Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Joseph Turner, a prisoner at HMP Frankland, on 8 August 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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*

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Joseph Turner, who was 68 years old, died of acute infective chronic obstructive pulmonary disease on 8 August 2019, while a prisoner at HMP Frankland. We offer our condolences to Mr Turner's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Turner received at Frankland was equivalent to that which he could have expected to receive in the community. She has made two recommendations about clinical issues, one of which was directly linked to Mr Turner's care and treatment and is outlined below.

5. We did not find any non-clinical issues of concern.

Recommendation

- **The Head of Healthcare, Pharmacy Lead and Lead GP at HMP Frankland should conduct a joint review to ensure that the current primary care and pharmacy processes have the flexibility to safely accommodate circumstances where there is a clinical need for increased supplies of inhalers.**

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Turner's clinical care at HMP Frankland.

7. The PPO has investigated the non-clinical issues in Mr Turner's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. Mr Turner's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at Frankland

10. Mr Turner was the seventh prisoner to die at HMP Frankland in the last two years. Six of those deaths were from natural causes. There have been two further deaths from natural causes since Mr Turner's death.

11. There are no similarities between our findings in the investigation of Mr Turner's death and the other deaths.

Key Events

12. On 25 April 2014, Mr Joseph Turner was sentenced to life imprisonment for murder. He received a minimum tariff of 15 years. On 24 May, Mr Turner was transferred to HMP Frankland.

13. Mr Turner arrived into prison with a number of pre-existing medical conditions, the most serious being chronic obstructive pulmonary disease (COPD), diagnosed in 2003. He also had mobility issues due to a previous broken hip and had a long history of alcohol misuse.

14. While at Frankland, Mr Turner was reviewed regularly by healthcare staff. His COPD was managed by nurse led clinics at the prison. Mr Turner's medications were appropriately reviewed and adjusted in line with NICE (National Institute for Health and Care Excellence) guidelines.

15. On 29 June 2019, prison officers were concerned that Mr Turner was breathless and agitated. Following a review by healthcare staff, he was admitted to the prison's healthcare inpatient unit for observation. Mr Turner's condition worsened and he was taken to University Hospital of North Durham (UHND) by emergency ambulance for further review. Hospital staff diagnosed him with a chest infection and he was admitted to hospital as an inpatient. Mr Turner was given oxygen therapy and a course of intravenous antibiotics.

16. On 5 July, Mr Turner told hospital staff that he wanted to sign a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, which meant that if he stopped breathing he did not want to be resuscitated. Mr Turner was discharged from hospital and was sent back to Frankland the same day.

17. However, on 27 July, Mr Turner's condition worsened and he was taken to UHND by emergency ambulance. Mr Turner was escorted by two officers and was restrained using an escort chain.

18. Hospital staff diagnosed Mr Turner with sepsis and multiple organ dysfunction and he was admitted to hospital as an inpatient. Prison staff removed the restraints.

19. On 29 July, prison staff applied for compassionate release on Mr Turner's behalf. However, the hospital prognosis letter had another patient's details referenced in the letter. As a result, the compassionate release process was delayed while the prison obtained the correct information from the hospital.

20. On 3 August, hospital staff decided to withdraw all active treatment and Mr Turner was placed on palliative end of life care. Hospital staff considered that a transfer to a hospice was not appropriate and that Mr Turner should remain in hospital until his death.

21. On 8 August, before his compassionate release application could be processed, it was confirmed that Mr Turner had died.

22. A post-mortem examination gave Mr Turner's cause of death as an acute infective exacerbation of non-industrial chronic obstructive pulmonary disease.

Lisa Burrell **March 2020**
Assistant Ombudsman