Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jayantilal Mistry a prisoner at HMP Thameside on 20 November 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

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 Jayantilal Mistry died on 20 November 2016 of a lung infection, following a head injury when he had a fall at HMP Thameside. He was 68 years old. I offer my condolences to Mr Mistry's family and friends.

Mr Mistry had complex medical problems and multiple long term conditions. I am satisfied that he received a good standard of health care. Healthcare staff responded promptly when he fell and gave appropriate emergency treatment. I do not consider that prison staff could have prevented his death.

However, the prison should have appointed a family liaison officer at an earlier point and I am concerned that prison staff initially restrained Mr Mistry when they took him to hospital, even though he was a low risk category D prisoner, immobile and seriously ill. My investigator was informed by the prison that all prisoners go to hospital under restraint apparently irrespective of risk and state of health. This is not in line with the legal position, national guidance or common humanity.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2017**

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Summary

Events

1. On 18 December 2015, Mr Jayantilal Mistry was sentenced to three years in prison for fraud and arrived at HMP Thameside that day.

2. Mr Mistry had a history of complex medical conditions. He had hypertension, arthritis, gout and had previously suffered a heart attack and stroke. In 2013, he developed speech problems, which left him unable to speak. He had difficulty swallowing. Healthcare staff admitted Mr Mistry to the prison's inpatient unit. They devised care plans to manage his conditions and reviewed him regularly. He often fell over and staff reminded him to wear appropriate footwear, which he appeared reluctant to do.

3. On 4 November, Mr Mistry fell in the communal area of the inpatient unit. Staff called an emergency code and the control room called an ambulance immediately. Nurses attended, and bandaged Mr Mistry's head, which was bleeding heavily. Paramedics attended and took Mr Mistry to hospital, where he was admitted.

4. While in hospital, Mr Mistry was restrained with an escort chain. Mr Mistry deteriorated further in hospital. The day before he died, prison managers granted him temporary release and removed the handcuffs. He died on 20 November 2016. His family were with him.

Findings

5. The clinical care provided at Thameside was equivalent to that Mr Mistry could have expected in the community.

6. We are concerned that although Mr Mistry was seriously ill and a minimal security risk, prison managers decided he should be restrained for the journey to hospital and for a further two weeks, up until the day before he died.

7. The prison did not appoint family liaison officers promptly.

Recommendations

- The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Director of Thameside should ensure that the prison complies with prison service instructions about contacting the families of deceased or seriously ill prisoners.

The Investigation Process

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

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

10. The investigator interviewed seven members of staff at Thameside on 26 January 2017.

11. NHS England commissioned a clinical reviewer to review Mr Mistry's clinical care at the prison. He conducted joint healthcare interviews with the investigator.

12. We informed HM Coroner for Southwark of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. The investigatator contacted Mr Mistry's wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She had a number of concerns and comments for the investigation to consider including:

    - She was not informed of any hospital admissions, prior to his final admission to hospital.
    - On one occasion the escort officers would not allow her to visit him in hospital as they said she did not have permission, and she could not visit for a number of days.
    - In hospital, restraints were only removed the day before he died when a doctor asked for them to be removed.
    - She said that the doctors and nurses at Thameside had treated him well.
    - She said the officers in Thameside at the weekends whenever she visited Mr Mistry were fantastic with her husband and very helpful.

14. Mr Mistry's wife received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Thameside

16. HMP Thameside is a local prison in south east London that holds up to 900 men. It is privately run by Serco. Health services were delivered by Care UK until 31 March 2015, when the contract passed to Oxleas NHS Foundation Trust. There is 24 hour nursing provision and an 18 bed inpatient unit.

HM Inspectorate of Prisons

17. The most recent inspection of Thameside was in September 2014. Inspectors reported that health care services were being transformed and that all care had improved. There was an appropriate range of clinics, and care plans were in place in line with national guidance. Inspectors noted that the prison was working on implementing recommendations made by the PPO from previous investigations into deaths.

Independent Monitoring Board

18. 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 June 2016, the IMB reported that health care had improved but there were still unnecessary delays and unsatisfactory communication between prisoners and staff.

Previous deaths at HMP Thameside

19. Mr Mistry was the fifth prisoner to die from natural causes at Thameside since January 2014. We have made a recommendation on the disproportionate use of restraints before.

Release on Temporary Licence

20. Release on temporary licence (ROTL) can be granted for precisely defined and specific activities, which cannot be provided in the prison. A risk assessment is completed to ensure that the prisoner's temporary release does not present unacceptable risks. The governor of the prison is able to grant the temporary licence and will decide on whether the prisoner is to be accompanied by staff.

Key Events

21. On 18 December 2015, Mr Jayantilal Mistry was sentenced to three years in prison for fraud offences and arrived at HMP Thameside that day.

22. At his reception medical screen a nurse noted that Mr Mistry had hypertension, arthritis, gout and had had a heart attack and stroke. In 2013 he had developed speech problems, which eventually left him unable to speak. He also had difficulty swallowing. Healthcare staff admitted Mr Mistry to the prison's inpatient unit to assess his needs.

23. Nurses created care plans to manage Mr Mistry's medical conditions. Doctors continued with his prescription of warfarin to prevent blood clots. Doctors developed a warfarin care plan to monitor the doses, as the side effects for warfarin are dizziness and faintness.

24. On 24 December, Mr Mistry fell in his cell. A prison GP noted that two days earlier he had asked healthcare staff to order some anti-slip socks. He said Mr Mistry had a face injury that should be checked in hospital. At the hospital staff noted he did not have a haemorrhage or fracture. However, after an electrocardiogram (ECG – measures the electrical rhythm of the heart) they noted Mr Mistry had a mild heart blockage. They prescribed a beta blocker to help treat this. Hospital staff also diagnosed an acute kidney injury and they treated him with intravenous fluids. After two days, hospital staff discharged him back to Thameside. At Thameside staff monitored his risk of falls, and often tried to encourage Mr Mistry to wear slippers and not socks or bare feet when walking around.

25. On 18 January 2016, a physiotherapist completed a mobility assessment. He suggested Mr Mistry should use a zimmer frame, but he refused. He concluded that Mr Mistry only needed information about general health exercises.

26. Mr Mistry fell again in his cell on 22 February. He was wearing socks and a prison GP examined him and noted there was no swelling or bruises. He told him that he should wear slippers when moving around. Healthcare staff continued to monitor Mr Mistry and treat him for his ongoing conditions.

27. On 17 July, a senior nurse completed a comprehensive care plan. He recommended that a nurse or support worker should escort Mr Mistry when moving around the prison due to his risk of falls. He also said, due to his history, if Mr Mistry had any heart problems or breathing difficulties he should be sent to hospital immediately.

28. Mr Mistry fell again on 6 August. A nurse examined him and noted there was no sign of injury and Mr Mistry said he was fine.

29. Ten days later Mr Mistry fell again. This time he had a cut to his forehead. A nurse arranged for him to go to hospital. Hospital staff sutured the cut and said the stitches would need to be removed within one week. On his return to Thameside, social care support worker ordered some anti-slip socks, which he received on 9 September.

30. Between 17 August and 1 September, Mr Mistry fell three times. Each time he said he was not injured. Nurses suggested he use a wheelchair, but he declined.

31. On 12 September, a prison GP examined Mr Mistry. He noted he had a slow pulse and diagnosed low blood pressure. He reduced the dose of his tablets for irregular heartbeat (amiodarone).

32. On 14 September, staff held a case conference. Staff from the inpatient unit, social care team, healthcare managers and the occupational therapy team discussed possible treatment, as they were concerned about his frailty and irregular pulse. They noted that Mr Mistry had a nail and skin infection and he was on the waiting list to see a chiropodist. He was to continue receiving warfarin. A prison GP arranged for Mr Mistry to have an urgent ECG and blood tests at the hospital as his pulse for the morning had been between 34 and 38 beats per minute (under 60 beats per minute is low).

33. When Mr Mistry arrived at the hospital, he was admitted due to his low blood pressure. He remained in hospital until 15 September. Hospital staff said his amidarone should be reduced and prison GPs altered his prescription.

34. A prison GP checked Mr Mistry's heart rate on 19 September (it was 60 beats per minute, the low end of the normal range) and noted that his amiodrane medication had been reduced. He also completed a referral to the cardiology department to arrange for 24 hour ECG check.

35. On 23 and 25 September, Mr Mistry was sent to hospital for a slow pulse. Each time hospital staff discharged him as they said no further action was necessary for Mr Mistry's irregular heart beat. They recommended antibiotics for a possible chest infection.

36. A speech and language therapist assessed Mr Mistry on 29 September and recommended that Mr Mistry should receive soft foods. At another assessment on 7 October, the therapist confirmed that Mr Mistry had swallowing problems and severely impaired tongue movement. In addition to the continued modified diet, the therapist said Mr Mistry needed an alternative means of communication and said he should have an urgent neurology review. Mr Mistry often wrote down what he wanted to communicate.

37. On 13 October, a nurse chaired a case conference as Mr Mistry's physical health was deteriorating. Managers from Oxleas, prison managers, social care managers and Mr Mistry's solicitor discussed various options for Mr Mistry's early release on compassionate grounds. Mr Mistry's solicitor said he would contact Mr Mistry's family and would start the process.

38. Mr Mistry had the 24 hour ECG test and, on 3 November, a consultant cardiologist at the hospital noted that he had an irregular heart rhythm and recommended further investigation.

39. For every hospital appointment, healthcare staff noted that there were no objections to the use of restraints and that Mr Mistry had limited mobility. Managers authorised two escorts and a single handcuff for every visit.

Events on 4 November 2016

40. On 4 November at approximately 3.30pm, Mr Mistry had another fall. He was in the inpatients unit and had just finished using the computer, which was available to order canteen or book visits, when he fell on the floor, hitting his head. A nurse said he was in an office and heard a shout for "help".

41. An officer said she was completing a review in the activities room when she heard noises outside. She left the room and saw Mr Mistry lying on the floor. She said she saw a lot of blood pooling on the floor from his head. A member of staff pressed the alarm (this investigation has not been able to identify who) and she called the radio emergency code red (indicating a prisoner with severe blood loss). She said that she was not sure if the radio call had gone through (as she knew there were blind spots around the prison where a signal could not be picked up) so she asked another officer to repeat the radio code red.

42. A nurse said he saw Mr Mistry lying on the floor, with a head wound and blood on the floor. He said other staff were also there. He said nurses turned Mr Mistry over and applied pressure to the wound to stop the bleeding. The wound was cleaned with saline and a bandage applied. Nurses helped Mr Mistry to sit down, they administered oxygen to him and they checked his vital signs. His oxygen levels were 97% initially and then dropped to 94%. His blood pressure was also initially low at 86/46, raising to 92/38.

43. Control room staff immediately called for an ambulance and paramedics arrived at 3.42pm. Before they left the prison, staff completed a security risk assessment and a prison manager decided that Mr Mistry should be accompanied by two officers using a single handcuff. In hospital, managers authorised the removal of handcuffs the next day, but then on 6 November they authorised that they should be reapplied. The escort officers reported that Mr Mistry had been trying to get out of bed and remove his catheter.

44. On 6 November, nurses from Thameside visited Mr Mistry in hospital and spoke to the hospital nurses. They remained in telephone contact for updates from hospital nurses.

45. On 19 November, a nurse told the escorts that Mr Mistry was dying. Prison managers granted Mr Mistry Release on Temporary Licence (ROTL) from 6.00pm authorised the removal of restraints and reduced the escort to one officer.

46. Mr Mistry continued to deteriorate and became unresponsive. He died at 12.25am on 20 November. His family were with him.

Contact with Mr Mistry's family

47. Mr Mistry's wife and family visited him in hospital on 5, 14, 15, 17 and 20 November.

48. After he died, a prison manager rang Mr Mistry's wife to offer condolences and support. The prison appointed a family liaison officer on 20 November.

49. Mr Mistry's funeral was on 26 November and the prison contributed to the funeral costs, in line with national guidance

Support for prisoners and staff

50. After Mr Mistry's death, the nursing team manager debriefed the healthcare staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

51. The prison posted notices informing other prisoners of Mr Mistry'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 Mistry's death.

Post-mortem report

52. A post-mortem examination concluded that the cause of Mr Mistry's death was aspiration pneumonia (a lung infection after inhaling food or liquid), head injury after a fall associated with ischaemic (reduced blood supply) heart disease.

Findings

Clinical care

53. The clinical reviewer said that healthcare staff in the prison provided Mr Mistry with multidisciplinary and comprehensive care. He was cared for in the inpatient unit, a high dependency unit in the prison, designed for prisoners with complex needs.

54. The clinical care provided at Thameside was equivalent to that expected had Mr Mistry been in the community.

55. Healthcare staff referred Mr Mistry to opticians, podiatrists, physiotherapists and speech language therapists. They also arranged for social carers to help him. Daily healthcare assistants helped Mr Mistry to eat, keep his cell tidy and maintain his personal hygiene.

Falls risk assessment

56. Mr Mistry was unsteady on his feet. Healthcare staff frequently reminded him about moving with the appropriate footwear and a zimmer frame, as he would often walk around in just his socks. This could account for the number of falls that he had. After his first fall, healthcare staff assessed Mr Mistry with an emphasis of keeping him safe in the environment in which he lived. In line with the NICE guidelines for dealing with the assessment and prevention of falls in older people, an assessment highlighted the hazards, interventions needed and the need for a medication review to determine what effect his medication might have had on his stability. He was referred for a falls risk assessment, received advice and adjustments were made and staff were alerted to his very high risk of falls. We find this appropriate.

Family liaison

57. Prison Service Instruction (PSI) 49/2011, 'Prisoner Communication Services', states that all prisoners should be able to communicate with family and friends, that prisons should actively encourage prisoners to maintain outside contact and that prisoners should normally have access to phones for at least two hours each day. The PSI also requires Governors to ensure that prisoners with disabilities are able to make a telephone call. Mr Mistry was unable to use the telephone as he could not speak, and was only able to write down what he needed to communicate. Healthcare staff in the prison had written to Mr Mistry's wife to inform her of her husband's health and care. This is good practice. However, once in hospital she reported that she found it difficult to get updates on her husband's condition.

58. Prison Service Instruction (PSI) 64/2011, Safer Custody, says, "Where prisoners have a terminal illness or suffer an unpredicted and/or rapid deterioration in their physical health, prisons must have in place procedures for supporting the prisoner [and] engaging with their next of kin".

59. A family liaison officer was not appointed until after Mr Mistry died. His wife said that she initially had difficulty visiting her husband in hospital, although on 5

November it had been agreed she could visit two days later. We can find no evidence of what officers told Mr Mistry's wife on 7 November, and we cannot see why she was unable to visit between 5 and 14 November. The earlier appointment of a family liaison officer would have benefited Mr Mistry's family, and may have facilitated easier visitation and access to information in hospital. We make the following recommendation:

The Director of Thameside should ensure that the prison complies with prison service instructions about contacting the families of deceased or seriously ill prisoners.

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. 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.

61. Thameside has a local security strategy regarding the use of restraints issued on 24 March 2016. This states that under normal circumstances two officers must escort a prisoner (other than a category D prisoner which is the lowest security category) and restraints will be applied. The strategy is not in line with the High Court judgment.

62. For every hospital appointment, various healthcare staff completed the medical section of the risk assessment, did not object to the use of restraints but did state that Mr Mistry was a wheelchair user. Several different managers authorised two escort officers and used a single handcuff for every trip.

63. For his emergency transfer to hospital, Mr Mistry's risk assessment concluded that his risk to the public was medium, risk of hostage taking, escape potential and likelihood of outside assistance were all low. It recorded that he had previously fallen over, had mobility issues and was a category D prisoner (considered to pose little or no risk of escape, and little danger to the public).

64. The Person Escort Record form noted that Mr Mistry had mobility issues and had fallen over previously. It incorrectly stated that there were no communication/language difficulties. A nurse completed the health risk section. She noted that Mr Mistry had a history of strokes, arthritis, deformities in both hands, chronic kidney disease, high blood pressure and was on warfarin.

65. The escort logs show that Mr Mistry was restrained in hospital for the first day there (4 to 5 November), when a prison manager authorised the removal of restraints. However the next day, on 6 November, another prison manager authorised handcuffs to be reapplied to Mr Mistry. There is no updated risk

assessment but a note in the escort log stating that 'cuffs were reapplied as instructed by Victor 2'. (Victor 2 is a radio sign within the prison.)

66. We are concerned that anyone could have felt that it would be appropriate to use a single handcuff for Mr Mistry. Mr Mistry was a category D prisoner, who was permanently housed in the inpatient healthcare unit because his health was so poor. He was unable to mobilise or communicate easily. He was seriously hurt when he fell. We can see no reason why restraints would be justified. It is difficult to see how the assessment concluded that such a seriously ill man had the ability to escape unaided from two escort officers. We are also concerned that when interviewed, the prison manager who authorised officers to restrain Mr Mistry with single handcuffs said that no prisoner left the prison unrestrained.

67. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. We are not satisfied that there was appropriate and considered healthcare input into the risk assessment, or that managers appropriately considered his condition at the time and how this affected his risk. We make the following recommendation:

The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

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