Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Taylor, a prisoner at HMP Littlehey on 20 June 2016

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*

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 Michael Taylor died on 20 June 2016, from heart disease, while a prisoner at HMP Littlehey. He was 76 years old. I offer my condolences to Mr Taylor's family and friends.

I consider that Mr Taylor received a good standard of care at Littlehey. However, I am concerned that healthcare staff did not discuss with him his wishes on resuscitation.

While it is unlikely to have affected the outcome for Mr Taylor, I am concerned that the officer who found him unconscious in his cell, did not immediately radio a medical emergency code.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2016**

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Summary

Events

1. On 22 May 1998, Mr Michael Taylor was sentenced to life imprisonment for sexual offences. He had been at HMP Littlehey since 13 February 2014. Mr Taylor had a number of serious and chronic medical conditions, including heart failure, lung disease, asthma, anaemia and high blood pressure. He had suffered three previous heart attacks. Mr Taylor smoked but repeatedly declined offers to help him to stop.

2. Healthcare staff monitored Mr Taylor's medical conditions and referred him to appropriate specialists. On 19 May, tests showed a build up of fluid in the cavity surrounding his lungs and a consultant referred him to a respiratory and chest specialist. Healthcare staff monitored him regularly thereafter. In December 2014, a consultant advised the prescription of anti coagulant medication (helps to prevent blood clots) and Mr Taylor began taking warfarin.

3. On 15 April 2015, a scan of Mr Taylor's chest showed changes consistent with cardiac disease. His consultant did not consider it necessary for further long term follow up of his condition. Prison healthcare staff continued to review him and monitor his condition. The results of blood tests in November 2015 were normal and his heartbeat, though irregular, was as expected.

4. On 20 April 2016, Mr Taylor experienced a loss of feeling in his left arm. He did not have chest pain and his vital signs were within the normal range. He had mild breathlessness but this improved with the use of an inhaler. A nurse examined him but did not consider further action necessary.

5. Mr Taylor had a planned review with a nurse in May when she described him as rather negative and difficult to engage with about ideas to improve his health. His vital signs were as expected and within the normal range.

6. On the morning of 20 June, an officer found Mr Taylor unresponsive when he unlocked his cell. The officer could not feel a pulse and he sent a prisoner to the wing office to get help. The control room called an ambulance. Other officers and healthcare staff attended. They began chest compressions and used a defibrillator. Paramedics arrived approximately 20 minutes later.

7. At 8.52am, a paramedic confirmed that Mr Taylor had died. A post-mortem examination found the cause of death was ischaemic heart disease (a disease of the blood vessels supplying the heart muscles with oxygen).

Findings

8. The clinical reviewer considered that the care Mr Taylor received at Littlehey was equivalent to that which he could have expected to receive in the community. We are satisfied that Mr Taylor received good care at the prison.

9. However, we are concerned that despite telling healthcare staff on his arrival at Littlehey that he had previously agreed with his solicitor that he did not want to be resuscitated if his heart or breathing stopped, there was no record of them

discussing this with him again. As a result, prison and healthcare staff attempted to resuscitate him on 20 June, though this may have been against his wishes.

10. Although the delay was only minimal, we are concerned that the officer who discovered Mr Taylor unresponsive on the morning he died, did not radio an emergency medical code immediately.

Recommendations

- The Head of Healthcare should ensure when a patient makes a statement about their resuscitation wishes, that conversations about resuscitation take place as appropriate, that they are recorded and that the patient's wishes are respected.
- The Governor should ensure that prison staff understand the importance of calling a medical emergency code to make sure healthcare staff attend with the appropriate medical equipment and there is no delay in calling an ambulance in a life-threatening situation.

The Investigation Process

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

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

13. The investigator interviewed three members of staff at Littlehey on 22 July 2016. He also spoke to two other members of staff and one prisoner to obtain background information on Mr Taylor's time in prison.

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

15. We informed HM Coroner for Cambridge and Peterborough District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Taylor's friend, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not raise any issues.

17. We discussed the report with Mr Taylor's friend. She did not wish to receive a copy but indicated that she was satisfied with the findings.

18. We shared the initial report with the Prison Service. There were no factual inaccuracies and their action plan has been appended to this report.

Background Information

HMP Littlehey

19. HMP Littlehey in Cambridge is a medium security prison holding approximately 1,200 men. A large proportion of the population are convicted of sexual offences.

20. Northamptonshire Health Care Foundation NHS Trust commissions healthcare services. Prior to April 2015, Cambridgeshire and Peterborough NHS Trust provided healthcare services. The prison healthcare centre is open from 7.30am to 5.00pm, Monday to Friday, and from 8.00am to 12.30pm at weekends. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Littlehey was in March 2015. Inspectors noted that an experienced nurse manager and two senior nurses provided effective clinical leadership. Despite chronic problems in recruiting nursing staff, health services had not been affected as regular highly skilled agency staff filled any shortfalls. A small group of regular GPs had significantly improved patient care. Prisoners with lifelong conditions were identified effectively and nurses with additional specialist training provided relevant clinics. There was excellent and compassionate joint working between the health provider, prison and community services for prisoners with palliative care and end-of-life needs.

Independent Monitoring Board

22. 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 January 2016, the IMB reported that the transfer to a new healthcare provider in April 2015 went smoothly with no adverse impact on service delivery.

23. The Board recognised the significant demands the elderly prison population made upon healthcare services, in particular the increasing number of hospital escorts, subsequent stays and the resulting risks associated with the redeployment of staff. They also expressed concern about future funding.

Previous deaths at HMP Littlehey

24. Mr Taylor was the eleventh person to die from natural causes since January 2015. One person has died since. There were no significant similarities with the circumstances of the previous recent deaths.

Key Events

25. On 22 May 1998, Mr Michael Taylor was sentenced to life imprisonment with a minimum time to serve of eight years. He spent time at other prisons and, on 13 February 2014, Mr Taylor transferred to HMP Littlehey, where he lived in a single cell on a wing for older prisoners.

26. At his initial health assessment at Littlehey, Mr Taylor told a nurse he had high blood pressure and had suffered three heart attacks in the last three years. He took medication for chronic heart failure, asthma and high blood pressure but did not have this with him when he arrived at Littlehey. Healthcare staff ordered it for him from the pharmacy.

27. On 14 February, a prison GP examined Mr Taylor. He told her he walked with a stick and could only manage about 50 yards. He said he had chronic obstructive pulmonary disease (COPD – a collection of chronic lung diseases), anaemia and heart disease, though in 2012, he declined bypass surgery or to have a pacemaker fitted. He also said he suffered from memory loss. Though the doctor found no convincing evidence that he had COPD, she referred him for further assessment and for a dementia screening. Mr Taylor smoked cigarettes but declined offers to help him to stop. He also said that he had agreed with his solicitor that he did not want staff to resuscitate him if his heart or breathing stopped and the GP planned to talk to him about this at a later date. However, there was no record that the GP or any other healthcare staff spoke to Mr Taylor about this.

28. On 20 February, Mr Taylor had a spirometry (breathing) test to measure his lung function. The results showed only mild breathlessness, more likely due to cardiac problems than lung disease. Despite taking medication for anaemia, a blood test, on 28 February, confirmed an iron deficiency and Dr Bastable referred him to a consultant gastroenterologist. A nurse tested Mr Taylor for dementia on 27 March, but the results gave no cause for concern. Mr Taylor told the nurse he had mobility concerns and had spoken to the disability unit about the issue of a wheelchair. He had a prison carer to help him with his daily needs.

29. Mr Taylor went to hospital for a specialist gastroenterology examination, on 19 May. The consultant found little evidence of anaemia but arranged for a chest x-ray, CT scan (computerised tomography, a scan that uses x-rays and a computer to create detailed images) and further blood test. The x-ray showed a right sided pleural effusion and consolidation (a build up of fluid in the cavity surrounding the lungs), suggesting cardiac failure or a lung infection, and the consultant referred him to a respiratory and chest specialist at hospital. Mr Taylor had previously had fluid drained from his lungs.

30. On 16 September, Mr Taylor reported left sided weakness and tingling. A prison GP arranged for an electrocardiogram (ECG – which measures the electrical activity of the heart). Due to his general poor health, staff called an ambulance and Mr Taylor went to hospital, where doctors diagnosed a transient ischaemic attack (mini stroke) and treated him overnight. They discharged him back to Littlehey the next day.

31. On 29 September, the consultant chest physician at the hospital wrote to Mr Taylor and explained that his past medical notes and recent tests showed a significant heart condition. Test results also indicated the collection of fluid around his lungs was longstanding (over three years) but stable. The consultant considered the risk of further invasive surgery was significant and advised against it. They planned instead to see him in three to six months.

32. On 15 December, Mr Taylor missed an appointment at the chest clinic at hospital. The reasons are unclear but when asked later Mr Taylor told prison a GP he refused to go as staff insisted he wore prison uniform.

33. Regular communication between hospital specialists and prison healthcare staff continued and in a letter, dated 22 December, a consultant advised the prescription of anti coagulant medication (this helps to prevent blood clots), which they should discuss with Mr Taylor. A prison GP spoke to Mr Taylor on 7 January 2015, and he agreed to take warfarin (anti coagulant medication), which started two weeks later.

34. However, on 26 March, Mr Taylor told a prison GP he did not want to take warfarin any more because we has fed up with the need for regular blood tests (these are done to measure how long it takes the blood to clot to ensure that the dose is correct). The GP agreed to stop warfarin and instead prescribed rivaroxaban.

35. On 15 April, a consultant chest physician wrote to Mr Taylor to explain that a recent scan of his chest showed changes consistent with his cardiac disease. The consultant did not consider it necessary for further long term follow up of Mr Taylor's condition at that time.

36. A nurse reviewed Mr Taylor on 15 May. He said his health was deteriorating. They discussed exercise and she referred him for physiotherapy. The also discussed smoking but Mr Taylor said he did not want to stop.

37. A physiotherapist saw Mr Taylor on 6 August. He said his mobility had deteriorated with his cardiac condition. He noted Mr Taylor's lower limbs were emaciated with very little muscle bulk. He explained the benefits of physiotherapy but Mr Taylor showed little interest.

38. On 13 November, a nurse saw Mr Taylor to review his various conditions. His most recent blood tests were normal, his weight steady and his heartbeat, though irregular, was as expected. The nurse arranged for a follow up review in six months.

39. On 20 April at 7.24pm, a nurse examined Mr Taylor in his cell when he experienced a loss of feeling in his left arm. Mr Taylor said he did not have chest pain and his vital signs were within the normal range. He had mild breathlessness but this improved with the use of an inhaler. The sensation returned to Mr Taylor's arm and the nurse did not consider further action necessary. However, he asked the night duty prison staff to monitor him.

40. Mr Taylor had his planned six monthly review with a nurse on 27 May. She described him as rather negative and difficult to engage with about ideas to improve his health. His vital signs were as expected and within the normal range.

She repeated the benefits of stopping smoking but Mr Taylor confirmed he did not want to stop.

Events of 20 June 2016

41. On 20 June at about 6.50am, Officer A began the early morning role count. He remembered seeing Mr Taylor alive, sat on his chair, in his cell. He described seeing Mr Taylor sat slightly forward with his head tilted down and said that this was a common position for him to sit in.

42. Shortly after 8.00am, Officer B began unlocking cells on the wing. At about 8.02am, when he opened the door of Mr Taylor's cell, he saw Mr Taylor sat on his chair, in an unnatural position, with his head back and his mouth open. He went into the cell and spoke to Mr Taylor, who did not respond. He checked Mr Taylor's neck and wrist for a pulse but could not feel one.

43. Officer B told a prisoner, who had joined him in the cell, to go to the wing office to tell the officers there to call healthcare staff and an ambulance and to ask Officer A to come to Mr Taylor's cell. Officer B had a radio but did not use it to call a code blue, to signify a medical emergency. He came out of the cell and locked the door while he waited for assistance. He was not first aid trained.

44. The prisoner went to the wing office, a very short distance away, taking only a few seconds to get there. He relayed Officer B's message and an officer telephoned the control room, who immediately called for healthcare staff to attend the wing. At 8.05am, the control room called for an emergency ambulance. Officer A left the office and joined Officer B at the cell.

45. The officers went into the cell and lifted Mr Taylor from his chair onto his bed. Officer A began chest compressions. Officer B radioed a code blue but because Officer A did not hear the appropriate response on the radio he told Officer B to confirm that they had called an ambulance.

46. Officer B returned to the wing office. He was told that the control room staff had called an emergency ambulance and he collected a defibrillator. He returned to Mr Taylor's cell at about 8.09am, at the same time as two nurses arrived.

47. One nurse examined Mr Taylor. He showed no sign of life, had no pulse and was not breathing. At the nurses' request, the officers moved Mr Taylor from the bed to the floor outside the cell. They started to attach the defibrillator pads to his chest but, in their haste, a wire connecting one of the pads to the machine became detached. An officer went to get a replacement machine while the nurses continued chest compressions. The officer returned about a minute later and a nurse attached the new machine to Mr Taylor. They put an airway into his throat and gave him oxygen.

48. The nurses and prison staff took it in turns to give chest compressions. The defibrillator shocked Mr Taylor twice before paramedics arrived and took over at 8.24am. They continued in their attempts to revive Mr Taylor until 8.52am when a paramedic confirmed that he had died.

Contact with Mr Taylor's family

49. After Mr Taylor's death, the prison appointed an officer as the family liaison officer. Mr Taylor had no recorded next of kin and had not contacted his family since his conviction.

50. From his prison records, the officer found the details of two ladies, one of whom visited Mr Taylor regularly with her husband. She attended the address but there was no reply. At approximately 7.00pm that evening, she telephoned and spoke to the husband, who explained that Mr Taylor was a friend of his wife's father and that, together, they had visited him for a number of years.

51. The officer spoke to the lady the next morning. She could not give any details of Mr Taylor's family but confirmed that he had not been in contact with them since going to prison.

52. On 22 June, the officer received a telephone call from the second person named in the prison records, whom the first person had subsequently contacted. She explained that she and Mr Taylor had been friends since before he went to prison and that they corresponded regularly. She confirmed he had no contact with his family. She had a letter from Mr Taylor asking her to act as his next of kin and the prison treated her as such from that time.

53. Later, on 22 June, the officer contacted Mr Taylor's solicitor, who also confirmed that Mr Taylor had no contact with his family.

54. Mr Taylor's funeral was held on 13 July. The prison arranged and paid for it, in line with national instructions.

Support for prisoners and staff

55. After Mr Taylor's death, a prison 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.

56. 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. A prison manager spoke to a prisoner who was a close friend of Mr Taylor's to offer support.

Post-mortem report

57. The post-mortem report recorded that Mr Taylor died from ischaemic heart disease.

Findings

Clinical care

58. The clinical reviewer was satisfied that the care Mr Taylor received at Littlehey was equivalent to that which he could have expected in the community.

59. When he arrived at Littlehey, Mr Taylor was an elderly prisoner with a number of physical health problems, including lung and heart disease. He had contact with the prison healthcare team for both the management of his chronic conditions, in the form of regular reviews, and also for his other acute illnesses. This included members of the wider healthcare team, such as physiotherapists and the dentist, as well as referral to hospital and treatments as required.

60. Treatment and assessments were comprehensive and well managed, including attention to his mobility and his ability to cope with medication. Mr Taylor smoked cigarettes and, despite regular advice, had no desire to stop.

61. During his initial healthcare assessment, Mr Taylor said he had previously agreed with his solicitor that he did not want staff to resuscitate him if his heart or breathing stopped. A prison doctor planned to talk to him about this later but there was no record of anyone having done so. Every effort was made to save Mr Taylor when staff found him unresponsive on 20 June, but we are concerned that this may not have been what he wanted. We make the following recommendation:

    The Head of Healthcare should ensure, when a patient makes a statement about their resuscitation wishes, that conversations about resuscitation take place as appropriate, that they are recorded and that the patient's wishes are respected.

62. The clinical reviewer also noted that some clinical entries in the medical records were not as comprehensive as would be expected and he recommends that the healthcare provider undertakes a regular audit of the clinical notes to ensure that entries made by clinical staff meet the required standard. Though we do not repeat the recommendation, the Head of Healthcare will need to address this.

Emergency response

63. On 20 June, when Officer B discovered Mr Taylor unresponsive in his cell, he did not call a code blue immediately. Prison Service Instruction (PSI) 3/2013 'Medical Emergency Response Codes', contains a mandatory instruction that prison staff should use a code blue (or code one) for any emergency where a prisoner is unconscious. This should result in the control room calling an ambulance immediately, without waiting for further information, and healthcare staff attending straight away, with the correct equipment. Littlehey has an appropriate local protocol.

64. Instead, Officer B sent a prisoner to the wing office to alert other officers and to ask for an ambulance and healthcare staff. He explained that a code blue call attracts the attention of other prisoners, who invariably gather at the scene, and he sent the prisoner to the wing office to avoid this.

65. Though we understand Officer B's explanation and we agree with the clinical reviewer that the minimal delay in calling the code blue or starting cardiopulmonary resuscitation did not change the outcome for Mr Taylor, it is important that staff always use the correct procedure so that there is no delay in calling an ambulance or obtaining assistance from healthcare. We make the following recommendation:

The Governor should ensure that prison staff understand the importance of calling a medical emergency code to make sure healthcare staff attend with the appropriate medical equipment and there is no delay in calling an ambulance in a life-threatening situation.

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