Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian McLaughlan, a prisoner at HMP Isle of Wight, on 27 March 2021

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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.

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

Mr Brian McLaughlan died in hospital from sepsis on 27 March 2021, while a prisoner at HMP Isle of Wight. He was 64 years old. I offer my condolences to Mr McLaughlan's family and friends.

Mr McLaughlan became unwell with chest pain and a cough at the end of December 2020. A prison GP diagnosed a chest infection but when Mr McLaughlan's condition did not improve, they referred him to hospital for tests. On 11 March 2021, hospital doctors diagnosed empyema (a condition where pockets of pus collect in the lung) and Mr McLaughlan was admitted to hospital. He died in hospital just over two weeks later.

I am satisfied that the standard of care Mr McLaughlan received at Isle of Wight was equivalent to that which he could have expected to receive in the community.

I make no 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.

Sue McAllister CB
Prisons and Probation Ombudsman **October 2021**

Contents

Summary

Events

1. On 13 February 2020, Mr Brian McLaughlan was sentenced to 12 years in prison for sexual offences. On 20 February, he was moved to HMP Isle of Wight.

2. On 31 December, a prison GP saw Mr McLaughlan because he complained of pain when breathing and he was coughing up blood. The GP diagnosed a chest infection and prescribed antibiotics.

3. Several weeks later, Mr McLaughlan told a nurse that he still had a cough, back and chest pain and a loss of appetite. The nurse referred Mr McLaughlan to a GP who referred him to the hospital for blood tests and a scan.

4. The scan showed that it was likely that Mr McLaughlan had lung cancer, so the GP made a further hospital referral using the two-week cancer pathway.

5. On 12 February, hospital doctors told the prison that Mr McLaughlan was more likely to have tuberculosis (a bacterial infection in the lungs) than lung cancer.

6. On 11 March, Mr McLaughlan was taken to hospital for an outpatient appointment. At that appointment Mr McLaughlan was told that he had empyema (a condition where pockets of pus collect in the lung). He was admitted to hospital where he was given antibiotics and a chest drain was inserted to remove the collection of pus in his lung.

7. Over the next two weeks Mr McLaughlan's health deteriorated and on 27 March he died.

8. A post-mortem examination found that Mr McLaughlan died from sepsis caused by cavitating lesion of the lung (abnormal growth in the lung).

Findings

9. The clinical reviewer found that the standard of care Mr McLaughlan received at Isle of Wight was equivalent to that he could have expected to receive in the community.

10. We did not find any non-clinical issues of concern. We make no recommendations.

The Investigation Process

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

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

13. NHS England commissioned an independent clinical reviewer to review Mr McLaughlan's clinical care at the prison.

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

15. One of the Ombudsman's family liaison officers contacted Mr McLaughlan's partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.

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

Background Information

HMP Isle of Wight

17. HMP Isle of Wight is an amalgamation of two former prisons, Parkhurst and Albany, and holds approximately 1,100 men, mainly convicted of sex offences. Practice Plus Group provides healthcare services at the prison. There is an inpatient healthcare unit (IHU) at the former Albany site, providing 24-hour care for prisoners. There are two palliative care suites on the IHU to accommodate end of life prisoners. The prison is opposite the island's hospital.

HM Inspectorate of Prisons

18. The most recent full inspection of HMP Isle of Wight was in April and May 2019. Inspectors reported that healthcare was very good at the prison, and that healthcare was delivered by a conscientious team who knew their patients well. They said there was good oversight of the implementation of healthcare recommendations from deaths in custody reports and evidence of learning from serious incidents. The inspectors reported that in-possession medication risk assessments were completed and reviewed, and spot checks of in-possession medication took place according to the policy. They also said relationships between prison staff and prisoners were good.

19. The report noted that 40% of the prison population were over 50 years old and that a significant proportion were elderly.

Independent Monitoring Board

20. 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 31 December 2020, the IMB found that the health provision had been excellent. They noted that prisoner representatives spoke positively about the role of healthcare.

Previous deaths at HMP Isle of Wight

21. Mr McLaughlan was the 17th prisoner at Isle of Wight to die since March 2019. Of the previous deaths, 11 were from natural causes and five were self-inflicted.

Key Events

22. On 13 February 2020, Mr Brian McLaughlan was sentenced to 12 years in prison for sexual offences. On 20 February, he was moved to HMP Isle of Wight.

23. Mr McLaughlan had several long-term health issues including chronic obstructive pulmonary disease (COPD - the term for a group of serious lung diseases), high cholesterol and osteoarthritis. He was prescribed regular medication for these conditions.

24. Throughout 2020, Mr McLaughlan remained reasonably well and had limited contact with healthcare staff.

25. On 31 December, Mr McLaughlan said that he was having pain when breathing and that he was coughing up blood. A prison GP saw Mr McLaughlan and diagnosed a chest infection and prescribed antibiotics.

26. On 14 January 2021, a prison GP saw Mr McLaughlan and noted that he still had a cough. Mr McLaughlan said he had not been taking his antibiotics because of the potential side effects. The GP prescribed different antibiotics and Mr McLaughlan agreed that he would take them.

27. On 27 January, a nurse saw Mr McLaughlan. She was concerned that he still had a cough, back and chest pain and a loss of appetite. The nurse made a referral to the GP. The GP referred Mr McLaughlan to the hospital for an X-ray and blood tests.

28. On 29 January, Mr McLaughlan was taken to hospital for a chest X-ray and a CT scan. The same day, a prison GP saw Mr McLaughlan and told him that his symptoms and the X-ray report showed it was likely that he had lung cancer. The GP made a referral to the hospital for further tests using the suspected cancer pathway (for an appointment in two weeks).

29. On 11 February, an appointment was made for Mr McLaughlan to go to hospital for an urgent scan. However, Mr McLaughlan refused to go as he said that he had constipation and stomach problems.

30. On 12 February, the prison received a letter from the hospital consultant that said after reviewing Mr McLaughlan's CT scan, it seemed more likely that he had tuberculosis (a bacterial infection that affects the lungs) and not lung cancer.

31. Mr McLaughlan was admitted to the prison healthcare unit to avoid the possibility of spreading tuberculosis to other prisoners.

32. On 2 March, Mr McLaughlan was taken to hospital for a bronchoscopy (examination of the inside of the lungs). On 5 March, Mr McLaughlan told a nurse that he felt unwell, she noted that he had a high temperature. A prison GP prescribed Mr McLaughlan with antibiotics and told him that he needed to go straight to hospital. Mr McLaughlan refused and signed a disclaimer to that effect.

33. On 11 March, Mr McLaughlan was taken to hospital for an outpatient appointment, where he was told that he had empyema (a condition where pockets of pus collect

in the lung). He was admitted to hospital where he was given intravenous antibiotics and a chest drain was inserted to drain the pus.

34. Over the next two weeks Mr McLaughlan's health deteriorated. On 26 March, he was admitted to the intensive care unit where he died the following day.

Contact with Mr McLaughlan's family

35. On 15 March, the prison appointed a family liaison officer (FLO). The FLO contacted Mr McLaughlan's next of kin, his partner, to tell her that he was in hospital. As Mr McLaughlan's partner was at the hospital when he died, the FLO waited to contact her until the following day.

36. The prison contributed to Mr McLaughlan's funeral in line with national guidelines.

Support for prisoners and staff

37. After Mr McLaughlan's death, a member of the care team contacted the staff that were on the bed watch to ensure they had the opportunity to discuss any issues arising, and to offer support.

38. The prison posted notices informing other prisoners of Mr McLaughlan's death.

Post-mortem report

39. A post-mortem examination found that Mr McLaughlan died from sepsis caused by cavitating lesion of the lung. COPD was listed as a contributory factor.

Findings

Clinical Care

40. When Mr McLaughlan became unwell at the end of December 2020, a prison GP appropriately prescribed him antibiotics for a chest infection. When Mr McLaughlan's cough did not improve, the GP referred him to the hospital for a scan and blood tests. The results showed that Mr McLaughlan may have cancer so he was referred to the hospital using the suspected cancer pathway (for an appointment in two weeks). We are satisfied that the prison did everything they could to support Mr McLaughlan when he became unwell.

41. The clinical reviewer concluded that the clinical care Mr McLaughlan received at the Isle of Wight was equivalent to that which he could have expected to receive in the community. We make no recommendations.

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