Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mervyn Tedbury, a prisoner at HMP Isle of Wight, on 3 April 2022

A report by the Prisons and Probation Ombudsman

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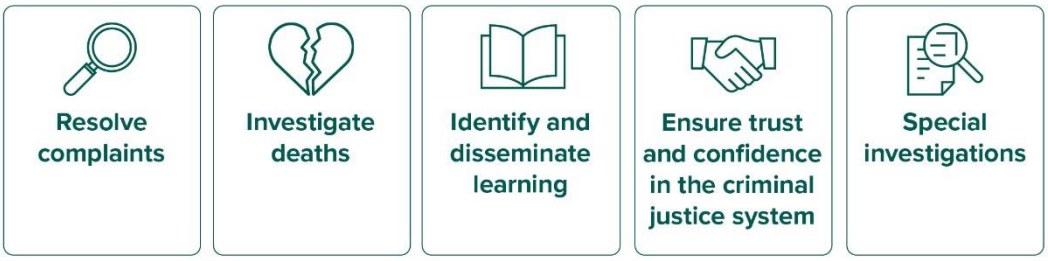
OUR VISION

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. 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 Mervyn Tedbury died in hospital of heart failure caused by COVID-19 pneumonia and chronic obstructive pulmonary disease (COPD – lung disease) on 3 April 2022, while a prisoner at HMP Isle of Wight. He was 82 years old. We offer our condolences to Mr Tedbury's family and friends.

4. Mr Tedbury tested positive for COVID-19 on 20 March 2022 and was taken to hospital a week later. Before that, Mr Tedbury had not left the prison since 22 February, when he was taken to hospital and discharged the same day, so it appears that he caught COVID-19 at the prison subsequently.

5. The clinical reviewer concluded that the healthcare Mr Tedbury received at Isle of Wight was of a reasonable standard and equivalent to that which he could have expected to receive in the community. However, she made three recommendations.

Recommendations

- The Head of Healthcare should ensure all healthcare staff are aware of and use disclaimers for patients who refuse recommended care.
- The Head of Healthcare should ensure all healthcare staff are aware of and abide by the recommendations of PCR testing of patients within a custodial setting.
- The Head of Healthcare should ensure that staff create timely care plans for the management of long-term conditions.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Tedbury's clinical care at HMP Isle of Wight.

7. The PPO investigator investigated non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners, Mr Tedbury's location, the security arrangements for his hospital escorts and liaison with his family.

8. The PPO's family liaison officer wrote to Mr Tedbury's next of kin, his daughter, to explain the investigation. She did not respond to our letter.

9. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

Previous deaths at HMP Isle of Wight

10. Mr Tedbury was the twentieth prisoner to die at Isle of Wight since April 2020. Of the previous deaths, 15 were from natural causes and four were self-inflicted. Four of the deaths were due to COVID-19. We have previously made recommendations on the need for timely care plans.

COVID-19 (coronavirus)

11. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.

12. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)

13. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners, or staff, who are clinically suspected, or have tested positive for COVID-19 within 14 days.) A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly arrived prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

14. On 17 September 2021, the Government advised that it was no longer necessary for the clinically vulnerable to shield. This was on the basis that vaccination had reduced the risk to them.

Key Events

15. In August 2017, Mr Mervyn Tedbury was sentenced to 13 years in prison for sexual offences. He was moved to HMP Isle of Wight on 22 September.

16. Mr Tedbury had several long-term health conditions including chronic obstructive pulmonary disease (COPD – a group of lung conditions that make it difficult to breathe), heart failure (when the heart is unable to pump the blood around the body properly) and chronic kidney disease (a long-term condition where the kidneys do not work as well as they should).

17. Mr Tedbury had the first and second doses of his COVID-19 Vaccine on 10 February and 5 May 2021 respectively. Mr Tedbury had the booster dose on 30 November.

18. On 11 March 2022, wing staff noticed that Mr Tedbury was confused and took him to the healthcare unit. A prison GP diagnosed Mr Tedbury with a urinary tract infection and prescribed antibiotics.

19. On 19 March, wing staff again noticed that Mr Tedbury was confused and asked for a nurse to see him. The nurse took Mr Tedbury's temperature which was slightly raised. She thought he might have COVID-19 so gave Mr Tedbury a lateral flow test, but this was negative.

20. On 20 March, Mr Tedbury took another lateral flow test, which was positive. He then took a PCR (polymerase chain reaction) test, which was also positive. (PCR tests are sent to a laboratory and are more accurate than lateral flow tests.)

21. On 21 March, a prison GP reviewed Mr Tedbury and recommended that he should go to hospital. Mr Tedbury declined to go to hospital. The GP arranged for Mr Tedbury to be moved to the prison's inpatient unit so he could be monitored by prison healthcare staff.

22. On 22 March, Mr Tedbury's blood oxygen level dropped, and staff requested an ambulance. The paramedics decided not to take Mr Tedbury to hospital.

23. Between 22 and 27 March, healthcare staff regularly monitored Mr Tedbury and took his clinical observations. On 27 March, Mr Tedbury took another lateral flow test, which was still positive.

24. On 27 March, Mr Tedbury's blood oxygen level dropped again, and healthcare staff called for an ambulance. This time, the ambulance paramedics took Mr Tedbury to hospital.

25. On 2 April, hospital staff told the prison that Mr Tedbury was declining medication and oxygen and was deteriorating rapidly.

26. On 3 April, Mr Tedbury died in hospital.

Post-mortem report

27. The post-mortem report concluded that Mr Tedbury died of cardiac failure caused by COVID-19 pneumonia and severe COPD. Chronic kidney disease was listed as a contributory factor.

Findings

Clinical care

28. The clinical reviewer considered that the care Mr Tedbury received at HMP Isle of Wight was equivalent to that which he could have expected to receive in the community. However, she made three recommendations.

Management of Mr Tedbury's risk of infection from COVID-19

29. Mr Tedbury tested positive for COVID-19 on 20 March 2022. He had not left the prison since 22 February, when he went to hospital and was discharged the same day. It appears, therefore, that he caught COVID-19 in prison. Mr Tedbury was fully vaccinated against COVID-19 but his health conditions put him at increased risk of serious illness if he contracted the virus.

30. On 21 April and 15 December 2020, the Department of Health and Social Care informed Mr Tedbury by letter that he was classed as extremely clinically vulnerable to COVID-19 and advised him to shield. Mr Tedbury declined to shield.

31. The clinical reviewer found no evidence that a disclaimer was signed by Mr Tedbury when he chose not to follow shielding advice. The clinical reviewer also found no evidence that a disclaimer was signed when Mr Tedbury refused to go to hospital on 21 March and on one occasion on 27 March before his eventual transfer. We recommend:

    The Head of Healthcare should ensure all healthcare staff are aware of and use disclaimers for patients who refuse recommended care.

COVID-19 testing

32. The clinical reviewer found that when Mr Tedbury showed possible symptoms of COVID-19, staff gave him a lateral flow test. This was not in line with recommended guidance from the Ministry of Justice and UK Health Agency Guidance who recommended a PCR test. Furthermore, a PCR test was not taken until Mr Tedbury had a positive lateral flow test on 20 March. We recommend:

    The Head of Healthcare should ensure all healthcare staff are aware of and abide by the recommendations of PCR testing of patients within a custodial setting.

Monitoring Mr Tedbury after he contracted COVID-19

33. The clinical reviewer found that healthcare staff appropriately managed Mr Tedbury's condition after he tested positive by isolating him appropriately, initiating the proper care plans, and monitoring him closely for signs of decline in the prison's inpatient unit.

34. The clinical reviewer found that the nursing team appropriately called for an ambulance on 22 March when Mr Tedbury's blood oxygen level dropped. Paramedics assessed Mr Tedbury and decided not to admit him to hospital.

Management of COPD

35. The clinical reviewer found that healthcare staff appropriately assessed and monitored Mr Tedbury during times of serious illness due to his COPD.

36. However, she noted that there was a delay in staff creating a care plan for his COPD, which was not created until December 2017 despite him arriving at the prison in September 2017. We recommend:

    The Head of Healthcare should ensure that staff create timely care plans for the management of long-term conditions.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **March 2023**

Inquest

At the inquest, held on 25 July 2025, the Coroner concluded that Mr Tedbury died from natural causes.

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