.

66. We are satisfied that the prison properly considered Mr Turner's compassionate release application. He declined investigations to establish the details of his terminal illness or life expectancy but the prison considered his application nevertheless. We consider that the Governor's decision to not support this application was appropriate in the circumstances, given that a recent parole release had been rejected on grounds of risk.

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