Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Tindill, a prisoner at HMP The Mount, on 9 May 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

Summary

1. 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.

2. If my office is to best assist His Majesty's 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.

3. Mr Mark Tindill died of a heart attack on 9 May 2023 at HMP The Mount. Diabetes was listed as a contributory factor. He was 62 years old. We offer our condolences to Mr Tindill's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Tindill received at The Mount was equivalent to that which he could have expected to receive in the community. She found that Mr Tindill received good care for his diabetes and that the emergency response on 9 May was delivered well. She made no recommendations.

5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Tindill's death on 9 May 2023.

7. The investigator issued notices to staff and prisoners at HMP The Mount informing them of the investigation and asking anyone with relevant information to contact her. We received several letters from prisoners who were concerned that Mr Tindill's dressings on his toe were not changed frequently enough, and that there were delays in the emergency response on 9 May. These issues are covered in this report and in the clinical review.

8. NHS England commissioned an independent clinical reviewer to review Mr Tindill's clinical care at The Mount.

9. We informed HM Coroner for Hertfordshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

10. The PPO family liaison officer wrote to Mr Tindill's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She asked about the care Mr Tindill received in relation to his diabetes and toe amputation, and how this impacted on his death. This has been addressed in our report and the clinical review.

11. Mr Tindill's daughter received a copy of the initial report. She did not make any comments.

12. The initial report was shared with HMPPS. There were no factual inaccuracies.

Previous deaths at HMP The Mount

13. Mr Tindill was the thirteenth prisoner to die at The Mount since May 2020. Of the previous deaths, four were from natural causes, four were self-inflicted, three were drug related and in one, the cause was unknown.

Key Events

14. On 23 March 2018, Mr Mark Tindill was sentenced to life imprisonment for murder.

15. Mr Tindill had diabetes. He was prescribed insulin in the community but had stopped taking it.

16. In September 2018, Mr Tindill was diagnosed with peripheral neuropathy (nerve damage that causes pain, numbness and weakness) in both legs, caused in this case by poorly controlled diabetes. He started taking insulin again on 18 May 2022.

17. On 23 August, Mr Tindill was moved to HMP The Mount. When he arrived, he had high blood sugar readings. He was referred to a GP and a long-term conditions nurse for a review of his diabetes care plan.

18. On 21 September, the long-term conditions nurse saw Mr Tindill in a clinic to review his diabetes management. She examined his feet and referred him to a podiatrist (foot specialist) as he had dry skin and was at risk of developing an ulcer (an open wound or sore on the skin that is slow to heal).

19. On 28 September, a GP at The Mount increased Mr Tindill's insulin dose as his blood sugars were poorly controlled. He asked Mr Tindill to check his blood sugars three times daily and to record them in a diary, along with a record of what he was eating. Mr Tindill had weekly phone appointments with the long-term conditions nurse to review his blood sugars and how he was feeling.

20. On 11 November, Mr Tindill saw a podiatrist at The Mount. He found that Mr Tindill had an ulcer on the tip of his right big toe and cleaned and dressed the wound. The healthcare team changed his dressing three times a week as instructed by the podiatrist.

21. On 30 November, a nurse saw Mr Tindill as he said that he had been feeling unwell for the past three days with chest pain and shortness of breath. The nurse took his clinical observations, which were abnormal, and called for an ambulance. Mr Tindill had an electrocardiogram (ECG – a test to check the heart's rhythm), which showed that he had atrial fibrillation (an irregular heartbeat). He was taken to hospital by ambulance and subsequently admitted.

22. While in hospital, Mr Tindill's ulcer continued to deteriorate. He was diagnosed with osteomyelitis (infection in the bone) in his toe and cellulitis (an infection of the deeper layers of skin and the underlying tissue). He was started on intravenous antibiotics to treat the infection.

23. Despite efforts by doctors to treat the infection with antibiotics, on 6 December, Mr Tindill had a partial amputation of his toe.

24. On 15 December, Mr Tindill was discharged from hospital and returned to The Mount.

25. Between 16 December and 3 January 2023, Mr Tindill had his dressings changed by healthcare at least twice a week in line with his care plan.

26. On 3 January, Mr Tindill was admitted to hospital for a review of his foot following concerns from nursing staff at The Mount. The next day, the hospital podiatrist told him that his osteomyelitis had deteriorated, in part due to a poor blood supply. The podiatrist cleaned his wound and started him on IV antibiotics.

27. On 6 January, Mr Tindill had an angioplasty (when a balloon is used to stretch open a narrowed or blocked artery) to help his blood flow.

28. On 14 January, Mr Tindill was discharged from hospital. He had his dressings changed twice weekly by the healthcare team at The Mount in line with his care plan.

29. Between 26 January and 10 February, Mr Tindill's dressings were changed by the healthcare team every two to four days. His toe showed signs of infection and the healthcare team took swabs of the wound to be tested.

30. On 15 February, Mr Tindill was seen by a nurse at The Mount. She told him that his swab results had returned and were positive for an infection and he was prescribed antibiotics to treat this.

31. Between 24 February and 6 March, Mr Tindill's dressings were changed daily by the healthcare team to closely monitor the infection and apply an antibacterial cream.

32. On 7 March, the healthcare team told Mr Tindill that his dressings would be changed twice weekly as they had been advised to do so by the hospital. Between 17 March and 19 March, Mr Tindill changed his dressing daily by himself, at his request.

33. On 27 March, Mr Tindill saw a podiatrist at the hospital. She told Mr Tindill that a recent X-ray showed he still had osteomyelitis and he may need the remainder of his toe amputated. She also noted that Mr Tindill had a small ulcer on his third toe.

34. On 6 April, Mr Tindill saw a podiatrist at the hospital. He changed Mr Tindill's antibiotics and asked the healthcare team to change his dressings twice a week. Between 9 April and 1 May, Mr Tindill's dressings were changed three times a week by the healthcare team.

35. On 1 May, Mr Tindill spoke to a nurse as he was experiencing chest pain, nausea and vomiting. He told the nurse he felt tired and unwell. She took his clinical observations and did an ECG, which showed he had an abnormal heartbeat. He was taken to hospital by ambulance and subsequently admitted.

36. Hospital doctors confirmed that Mr Tindill was having a heart attack. He had two stents inserted (a small mesh tube used to open weakened and narrowed arteries).

37. On 4 May, the hospital's diabetes nurse specialist saw Mr Tindill. He had his diabetes medication titrated (increased in monitored stages) and had an echocardiogram and chest X-ray before he was discharged back to The Mount.

38. On 5 May, a nurse at The Mount reviewed Mr Tindill's dressing. He told the nurse he was feeling well but was getting a little breathless at times. The nurse took his clinical observations which were within normal range.

39. On 8 May, a nurse reviewed Mr Tindill's dressing, and she recorded that his toe looked clean and dry.

Events of 9 May

40. Shortly after 11.00am, a prisoner told an officer that Mr Tindill was feeling unwell in his cell. The officer found him sitting on his chair in his cell. He had shortness of breath and chest pain and asked for an ambulance. The officer went back to the office to call an ambulance and a second officer went into Mr Tindill's room to support him.

41. At 11.08am, the officer with Mr Tindill radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts staff in the control room to call an ambulance) as she was aware that Mr Tindill had recently been in hospital for a heart attack and was concerned by his condition. An officer was already on the phone to the ambulance service at this time. As Mr Tindill was conscious, the call handler logged this as a category 2 ambulance (second most urgent – for a serious condition, such as stroke or chest pain) and instructed the officer to update them if his condition deteriorated.

42. A nurse and an emergency medical technician (EMT) responded to the code blue at 11.18am. Mr Tindill was sitting on his chair. He was responsive but was pale, clammy and clutching his chest. They took his clinical observations and gave him medication to help with his chest pain. The healthcare team and officers moved Mr Tindill and his mattress into the corridor to give them better access to treat him.

43. The healthcare team raised Mr Tindill's legs above his chest and gave him oxygen. They then did an ECG, which showed an abnormal reading (suggesting he was having a heart attack). At this point they attached a defibrillator (shocks the heart to restore a normal heartbeat). The defibrillator did not recommend a shock with Mr Tindill's abnormal heartbeat.

44. An officer phoned the ambulance service at 11.43am to tell them his ECG reading and to request an update on the ambulance time.

45. At 11.48am, the healthcare team were unable to find a pulse and a nurse started CPR.

46. The officer on the phone to the ambulance service told them Mr Tindill had gone into cardiac arrest and the ambulance was upgraded to a category one (most urgent).

47. The healthcare team did CPR on Mr Tindill, and he began to breathe again. They continued to monitor his pulse which was very weak.

48. The ambulance crew arrived at Mr Tindill's side at 12.08pm. As they arrived, he stopped breathing again and they immediately started CPR. The paramedics moved him to the ambulance and continued CPR.

49. While in the ambulance, Mr Tindill's condition deteriorated despite further CPR attempts. Paramedics agreed to stop treatment and declared Mr Tindill deceased at 1.16pm.

Post-mortem report

50. The post-mortem report concluded that Mr Tindill died of a heart attack caused by coronary artery atherosclerosis (narrowing of the arteries). Type two diabetes was also listed as a contributory factor.

Findings

Governor to Note

51. Body Worn Video Cameras (BWVC) provide a clear and irrefutable record of events and allow for the detailed examination of an incident, after it has happened. They provide evidence that can protect both staff and prisoners, increase the level of perceived safety and promote positive interactions between staff and prisoners. They also provide an opportunity to review and reflect on incidents and develop staff skills.

52. Prison Service Instruction 04/2017, Body Worn Video Cameras, says the use of BWVC to record footage is mandated to be "incident related", which is therefore likely to include incidents involving injury to or illness of a prisoner. This may also include situations where medical interventions are taking place.

53. At the time of Mr Tindill's death, the CCTV on his wing was not working. This had been out of order since 10 April 2023 and the prison was waiting for a specialist contractor to fit new parts. (It was fixed on 23 May.)

54. On 9 May, when the code blue was radioed for Mr Tindill, the staff who responded to the code did not turn on their BWVC. Therefore, there is no video footage of the emergency response.

55. Although the lack of footage did not affect the care Mr Tindill received or the outcome of the incident, we suggest that those roles designated by the Governor as being required to wear a BWVC must do so while on shift and ensure that they record any incident that they attend, as per the policy.

56. The Head of Safety told the PPO investigator that since the death of Mr Tindill, when a code blue is called, they now issue a reminder to staff to turn on their BWVC. We regard this as good practice.

Adrian Usher
Prisons and Probation Ombudsman **November 2023**

Inquest

At the inquest, held on 8 September 2026, the Coroner concluded that Mr Tindill died from natural causes.

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