Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Taylor a prisoner at HMP Isle of Wight on 24 May 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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.

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

Mr David Taylor died of lung cancer at HMP Isle of Wight on 24 May 2016. He was 71 years old. I offer my condolences to Mr Taylor's family and friends.

I consider that Mr Taylor received a good standard of care at Isle of Wight, equivalent to that he could have expected to receive in the community. Prison clinicians treated his respiratory conditions well and appropriately arranged for tests to be carried out once his condition worsened. Although prison staff did not follow up the results of an important chest X-ray, I note that they have taken steps to prevent this happening again. I agree with the clinical reviewer that due to the significant spread of his disease, the resulting delay in diagnosis did not affect the outcome for Mr Taylor.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **November 2016**

Contents

Summary 1
The Investigation Process 2
Background Information 3
Findings 4

Summary

1. On 8 July 2011, Mr David Taylor was sentenced to life imprisonment for sexual offences. He spent time at several prisons before he moved to HMP Isle of Wight on 19 March 2014. During his time in prison Mr Taylor suffered from recurring chest infections and breathing difficulties caused by lifelong smoking.

2. In August 2013, doctors diagnosed Mr Taylor with chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema). Doctors managed his condition with appropriate medications and regular reviews.

3. On 7 October 2015, Mr Taylor complained of breathlessness and chest pains. A prison doctor arranged for urgent blood tests, heart scans and chest X-rays but the results were not available for Mr Taylor's consultation on 30 October. Despite assurances from the hospital, the X-ray results were not sent.

4. On 26 April, Mr Taylor awoke with severe chest pains and nurses sent him to hospital for emergency treatment. Hospital clinicians diagnosed severe pneumonia (a type of chest infection) and treated Mr Taylor with intravenous antibiotics.

5. On 10 May, the hospital carried out a CT scan which showed cancerous tumours in his lungs. The following day, the hospital discharged him to the prison's in-patient unit for end of life care. Mr Taylor's condition deteriorated and he died on 24 May.

Findings

6. Mr Taylor suffered from breathing difficulties and recurring chest infections throughout his time in prison. In order to limit these problems, healthcare staff tried to get him to stop smoking, without success. We are satisfied that clinicians treated and managed his respiratory problems appropriately, particularly as his condition deteriorated.

7. The results of the X-rays ordered on 7 October 2015 showed lesions in Mr Taylor's lungs and recommended repeat X-rays within six weeks. This did not happen as the results were not sent to the prison until after his death six months later. The clinical reviewer states that the failure to further investigate the abnormalities was a missed opportunity to obtain an earlier diagnosis. We are satisfied that the healthcare department have improved the processes for tracking the receipt of medical reports and therefore make no recommendation.

8. Although there was a delay in starting an application for compassionate release, we acknowledge that it was unlikely that such an application would have been successful.

The Investigation Process

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

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

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

12. We informed HM Coroner for Isle of Wight of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Taylor's brother to explain the investigation and to ask if he had any matters they wanted the investigation to consider. Mr Taylor's brother said that he did not want to be involved in the investigation.

14. The investigation has assessed the main issues involved in Mr Taylor'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.

15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Isle of Wight

16. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany, and holds approximately 1,100 men, mostly convicted of sex offences. Care UK provides healthcare services at the prison. There is a healthcare inpatient unit at the Albany site, providing 24-hour care for prisoners with a wide range of health needs. The inpatient unit includes special facilities for end of life care.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Isle of Wight was in June 2015. Inspectors reported that health services were good, the inpatient unit provided compassionate care to men with complex needs and prisoners with palliative and end of life needs received excellent care. Handcuffing arrangements for men leaving the prison on escort were proportionate and inspectors found many examples of appropriately reduced levels of restraint for prisoners who were physically incapacitated.

Independent Monitoring Board

18. 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 December 2015, the IMB said that it was impressed by the standard of healthcare provided by Care UK and the care given by the prison's 24-hour inpatient unit.

Previous deaths at HMP Isle of Wight

19. Mr Taylor was the eleventh prisoner to die of natural causes at Isle of Wight since January 2015. There were no significant similarities between the issues identified in this investigation and those from previous investigations.

Findings

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

20. On 8 July 2011, Mr David Taylor was sentenced to life imprisonment for sexual offences. He spent time at a number of prisons before he moved to HMP Isle of Wight on 19 March 2014.

21. Before arriving in prison Mr Taylor suffered with hypertension (high blood pressure), heart disease and high cholesterol. Healthcare staff managed these conditions with regular reviews and medication. Mr Taylor had smoked for most of his life, which caused regular respiratory illnesses. Healthcare staff tried to help Mr Taylor to stop smoking but he was not successful.

22. In August 2013, prison doctors diagnosed Mr Taylor with chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema) which they treated with carbocisteine (used to make mucus easier to cough up). Over the next two years Mr Taylor had recurring chest infections and breathing difficulties which doctors treated with inhaler medications and antibiotics.

23. Mr Taylor's respiratory problems gradually worsened and, on 29 May 2015, he awoke with severe shortness of breath and chest pain. A prison GP examined Mr Taylor but found no evidence of abnormalities in his lungs. The GP offered to admit Mr Taylor to the inpatient unit for further treatment but Mr Taylor declined.

24. On 7 October, a prison GP reviewed Mr Taylor, as he complained that he was breathless at night and had pains in his lower chest. The GP ordered blood tests, a liver function test, a scan of his heart and a chest X-ray, as he was concerned that Mr Taylor's symptoms indicated a worsening of his lung disease or heart problems. He also prescribed prednisolone (a steroid medication) to help reduce inflammation of his lungs. Mr Taylor visited the hospital for the X-ray on 14 October.

25. On 30 October, a prison GP told Mr Taylor that the results of the tests raised no clinical concerns but he strongly advised him to stop smoking. Later that day the GP telephoned the hospital to request the X-ray results. The hospital assured him that they would send the results but they never did and the prison did not chase them again.

26. On 15 March 2016, Mr Taylor told a prison GP that he felt sharp stabbing pains in his chest which increased with breathing. The GP suspected muscular issues and prescribed a topical pain relief cream.

27. Over the following weeks, Mr Taylor's chest pains continued and, on 5 April, he told a prison GP that he had coughed up traces of blood. The GP arranged for another chest X-ray. Mr Taylor attended hospital for the X-ray on 25 April. Shortly after he returned to prison he had significant breathing difficulties. That evening, the GP admitted him to the inpatient unit and treated with him salbutamol (an inhaler medication).

28. On 26 April, Mr Taylor awoke with breathing difficulties and strong pain in the right side of his chest. A nurse took his clinical observations and noted that they were abnormal. She measured them against a Modified Early Warning Score system (MEWS) which gave a score of eight (a score over five is concerning) and sent him to hospital for emergency treatment. Hospital clinicians diagnosed severe pneumonia (a form of chest infection) in his right lung and fitted a surgical device to drain fluid from his chest. Over the next two weeks hospital doctors treated the infection with intravenous antibiotics.

29. On 10 May, the hospital carried out a CT scan which showed cancerous tumours in Mr Taylor's lungs. The hospital discharged him the next day and he was admitted to the prison's inpatient healthcare unit for end of life care. While in hospital, Mr Taylor decided that he did not want to be resuscitated if his heart or breathing stopped and a doctor completed and signed an order to that effect.

30. Clinicians managed Mr Taylor's lung disease well and treated infections associated with his lung disease appropriately when they occurred. However, the hospital did not send the results of a chest X-ray taken on 14 October until after Mr Taylor's death. A prison GP had chased the hospital for the results on one occasion and then noted on Mr Taylor's medical record that they had been received. The GP said that he did this after receiving an assurance from the hospital that they would send the results, though this meant that the prison did not chase the hospital again.

31. We note that the X-ray results showed lesions in Mr Taylor's lungs and the recommendation for a repeat of the X-ray within six weeks. The clinical reviewer stated that although the symptoms of COPD and lung cancer are similar, the absence of the X-ray results was a missed opportunity to diagnose Mr Taylor's cancer sooner. However, we agree with the clinical reviewer that due to the location and spread of the cancer, an earlier diagnosis would not have changed the outcome for Mr Taylor.

32. The clinical reviewer was told that the problem with the X-ray results was due to a change in the electronic mail systems used by the hospital and the prison healthcare department. Since January 2016, administrative staff at the prison carry out daily checks to make sure medical reports are received before closing tracking processes. We are satisfied that this verification process will improve the tracking of medical results and, therefore, do not make a recommendation.

Mr Taylor's clinical care

33. On his return to prison, Mr Taylor and a prison GP discussed his diagnosis and treatment. They agreed to fit a syringe driver (a pump used to give medication continuously under the skin) to manage his pain and nausea.

34. On 14 May, a nurse created an end of life care plan to monitor Mr Taylor's pain relief and ensure his comfort. Mr Taylor received ongoing support from prison healthcare staff and a palliative care consultant.

35. On the morning of 23 May, a prison GP removed Mr Taylor's oxygen mask as he was no longer responding to oxygen support. Nursing staff monitored his condition closely as his condition declined.

36. At 7.45am on 24 May, the nurse discovered Mr Taylor sitting on the floor. After helping him return to his bed, Mr Taylor became agitated and attempted to climb out of bed again. Healthcare staff remained with him to provide continual support and ensure he did not climb out of bed.

37. At 9.54pm, a nurse noted that Mr Taylor was struggling to breathe and did not respond when spoken to. She spoke to a prison GP, who came into the prison. The GP recorded that Mr Taylor had died at 10.45pm. A post-mortem examination showed that Mr Taylor died of lung cancer which had spread to his lymph nodes and adrenal glands.

38. We are satisfied that following his diagnosis, Mr Taylor received a good standard of care at Isle of Wight, equivalent to that which he could have expected to receive in the community. Once Mr Taylor required end of life care, clinicians monitored his condition consistently, treated him daily and adjusted his medication when needed.

Mr Taylor's location

39. Mr Taylor lived on a normal accommodation wing at Isle of Wight and occupied a single cell. In the early stages of his condition, Mr Taylor did not present with symptoms that required admission to the prison's inpatient unit or hospital so he was appropriately located in his cell during this time.

40. On occasions where Mr Taylor had significant breathing difficulties, clinicians offered to admit him to the inpatient unit but Mr Taylor preferred to remain on his wing. On 25 April, a nurse advised Mr Taylor to attend the inpatient unit for treatment. Mr Taylor initially refused but later agreed. Later that day, he went to hospital for a chest X-ray and returned to prison that evening. His breathing difficulties worsened and he was again admitted to hospital the next day.

41. On 9 May, prior to his final discharge, the hospital telephoned to advise that Mr Taylor required continual oxygen support. An oxygen mask and compressor were available when the hospital discharged Mr Taylor to the prison's inpatient unit for end of life care on 11 May. We are satisfied that the prison appropriately located Mr Taylor during his time at Isle of Wight.

Restraints, security and escorts

42. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

43. The risk assessment for Mr Taylor's visit to hospital on 25 April did not raise medical objections to the use of restraints and noted that Mr Taylor presented a high risk to the public. As a result, an officer recommended restraining him with double cuffs while in hospital. (Double cuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.) The Head of Operations reviewed the assessment and decided to reduce the restraints to a single pair of handcuffs.

44. The risk assessment for Mr Taylor's emergency admission to hospital on 26 April noted that he suffered from breathing difficulties and reduced mobility. On that basis, a Custodial Manager (CM) decided not to use restraints. Officers did not use restraints for the duration of Mr Taylor's stay in hospital.

45. We consider that when Mr Taylor went to hospital for a routine X-ray on 25 April, his condition had not deteriorated to an extent that using restraints was inappropriate. When his condition worsened the following day, the CM appropriately considered how Mr Taylor's health affected his risk to the public and of escape so decided not to restrain him. We are pleased that the prison reconsidered the level of restraints taking account of to Mr Taylor's deteriorating condition.

Liaison with Mr Taylor's family

46. On 26 April, hospital staff told the prison that Mr Taylor's condition was deteriorating. As a result, the following day, the prison appointed a Supervising Officer (SO) as the family liaison officer.

47. Mr Taylor did not provide any contact details for his next of kin when he arrived at the prison, so the SO visited him on 1 May to discuss this. Mr Taylor asked the SO to obtain contact details for his brother from the chaplaincy department and inform him that he was unwell. The SO telephoned Mr Taylor's brother on 3 May. Mr Taylor's brother said that he did not know if he would visit Mr Taylor in hospital and that he would like to be informed of his deterioration or death by telephone.

48. On 20 May, the SO attempted to tell Mr Taylor's brother that Mr Taylor was terminally ill, but could not reach him. The SO telephoned Mr Taylor's brother on 23 May to tell him that Mr Taylor was approaching the end of his life.

49. At around 11.45pm on 24 May, the SO called Mr Taylor's brother to inform him of Mr Taylor's death and to offer his condolences and support. The SO visited Mr Taylor's brother on 27 May.

50. Mr Taylor's funeral was on 17 June 2016. The prison arranged and paid for the funeral, in line with national policy.

51. We are satisfied that the prison promptly appointed a family liaison officer when it became clear that Mr Taylor was seriously ill and that there was appropriate family liaison with Mr Taylor's brother.

Compassionate release

52. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for indeterminate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on

compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

53. After Mr Taylor returned to the Isle of Wight for palliative care on 11 May a prison GP estimated that his life expectancy was around two weeks. On 17 May, a prison manager telephoned a nurse to ask if the prison should pursue compassionate release for Mr Taylor. The nurse said that Mr Taylor might die within a week and that he could not be safely moved.

54. Records show that Head of Offender Management contacted healthcare for medical input to a compassionate release application on 24 May. We found no record of when the Head was notified of Mr Taylor's condition. A prison GP sent an email to the Head, noting that Mr Taylor's life expectancy was less than 48 hours. He emphasised that when discharged back to prison for palliative care, Mr Taylor was in extremely poor health. Given the seriousness of his offences, the GP noted that there was 'never any realistic prospect' of achieving release on compassionate release. On that basis, the GP did not recommend release. The same day, Mr Taylor's probation officer added to Mr Taylor's compassionate release application but did not support release. Mr Taylor died that evening before the application was completed.

55. We consider that there were unnecessary delays in applying for compassionate release. The prison did not begin considering compassionate release until 17 May and did not actually start the application until 24 May, almost two weeks after he returned to prison. However, we acknowledge that with no family willing to care for him and a history of very serious sexual offences, he was very unlikely to have fulfilled the criteria for compassionate release, so we do not make a recommendation.

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