

PRESS RELEASE

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DAMNING JURY VERDICT FINDS SYSTEMIC FAILURES LED TO DEATH OF VULNERABLE PRISONER

The jury at the inquest into the death of a vulnerable prisoner has found that a series of system failings led to his death.

Michael Taylor was found hanging from the window bars of his cell by torn bed sheets in HMP Bedford on 17 April 2007 aged 39. He was a vulnerable prisoner suffering from significant mental health problems and long-term opiate dependency. Michael had been receiving methadone maintenance treatment in the community to stabilise his drug addiction. On 13 March 2007 he was remanded in custody and sent to HMP Wormwood Scrubs. His methadone maintenance prescription was continued by the healthcare staff there and he remained stable. Following a court appearance on 12 April 2007, Michael was unable to return to Wormwood Scrubs because of overcrowding. Under a policy somewhat ironically called Operation Safeguard he was taken to a police station where he was kept overnight. The following day he was not returned to Wormwood Scrubs as he should have been, but instead was sent to HMP Bedford.

Michael's vulnerability and his treatment regime meant that he should never have been included in Operation Safeguard. He should certainly not have been sent to HMP Bedford where there were well-recognised problems in healthcare provision, particularly with regard to the treatment and care of substance users. A Prison Service Order had mandated that from October 2001 prisons were to have maintenance treatment regimes for those with opiate misuse. Despite this, five years later in 2006 an HM Prisons Inspectorate report concerning HMP Bedford found that "clinical management of substance users was poor or nonexistent...men who arrived on a maintenance prescription of methadone were not able to continue with it." The Inspectorate recommended that matters should be "urgently reviewed" so that appropriate treatment could be given.

In February 2007, two months before Michael was sent to HMP Bedford, the prison medical officer Dr Croft wrote in desperation to Patricia Hewitt MP, the then Secretary of State for health, urging change. Still nothing happened, and so when Michael arrived on 13 April 2007 he was forcibly taken off his prescribed methadone maintenance treatment and subjected to detoxification. This "cold turkey" treatment was later described by Dr Croft in a letter to the Primary Care Trust as "dangerous, cruel and outmoded". Four days later on 17 April 2007 Michael was found hanging in his cell.

Within a matter of weeks, without requiring any major refurbishment, additional resources or funding, HMP Bedford managed to put in place a system to prescribe methadone to those in Michael's situation.

Inquest

In chilling evidence on the last full day of the inquest a witness from the Population Management Unit (PMU) warned that with the current prison population at 84,000 and rising, Operation Safeguard could be re activated at any time. When asked if the safeguards in relation to vulnerable prisoners would be adhered to any better this time he admitted that even if a Prisoner Escort Record (PER) did show some medical need, whether for drug treatment or cancer, it would in the last resort be ignored. What ruled Operation Safeguard was "necessity." Prisoners could be sent wherever there was an empty cell regardless of medical circumstances.

At the conclusion of the inquest on Friday 6 November the jury in their narrative verdict found that Michael Taylor did not intend to die and that the following factors contributed to his death:

- Inadequate information provided on the Prisoner Escort Form issued by Wormwood Scrubs to Harrow Magistrates Court, firstly in the deletion and statement of no known medical risk and that although it is stated that Mr Taylor was on methadone maintenance this information is not prominent.
- As a prisoner on a methadone maintenance regime Mr Taylor should have been excluded from Operation Safeguard as set out in Prison Service Instruction 30/2006.
- Having been locked out under Operation Safeguard and sent to Ampthill Police Station, Michael Taylor should have been returned to a prison with a methadone maintenance programme in place.
- Having been placed at HMP Bedford the treatment regime available was inadequate at that time.

The coroner has indicated that he will be considering matters for his rule 43 report designed to alert the relevant authorities to action that needs to be taken to prevent further deaths.

The Taylor family said:

Michael died as a result of a government failure to follow expert advice on the medical treatment of drug misusers. Prison overcrowding also led to a macabre game of "prison chess" that ignores individual needs. Most disturbing of all was the evidence that we heard at the inquest that with the prison population rising the same thing could happen again.

Mark Scott of Bhatt Murphy Solicitors, who represented the family of Michael Taylor, commented:

Michael Taylor was a prisoner but he still had an entitlement to reasonable healthcare; the inquest heard very disturbing evidence of failures to provide basic medical care to prisoners which the jury found led to Michael Taylor's tragic death.

Deborah Coles, Co-Director of INQUEST, said:

Both the Prison Service and the PCT tried to restrict the scope of this inquest and prevent proper public scrutiny of the systemic failures that led to this death. In failing

Inquest

to act on the recommendation of the Prisons Inspectorate a man died. The chaos and constant movement of prisoners arising from overcrowding means that there is the ever present risk of suicide and self-harm. INQUEST will raise these concerns with Ministers as a matter of urgency.

Notes to editors:

INQUEST is the only organisation in England and Wales that provides a specialist, comprehensive advice service on contentious deaths and their investigation to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. Its casework priorities are deaths in prison and in police custody, in immigration detention and in secure training centres. INQUEST develops policy proposals and undertakes research to campaign for changes to the inquest and investigation process, reduce the number of custodial deaths, and improve the treatment and care of those within the institutions where the deaths occur.

INQUEST is campaigning to ensure that the Coroners and Justice Bill 2009 results in fundamental reform of an inquest system currently hampered by delay, inconsistency of approach and lack of resources and unable to fulfil its vital function of preventing unnecessary deaths.

The government must also make changes to ensure that bereaved families can participate effectively in inquest hearings by having equal access, alongside the police and Prison Service, to non means-tested public funding for their legal representation. [INQUEST's briefing on the Coroners & Justice Bill](#)

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