

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Tutchings, a prisoner at HMP North Sea Camp, on 19 May 2020

A report by the Prisons and Probation Ombudsman

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*



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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 Robert Tutchings died in hospital on 19 May 2020 from pneumonia following a stroke at HMP North Sea Camp on 8 May. He was 63 years old. I offer my condolences to Mr Tutchings' family and friends.

Mr Tutchings had several long-term medical conditions, including asthma, hypertension (high blood pressure), diabetes and atrial fibrillation (abnormal heartbeat). He consistently refused medication and clinical intervention, which put him at high risk of stroke and other life-threatening health events.

The clinical reviewer identified a number of issues relating to Mr Tutchings' clinical care at HMP Hewell and HMP Featherstone, his previous prisons, and North Sea Camp. As Mr Tutchings was judged to have the mental capacity to refuse treatment, we cannot say whether any of these issues contributed to his death.

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

Sue McAllister CB
Prisons and Probation Ombudsman

January 2021

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Summary

Events

1. Mr Robert Tutchings was sentenced to five years imprisonment on 29 November 2018. He had not been in prison before. He was admitted to HMP Hewell and gave a history of asthma and hypertension (high blood pressure). He transferred to HMP Featherstone in December 2018.
2. In January 2019, a prison GP noted diagnoses of hypertension and diabetes from Mr Tutchings' community GP records. Mr Tutchings declined medication for his blood pressure. The GP warned him of the risk of stroke, especially for diabetic patients with uncontrolled blood pressure. Mr Tutchings said he accepted the risks. He was assessed as having the capacity to refuse treatment.
3. In August, another GP persuaded him to start blood pressure medication. In November, Mr Tutchings was diagnosed with atrial fibrillation (abnormal heartbeat). He disclosed that he had not been taking his medication.
4. In December, Mr Tutchings resumed medication for high blood pressure and started medication for atrial fibrillation. The GP planned to review him after a month, but this did not happen, and his prescriptions lapsed.
5. On 19 March 2020, Mr Tutchings transferred to North Sea Camp. Handover information from Featherstone was inadequate and a medicine reconciliation failed to identify Mr Tutchings' lapsed prescriptions and his atrial fibrillation.
6. Nurses monitored Mr Tutchings' blood pressure and referred him to the advanced nurse practitioner. Mr Tutchings was not referred for further intervention and did not see a member of the healthcare team after this.
7. On 8 May, he was found collapsed and taken to hospital with a suspected stroke. He died in hospital on 19 May.

Findings

8. Mr Tutchings refused clinical intervention and monitoring for his long-term conditions despite being made aware of the serious risks of untreated hypertension, including stroke, which was the cause of his death. His mental capacity was appropriately assessed, and he was judged to have the capacity to refuse treatment.
9. No one at Hewell read Mr Tutchings' community GP records or entered him on to the diabetes register for regular monitoring.
10. A GP at Featherstone read the community GP records but did not place Mr Tutchings on the diabetes register for regular monitoring. No one at Featherstone added hypertension to Mr Tutchings' clinical record as an active problem or monitored Mr Tutchings' compliance with his medication. He did not have a planned GP review after December 2019.
11. The healthcare handover form completed by Featherstone for North Sea Camp said that Mr Tutchings had asthma and hypertension but did not include diabetes

or atrial fibrillation. The medication reconciliation completed at North Sea Camp did not identify his prescriptions for amlodipine and rivaroxaban.

12. An advanced nurse practitioner at North Sea Camp recorded an abnormal blood pressure reading but did not plan further clinical intervention because of confusion over instructions issued by the healthcare provider as part of the response to the Covid-19 pandemic.
13. The clinical reviewer identified a need for improved primary care and long-term disease management at senior clinician level at North Sea Camp.

Recommendations

- The Head of Healthcare at North Sea Camp should ensure that advanced nurse practitioners are competent in the management of long-term disease. A development plan should be documented within the appraisal system and monitored by regular auditing of clinical notes.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP North Sea Camp informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
15. The investigator obtained copies of relevant extracts from Mr Tutchings' prison and medical records and copies of local healthcare guidance.
16. NHS England commissioned a clinical reviewer to review Mr Tutchings' clinical care at the prison. The investigator and clinical reviewer interviewed two members of staff in June 2020. The investigator spoke to two further staff alone. All the interviews took place by telephone due to the restrictions in place during the COVID-19 pandemic.
17. We informed HM Coroner for Lincolnshire of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.
18. Our family liaison officer wrote to Mr Tutchings' next of kin, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Tutchings' next of kin did not have any specific questions. We have sent them a copy of this report.

Background Information

HMP North Sea Camp

19. HMP North Sea Camp is an open resettlement prison near Boston in Lincolnshire. It holds about 400 men. Healthcare is provided by Nottinghamshire Healthcare NHS Foundation Trust.

HM Inspectorate of Prisons

20. HM Inspectorate of Prisons most recently inspected North Sea Camp in July 2017. Inspectors found excellent progress since the previous inspection in 2014. It was a safe prison and rated good for resettlement. Inspectors found the prison had an appropriate range of nurse-led clinics, and positive relationships had been formed with local hospitals.

Independent Monitoring Board

21. 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 March 2019, the IMB said it was satisfied that healthcare provision in the prison was equivalent to that provided in the community and in some cases exceeded it. Residents who needed medical attention were generally seen the same day by a triage nurse. The healthcare facility was modern, and the healthcare provider paid for four extra prison officers to escort residents to hospital when required.

Previous deaths at HMP North Sea Camp

22. Mr Tutchings was the sixth prisoner to die at North Sea Camp since May 2018. Four of the previous deaths were from natural causes and one was drug-related. There are no similarities between these previous deaths and that of Mr Tutchings.
23. Two prisoners have died since Mr Tutchings, also from stroke.

Blood pressure

24. Normal blood pressure is between 120/80mmHg and 140/90mmHg. The top number refers to the amount of pressure in the arteries during the contraction of the heart muscle. This is called systolic pressure. The bottom number refers to the blood pressure when the heart muscle is between beats. This is called diastolic pressure. Both numbers are important in determining heart health. Numbers greater than the ideal range indicate that the heart is working too hard to pump blood to the rest of the body.
25. High blood pressure, or hypertension, rarely has noticeable symptoms, but if untreated, increases the risk of heart attacks and strokes.

Key Events

HMP Hewell

26. Mr Robert Tutchings was sentenced to five years imprisonment for drugs offences on 29 November 2018. He had not been in prison before. He was admitted to HMP Hewell and gave a history of asthma and hypertension (high blood pressure). His blood pressure was high, and he was referred to the prison GP.
27. On 30 November, Mr Tutchings' community GP records were scanned into his prison medical record. These showed that he had been diagnosed with type 2 diabetes in 2011 and his last community consultation was a failure to attend a clinic for diabetic retinopathy (damage to the eyes caused by diabetes).
28. At a second health assessment on 2 December, Mr Tutchings told a nurse that he had a family history of diabetes. His blood pressure was again high. Mr Tutchings was not placed on the diabetes register for regular monitoring or given a hypertension care plan, as he should have been in line with national guidance.

HMP Featherstone

29. Mr Tutchings transferred to HMP Featherstone on 14 December 2018. A nurse completed an initial health assessment including a medical records review. She did not identify that he was diabetic, but his blood pressure was high, so she referred him to the GP.
30. Mr Tutchings saw a prison GP on 17 January 2019. The GP read the community GP records and noted the diagnoses of hypertension and diabetes. He did not put Mr Tutchings on the diabetes register. Mr Tutchings declined medication for his blood pressure. The GP warned him of the risk of stroke, especially for diabetic patients with uncontrolled blood pressure. Mr Tutchings said he accepted the risks.
31. Mr Tutchings' blood pressure was checked weekly and found to be high each time. He continued to refuse medication to treat it. He was referred back to the GP on 14 March for persistently high blood pressure. On 25 March, a prison GP again discussed the risks of uncontrolled blood pressure with Mr Tutchings. Mr Tutchings refused medication because he did not want regular blood tests. The GP concluded that Mr Tutchings had capacity to refuse treatment.
32. On 30 August, a prison GP persuaded Mr Tutchings to start taking amlodipine to lower his blood pressure. His blood pressure remained high at weekly checks. In November, Mr Tutchings was diagnosed with atrial fibrillation (an irregular heart rate). On 28 November, he admitted that he had not taken his amlodipine since September.
33. The next day a prison GP re-prescribed amlodipine and started Mr Tutchings on rivaroxaban (a blood thinner). The GP reviewed him on 13 December and Mr Tutchings said he felt better. The GP planned to review Mr Tutchings four weeks later, however, Mr Tutchings did not see a GP at Featherstone before he

transferred to North Sea Camp and his amlodipine and rivaroxaban were not re-prescribed.

HMP North Sea Camp

34. On 19 March 2020, Mr Tutchings moved to North Sea Camp. Featherstone complete a healthcare handover form. The form showed Mr Tutchings' long term medical conditions were asthma, obesity and hypertension, but did not list his diagnoses of diabetes or atrial fibrillation.
35. A nurse completed an initial health assessment and recorded that Mr Tutchings was overweight and had asthma and hypertension. She took a blood pressure reading, which was high. She booked three follow up blood pressure readings in line with local and national guidance.
36. The pharmacist completed a medicine reconciliation but did not identify Mr Tutchings' previous prescription for amlodipine and rivaroxaban.
37. On 24 March, a nurse took Mr Tutchings' blood pressure and recorded a normal reading. On 31 March, a nurse recorded a high reading. In light of the persistent abnormal readings, she sent a task to an advanced nurse practitioner and the prison GP service, to review Mr Tutchings with a view to prescribing medication to control his blood pressure.
38. On 8 April, the advanced nurse practitioner recorded Mr Tutchings' blood pressure was 160/80mmHg (which showed an abnormal systolic reading). He said Mr Tutchings did not have any symptoms and he advised him to come back to healthcare if he experienced any problems. At interview, he said he did not mark Mr Tutchings for follow up because he was uncertain what was available in terms of managing long-term conditions under measures brought in in response to the COVID-19 pandemic. He said he was aware that some aspects of long-term condition management had been curtailed and that GP sessions had been reduced. He said he could not remember whether he looked back over Mr Tutchings' notes to check previous blood pressure readings and he acknowledged that he had not documented this or outlined a plan.
39. Mr Tutchings did not see anyone from healthcare after 8 April.

Events of 8 May 2020

40. A Supervising Officer (SO) was the orderly officer responsible for running the prison regime on 8 May. He said he was doing his rounds when a prisoner told him that he thought Mr Tutchings was unwell. The SO said Mr Tutchings looked "groggy", he was mumbling and his speech was slurred.
41. The SO asked Mr Tutchings to come to the wing office. Mr Tutchings repeatedly made a fist with one of his hands and the SO began to suspect that he had suffered a stroke. The SO said there were posters up in the prison listing the signs of stroke using the FAST acronym to identify symptoms. Healthcare staff had already left the prison, so he asked gate staff to call an ambulance.

42. The emergency call was put through to the wing and an officer relayed information about Mr Tutchings' condition while the SO prepared the necessary paperwork for a hospital escort.
43. East Midlands Ambulance Service records show that the prison called 999 at 6.13pm. An ambulance was dispatched at 6.15pm and arrived at the prison at 6.27pm. The officer accompanied Mr Tutchings to the specialist stroke unit at Peterborough Hospital in the ambulance. Mr Tutchings was released on an emergency special purpose licence, initially for two days. No restraints were used.
44. The senior probation officer at North Sea Camp began an application for early release on compassionate grounds, but Mr Tutchings deteriorated suddenly, and he died on 19 May.

Contact with Mr Tutchings's family

45. The prison tried to contact Mr Tutchings' next of kin by telephone when he was taken to hospital on 8 May. The SO eventually made contact on 9 May. Mr Tutchings' next of kin were unable to visit him in hospital because of the COVID-19 lockdown but remained in contact with the prison and the hospital until Mr Tutchings' death. The prison contributed to the cost of Mr Tutchings' funeral in line with national guidance.

Support for prisoners and staff

46. The prison posted notices informing other prisoners of Mr Tutchings' death, and to offer support.

Post-mortem report

47. No post-mortem was carried out. The Coroner accepted the cause of Mr Tutchings' death from the hospital doctor as aspiration pneumonia caused by stroke against a background of hypertension, atrial fibrillation and non-insulin dependent diabetes.

Findings

Clinical care

48. Mr Tutchings refused clinical intervention and monitoring in for his long-term conditions despite being made aware of the serious risks of untreated hypertension, including stroke, which was the cause of his death. His mental capacity was appropriately assessed, and he was judged to have capacity to refuse treatment.
49. North Sea Camp has a high proportion of older prisoners and the likelihood is that many of them will have long-term conditions. The clinical reviewer identified a need for improved primary care and long-term disease management at senior clinician level at the prison. The Head of Healthcare and the advanced nurse practitioner both had backgrounds in acute rather than primary care. The advanced nurse practitioner acknowledged that he did not have specific long-term disease management skills and knowledge. We make the following recommendation:

The Head of Healthcare at North Sea Camp should ensure that advanced nurse practitioners are competent in the management of long-term disease. A development plan should be documented within the appraisal system and monitored by regular auditing of clinical notes.

50. The clinical reviewer also found a number of learning points for North Sea Camp, Featherstone and Hewell, including that:
- No one at Hewell read Mr Tutchings' community GP records or entered him on to the diabetes register for regular monitoring.
 - A GP at Featherstone read the community GP records but did not place Mr Tutchings on the diabetes register for regular monitoring.
 - No one at Featherstone added hypertension to Mr Tutchings' clinical record as an active problem.
 - No one at Featherstone monitored Mr Tutchings' compliance with his amlodipine and rivaroxaban and he did not have a planned GP review after December 2019.
 - The healthcare handover form completed by Featherstone for North Sea Camp said that Mr Tutchings had asthma and hypertension but did not include diabetes or atrial fibrillation (his other long-term conditions) and the medication prescribed for him.
 - The medication reconciliation completed at North Sea Camp did not identify his prescriptions for amlodipine and rivaroxaban.
 - Mr Tutchings' was referred to an advanced nurse practitioner at North Sea Camp for persistent high blood pressure but he did not plan further clinical intervention because of confusion over instructions issued by the

healthcare provider as part of the response to the Covid-19 pandemic. (In fact, this guidance did not preclude further referrals and intervention.)

51. As Mr Tutchings refused treatment, it is difficult to say whether these failings contributed to his death. However, they could make a significant difference in other cases. The clinical reviewer has made a number of recommendations about these failings that the Heads of Healthcare at all three prisons will need to address.

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