Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Tyler a prisoner at HMP Thameside on 31 October 2016

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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.

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

Mr Christopher Tyler died on 31 October 2016 at HMP Thameside of an acute infection of the heart valves. He was 33 years old. We offer our condolences to his family and friends.

Overall, the care that Mr Tyler received at Thameside was not equivalent to that which he could have expected to receive in the community.

Healthcare staff failed to ask his community GP for his medical history, and therefore they did not know that he had heart problems.

Mr Tyler's cell bell was not working properly, and this caused a delay in responding to him.

We are also concerned that staff did not call an ambulance when his vital signs indicated that he was critically ill and that no one from the healthcare team remained with him when he was clearly unwell.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **March 2018**

Contents

Summary

Events

1. On 14 October 2016, Mr Christopher Tyler was admitted to HMP Thameside. At his initial health screen, a nurse noted his history of substance misuse, and referred him to see a GP as part of his secondary health screening. The GP noted that he also had asthma and hypertension. No one in the healthcare team asked his community GP for his medical records.

2. Mr Tyler complained of chest pain on 19, 20 and 23 October. On 20 October, a nurse gave him paracetemol and on 23 October, a nurse referred him to see a GP.

3. On 24 October, a GP diagnosed Mr Tyler as having a chest infection and prescribed antibiotics. She saw Mr Tyler again on 29 October for a follow-up appointment, and he told her that he believed the antibiotics were working.

4. On 31 October, Mr Tyler's cellmate pressed the cell bell for staff assistance. There is a light outside the cell which goes on when the cell bell is pressed, and then goes off when a member of staff responds. CCTV footage showed that the light went on and off five times within a half hour period. No one responded to these calls.

5. An officer then walked past Mr Tyler's cell and noticed that the light was flashing. After speaking to him, he called for a medical emergency response as Mr Tyler had severe chest pains. He did not call an emergency code.

6. Healthcare staff responded to the call, and took Mr Tyler's oxygen saturation levels which were recorded at 79%. (Anything below 90% is considered low.) They gave him oxygen therapy. When his oxygen levels reached above 90%, staff decided that he should be taken to hospital by ambulance as a non-emergency case.

7. As they waited for an ambulance, Mr Tyler was left alone in his cell. When his chest pains became worse, he pressed his cell bell alarm. Another officer was passing, went into his cell and called for an immediate medical response. Again, no emergency code was used. When healthcare staff arrived, they took Mr Tyler's oxygen saturation levels and called an emergency code blue (indicating that a prisoner is unconscious or having difficulties breathing). During the time that it took for an ambulance to arrive, Mr Tyler went in to cardiac arrest. Healthcare and prison staff undertook cardiopulmonary resuscitation until the ambulance arrived. Paramedics unsuccessfully continued resuscitation efforts. Mr Tyler died of acute bacterial endocarditis (an infection in the heart valves).

Findings

Clinical care

8. We are not satisfied that Mr Tyler received a good standard of care at Thameside, or that his care was equivalent to that which he could have expected to receive in the community. Healthcare staff did not obtain Mr Tyler's community medical

records when he first arrived at Thameside, and did not therefore know of his underlying medical conditions.

Response to cell bell

9. On 31 October, when Mr Tyler first showed signs of being seriously ill, his cell bell did not work and staff did not therefore know that Mr Tyler's cellmate was calling for assistance.

Emergency response

10. When healthcare staff responded to him, they did not consider it necessary to send him to hospital as an emergency, even though his oxygen saturation levels indicated that he was seriously ill.

11. When staff arranged Mr Tyler's transfer to hospital, he was left alone in his cell, and was not continually monitored by healthcare staff as he should have been.

Payment of funeral expenses

12. There was a significant delay before Thameside paid Mr Tyler's funeral costs.

Recommendations

- The Head of Healthcare should ensure that the community records of newly arrived prisoners are requested as part of their initial health screen and considered promptly.
- The Head of Healthcare should ensure that staff who respond to an emergency record their actions and involvement in the SystmOne medical record.
- The Director and Head of Healthcare should ensure that all staff are aware of PSI 03/2013 and local guidance and understand their responsibilities during medical emergencies, including that staff use the appropriate code to communicate a medical emergency immediately.
- The Head of Healthcare should ensure that when a prisoner is in a potentially life threatening situation, healthcare staff continue to monitor them and do not leave them alone.
- The Director and Head of Security should ensure that all staff are told immediately about any malfunction in the cell bell system and know what to do in such circumstances.
- The Director should ensure that there are processes in place to make sure that funeral expenses are paid without delay.

The Investigation Process

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

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

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

16. The investigator and the clinical reviewer jointly interviewed three members of healthcare staff on 27 September 2017.

17. We informed HM Coroner for Southwark of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. We suspended this investigation while the police investigated the circumstances of Mr Tyler's death.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

20. Mr Tyler's sister received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Thameside

21. HMP Thameside is a local prison in South East London that holds up to 1232 men. It is privately run by Serco. The Oxleas NHS Foundation Trust delivers primary health services. Turning Point delivers substance misuse services, and Atrium delivers mental health services. There is 24 hour nursing provision and an 18 bed inpatient unit.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Thameside was in May 2017. Inspectors reported the clinical records being of a mixed standard, and that prisoners did not have prompt access to health services. They concluded that there were a number of areas in the healthcare department which needed to improve.

Independent Monitoring Board

23. 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 June 2016, the IMB reported that staff did not communicate satisfactorily with prisoners and some staff were reluctant to take responsibility for addressing prisoners' needs.

Previous deaths at HMP Thameside

24. Mr Tyler was the sixth prisoner to die of natural causes at Thameside since January 2013. One prisoner has since died of natural causes. We have previously made recommendations about the adequacy of healthcare records.

Key Events

25. On 14 October 2016, Mr Christopher Tyler was sentenced to four months and 17 days for robbery and sent to HMP Thameside. At his initial health screen, a nurse noted that Mr Tyler had a 20 year history of substance misuse and was prescribed methadone in the community. Mr Tyler told her that he had not taken methadone for the past three days, and was in withdrawal. A nurse referred Mr Tyler to a prison GP to review his methadone prescription and to Turning Point (drug intervention services). There is no evidence that healthcare staff obtained Mr Tyler's medical history from his community GP.

26. Later that day, a prison GP completed the second stage of Mr Tyler's health screen. He recorded that Mr Tyler had a history of substance misuse, asthma and hypertension. He assessed that he was suitable for in-possession medication and prescribed drugs, including methadone, to manage these conditions.

27. On 17, 18 and 19 October, Mr Tyler attended healthcare appointments to manage his methadone intake. On 19 October, during an appointment with a nurse Mr Tyler complained of chest pain and breathing problems. The nurse noted that Mr Tyler had asthma and that he was not using his inhaler. A plan was put in place for Mr Tyler to have an echocardiogram (ECG), but there is no evidence that this happened.

28. The next day, Mr Tyler complained of back pain and a nurse went to see him in his cell. The nurse took his vital signs and recorded his oxygen saturation levels as 92% (which was within the normal range). As Mr Tyler appeared agitated and was sweating, she asked him if he was withdrawing. Mr Tyler said that he was not, and she gave him paracetemol to manage the pain.

29. On 23 October, a nurse saw Mr Tyler as he complained that he had ongoing back pain, pain to the right lower abdomen, and was nauseous after he ate. He said that he was not withdrawing, had not opened his bowels for one week and felt feverish most days. The nurse took his vital signs, all of which were in the normal range, and arranged for him to see a doctor the next day.

30. At 3.16pm on 24 October, a prison GP saw Mr Tyler about his substance misuse. He recorded that he had a temperature of 39 degrees (within the high range) and that he appeared acutely unwell, with a possible infection. He referred him to see a GP immediately. At 4.06pm that day, a prison GP saw Mr Tyler and diagnosed him as having a possible chest infection. She prescribed an antibiotic, paracetamol and ibuprofen and recommended that he be seen again in three days.

31. On 28 October, a nurse saw Mr Tyler. He said that his chest pain remained the same as before he was given antibiotics. The nurse said that Mr Tyler did not appear particularly distressed and was not in severe pain. She recorded that his observations were normal, but did not measure his oxygen saturation levels. She said that she performed an ECG at this appointment, but there is no evidence in Mr Tyler's medical records that this happened.

32. A prison GP saw Mr Tyler later that afternoon and recorded that he told her that the antibiotics were working, and that he was only getting chest pain at night. She noted that although he was sweaty, he looked well. She did not take his temperature. Healthcare staff did not see Mr Tyler over the next two days.

Events of 31 October 2016

33. Mr Tyler shared a cell. In his police statement, he said that on 31 October, Mr Tyler became very unwell, and he (the cellmate) pressed the cell bell for staff assistance. There is a light outside the cell which goes on when the cell bell is pressed, and then goes off when a member of staff responds. CCTV footage showed the light going on at 12.51pm. Between 12.51pm and 1.17pm, the light to their cell went on, and then off (presumably indicating that it had been switched off) on five separate occasions. No one responded to the cell bell by going to the cell.

34. At 1.19pm, an officer returned from lunch and saw Mr Tyler's cell bell light flashing. The light outside Mr Tyler's cell was working, but the computerised system across the wing was broken, which meant that staff could not hear it from the main wing office. In his police statement, the officer said that he spoke to Mr Tyler and the cellmate through the cell door. He described Mr Tyler as looking 'okay', and although Mr Tyler said that he would like to see a nurse, he said that he was happy to wait while the officer finished his duties, unlocking other prisoners. They agreed that the cellmate would call for assistance if Mr Tyler's health deteriorated. At 1.20pm, the officer left the cell door, and returned at 1.22pm to unlock the door.

35. CCTV footage showed that at 1.23pm the cellmate left the cell and was socialising with other prisoners on the wing. At 1.28pm, the officer returned to Mr Tyler's cell. In his police statement, he said that even though Mr Tyler did not look unwell, he radioed for an immediate emergency response as Mr Tyler complained of a stabbing pain in his chest. No one called a medical emergency code at this point which would have activated contingencies, including calling an ambulance.

36. Two nurses and a prison GP responded to the emergency call. A nurse said that she found Mr Tyler breathless, seated on his bed. She took Mr Tyler's oxygen saturation levels and recorded them at 79%. (Anything below 90% is considered low.) As they were in the low range, she began giving him oxygen therapy. She said that Mr Tyler was anxious, and she tried to reassure him while administering oxygen, which raised his saturation level to 98%, which is within the normal range.

37. A nurse completed an ECG on site, which recorded Mr Tyler's heart rate at 122 beats per minute (bpm). As Mr Tyler was still tachycardic (a heart rate that exceeds 100bpm), she took his radial pulse and asked the prison GP whether he should be taken to hospital to manage his condition. As he was able to communicate and did not seem in distress, she noted that the prison GP did not think an emergency ambulance was necessary.

38. CCTV footage showed that the nurse and other members of healthcare and prison staff had left Mr Tyler's cell by 2pm. At 2.10pm, an officer left Mr Tyler's

cell and a member of the healthcare team remained outside his cell, writing up notes. There is no evidence that oxygen was continued while Mr Tyler was on his own.

39. At 2.27pm, the officer returned to the wing, and noticed that Mr Tyler's cell bell light was flashing. He responded immediately. The officer said that when he approached Mr Tyler's cell, he was surprised that he had been left alone. He said that Mr Tyler looked very ill and was breathing very loudly so he again radioed for an immediate medical response.

40. A number of healthcare and prison staff attended, CCTV footage showed a nurse arriving at 2.32pm. She recorded that members of the healthcare team were unsuccessfully trying to take Mr Tyler's vital signs. The nurse told the investigator that Mr Tyler felt dizzy and nauseous and after taking his vital signs, she began administering oxygen therapy. An officer, who was also present, called a medical emergency code blue. A nurse responded to the code blue and told the investigator that Mr Tyler looked noticeably more unwell than when he had seen him earlier

41. Ambulance records indicate that they received a call for an emergency ambulance at 2.42pm. A nurse said that she kept Mr Tyler calm, while administering oxygen.

42. As Mr Tyler's cell was on the third floor of the wing, two officers decided to move him to the entrance of the block so that paramedics could treat him more quickly. The officers moved Mr Tyler in an evacuation chair, with his oxygen attached. As they reached the ground floor, one of the officers noticed that the oxygen tank was empty and told a member of the healthcare team. Mr Tyler went into cardiac arrest and at approximately 2.53pm, healthcare staff began cardiopulmonary resuscitation (CPR).

43. The ambulance had arrived at prison at 2.50pm and paramedics reached Mr Tyler at 2.58pm. They took over Mr Tyler's care and continued CPR. At 3.49pm, a paramedic confirmed Mr Tyler's death.

Contact with Tyler's family

44. At 6.00pm on 31 October 2016, an Imam appointed a prison chaplain as the family liaison officer (FLO). Mr Tyler's next of kin was recorded as his sister.

45. At 7.30pm, the Imam and FLO arrived at Mr Tyler's sister's address. No one appeared to be at home so they waited at the address and tried to call her. After some time, she returned the FLO's call but refused to meet him unless he said what was wrong. The FLO recorded in the family liaison log that he tried to avoid this question as he wanted to tell her of Mr Tyler's death face to face but felt that he had no choice but to inform her over the phone.

46. When the FLO discussed visiting Mr Tyler's sister, she was so distressed that she asked the FLO to visit her mother's address. They did so and then informed his parents of Mr Tyler's death.

47. The FLO offered ongoing support until Mr Tyler's funeral, which was held on 30 September 2016. Thameside offered to contribute towards the cost of the

funeral but there was a payment delay. The prison was invoiced on 8 November 2016 but had not settled the invoice by February 2017. After some pressure from Mr Tyler's legal representative, the prison paid the invoice on 6 March.

Support for prisoners and staff

48. After Mr Tyler's death, the Director debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

49. The prison posted notices informing other prisoners of Mr Tyler's death, and offering support. Mr Tyler's cellmate was offered individual support.

Post-mortem report

50. The post-mortem examination confirmed that Mr Tyler died of acute bacterial endocarditis (an infection in the heart valves).

Findings

Clinical care

51. We agree with the clinical reviewer that the care Mr Tyler received at HMP Thameside was not equivalent to that which he could have expected to receive in the community. Mr Tyler was admitted to Thameside 15 days before he died and first raised concerns with healthcare staff that he had chest pain on his fifth day at the prison. He was seen on three occasions by members of the healthcare team, who assessed that his symptoms were probably related to the withdrawal of methadone. On 24 October, a prison GP diagnosed Mr Tyler as having a possible chest infection, and prescribed him antibiotics.

52. The healthcare team at Thameside did not obtain Mr Tyler's medical history from his community GP when he arrived. This would have shown that Mr Tyler had a history of a heart murmur. The clinical reviewer said that acute bacterial endocarditis is an uncommon condition that usually requires specialist investigation and involvement. If healthcare staff had checked Mr Tyler's medical history, they would have known that he had a heart murmur and this, in turn, might have helped them to consider whether he had heart disease and investigate further. We make the following recommendation

    The Head of Healthcare should ensure that healthcare staff request the community records of newly arrived prisoners as part of their initial health screen.

Emergency response

53. From CCTV evidence and a nurse's interview, it is clear that a number of medical staff involved in the emergency response failed to record their actions in Mr Tyler's medical records. Unfortunately, we were unable to interview all the healthcare staff as a number of them were no longer working at the prison. Without a clear record about what happened, we cannot reach as full a conclusion about the events that day as we would have wished. We make the following recommendation:

    The Head of Healthcare should ensure that staff who participate in an emergency response record their actions and involvement in the SystmOne medical record.

54. What we do know is that there were three phases to emergency response: an initial medical emergency response (without a formal emergency code being called), a second medical emergency response (again, without a code), and finally, a code blue was called. When a nurse and a prison GP responded to the first medical emergency response, Mr Tyler's oxygen saturation levels were recorded at 79% (which was dangerously low). The nurse acknowledged that this indicated that Mr Tyler's condition was life threatening but said that, at the time, they did not think it necessary to call a code blue because his saturation levels rose after oxygen therapy.

55. We agree with the clinical reviewer that it is unclear why healthcare staff did not decide to transfer Mr Tyler urgently. The post mortem results suggested that he

was very ill at this stage, which is evidenced by his low oxygen saturation and tachycardia. We make the following recommendation:

The Director and Head of Healthcare should ensure that all staff are aware of PSI 03/2013 and local guidance and understand their responsibilities during medical emergencies, including that staff use the appropriate code to communicate a medical emergency immediately.

56. CCTV footage and an officers statement showed that Mr Tyler was left alone in his cell while healthcare and prison staff arranged for him to be transferred to hospital. While Mr Tyler's oxygen saturation levels had risen, he was clearly unwell, and should not have been left on his own. We make the following recommendation:

The Head of Healthcare should ensure that when a prisoner is in a potentially life threatening situation, healthcare staff continue to monitor him and do not leave him alone.

Response to cell bell

57. The timings on Mr Tyler's cell bell records for 31 October did not correspond with CCTV footage. The police investigation found that a cell bell could only be cancelled from outside the cell and there is no CCTV evidence that this happened. The prison has since confirmed that the cell bell system was subsequently discovered to be faulty and, although the cellmate was pressing his cell bell, it might not have connected anywhere and staff may not have known he was calling for assistance. Thameside gave us evidence that they fixed the cell bell system in November 2016.

58. An officer attended the cell and spoke to Mr Tyler at 1.19pm, and Mr Tyler said that he could wait for assistance. We therefore do not think it likely that the delay in responding to Mr Tyler would have affected the outcome for him. In other emergencies, however, this might not be the case. We make the following recommendation:

The Director and Head of Security must ensure that all staff are told immediately about any malfunction in the cell bell system and know what to do in such circumstances.

Payment of funeral expenses

59. Although HMP Thameside appropriately offered to contribute towards Mr Tyler's funeral in line with national instructions, there was a lengthy delay in the prison paying the invoice. The investigator was unable to speak to the FLO as he no longer worked for Thameside but a member of the prison team contacted him on our behalf. He confirmed that there was a delay in paying the funeral directors but said he did not know why. Mr Tyler's prison records gave no indication about why the payment had not been made. The delay in payment would have undoubtedly caused distress to Mr Tyler's family at what was already a distressing time. We therefore make the following recommendation:

The Director should ensure that there are processes in place to make sure that funeral expenses are paid without delay.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

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

T | 020 7633 4100
F | 020 7633 4141