

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Phillip Isaac, a prisoner at HMP High Down, on 17 May 2021

A report by the Prisons and Probation Ombudsman



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

OGL

© Crown copyright, 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Phillip Isaac died at HMP High Down on 17 May 2021. His cause of death was massive gastrointestinal haemorrhage (internal bleeding), caused by aortic oesophageal fistula (an abnormal connection between an artery and the food pipe) due to lung cancer. Mr Isaac was 56 years old. I offer my condolences to Mr Isaac's family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Isaac received at High Down was equivalent to that which he could have expected to receive in the community. The clinical reviewer made several recommendations to the Head of Healthcare regarding matters not directly affecting Mr Isaac's death. She was also concerned that Mr Isaac had not had the opportunity to discuss his wishes relating to his death. We share this concern.

Recommendation

- **The Head of Healthcare should consider the 'Dying Well in Custody Charter' and ensure that all prisoners with a terminal diagnosis explore advanced decision planning with the healthcare team.**

The Investigation Process

5. NHS England and NHS Improvement (NHSE&I) commissioned an independent clinical reviewer to review Mr Isaac's clinical care at HMP High Down.
6. The PPO investigator has investigated non-clinical issues, including Mr Isaac's location, the security arrangements for his hospital escort/s, liaison with his family and whether compassionate release was considered.
7. The PPO family liaison officer wrote to Mr Isaac's next of kin, his partner, to explain the investigation. She did not have any specific questions for us to consider.
8. Mr Isaac's partner received a copy of the draft report. She did not make any comments.
9. We shared the initial report with the Prison Service. There were no factual inaccuracies, and the action plan has been appended to this report.

Previous deaths at HMP High Down

10. Seven prisoners died at HMP High Down in the two years before Mr Isaac's death. Four of the previous deaths were from natural causes and three were self-inflicted. There are no significant similarities between our findings in the investigation into Mr Isaac's death and our investigation findings for the previous deaths.

Key Events

11. On 19 July 2019, Mr Phillip Isaac was remanded in custody for drug offences. He was sent to HMP High Down and later sentenced to eight years in prison.
12. On 2 November 2020, a prison GP saw Mr Isaac because he was complaining of hoarseness of his voice, headaches, and coughing. The GP recorded that cancer needed to be ruled out and made a fast-track cancer referral under the two-week rule.
13. On 17 November, Mr Isaac attended a local Ear, Nose and Throat (ENT) clinic. He was diagnosed with tinnitus.
14. On 2 December, a Healthcare Assistant (HCA) saw Mr Isaac when he came to the medication hatch. Mr Isaac told her that his voice had changed dramatically and that he had 2 lumps under his jawline. She sent an urgent message to the GP to make him aware.
15. A prison GP saw Mr Isaac that morning and examined him. He requested a second two-week cancer referral, which he sent that day.
16. On 15 December, Mr Isaac attended the local Ear, Nose and Throat (ENT) clinic with an associate specialist in ENT. The specialist recorded that Mr Isaac's left vocal cord was damaged and that he needed a CT scan and blood tests.
17. On 30 December, Mr Isaac attended a CT scan. The scan showed soft tissue masses and abnormal lymph nodes which the associate specialist suggested might be a type of cancer. The specialist asked for an urgent gastroenterology referral.
18. On 14 January 2021, Mr Isaac attended a hospital appointment for a camera to look inside his food pipe and for tests to be taken of his body tissue (biopsies).
19. On 25 January, a multi-disciplinary meeting was held at the hospital which determined that it was likely that Mr Isaac had primary lung cancer. A letter was sent to High Down to tell them.
20. On 30 January, a prison GP saw Mr Isaac and told him that he had lung cancer. Over the following two months, Mr Isaac attended hospital for various tests. On 21 March, a prison GP discussed Mr Isaac's prognosis with him.

9 April

21. At 2.10am on 9 April, Mr Isaac complained of chest pains and feeling breathless. A nurse radioed a medical emergency code blue. A code blue triggers the control room to call an emergency ambulance.
22. Ambulance paramedics attended and took Mr Isaac to hospital due to his worsening pain and recent cancer diagnosis. At the hospital, it was found that he had a clot on his lungs and that the cancer had spread to his oesophagus. Mr Isaac remained in hospital to receive cancer treatment and High Down released Mr Isaac on temporary licence (ROTL) that day. High Down granted the ROTL until 23 April.

23. Later that afternoon, the Deputy Governor appointed an operational manager as the family liaison officer (FLO). The FLO contacted Mr Isaac's next of kin, his partner, to introduce herself as the FLO and inform her of his condition.
24. On the same day, an application for Mr Isaac's early release on compassionate grounds was submitted to the Public Protection Casework Section (PPCS) of Her Majesty's Prison and Probation Service (HMPPS). The application included a statement from a prison GP, who said that Mr Isaac was rapidly terminal in prognosis and that he believed Mr Isaac had a limited lifespan.
25. On 16 April, High Down granted another ROTL, which allowed Mr Isaac to return home to his family, and to attend treatment at hospital appointments.
26. On 17 April, the FLO visited Mr Isaac at home to take his property and to go through his temporary licence with him. She spent an hour at his home talking to him and his family.
27. On 19 April, Mr Isaac attended the hospital to make a palliative treatment plan. This involved four cycles of chemotherapy and then maintenance therapy for up to two years.
28. On 4 May, the treatment plan was changed to oral immunotherapy (the use of medicines to boost the patient's immune system and destroy cancer cells) and chemotherapy was put on hold.
29. On 6 May, a consultant oncologist wrote that he did not support Mr Isaac's compassionate release application. He said that Mr Isaac's cancer was incurable but explained that Mr Isaac was undergoing immunotherapy treatment. He also wrote that average survival can be measured in short years and that a more accurate assessment of prognosis would be clearer in the next 3 months. He also wrote that he did not believe Mr Isaac's health condition would prevent offending.
30. Later that day, High Down recalled Mr Isaac from ROTL due to the consultant oncologist's opinion of longer life expectancy. The FLO and the Head of Offender Management went to Mr Isaac's home and accompanied him back.
31. On 7 May, Mr Isaac moved onto the healthcare unit, where observations were carried out on an hourly basis.

17 May onwards

32. At 9.07pm, a nurse was completing the hourly observations and medication round. He saw Mr Isaac on the floor of his cell with blood around him. He called a medical emergency code red over the radio. (A code red indicates a person is bleeding and triggers the control room to request an ambulance.) Several prison officers and healthcare staff attended the scene to support the emergency response.
33. An officer unlocked Mr Isaac's cell and a code blue was called at 9.09pm as Mr Isaac was unresponsive. The officer began cardiopulmonary resuscitation (CPR). Prison officers continued rotations of chest compressions for CPR whilst healthcare staff managed his airways and administered medication.

34. At 9.27pm, ambulance paramedics arrived on scene and healthcare staff began a handover. Paramedics noted that the scene was chaotic, the handover was poor, and they were unable to gain a history of events. A second ambulance arrived at the prison shortly after, followed by the Helicopter Emergency Medical Service (HEMS).
35. At 9.47pm, ambulance paramedics declared that Mr Isaac had died.
36. At 10.25pm, the FLO made contact with Mr Isaac's partner by telephone to inform her of his death.
37. On 18 May, the FLO and the Head of Offender Management visited Mr Isaac's partner at her home to offer condolences and support.

Post-mortem report

38. A post-mortem examination established that Mr Isaac died from massive gastrointestinal haemorrhage, caused by aortic oesophageal fistula due to lung cancer.

Clinical Findings

Mr Isaac's clinical care

39. The clinical reviewer found that the clinical care that Mr Isaac received at High Down was equivalent to that which would be expected in the wider community. She was satisfied that the access to a range of clinical specialities and often complex diagnostic tests requested within the two-week wait target were all achieved within the target time.
40. The clinical reviewer made six recommendations to High Down which did not directly relate to Mr Isaac's death, but which the Head of Healthcare will need to address.
41. The clinical reviewer also found that High Down had not completed advanced care planning with Mr Isaac which would have informed staff of his wishes in the event of his death. If it was the case that Mr Isaac had not wished to be resuscitated if his heart or breathing stopped, then he could have signed an order to this effect. This could have prevented the traumatic emergency response for the staff involved, and the need for the attendance of ambulance and helicopter paramedics. We make the following recommendation:

The Head of Healthcare should consider the 'Dying Well in Custody Charter' and ensure that all prisoners with a terminal diagnosis explore advanced decision planning with the healthcare team.

Mark Judd

Acting Assistant Prisons and Probation Ombudsman

July 2022

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100