Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr George Taylor a prisoner at HMP Oakwood on 12 September 2017

**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.

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 George Taylor died on 12 September of bronchopneumonia at New Cross Hospital. He was 76 years old. We offer our condolences to Mr Taylor's family and friends.

Mr Taylor had a number of health issues. Healthcare staff regularly reviewed him and formulated care plans to ensure they monitored his situation and provided assistance when necessary.

We are satisfied that the care Mr Taylor received was equivalent to that which he could have expected to receive in the community.

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

**Elizabeth Moody**
**Acting Prisons and Probation Ombudsman** **February 2018**

## Contents

# Summary

## Events

1. On 4 January 2011, Mr George Taylor was remanded in to custody and was sent to HMP Highdown. On 9 September, he was sentenced to eight years imprisonment for sexual offences. On 21 October 2014, Mr Taylor received an extended sentence for historical sex offences of ten years (comprising of 8 years imprisonment and an additional 2 years on licence).

2. On 17 December 2014, Mr Taylor was transferred to HMP Oakwood. He had a history of chronic obstructive pulmonary disorder (COPD), blindness in his left eye, had had a kidney removed when he was 15 years old and had a low body weight.

3. Throughout his time in prison, staff monitored and attended to Mr Taylor's needs. They reviewed his weight, mobility, sight and COPD and provided appropriate equipment including a personal alarm to aid his daily living. Mr Taylor had occasional spells of dizziness and falls in 2015 and 2016, and the healthcare team devised and revisited care plans in order to prevent further occurrences.

4. On 26 January 2017, a healthcare assistant conducted a COPD and asthma review but she did not include a spirometry test (measures how much air an individual can breathe out in one forced breath), which is standard in the community. This was because no healthcare staff including the healthcare assistant had been trained to conduct spirometry tests. Some healthcare staff are now trained.

5. On 6 September, Mr Taylor had a fall in his cell and was admitted to hospital with a suspected fracture in his leg. His condition deteriorated significantly over the following days and he died on 12 September at 8.30am.

## Findings

6. The clinical reviewer found that the care Mr Taylor received was equivalent to that which he could have expected to receive in the community. Although a spirometry test was not included in a COPD assessment (because no staff were trained to conduct one), this matter has now been resolved and some staff have been trained.

7. We make no recommendations.

# The Investigation Process

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

9. She obtained copies of relevant extracts from Mr Taylor's prison and medical records.

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

11. We informed HM Coroner for South Staffordshire District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. Mr Taylor had no contact with his family and his next of kin could not be traced.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Background Information

### HMP Oakwood

14. HMP Oakwood opened in 2012. It is near Wolverhampton, managed by G4S and provides places for up to 1,605 Category C male prisoners.

15. Care UK provides the healthcare services, which include a daily GP clinic, some specialist services and out-of-hours GPs. Healthcare staff are on duty from 7.00am to 8.00pm on weekdays and from 7.30am to 5.30pm on weekends.

### HM Inspectorate of Prisons

16. The last inspection of HMP Oakwood was in December 2014. Inspectors reported that health services, including care for older prisoners had much improved since the last inspection. There were some chronic staff shortages in healthcare which did affect some areas of delivery and agency staff were used to fill the shortages. Care planning was well developed and clinical records were good.

### 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 March 2017, the IMB reported that staff turnover was quite high with the number of officers under the age of 25 increasing. The change of healthcare contractor in April 2016 went reasonably well but there was an ongoing problem with a shortage of nurses and a reliance on agency nurses. The number of hospital appointments that needed rearranging because of escort issues had decreased compared to the year before.

### Previous deaths at HMP Oakwood

18. Mr Taylor's is the eighth death from natural causes at Oakwood since the beginning of 2017. There are no similarities with those deaths.

# Key Events

19. On 4 January 2011, Mr George Taylor was remanded into custody and was sent to HMP Highdown. On 9 September, he was sentenced to eight years imprisonment for sexual offences. On 21 October 2014, Mr Taylor received an extended sentence for historical sex offences of ten years (comprising 8 years imprisonment and an additional 2 years on licence). Mr Taylor was transferred to HMP Oakwood on 17 December 2014. He had a history of chronic obstructive pulmonary disorder (COPD), blindness in his left eye, had had a kidney removed when he was 15 years old and had a low body weight.

20. On 17 December 2014, a nurse conducted Mr Taylor's reception screen at Oakwood. He noted that he had COPD, blindness, cataracts, a bodyweight of 7 stone 9 pounds and smoked cigarettes.

21. On 22 December, a healthcare assistant (HCA) conducted a weight review and an Elderly Care Assessment to assess Mr Taylor's needs. She concluded that he was fully able to self-care without support. She opened care plans to monitor and manage his pressure areas, physical disabilities and COPD. Mr Taylor did not see his weight as a problem as he said he had always been very underweight.

22. On 7 February 2015, a HCA conducted a COPD and asthma review and concluded Mr Taylor's respiratory issues were not limiting his activities. He experienced symptoms once or twice a month during the day. A HCA discussed smoking cessation with Mr Taylor but he said he had given up and not smoked for ten days.

23. On 29 March, Mr Taylor complained of chest pains but refused to go to hospital, even when paramedics attended and detected a number of cardiac abnormalities. On 30 March, a prison GP discussed Mr Taylor's treatment refusal and repeated an ECG, which was normal. (An electrocardiogram measures electrical activity in the heart.)

24. On 7 April, Mr Taylor started a smoking cessation course and was prescribed nicotine lozenges (He discontinued the programme on 19 May and restarted it later in 2017.)

25. On 17 May, a HCA created a weight monitoring care plan and scheduled monthly reviews. Although Mr Taylor did not see his weight as a problem, the HCA encouraged him to take on a high calorie, protein rich diet.

26. During the remainder of 2015, staff kept an eye on Mr Taylor's weight and he was referred for an MRI scan on his brain, which revealed some inflammation in September 2015. Following screening for an abdominal aortic aneurysm in June 2015, samples were analysed, which did not identify any significant issues. He later had a colonoscopy, which also did not identify any issues.

27. On 6 October 2015, Mr Taylor fell in his cell and hit his head. He was assigned a nurse on 9 October.

28. On 20 January, the head of healthcare completed an Elderly Assessment of Need (an assessment tool to establish if an individual needs any kind of daily

living support.) He did not have any concerns about Mr Taylor. On 16 February 2016 Mr Taylor saw physiotherapist who gave him advice as he was experiencing some pains in his neck. She noted that he had a special pillow and gave him some exercises to complete.

29. On 21 April 2016, Mr Taylor complained again of pain in his hip but it seemed to improve the next day. He had dizzy spells in May and July but refused to see a GP to be checked. Staff continued to monitor Mr Taylor throughout the remainder of the year but he would sometimes refuse GP or ophthalmic appointments.

30. On 25 January 2017, a nurse noted that she had created a support care plan to help Mr Taylor remain as independent as possible and opened a physical disability care plan. Although Mr Taylor had and used a white stick, he refused a Zimmer frame. Other equipment provided by the prison included a high back chair, a special mattress, an alarm mug that beeped when full, a personal alarm, a shower chair and care from a prison buddy.

31. The next day, a nurse conducted a COPD and asthma review but noted she was unable to perform a spirometry test. This is a simple test, which helps to monitor COPD and asthma by measuring how much air an individual can breathe out in a forced breath. It is usual to perform these tests as part of the reviews but a nurse told the clinical reviewer there was no one in healthcare qualified to carry out the test. Two healthcare assistants have since been trained to conduct the spirometry test.

32. On 23 March 2017, a nurse prescribed Mr Taylor nutritional soups and on 2 June 2017, another nurse noted that he had gained weight and looked better.

33. On 13 June, a physiotherapist noted that Mr Taylor had been discharged from the physiotherapy clinic as he felt that the treatment and exercises gave him more pain.

34. On 6 September, at an unknown time that morning (but likely to be sometime after 11am)**,** Mr Taylor had another fall after standing on a chair in his cell while arranging his curtains. He sounded his personal alarm and other prisoners shouted to an officer for help. The officer went to Mr Taylor's cell where he was on the floor with a pillow that another prisoner had put there under his head. Mr Taylor did not report any chest pains or have any other concerning symptoms except that he was unable to straighten his leg. Another officer, radioed for a healthcare assistant to attend.

35. A nurse attended the scene and immediately radioed for a paramedic to attend. He arrived promptly and asked a prison manager to call an ambulance, which she did at 11.36am. Mr Taylor did not appear to have any significant head injury or memory loss but was in pain. The ambulance arrived at 12.20pm and left for hospital at 1.35pm.

36. Staff conducted a risk assessment and, although there is no record that healthcare staff had any input, restraints were not used.

37. Mr Taylor developed fluid on his lungs and hospital staff were concerned he had also had developed a pulmonary embolism. Healthcare staff from the prison

stayed in touch with hospital staff and they were told on 12 September that Mr Taylor had died at 8.30am.

### Contact with Taylor's family

38. Mr Taylor was not in touch with any members of his family and neither the police nor the coroner were able to trace his next of kin.

39. Mr Taylor's funeral was held on 20 October 2017. The prison covered the costs of the funeral in line with national guidance.

### Support for prisoners and staff

40. After Mr Taylor's death, a prison manager debriefed the staff involved in the hospital escort to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

41. The prison posted notices informing other prisoners of Mr Taylor'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 Taylor's death.

### Post-mortem report

42. We have not received a copy of the post-mortem report but the coroner informed us that the cause of death was 1a) bronchopneumonia, 1b) chronic obstructive pulmonary disease and 2) acetabular fracture.

# Findings

## Clinical care

43. The clinical reviewer found that the care Mr Taylor received was equivalent to that which he could have expected to receive in the community. He presented the healthcare team with a number of diverse challenges given the issues with his sight, mobility and COPD, but staff regularly reviewed him and provided equipment to aid his daily living.

44. We note that when asthma and COPD reviews were undertaken they did not include a spirometry test, which would be a standard measure in the community. The clinical reviewer was told that there were no staff in healthcare who were trained to perform these tests at that time. Two healthcare assistants have now been trained to conduct these assessments. We therefore make no recommendation.

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