Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Taylor, a prisoner at HMP Kirkham, on 23 August 2023

A report by the Prisons and Probation Ombudsman

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

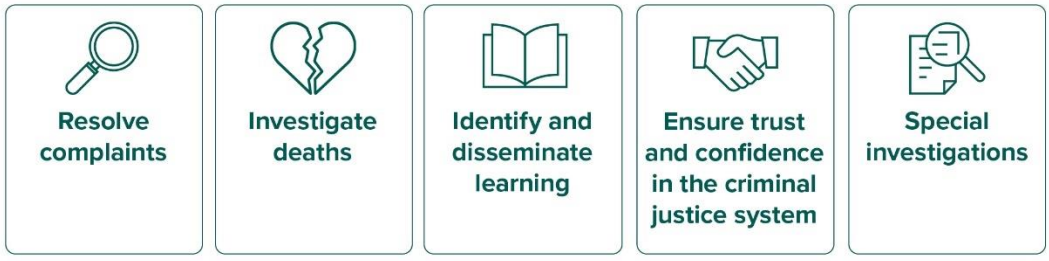
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Ian Taylor died in hospital of acute left ventricular failure (heart failure) on 23 August 2023, while a prisoner at HMP Kirkham. He was 54 years old. I offer my condolences to Mr Taylor's family and friends.

The clinical reviewer concluded that the care Mr Taylor received at Kirkham was of a good standard and equivalent to what 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.

Adrian Usher
Prisons and Probation Ombudsman **December 2024**

Contents

Summary

Events

1. On 5 November 2021, Mr Ian Taylor was convicted of drug offences and sentenced to 63 months in prison. He was sent to HMP Durham.

2. On 8 June 2023, Mr Taylor was transferred to HMP Kirkham.

3. Mr Taylor had a significant medical history. He was supported by the long-term conditions clinic and was prescribed appropriate medication to manage his conditions.

4. At 10.45am on 23 August, some prisoners found Mr Taylor unresponsive in his cell. They alerted staff and an officer radioed a medical emergency code.

5. Prison staff and healthcare staff attended and started CPR. Control room staff called the emergency services.

6. At 11.46am, paramedics arrived at the prison and took over Mr Taylor's care. At 12.56pm, Mr Taylor was taken to hospital where he died shortly after his arrival.

Findings

7. The clinical reviewer concluded that the care Mr Taylor received at Kirkham was of a good standard and equivalent to what he could have expected to receive in the community.

8. She found that Mr Taylor was appropriately reviewed by the long-term condition's clinic for his underlying health conditions, and he was promptly referred to specialist services.

The Investigation Process

9. HMPPS notified us of Mr Taylor's death on 23 August 2023.

10. The investigator issued notices to staff and prisoners at Kirkham informing them of the investigation and asking anyone with relevant information to contact her. Six prisoners responded and provided written statements.

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

12. The investigator interviewed three members of staff at Kirkham on 12 October 2023.

13. NHS England commissioned a clinical reviewer to review Mr Taylor's clinical care at the prison. She conducted joint interviews with the investigator on the 12 October 2023.

14. We informed HM Coroner for Blackpool 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. The Ombudsman's office contacted Mr Taylor's wife to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Taylor's wife was concerned about the quality of care Mr Taylor received in prison. Her concerns have been addressed in the clinical review.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies, and this report has been amended accordingly.

17. Mr Taylor's family received a copy of the initial report. They did not make any comments.

Background Information

HMP Kirkham

18. HMP Kirkham is a category D (open) prison holding male prisoners. It is managed by HMPPS. Spectrum community health provide health and social care services.

HM Inspectorate of Prisons

19. The most recent inspection of Kirkham was in June and July 2018. Inspectors reported that the prison continued to be an effective open prison. Health services and governance were mostly good, as was health promotion. There was good identification of complex conditions, and nurses with specialist training provided clinics for most conditions.

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 December 2021, the IMB reported that prisoners were treated fairly and humanely. The good links and working relationships between all departments meant that the health and wellbeing of the prisoners had been a priority.

Previous deaths at HMP Kirkham

21. Mr Taylor was the first prisoner to die at Kirkham since August 2020.

Key Events

22. On 5 November 2021, Mr Ian Taylor was convicted of drug offences and sentenced to 63 months in prison. He was 52 years old. Mr Taylor was sent to HMP Durham.

23. Mr Taylor had ongoing health issues, including asthma, chronic obstructive pulmonary disease (COPD), obesity, hypertension, type two diabetes, fluid retention, cellulitis (infection of the skin) and attention deficit hyperactivity disorder (ADHD). He was prescribed appropriate medication to manage these conditions and was managed by the long-term condition's clinic.

24. On 8 June 2023, Mr Taylor was transferred to Kirkham.

25. A nurse completed Mr Taylor's initial health screen. She noted that Mr Taylor had a history of illicit drug use, anxiety, depression, and panic attacks. Mr Taylor said that he had not used any illicit drugs in prison and had stopped taking his medication for anxiety and depression. Mr Taylor agreed to engage with the drug and alcohol recovery team. She referred Mr Taylor to the long-term condition's clinic for monitoring and oversight of his underlying health needs and she created a care plan for his diabetes. He was reviewed regularly.

26. On 16 June, a nurse saw Mr Taylor and completed a QRISK2 cardiovascular 10-year risk score (a tool used to calculate the likelihood of a person having a stroke or heart attack within 10 years). Mr Taylor scored 25.41% (a score over 10% would warrant some intervention and support).

27. On 6 July, the nurse saw Mr Taylor again to discuss his QRISK2 score. Mr Taylor was offered and refused statin medication to reduce the risk of illness and developing cardiovascular disease.

28. On 3 August, Mr Taylor was referred to the specialist weight management service at the hospital. He was given an initial appointment for 19 September 2023.

29. On 16 August, a nurse saw Mr Taylor to review his legs as he had oedema (fluid retention). Healthcare suspected that he had lymphoedema (long-term condition that causes swelling in tissues) which is secondary to heart failure or other circulatory diseases.

30. On 17 August, a GP at the prison saw Mr Taylor as his lymphoedema symptoms were still present. Mr Taylor had normal heart sounds, clear lung fluids and no abnormal lung sounds. The GP requested blood tests to determine whether Mr Taylor had heart failure. The GP noted that he wanted to review the results of the blood tests, but this was not completed prior to Mr Taylor's death. Mr Taylor was referred to the lymphoedema service the day before he died.

Events of 23 August 2023

31. In his written statement of 25 August 2023, a prisoner said that he went to Mr Taylor's door at approximately 8.50am, and he saw Mr Taylor sitting in his chair, snoring. He left the cell and went back at 10.00am. He knocked on Mr Taylor's door, but Mr Taylor was still sitting in his chair asleep and snoring. When he went

back to his door at approximately 10.45am, he knocked again but got no response. He then approached two other prisoners and told them that he could not wake Mr Taylor up.

32. The prisoners went to Mr Taylor's cell and found that he was unresponsive. They noticed that Mr Taylor was shaking, his head was tilted to one side and dribble was coming from his mouth. The prisoners tried waking Mr Taylor by kicking his door, and they went outside and shouted to him through his cell window, but he did not respond. The prisoners pressed Mr Taylor's emergency cell bell to alert staff and two of them left his cell to find staff. At approximately 11.15am, the two prisoners approached an officer and told her that Mr Taylor was unresponsive and not breathing. The officer radioed a medical emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties).

33. Prison staff arrived at the cell and asked the prisoners to go back to their own cells.

34. A nurse arrived at the cell and radioed for urgent assistance from healthcare. Another nurse responded and, when he entered Mr Taylor's cell, he noticed a quantity of illicit substances in his cell. He alerted prison staff and informed the paramedics. The drugs were placed in an evidence bag and given to the police.

35. Mr Taylor was not breathing correctly, and there was limited space in his cell, so four prison officers moved Mr Taylor from the chair to the floor outside of his cell so there was more room to treat him.

36. At 11.41am, prison staff and healthcare staff commenced CPR. At 11.43am, staff attached a defibrillator which advised no shockable rhythm. Staff continued with CPR.

37. At 11.46am, the first response paramedic arrived and examined Mr Taylor while prison and healthcare staff continued with CPR.

38. At 12.17am, more paramedics arrived and at 12.56pm, Mr Taylor was taken to hospital by emergency ambulance. Two officers escorted him, and he was not restrained. The allocated family liaison officer (FLO) also accompanied Mr Taylor to the hospital due to his condition.

39. At 1.30pm, the FLO called the prison to inform them that Mr Taylor had died.

Events following Mr Taylor's death

40. Lancashire police took the illicit drugs found in Mr Taylor's cell as evidence and conducted an investigation. The police concluded that the drugs found in Mr Taylor's cell were class B and class C drugs, which were consistent with quantities for personal use. They noted that Mr Taylor's cause of death was of natural causes, and not drug related.

Contact with Mr Taylor's family

41. While Mr Taylor was being escorted to hospital, a senior manager informed Mr Taylor's wife that he was on his way to the hospital and made arrangements to take

her there. Unfortunately, Mr Taylor died before his wife arrived. The FLO offered her condolences to Mr Taylor's wife and provided on-going support.

42. The prison contributed to the funeral costs in line with prison policy.

Support for prisoners and staff

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

44. 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

45. The post-mortem report gave Mr Taylor's cause of death as acute left ventricular failure (where the heart fails to deliver sufficient blood to vital organs). Hypertensive heart disease (caused by unmanaged high blood pressure) and steatohepatitis (a type of fatty liver disease) were contributing factors but did not cause his death.

46. The toxicology report showed Mr Taylor had low levels of buprenorphine and pregabalin in his system at the time of his death. Mr Taylor was not prescribed these medications at Kirkham.

47. At the inquest held on 6 December 2024, the coroner concluded Mr Taylor died of natural causes.

Findings

Clinical care

48. The clinical reviewer concluded that the care Mr Taylor received at Kirkham was of a good standard and was equivalent to what he could have expected to receive in the community.

49. She found that Mr Taylor was appropriately reviewed in the long-term condition's clinic for his underlying health conditions, and he was promptly referred to specialist services when required. Mr Taylor was made aware of how to access healthcare if he needed support, and he attended all his appointments with healthcare.

50. The clinical reviewer said that the emergency response on 23 August 2023, was timely and well documented in Mr Taylor's medical records.

51. We make no recommendations.

Good practice

52. Prison and healthcare staff demonstrated care and compassion during the emergency response. Nurses ensured they continued to speak to Mr Taylor throughout, so he heard their voices, and they held his hand until he was taken to hospital.

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 l 020 7633 4100