Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Tunney, a prisoner at HMP Northumberland, on 16 March 2023

A report by the Prisons and Probation Ombudsman

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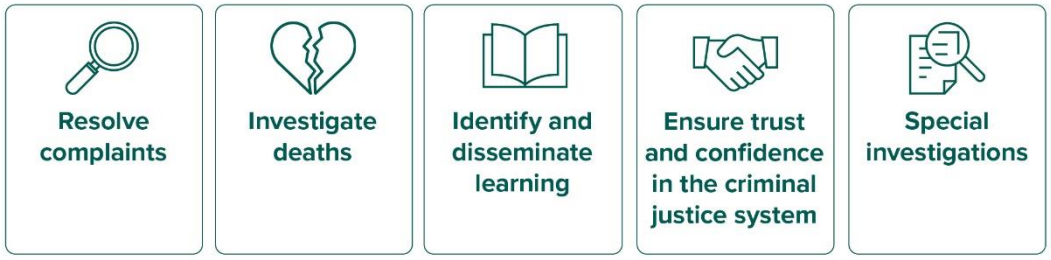
OUR VISION

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 HM 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 John Tunney died from pneumonia in hospital, on 16 March 2023, while a prisoner at HMP Northumberland. He was 79 years old. I offer my condolences to Mr Tunney's family and friends.

The clinical reviewer concluded that, overall, Mr Tunney's clinical care was equivalent to that which he could have expected in the community.

While staff completing Mr Tunney's security risk assessment acknowledged his advanced age, frailty and medical condition, these factors were given insufficient weight in the decision-making. I consider that the use of restraints on this elderly wheelchair user was disproportionate to his risk and does not reflect well on the prison.

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 **November 2023**

Contents

Summary

Events

1. Mr John Tunney transferred to HMP Northumberland on 22 June 2017, while serving a prison sentence of 12 years and 4 months for sexual offences.

2. In January 2022, Mr Tunney was diagnosed with fluid between his lungs and chest wall. Over the next few months, he became increasingly frail, and his mobility decreased. He received help with cell tasks, collecting meals and was given access to a wheelchair and walking aids. Towards the end of the year and at the beginning of 2023, Mr Tunney had recurrent falls and staff noticed that he had lost a significant amount of weight.

3. On 8 March 2023, a GP at the prison noted that Mr Tunney was seriously underweight and requested tests. The next day, after another fall and irregular clinical observations, Mr Tunney was admitted to hospital, where he was initially diagnosed with a bleed in his brain.

4. Mr Tunney died from pneumonia on 16 March. Frailty and heart failure contributed to his death.

Findings

5. The clinical reviewer concluded that Mr Tunney's clinical care was equivalent to that which he could have expected to receive in the community. However, she identified some weaknesses which the Head of Healthcare should consider.

6. In spite of Mr Tunney's age, frailty, limited mobility and poor medical condition, an escort chain was used for his final journey and admission to hospital. This decision was inconsistent with HMPPS' policy on security risk assessments and the use of restraints.

Recommendation

- The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:

    - healthcare staff complete the medical section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and

    - authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.

The Investigation Process

7. HMPPS notified us of Mr Tunney's death on 16 March 2023. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

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

9. NHS England commissioned an independent clinical reviewer to review Mr Tunney's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed four healthcare staff on 11 May, using Microsoft Teams videoconferencing.

10. We informed HM Coroner for Northumberland of the investigation. He gave us the cause of death. We have sent the coroner a copy of this report.

11. The Ombudsman's family liaison officer contacted Mr Tunney's sister, his nominated next of kin, to explain the investigation and to ask if she had any matters for the investigation to consider. She did not reply.

12. The initial report was shared with HMPPS, and they found no factual inaccuracies.

Background Information

HMP Northumberland

13. HMP Northumberland is a Category C prison, located near Morpeth, with an operational capacity of 1,348 adult men. Sodexo Justice Services manages the prison under contract from the Ministry of Justice.

14. Spectrum Community Health provides healthcare services. Nurses are on duty during the day and early evening. In addition to the NHS 111 service, prison staff can speak to a GP or Advanced Nurse Practitioner provided by Spectrum, for advice out-of-hours.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Northumberland was in August and September 2022. Inspectors considered that the commissioned healthcare staffing profiles were insufficient to meet demand, but staff worked flexibly and were committed to providing good care. There was limited capacity for the GPs service to meet additional demand and there were extended waiting times for services, such as reviews of long-term conditions.

16. Inspectors reported that healthcare facilities were clean and patient records were reasonable. PPO recommendations were addressed and shared at a monthly forum. The Care Quality Commission issued 'requirement to improve' notices after the inspection.

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 its latest annual report, for the year to 31 December 2022, the IMB reported that the healthcare provider had experienced staffing and leadership difficulties, which had led to unreliability in provision. Recruitment of additional staff and a locum GP had led to some improvement.

Previous deaths at HMP Northumberland

18. Mr Tunney was the nineteenth prisoner at Northumberland to die since March 2020. Of the previous deaths, eleven were from natural causes, six were self-inflicted and one was due to substance misuse. There have been two further deaths from natural causes.

19. We have previously made a recommendation about security risk assessments and the inappropriate use of restraints. Northumberland undertook to provide training for those involved in completing such assessments, as well as a briefing for healthcare staff. They also intended to quality assure ten per cent of completed risk assessments and discuss the findings at safer prisons and security meetings chaired by the Director and Deputy Director, respectively.

Key Events

20. Mr John Tunney was convicted of sexual offences on 23 June 2016 and remanded to HMP Durham. On 11 October, he was sentenced to 12 years and 4 months imprisonment, with an extended licence period of one year. Mr Tunney transferred to HMP Northumberland on 22 June 2017.

21. At his reception health screen, Mr Tunney's health conditions were noted as rheumatoid arthritis and atrial fibrillation (an irregular and fast heartbeat).

22. In November 2021, Mr Tunney had symptoms of pneumonia and pleural effusion (excessive fluid between the lungs and the chest wall). He was formally diagnosed with the latter condition in January 2022 and was initially treated in hospital. The respiratory medicine team continued to manage his condition as an outpatient after he was discharged.

23. During 2022, Mr Tunney's key workers noted that he was increasingly frail and struggling to breathe. He received help to collect meals and clean his cell, as well as use of a wheelchair and walking aids.

24. On 17 December, Mr Tunney had a fall. There were conflicting accounts about its severity. Wing staff indicated that he had hit his head, whereas healthcare staff recorded that had felt dizzy and fell onto a chair. He was examined by a nurse and no injuries were found.

25. On 30 December, a prisoner raised concerns about Mr Tunney's weight. A nurse examined and weighed him. He also underwent blood tests and screening for malnutrition.

2023

26. By January 2023, Mr Tunney was increasingly using a wheelchair. Wing staff documented his weight loss and restricted mobility in his personal records and later raised concerns with healthcare staff.

27. Mr Tunney had further falls on 25 and 28 February. After the latter, the healthcare team discussed him at the safety huddle (a short, daily multidisciplinary briefing about patients most at risk). They noted his recurrent falls, weight loss and that he was throwing away his food.

28. On 8 March, a GP at the prison examined Mr Tunney. The GP recorded that he was 'massively underweight' and requested blood and urine tests to determine whether he had an infection. He also referred him to the dietitian and prescribed a dietary supplement.

Events of 9 March

29. In the early hours of 9 March, Mr Tunney had a fall, but was able to get back into bed unaided when night staff attended. Later that morning, a wing officer was worried and asked healthcare staff to check him again. Mr Tunney looked and sounded unwell, did not have enough strength to engage with staff and was in pain

all over his body. On the advice of healthcare staff, the officer checked him several times during the morning.

30. Mr Tunney's carer told a nursing associate about the earlier falls. The nurse discussed this with colleagues at the safety meeting and the GP, who asked her to take clinical observations and assess whether his falls were mechanical or due to collapse.

31. Just before 4.00pm, the nurse reviewed Mr Tunney in his cell. He was too weak to stand, and both his blood pressure and blood oxygen saturation level were low. Using the National Early Warning Score 2 (NEWS2), she calculated a score of 9, which indicated the need for emergency assessment by a critical care team and possible high dependency care. (NEWS2 is a clinical assessment tool to detect acute illness.)

32. Paramedics took Mr Tunney to hospital. He was escorted by two prison officers and handcuffed with an escort chain (which was removed the following day). A CT scan showed that Mr Tunney had an acute subdural haemorrhage (bleeding in the brain caused by a head injury) and he was admitted as an inpatient for neurological observations and treatment. Healthcare staff sought updates from the hospital, but there was no contact for a few days between 12 and 15 March.

Contact with Mr Tunney's Family

33. On 13 March, the prison assigned a family liaison officer (FLO). She informed Mr Tunney's sister that Mr Tunney was in hospital and gave details of his condition.

34. On 15 March, it was decided that Mr Tunney could not return to the prison or leave hospital, as he needed constant medical care. The FLO updated his sister.

35. Mr Tunney died at 3.05am on 16 March. The FLO and a colleague visited his sister to break the news and offer support. She also informed another family member through their solicitor.

36. In line with national policy, the prison contributed to the costs of Mr Tunney's funeral, which was held on 3 April.

Support for prisoners and staff

37. The prison posted notices informing staff and other prisoners of Mr Tunney's death and signposting the avenues of support.

Cause of death

38. No post-mortem examination was carried out. The coroner accepted certification by a hospital doctor that the cause of Mr Tunney's death was pneumonia. Frailty and chronic heart failure were listed as contributory factors.

Findings

Clinical care

39. The clinical reviewer concluded that, overall, Mr Tunney's clinical care was of a good standard and equivalent to that he could have expected to receive in the community. She considered that his chronic medical conditions were appropriately monitored, but identified shortcomings, which are explained in detail in the clinical review report. We comment on the clinical issues later in this report.

Security risk assessments and the use of restraints

40. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

41. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that a medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

42. These requirements are reflected in HMPPS' *Prevention of Escape – External Escorts Policy Framework*, on the use of restraints. The policy encourages sensitive handling to ensure that the needs of security are balanced against the clinical needs of a seriously ill prisoner. The expectation is that restraints should not be used when mobility is severely limited due to advanced age, or disability, unless there is intelligence to suggest that an escape attempt might be made.

43. Mr Tunney was a 79-year-old, Category C prisoner, on the enhanced level of the prison's privileges scheme. There had been no disciplinary problems in prison, nor any concerns about his behaviour during hospital visits. His frailty and diminished mobility were well documented by clinical and operational staff.

44. The medical section of Mr Tunney's escort risk assessment form was blank. He was assessed as low risk on all the specific factors of concern, such as the risk of escape and the likelihood of assistance to do so. The person who completed the risk assessment recommended the use of handcuffs, but the duty manager who took the decision reduced the level of restraints to an escort chain. He noted the reason for his decision as, "… due to frail elderly prisoner and medical condition…"

45. Although the duty manager acknowledged Mr Tunney's frailty, he seemed not to have taken it into account in considering the necessity of restraints and therefore failed to comply with the guidance. The Ombudsman has repeatedly criticised HMPPS culture on this issue as being too risk averse and there not being a sufficiently strong body of evidence to support that aversion. We recommend:

The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:

- **healthcare staff complete the medical section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and**
- **authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.**

Director and Head of Healthcare to Note

Assessment and monitoring of Mr Tunney's falls

46. The clinical reviewer noted inconsistencies between operational and healthcare staff in recording and communicating medical incidents, as well as weaknesses in assessing and monitoring Mr Tunney's fall. Notably, there were significant anomalies in the description of his fall on 17 December 2022.

47. In response to this, the Head of Healthcare and Head of Residence were working together to improve communication and the reporting of incidents. However, there had been some difficulty in addressing overnight reporting when there are no healthcare staff on duty.

48. Additionally, no falls risk assessments were completed after Mr Tunney's falls and no clinical observations were taken on 25 February 2023. Although Mr Tunney was discussed at a lunchtime safety huddle meeting on 28 February, no further assessments were planned.

49. The Head of Healthcare said that falls risk assessments had already been implemented for new prisoners who are over 70 years old, and he was working on new processes to ensure that they are automatically completed after a fall.

50. We are satisfied that work is in progress to ensure consistency in completing falls risk assessments; clinical observations; and improving accuracy in recording and communicating medical incidents. In view of the actions already taken, we make no further comment, but the Director and Head of Healthcare will need to address the formal recommendations in the clinical review.

Contact with Mr Tunney's next of kin

51. Prison Service Instruction (PSI) 64/2011, about safer custody, states that prisons must have arrangements in place for an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill. In addition, the PSI and Prison Rule 22 says that a prisoner's next of kin should be informed immediately if they become seriously ill, or if there is an unpredicted or rapid deterioration in their physical health. Staff at Northumberland did not comply with these policies.

52. We consider that, given the seriousness of his condition, Mr Tunney's next of kin should have been informed that he was in hospital at the outset. We commented on this issue recently in another investigation at Northumberland, where assurances were given that weaknesses in this area had been recognised and improvements made. The Director will wish to ensure that the improvements are sustained.

Inquest

53. The inquest, held on 19 April 2024, concluded that Mr Tunney died from natural causes.

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