Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Stuart Tomlinson, a prisoner at HMP Rye Hill, on 16 August 2021

## A report by the Prisons and Probation Ombudsman

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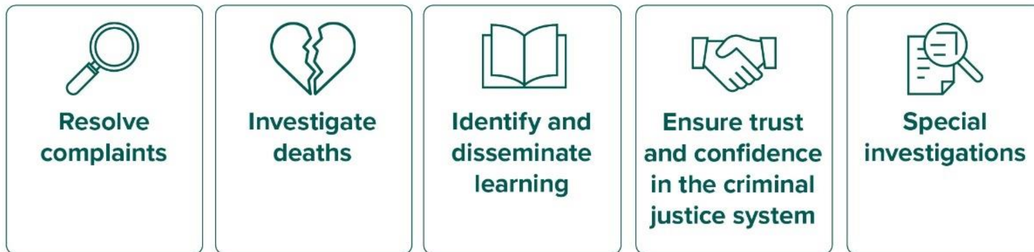
## OUR VISION

**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

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# 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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Tomlinson died of congestive cardiac failure caused by hypertensive heart disease on 16 August 2021 while a prisoner at HMP Rye Hill. He was 61 years old. We offer our condolences to Mr Tomlinson's family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Tomlinson received at HMP Rye Hill was equivalent to that which he could have expected to receive in the community.

5. However, the clinical reviewer said healthcare staff missed an opportunity to escalate Mr Tomlinson's care in relation to his diabetes and the cancellation of hospital appointments.

6. We are concerned that the use of restraints in Mr Tomlinson's final hours were not justified given his poor health and very rapid deterioration. We have made a recommendation accordingly.


## Recommendations

- The Head of Healthcare must ensure all clinical staff understand the national guidance for the management of diabetes.
- The Governor and Head of Healthcare should ensure that urgent medical appointments are cancelled as a last resort and there is a clear record of the reason for the cancellation.
- The Governor should ensure that all staff undertaking risk assessments for prisoners in hospital understand the legal position, and that assessments fully take into account the health of the prisoner and are based on the actual risk the prisoner presents at the time.

# The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Tomlinson's clinical care at Rye Hill.

8. The PPO investigator has investigated the non-clinical issues in Mr Tomlinson's care, including his location, the security arrangements for his hospital escorts and liaison with his family.

9. The PPO family liaison officer wrote to Mr Tomlinson's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Tomlinson's family had no questions but requested a copy of the report.

10. Mr Tomlinson's family received a copy of the draft report and indicated that they did not identify any inaccuracies.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

## Previous deaths at HMP Rye Hill

12. There were 13 deaths from natural causes (four of which were related to COVID-19) at Rye Hill in the two years before Mr Tomlinson's death.

13. There are similarities between Mr Tomlinson's death and four previous deaths at Rye Hill between February 2020 and February 2021, in which the use of restraints was not appropriately reviewed for seriously ill prisoners in hospital. We also made recommendations for the Head of Healthcare to ensure that diabetes was managed in line with NICE guidelines, in February 2020 and December 2020. The prison had not responded to our recommendations at the time of our investigation.

## Key Events

14. On 10 June 2016 Mr Tomlinson was sentenced to 13 years in prison for sexual offences and sent to HMP Liverpool. He transferred to HMP Rye Hill on 29 September 2016.

15. Mr Tomlinson had a history of type II diabetes, hypertension and depression. The clinical reviewer is satisfied that he was appropriately screened and monitored for his health conditions when he arrived at Rye Hill.

16. Mr Tomlinson first reported to have shortness of breath and wheeziness in October 2019. He was diagnosed with irritable airways and prescribed an inhaler. His breathing improved until 26 May 2021 when he presented with similar symptoms.

17. On 10 June, Mr Tomlinson said that he had very swollen ankles and was short of breath. A prison GP recorded that his pulse and blood pressure were within the normal range. He was appropriately referred for an ECG, which was normal, although it was noted that Mr Tomlinson had an occasional irregular heartbeat.

18. During a routine review later in June, a nurse recorded that Mr Tomlinson's diabetes was not well controlled, so prescribed him more medication. She also advised Mr Tomlinson to eat more carbohydrates to control his blood sugar.

19. On 1 July, a wound management plan was put in place to manage Mr Tomlinson's leg ulcers. At the time of this review, a nurse recorded Mr Tomlinson's ketone level as 15.7mmols (a normal ketone level is below 0.6mmols and a reading over 3mmols is considered very high, requiring immediate emergency intervention). She told him to eat more carbohydrates and requested that he be reviewed by the GP the next day. Results of a blood test taken earlier that day showed poorly controlled diabetes and symptoms of heart failure. The laboratory recommended that Mr Tomlinson was referred to the cardiology department to investigate his heart condition further.

20. During the evening of 2 July, Mr Tomlinson's ketone levels showed that he was at risk of ketoacidosis (a life threatening situation caused by a lack of insulin). He was taken by ambulance to University Hospital of Coventry and Warwickshire (UHCW) and discharged the following day when his ketone level had returned to the normal range. The hospital also told prison healthcare staff to refer Mr Tomlinson to cardiology for further assessment.

21. On 5 July, Mr Tomlinson developed more leg ulcers. A prison GP prescribed medication to treat his leg ulcers and breathlessness. He also referred Mr Tomlinson to cardiology because he suspected he had heart failure.

22. Mr Tomlinson's health conditions were regularly monitored and treated accordingly between July and August. However, he continued to have symptoms indicating a heart condition and his leg ulcers became worse. A prison GP reviewed him on 9 August and noted that he had still not had a cardiology appointment following the referral on 5 July.

23. On 10 August, another prison GP found that Mr Tomlinson's cardiology appointment had been cancelled by the prison regime department for logistical

reasons and rescheduled for December. The GP wrote to the cardiology department to tell them that an appointment was needed urgently.

24. On 12 August 2021 Mr Tomlinson's health worsened and his pulse was consistently high (120 bpm). A nurse radioed a medical emergency code blue (which indicates that a prisoner is unconscious or having breathing difficulties and triggers the control room to call an ambulance immediately). Mr Tomlinson was admitted to hospital with suspected heart failure.

25. The escort risk assessment for hospital assessed Mr Tomlinson as a medium risk. The duty Director authorised the use of an escort chain and confirmed that restraints could be removed for medical treatment and emergencies, if authorised by a duty manager. She acknowledged in the decision making log that Mr Tomlinson was "seriously unwell and had low walking mobility" but described him as "able". Healthcare staff indicated that there were no medical objections to the use of restraints.

26. Mr Tomlinson was admitted to University Hospital of Coventry and Warwickshire and he remained on an escort chain until the morning of 16 August. Restraint risk assessments were completed regularly during this time and reflected no significant changes to his health or risk.

27. On 16 August at 4.15am Mr Tomlinson fell over when going to the toilet. He asked a Prison Custody Officer (PCO) if the escort chain could be removed. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) The bedwatch staff did not ask for the restraints to be removed or for the risk assessment to be reviewed, so he remained restrained by an escort chain. A hoist was used to assist Mr Tomlinson as he could not get up independently.

28. Mr Tomlinson's health continued to worsen and, at 8.35am, he was struggling to breathe. At 9.40am, bedwatch staff asked for the prison duty director to authorise the removal of the escort chain, which was approved.

29. Mr Tomlinson was moved to a smaller bay on the same ward at 10.00 am and died at 10.27am from heart failure. Restraints were not reapplied to Mr Tomlinson before he died.

## Post-mortem report

30. The post-mortem report concluded that Mr Tomlinson died of congestive cardiac failure (heart failure) caused by hypertensive heart disease. He also had type II diabetes which did not cause but contributed to his death.

# Findings

## Clinical Findings

31. The independent clinical reviewer concluded that the care that Mr Tomlinson received was equivalent to that he could have expected to receive in the community.

32. The clinical reviewer was satisfied that Mr Tomlinson' diabetes, hypertension and later his leg ulcer, were regularly and appropriately monitored. However, on 1 July, the prison nurse did not treat Mr Tomlinson's potential high ketone level as a medical emergency in accordance with national diabetes guidelines (NICE 2020). We make the following recommendation:

    **The Head of Healthcare must confirm that all clinical staff fully understand the national guidance for the management of diabetes.**

### Cancellation of medical appointment

33. On 10 August, a prison GP identified in medical records that Mr Tomlinson's cardiology appointment had been cancelled by the prison regime department. We are concerned that this urgent medical appointment was cancelled by the prison without a clinical opinion.

34. The Head of Security told us that there is a process in place to discuss weekly hospital appointments and consult with healthcare staff in the event that an appointment cannot be facilitated. This does not appear to have prevented Mr Tomlinson's urgent appointment from being cancelled. We make the following recommendation:

    **The Governor and Head of Healthcare should ensure that a record is made of the decision-making process in any case where an urgent medical appointment is cancelled.**

## Non-Clinical Findings

### Restraints, security and escorts

35. 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.

36. 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 suffering from 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.

37. We are concerned that staff did not consider a review of restraints when Mr Tomlinson's health changed, and he fell on the morning of 16 August. He could not get up without a hoist and had infected leg ulcers, which further affected his mobility.

38. It is difficult to understand why restraints were considered necessary at that time, when Mr Tomlinson was escorted by two officers. The risk assessment was not reviewed in line with expectations and failed to consider the actual risk, as the High Court judgment requires. The night manager was not aware of Mr Tomlinson's fall until after he had died. We make the following recommendation:

**The Governor should ensure that all staff undertaking risk assessments for prisoners in hospital understand the legal position, and that assessments fully take into account the health of the prisoner and are based on the actual risk the prisoner presents at the time.**

**Sue McAllister CB**
**Prisons and Probation Ombudsman** **April 2022**

## Inquest

The inquest, held on 26 July 2023, concluded that Mr Tomlinson died from natural causes.

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