Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Turner, a prisoner at HMP Gartree, on 12 August 2022

A report by the Prisons and Probation Ombudsman

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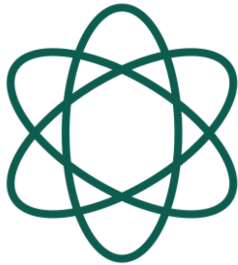
Our vision

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

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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 Mark Turner died in hospital on 12 August 2022 of intracranial haemorrhage caused by a stroke, while a prisoner at HMP Gartree. He was 58 years old. I offer my condolences to Mr Turner's family and friends.

Prison staff found Mr Turner slumped on his bed on the evening of 3 August. Healthcare staff suspected a stroke and sent Mr Turner to hospital. He remained there until his death nine days later.

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

However, we are concerned that Mr Turner was taken to hospital in handcuffs. Staff failed to consider Mr Turner's poor state of health when making the decision to restrain him. We consider that the use of restraints was not proportionate to the risks he posed.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **April 2023**

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Summary

Events

1. In September 2012, Mr Mark Turner was sentenced to life imprisonment for murder. He was moved to HMP Gartree on 9 April 2015.

2. At around 6.00pm on 3 August 2022, officers found Mr Turner slumped on his bed and were unable to rouse him. They called healthcare staff who suspected a stroke.

3. Mr Turner was taken to hospital by ambulance. He was accompanied by two officers and was ‘double-cuffed’ using an escort chain (his wrists were cuffed together with a set of handcuffs and he was attached to an escort chain – a long chain with a cuff at each end, one of which is attached to the prisoner’s wrist and the other to an officer’s wrist).

4. Shortly after he arrived at hospital, Mr Turner was taken to intensive care. His handcuffs were removed but he remained on the escort chain. The next day, after Mr Turner had been placed on a ventilator, a prison manager authorised the removal of the escort chain.

5. Mr Turner died in hospital on 12 August. A hospital doctor recorded Mr Turner’s cause of death as intracranial haemorrhage caused by a stroke.

Findings

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

7. Mr Turner was very ill when he was taken to hospital on 3 August. Despite this, the healthcare section of the escort risk assessment noted no concerns about Mr Turner’s health or mobility. We consider that the use of restraints on Mr Turner was not proportionate to the risks he posed.

8. In two recent investigations into deaths at Gartree, we found that the use of restraints was inappropriate. We are disappointed, therefore, to be making a similar recommendation again.

Recommendations

- The Governor and Head of Healthcare should ensure that when a prisoner is taken to hospital:
    - healthcare staff complete the healthcare section of the escort risk assessment fully and accurately; and
    - managers responsible for authorising restraints consider the healthcare input into the escort risk assessment and base their decision on the actual risk the prisoner presents at the time.

- The Executive Director for the Long-Term and High Security Estate should review the measures that Gartree has introduced to address the inappropriate use of restraints to ensure they adequately address this issue.

The Investigation Process

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

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

11. NHS England commissioned an independent clinical reviewer to review Mr Turner's clinical care at the prison.

12. We informed HM Coroner for Leicestershire of the investigation. The Coroner gave us the cause of death. We have sent the Coroner a copy of this report.

13. The Ombudsman's family liaison officer contacted Mr Turner's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

14. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

Background Information

HMP Gartree

15. HMP Gartree is a medium security prison located outside Market Harborough in Leicestershire. It has capacity to hold 708 men and is predominantly for prisoners serving life or other indeterminate sentences. Healthcare services are provided by Nottinghamshire Healthcare NHS Foundation Trust.

HM Inspectorate of Prisons

16. The most recent full inspection of HMP Gartree was in September 2020. Inspectors found that health care services had markedly improved since their last inspection, particularly in clinical governance, care of patients with long-term conditions, social care and pharmacy services.

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 30 November 2021, the IMB noted that before the COVID-19 pandemic, the healthcare provider had begun to make progress on addressing some of the issues highlighted by the IMB on the quality of and access to services. However, there was little progress to report this year and recruitment and retention of permanent staff remained a huge issue. This had led to increased waiting times. Also, they noted that access to external services and clinics had been affected by the pandemic.

Previous deaths at HMP Gartree

18. Mr Turner was the eleventh prisoner to die at Gartree since August 2020. Two of the previous deaths were self-inflicted and the rest were from natural causes. We have previously made recommendations about the inappropriate use of restraints.

Key Events

19. In September 2012, Mr Mark Turner was sentenced to life imprisonment for murder, with a minimum term of 22 years. He was moved to HMP Gartree on 9 April 2015.

20. Mr Turner had hypertension (high blood pressure), hypercholesterolemia (high cholesterol in the blood) and non-diabetic hyperglycaemia (blood glucose level is above normal but not in the diabetic range).

21. Mr Turner was on a care plan for his hypertension and was reviewed twice in 2021 and once in July 2022 when the prison GP noted that Mr Turner's QRISK (an algorithm that calculates a person's risk of developing a heart attack or stroke over the next 10 years) had reduced from 12.8% (in December 2019) to 10.9%.

22. At around 6.00pm on 3 August, officers found Mr Turner slumped on his bed and were unable to rouse him. They asked healthcare staff to attend.

23. At 6.10pm, nursing staff arrived at Mr Turner's cell. He was slumped sideways on the bed and was snoring, with his eyes flickering. They took his observations and suspected a stroke. At 6.15pm, they called a code blue (a medical emergency code used when a person is unconscious or having breathing difficulties). While waiting for the ambulance, nursing staff continued to take his observations every ten minutes.

24. The ambulance arrived at 8.52pm and took Mr Turner to Kettering General Hospital. Two officers escorted Mr Turner and he was 'double-cuffed' using an escort chain (his wrists were cuffed together with a set of handcuffs and he was attached to an escort chain – a long chain with a cuff at each end, one of which is attached to the prisoner's wrist and the other to an officer's wrist).

25. Shortly after he arrived at hospital, Mr Turner was placed in the Intensive Care Unit (ICU). The escorting staff removed the handcuffs after a hospital doctor requested their removal but Mr Turner remained on the escort chain. The next day, after Mr Turner had been placed on a ventilator, a prison manager authorised the removal of the escort chain.

26. On 4 August, hospital staff told healthcare staff at Gartree that Mr Turner had been taken off sedation but four hours later, he was still not responding and there was no change in his condition.

27. On 5 August, hospital staff re-sedated Mr Turner and moved him to the ICU at Burton Hospital, where he was again taken off sedation. He responded to a command by squeezing a nurse's hand but did not open his eyes.

28. On 10 August, Mr Turner was moved to Royal Derby Hospital for more specialist care.

29. On the morning of 12 August, hospital staff told healthcare staff at Gartree that Mr Turner had a severe brain haemorrhage and was being kept on life support until his family arrived.

30. Mr Turner died in hospital at approximately 2.42pm.

Contact with Mr Turner’s family

31. On 9 August, the prison appointed a family liaison officer who contacted Mr Turner’s sister, who had already been to the hospital to see him. On 12 August, after his death, the family liaison officer called to offer her condolences and support. The prison contributed to the funeral costs in line with policy.

Support for prisoners and staff

32. The prison posted notices informing other prisoners of Mr Turner’s death, and offering support. The prison arranged a memorial for prisoners and visiting family members in honour of Mr Turner on 6 November.

Cause of death

33. A hospital doctor concluded that Mr Turner died of an intracranial haemorrhage caused by an ischaemic stroke. The doctor also concluded that hypertension did not cause but contributed to his death. The Coroner accepted the cause of death provided by the hospital doctor and no post-mortem examination was carried out.

34. The inquest, held on 18 April 2023, concluded that Mr Turner died from natural causes.

Findings

Clinical care

35. The clinical reviewer concluded that the care Mr Turner received at Gartree was equivalent to that which he could have expected to receive in the community. She found that his physical health was appropriately managed and monitored, and his acute deterioration on 3 August was managed by confident and competent healthcare staff.

Use of restraints

36. 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. 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 said 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.

37. Mr Turner was 'double-cuffed' when he was taken to hospital on 3 August. We have not seen an escort risk assessment for 3 August, but we were provided with an escort risk assessment dated 4 August. This indicates that Mr Turner had been double-cuffed. In the healthcare section, in answer to the question, 'Any concerns about their mobility or other HCC [healthcare] concerns', the healthcare member of staff had marked 'No'. Mr Turner had been found slumped on his bed with a suspected stroke and was semi-conscious when taken to hospital. It was clearly inaccurate to say that he had no mobility or health concerns.

38. Mr Turner was a Category B prisoner. It is standard procedure for Category B prisoners to be double-cuffed when escorted outside the prison. However, a prisoner's health and mobility must be taken into account to assess whether the level of restraints used is proportionate to the risks posed by the prisoner. We consider that the use of restraints on Mr Turner was not proportionate to the risks he posed. He was very unwell when he was escorted to hospital having had a suspected stroke. In two recent investigations into deaths at Gartree, we have found that there was an inappropriate use of restraints. In May 2022, we were told that prison managers and healthcare staff had been reminded of the guidance on the use of restraints and the need for accurate completion of the escort risk assessment. We are disappointed, therefore, to have found an inappropriate use of restraints again in this case. We recommend:

    The Governor and Head of Healthcare should ensure that when a prisoner is taken to hospital:

    - **healthcare staff complete the healthcare section of the escort risk assessment fully and accurately; and**

- **managers responsible for authorising restraints consider the healthcare input into the escort risk assessment and base their decision on the actual risk the prisoner presents at the time.**

The Executive Director for the Long-Term and High Security Estate should review the measures that Gartree has introduced to address the inappropriate use of restraints to ensure they adequately address this issue.

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