

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bruce Turner, a prisoner at HMP Doncaster, on 13 December 2020

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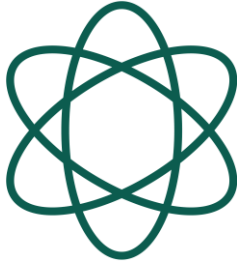
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Our vision

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

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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 Bruce Turner died on 13 December 2020 of acute myocardial ischaemia (a heart attack caused by a shortage of blood to the heart muscle) in his cell at HMP Doncaster. He was 54 years old. I offer my condolences to Mr Turner's family and friends.

The clinical reviewer concluded that the healthcare Mr Turner received at Doncaster was generally equivalent to that which he could have expected to receive in the community. However, the clinical reviewer identified some concerns: the failure to refer Mr Turner for a mental health review when Mr Turner arrived at Doncaster; the failure to escalate Mr Turner's care in the light of his NEWS-2 scores following a series of seizures on 29 October; and the failure to refer Mr Turner to a prison GP for further investigation of his seizures.

Although the prison and healthcare staff suspected that Mr Turner's seizures were due to drug misuse, they could not test him. This was because the COVID-19 regime restrictions that were in place in October 2020 heavily restricted the use of drug tests. Mr Turner did not meet the criteria for a test.

I am concerned that the roll check was not completed properly on the morning of Mr Turner's death and that this may have been a missed opportunity to find him sooner. We cannot say if this might have changed the outcome.

I am concerned that in this report I am repeating recommendations that I have made before. The Director of Doncaster and the Head of Healthcare will need to ensure that these issues are now addressed.

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

January 2022

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Summary

Events

1. On 9 October 2020, Mr Bruce Turner was convicted of indecent exposure and harassment and was remanded to HMP Doncaster. On 30 November, he was sentenced to 20 weeks in prison.
2. On the early morning of 29 October, Mr Turner suffered a series of seizures in his cell. He was seen by a nurse on four occasions between midnight and 6.00am. The cause of these seizures was not determined, as Mr Turner was not referred to a doctor for assessment. He was not subject to drug testing due to COVID-19 restrictions.
3. At 9.30am on 13 December, staff unlocking Mr Turner for exercise found him unresponsive in his cell. A 999 call was made, and prison staff quickly started CPR. An ambulance arrived at 9.39am and paramedics from took over CPR. At 10.10am, the paramedics confirmed that Mr Turner had died.

Findings

4. The clinical reviewer concluded that the healthcare Mr Turner received at Doncaster was generally equivalent to that which he could have expected to receive in the community.
5. The clinical reviewer did, however, identify some areas where care was not equivalent.
6. The clinical reviewer found that healthcare staff did not refer Mr Turner for a mental health review when he arrived at Doncaster as they should have done; they did not escalate his care in the light of his NEWS-2 scores following his seizures; and they did not refer Mr Turner to a prison GP to investigate his seizures, which was not in line with clinical guidance.
7. Mr Turner did not have a drug test following his seizures. This was because the COVID-19 regime restrictions that were in place in October 2020 heavily restricted the use of drug tests. Mr Turner did not meet the criteria for a test.
8. On the morning of his death, prison staff did not check on Mr Turner during the 6.30am roll check as they should have done.

Recommendations

- The Head of Healthcare should ensure that:
 - prisoners are assessed correctly during their reception screening; and
 - prisoners identified as having mental health issues are referred to the mental health team for assessment.
- The Head of Healthcare should ensure that all prisoners suffering from unexplained first seizures are referred for further investigation, initially to the prison GP, in line with NICE guidance 137: Epilepsies: diagnosis and management.

- The Head of Healthcare should ensure clinical staff understand and are trained on how to use the NEWS-2 observation tool correctly and escalate appropriately.
- The Director should ensure that roll counts and welfare checks are completed in line with local policy.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator wrote to Doncaster on 15 December 2020. He obtained a range of documents including copies of relevant extracts from Mr Turner's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Turner's clinical care at the prison.
12. The investigator interviewed one member of staff on 13 April 2021. The interview was conducted by telephone because of the restrictions imposed in response to the COVID-19 pandemic. In addition, written statements were received from five members of staff.
13. We informed HM Coroner for Yorkshire South East of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. The Ombudsman's family liaison officer contacted Mr Turner's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Turner's mother asked what caused Mr Turner's death. We have answered her question in this report. She also asked for a copy of our report.
15. Mr Turner's sister contacted the PPO in June 2021. She asked for a copy of this report.
16. Mr Turner's family received a copy of the initial report. They raised two issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
17. The initial report was shared with the Prison Service. The Prison Service pointed out a factual inaccuracy relating to the drug testing regime in October 2020. This report has been amended accordingly.

Background Information

HMP & YOI Doncaster

18. HMP & YOI Doncaster prison is a medium security prison holding 1,145 remand and sentenced young offenders and adult male prisoners. As part of its role, it serves the courts of South Yorkshire. The prison is operated by Serco.
19. Physical and mental healthcare services and substance misuse services are provided by Practice Plus Group (formerly known as Care UK). There is an inpatient healthcare unit and 24-hour nursing cover.

HM Inspectorate of Prisons (HMIP)

20. The most recent inspection of HMP & YOI Doncaster was an unannounced inspection in September 2019. Inspectors reported that the mental health team, although well-led and committed, was under-resourced and could not meet the high demand for its services.

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 30 September 2019, the IMB reported that they were concerned that not all the mental health needs of prisoners were being met. In their view the number of healthcare staff needed to be increased.

Previous deaths at HMP & YOI Doncaster

22. Mr Turner was the 19th prisoner to die at Doncaster since December 2018. Of the previous deaths, seven were from natural causes, nine were self-inflicted and two were drug-related.
23. In a previous investigation in 2019, we found that welfare checks had not been completed as they should have been. In another investigation in 2019, we found that a prisoner's mental health needs had not been met, including assessment and intervention.

Psychoactive Substances (PS)

24. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a significant problem across the prison estate. There are many types of PS, including synthetic cannabinoids, often referred to as "Spice". They are difficult to detect and can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is

potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

Key Events

25. On 9 October 2020, Mr Bruce Turner was convicted of indecent exposure and harassment and was remanded to HMP Doncaster. Mr Turner had previously spent time at Doncaster in 2015, 2016 and 2018.
26. When he arrived at the prison, Mr Turner had an initial health screen with a nurse. He noted that Mr Turner had no current physical health concerns and was not receiving any specialist care in the community. He recorded in the mental health section of the screening both that Mr Turner had a history of mental health issues and nil mental health issues. He did not refer Mr Turner to the prison's mental health team.
27. The nurse also carried out a substance misuse screen, including an AUDIT-C screening for alcohol use. Mr Turner declined a brief intervention for excessive alcohol consumption. The screening assessment also recorded that Mr Turner had previously used drugs and had a history of amphetamine misuse. There was no record that he was using, or reported using, any substances at the time of the assessment and he did not refer him to the substance misuse team.

Events of 29 October 2020

28. At around 12.35am, Mr Turner's cellmate alerted night staff that Mr Turner was having a fit. A code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) was called and a nurse attended the cell. She found Mr Turner snoring heavily. He had also vomited. She struggled to rouse Mr Turner, but eventually was able to by use of a sternum rub (applying pressure to a patient's chest bone using a fist). She carried out a NEWS-2 assessment (NEWS-2 is a tool to measure clinical deterioration). The score was 6 which indicated Mr Turner needed urgent clinical assessment. However, there is no evidence that any escalation or action took place. After he had been seen by the nurse, Mr Turner and his cellmate were locked in their cell.
29. At around 1.53am, Mr Turner's cellmate alerted night staff that Mr Turner was having another fit. A second code blue was called, and the nurse attended. This time the score was 1. It is unclear how this score was reached, as only part of the NEWS-2 assessment was recorded. The nurse noted that Mr Turner had wet himself. She asked him if he had taken any substances, but he appeared too disorientated to answer. She recorded she had no further concerns. Again, the cell was locked.
30. At around 3.40am, Mr Turner's cellmate alerted night staff for a third time that Mr Turner was having a fit. A different nurse attended. The nurse carried out a third NEWS-2 assessment. This time the score was 5, which indicated Mr Turner needed an urgent clinical assessment. His speech was incoherent, and he was unable to hold a conversation or to confirm if he had taken any substances. Mr Turner had urinated on the floor. Prison staff gave him fresh clothes and a duvet. The cell was then locked. The nurse added Mr Turner to the healthcare appointments list for later that day.

31. At around 6.00am the first nurse reviewed Mr Turner in his cell. She carried out a fourth NEWS-2 assessment which was 2. A Prison Custody Officer (PCO) asked Mr Turner if he had taken any substances. He said he had but did not disclose what he had taken. The cell was locked.
32. At around 12.30pm a nurse saw Mr Turner in the healthcare unit. He recorded on in Mr Turner's patient notes that Mr Turner "was on NPS [psychoactive substances] all night". He noted that Mr Turner's gait was unsteady, and he did not communicate clearly. He carried out a NEWS-2 assessment and the score was 1. He referred Mr Turner to the prison's substance misuse service (SMS).
33. Over the next couple of days, Mr Turner displayed behaviour that was hostile to staff and challenging to manage. On 30 October, he was racially abusive towards a black member of staff. At around 3.00pm, Mr Turner had an assessment for his seizures. Healthcare staff checked his observations using NEWS-2 and the score was zero. He also had an ECG, and the results were normal. His seizures were not referred to a GP for further investigation.
34. On 31 October at around 4.39am, Mr Turner pressed his cell bell. When a PCO went to the cell, Mr Turner appeared unresponsive. A code blue was called and the PCO and another officer entered his cell. At this point Mr Turner jumped out at staff members. He was pushed back into the cell and it was locked.
35. Later that morning around 9.41am, Mr Turner assaulted a member of staff and was taken to the Care and Separation Unit (CSU) under restraint. He was seen by a nurse in the CSU who recorded that he had sustained no injuries. He attended a disciplinary hearing that day for the charge of racially abusing a member of staff on 30 October. He pleaded guilty and was given 14 days cellular confinement in the CSU as a punishment.
36. On 2 November, following the referral of 29 October, the duty substance misuse worker saw Mr Turner in the CSU. He had reviewed Mr Turner's clinical records including those relating to his fits on 29 October. They discussed his health and drug use. Mr Turner told him that he had not been taking drugs in prison but acknowledged he had taken drugs in the past. Mr Turner declined one-to-one support and signed a service withdrawal disclaimer.
37. On 13 November, Mr Turner completed his 14 days cellular confinement in the CSU and returned to his wing where he was located in a single cell.
38. On 30 November, Mr Turner was sentenced to 20 weeks in prison for indecent exposure and harassment. Because he had already served seven weeks in prison, his release date was set for 17 December.
39. On 12 December, at 4.34pm Mr Turner pressed his emergency call bell. A PCO answered the call at 4.46pm, 12 minutes later. He opened Mr Turner's cell and found him watching television. He said that they had a conversation but that he could not recall what they discussed. He said Mr Turner did not raise any health issues.
40. At 7.03pm that evening Mr Turner rang his mother. The call lasted around ten minutes.

41. Staff on duty that evening reported no interactions with Mr Turner while carrying out their duties. It is not clear from their written statements when they completed the evening roll check on prisoners on the wing.

Events of 13 December 2020

42. At around 6.30am, the first day PCO took over from the night PCO. Sometime afterwards, he began a roll check. As he made his way down the wing landing carrying out his checks, another prisoner pressed his emergency call bell, and he went to that prisoner's cell. After checking on the prisoner, he left the landing and did not complete the roll check. He did not check on Mr Turner.
43. At around 9.30am, another PCO began unlocking prisoners for morning exercise. When he opened Mr Turner's cell, he immediately smelt faeces and saw Mr Turner lying on the floor. He radioed a code blue emergency. At 9.32am the prison control room called for an emergency ambulance.
44. Prison staff and healthcare staff responded to the code blue. Staff entered the cell and found Mr Turner naked and covered in faeces, lying on his chest with his chin resting on his bed and his feet under a piece of furniture. He was unconscious and unresponsive. A Custodial Operational Manager (COM) moved Mr Turner onto his back and he and a PCO began CPR. A blanket was placed over Mr Turner's lower half for dignity.
45. A healthcare assistant (HCA) inserted a nasal airway and she and a nurse applied an oxygen mask to Mr Turner. The HCA placed defibrillator pads on Mr Turner. The defibrillator advised no shock three times. Prison staff continued CPR.
46. At 9.39am an ambulance arrived at the prison. Paramedics took over CPR and administered several adrenaline shots to Mr Turner. At 10.10am, paramedics made the decision to stop treatment and confirmed that Mr Turner had died.

Contact with Mr Turner's family

47. The prison appointed a Family Liaison Officer (FLO) at around 11.00am. The FLO rang Mr Turner's mother twice without answer. At 11.49am she rang again and spoke with Mr Turner's mother to tell her of her son's death.
48. Mr Turner's funeral was held on 6 January 2021. Doncaster paid all the costs of Mr Turner's funeral in line with national guidance.

Support for prisoners and staff

49. After Mr Turner's death, the Assistant Director 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.
50. 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

51. The pathologist concluded that Mr Turner died of acute myocardial ischaemia (a heart attack caused by shortage of blood to the heart muscle) caused by ischaemic heart disease and severe coronary artery atheroma (a narrowing or blockage of arteries around the heart). He also had chronic kidney disease which did not cause but contributed to his death.
52. Toxicology tests did not suggest that Mr Turner had used illicit substances before his death.

Findings

Clinical Care

53. The clinical reviewer concluded that the care Mr Turner received at Doncaster was reasonable and at least equivalent to that which he could have expected to receive in the community.
54. The clinical reviewer did, however, identify some shortcomings in Mr Turner's care.

Initial health screening and mental health referral

55. At Mr Turner's initial health screening on 9 October 2020, a nurse recorded that Mr Turner had "history of mental health problem" but also reported "nil mental health issues". There was no further information to indicate which of these statements was correct.
56. Mr Turner had been diagnosed in 2008 with anxiety with depression and the medical record from Mr Turner's 2016 imprisonment at Doncaster recorded that he was experiencing depression and was on anti-depressant medication. The reception screening was, therefore, not in line with NICE guidance NG57 which requires further investigation and referral on to mental health services if a prisoner has had a previous mental health condition. We make the following recommendation:

The Head of Healthcare should ensure that:

- **prisoners are assessed correctly during their reception screening; and**
- **prisoners identified as having mental health issues are referred to the mental health team for assessment.**

Managing and referring seizures

57. In the early morning of 29 October 2020, Mr Turner was reported to have had three seizures and a code blue was called on two occasions. He was seen on four occasions by nursing staff in the early hours and then again around midday by another nurse. During these assessments he consistently presented as unwell. However, Mr Turner was not referred to a GP to assess him further or to complete a more detailed history of seizures. This was contrary to NICE guidance 137: Epilepsies: diagnosis and management. We make the following recommendation:

The Head of Healthcare should ensure that all prisoners suffering from unexplained first seizures are referred for further investigation, initially to the prison GP, in line with NICE guidance 137: *Epilepsies: diagnosis and management*.

Use of NEWS-2

58. On 29 October, when Mr Turner was assessed following reported seizures, his observations were recorded using the NEWS-2 assessment tool. On two occasions Mr Turner's score reached the level that required further clinical intervention. On a

further occasion a NEWS-2 assessment was not completed in full, and the score is likely to have been wrong.

59. There are no entries in the medical record to suggest that healthcare staff considered calling for an ambulance or admitting him to the prison healthcare unit, and he was not referred to the prison GP for review and assessment. Appropriate action and escalation enable early detection and clinical intervention when a patient's health is deteriorating. We make the following recommendation:

The Head of Healthcare should ensure clinical staff understand and receive training on how to use the NEWS-2 observation tool correctly and escalate appropriately. Additional training should be provided as required.

60. The clinical reviewer has made other recommendations about the use of pain stimuli and vaccination schedules which we do not repeat in this report but which the Head of Healthcare will need to address.

Mandatory Drug Testing

61. Prison Service Order (PSO) 3601, Mandatory Drug Testing, provides guidance on drug testing. It says, "Any prisoner reasonably suspected of misusing drugs may be required to provide a sample for testing at any time".
62. In the early hours of 29 October, prison and healthcare staff went to Mr Turner's cell on four occasions following reports that he had had a fit, and once again around midday. Both prison and healthcare staff recorded in Mr Turner's medical and prison records that they suspected he was using drugs. Mr Turner did not have a drug test following his seizures. This was because the COVID-19 regime restrictions that were in place in October 2020 heavily restricted the use of drug tests. Mr Turner did not meet the criteria for a test. Had drug testing been operating as usual, we would have expected Mr Turner to have been tested.

Roll counts

63. We cannot say when Mr Turner died. We know that he spoke to his mother on the phone at about 7.00pm on 12 December and that he was found unresponsive in his cell when prisoners were unlocked at about 9.30am the following morning.
64. The PCOs on duty overnight could not remember when they completed the required roll counts. Although a PCO began a roll count at around 6.30am on 13 December, he said he did not complete it because he broke off to answer another prisoner's cell bell and he did not check Mr Turner's cell.
65. The primary purpose of a roll check is to confirm that all prisoners are present and correctly accounted for. Not completing a roll check is, therefore, a serious breach of security. However, roll checks are also an opportunity to check on prisoners' well-being and to identify any obvious signs that a prisoner may be ill or dead.
66. When Mr Turner was discovered unresponsive in his cell, he was lying, naked, with his chin on the bed and his feet on the floor. If he had been seen in this position during a roll check, we would have expected officers to be concerned for his wellbeing and to try to get a response from him and to raise the alarm if they could not.

67. We cannot say that if he had been found sooner the outcome would have been different for Mr Turner, but carrying out effective roll checks may be critical in future cases.
68. HMP Doncaster carried out an enquiry into the events leading up to Mr Turner's death and, following this, the Director issued a Director's Order on 4 February 2021. The Order reminded staff of the times that roll count checks are required and that staff should check on prisoners' welfare when conducting roll count checks. It also introduced two additional welfare checks in the core day and a new requirement that staff make an entry in the Houseblock Assurance Book to confirm that the checks have been completed. Managers are required to check the Assurance Book regularly. We make the following recommendation:

The Director should ensure that roll counts and welfare checks are completed in line with local policy.

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