Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Tew, a prisoner at HMP Littlehey, on 17 September 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 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.

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 David Tew died on 17 September 2019 of heart disease at HMP Littlehey. He was 69 years old. I offer my condolences to Mr Tew's family and friends.

The clinical reviewer found that Mr Tew's long-term health conditions were mostly well-managed at Littlehey and that his care was equivalent to that he could have expected to receive in the community.

However, the clinical reviewer identified some failings in his care. Healthcare staff failed to take appropriate action when Mr Tew had high blood pressure readings, and they did not monitor him correctly when he reported pain and his physical observations were not all in normal ranges. Also, when Mr Tew was found unresponsive, staff attempted to resuscitate him when he had an order in place stating that he did not wish to be resuscitated.

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

Sue McAllister CB
Prisons and Probation Ombudsman **April 2020**

Contents

Summary

Events

1. On 20 December 2016, Mr David Tew was sentenced to six years imprisonment for sexual offences. He was moved to HMP Littlehey on 15 August 2018.

2. Mr Tew had chronic obstructive pulmonary disease (COPD – the term for a group of serious lung diseases). In August 2008, he was diagnosed with type 2 diabetes and considered to be at high risk of a cardiovascular event in the next ten years. Mr Tew began taking medication to regulate his blood sugar levels and reduce his cholesterol. His conditions were regularly reviewed but he continued to deteriorate.

3. In July 2019, Mr Tew signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order although he still wanted to receive active treatment. In August, Mr Tew went to hospital for one night after experiencing significant pain and blood clots from a previously inserted catheter.

4. On 17 September, at morning unlock, an officer found Mr Tew on the floor of his cell, not moving. The officer called a medical emergency code. When nurses arrived, they started cardiopulmonary resuscitation (CPR) and continued for several minutes until another nurse arrived with the DNACPR order. A prison doctor pronounced Mr Tew dead at 8.20am.

5. The post-mortem examination found that Mr Tew died from coronary artery occlusion (obstruction of blood flow in a coronary artery) caused by atherosclerotic coronary artery disease (narrowing of the arteries).

Findings

6. The clinical reviewer found that Mr Tew's long-term conditions were mostly well-managed at Littlehey and his care was equivalent to that he could have expected to receive in the community. However, she found some failings.

7. Nurses did not act on high blood pressure readings on two occasions and did not use the National Early Warning Score (NEWS) tool in August 2019, when Mr Tew presented with pain and some abnormal observations. They also proceeded with resuscitation attempts when Mr Tew had a DNACPR order in place.

Recommendations

- The Head of Healthcare should ensure staff are familiar with, and act in accordance with, NHS recommendations and NICE guidelines for blood pressure monitoring.

- The Head of Healthcare should ensure staff are familiar with, and where appropriate use, the National Early Warning Score tool.

- The Head of Healthcare should ensure all staff are aware of prisoners' resuscitation wishes.

The Investigation Process

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

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

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

11. We informed HM Coroner for Cambridgeshire and Peterborough District of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Tew's partner to explain the investigation and ask if she wished to raise any issues. Mr Tew's partner asked about the standard of healthcare Mr Tew had received. This is addressed in this report and in the clinical reviewer's report.

13. Mr Tew's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Littlehey

15. HMP Littlehey is a medium security prison housing approximately 1,200 men. A high proportion of the prison's population are men who have been convicted of sexual offences.

16. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services at the prison. The prison healthcare centre is open on weekdays from 7.30am to 7.30pm, and at weekends from 8.00am to 5.30pm. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Littlehey was in July to August 2019. Inspectors reported that healthcare provided prompt access to a range of primary care clinics, and referrals to secondary care were well managed. Innovative means of increasing secondary care consultation slots, such as Skype, were being introduced where demand outstripped escort availability. Palliative care, led by a specialist consultant and advanced nurse practitioner, was considered to be highly developed.

Independent Monitoring Board

18. 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 January 2019, the IMB reported that a prison and healthcare agreement exists which allows only four external morning prisoner appointments and four external afternoon prisoner appointments per day (increases were allowed where there were emergencies). On average, 25 appointments were cancelled every month due to staff shortages or emergencies. More generally, the IMB commended healthcare's holistic treatment approach.

Previous deaths at HMP Littlehey

19. Mr Tew was the 13th prisoner to die at Littlehey since September 2017. Of the previous deaths, eleven were from natural causes and one was self-inflicted. There are no similarities between our findings in the investigation into Mr Tew's death and the other deaths.

Key Events

20. On 20 December 2016, Mr David Tew was sentenced to six years imprisonment for sexual offences and sent to HMP Woodhill. On 15 August 2018, he was moved to HMP Littlehey.

21. Mr Tew had chronic obstructive pulmonary disease (COPD – the term for a group of serious lung diseases including emphysema and chronic bronchitis) for which he had been on oxygen therapy since June 2016 (overnight and while moving around).

22. When Mr Tew arrived at Littlehey, Nurse A conducted Mr Tew's reception screen and his secondary screen. She recorded his health conditions, assessed him as suitable to have his medication in possession and declared him unfit for work. She also recorded that his cell had been prepared for him in advance to meet his oxygen therapy requirements.

23. On 22 August, Nurse B saw Mr Tew for a review. She arranged blood tests as Mr Tew had not had any recently. She described Mr Tew as needing to lose weight and noted that although he did not have a history of heart issues, he did sometimes suffer from swollen ankles.

24. On 23 August, Dr A entered the blood results onto Mr Tew's record. They showed he had type 2 diabetes (blood sugar levels are too high, and the condition can increase risks to the eyes, heart and nerves). The doctor also noted that Mr Tew should discuss his cholesterol levels with a GP and that he was not prescribed statins (cholesterol reducing medication) at that time. The doctor referred Mr Tew to the prison's diabetes team.

25. On 23 August, Mr Tew completed a QRISK2 test (a tool to assess likelihood of having a cardiovascular event in the next 10 years). Mr Tew's score (22.12%) indicated his risk was high.

26. On 26 August, Nurse C discussed Mr Tew's diabetes diagnosis with him. She gave him written information and booked a review date. Mr Tew declined an education programme which offered self-management advice and care pathways. He was prescribed metformin which helps to control blood sugar levels.

27. On 13 September, the doctor also discussed Mr Tew's diagnosis with him. He agreed to take a statin and had already started metformin and made some dietary changes.

28. On 25 January 2019, as part of a pulmonary rehabilitation assessment, a healthcare assistant, recorded that Mr Tew's blood pressure reading was 169/94 (diabetic patients are advised to keep it below 130/80). However, no one took his blood pressure again until 11 June.

29. On 8 March, Mr Tew failed to attend a diabetes clinic appointment and declined retinal screening on 20 March.

30. On 11 April, Nurse D took repeat bloods and recorded that Mr Tew's blood sugar levels were steadily creeping up. She booked a review for three months' time.

31. On 20 April, Nurse D created a diabetes care plan for Mr Tew. The plan suggested retinal screening, footcare, annual reviews and liaison with doctors and nurses in the event of any complications.

32. On 11 June, Nurse D conducted a diabetes review. She noted that Mr Tew was wheelchair-bound and obese. She discussed diet and exercise with him and assessed his feet which she noted did not show signs of diabetic neuropathy. Mr Tew's blood pressure was 145/90. Again, this was not in the normal range for an individual with diabetes but there is no record of any further action being taken.

33. On 29 July, Dr B and Nurse C saw Mr Tew on the wing. He had recently been referred to a urology clinic (because of a number of urinary issues) and his COPD still impacted significantly on his health and mobility. They discussed his wishes for the future and he agreed to be added to the palliative care register and to complete a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order (stating that he did not want to be resuscitated if his heart or breathing stopped, although he still wanted to receive full active treatment for his conditions).

34. Investigations continued regarding Mr Tew's urinary issues which transpired to have been caused by an enlarged non-cancerous prostate gland. He had a catheter inserted on 30 July at a hospital urology clinic.

35. On 9 August, Mr Tew told Nurse E that the catheter was giving him pain and that he had passed some blood clots. The nurse took his observations (all in the normal range apart from blood pressure which was high at 160/92) and removed the catheter which relieved his pain. She updated the medical record at 3.34pm.

36. Nurse E referred Mr Tew to Dr C who arranged his transfer to hospital for a replacement catheter. The doctor updated the medical record at 3.48pm. The hospital decided not to replace the catheter and Mr Tew returned to the prison the next day with a supply of incontinence pads.

37. On 17 September, at approximately 6.15am, Officer A started the roll check (count of prisoners) on Mr Tew's wing. He saw Mr Tew sitting on his bed. At approximately 8.00am, the officer started to unlock prisoners. When he got to Mr Tew's cell he found him on the floor and not moving. The officer called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and asked Officer B to bring the defibrillator. The communications room's log shows that an ambulance was called at 8.06am, straight after the code blue was called. Several prison staff attended straightaway. Officer A could not locate a pulse and positioned Mr Tew for CPR just as nurses arrived.

38. At approximately 8.07am, Nurse F and Nurse E attended and started CPR. They were unable to insert an airway due to jaw stiffness. The nurses' entries in the medical record describe how they administered CPR for a few moments before the defibrillator recommended they stop in order to read the patient's status – they then proceeded with CPR until colleagues arrived. (It is not clear how long the second cycle of CPR lasted.) Nurse D arrived with the DNACPR paperwork and CPR was stopped. Dr D pronounced Mr Tew deceased at 8.20am.

Contact with Mr Tew's family

39. On 17 September, the prison appointed two prison managers, as the family liaison officers (FLOs). They visited Mr Tew's next of kin's (his partner's) address that day to break the news of Mr Tew's death. No one was home and they could not contact her on the telephone. The FLOs drove to Mr Tew's son's address instead but he was not home. They left a note asking him to call one of them on his return.

40. On 18 September, the FLOs continued to try and contact Mr Tew's partner by phone. They were ultimately able to do this although she had a fault on her landline, and the prison held the wrong mobile number for her (two digits had been transposed when given to the FLOs by another member of prison staff). The FLOs decided to go back and break the news of Mr Tew's death to her in person which they did that day.

41. Mr Tew's funeral was on 8 October 2019**.** No one from the prison attended (as requested by the next of kin), but the prison did pay for the funeral, in line with national policy.

Support for prisoners and staff

42. After Mr Tew's death a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

43. The prison posted notices informing other prisoners of Mr Tew'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 Tew's death.

Post-mortem report

44. The post-mortem report concluded that Mr Tew died from coronary artery occlusion (obstruction of the blood flow in a coronary artery) caused by atherosclerotic coronary artery disease (narrowing of the arteries caused by the build-up of fat, cholesterol and other substances in the blood). Catheter-associated urinary tract infection and COPD with cor pulmonale (abnormal enlargement of the right side of the heart as a result of disease of the lungs or the pulmonary blood vessels) were listed as contributory factors. Toxicology tests showed no illicit drugs were present.

Findings

Clinical care

45. The clinical reviewer found that the care Mr Tew received at HMP Littlehey was equivalent to that he could have expected to receive in the community. She found that the care for his long-term conditions was in line with guidance. She did, however, identify some areas for improvement.

46. Mr Tew's blood pressure readings exceeded the range considered normal for diabetic patients on two occasions. On 25 January 2019, the healthcare assistant recorded that Mr Tew's blood pressure reading was 169/94. No action was taken and Mr Tew's blood pressure was not measured again until 11 June, when Nurse D recorded it was 145/90. The clinical reviewer considered in both instances that the lack of action taken was not in line with NHS guidance or NICE guidelines. We make the following recommendation:

    The Head of Healthcare should ensure staff are familiar with, and act in accordance with, NHS recommendations and NICE guidelines for blood pressure monitoring.

47. On 9 August, Nurse E took Mr Tew's observations after he reported his catheter was giving him pain. His blood pressure was high at 160/92. She did not calculate a National Early Warning Score (NEWS). (NEWS is a tool based on an individual's clinical observations which among other things helps clinicians know when to escalate a patient's case.) The medical record indicates there was probably only a short time between the nurse and then Dr C seeing Mr Tew, but the use of NEWS would have helped staff detect any deterioration in his condition. We make the following recommendation:

    The Head of Healthcare should ensure staff are familiar with, and where appropriate use, the National Early Warning Score tool.

48. Mr Tew had a DNACPR order in place and yet on 17 September, nurses attempted to resuscitate him for several minutes. This is despite it being recorded on several occasions within the medical record that everyone was aware of Mr Tew's wishes and Nurse E in particular, having had recent contact with him. We make the following recommendation:

    The Head of Healthcare should ensure all staff are aware of prisoners' resuscitation wishes.

Family liaison

49. The family liaison officers visited Mr Tew's partner's address to break the news of his death but she was not at home. They tried to telephone her but the mobile number they had written down was incorrect (two digits had been switched around accidentally – it is unclear whether the number was read out incorrectly or the FLO recorded it incorrectly). This led to a delay in informing Mr Tew's partner of his death. However, we are satisfied that the FLOs did try to visit her in person and while it was unfortunate that they had the wrong mobile number for

her, we accept that this was an unintended mistake. We therefore make no recommendation.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T I 020 7633 4100
F I 020 7633 4141