Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Siva Mathyalaka, a prisoner at HMP Elmley, on 3 November 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.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*

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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 Siva Mathyalaka died of cardiomyopathy (a disease of the heart muscle) and fatty liver disease, as a result of alcohol dependence and misuse, on 3 November 2020 at HMP Elmley. He was 49 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the clinical care that Mr Mathyalaka received at Elmley was of a reasonable standard and was equivalent to that which he could have expected to receive in the community.

Mr Mathyalaka was a Sri Lankan national and his understanding of the English language was poor. The use of interpreter and translation services by prison and healthcare staff was variable and was not always available to him, particularly on the houseblock where he lived.

I am concerned that the prison officer who found Mr Mathyalaka unresponsive on the floor did not consider entering the cell to provide first aid.

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 **October 2021**

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 5

Findings 8

Summary

Events

1. In January 2020, Mr Siva Mathyalaka was remanded to HMP Elmley and in March, he was sentenced to 14 months in prison for sex offences. In July, he was released on licence. On 22 September, his licence was revoked and he was sent back to Elmley.

2. Mr Mathyalaka was a Sri Lankan national whose understanding of English was poor. He had a number of health concerns and was obese.

3. On the night of 2/3 November, Mr Mathyalaka pressed his emergency cell bell six times. The officer and Operational Support Grade (OSG) who responded thought that he wanted his in-cell light switched off. They were unable to explain to Mr Mathyalaka that the light switch was in the cell.

4. At 5.21am, the officer carried out a roll check and saw Mr Mathyalaka lying on the floor of his cell, naked from the waist down. The officer thought that Mr Mathyalaka was breathing faintly but the OSG was unsure.

5. The officer promptly radioed a medical emergency code blue (which indicates that a prisoner is unconscious or having difficulty breathing and triggers the control room to call an ambulance immediately). At 5.25am, a custodial manager (CM) arrived and went into the cell.

6. A nurse also arrived and saw that Mr Mathyalaka was not breathing. Prison and healthcare staff tried unsuccessfully to resuscitate him. At 5.50am, ambulance paramedics arrived at the cell and took over life support, but at 6.29am, they pronounced that Mr Mathyalaka had died.

7. A post-mortem examination found that Mr Mathyalaka died of cardiomyopathy (a disease of the heart muscle) and fatty liver disease, as a result of alcohol dependence and misuse.

Findings

Clinical care

8. The clinical reviewer concluded that the clinical care that Mr Mathyalaka received at Elmley was of a reasonable standard and was equivalent to that which he could have expected to receive in the community.

Interpreter and translation services

9. The clinical reviewer said that on occasion, there was a lack of access to an interpreter which did not meet the requirements of NHS guidance.

10. The night before Mr Mathyalaka died, he pressed his emergency cell bell several times. Although prison staff who responded thought that he wanted to know how to switch his cell light off, they did not use an interpreter and we cannot therefore know what Mr Mathyalaka wanted or whether staff could have identified any health concerns and intervened earlier.

Emergency response

11. We are concerned that the officer who found Mr Mathyalaka lying on the floor of his cell did not consider entering the cell to provide first aid because he thought there must always be three officers present before a cell could be opened at night.

Recommendations

- The Governor and Head of Healthcare should ensure that prison and healthcare staff use interpretation services when managing prisoners with limited English language skills.
- The Governor should ensure that staff understand that, where there is a risk to life, they should enter a cell as quickly as possible, subject to a dynamic risk assessment.
- The Governor should share this report with Officer A and ensure that a senior manager discusses the Ombudsman's findings with him.

The Investigation Process

12. 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. A prisoner responded and was interviewed by the investigator by telephone on 7 January 2021.

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

14. The investigator interviewed three members of staff by video on 14 December 2020. All the interviews were conducted by video and telephone because of the COVID-19 restrictions.

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

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

17. The Ombudsman's family liaison officer wrote to Mr Mathyalaka's next of kin to explain our investigation. They did not respond.

18. Where shared the initial report with the Prison Service. There were no factual inaccuracies and their action plan has been appended to the report.

Background Information

HMP Elmley

19. HMP Elmley holds up to 1,088 prisoners, remanded or sentenced, in six houseblocks, with a mixture of single and double cells. A significant number of prisoners are foreign nationals or sex offenders. Integrated Care 24 Ltd provides 24-hour primary healthcare services, with input from Minster Medical Group. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons (HMIP)

20. The most recent inspection of HMP Elmley was in April 2019. Inspectors found that, although there had been some improvements to reception and induction processes since the previous inspection, there was no effective induction for prisoners who did not speak English.

21. HMIP also carried out a scrutiny visit at Elmley in April 2020 to look at the prison's response to the COVID-19 pandemic. Inspectors reported that there had been a good leadership and management response to a fast-changing situation. A dedicated COVID-19 team was set up and frequently met to discuss safety and security concerns. Inspectors reported that specific action had been taken to ensure that prisoners who did not speak fluent English were kept informed about the unfolding situation. They were held on a dedicated wing and helped by staff who spoke a range of languages.

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 October 2020, the IMB reported that, given the conditions due to COVID-19, the treatment of prisoners was as fair as possible. The IMB reported that access to medical treatment continued routinely, apart from dentistry, although prisoners reported that they were unhappy with their medication regime and how difficult it had become to see a doctor.

Previous deaths at HMP Elmley

23. There were three deaths from natural causes, one self-inflicted death and one drug-related death at Elmley in the two years before Mr Mathyalaka's death. Six prisoners have died at Elmley since Mr Mathyalaka's death: five from natural causes (two of which were as a result of COVID-19) and one self-inflicted death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

24. On 10 January 2020, Mr Siva Mathyalaka was remanded to HMP Elmley. On 16 March, he was sentenced to 14 months in prison for sex offences. On 31 July, he was released on licence. His licence was revoked on 22 September, and he was sent back to Elmley.

25. On 22 September, a nurse carried out Mr Mathyalaka's initial health screen. He was a Sri Lankan national and the nurse used an interpreter to speak to him. He noted that Mr Mathyalaka needed ongoing interpretation and translation support. Mr Mathyalaka had a history of hypertension, asthma and bipolar disorder and had recently been admitted to hospital under the Mental Health Act. The nurse noted that Mr Mathyalaka was overweight. He planned for a prison GP and the mental health inreach team to review Mr Mathyalaka.

26. On 23 September, a nurse carried out Mr Mathyalaka's second health screen but was unable to complete it because Mr Mathyalaka did not cooperate with him.

27. On 24 September, healthcare staff admitted Mr Mathyalaka to the inpatient unit for a mental health assessment. A nurse saw him but was unable to assess him because of the language barrier.

28. On 25 September, a prison GP saw Mr Mathyalaka and found that he had swollen legs which he thought was cellulitis (an infection of the skin). The prison GP prescribed antibiotics and asked for blood tests.

29. On 29 September, the prison GP prescribed a laxative because Mr Mathyalaka was constipated. A consultant psychiatrist reviewed Mr Mathyalaka and noted that he was hypomanic (in a state of increased energy, exhilaration, and irritability, commonly associated with bipolar disorder) but was improving. She planned to review him with the support of the Tamil Language Line (an interpreting service). Mr Mathyalaka was discharged from the inpatient unit on 8 October because he was calmer.

30. On 12 October, a prisoner and a wing diversity representative, made an application (a formal request) on behalf of Mr Mathyalaka to have access to The Big Word (an interpreting service) on the houseblock. A prisoner and diversity representative said that they did not receive a reply. He said that when he asked wing officers about it, they told him that Mr Mathyalaka's understanding of English was fine. A Senior Officer (SO) told the investigator that there was no record of the application.

31. On 13 October, a prison GP, reviewed blood test results which showed that Mr Mathyalaka had iron deficiency anaemia. The prison GP thought that Mr Mathyalaka may have colorectal cancer and referred him urgently to a hospital specialist under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

32. On 14 October, a mental health nurse, saw Mr Mathyalaka. A prisoner was present to interpret. Mr Mathyalaka told the nurse that he was not good, he was overwhelmed, tearful and said that he had vertigo when standing, itchy skin and a lack of sensation in his legs.

33. On 15 October, a nurse assessed Mr Mathyalaka because he had a risk of diabetes and was obese. The nurse spoke to him about diet and lifestyle, using The Big Word.

34. On 19 October, a pharmacist, assessed that Mr Mathyalaka's blood pressure was high (154/86). The pharmacist planned to monitor his blood pressure and refer him to a prison GP if it remained high.

35. On 21 October, a prison GP prescribed a laxative as Mr Mathyalaka had ongoing constipation. The following day, Mr Mathyalaka told the prison GP that he had chest pains, burning pain and constipation. The prison GP asked for a repeat chest X-ray and blood tests to be taken. The chest X-ray result was normal.

Events of 2 and 3 November

36. At 9.50pm and 10.30pm on 2 November, Mr Mathyalaka pressed his cell bell. Between 2.09am and 4.39am on 3 November, he pressed his cell bell a further four times. Officer A that he and an Operational Support Grade (OSG) were working on Houseblock 6, where Mr Mathyalaka lived in a single cell. Officer A said that he understood that Mr Mathyalaka had pressed his cell bell because he was concerned about the main light that was switched on in his cell. Officer A said that there is an in-cell switch for prisoners to use and prison staff were unable to operate the lights from outside the cell. The OSG said that when she responded to Mr Mathyalaka's cell bell, he indicated to her that the light was still on. She said that Mr Mathyalaka did not speak English but gestured towards the light. The OSG said that she tried to explain to him how to turn the light off, but he just looked at her and then returned to his bed.

37. At 5.21am, Officer A carried out a roll check. Officer A looked into Mr Mathyalaka's cell and saw that he was lying on the floor of the cell at an awkward angle, with his trousers around his ankles, naked from the waist down. He called the OSG to the cell door who also looked into the cell. Officer A thought that Mr Mathyalaka was breathing faintly but the OSG was unsure if this was the case. Officer A did not open the cell door because he said that three officers had to be present before the door could be opened.

38. Officer A radioed a medical emergency code blue and rattled and knocked on the door and called through the cell door observation panel

39. At 5.25am, a CM, the night orderly officer (the senior officer on duty in the prison), and an officer went to Mr Mathyalaka's cell, opened the door and went in. The CM called to Mr Mathyalaka and pulled him by the arm, but he did not respond.

40. Another CM went into the cell and saw that Mr Mathyalaka was lying on the floor in an unnatural position, with his head bent forward in a prone position. He saw that Mr Mathyalaka was a large man and that his trousers were around his ankles. Both CM's rolled Mr Mathyalaka onto his back. A CM saw that Mr Mathyalaka's eyes were open and he thought that he was dead.

41. A CM and a nurse went to Mr Mathyalaka's cell. The nurse noted that he was not breathing, his pupils were fixed and dilated but he was warm to the touch. She attached a defibrillator to Mr Mathyalaka but on several occasions, it advised

not to shock. The nurse was unable to insert an airway because Mr Mathyalaka's jaw was stiff.

42. A CM started CPR and he, two officers took turns to carry out chest compressions. The officers used a bag valve mask to give Mr Mathyalaka air.

43. At 5.50am, ambulance paramedics arrived at the cell. The officers moved Mr Mathyalaka to the landing and continued CPR. The paramedics took over life support but at 6.29am, pronounced that Mr Mathyalaka had died.

Contact with Mr Mathyalaka's family

44. On 3 November, the Joint Head of Residential Services, appointed a prison chaplain, as the family liaison officer (FLO). The FLO telephoned Mr Mathyalaka's father (in line with the COVID-19 policy) but had difficulty in communicating with him because he did not speak English well.

45. The FLO asked an officer a Tamil language speaker, to interpret for him. The FLO telephoned Mr Mathyalaka's father, and through the officer, explained that Mr Mathyalaka had died and offered his condolences.

46. On 5 November, Mr Mathyalaka's father and his family visited Elmley. The FLO remained in contact with Mr Mathyalaka's family. Mr Mathyalaka's funeral took place on 19 November, and the prison contributed to its cost in line with national instructions.

Support for prisoners and staff

47. After Mr Mathyalaka's death, the Joint Head of Residential Services debriefed the 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.

48. The prison posted notices informing other prisoners of Mr Mathyalaka'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 Mathyalaka's death.

Post-mortem report

49. A post-mortem examination established that Mr Mathyalaka died of cardiomyopathy (a disease of the heart muscle) and fatty liver disease, as a result of alcohol dependence and misuse.

Findings

Clinical care

50. The clinical reviewer concluded that the care that Mr Mathyalaka received at Elmley was of a reasonable standard and was equivalent to that which he could have expected to receive in the community.

51. The clinical reviewer found that overall, Mr Mathyalaka received a high level of primary care at Elmley and healthcare staff saw him regularly and promptly.

52. The clinical reviewer said that a prison GP promptly reviewed Mr Mathyalaka's abnormal blood test results and referred him under the NHS suspected cancer two-week pathway.

53. The clinical reviewer made a recommendation about the care of prisoners with ongoing complaints of constipation and suspected colorectal cancer which, although not directly related to Mr Mathyalaka's death, the Head of Healthcare will need to address.

Interpreter and translation services

54. The NHS guidance on translation and interpreter services states that patients should be able to access primary care services in a way that ensures their language and communication requirements do not prevent them receiving the same quality of healthcare as others.

55. A prison GP told the clinical reviewer that during Mr Mathyalaka's care, healthcare staff used The Big Word but on occasions when they did not use it, they had difficulty in communicating with him.

56. Although the clinical reviewer found no evidence that the lack of a consistent approach to interpretation and translation services affected the healthcare that Mr Mathyalaka received, she found that the inconsistent access to these services was not best practice and did not meet the requirements of the NHS guidance.

57. A CM said that the main form of translation and interpreter services at Elmley was The Big Word. She said that prison staff had access to it in Reception and on the First Night Centre. She said that prison staff also used trusted prisoner translators. She said that Houseblock 6, where Mr Mathyalaka lived, had access to The Big Word but it was underused because prison staff did not know how to use it.

58. A prisoner diversity representative told the investigator that there was a language and communication barrier between Mr Mathyalaka and healthcare and prison staff. He said that on 12 October, the diversity representatives on Houseblock 6 complained to prison managers because Mr Mathyalaka did not have access to The Big Word. A SO said that The Big Word was regularly used on Houseblock 6 and he did not understand why an application had not been processed if it was submitted.

59. It appears that on the night of 2/3 November, Mr Mathyalaka was asking prison staff for the in-cell light to be switched off but we cannot be certain that that was

the only reason he frequently used his cell bell that night. If an interpreting service had been used at that time, staff would have known why Mr Mathyalaka was using his emergency cell bell. We cannot say whether this might have led to earlier and potentially life-saving intervention. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prison and healthcare staff use interpretation services when managing prisoners with limited English language skills.

Emergency response

60. PSI 24/2011 says that under normal circumstances cells should only be opened at night with the authority of the Night Orderly Officer (NOO) and that two or three officers must be present (depending on the local policy). However, the PSI also says that the preservation of life must take precedence and that where there is a risk to life, an individual member of staff may enter a cell alone without the authority of the NOO after undertaking a dynamic risk assessment of the situation.

61. We are concerned that when Officer A saw Mr Mathyalaka lying half naked in an unnatural position on the cell floor, breathing faintly, if at all, he did not consider entering the cell with the OSG to provide immediate first aid because he thought three officers had to be present to enter a cell at night. As a result, there was a delay of four minutes before other officers arrived and entered the cell. We cannot say if this affected the outcome for Mr Mathyalaka, but we do know that a delay of even a few minutes can make a critical difference in a medical emergency.

62. We recommend;

The Governor should ensure that staff understand that, where there is a risk to life, they should enter a cell as quickly as possible, subject to a dynamic risk assessment.

The Governor should share this report with Officer A and ensure that a senior manager discusses the Ombudsman's findings with him.

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