Prisons & Probation Ombudsman
Independent Investigations

Investigation into the death of Mr James Tagg, a prisoner at HMP Bristol on 29 April 2015

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 we oversee can improve their work in the future.

Mr James Tagg died of lung cancer on 29 April 2015, while a prisoner at HMP Bristol. He was 54 years old. I offer my condolences to Mr Tagg's family and friends.

Mr Tagg had reported a number of symptoms over several months in 2013, which should have prompted earlier radiological examination and led to an earlier diagnosis. The delay is a concern, but we cannot know whether this affected his survival chances. In most other respects, I am satisfied that the clinical care Mr Tagg received at Bristol was of a generally good standard. The investigation found a need for improved family liaison arrangements for prisoners who are terminally ill and I am not satisfied that managers fully considered Mr Tagg's health and mobility when authorising the use of restraints for hospital visits.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2015**

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Summary

Events

1. Mr James Tagg was remanded to HMP Bristol on 16 May 2012. (He was subsequently sentenced to three years in prison.) He was a heavy smoker and dependent on drugs and alcohol. He refused help to give up smoking but received methadone treatment for opiate addiction.

2. In July 2012, Mr Tagg reported chest pains and an electrocardiogram (ECG) found nothing abnormal. In September 2012, after Mr Tagg complained of further chest pains, a prison GP referred him for a chest X-ray, which did not show any significant problems. A prison GP later diagnosed asthma and a bacterial infection in his stomach.

3. In May 2013, Mr Tagg again complained of chest pain and an ECG showed nothing abnormal. Between June and October, he saw healthcare staff ten times and complained of chest and shoulder pain, shortness of breath and a chesty cough. Shortly before the prison released him on licence, on 19 November, a doctor suggested referring Mr Tagg for another X-ray, but it was too late to organise this before he was released. About a month later, his community GP referred him to hospital and doctors diagnosed lung cancer. He completed a course of radiotherapy.

4. At the end of October 2014, Mr Tagg was recalled to Bristol after breaching his licence conditions. Healthcare staff referred him to the oncology department at outside hospital to review his condition. The hospital monitored his condition and, in February 2015, a CT scan showed that Mr Tagg's cancer had progressed and was terminal.

5. Mr Tagg began a course of palliative chemotherapy. Prison nurses monitored his condition daily, and gave him pain relief medication. Mr Tagg went to hospital for oncology appointments in March and was taken to hospital as an emergency in April when a chest infection caused his condition to deteriorate. Managers decided officers should use restraints for these escorts.

6. On 29 April, found Mr Tagg coughing up blood in his cell and radioed a code red emergency but the control room did not call an ambulance until a nurse who responded to the emergency, requested one. Mr Tagg had a cardiac arrest and nurses gave emergency treatment but he died shortly after paramedics arrived.

Findings

7. The clinical reviewer noted that a chest X-Ray in October 2012 and an ultrasound scan in January 2013, had been normal but Mr Tagg's continuing symptoms from May 2013, should have led to another chest X-ray by August 2013. He considered that doctors spent too long investigating other causes. When a doctor identified the need for an X-ray, it was too late to arrange this before Mr Tagg's release in November 2013. This led to a delay in diagnosing his cancer but it is not clear that this affected the outcome for Mr Tagg.

8. When Mr Tagg returned to Bristol at the end of October 2014, he had missed several hospital appointments and staff sought an update on his condition. The hospital began further monitoring. Healthcare staff developed clear and concise care plans for Mr Tagg and there was effective liaison with the hospital and palliative care teams, when his condition was found to be terminal. There was one occasion when there was a delay supplying pain relief medication, which should have been avoided. However, the clinical reviewer was satisfied that, apart from the delay in diagnosis; the overall standard of Mr Tagg's care in prison was equivalent to that he could have expected to receive in the community.

9. The prison did not keep Mr Tagg's next of kin's contact details up to date and did not appoint a family liaison officer until shortly after he died. This meant that the prison informed his next of kin by telephone after he died and did not afford her all reasonable support before his death. We are also concerned that managers authorised the use of restraints when Mr Tagg went to hospital, without fully considered risk assessments.

Recommendations

- The Head of Healthcare should ensure that prison healthcare staff follow National Institute for Health and Clinical Excellence (NICE) guidelines on the early diagnosis of cancer and that doctors refer prisoners for a chest X-ray or to a specialist urgently if they present with unexplained and persistent symptoms of suspected cancer.
- The Head of Healthcare should ensure that prisoners diagnosed with cancer and other serious illnesses have immediate access to effective pain relief when required.
- The Governor should ensure that control room staff call an ambulance as soon as an emergency medical code is received.
- The Governor and Health of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should ensure that a member of staff is appointed promptly to engage with families of terminally or seriously ill prisoners, who should keep contact details up to date, inform them at once if they are admitted to hospital and afford them all reasonable support.

The Investigation Process

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

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

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

13. We informed HM Coroner for Avon of the investigation, who sent the results of the post-mortem examination and the cause of death. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Tagg's ex-partner, who he had named as his next of kin, to explain the investigation. She asked for the following to be considered:

    - Whether Mr Tagg's physical symptoms were identified and responded to in an appropriate and timely manner.
    - Whether the prison had her correct contact details and should have done more to inform her of the progress of his condition.
    - Whether Mr Tagg had haemorrhaged.
    - Whether there were any delays in the emergency response, on the day Mr Tagg died.

15. The investigation has assessed the main issues involved in Mr Tagg'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.

16. Mr Tagg's ex-partner received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

17. The initial report was shared with the prison service. There were no factual accuracies and the action plan has been annexed to this report.

Background Information

HMP Bristol

18. HMP Bristol is a local prison, which can hold up to 614 sentenced and remanded men. Bristol Community Health and Medco Secure Health Services provide primary healthcare and substance misuse services. Avon and Wiltshire Partnership provide mental health services.

19. All wings have a treatment room staffed by a nurse and healthcare assistants during the day. There is a nurse and a healthcare assistant on duty to cover the prison throughout the night. At least one GP is on duty during the week from 7.00am to 8.30pm, and on Saturday afternoon and Sunday morning. An out of hours service is used at other times. There are no inpatient beds.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Bristol was in October 2014. Inspectors found healthcare provision had improved and reception screening was streamlined and swift. Access to the nurse and GP were good and clinical treatment was sound. There was a wide range of clinics, including one for chronic diseases. Prisoners with drug or alcohol problems received prompt treatment and a good level of care. Emergency resuscitation equipment on all wings and in the health centre was well maintained. Mental health provision was high quality.

Independent Monitoring Board

21. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to July 2014, the IMB commented that prisoners were able to see a nurse every day on the wings, including when collecting medication and could see a GP on the same day for urgent needs. They noted that healthcare staff referred new prisoners for mental health assessments or substance misuse services as necessary.

Previous deaths at HMP Bristol

22. Mr Tagg was the third prisoner to die from natural causes at Bristol since the beginning of 2014. We have raised the issues of the unjustified use of restraints and poor liaison with a prisoner's next of kin before.

Findings

The diagnosis of Mr Tagg's terminal illness and informing him of his condition

23. Mr James Tagg was remanded to HMP Bristol on 16 May 2012, and sentenced to three years in prison in October. He was a heavy cigarette smoker, but declined help to give up. He had a history of substance and alcohol misuse and, when he arrived, a nurse referred him to the substance misuse team who began a methadone programme for opiate dependency.

24. On 30 July 2012, a prison GP examined Mr Tagg after he complained of chest pains. She prescribed ibuprofen and arranged an electrocardiogram (ECG – a test that records the heart's electrical activity), which was normal. During the next two months, healthcare staff saw Mr Tagg daily to give him methadone and there is no record that he reported chest pain during this time.

25. On 28 September, a locum GP referred Mr Tagg for an X-ray after he reported chest pains. The X-ray, on 31 October and an ultrasound scan in January 2013, showed nothing significant. On 5 February, a prison GP referred Mr Tagg for an endoscopy to investigate ongoing pain in his chest and pains in his abdomen.

26. On 21 March 2013, a prison GP diagnosed Mr Tagg with asthma after he complained of pain all over his body and a tight chest. On 22 March, the endoscopy showed he had a bacterial infection (helicobacter pylori). A further prison GP prescribed a course of antibiotics to treat this.

27. On 15 May, Mr Tagg had another ECG after he complained of chest pain. The results did not indicate any heart problems. On 14 June, a locum GP examined Mr Tagg, who as well as chest pain, had a cough and was having difficulty clearing his lungs of phlegm. She encouraged him to exercise and prescribed a course of omeprazole (which reduces the acid in the stomach).

28. Between July and October 2013, a doctor or a nurse saw Mr Tagg nine times after he complained of chest pain, shoulder pain, shortness of breath or a chesty cough. Mr Tagg had previously been stabbed in a rib and doctors diagnosed muscular-skeletal pain, prescribed pain relief gels and oral pain relief and advised him to exercise.

29. On 6 October, a nurse saw Mr Tagg when he reported shoulder pain and said the analgesic gel was not working. The nurse thought that this might be 'drug seeking behaviour'. In late October, doctors considered that his pain was due to arthritis.

30. On 4 November, a prison GP recorded that the pain was linked to his reducing dose of methadone, as part of his detoxification programme and that the previous higher doses might have been masking the symptoms. She considered referring Mr Tagg for another X-ray to establish the cause of the pain but it appears it was not possible to arrange this before Mr Tagg was released on licence on 19 November.

31. After he was released from prison, Mr Tagg went to see his community GP, who arranged an X-ray. This showed a suspicious mass on his lungs. After further

scans and tests in hospital, doctors diagnosed Mr Tagg with lung cancer on 23 January 2014.

32. Although some of his symptoms might have been masked by his methadone treatment, drug withdrawal and other conditions, the clinical reviewer considered that, given Mr Tagg's reported chest symptoms of a daily productive cough and shortness of breath associated with heavy smoking, further radiological investigations would have been prudent by August 2013. He considered that healthcare staff spent too long investigating other causes, which had already been examined.

33. The National Institute for Health and Care Excellence (NICE) Guidance 'Referral Guidelines for Suspected Cancer' suggests that an urgent referral for a chest X-ray should be offered when a patient presents with a number of unexplained or persistent symptoms, lasting more than 3 weeks, which include a cough and chest or shoulder pain and difficulty breathing. Although Mr Tagg had an X-ray in October 2012 after complaining of chest pains and a scan in January 2013, which did not show any signs of cancer, he was not referred again.

34. The clinical reviewer considered that the failure to request a chest X-ray or other investigations sooner, meant that this aspect of Mr Tagg's care was not equivalent to that he could have expected to receive in the community. However, he noted that it is not possible to know whether the delay in further investigations affected the outcome of Mr Tagg's treatment or his chances of surviving the cancer. We make the following recommendation:

The Head of Healthcare should ensure that prison healthcare staff follow National Institute for Health and Clinical Excellence (NICE) guidelines on the early diagnosis of cancer and that doctors refer prisoners for a chest X-ray or to a specialist urgently if they present with unexplained and persistent symptoms of suspected cancer.

Mr Tagg's medical treatment

35. After his diagnosis, doctors considered that Mr Tagg was unfit for surgery but instead he had radical radiotherapy in the community between February and April 2014, with a good initial response. However, Mr Tagg did not turn up for a number of follow-up appointments.

36. On 31 October 2014, Mr Tagg was recalled to prison for breaching his licence conditions and arrived back at HMP Bristol the next day. At an initial health screen, a nurse noted his cancer diagnosis and referred him back to the substance misuse team as he tested positive for drugs.

37. On 6 November, a prison GP saw Mr Tagg and recorded that it was unclear at what stage Mr Tagg was with his cancer treatment or what his prognosis was, as he had missed hospital appointments, while in the community. Healthcare staff arranged an oncology appointment at outside hospital for 16 December to assess his condition. A prison GP prescribed morphine sulphate as pain relief. Later that day, a nurse reviewed Mr Tagg's medication and spoke to him about his condition. He told the nurse that he had been depressed since his diagnosis and that he would want to be resuscitated in an emergency. She referred him to

the mental health team. On 24 November, a mental health nurse assessed Mr Tagg and found no evidence of a depressive illness.

38. Healthcare staff saw Mr Tagg daily to give him medication and doctors monitored and adjusted his pain relief. Nurses liaised with a Macmillan nurse for specialist care and advice.

39. On 16 December, Mr Tagg attended an appointment with an oncologist at outside hospital. An X-ray in December showed that there might be a recurrence of the cancer and the hospital scheduled a follow up CT scan. On 24 February 2015, the CT scan showed the cancer was inoperable and terminal.

40. Mr Tagg agreed to a course of palliative chemotherapy aimed at increasing his life expectancy, which doctors advised was likely to be up to one year. Prison healthcare staff liaised with the hospital and with palliative care nurses at a hospice, for specialist advice. Mr Tagg began chemotherapy on 24 March.

41. On 11 April, Mr Tagg was admitted to hospital after coughing up blood, a symptom of lung cancer, and he was struggling to breathe. Doctors treated him for a chest infection and he returned to the prison on 20 April. Nurses took his observations twice daily. At a hospital appointment on 28 April, doctors prescribed a further course of antibiotics and pain relief.

42. At around 8.20pm on 29 April, an officer responded to Mr Tagg's cell bell. Mr Tagg was coughing up a lot of blood and immediately called a code red emergency response over his radio, which should trigger the control room to call an ambulance immediately. However, an ambulance was not called until 8.25pm, after a nurse specifically requested one.

43. A nurse arrived within a minute and gave Mr Tagg oxygen. Other nurses arrived shortly afterwards with emergency equipment. Mr Tagg lost consciousness, stopped breathing and went into cardiac arrest. Two nurses tried to resuscitate him and attached a defibrillator, which found no shockable heart rhythm. Paramedics arrived at 8.34pm. The resuscitation attempts continued until, at 8.44pm, paramedics declared that Mr Tagg had died.

44. A post-mortem examination found that Mr Tagg died of lung cancer; the suddenness of his death had been caused by the tumour rupturing.

45. The clinical reviewer was satisfied that Mr Tagg's care at Bristol, after his diagnosis, was equivalent to that he could have expected to receive in the community. Prison healthcare staff created appropriate care plans and worked well with hospital staff and palliative nurses to ensure Mr Tagg was well cared for in his final weeks of life. However, the clinical reviewer noted that there was one occasion over the Easter weekend of 4 and 5 April 2015, when supplies of oramorph (pain relief) ran out and Mr Tagg was left for nearly a day with inadequate analgesic cover. He noted that this fell below the expected level of cancer care for patients in the community. We make the following recommendation:

The Head of Healthcare should ensure that prisoners diagnosed with cancer and other serious illnesses have immediate access to effective pain relief when required.

46. The control room did not call an ambulance immediately after an officer radioed an emergency medical code on the evening that Mr Tagg died. Prison Service Instruction (PSI) 03/2013 and Bristol's local protocol states that this should be done automatically and there should be no delay, such as requiring a nurse of member of staff at the scene to confirm separately that one is required. While there was a quick emergency response, and it does not appear that the delay affected the outcome for Mr Tagg, in other emergencies, such a delay could be crucial. We make the following recommendation:

The Governor should ensure that control room staff call an ambulance as soon as an emergency medical code is received.

Mr Tagg's location

47. After he returned to the prison on 1 November 2014, Mr Tagg lived initially in the prison's integrated drug treatment and detoxification unit. On 22 November, he transferred to a standard residential wing. In March, a locum prison GP contacted outside hospital to start plans for his care when his condition reached a stage at which he needed hospice care or when he was due to be released from prison on 14 May 2015.

48. The clinical reviewer was satisfied that staff at Bristol were able to care for Mr Tagg on the wing. In April 2015, when his condition deteriorated rapidly after he contracted a chest infection, healthcare staff started planning to move him to HMP Exeter's palliative care suite. They were in the process of arranging this when he died suddenly.

49. We are satisfied that Mr Tagg's was appropriately located throughout his time in prison.

Restraints, security and escorts

50. 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 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. It found that the use of restraints for prisoners undergoing life saving treatment for cancer was inhuman and degrading unless supported by evidence to show their use was justified.

51. On 11 April, Mr Tagg went to hospital as an emergency as he was coughing up blood. A manager decided he should be restrained by handcuffs, which was changed to an escort chain when he arrived at the hospital. (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.) Mr Tagg was terminally ill and very unwell at the

time. He was weak, coughing up blood and struggling to breathe. The healthcare section of the risk assessment had a ticked box to indicate no objections to the use of restraints but there was nothing about his condition at the time or how it might affect his risk of escape. There was no name recorded in the healthcare section of the risk assessment and it was unsigned, so we do not know that it was completed by a clinician. The risk assessment noted Mr Tagg was low risk to the public and of escape.

52. On 28 April, the day before he died, Mr Tagg went to hospital for an appointment. At the time, his condition had deteriorated to the extent that a palliative care place was being sought. However, a senior prison manager authorised that Mr Tagg should be restrained by handcuffs. Mr Tagg's level of risk was still assessed as low. There was no information on the risk assessment about the impact of his medical condition. The senior prison manager told us that, as there was minimal health information on the risk assessments, staff would have relied on the tick boxes completed by healthcare staff to say there were no medical objections. However, this is not the required test.

53. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. When managers approved the use of restraints shortly before Mr Tagg died, his health had deteriorated significantly, he was weak, ill and short of breath and his risk of escape was regarded as low. We are concerned that the healthcare sections of the risk assessments were not completed fully and managers therefore seem to have assumed the default position that the use of restraints was necessary.

54. Ultimately, it is the Governor's responsibility to ensure that the risk assessment process is managed properly and the responsibility of authorising managers to make sure they have all necessary material to make informed decisions. However, healthcare staff also need to understand their responsibilities, and have appropriate and considered input into risk assessments. We make the following recommendation:

The Governor and Health of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Tagg's family

55. Mr Tagg had nominated his ex-partner as his next of kin. On 2 March, Mr Tagg's ex-partner wrote to the prison, giving her new address, asking the prison to consider compassionate release and for permission to attend hospital appointments with Mr Tagg. On 4 March, the Governor replied and offered sympathy about Mr Tagg's terminal diagnosis. She explained the compassionate release process and said it was not possible for Mr Tagg's ex-partner to attend appointments with him because of security issues. No one at the prison updated Mr Tagg's next of kin record and there was no record that the prison contacted her again until after Mr Tagg died.

56. On 29 April, after Mr Tagg's death, an officer and a senior prison manager went to the old address for Mr Tagg's next of kin. They arrived at the house at around 11.30pm, but learnt from a neighbour that Mr Tagg's ex-partner had moved. The next day, the officer telephoned Mr Tagg's ex-partner and told her that Mr Tagg had died. She arranged to visit the following day.

57. The prison appointed a custodial manager as the family liaison officer and on 1 May an officer and the family liaison officer visited Mr Tagg's ex-partner and offered their condolences. The family liaison officer remained in contact for support and helped organise the funeral. Mr Tagg's funeral was on 3 June and the prison offered a contribution in line with national guidelines.

58. Prison Rule 22 says that prisons should inform the next of kin of prisoners who are seriously ill. Similarly, Prison Service Instruction (PSI) 64/2011 says that prisons should have arrangements in place for an appropriate member of staff to engage with the next of kin or nominated person of prisoners who are either terminally or seriously ill. Mr Tagg was diagnosed with terminal cancer in February 2015 and the prison should have appointed someone at that time, to liaise with his ex-partner and ensure that contact details were correct. At the very least, Mr Tagg's ex-partner's letter in March should have prompted the Governor to appoint someone to liaise with her. In addition, the prison should have informed her of his hospital admission in April

59. We are also surprised at the blanket refusal, apparently on security grounds, not to allow Mr Tagg's ex-partner to attend cancer appointments with him. We come across many cases, particularly where the condition is serious and assessed risk low, where family members are allowed to accompany prisoners with cancer on their appointments. We can see no good reason why Mr Tagg's next of kin was not allowed to accompany him for support.

60. More effective liaison from the time of his terminal diagnosis might have helped avoid these difficulties.

The Governor should ensure that a member of staff is appointed promptly to engage with families of terminally or seriously ill prisoners, who should keep contact details up to date, inform them at once if they are admitted to hospital and afford them all reasonable support.

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. In February 2015, doctors gave Mr Tagg a prognosis of up to one year. At the time of his death, Mr Tagg was continuing to receive chemotherapy to prolong his life. Mr Tagg was due to be released in May, at the end of his sentence, and until his condition deteriorated rapidly in April, he was expected to live for some time beyond that. Sadly, although he had a very serious condition, Mr Tagg's death was sudden and unexpected. As Mr Tagg had a prognosis of more than

three months, it was reasonable that the prison had not considered an application for compassionate release at that stage.

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