Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Joseph Taylor, a prisoner at HMP North Sea Camp, on 19 January 2021

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*

Summary

1. 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.

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

3. Mr Joseph Taylor died in Pilgrim Hospital, Boston on 19 January 2021 of congestive cardiac failure while a prisoner at HMP North Sea Camp. Mr Taylor was 79 years old. I offer my condolences to Mr Taylor's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Taylor received at North Sea Camp was equivalent to that which he could have expected to receive in the community.

5. She made two recommendations: one about the unexplained month-long delay in Mr Taylor receiving mental health support in December 2020, and one about healthcare staff's failure to use clinical assessment tools when Mr Taylor's health began to deteriorate on 15 January 2021. The clinical reviewer said the latter may have been a missed opportunity to accurately gauge any deterioration in his condition, although as he died only four days later, it is not clear if the outcome would have been different if the assessment had been completed.

6. We found no non-clinical issues of concern.

Recommendations

- The Head of Healthcare should review the delay in Mr Taylor receiving intervention from the mental health services from the time of his referral in December 2020, until he was first reviewed over one month later.

- The Head of Healthcare should ensure that the clinical assessment tools are used for prisoners who are experiencing a worsening of their condition in order to accurately monitor and report any deterioration in a timely manner.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Taylor's clinical care at HMP North Sea Camp.

8. A PPO investigator has investigated non-clinical issues, including Mr Taylor's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. We informed HM Coroner for Lincolnshire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

10. The PPO family liaison officer wrote to Mr Taylor's next of kin, his nephew, to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He did not respond to our letter.

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

Previous deaths at HMP North Sea Camp

12. Mr Taylor was the sixth prisoner to die at North Sea Camp since January 2019. The previous five deaths were all from natural causes. Since Mr Taylor's death, there has been one death from natural causes. There are no similarities with our findings in this investigation.

Key Events

13. Mr Joseph Taylor was serving a life sentence and had been at HMP North Sea Camp since 5 January 2018.

14. Mr Taylor had several complex, long term medical conditions. He had coronary heart disease, lung disease, high blood pressure, asthma, obesity, and hearing and visual problems. He was also in remission for brain cancer. He was a smoker who declined assistance to stop.

15. Mr Taylor saw healthcare staff frequently and they created care plans for his conditions. His coronary heart disease care plan covered his risks factors including diet, smoking, body mass index (BMI) and medication. Healthcare staff arranged annual hospital reviews to ensure his brain cancer had not reoccurred.

16. Between January 2019 and May 2019 Mr Taylor had dizzy spells. Healthcare staff arranged for a series of tests to be taken. Scans and urine tests showed abnormal results. Two prison GPs reviewed the results and referred Mr Taylor to hospital urology specialists under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. Hospital specialists diagnosed Mr Taylor with a urine infection.

17. On 3 October 2019, Mr Taylor had a cardiology review at Pilgrim Hospital, as he had shortness of breath, high blood pressure and an irregular heartbeat. Hospital staff advised him to stop smoking and referred him for an echocardiogram (an ultrasound of the heart). The results showed impaired heart function and a narrowed heart valve. Mr Taylor said that he did not want any invasive treatment.

18. Mr Taylor had several episodes when he complained about shortness of breath. Hospital staff diagnosed chronic obstructive pulmonary disease (COPD - a lung disease), congestive cardiac failure (CCF) and aortic stenosis (narrowing of the aortic valve). Mr Taylor signed a disclaimer confirming that he did not want any surgery.

19. While in hospital, Mr Taylor signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order which meant that if his heart or breathing stopped no attempt at resuscitation would be made. On 23 November 2020, a prison GP discussed the DNACPR order with Mr Taylor to make sure he fully understood he would not be resuscitated with the order in place. Mr Taylor said that this was what he wanted.

20. On 4 December, Mr Taylor told a nurse that he felt low in mood and he wanted to go to hospital as he felt safer there. She completed a mental health and social care referral.

21. On 6 December, Mr Taylor complained of breathlessness. Healthcare staff arranged for his transfer to hospital. Hospital staff diagnosed Mr Taylor with a lower respiratory tract infection and acute renal failure. He had a COVID-19 test which was negative, despite one of the officers who had escorted him testing positive. On return to North Sea Camp, he was placed in isolation in line with the COVID-19 guidelines for prisons.

22. Mr Taylor had a mental health check on 7 January 2021. He said that he had felt low in mood but felt a little better. Records showed he had three mental health/wellbeing checks in January and each time he seemed happier in mood.

23. On 15 January, prison staff reported to healthcare staff that Mr Taylor had not been taking his medication and appeared to be deteriorating. Healthcare staff noted that staff needed to visit him twice a day to ensure he took his medication. No-one completed a review of his clinical observations.

24. On 17 January, Mr Taylor vomited. Prison staff noted he appeared very unwell and contacted NHS 111 for advice. Following the advice, prison staff arranged an ambulance to take Mr Taylor to hospital.

25. On 17 January, while still in hospital, the Governor granted Mr Taylor release on temporary licence (ROTL). He was accompanied by one member of staff.

26. On 19 January, at 9.35am Mr Taylor died at Pilgrim Hospital.

Post-mortem report

27. The post-mortem found that Mr Taylor died from congestive cardiac failure caused by ischaemic heart disease and aortic stenosis (heart valve disease).

Sue McAllister, CB
Prisons and Probation Ombudsman **September 2021**

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