

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Taylor a prisoner at HMP Lancaster Farms on 21 October 2017

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*



© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

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

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 Lee Taylor died on 21 October 2017 from the effects of taking a psychoactive substance at HMP Lancaster Farms. He was 31 years old. I offer my condolences to Mr Taylor's family and friends.

Mr Taylor's death is the second death at Lancaster Farms linked to the use of psychoactive substances (PS). Security intelligence at HMP Preston indicated that Mr Taylor obtained the PS in the segregation unit there, the day before he transferred to Lancaster Farms. Mr Taylor became seriously ill only 14 hours after he transferred and before the intelligence had been processed at Preston. Lancaster Farms were therefore unaware that he might have drugs in his possession and we do not consider that his death was predictable. The emergency response was good and staff tried to save Mr Taylor's life in challenging circumstances.

I am very concerned by the increasing number of deaths I investigate in which PS plays at least some part. Mr Taylor's death is another example of how dangerous PS is and how prisons are struggling to reduce supply and demand. I will be raising my concerns with Ministers.

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

July 2018

Contents

Summary	1
The Investigation Process	2
Background Information	3
Key Events	5
Findings.....	10

Summary

Events

1. On 16 May 2017, Mr Lee Taylor was sentenced to 14 weeks imprisonment and was taken to HMP Preston. He faced further charges of robbery and remained in Preston as a remand prisoner at the end of this sentence.
2. Mr Taylor was kept in the segregation unit between 1 September and 19 October because he refused to go to a cell on a standard wing. On 19 October, he suddenly agreed to move back to a wing. Later the same day, an officer found another prisoner in the segregation unit in possession of a psychoactive substance (PS) sprayed on to paper. The prisoner said he had given the rest of his PS to Mr Taylor, which is why Mr Taylor had suddenly agreed to move.
3. The officer completed an intelligence report and told Preston's dedicated search team that Mr Taylor had PS. Mr Taylor was transferred to Lancaster Farms on 20 October before the information had been processed. The incident was not recorded on Mr Taylor's prison record (NOMIS) or person escort record (PER). Lancaster Farms were, therefore, unaware that Mr Taylor might have brought PS with him.
4. On 20 October, Mr Taylor and his cellmate began smoking NPS in their cell from 5.00pm. At about 1.45am on 21 October, Mr Taylor's cellmate found him vomiting on the floor. He alerted night staff who began cardiopulmonary resuscitation (CPR) promptly but found it difficult to clear Mr Taylor's airway. Paramedics attended and took Mr Taylor to hospital, where he died at 7.00am.

Findings

5. The officer at Preston who was told Mr Taylor had PS completed an intelligence report in line with local guidance. Mr Taylor moved to Lancaster Farms and became seriously ill within 36 hours of the submission of her report and before completion of the process that would have alerted Lancaster Farms that he might have PS.
6. The emergency response was good but the chances of saving Mr Taylor's life might have been improved by the availability of an electronic suction machine.

Recommendations

- The Governor and Head of Healthcare should review the provision of emergency equipment and ensure that it is appropriate and adequate for dealing with prisoners suffering the effects of PS.
- The Governor should reiterate to all staff the importance of carrying and using breathing masks for life support.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Lancaster Farms informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator visited Lancaster Farms on 25 October 2017. She obtained copies of relevant extracts from Mr Taylor's prison and medical records, copies of relevant prison policies and a copy of CCTV footage from the night of 20-21 October. She also interviewed a prisoner and spoke to Mr Taylor's brother.
9. The investigator interviewed nine members of staff at Lancaster Farms on 21 and 22 November 2017. She also spoke to the custodial manager in charge of security, for further information on night security procedures. She spoke to two nurses and the reception nurses on 20 October, but neither remembered anything about Mr Taylor and they were not interviewed. The investigator spoke on the telephone to a prison officer at HMP Preston and obtained further information from HMP Preston's security department and drug and alcohol rehabilitation service (DARS).
10. NHS England commissioned a clinical reviewer to review Mr Taylor's clinical care at the prison.
11. We informed HM Coroner for Lancashire and Blackburn of the investigation and have sent the coroner a copy of this report.
12. The investigator contacted Mr Taylor's mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She spoke to Mr Taylor's mother on the telephone about her findings.

Background Information

HMP Lancaster Farms

13. HMP Lancaster Farms is a modern medium security resettlement prison with accommodation for 555 adult male prisoners. Healthcare is provided by Lancashire Care Foundation Trust. Healthcare staff work from 7.30am to 8.00pm on weekdays and 8.00am until 6.00pm at weekends.

HM Inspectorate of Prisons

14. The last inspection of HMP Lancaster Farms was in 2015. Inspectors reported that Lancaster Farms was a basically safe and respectful prison. Most prisoners felt safe and despite challenges with PS, violence levels were not excessive. Most prisoners reported that PS were freely available, but Inspectors were reassured that robust management action was being taken to address this.
15. Emergency equipment was well organised and regularly checked. Approximately a quarter of custodial staff were trained in first aid and in operating a defibrillator. First Aid cover was provided on each shift, including at night.
16. The most recent inspection of HMP Preston was in March 2017. Inspectors found that the management of security was robust and intelligence reports were promptly collated and well analysed. However, too many target searches and suspicion drug tests were not completed and HMIP recommended that these be carried out swiftly.

Independent Monitoring Board

17. 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 their latest annual report, for the year to July 2017, the IMB reported that Lancaster Farms had experienced an increase in the use of PS. A new intelligence-led cell search policy had resulted in significant finds although there was an issue with contraband being thrown over the perimeter fence or flown in by drones.

Previous deaths at HMP Lancaster Farms

18. Mr Taylor's is the third death at Lancaster Farms since it re-roled as an adult prison in 2014. Our investigation into the second death, in 2015, found that the prisoner used PS but a post-mortem was unable to establish a cause of death. There are no other similar issues with Mr Taylor's death.

Psychoactive Substances (PS)

19. Psychoactive substances, previously known as 'legal highs', are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and causing vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential

for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

20. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
21. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

Key Events

HMP Preston

22. On 16 May 2017, Mr Lee Taylor was sentenced to 14 weeks imprisonment for trespassing and was taken to HMP Preston. Mr Taylor had a history of substance misuse in the community and in prison and had served several prison sentences since 2008. On this occasion he underwent detoxification for alcohol dependence. Mr Taylor faced further charges of robbery and remained in Preston as a remand prisoner after his sentence expired on 2 July 2017. On 17 July, staff suspected Mr Taylor was under the influence of PS.
23. On 2 August, Mr Taylor was found with facial injuries. He said that three prisoners had assaulted him in his cell but would not give their names or say why they had assaulted him. On 1 September, Mr Taylor refused to allow his cellmate to return to their cell and he was taken to the segregation unit. He subsequently refused to move back to a cell on a standard wing. On 12 October, Mr Taylor was sentenced to six years imprisonment for robbery.
24. On 19 October, Mr Taylor suddenly agreed to move to a cell on a standard wing. An officer said she was surprised because until then he had been adamant he would not. Later the same day, the officer found another prisoner in the segregation unit with paper sprayed with PS. The prisoner told her this was the last of it and he had given the rest to Mr Taylor, which was why Mr Taylor had agreed to go back to normal location.
25. An officer completed an intelligence report for the security department in line with Preston's strategy for tackling PS. She did not make an entry on Mr Taylor's prison record (NOMIS) about the incident. She said the designated segregation unit paperwork officer for each day usually made case notes of significant events. (It is likely that this did not happen because Mr Taylor had moved to a standard wing by the time she found the PS and was therefore not included in the daily update of case notes.)
26. The dedicated search team came to the segregation unit that afternoon because the unit had been inundated with PS that week. The officer told them that a prisoner had alleged that Mr Taylor had the remainder of his PS paper and they told her that they would search him once they had received her intelligence report.

HMP Lancaster Farms

27. Mr Taylor was transferred to Lancaster Farms the next morning, before the officer's security report had been collated and analysed. The officer said she was not aware that Mr Taylor might be transferred. The person escort record (PER) which accompanied him from Preston to Lancaster Farms did not include information that he allegedly had PS in his possession because this had not yet been processed.
28. Another prisoner was transferred from Preston the same day. He said he knew Mr Taylor from his current and previous sentences. They arrived at Lancaster Farms at about 11.20am and went through the normal reception process which

involved a strip search and sitting on the Body Orifice Scanner (BOSS chair – a device for detecting metal objects concealed inside the body).

29. The prisoner said he and Mr Taylor agreed to share a double cell on Coniston 1 Unit, a standard wing. He said Mr Taylor was very happy to be transferred to Lancaster Farms because his brother was there. Staff took them to Coniston 1 after lunch. The prisoner said he and Mr Taylor had both brought Spice (a type of PS) with them from Preston but from different sources. The Spice was sprayed on to paper.
30. At 3.54pm, Mr Taylor telephoned his partner. They talked for almost quarter of an hour and Mr Taylor said he was happy to be at Lancaster Farms although he was upset with the length of his sentence. He sounded happy and in a positive mood.
31. The prisoner said they were locked in their cell at about 5.00pm and almost immediately began smoking the Spice. They made roll ups using tea and a homemade pipe from a vaping inhalator. The prisoner later told officers that he thought Mr Taylor had got the pipe from another prisoner on Coniston 1. The Spice looked and smelled like it usually did but was stronger than usual and made them almost black out. The prisoner said they alternately smoked and passed out for the rest of the evening. He estimated they both smoked about eight roll ups each in addition to using their pipe, which he described as a normal amount.
32. The prisoner said he passed out on the lower bunk bed at around 2.00am, with Mr Taylor sitting at the end of the bed. He did not know how long he was unconscious, but he woke up to find Mr Taylor kneeling on the floor being sick. He said it was quite normal to be sick on Spice, but Mr Taylor's condition caused him alarm because he was unable to speak or get himself to the cell toilet. He rang the cell bell and the night patrol officer arrived within a minute.
33. The night patrol officer on Coniston 1 said he did not remember going to Mr Taylor's cell until he responded to the cell bell at about 1.45am. He said he did not notice the smell of any substances being smoked coming from Mr Taylor's cell. The prison had gone smoke free on 16 October and prisoners had stockpiled tobacco. He said it is possible to smell tobacco on the landings if prisoners are smoking in their cells but he was not familiar with the smell or effects of PS.

Emergency response

34. The night patrol officer on Coniston 1 said he heard the cell bell and collected a toilet roll before going to the cell straight away (because this was the most common reason for prisoners to press their bells at night). The investigator viewed CCTV from that night. The landing lights were turned off and it was hard to distinguish what had happened. The light outside Mr Taylor's cell that indicates the cell bell has been pressed, turned on at 1.41am. The night patrol officer went to the cell about 30 seconds later and the cell bell light turned off at 1.42am. The prison was unable to provide a printout of the cell call record for technical reasons.

35. The night patrol officer said the prisoner who was with Mr Taylor told him that Mr Taylor had been sick. Mr Taylor was on his knees facing the back of the cell. He did not appear unconscious. The night patrol officer asked whether Mr Taylor had taken anything, and the prisoner told him he "might have smoked some tea". The night patrol officer told him to support Mr Taylor's head. The prisoner said he could not get a response from Mr Taylor and the night patrol officer radioed for assistance from the night orderly officer. He did not call an emergency code because the situation did not appear life threatening.
36. An officer was on duty on Coniston 2 and arrived first. She said she went to Coniston 1 as soon as she heard the night patrolman's radio call. Mr Taylor was on the floor of the cell and her initial reaction was that he was heavily under the influence of PS, which was a regular occurrence in the prison.
37. The officer said that night regulations required three officers to be present to open a cell. She and the night patrol officer had cell keys in sealed pouches and were allowed to break these in order to preserve life, however the situation did not appear life threatening.
38. An operational support grade (OSG) was on duty in the control room. As soon as he heard the night patrol officer's call for the orderly officer, he directed the CCTV cameras on Coniston 1 towards Mr Taylor's cell and prepared to ring an ambulance in case an emergency code was called.
39. The night orderly officer, a custodial manager, said the night patrol officer told him on the radio that he had a prisoner unresponsive and covered in vomit. He was on the centre when the call came in and collected two officers from Windermere and Derwent Units before going to Coniston. He said that according to night regulations he should have also collected an officer from Buttermere Unit but decided to take only two because it sounded as though the prisoner was unwell.
40. The night orderly officer opened Mr Taylor's cell as soon as he arrived. CCTV appears to show the cell door was opened at 1.49am. The night orderly officer said Mr Taylor was face down on the floor and the prisoner he shared a cell with was panicking. Mr Taylor was warm and floppy but completely unresponsive. The night orderly officer realised his condition was serious and instructed the other officers to radio a code blue (indicating that a prisoner is unconscious, not breathing or is having breathing problems) and ask for an emergency ambulance. The OSG in the control room noted the time of the code blue in his occurrence log as 1.51am and called an ambulance immediately. [Ambulance records show the time of the 999 call was 1.47am. The CCTV, the control room log and North West Ambulance Service automated call system all give different times.]
41. The night orderly officer and an officer turned Mr Taylor on to his back and the night orderly officer checked if he was breathing. He tried to clear Mr Taylor's airway of vomit and began chest compressions (cardiopulmonary resuscitation - CPR). He did not have a breathing mask but tried to give Mr Taylor rescue breaths as well. The chest compressions dislodged more vomit which made rescue breaths extremely difficult. The night orderly officer said it was impossible to clear Mr Taylor's airway entirely using his fingers. One of the other officers

gave him a breathing mask. An officer brought the defibrillator, which advised them to continue CPR.

42. At the same time an officer updated the OSG by telephone so he could pass accurate information to the ambulance service. The OSG said the ambulance service triaged the call at the highest level of priority. As soon as he saw the ambulance approaching the prison he turned the overrides on the gates so he could open them as the ambulance arrived. Ambulance records show the ambulance left its station at 1.54am and arrived at the gate at 1.58am. An officer waited at the gate to escort the paramedics to Coniston.
43. The paramedics set up their own equipment and took over. The North West Ambulance Service patient report form shows that Mr Taylor's airway was very obstructed by vomit and continued to fill up even after suctioning. At 2.20am they recovered a pulse, but Mr Taylor was unable to breathe unaided. The paramedics took Mr Taylor to hospital. No restraints or handcuffs were applied. Ambulance records show the first ambulance left the prison at 2.39am.
44. Mr Taylor was taken to the intensive care unit at hospital where he died at 7.00am.

Contact with Mr Taylor's family

45. The Duty Governor telephoned Mr Taylor's mother at 4.30am to break the news that her son was seriously ill in hospital. He arranged for a taxi to bring her to hospital and was there when she arrived. Mr Taylor's mother and partner were with him when he died.
46. The prison contributed towards the costs of Mr Taylor's funeral in line with national guidance.

Support for prisoners and staff

47. There was no debrief of the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising. Members of staff said they were subsequently offered support from the staff care team and a telephone support service. One of the members of staff interviewed expressed dissatisfaction with the level of support offered and this has been fed back to the Governor.
48. The prisoner who shared a cell with Mr Taylor was moved to a different cell that night and the prison placed him under suicide and self-harm monitoring procedures. He told the investigator that he had received a lot of support from the prison.
49. 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

50. The post-mortem report was not available at the time of writing this report. The toxicology report showed the presence of codeine, consistent with therapeutic use and synthetic cannabinoids (a form of PS).

Findings

Information that Mr Taylor had PS at Preston

51. The target for processing intelligence reports at HMP Preston is 72 hours during non-public holiday days Monday to Friday. Intelligence is graded by a collator and then reviewed by an analyst and a custodial manager before action is authorised by a governor. The officer's submission of her information report (on Thursday afternoon) about Mr Taylor was timely, but he transferred to Lancaster Farms the next morning and died that night before the report was processed at Preston.
52. The officer could not remember why she did not also make an entry on Mr Taylor's NOMIS case notes as we would have expected her to have done. However, the fact that Mr Taylor moved very suddenly and unexpectedly from the segregation unit to a standard wing at Preston and then to Lancaster Farms meant that the intelligence that he might have PS had not caught up with him before he died. This is unfortunate. It meant that Lancaster Farms did not have information that might have led to them searching and monitoring Mr Taylor more closely. We do not criticise the officer, who followed the correct procedures and was unaware that Mr Taylor might transfer to another prison.
53. It is a cause for serious concern that Mr Taylor was able to secure PS while held in the segregation unit at Preston, a location where prisoners should be held securely and safely and closely monitored. In common with most prisons, Preston and Lancaster Farms have a significant issue with PS being sprayed on to paper and sent in via prisoners' mail. As a result, both prisons have recently taken the exceptional measure of photocopying all non-legal prisoner mail and giving prisoners the photocopy rather than the original. This is a resource intensive process which we are told the prisons are not resourced to sustain in the long term. PS is also sent in to prisoners via legally privileged mail which the prison is not generally allowed to open. Intelligence at Preston suggests that the prisoner who gave Mr Taylor the PS in the segregation unit had obtained it via legally privileged mail.
54. We are satisfied that, as far as they are able, both prisons have responded appropriately to PS being sent in via prisoner's mail. We note that Lancaster Farms called 77 emergency codes which required ambulance attendance due to PS use in September and October last year. Although we make no recommendations on this point, we remain very concerned at the evident weaknesses in the prison system which this case and these statistics demonstrate.

Emergency response

55. Prison Service Instruction 03/2013 requires governors to have a two code medical emergency response system based on the instruction. In line with this, Lancaster Farms use code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance.

56. Governor's Notice to Staff 164/17, implemented in July 2017, clarified that incidents related to the use of PS should only be called as a code blue if the prisoner is choking, fitting or unconscious. The night patrol officer on Coniston 1, did not think that Mr Taylor was unconscious when he answered the cell bell because he was kneeling on the floor. For this reason he did not call an emergency code. The night orderly officer called a code blue as soon as he realised that Mr Taylor was in fact unconscious and the OSG in the control room immediately telephoned for an ambulance. We are satisfied that this was reasonable in the circumstances.
57. Prison Service Instruction (PSI) 24/2011 gives national guidance for entering cells at night. The PSI says that under normal circumstances, the night orderly officer must give authority to unlock a cell at night and minimum number of staff (according to local risk guidelines) must be present. However, the PSI goes on to say, that the preservation of life must take precedence over this. Where there is or appears to be threat to life, staff may open and enter cells on their own if they feel safe to do so, having performed a dynamic risk assessment and informed the control room.
58. Neither the night patrol officer nor the other officer considered there was a threat to Mr Taylor's life from what they could see and from what the prisoner told them. They believed he was under the influence of a substance but not unconscious. We are satisfied that in the circumstances it was reasonable for them to wait for the night orderly officer to open the cell. CCTV indicates that the night orderly officer opened the cell at 1.49am, some seven minutes after the night patrol officer, first went to the cell. We consider this is a reasonable response time given that no code had been called at this point. The night orderly officer called a code blue within a minute of entering the cell and checking Mr Taylor.
59. We consider the emergency response was good. Staff tried hard to save Mr Taylor's life in extremely challenging circumstances. Their chances of saving Mr Taylor's life would have been improved by the availability of an electronic suction machine to clear Mr Taylor's airway. Vomiting and losing consciousness is common in prisoners affected by PS and prisons must prepare as best they can to respond to the increase in these incidents. We make the following recommendation:

The Governor and Head of Healthcare should review the provision of emergency equipment and ensure that it is appropriate and adequate for dealing with prisoners suffering the effects of PS.

60. The night orderly officer chose to perform rescue breaths without a breathing mask. He told the investigator that he had neglected to collect one. While his determination to carry on with CPR regardless was commendable, it also carried a high degree of risk. We make the following recommendation:

The Governor should reiterate to all staff the importance of carrying and using breathing masks for life support.

**Prisons &
Probation**

Ombudsman
Independent Investigations