Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bryan Tuckwell a prisoner at HMP Elmley on 24 July 2018

A report by the Prisons and Probation Ombudsman

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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 Bryan Tuckwell died of a heart attack in hospital on 24 July 2018 while a prisoner at HMP Elmley. The post-mortem report indicated that this was caused by ischaemic heart disease (with a blocked cardiac stent) and an overdose of prescribed medication. Mr Tuckwell was 67 years old. I offer my condolences to his family and friends.

I am satisfied that there were no indications that Mr Tuckwell was at imminent risk of suicide or self-harm and that staff could not have predicted his actions.

Mr Tuckwell had insulin-dependent diabetes and heart disease. While most of the clinical care that Mr Tuckwell received at Elmley was satisfactory, his heart disease was not properly managed.

I am concerned that when Mr Tuckwell was taken to hospital, he was restrained with an escort chain. I consider that the use of restraints was not justified given Mr Tuckwell's poor health. We have raised this issue with Elmley before, as recently as November 2018. The prison has committed to improving its risk assessment process to ensure that the level of restraint used is proportionate to the risk posed by the prisoner.

There was also a delay in calling an ambulance, which the prison will need to address.

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 **June 2019**

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Summary

Events

1. On 21 February 2018, Mr Bryan Tuckwell was remanded to HMP Elmley for sexual offences.

2. At an initial reception screen, a mental health nurse noted that Mr Tuckwell had several long-term health conditions, including heart disease, insulin-dependent diabetes and anxiety. The nurse obtained Mr Tuckwell's consent to request his community medical record, but there is no evidence that staff received this information. Mr Tuckwell did not report thoughts of suicide or self-harm and was assessed as suitable to keep his medication in his cell and administer it himself.

3. On 26 February, a prison GP examined Mr Tuckwell and asked for him to be referred to the hospital cardiology department and for an echocardiogram (ECG – to monitor the electrical rhythms of the heart). However, there is no record that this happened.

4. On 26 April, a prison GP reviewed Mr Tuckwell and requested an ECG. The prison confirmed that this took place the next day, although they could not find the result. On 10 May, a prison GP saw Mr Tuckwell and asked a nurse to complete an ECG, but there is no record of this. The GP referred Mr Tuckwell to the hospital cardiothoracic department.

5. On 28 May, Mr Tuckwell experienced increased anxiety and had a panic attack. A nurse noted that he reported chest pain and advised him to use glyceryl trinitrate (GTN) spray. On 31 May, a nurse examined Mr Tuckwell and recorded that he continued to feel anxious. She diagnosed a panic attack and requested a GP review. On 7 June, a prison GP saw Mr Tuckwell and referred him to the mental health team. There is no record that she spoke to him about his chest pain.

6. At 7.17am on 23 July, an unidentified officer responded to Mr Tuckwell's cell bell and looked through the cell door observation panel. At 7.35am, an officer responded to Mr Tuckwell's cell bell and noticed that he had collapsed on the floor. He shouted to an officer who was nearby, and who called an emergency medical code. At 7.37am, a nurse arrived and Mr Tuckwell indicated that he had chest pain. She gave him oxygen, GTN spray and aspirin. An ambulance took Mr Tuckwell to hospital, where staff diagnosed euglycemic diabetic ketoacidosis (a diabetic metabolic abnormality).

7. On 24 July, Mr Tuckwell started to make grunting noises while a hospital nurse attended to him. The nurse pressed the emergency alarm and an escort officer removed the escort chain. Hospital doctors and nurses attended and tried to resuscitate Mr Tuckwell but a doctor confirmed that he had died.

8. The post-mortem report found that Mr Tuckwell died of a heart attack caused by heart disease (with a blocked cardiac stent) and a paracetamol and citalopram overdose.

Findings

9. Mr Tuckwell took an overdose of prescribed medication and gave no indication to staff that he was at risk of suicide or self-harm. We are satisfied that staff could not reasonably have predicted his actions.

10. The clinical reviewer considered that most of the care that Mr Tuckwell received at Elmley was equivalent to that which he could have expected to receive in the community. However, healthcare staff did not appropriately manage his long-term heart condition.

11. The decision to use restraints when Mr Tuckwell was taken to hospital on 23 July 2018 was unjustified given he had significant chest pain and difficulty talking. We have raised concerns with Elmley before about the unjustified use of restraints, most recently in November 2018. The prison has committed to improving its risk assessment process to ensure that the use of restraints is proportionate to the risk posed by the prisoner.

12. After the emergency medical code had been called, there was a delay of seven minutes before control room staff called an ambulance. Although this did not affect the outcome in Mr Tuckwell's case, it could be critical in future cases.

Recommendations

- The Head of Healthcare should ensure that healthcare staff obtain community medical records for newly arrived prisoners, in line with PSO 3050.
- The Head of Healthcare should ensure that healthcare staff:
  - promptly follow-up on requests from doctors for investigations and secondary care;
  - carry out an ECG and arrange for a follow-up review when a prisoner presents with chest pain and shortness of breath; and
  - maintain accurate medical records, including the results of any investigations.
- The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called.

The Investigation Process

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

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

15. The investigator interviewed one member of staff by telephone on 31 August 2018.

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

17. We informed HM Coroner for Mid Kent and Medway District of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The investigator wrote to Mr Tuckwell's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Elmley

20. HMP Elmley serves the courts in Kent and holds up to 1,252 men, remanded and sentenced, in six houseblocks, with a mixture of single, double and triple cells. Integrated Care 24 Ltd provides 24-hour primary healthcare services, with input from Minster Medical Group. The prison's healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Elmley was in November 2015. Inspectors reported that healthcare services at the prison had improved since the last inspection in June 2014 and were generally good. The inpatient unit provided good care for prisoners with the most acute needs, though general access to healthcare services remained a problem. They also found that prisoners sometimes missed routine external hospital appointments because of competing prison priorities for escort staff.

Independent Monitoring Board

22. 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 October 2017, the IMB reported that the overall care for prisoners located in the inpatient unit was of a high standard. They reported that the outpatient department remained very busy and that despite every effort from staff, the number of complaints from prisoners remained high.

Previous deaths at HMP Elmley

23. Mr Tuckwell was the twenty first prisoner to die at Elmley since July 2015. Of the previous deaths, 16 were due to natural causes, two were self-inflicted and two were drug-related. There has been one natural causes death since Mr Tuckwell's death.

24. We have made recommendations to address the need for staff to justify using restraints on prisoners taken to hospital in six previous investigations, most recently in November 2018 when we escalated our recommendation to the Prison Group Director for Kent, Surrey and Essex. We have identified the inappropriate use of restraints yet again in this case.

Key Events

25. On 21 February 2018, Mr Bryan Tuckwell was remanded to custody for sexual offences and sent to HMP Elmley.

26. At an initial reception screen, a mental health nurse noted that Mr Tuckwell had several long-term health conditions including, heart disease, insulin-dependent diabetes and anxiety. He created care plans and obtained Mr Tuckwell's consent to request his community medical record. However, there is no record that staff received this information.

27. The nurse recorded that Mr Tuckwell took citalopram (an antidepressant) but had not seen a psychiatrist in the community. Mr Tuckwell did not report thoughts of suicide or self-harm and he assessed him as suitable to keep his medication in his cell and administer it himself. A prison GP reviewed Mr Tuckwell who told him that he had had heart bypass surgery about three years earlier. He booked a GP appointment to discuss referring Mr Tuckwell to the cardiology department at hospital and prescribed 28 days of appropriate medication.

28. On 23 February, Mr Tuckwell failed to attend a secondary health screen. Later that day, prison staff found him collapsed on the floor of his cell and called an emergency medical code blue (which indicates that a prisoner is unconscious or has breathing problems). A nurse attended and noted that although Mr Tuckwell appeared anxious, he was alert and breathing normally. He took his clinical observations, which were normal, and recorded that he had an upcoming GP appointment.

29. On 26 February, a prison GP examined Mr Tuckwell and noted that he had a history of chest pain and breathing problems. Mr Tuckwell said that he was due to have a follow-up hospital appointment after his heart bypass but that it had been cancelled four times. The GP requested an ECG and a cardiology referral. However, there is no record this took place.

30. Over the next two months, healthcare staff prescribed medication and saw Mr Tuckwell when they could but he did not always attend appointments. On 24 April, a nurse saw Mr Tuckwell to discuss his non-attendance and he said that officers had not told him about his appointments. She requested an urgent diabetic review and referred him to the prison's complex care clinic.

31. On 26 April, Mr Tuckwell failed to attend the diabetic clinic. A healthcare assistant spoke to prison staff and confirmed that officers had told him about his appointment. Later that day, officers sent Mr Tuckwell to the healthcare department and he told a prison GP that he had waited without being seen by healthcare staff on several occasions. He did not know why he was due to be seen but after checking the prisons electronic medical record, the GP noticed that he was due an ECG. She arranged for him to have one the following day.

32. On 27 April, a nurse conducted a complex case review and Mr Tuckwell reported angina (chest pain caused by reduced blood flow to the heart muscles), which he treated using GTN spray. She noted that Mr Tuckwell took citalopram for anxiety and that he had not reported any concerns since he arrived at Elmley. The mental health nurse at the time of Mr Tuckwell's reception screen but had

changed jobs to become the Clinical Operational Lead, confirmed that an ECG took place, but the prison could not find evidence of the result.

33. On 10 May, a prison GP saw Mr Tuckwell in the healthcare department and noted that he did not know why he was there. She suspected that he might have missed an appointment for an ECG and arranged for a nurse to complete one while he was there. However, there is no record of the ECG result in the prison's electronic medical records. The GP referred Mr Tuckwell to the thoracic (chest) medicine department at a private London hospital, but the referral was re-routed to Medway Maritime Hospital the next day.

34. On 28 May, Mr Tuckwell experienced increased anxiety about his cellmate's controlling behaviour and had a panic attack. A nurse reviewed him, noted that he reported chest pain and advised him to use GTN spray. On 31 May, a nurse examined Mr Tuckwell in response to a code blue and recorded that he continued to feel anxious despite prison staff moving his cellmate. She diagnosed a panic attack and requested a GP review.

35. On 7 June, a prison GP referred Mr Tuckwell to the prison's mental health team after he told her there was "another one" inside of him. There is no record that she spoke to him about his panic attacks and chest pain. A week later, a mental health manager completed an initial assessment and noted that Mr Tuckwell reported seeing a psychiatrist but had not received a diagnosis. He requested Mr Tuckwell's community mental health record and put his case on hold. On 6 July, a mental health nurse recorded that she had received Mr Tuckwell's mental health record, but there is no evidence of this information.

36. Mr Tuckwell went to court four times between 16 and 20 July. Healthcare staff reviewed him in reception but there is no record that he reported any thoughts of suicide or self-harm. On 20 July, a prison administrator noted that Medway Maritime Hospital had made Mr Tuckwell a cardiology appointment for September as thoracic medicine was not the correct specialist department.

Events between Monday 23 July and Tuesday 24 July 2018

37. At 7.17am on 23 July, an officer responded to Mr Tuckwell's cell bell and looked through the cell door observation panel. The prison could not identify the officer.

38. At 7.35am, an officer responded to Mr Tuckwell's cell bell, looked through the cell door observation panel and saw him collapsed on the floor. He shouted to another officer, who immediately called a medical emergency code blue. CCTV footage shows that they went into Mr Tuckwell's cell within one minute.

39. At 7.37am, a nurse arrived and noticed that Mr Tuckwell had chest pain and difficultly speaking. She recorded that his oxygen saturation level was between 72 and 100% (normal is between 95 and 100%) and gave him oxygen, GTN spray and aspirin. An ambulance arrived at 8.06am and paramedics attended to Mr Tuckwell. He was due to appear in court later that morning but he was assessed as unfit to attend.

40. At 9.30am, paramedics took Mr Tuckwell to Medway Maritime Hospital. Two officers escorted him and restrained him using an escort chain (a long chain with

a handcuff at each end, one of which is attached to the prisoner and the other to an officer). Hospital staff diagnosed euglycemic diabetic ketoacidosis (a diabetic metabolic abnormality) and admitted him for treatment. Escort records show that Mr Tuckwell's urine tested positive for diazepam (a medication used to treat anxiety, which he had not been prescribed, but he denied taking anything.

41. At 5.30am, on 24 July, two officers took over as Mr Tuckwell's escort officers. They noted that he talked to them but did not report any concerns. At 2.40pm, a hospital nurse helped Mr Tuckwell to move onto his back so that she could insert a cannula. Mr Tuckwell started to make a grunting noise and the nurse pressed the emergency alarm. One of the officers immediately removed the escort chain. Hospital doctors and nurses tried unsuccessfully to resuscitate Mr Tuckwell and a doctor confirmed that he had died at 1.28pm.

Contact with Tuckwell's family

42. At around 1.25pm, on 24 July, the prison appointed a prison chaplain as the family liaison officer. Shortly afterwards, a custodial manager told him that Mr Tuckwell had died. The chaplain identified that Mr Tuckwell had named his sister as his next of kin and visited her with a supervising officer. At 3.00pm, the chaplain broke the news to Mr Tuckwell's sister's husband as she had gone out. Her husband said that he would tell her when she got home and they returned to the prison. At 6.45pm, the chaplain phoned Mr Tuckwell's sister to confirm that she was aware of his death.

43. On 25 July, the chaplain and a colleague visited Mr Tuckwell's sister to offer their condolences and support. The chaplain supported her until his funeral, which he attended with his colleague, on 3 September. The prison did not contribute towards the cost as Mr Tuckwell had a pre-paid funeral plan.

Support for prisoners and staff

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

45. The prison posted notices informing other prisoners of Mr Tuckwell'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 Tuckwell's death.

Post-mortem report

46. A post-mortem examination found that Mr Tuckwell had died of a heart attack caused by underlying heart disease (with a blocked cardiac stent) and an overdose of paracetamol and citalopram, which had been prescribed to him. The post-mortem report notes that paracetamol and citalopram are recognised as having effects on the heart. It concludes that the presence of these drugs in high levels ultimately caused his death.

Events after Mr Tuckwell's death

47. On 24 July, prison staff submitted an intelligence report which stated that a prisoner had asked if Mr Tuckwell had died and said, "I bet he wishes he didn't

take them meds off another prisoner now”. It is not clear which medications this referred to.

Findings

Overdose of prescribed medication

48. The post-mortem report found that the high levels of citalopram and paracetamol in Mr Tuckwell's blood ultimately caused his death. Mr Tuckwell was prescribed citalopram and paracetamol which he was allowed to keep in his cell and administer himself. He collected his supply every 28 days. We therefore consider it likely that Mr Tuckwell took a large amount of this medication.

49. Prison and healthcare staff had frequent contact with Mr Tuckwell and there is no record that he reported any thoughts of suicide or self-harm. There is no record that healthcare staff reviewed his risk of keeping and administering his own medication but we are satisfied that there was no evidence that he presented a risk of overdose.

50. Prison escort records show that Mr Tuckwell's urine tested positive for diazepam at hospital, but analysis of post-mortem toxicology tests did not find diazepam in his system. While it is possible that Mr Tuckwell might have obtained diazepam from another prisoner, we are satisfied that it did not contribute to his death.

51. No one who saw Mr Tuckwell before his death had reason to consider that he was at risk. He did not report any thoughts of suicide or self-harm to staff and we are satisfied there was no intelligence to suggest he was at risk of an overdose.

Healthcare procedures for newly arrived prisoners

52. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners requires that when a new prisoner arrives in reception, prison staff try to obtain relevant information from the prisoner's GP or other relevant health services the prisoner has recently been in contact with.

53. Given the fact that Mr Tuckwell had medication to treat several conditions and had reported a history of heart bypass surgery, it was particularly important that healthcare staff should have obtained his community medical records for up to date information on his health conditions and treatment. Despite obtaining Mr Tuckwell's consent to request his community medical records, healthcare staff did not follow this up and did not ensure that they received information from his GP. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff obtain community medical records for newly arrived prisoners, in line with PSO 3050.

Clinical care

54. The clinical reviewer considered that most of the care that Mr Tuckwell received at Elmley was equivalent to that which he could have expected to receive in the community. His diabetes care was satisfactory and he was appropriately seen by a mental health nurse.

55. However, healthcare staff did not manage his heart condition appropriately. The clinical reviewer considered that Mr Tuckwell's history of heart surgery, ongoing

chest pain and difficulty breathing should have raised a high level of suspicion of unstable heart disease. Healthcare staff did not refer Mr Tuckwell to the hospital cardiology department when first requested, and when they did, it was given normal priority and made to the wrong hospital and department. While the hospital issue was resolved promptly, the clinical reviewer noted that an urgent referral might have been more appropriate given Mr Tuckwell's history, symptoms and level of risk.

56. Mr Tuckwell had several panic attacks in prison and healthcare staff did not appropriately follow these up with an ECG or GP review. The clinical reviewer considered that it would have been prudent for healthcare staff to take further action after Mr Tuckwell's panic attacks, as they are often difficult to differentiate from more serious conditions such as a heart attack. We are concerned that staff only conducted one ECG and that they had no records of the result. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff:

- **follow-up on requests from doctors for investigations and secondary care;**
- **carry out an ECG and arrange for a follow-up review when a prisoner presents with chest pain and shortness of breath; and**
- **maintain accurate medical records, including the results of any investigations.**

Emergency response

57. We have not been able to establish why Mr Tuckwell's cell bell was activated at 7.17am on 23 July. The prison could not identify the officer who responded, and we therefore cannot conclude whether the call related to Mr Tuckwell.

58. Prison Service Instruction (PSI) 03/2013 on medical response codes requires the control room to call an ambulance as soon as a medical emergency code is called, and for healthcare staff to attend with the appropriate emergency equipment.

59. Although an officer responded promptly when he found Mr Tuckwell unresponsive and another officer used an appropriate emergency medical code, control room records show that there was a seven-minute delay in the control room calling for an ambulance. The prison was unable to provide us with a specific reason for the delay. While the immediate calling of an ambulance would not have changed the outcome for Mr Tuckwell, in other emergency situations, it could be crucial. We therefore make the following recommendation:

The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called.

Restraints, security and escorts

60. 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.

61. 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 they have a serious medical condition. The judgment indicated that 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.

62. When Mr Tuckwell was taken to hospital on 23 July, a prison manager authorised two officers to restrain him using an escort chain. A risk assessment was completed and stated that Mr Tuckwell presented a low risk of escape and should be restrained by a single handcuff due to his poor health. (The standard level of restraint for an unsentenced prisoner in good health is a double handcuff - when the prisoner has his hands handcuffed in front of him and one wrist attached to a prison officer by an additional set of handcuffs.). The medical section of the risk assessment was not completed.

63. The manager told the investigator that he reviewed the assessment before Mr Tuckwell left for hospital and reduced the level of restraint to an escort chain so that paramedics could attend to him. He said that his understanding was that Mr Tuckwell had recovered to the extent that he could walk without a stretcher. However, CCTV shows that he was carried out of the houseblock on a stretcher.

64. While we acknowledge that the manager authorised a lower level of restraint for Mr Tuckwell, we consider that the use of a restraint was still unjustified. Mr Tuckwell had chest pain, difficulty talking and limited mobility when he was taken to hospital. We are particularly concerned that the medical section of the escort risk assessment was not completed. This meant that there was no input from healthcare staff about Mr Tuckwell's current medical condition and how that affected his risk of escape.

65. Elmley's local policy states that a prisoner's initial risk assessment should be reviewed within 72 hours of admission to hospital or when there has been any relevant change in circumstances. We are pleased that an officer acted promptly and removed Mr Tuckwell's escort chain immediately after hospital staff pressed the emergency alarm.

66. We have previously expressed concerns about the inappropriate use of restraints on sick and aging prisoners at Elmley, and the prison has committed on each occasion to address these failings. In November 2018, we drew our concerns to the attention of the Prison Group Director for Kent, Surrey and Essex. In response, the prison updated the healthcare section of the escort risk assessment to include age and mobility. The Prison Group Director said that their regional team would carry out random quality checks of risk assessment during monthly assurance visits. On that basis, we have not made a recommendation about this issue in this case.

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