Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Tilley, a prisoner at HMP Isle of Wight, on 26 September 2021

A report by the Prisons and Probation Ombudsman

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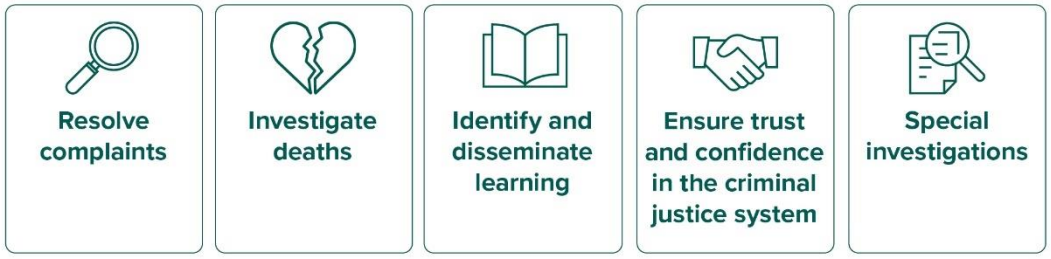
OUR VISION

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

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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr David Tilley died in hospital from COVID-19 on 26 September 2021, while a prisoner at HMP Isle of Wight. He was 70 years old. I offer my condolences to Mr Tilley's family and friends.

4. Mr Tilley caught the infection at Isle of Wight as he had not left the prison for several months.

5. The clinical reviewer found that Mr Tilley's care was not equivalent to that which he could have expected to receive in the community. She made recommendations on vaccine disclaimers; clinical assessment and escalation following a head injury; monitoring of long-term conditions; clinical tasks; and record keeping.

6. The investigation also found weaknesses in the management of Mr Tilley's risk of infection from COVID-19 and the action taken when he reported possible symptoms of the virus. However, we make no formal recommendations given the changes in policy and processes since the COVID-19 pandemic.

The Investigation Process

7. HMPPS notified us of Mr Tilley's death on 26 September 2021.

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

9. The PPO investigator investigated the non-clinical issues.

10. The Ombudsman's family liaison officer wrote to Mr Tilley's next of kin, his wife, to explain the investigation and ask if there were any issues she wanted us to consider. She did not respond.

11. The initial report was shared with HMPPS, who reported two inaccuracies. These have been amended.

Previous deaths at HMP Isle of Wight

12. Mr Tilley was the twenty-sixth prisoner at Isle of Wight to die since September 2018. Of the previous deaths, nineteen were from natural causes (one due to COVID-19) and six were self-inflicted. There have been eighteen deaths since, fourteen from natural causes (of which three were COVID-19 related), two self-inflicted and two awaiting classification. There are no significant similarities between our findings in this investigation and those in the previous deaths.

COVID-19 (coronavirus)

13. 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.

14. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. In response to the pandemic, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain outbreaks - to be implemented at local level, depending on the needs of individual prisons. (A key strategy was '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.)

15. In September 2021, the shielding programme ended in the community, but HMPPS continued to routinely offer shielding to clinically high-risk prisoners. This has recently been replaced by a system of individual risk assessments by clinical staff, to determine the measures necessary to support such prisoners. The agreed adjustments are documented in a Personal Management Plan, which is then facilitated by operational staff.

Key Events

16. Mr David Tilley was convicted of sexual offences on 26 April 2018 and remanded to HMP Exeter. The next day, he was sentenced to 14 years imprisonment, as well as an extended licence period of one year in the community. He transferred to HMP Isle of Wight on 23 August.

17. Mr Tilley had several chronic health conditions, including a mini stroke a week before he went into prison, low blood pressure, urinary problems, raised cholesterol, depression and osteoarthritis, which had led to reduced mobility. In August 2019, Mr Tilley was diagnosed with mild dementia.

18. On 1 April 2020, shortly after confirmation of the COVID-19 pandemic, Mr Tilley was assessed as at moderate risk of developing complications if he contracted the virus. Throughout the pandemic, he had regular welfare checks and meetings with his prison key worker. He also received a weekly COVID-19 newsletter. Wing staff noted that Mr Tilley understood the altered regimes and how to minimise his risk.

19. Healthcare staff at the prison monitored Mr Tilley's medical conditions and social care was provided three times a week from August 2020.

20. In February 2021, the prison considered an application for early release on compassionate grounds, but Mr Tilley did not meet the criteria.

21. On 10 and 17 February, healthcare staff offered Mr Tilley a COVID-19 vaccination. He declined both times and signed a disclaimer to confirm this.

Events from 15 September 2021

22. On 15 September, Mr Tilley told wing officers that he had symptoms of COVID-19. A nurse assessed him. She noted his symptoms as a headache, feeling hot and cold, as well as problems with smell and taste (which he said were not new). She told Mr Tilley that he had not described any COVID-19 symptoms, but healthcare staff would conduct another welfare check the following day. There is no evidence that this took place.

23. The nurse arranged a GP appointment to discuss urinary problems that Mr Tilley had mentioned in passing. A prison GP reviewed him on 16 September and noted that he appeared to be well. There was no reference to COVID-19.

24. In the early hours of 18 September, Mr Tilley told night staff that he had fallen next to his bed and hit his head. He was assessed by a healthcare assistant and told her that he had a headache, dizziness and had been nauseous for a few days. She found no injuries but asked officers to monitor him. Clinical observations, taken at that time and later in the morning, were within normal range.

25. On 21 September, there was an outbreak of COVID-19 at Isle of Wight. The prison conducted mass testing of prisoners, but Mr Tilley was not included.

26. Just before 4.00pm on 23 September, Mr Tilley slipped in the bathroom, which he attributed to weakness in his legs and an officer helped him into bed. A nurse and a

healthcare assistant assessed Mr Tilley. He said that he had a headache, neck pain and had felt 'rough' for several days. Although he was alert, it was clear to the healthcare staff that he was very unwell.

27. The nurse took clinical observations and found that Mr Tilley had a low blood oxygen level. She calculated a score of 10, using the National Early Warning Score 2 (NEWS2), which indicated the need for emergency assessment by a critical care team and possible high dependency care. (NEWS2 is a clinical assessment tool to detect acute illness in patients.) She called a code blue medical emergency, and an ambulance was requested at 4.01pm.

28. Paramedics arrived at 4.25pm and took Mr Tilley to St Mary's Hospital. He was accompanied by two prison officers and no restraints were used for the journey (or in hospital). On arrival, Mr Tilley tested positive for COVID-19. He was initially admitted to a general ward but moved to the critical care unit that evening.

29. On 24 September, the prison's family liaison officer told Mr Tilley's wife that he was in hospital and gave details of his diagnosis and condition. They spoke again the following day.

30. Mr Tilley died at 10.00am on 26 September. The family liaison officer broke the news to his wife within half an hour and offered support.

31. Notices were issued to staff and prisoners, informing them of Mr Tilley's death and reminding them of the support available.

Cause of death

32. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Tilley's cause of death as COVID-19.

Findings

Clinical findings

33. The clinical reviewer considered that Mr Tilley's clinical care was not of a reasonable standard; and that it was not equivalent to that which he could have expected to receive in the community. She identified shortcomings in the clinical assessment and monitoring of Mr Tilley when he reported COVID-19 symptoms and after a fall with a possible head injury; advanced care planning; management of long-term conditions; and record keeping.

34. Full details of these findings are in the clinical review report. We reflect in this report the issues directly linked to Mr Tilley's cause of death.

35. Mr Tilley contracted COVID-19 at Isle of Wight, as he had not left the prison for some time.

Head of Healthcare to note

Management of Mr Tilley's risk of infection and symptoms of COVID-19

36. Mr Tilley was promptly identified as at moderate risk of complications from COVID-19. At that time, government policy required people at high risk to shield, but HMPPS' national policy also allowed those at moderate risk to shield where individual prisons could facilitate it. There is no evidence that Mr Tilley's risk was communicated to him, or that staff discussed the risks and options with him. However, entries in his personal records later indicated that he understood the protective measures.

37. The clinical reviewer noted that the disclaimers signed when Mr Tilley refused COVID-19 vaccines were incomplete, as staff did not record the reasons for his refusal and whether they had explained the risks and potential consequences. The clinical reviewer also considered that Mr Tilley should have been tested for COVID-19 on 15 September, when he reported symptoms of the virus.

38. We are not satisfied that Mr Tilley's risk was appropriately managed, or that his concerns about COVID-19 symptoms were handled correctly. Given the lapse of time and the consequent changes in COVID-19 policy and practice, we make no formal recommendations, but the Head of Healthcare should note the weaknesses highlighted.

Adrian Usher
Prisons and Probation Ombudsman **November 2023**

Inquest

At the inquest, held on 11 August 2025, the Coroner concluded that Mr Tilley died from natural causes.

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