

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Turner, a prisoner at HMP Wayland, on 6 October 2021

A report by the Prisons and Probation Ombudsman



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



© Crown copyright, 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 James Turner died of heart failure on 6 October 2021 at HMP Wayland. He was 58 years old. I offer my condolences to his family and friends.

The clinical reviewer found that the clinical care Mr Turner received at Wayland was equivalent to that which he could have expected to receive in the community.

I am concerned that the officer who found Mr Turner unresponsive did not immediately radio a medical emergency code. The second officer who arrived then radioed the incorrect medical emergency code, which meant that healthcare staff took the wrong equipment. While the delays made no difference to the outcome for Mr Turner as he was dead when he was found, it is important that staff call the correct code promptly to ensure there are no delays in providing emergency care.

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

June 2022

Contents

- Summary 1
- The Investigation Process.....3
- Background Information.....4
- Key Events.....5
- Findings8

Summary

Events

1. Mr James Turner was recalled to prison custody on 23 March 2019. On 20 December, he was moved to HMP Wayland.
2. During a morning roll check at 7.37am on 6 October 2021, an officer saw Mr Turner lying on his bed. She told the investigator that she was certain she saw him breathing.
3. At about 10.45am, a prisoner went to Mr Turner's cell as he had not seen him that morning. He found that his cell door was locked, and his observation panel was covered on the inside. He looked through a small gap at the bottom of the observation panel and thought that Mr Turner had fallen onto the cell floor. He banged on the door.
4. An officer heard the banging and went to Mr Turner's cell. She opened Mr Turner's cell door and saw him lying on the floor. The officer radioed another officer who was in the wing office. The second officer went into Mr Turner's cell and found that Mr Turner did not have a pulse. At 10.48am, the second officer radioed a medical emergency code red (used for severe blood loss or burns or a suspected fracture).
5. A Custodial Manager (CM) and four officers went to Mr Turner's cell. They described Mr Turner as stiff and cold. The CM told staff to start CPR. However, when healthcare staff arrived, they told them to stop as it was clear Mr Turner was dead.
6. At 11.01am, an ambulance paramedic confirmed that Mr Turner had died.
7. The post-mortem report concluded that Mr Turner died from heart failure.

Findings

8. The clinical reviewer concluded that the clinical care Mr Turner received at Wayland was equivalent to that which he could have expected to receive in the community.
9. The early morning roll check which should have been carried out at about 6.00am on 6 October, did not take place.
10. The officer who found Mr Turner lying on the floor of his cell should have called a medical emergency code rather than radioing her colleague for assistance. Although the second officer did call a medical emergency code, she called a code red when it should have been a code blue (used when a prisoner is unconscious or having breathing difficulties). Healthcare staff therefore took the wrong emergency bag to Mr Turner's cell. It made no difference to the outcome for Mr Turner as he was dead when he was found, but it could be critical in a future emergency.

Recommendations

- The Governor should ensure that in line with Prison Service Instruction 75/2011 and local instructions on roll checks, four roll checks are carried out each day.
- The Governor should ensure that staff understand the importance of calling the correct medical emergency code promptly.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Wayland informing them of the investigation and asking anyone with relevant information to contact him. A prisoner responded.
12. The investigator obtained copies of relevant extracts from Mr Turner's prison and medical records.
13. The investigator interviewed five members of staff and a prisoner at HMP Wayland on 25 November and a prisoner by telephone on 2 December.
14. NHS England commissioned a clinical reviewer to review Mr Turner's clinical care at the prison.
15. We informed HM Coroner for Norfolk of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
16. The Ombudsman's family liaison officer wrote to Mr Turner's son to explain our investigation. Mr Turner's son questioned if prisoners on G Wing, where Mr Turner lived, could access immediate medical attention if needed. He also raised some issues that were outside the remit of our investigation, which we have addressed in separate correspondence.
17. We shared the initial report with the Prison Service. There was one factual inaccuracy, and this report has been amended accordingly.
18. We shared the initial report with Mr Turner's son who raised a number of issues that do not impact on the factual inaccuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Wayland

19. HMP Wayland is a medium security prison in Norfolk. The prison holds just under 1,000 convicted adult male prisoners. Virgin Care provides healthcare services. Drug and alcohol services are provided by Phoenix Futures. There are no nurses on duty at night.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Wayland was in June 2017. Inspectors found that staff took a courteous and constructive approach to prisoners, with most prisoners being reasonably positive about staff engagement with them. Inspectors found that prisoners with lifelong health conditions were poorly managed and that there were no nurse led clinics for them as healthcare staff were not appropriately trained.

Independent Monitoring Board

21. 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 2021, the IMB reported that as the prison came out of the COVID-19 pandemic they were concerned that there were low staffing numbers and a high proportion of prison officers who had almost no experience of the challenging management of prisoners outside of a tightly controlled pandemic restricted environment.
22. The IMB reported that they had a professional relationship with the Head of Healthcare but, that they found it difficult to get an evidenced view on how the health and wellbeing of prisoners had been met as they were excluded from healthcare meetings. The IMB were pleased to report that the healthcare unit was fully staffed with one full-time GP, a long-term conditions nurse and a nurse practitioner.

Previous deaths at HMP Wayland

23. Mr Turner was the fourth prisoner to die at Wayland since October 2019. Of the previous deaths, two were from natural causes and one was self-inflicted. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

24. In 2005, Mr James Turner received an indeterminate sentence for public protection (IPP) for robbery, with a minimum tariff of four years and ten months. He was released on licence on 5 April 2017 but was recalled on 23 March 2019, after committing a further offence. On 20 December, he was moved to HMP Wayland.
25. Mr Turner, who was obese, was prescribed a statin to treat high cholesterol in his blood (high cholesterol can lead to heart attack or stroke). He had a history of illicit drug use.
26. In June 2020, Mr Turner was moved to G Wing, a drug rehabilitation unit. G Wing is an open wing where prisoners have their own key and can move around both landings freely from morning until 10.00pm. The wing office is on the ground floor where there is a CCTV monitor with a view of the landings.

Events of 5 and 6 October 2021

27. At about 5.15pm on 5 October 2021, Officer A carried out a roll check on G Wing. He saw that Mr Turner's cell door was closed and that his observation panel was covered on the inside. He said that this was not uncommon for Mr Turner to do this but that his observation panel was always uncovered for pre-unlock roll check, as prisoners were aware that if their panel was covered at this time, they could receive a warning that might affect their incentives and earned privileges (IEP) level. He unlocked the cell door, opened it and saw Mr Turner lying on his bed watching television. He said that Mr Turner lifted his head from the pillow and turned his head towards the door but said nothing. He closed the door.
28. CCTV shows Mr Turner left his cell at 5.42pm and returned at 5.55pm. A prisoner went into Mr Turner's cell at 7.24pm and left a short while later.
29. The investigator has seen the roll check document for 6 October, which states that at the handover to the day staff the pre-unlock roll check was not carried out because there were no staff available.
30. At 7.37am on 6 October, Officer B carried out a roll check on G Wing. She told the investigator that Mr Turner's observation panel was not covered on the inside and that when she looked into Mr Turner's cell, she saw him lying on his bed. She said that his feet were nearest the door and his head towards the window and that he had an orange blanket on his bed. She said that there was daylight coming through the window. She was certain that she saw Mr Turner breathing.
31. At about 10.45am, a prisoner went to Mr Turner's cell because he had not seen him that morning as usual. He found that Mr Turner's cell door was locked, and his observation panel was covered on the inside. He looked through a small gap at the bottom of the observation panel and thought it looked like Mr Turner had fallen over. He banged on the door. He told another prisoner that he thought Mr Turner had fallen over. They continued to bang on the door, but Mr Turner did not move.
32. Officer C said that she was in the wing office when she heard banging and went onto the landing. Prisoners told her that they were concerned about Mr Turner.

She said that she was in the wing office when she heard banging and saw on the CCTV cameras that prisoners had gathered outside Mr Turner's cell.

33. Officer C radioed Officer B, unlocked and opened Mr Turner's cell door and saw him lying on the floor. Officer C said that Mr Turner was dead: he was grey in colour, his lips were blue, and he had 'yellow stuff' on his lips and that he looked stiff with his arms raised and his hands just beneath his chin. She again radioed Officer B.
34. Officer B went into Mr Turner's cell and saw him lying on the floor, fully clothed with his head facing towards the window and his feet towards the door. She said that he did not have a pulse, was cold to touch, that his face was blue in colour and that he had liquid coming from his nose. At 10.48am, she radioed a medical emergency code red (which should be used for severe blood loss or burns or a suspected fracture).
35. Two more officers went to Mr Turner's cell. Officer D saw Mr Turner, who had his left shoulder and part of his head under the bed with his head facing towards the window, and said that they needed to get him out so that they could carry out cardiopulmonary resuscitation (CPR). With Officer E, they tried to move Mr Turner but, when they tried to lift him, found that he was stiff.
36. A Custodial Manager (CM) went to Mr Turner's cell. He said that healthcare staff arrived with their 'code red kit' rather than the equipment for a code blue (which indicates that a prisoner is unconscious or having breathing difficulties). He told staff to start CPR, but told the investigator that in hindsight, it was probably the wrong decision because Mr Turner looked dead.
37. Officer E went into the cell with Officer D and saw a chair close to Mr Turner's head, which he moved out of the way. Officer E saw that Mr Turner had no colour in his face and that there was a clear, yellow liquid around his head, which was also around his nose and mouth. He said that they realised that Mr Turner was not breathing, and they had to carry out CPR. When they moved Mr Turner, Officer E said that one of his arms was across his chest, and when he tried to move it out of the way he said that it was very stiff and very difficult to move. He thought that Mr Turner was dead but said that it was not his decision to make (regarding CPR). He said that he started chest compressions and Officer F carried out rescue breaths, but she found that his jaw was closed so they decided just to perform chest compressions. Officer E said that healthcare staff then arrived and took over from them.
38. Officer F said that she went to Mr Turner's cell and tried to move his left arm but found that it was stiff. She tried to carry out chest compressions but found that his chest was hard, so Officer E took over. Officer F used a face shield to carry out rescue breaths but was unable to do so because she was unable to open Mr Turner's mouth as his jaw was locked in place. Officer F said that Mr Turner did not have any colour in his skin and did not have any warmth in his body. She said that this was a clear sign that he was no longer alive but, they were unable to say that as they were not medically trained.
39. Two nurses went into the cell with the code red emergency bag and oxygen cylinders. One nurse told the officers to stop CPR as it was clear that Mr Turner

had died. She noted that his face was purple and slightly swollen, that his lips were blue, that he was very cold, that his jaw was locked, and that his limbs were stiff, that his eyes were slightly open and pooled with a straw-coloured fluid which she wiped away to check his pupils which were fixed and dilated. She said that there was a small pool behind his head of what appeared to be the same fluid. She noted that rigor mortis had set in (stiffening of the body that occurs two to six hours after death). The nurses attached a defibrillator which advised not to shock.

40. At 11.01am, an ambulance paramedic confirmed that Mr Turner had died.

Contact with Mr Turner's family

41. On 6 October, the prison appointed a family liaison officer (FLO) and a deputy FLO. At 12.20pm, the FLO telephoned Mr Turner's son and told him that Mr Turner had died and offered his condolences. Mr Turner's funeral took place on 18 November. The prison contributed to the cost in line with national instructions.

Support for prisoners and staff

42. After Mr Turner's death, the Head of Security 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.
43. The Acting Governor 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

44. A post-mortem examination established that Mr Turner had died of heart failure (acute left ventricular heart failure) as a result of ischaemic and hypertensive heart disease (heart disease caused by narrowed heart arteries and high blood pressure). He also had fatty liver (high levels of fat in the liver) which contributed to, but did not cause, his death.

Findings

Clinical care

45. The clinical reviewer concluded that the clinical care that Mr Turner received at Wayland was of a reasonable standard and was equivalent to that which he could have expected to receive in community.

Alarm system

46. Officer C was the first officer to go to Mr Turner's cell. She was in the wing office and heard prisoners banging on Mr Turner's cell door. At the time, there was no way for prisoners to raise the alarm. We note that since Mr Turner's death, the prison has fitted doorbells on both landings on G Wing which ring through to the wing office. We therefore make no recommendation.

Roll check

47. Prison Service Instruction 75/2011 on residential services says that four formal roll checks should be carried out each day.
48. Wayland's local instruction on routine roll checks – timing and reconciliation states that night staff will commence roll checks at the start of their duty at approximately 9.00pm and 6.00am. On G Wing the local instruction states that the Night Orderly Officer (NOO - the senior officer on duty) or their assistants will unlock the corridor doors to allow the night Operational Support Grade (OSG) onto the wing to carry out the roll check and, on completion, the NOO will re-secure the wing.
49. The early morning roll check, which should have been carried out at about 6.00am by night duty staff, was not carried out because of operational reasons and sufficient staff were not available to complete the roll check safely.
50. We are aware that there was a roll check at 7.37am and that Officer B said that Mr Turner was alive at that point. We accept therefore that a roll check at 6.00am would have made no difference to the outcome for Mr Turner. Nevertheless, roll checks should be carried out in line with the local policy. We recommend:

The Governor should ensure that in line with Prison Service Instruction 75/2011 and local instructions on roll checks, four roll checks are carried out each day.

Emergency response code

51. When Officer C found Mr Turner lying on the floor of his cell, she radioed Officer B for assistance. When Officer B went to Mr Turner's cell, she radioed a medical emergency code red, the incorrect code in these circumstances. The correct medical emergency code would have been a code blue. As a result of the incorrect code, healthcare staff took a 'red bag' to Mr Turner's cell, which contained equipment more appropriate for a prisoner who had suffered blood loss rather than for a prisoner with breathing difficulties.

52. We accept that in these circumstances it would have made no difference to the outcome for Mr Turner. However, it is important that the correct code is called promptly in a medical emergency so that there is no delay in providing emergency care and healthcare staff know the nature of the emergency so they can take the correct equipment with them. We recommend:

The Governor should ensure that staff understand the importance of calling the correct medical emergency code promptly.

Resuscitation

53. We are satisfied that officers only briefly attempted resuscitation before nurses went into Mr Turner's cell and told them to stop when it was obvious to them that he had died.

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100