Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Taylor a prisoner at HMP Bure on 6 May 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*

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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.

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 John Taylor died on 6 May 2017 of heart disease caused by coronary alveosclerosis (hardening of the arteries), with additional causes of bilateral lower lobe bronchopneumonia (lung infection) and metastatic prostate cancer, while in the custody of HMP Bure. He was 67 years old. We offer our condolences to Mr Taylor's family and friends.

The care Mr Taylor received at HMP Bure was not equivalent to that which he could have expected to receive in the community. Healthcare did not fully investigate his abnormal blood test results for two months, and, he was not urgently referred to a specialist as he should have been. It is impossible to tell if earlier diagnosis would have affected his prognosis.

No arrangements were made to ensure Mr Taylor could receive appropriate pain relief at Bure after he was discharged from hospital.

We are concerned to see that a very ill man who was in severe pain and who posed minimal risk, was restrained when he was taken to hospital as an emergency. We have made recommendations to Bure about this issue on two previous occasions, and we will be doing so again in relation to another death that occurred at Bure in May 2017. Effective action now needs to be taken to implement our recommendations.

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 **November 2017**

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Summary

Events

1. On 17 May 2012, Mr John Taylor was sentenced to 15 years imprisonment for sexual offences and went to HMP Norwich. He was transferred to HMP Bure on 23 May 2014.

2. In September 2016, Mr Taylor told a prison nurse that he had pain in his hips, back and upper legs, and was constipated. She offered him pain relief, (which he declined) and prescribed him a laxative and reviewed him five days later. Mr Taylor told the nurse that he was no longer constipated and his pain had improved but had not stopped. The nurse referred him to a physiotherapist.

3. Mr Taylor saw the physiotherapist in October. He told her that he had been in pain for three weeks. She gave him a list of exercises and planned to review him in three weeks time.

4. Mr Taylor complained of back pain again in November 2016. He said that he could not sleep due to the pain and had started to limp when walking. A prison nurse prescribed him stronger pain relief and anti-inflammatory medication. She planned to review him the following month. Mr Taylor also had some blood samples taken and results showed abnormalities but healthcare did not follow this up.

5. Another prison nurse reviewed Mr Taylor in December. He told her that the anti-inflammatory had helped with the pain but he still could not sleep properly. The nurse planned to continue to review him regularly and asked him to report any new symptoms to healthcare staff.

6. At the beginning of January 2017, Mr Taylor saw a prison doctor. He said that he still had pain in his legs, had lost weight and had requested a test for bowel cancer. The doctor referred Mr Taylor for a physiotherapy review and for blood tests to screen for prostate cancer.

7. Mr Taylor had the blood tests in February. The results indicated that he had prostate cancer, which had spread to his bones. A prison doctor saw Mr Taylor to discuss his results, offered him pain relief, and made an urgent referral to the hospital urology department. Mr Taylor attended his urology appointment and the hospital consultant confirmed that he had cancer.

8. In March, Mr Taylor attended hospital to have surgery to protect his spinal cord from cancer. He returned to Bure after five days.

9. In April, a prison doctor sent Mr Taylor to hospital for tests after he suspected he had deep vein thrombosis. The hospital confirmed the diagnosis. Mr Taylor returned to Bure and the prison doctor prescribed anti-coagulant injections (to prevent blood clotting).

10. Mr Taylor saw the prison doctor for a review on 21 April. He told the doctor his pain was getting worse. The doctor told him he could not supply more opiate-

based pain relief in prison and he would need to go to hospital. Mr Taylor said he wanted to think about it.

11. A nurse saw Mr Taylor the following day, 22 April, when he went to collect his medication. He had a fever so she called the hospital. They told her to call NHS emergency and urgent care services, who agreed to send a doctor to the prison to assess Mr Taylor. The doctor arranged for Mr Taylor to be admitted to hospital.

12. On 23 April, Mr Taylor went to hospital as an emergency. He remained there until his death on 6 May.

Findings

13. We agree with the clinical reviewer that the care Mr Taylor received was not equivalent to the care he could have expected to receive in the community. Healthcare staff at Bure did not investigate the reasons for Mr Taylor's abnormal blood test results in November 2016 and urgently refer him to a specialist; did not conduct and review blood tests quickly enough or refer Mr Taylor urgently to a specialist in January 2017; and did not provide appropriate pain relief after he was discharged from hospital in April 2017.

14. When Mr Taylor went to hospital as an emergency on 23 April, he was inappropriately restrained. The initial risk assessments did not fully take into account Mr Taylor's risk given his very poor health and limited mobility. Appropriately, the restraints were removed later that day.

Recommendations

- The Head of Healthcare should ensure that GPs follow relevant National Institute for Health and Clinical Excellence (NICE) guidelines for suspected cancer and refer patients appropriately.

- The Head of Healthcare should review how the needs of prisoners with a diagnosis of life threatening conditions (such as cancer) are met to ensure they have appropriate access to pain relief and other drugs, and appropriate medical and nursing care.

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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 Investigation Process

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

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

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

18. We informed HM Coroner for Greater Norfolk District of the investigation who gave the cause of death. We have sent the coroner a copy of this report.

19. The investigator wrote to Mr Taylor's wife to explain the investigation and to ask if she had any matters he wanted the investigation to consider. She raised concerns about Mr Taylor's weight loss and late diagnosis.

20. Mr Taylor's wife received a copy of the initial report. She pointed out a factual inaccuracy. This report has been amended accordingly.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Bure

22. HMP Bure is a medium security prison near Norwich, which holds over 600 men, convicted of sexual offences.

23. Virgin Care provides healthcare services. Healthcare staff are on duty between 8.00am and 6.30pm on weekdays and between 8.00am and 6.00pm at weekends. Five GP clinics are scheduled each week. There is an out of hours service.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Bure was in April 2017. Inspectors reported that the healthcare centre was clean and clinical rooms were fit for purpose. Healthcare equipment was checked and maintained regularly and healthcare staff received intermediate-level resuscitation training. Defibrillators were in place on all residential units, and rotas were arranged to ensure that first-aid-trained prison staff were consistently on duty. An appropriate range of primary care services was provided and waiting times were short. Routine GP appointments were available within two days and urgent appointments were facilitated based on clinical need. Long-term conditions and complex health needs were overseen by the GP, who coordinated their approach with healthcare staff.

Independent Monitoring Board

25. 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 July 2016, the IMB reported that there were concerns with the Virgin Health Care Contract, their complaints system and the restriction on recruiting staff. Healthcare staff regularly worked additional days in order to provide a service but staff sickness and retention levels remained a cause for concern.

Previous deaths at HMP Bure

26. Mr Taylor was the fourth prisoner to die of natural causes at Bure since January 2016. We have made recommendations in three previous cases about risk assessments for the use of restraints.

Key Events

27. On 17 May 2012, Mr Taylor was sentenced to 15 years in prison for sexual offences and went to HMP Norwich. He was transferred to HMP Bure on 23 May 2014.

28. On 29 September 2016, Mr Taylor saw a nurse and complained of pain in his hips, back and upper legs. He told her that felt he felt pain when standing up and getting out of bed and was constipated. He refused pain relief but she prescribed him a laxative and planned to review him after five days. She saw Mr Taylor again on 4 October. He told her that he was no longer constipated and his back pain had improved but had not stopped. She referred him for physiotherapy and told him to see a nurse if he had any more symptoms.

29. On 18 October, Mr Taylor saw physiotherapist. He told her that he had been in pain for three weeks and that at first it was a sharp pain that had become an ache. She gave him some exercises and corrected his posture. She planned to review him within the next three weeks.

30. On 18 November, Mr Taylor complained of back pain to a healthcare assistant. She arranged for him to see a nurse on 24 November. Mr Taylor told the nurse that paracetamol (pain relief) was not working, that he could not sleep due to the pain and that the discomfort was causing him to limp. She planned to prescribe him more pain relief as well as anti-inflammatory medication. She booked a review appointment for December.

31. On 27 November, Mr Taylor had a blood test. His results showed that he had low haemoglobin (a red protein responsible for transporting oxygen in the blood) levels and raised alkaline phosphatase levels (a protein enzyme found in the liver and bones). There is no record to suggest that healthcare staff investigated the cause of these abnormalities.

32. A nurse saw Mr Taylor to review his back pain on 22 December. He told her that he felt better since taking the anti-inflammatory but was still unable to sleep properly due to the pain. The nurse did not examine him. She planned to continue to review him regularly and told him to report any new symptoms.

33. On 9 January 2017, Mr Taylor complained to a prison GP of pain in both legs and across his back. He told the prison GP that he had requested a test for bowel cancer due to his weight loss and inability to empty his bowels regularly. He told him that the pain started two months ago and he had not been able to go to the gym for three weeks. The prison GP recorded that Mr Taylor did not consent to a rectal examination, so no examination was carried out. He planned to send Mr Taylor for blood tests to screen for prostate cancer and refer him to physiotherapy for a review. There is no record that the prison GP recorded Mr Taylor’s weight. The blood tests were not carried out until 1 February.

34. A prison GP saw Mr Taylor on 21 January, after he complained of continuing back pain. He noted that Mr Taylor had an abnormal blood test result in November 2016. He planned to send Mr Taylor for a MRI scan (Magnetic Resonance Imaging uses strong magnetic fields and radio waves to produce

detailed images of the inside of the body) and blood tests. He prescribed Mr Taylor laxatives and an anti-inflammatory gel.

35. On 1 February, Mr Taylor went to healthcare for the blood tests that a prison GP had planned on 9 January. He saw Mr Taylor to discuss the results of his blood tests on 6 February and told him that his results suggested he had prostate cancer, which had spread to his bones. He recorded that Mr Taylor was in too much pain to have an examination. He sent an urgent referral to urology at a hospital and offered Mr Taylor more pain relief.

36. On 17 February, Mr Taylor attended hospital for his urology appointment. The hospital doctor told him he had prostate cancer and prescribed hormone therapy and pain relief.

37. On 6 March, a nurse spoke to the uro-oncology nurse from the hospital. The uro-oncology nurse said that they were admitting Mr Taylor to hospital for an urgent MRI of his spine and surgery to protect his spinal cord from cancer. On 11 March, Mr Taylor was returned to HMP Bure.

38. On 3 April, Mr Taylor attended the hospital to start daily radiotherapy treatment. His last radiotherapy treatment was on 7 April.

39. On 10 April, a nurse recorded that Mr Taylor did not attend healthcare to collect his morning medication due to a swollen leg. She spoke to a prison doctor who told her that Mr Taylor would need a scan to rule out deep vein thrombosis. She contacted the hospital who arranged an appointment for Mr Taylor for that afternoon. Mr Taylor was diagnosed with deep vein thrombosis. He was returned to Bure and a prison GP prescribed him anti-coagulant injections (to prevent blood clotting).

40. On 21 April, a prison GP saw Mr Taylor to discuss his pain relief. Mr Taylor said that his pain was getting worse. The prison GP told him that he would not be able to give him more morphine (opiate-based pain relief) in prison. (This was because Mr Taylor needed to have injections every 12 hours and healthcare cover at Bure would not be able to facilitate this.) He asked Mr Taylor if he would like to be transferred to HMP Norwich Prison Hospital and Mr Taylor said that he would like to speak to his wife before making a decision.

41. A nurse saw Mr Taylor when he went to get his medication on 22 April. She recorded that he was shaking and felt warm. She called the acute oncology department at the hospital and the hospital consultant told her to contact the NHS emergency and urgent care services and arrange an appointment with a doctor. She contacted the NHS emergency and urgent care services and they sent a doctor to assess Mr Taylor. The doctor examined Mr Taylor and arranged for him to be admitted to hospital.

42. Mr Taylor was reluctant to go to hospital and wanted to return to his cell. He was taken to hospital as an emergency at 2.20am on 23 April. He remained there until his death on 6 May.

Contact with Mr Taylor's family

43. The prison appointed an officer as the family liaison officer (FLO) on 23 April 2017, after Mr Taylor's health deteriorated. The FLO contacted Mr Taylor's wife that day to inform her of Mr Taylor's condition and to ask her if she would like to visit him and provided her with the procedures for arranging visits to the hospital. Mr Taylor had a heart attack on 5 and 6 May, Bure asked him if he wanted them to contact his wife but he declined.

44. After Mr Taylor's death, the FLO and a prison manager went to visit Mr Taylor's wife to inform her of his death. The FLO remained in regular contact with Mr Taylor's wife and continued to offer support.

45. Mr Taylor's funeral was held on 25 May. The prison contributed to the costs of the funeral in line with national policy.

Support for prisoners and staff

46. After Mr Taylor's death, a prison manager debriefed the staff and offered support. The staff care team also offered support.

47. 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.

Cause of death

48. HM Coroner for Greater Norfolk district gave the cause of death as heart disease caused by coronary alveosclerosis (hardening of the arteries), with additional causes of bilateral lower lobe bronchopneumonia (lung infection) and metastatic prostate cancer.

Findings

The clinical care

49. Mr Taylor had a blood test in November 2016, but, although his results were abnormal, but healthcare staff at Bure did not investigate them or take any action until 21 January 2017. Healthcare staff should have investigated Mr Taylor's raised alkaline phosphatase levels to determine if they were due to liver disease or cancer in the bones.

50. On 9 January 2017, Mr Taylor complained to the prison GP about weight loss. The GP did not record his weight. Mr Taylor's medical records show his weight was recorded in 2012 and 2014 but was not recorded during his older person's health screen in January 2016. After Mr Taylor expressed concerns about his weight loss, staff should have regularly reviewed, monitored and recorded his weight.

51. Mr Taylor also asked to be tested for bowel cancer when he saw the GP on 9 January. The GP arranged for Mr Taylor to have a blood test that screened for prostate cancer. However, Mr Taylor did not have this blood test until 1 February, 23 days after it was requested, and the abnormal result was not reviewed for another five days. At this point the GP referred Mr Taylor urgently to a specialist.

52. The clinical reviewer concluded that, under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks, the GP should have referred Mr Taylor to a specialist urgently after the abnormal blood tests on 27 November 2016. The GP should also have ensured that the blood tests to screen for prostate cancer were conducted and reviewed quickly after he saw Mr Taylor on 9 January or referred Mr Taylor to a specialist urgently at this point. As it was, the blood tests were not carried out for three weeks and the GP did not review them for another five days.

53. When the hospital discharged Mr Taylor, he was prescribed an increased dose of morphine. The prison was unable to facilitate this request as the healthcare cover at Bure did not allow staff to administer Mr Taylor's medication every twelve hours. A prison doctor asked Mr Taylor if he wanted to transfer to hospital but he declined. Healthcare staff at Bure should have been aware that they were unable to provide the care Mr Taylor needed and informed prison managers so that alternative arrangements could be made.

54. We are concerned that healthcare staff at Bure did not investigate the reasons for Mr Taylor's abnormal blood test result in November 2016 and urgently refer him to a specialist; did not conduct and review blood tests quickly enough or refer Mr Taylor urgently to a specialist in January 2017; and did not provide appropriate pain relief after he was discharged from hospital in April 2017. The clinical reviewer has made a number of recommendations which we do not repeat in this report but which the Head of Healthcare will wish to address

55. We agree with the clinical reviewer that the care Mr Taylor received was not equivalent to which he could have expected to receive in the community. We make the following recommendations:

The Head of Healthcare at Bure should ensure that GPs follow relevant National Institute for Health and Clinical Excellence (NICE) guidelines for suspected cancer and refer patients appropriately.

The Head of Healthcare should review how the needs of prisoners with a diagnosis of life threatening conditions (such as cancer) are met to ensure they have appropriate access to pain relief and other drugs, and appropriate medical and nursing care.

Restraints

56. 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.

57. Mr Taylor went to hospital for radiotherapy in April. On each occasion, he was restrained using an escort chain, despite his poor health and restricted mobility. On 23 April, Mr Taylor went to hospital as an emergency. Healthcare did not complete any medical information in the escort risk assessment, which should have contained information about the circumstances in which restraints should not be applied. Although this was an emergency escort situation, healthcare should have provided a view about the impact Mr Taylor's condition had on risk. A prison manager authorised the use of restraints and recorded that an escort chain should be used even though Mr Taylor was in pain and unstable on his feet. It is hard to see the legal requirements justifying restraint were met. We note that four hours after arriving at hospital, the Head of Offender Management recorded that Mr Taylor was terminally ill and appropriately authorised the removal of restraints.

58. We are concerned that we have made recommendations in three previous investigations to Bure about the use of restraints on severely ill and infirm prisoners. We are not satisfied that the risk assessment properly took into account how Mr Taylor's health and impaired mobility affected his already low risk of escape. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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.

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