Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thokozani Shiri, a prisoner at HMP Chelmsford, on 14 April 2019

A report by the Prisons and Probation Ombudsman

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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 Thokozani Shiri died on 14 April 2019 of disseminated cryptococcal infection (a fungal infection) while a prisoner at HMP Chelmsford. He was 21 years old. I offer my condolences to Mr Shiri's family and friends.

This is a very troubling case. The healthcare provided to Mr Shiri was unacceptably poor and our investigation has identified a catalogue of systematic failings by both healthcare and custodial staff.

I am extremely concerned that, although healthcare staff knew that Mr Shiri was HIV positive, he did not receive his essential anti-retroviral medication for his first five months at Chelmsford. By this time, his immune system was seriously weakened and the pathologist who conducted the post-mortem concluded that it was highly likely that this led to his death from an opportunistic virus. This was unacceptable.

I am also concerned that there were no long-term condition plans or care plans in place to manage Mr Shiri's HIV, that the follow-up of essential blood tests was poor, and that there were numerous missed opportunities to escalate Mr Shiri to secondary care.

I am also very concerned that the prison did not tell Mr Shiri's mother that he had been admitted to hospital and was seriously ill, and that she found out by chance when she went to visit him at the prison the following day; and that she was kept waiting at the hospital for two and a half hours before she was allowed to see her son, by which time he was in a medically induced coma from which he did not recover. I also consider it was unacceptable that Mr Shiri continued to be restrained while he was unconscious.

In summary, therefore, this is a case in which a young man died a preventable death as a result of what I can only describe as neglect by healthcare staff, and whose mother was then treated with gross insensitivity by prison staff.

I have escalated my concerns about the unacceptably poor treatment Mr Shiri and his mother received to the relevant Prison Group Director and to the NHS England Regional Director who is responsible for commissioning healthcare services at Chelmsford.

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 **March 2022**

Contents

Summary

Events

1. On 10 October 2018, Mr Thokozani Shiri was remanded to HMP Chelmsford charged with violent offences. He was subsequently sentenced to two years and 10 months imprisonment.

2. Mr Shiri had Human Immunodeficiency Virus (HIV). He did not bring his anti-retroviral medication with him to prison on 10 October and did not tell healthcare staff that he had HIV. However, staff were aware of Mr Shiri's HIV status as he had served a previous sentence at Chelmsford. Despite this, Mr Shiri did not receive anti-retroviral medication until 25 March 2019.

3. On 19 October, Mr Shiri had a blood test. His full blood count results were abnormal, and he needed a follow up appointment with the Crompton Clinic, a specialist HIV service, but this was not arranged. Mr Shiri also needed to have more blood taken, to repeat a specific test relating to HIV but this was not followed up until 4 March 2019.

4. Between October 2018 and March 2019, Mr Shiri missed a number of appointments with healthcare staff which were not followed up. When he did attend, staff did not consider his HIV status or failed blood tests.

5. On 4 March, Mr Shiri had a blood test specific to HIV, and the results indicated that his immune system was significantly weakened. Healthcare staff noted that he needed to be seen urgently by the specialist HIV clinic. After a week, staff contacted the correct service and arranged for them to assess Mr Shiri on 22 March.

6. On 22 March, Mr Shiri was reviewed by a consultant at the Crompton Clinic and received his anti-retroviral medication four days later.

7. Between 29 March and 11 April, Mr Shiri was seen repeatedly by healthcare staff, the GP and a pharmacy technician, as he complained of feeling unwell with various symptoms, such as a headache and fever. The pharmacy technician escalated his concerns every time he saw Mr Shiri, but healthcare staff did not do a full set of physical observations or use the National Early Warning Score (NEWS) scoring tool.

8. On 7 April, Mr Shiri told an officer that he could not breathe properly and needed to go to hospital. The officer said that he would contact healthcare, but there is no evidence that he did, and Mr Shiri was not reviewed by healthcare until the next day. The next day, Mr Shiri's mother contacted his HIV consultant as she was very worried about Mr Shiri's breathing difficulties. The consultant contacted Chelmsford urgently but could not get through to the healthcare department.

9. On 12 April, a prisoner told healthcare staff that Mr Shiri needed to be seen urgently. Staff went to his cell straight away and radioed a medical emergency code blue. At 10.47am, Mr Shiri was taken to hospital. Mr Shiri was initially restrained using double cuffs, but this was changed to an escort chain at

12.00pm for him to have tests. At 7.30pm, Mr Shiri was admitted to the hospital's High Dependency Unit.

10. The following morning, at 9.20am, Mr Shiri was moved to the Intensive Care Unit (ICU), and between 10.39am and 11.43am, he was put into a medically induced coma to assist his breathing. He remained restrained by an escort chain.

11. That morning, Mr Shiri's mother went to visit him at Chelmsford and was told that he was in hospital, although staff would not tell her which hospital, and said she was not allowed to visit him. She went to the hospital and had to wait two and a half hours for the prison to authorise her to see her son. Mr Shiri's restraints were removed for the family visit, but authorisation was given for them to be reapplied after the visit. However, Mr Shiri's mother did not leave him, and he remained uncuffed.

12. Mr Shiri did not regain consciousness and he died, with his family present, at 1.10am on 14 April.

Findings

13. Our investigation has found serious failings by both healthcare and custodial staff in relation to Mr Shiri's care.

Clinical care

14. The care that Mr Shiri received at Chelmsford was sub-standard and not equivalent to that which he could have expected to receive in the community.

15. There was a significant and unacceptable delay in Mr Shiri receiving his anti-retroviral medication. He was prescribed anti-retroviral medication on 10 October 2018, but he did not receive it until 26 March 2019, five months after he arrived at Chelmsford. The post-mortem found that it was highly likely that this led to his death.

16. No long-term condition or HIV care plans were put in place for Mr Shiri.

17. Healthcare staff did not use the National Early Warning Score (NEWS) scoring tool to identify whether Mr Shiri's condition was deteriorating in the weeks before his death and there were numerous missed opportunities to escalate Mr Shiri to secondary care.

18. The follow up of blood test results was poor. There was no system for reviewing and communicating blood test results, or for following up blood tests that needed to be repeated.

19. Mr Shiri's HIV consultant made telephone calls to Chelmsford to try to communicate her urgent concerns about Mr Shiri but could not get through to the healthcare department and was unable to leave an answerphone message.

Non-clinical

20. An officer did not use a medical emergency code on 7 April 2019, when Mr Shiri had difficulty breathing, as he should have done. There is also no evidence that the officer asked healthcare staff to review Mr Shiri.

21. The prison did not respond effectively or promptly to the messages Mr Shiri's mother left on the safer custody helpline answerphone in the days before his admission to hospital.

22. After Mr Shiri was taken to hospital on 12 April, bedwatch staff did not report significant changes in his condition to the Duty Governor. As a result, the prison did not notify Mr Shiri's mother that he was critically ill in hospital, as they should have done when he was admitted to the High Dependency Unit that evening. Mr Shiri's mother only found out he was in hospital by chance when she went to visit him at the prison the following day.

23. The prison did not authorise a family visit as a matter of urgency when Mr Shiri was critically ill in hospital, and his mother was left waiting at the hospital for two and a half hours before she was allowed to see him. By then he was in a medically induced coma in the Intensive Care Unit.

24. We do not consider that Mr Shiri's mother was treated with appropriate sensitivity by prison staff.

25. Mr Shiri was inappropriately restrained in hospital when he was in a medically induced coma.

Recommendations

Clinical

- The Head of Healthcare should ensure that all patients with HIV are referred to the appropriate external sexual health service and sexual health link nurse from the local hospital and their medication is obtained to provide continuity in treatment.

- NHS England's Regional Director for the East of England should refer Nurse A to the nursing and Midwifery Council with a view to an investigation to determine why Mr Shiri did not receive his anti-retroviral medication for five months.

- The Head of Healthcare should ensure that patients with immuno-supressing illnesses have access to any specialised care required in accordance with NICE guidelines.

- The Head of Healthcare should ensure that all patients with long-term conditions are seen in the long-term conditions' clinic and a plan of care is documented in their medical records.

- The Head of Healthcare should ensure that all physical observations are undertaken in full, and NEWS 2 scoring guidance is used to inform ongoing care, interventions, monitoring and escalation pathways.

- The Head of Healthcare should ensure that there is a systematic process in place for reviewing blood test results, and that they are done in a timely manner and clearly documented within the medical records with a plan of care.

- The Governor and Head of Healthcare should ensure that custodial staff and healthcare staff record when custodial staff refer prisoners to healthcare.

- The Head of Healthcare should ensure that medical practitioners in the community can contact the healthcare department at Chelmsford by telephone to communicate emergency concerns about a prisoner's health.

- NHS England's Regional Director for the East of England should write to the Ombudsman setting out what she has done to satisfy herself that effective action has been taken to address the serious healthcare failings identified in this report.

Non-clinical

- The Governor should ensure that all staff are aware of PSI 03/2013 and radio a medical emergency code appropriately.

- The Governor should ensure that staff respond promptly to messages left on the safer custody helpline.

- The Governor should ensure that bed watch staff record all important events in the bed watch log, and immediately report significant changes in a prisoner's condition to the Duty Governor.

- The Governor should ensure that bedwatch staff record all important events in the bed watch log, and immediately report significant changes in a prisoner's condition or location to the Duty Governor.

- The Governor should ensure that when a prisoner is in hospital in a critical condition, their next of kin is informed and authorised to visit without delay.

- The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners taken to and admitted to hospital understand the legal position on the use of restraints, and that assessments fully take in to account a prisoner's health and are based on the actual risk he presents at the time.

- The Governor should ensure that a copy of this report is shared with staff named in this report.

- The Prison Group Director for Hertfordshire, Essex and Norfolk should write to the Ombudsman setting out what he is doing to satisfy himself that effective action has been taken to address the serious failings identified in this report.

The Investigation Process

26. The investigator issued notices to staff and prisoners at HMP Chelmsford informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.

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

28. The investigator interviewed nine members of staff at HMP Chelmsford in June and July. She interviewed one prisoner by telephone.

29. NHS England commissioned a clinical reviewer to review Mr Shiri's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator. The clinical reviewer also interviewed Mr Shiri's Consultant in Sexual Health and HIV by telephone in August.

30. Arranging interviews at HMP Chelmsford was problematic. The investigator and clinical reviewer were unable to interview key members of staff.

31. We informed HM Coroner for Essex and Thurrock of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

32. One of the Ombudsman's family liaison officers contacted Mr Shiri's mother to explain the investigation and to ask if she had any matters she wanted to be considered during the investigation.

33. Mr Shiri's uncle responded on her behalf and gave us a copy of her statement to the Coroner and PPO. It included questions about blood pressure, prison protocol for reporting poor health and accessing medical help, medical records, medical facilities at Chelmsford, responding to the consultant's emails and telephone calls, Mr Shiri's medication, personal care and transfer to hospital, informing the next of kin that he was in hospital, CCTV footage, hospital treatment, access to Mr Shiri in hospital, his treatment plan and the ambulance report.

34. We have addressed these matters in this report, the clinical review and separate correspondence.

35. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies but following feedback from them during the consultation period, we agreed to remove some of our recommendations and add a new recommendation. HMPPS provided an action plan.

36. We sent a copy of our initial report to Mr Shiri's mother. She did not notify us of any factual inaccuracies.

Background Information

HMP Chelmsford

37. HMP Chelmsford is a local prison that takes prisoners directly from the courts. It holds nearly 730 men over the age of 18 years. Essex Partnership University NHS Foundation Trust (EPUT) was commissioned to provide 24-hour healthcare for the majority of the time that Mr Shiri was at Chelmsford. From 1 April 2019, Castle Rock Group (CRG) Medical took over the contract. The prison has a twelve-bed inpatient unit.

HM Inspectorate of Prisons

38. The most recent full inspection of HMP Chelmsford was in June 2018, and HMIP had concerns in many areas. This resulted in the prison being put under special measures until July 2019. This means that HM Prisons and Probation Service determined that it needed additional, specialist support to improve its performance.

39. HMIP found that some important aspects of health provision were poor, including incident reviews and complaints management, exacerbated by health staffing shortages. They said that many prisoners waited too long for primary care services and some aspects of medications management were unsafe. Partnership working between health and prison managers needed to be stronger to drive improvements. HMIP also recommended that there should be a better focus on the issues raised by the PPO in relation to deaths in custody.

40. In April 2019, HMIP reviewed Chelmsford's progress against the main recommendations. Inspectors found that there had been reasonable progress in the provision of healthcare and that the new provider had already begun to address many of their concerns. For example, the health application appointment process had been revised and the high failure-to-attend rate had since decreased. Waiting times for primary care services had reduced and were now within acceptable timescales. They said that positive partnership working between the new provider and the prison was evident, with several examples of proactive joint strategic and operational work. There was now strong leadership, and the new senior health team was visible to patients and accessible to health and prison staff.

41. HMIP also said that PPO recommendations relating to healthcare were monitored well, and there had been good progress in this area. However, not all the recommendations were actively reviewed to ensure that progress was made or sustained.

Independent Monitoring Board

42. 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 31 August 2018, the IMB reported that there were significant healthcare staff shortages which adversely affected the level of services provided and caused delays in dealing with

prisoner's health issues. There was also significant prisoner non-attendance at healthcare appointments.

Previous deaths at HMP Chelmsford

43. Mr Shiri's death was the tenth death at Chelmsford since April 2017. Of the previous deaths, two were from natural causes, four were self-inflicted, and three were drug-related. Since Mr Shiri died, there have been three more deaths at Chelmsford, of which one was from natural causes and two were self-inflicted.

44. In our investigations into previous deaths at Chelmsford since 2017, we have made recommendations about the inappropriate use of restraints, and numerous recommendations designed to improve healthcare.

Key Events

45. On 10 October 2018, Mr Thokozani Shiri was remanded to HMP Chelmsford for violent offences. He had previously been released from Chelmsford in March 2018.

46. Mr Shiri had Human Immunodeficiency Virus (HIV – a virus that targets the immune system and if untreated, weakens the body's ability to fight infections and disease). From February 2014, Mr Shiri had been under the care of a consultant in Sexual Health and HIV at Princess Alexandra Hospital in Harlow.

47. A nurse completed a reception screening with Mr Shiri. Mr Shiri did not tell her that he had HIV and did not bring any medication with him to prison. She looked at Mr Shiri's medical history from when he was previously at Chelmsford and saw that he had HIV and had been prescribed anti-retroviral medication. (Anti-retroviral medication works by stopping the virus replicating in the body. This allows the immune system to repair itself and prevent further damage.) Mr Shiri did not want anyone to know he had HIV. The nurse referred Mr Shiri to the long-term conditions' clinic for an appointment with the advanced nurse practitioner (ANP). Mr Shiri was assessed as suitable to have medication in his possession and to share a cell.

48. Later that day, Mr Shiri had a second reception screening. He was offered a blood-borne virus screening, but he declined. It is unclear whether Mr Shiri was told how to contact healthcare and how to ask for medication. Mr Shiri's mother told us that she received a telephone call from the prison in October 2018 enquiring about Mr Shiri's medical history and medication. She said that she gave the prison the details with the hope that they would continue his medication. There is no record of this telephone call in Mr Shiri's medical record.

49. On 19 October, Nurse A assessed Mr Shiri. She prescribed Mr Shiri anti-retroviral medication. An advanced clinical pharmacist cancelled the prescription the same day, as the medication was not kept at the prison and had to be obtained from a specialist service or the hospital. He told us that the normal process is that medication is only prescribed once it is received by the pharmacy. He said he remembered speaking to Nurse A in person about withdrawing the prescription for the anti-retroviral prescription, but this conversation was not documented. It was not possible to interview the nurse.

50. There is nothing further documented in Mr Shiri's medical record after 19 October about his anti-retroviral medication until March 2019, five months after he had arrived at Chelmsford.

51. On 19 October, Mr Shiri's blood was tested to check his full blood count (a full blood count test checks the red blood cells, white blood cells, platelets and can indicate levels of infection) and a sample of blood was sent to Mid-Essex Hospital NHS Trust to check his CD4 count and his viral load. (CD4 counts are used as a marker for the health of the immune system. The viral load is the amount of HIV virus present in the blood stream. A high viral load indicates that the person is very infectious to others and often goes along with a low CD4 count. The aim of anti-retroviral treatment is to get and maintain the viral load as undetectable.)

52. Nurse A noted that Mr Shiri's full blood count results were abnormal, but that due to his HIV status this was expected and that he would need a follow up appointment with the specialist HIV clinic. The local specialist HIV service in Chelmsford was the Crompton Clinic (now called the Coelho Clinic) at Broomfield Hospital. There is no evidence that this was followed up, that an appointment was made with a GP, or that any further full blood tests were planned.

53. Nurse A also noted that Mr Shiri's blood test for his CD4 count and viral load needed to be repeated, as the sample had been sent in the wrong blood collection tube to Mid Essex Hospital NHS Trust. It was also sent on a Friday, and this test can only be performed from Monday to Thursday. This test was not repeated as it should have been.

54. On 26 October, an administrator noted that Mr Shiri had refused to go to healthcare for an appointment with the ANP. There is no evidence that this was followed up. Mr Shiri was not seen again by healthcare staff until 12 January 2019 when he approached a healthcare assistant, as he was concerned about infected toenails which were painful. She added Mr Shiri to the nurses' waiting list.

55. On 16 January, a nurse examined Mr Shiri and noted that he had a fungal infection on the big toe on his right foot that was causing him slight discomfort. She added him to the GP list for treatment. On 21 January, a locum GP noted that Mr Shiri had had a fungal nail infection for a long time and prescribed medication to treat the infection. He planned to review Mr Shiri in four to five weeks and noted that Mr Shiri did not raise any other issues. There is no evidence that he considered Mr Shiri's HIV status or blood test results.

56. On 26 January, a nurse noted that Mr Shiri complained of feeling unwell, including a fever, headache and backache. She gave him painkillers, advised him to drink plenty of water and apply a cold compress to his forehead. She arranged for him to be reviewed by a nurse the following morning. The next day, another nurse reviewed Mr Shiri. She noted that he said he was feeling ok and advised him to contact healthcare staff if necessary.

57. On 19 February, Mr Shiri did not attend his appointment with the ANP. Prison staff on Mr Shiri's wing said that he was not on the list to be unlocked for an appointment, but he was on the list. There is no evidence that another appointment was made. On 24 February, a healthcare assistant noted that Mr Shiri told her that he was concerned that he had not been unlocked for his appointment with the ANP on 19 February as he was desperate to speak about his concerns about his sexual health. She noted that he had an appointment with the GP booked for the following day, as the ANP was on annual leave.

58. On 25 February, a locum GP reviewed Mr Shiri and diagnosed him with dermatophytosis (an infection) of the nail. He noted that Mr Shiri had been taking his medication for the infection once a week, as advised by the pharmacy technician, but that he was supposed to take it once a day, and he explained this to Mr Shiri.

59. The locum GP also noted that Mr Shiri had not received his HIV medication since October 2018, and that he did not have an appointment with the HIV service. He

rang the pharmacy, but no one answered. The ANP was not at work. The GP told Mr Shiri that he would speak to the pharmacist later that day about his medication. He noted that Mr Shiri asked for pain relief for general body pain and said that he was feeling ill in general.

60. The locum GP noted that Mr Shiri's last CD4 count was very low. He booked him for routine blood tests and planned to review him afterwards. He noted that he added Mr Shiri to the list to see him again on 4 March. There is no evidence that he communicated this to any members of staff or that he reviewed Mr Shiri.

61. On 26 February, a healthcare support worker noted that he had made several attempts to take a blood sample from Mr Shiri, but that he appeared to be dehydrated and he could not get a sample. He noted that staff would try again on 1 March. This was not treated as urgent and there is no record of Mr Shiri having a blood sample taken on 1 March.

62. On 27 February, Mr Shiri attended court and was reviewed by nurses before and after. Mr Shiri did not want his vital signs checked and did not raise any health concerns.

March/April 2019

63. On 4 March, Mr Shiri had a blood test to check his CD4 count. The result indicated that his immune system was significantly weakened (meaning he did not have the ability to fight infection normally). Nurse A noted, "*Make an appointment to see doctor, need to speak to doctor, communicate patient: urgent appointment arranged for this man at Crompton Clinic.*" On 5 March, a GP reviewed Mr Shiri as he had back pain on his right side. He diagnosed Mr Shiri with muscular pain. Mr Shiri said he did not have his HIV medication, but that Nurse A was resolving this issue.

64. On 7 March and 8 March, Nurse A noted that she had been ringing various telephone numbers (she listed the telephone numbers but not who they belonged to - they were for the Essex Sexual Health Service in Harlow, the Chelsea and Westminster Hospital, and a consultant - since 4 March, trying to contact someone about Mr Shiri's HIV care, but that she had still not managed to speak to anyone. However, the Crompton Clinic in Chelmsford provided Mr Shiri's care. The GP told us that she made telephone calls to the prison about Mr Shiri but that she could not get through to the healthcare department.

65. On 14 March, a GP prescribed Mr Shiri iron tablets as he was feeling tired. It is not clear whether the GP saw Mr Shiri face to face. On 15 March, Nurse A noted that she had still not been able to contact the HIV service in Harlow. She noted that Mr Shiri had an extremely low CD4 count, and she was concerned that he had no immunity from others. She planned to chase the HIV service in Harlow again and noted that if she was unable to get through, she would send him somewhere else urgently. She prescribed him antibiotics and iron tablets.

66. Later that day, Nurse A noted that she had got through to Harlow HIV service, but had been told that there was no one from the HIV team there until next week and was given another telephone number. She noted that she had tried to ring more numbers but only got through to answer machines. She noted that she

therefore thought it was necessary to change the care provider to get Mr Shiri HIV care.

67. Later that day, Nurse A noted that she had contacted the Crompton Clinic and arranged for him to be seen on 22 March. She also arranged for him to have blood tests on 18 March. She noted that she kept making requests for him to have blood tests, but that they kept being done in the wrong bottle.

68. On 17 March, Mr Shiri telephoned his mother. He told her that he did not know why he had not received his medication. Mr Shiri told his mother that he had been given iron tablets and that his CD4 count was dangerously low. He also said that he had told healthcare staff that GP A had been trying to call, but that the call was not going through.

69. On 19 March, Mr Shiri was relocated to a single cell, due to his risk of infection.

70. On 21 March, Mr Shiri was sentenced to two years and 10 months in prison and returned to Chelmsford. Nurses assessed Mr Shiri both before and after court. He did not want his vital signs checked and said he had no physical health concerns.

71. On 25 March, Nurse A noted that Mr Shiri had been seen by the Crompton Clinic. She noted that the plan of care was for Mr Shiri to continue on antibiotics, restart the anti-retroviral medication, have a blood test to check his viral load and other markers, and for the results to be sent to the Crompton Clinic before another appointment was arranged.

72. On 26 March, a pharmacy technician noted that three months' worth of anti-retroviral medication had been received from the Crompton Clinic and given to Mr Shiri.

73. On 29 March, Mr Shiri told a pharmacy technician that he had a sore mouth and gums, with blisters around his mouth. Mr Shiri said that he was unable to chew or eat food and that he had no appetite. The pharmacy technician sent a task to healthcare to follow this up with Mr Shiri.

74. On 31 March, a nurse went to Mr Shiri's cell to review him, but he was not there, and she made an appointment for Mr Shiri to attend the healthcare clinic the next day. Mr Shiri did not attend this appointment. There is no evidence that healthcare staff followed this up with Mr Shiri or checked on his welfare.

75. On 2 April, a nurse reviewed Mr Shiri in his cell. He noted that Mr Shiri was sitting up, that his vital signs were within the normal range and that he gave him painkillers. He did not complete a full set of observations or use the NEWS 2 scoring tool (used to identify clinical deterioration). He planned for Mr Shiri to be seen by healthcare staff the next day for a welfare check.

76. That afternoon, Mr Shiri's key worker saw him and recorded that Mr Shiri was "a little less settled compared to normal" and "seemed noticeably less upbeat".

77. On 3 April, a nurse reviewed Mr Shiri. He noted that Mr Shiri had been feeling sick for a few days and that his stomach was painful. He did not complete a full

set of observations or use the NEWS 2 scoring tool. He arranged for Mr Shiri to be reviewed by a GP the next day. Mr Shiri did not attend this appointment.

78. Later that day, a nurse reviewed Mr Shiri in his cell. She noted that he was lying down on his bed, feeling tired, had pain at the back of his neck and that he had vomited that morning. She noted that Mr Shiri had taken his medication, that she observed no vomit and that he was alert and orientated. She checked his vital signs, recorded that they were within the normal range, gave him painkillers and arranged for him to be reviewed by a GP that afternoon. She did not complete a full set of observations or use the NEWS 2 scoring tool, and there is no evidence that Mr Shiri was reviewed by a GP, as planned.

79. The following day, Mr Shiri told a HCA that he was constipated. The HCA noted that this could be due to Mr Shiri's iron deficiency medication. He explained this to Mr Shiri and noted that he could benefit from changing to a different iron supplement. He sent the GP a task to change his prescription, which a GP did the following day.

80. A prisoner told us that around this time, Mr Shiri told him that he thought he was dying. He said that in the last week of Mr Shiri's life, he could not walk very well and that after Mr Shiri had collected his meals, there were a few times when he and other prisoners carried Mr Shiri back to his cell. (There is no evidence of this as Chelmsford only retained CCTV footage of Mr Shiri's wing from 8, 11 and 12 April.) He told us that Mr Shiri was shivering in bed, in a lot of pain and miserable. He said that Mr Shiri had problems with his vision and struggled to breathe and that he had asked to see healthcare staff regularly. He told us that he had informed a senior manager, prison staff and healthcare staff that Mr Shiri was unwell. He was unable to recall the names of the staff he had informed.

7 April

81. On Sunday, 7 April, healthcare support worker noted that healthcare had had a call from prison staff to say that Mr Shiri was unwell, dizzy and having blurred vision. She told us that she reviewed Mr Shiri, accompanied by a nurse. She noted that she checked Mr Shiri's observations and there was no immediate concern at that time. However, she did not complete a full set of observations or use the NEWS 2 scoring tool. She advised Mr Shiri to drink plenty of fluids and tell prison staff on his wing if his health deteriorated. She noted that Mr Shiri had an urgent medical review booked for 9 April.

82. At 7.53pm, Mr Shiri telephoned his mother. He told her that he had been taking medication for two weeks and that it was causing him to feel sick, that he was unable eat and sometimes had blurred vision. He told his mother that sometimes his whole body felt painful and that his chest felt heavy. Mr Shiri told his mother that he had an appointment with the GP the next day, and that he would ask to go to hospital. Mr Shiri's mother told him to ring his cell bell and tell staff that he was not feeling well.

83. At 8.04pm, Mr Shiri telephoned his mother again. He told her that he had pressed his cell bell, that he was getting short of breath and had no strength at all. His mother told him that he should go to hospital to get checked properly.

84. While Mr Shiri was on the telephone to his mother, Officer A responded to the cell bell. The officer told us that he could not remember whether he had opened Mr Shiri's cell door or looked through the panel in his door. Mr Shiri's recorded telephone call to his mother partially picked up the officer's conversation with Mr Shiri. The officer asked Mr Shiri what was wrong. Mr Shiri told him that he was ill and could not breathe properly. The officer replied, "You can't breathe properly?" Mr Shiri confirmed this and said that his head was also "killing" him and that he needed to go to hospital. Shortly after, Mr Shiri could be heard saying, "Healthcare?" and the officer responded, "Yeah". Mr Shiri could be heard asking, "Can I go there, please?"

85. Officer A told us that when he went to Mr Shiri's cell, he saw him lying on his bed, speaking on the telephone. He said that Mr Shiri told him that he was unwell and tried to pass him the telephone, asking him to speak to his mother.

86. Officer A told us that he told Mr Shiri that he did not know if he was allowed to speak to his relative, but that he would get healthcare staff to see him. He told us that he heard Mr Shiri say that he was unwell, but that he did not remember Mr Shiri telling him that he could not breathe, or that he needed to go to hospital. He told us that if he had heard Mr Shiri say that he could not breathe, he would have called an emergency code blue.

87. Officer A told us that he contacted healthcare. He could not remember if he had contacted healthcare directly by telephone or by radio. Mr Shiri told his mother, who was still on the telephone, that the officer had asked why he was feeling unwell and had said he would contact healthcare. There is no evidence to show that healthcare was contacted, although we have no reason to doubt what the officer told us.

88. At 8.39pm, Mr Shiri telephoned his mother again. He told her that Officer A had returned to his cell and told him that healthcare staff were coming. He told his mother that he had no appetite, was unable to walk far and that his body was hot, but that he was feeling cold. Mr Shiri's mother told him that she would telephone the prison that evening to ask why they had not taken him to hospital, and that she would also contact the consultant the next day.

89. Mr Shiri's mother told us that she was worried when Mr Shiri told her that he had breathing difficulties. She said that, as a qualified nurse, she could tell that he was having significant difficulties breathing. His breathing was laboured and was clearly affecting his ability to have a conversation on the phone. (This was evident from listening to the telephone calls that Mr Shiri made to his mother.) Mr Shiri's mother said that she was very concerned that he would lose consciousness. She telephoned 111 (an NHS medical advice helpline) for advice and was told that while respiratory distress was serious and warranted treatment, they were unable to help as Mr Shiri was in prison.

90. Mr Shiri's mother told us that when Mr Shiri telephoned her again at 8.39 pm, he said that he was struggling and that no one had come to help him. She said that she was desperate for Mr Shiri not to fall asleep as he was clearly getting worse. She said that she encouraged him not to panic and to keep breathing. She said that he was clearly frightened, weak and very unwell. She said that they only ended the call to save his telephone credit as she wanted him to be able to call her again if he got worse or needed to talk. She said that she would contact his solicitor to liaise with the prison on his behalf.

91. At 9.10pm, Mr Shiri's mother telephoned his solicitor and left an answerphone message outlining her concerns about Mr Shiri's health. She told us that she did not get a response.

92. At 9.20pm, Mr Shiri telephoned his mother and told her that he had still not been seen by healthcare staff. This was the last time Mr Shiri spoke to his mother. There is no evidence that Mr Shiri was reviewed by healthcare staff that day.

93. Mr Shiri's mother told us that she was very worried and telephoned the prison's safer custody helpline that night and left a message.

8 April

94. Safety custody staff tried to contact Mr Shiri's mother the next day at 00.36am in response to her answerphone message. She told us that she returned the call when she woke up, but no one answered. She said that she tried to call the prison again at 6.31am, 8.31am and 9.41am but there was no answer. Mr Shiri's mother then contacted the consultant and shared her concerns about Mr Shiri. She said that the consultant told her that she would contact the prison straight away.

95. Later that day, a nurse reviewed Mr Shiri in his cell, as he was feeling dizzy. She noted that he was sitting in his cell, eating lunch, and that he said he had been feeling dizzy and generally unwell for the past few days. Mr Shiri said he was feeling lethargic and weak. She noted that Mr Shiri had been seen by a nurse the day before for the same reason – there is no record of this - and that he told her that he had not been eating. She noted that there was evidence in his room that he had been eating. She checked Mr Shiri's vital signs. His blood pressure was low. However, she did not use the NEWS 2 scoring system, which could have potentially given a score indicating that he needed to be escalated for secondary care, such as a hospital admission. She arranged for him to see the GP the next day and told staff on the wing to contact healthcare if there were any further problems.

9 April

96. On 9 April, a GP reviewed Mr Shiri. He noted that Mr Shiri was complaining of dizziness and of being tired and increased his iron supplement. There is no

evidence that he completed a set of observations or used the NEWS 2 scoring system.

97. Also, on 9 April, the consultant emailed the healthcare department at Chelmsford about Mr Shiri. She said that she was very concerned that he had a serious chest complaint and needed urgent medical attention. She said that his mother had been speaking to him and that he could barely breathe. Healthcare staff did not receive her email as the healthcare provider had changed on 1 April.

98. Mr Shiri's mother told us that at 2.12pm she telephoned the main prison number and said that she was worried about her son who had been in severe respiratory distress when she had spoken to him two days earlier. She said that she expressed concern about not having heard from her son or the prison. She said that she was told that the prison was unable to provide any information about Mr Shiri due to prison protocols and was transferred to the safer custody helpline. Mr Shiri's mother said that she left a message on the safer custody helpline, expressing her concerns.

10 April

99. Mr Shiri's mother told us that on 10 April, the consultant contacted her to say that no one at the prison was available to speak to her, but that she had emailed the prison and was waiting for a response.

11 April

100. On 11 April, a healthcare assistant noted that Mr Shiri looked pale, had blurred vision and was complaining about the side effects of his medication. He arranged for healthcare to review Mr Shiri urgently. Later, a nurse reviewed Mr Shiri. He noted that Mr Shiri said that his vision had been getting worse and that he had not been able to see clearly for the last four days. He noted that Mr Shiri was concerned about his general health, but not as much as about his vision. The nurse checked Mr Shiri's blood pressure and heart rate which were acceptable. He did not use the NEWS 2 scoring tool which may have indicated that Mr Shiri needed to go to hospital. He planned for him to see the GP and optician.

101. An officer recorded that he had seen Mr Shiri during afternoon association and spoken to him briefly but that, although Mr Shiri was usually very keen to talk, he "seemed more interested in association for once".

102. At 3.19pm an officer from the safer custody team telephoned Mr Shiri's mother. He told her that he had checked with the wing, and that although Mr Shiri had been unwell over the weekend, he had since been out on the wing engaging and joking with staff.

12 April

103. On 12 April, at 9.34am, a code blue emergency response was called for a prisoner on Mr Shiri's wing. A Supervising Officer (SO) responded, along with other staff. The SO told us that as she made her way to the prisoner's cell, another prisoner told her that Mr Shiri needed to be seen urgently as he was unwell. She said that she told an officer to check on Mr Shiri while she went to the first incident. The officer quickly returned to the SO and told her that Mr Shiri was not well. The SO left the first incident, which had enough staff present, and went to Mr Shiri's cell.

104. The SO told us that Mr Shiri appeared to be short of breath. She said that she asked him if he had taken any illegal substances and if he had any medical conditions, to which he said yes. She asked Mr Shiri if he could tell her what was happening, but he said that he did not know. As she was talking to Mr Shiri, two nurses arrived on the landing. She shouted for one nurse to attend the first incident and for Nurse B to attend to Mr Shiri.

105. Nurse B told us that Mr Shiri had difficulty breathing, chest pains and said he had not been feeling well for the past week. She said that she tried to check his blood pressure and oxygen saturation level but was unable to. Soon after, a healthcare assistant arrived with the emergency and oxygen bag. The nurse told us that she checked Mr Shiri's oxygen saturation level again and found that it was very low.

106. Another SO told us that when he entered Mr Shiri's cell, Nurse B told him and the other SO that an ambulance was needed. At 9.39am, the second SO called a medical emergency code blue and staff called an ambulance immediately. The nurse told us that she continued to do Mr Shiri's observations and gave him oxygen.

107. The ambulance arrived at Chelmsford at 9.59am, left the prison at 10.47am and arrived at Broomfield Hospital at 11.15am. A Custodial Manager (CM) authorised that Mr Shiri should be restrained using double cuffs, with the agreement of paramedics, and he was escorted by two prison officers, including Officer B.

108. At 12.00pm, Officer B noted that Mr Shiri's restraints had been changed to an escort chain so that he could undergo tests. At 4.00pm, he noted that Mr Shiri had been assessed, but that hospital staff still did not know what the issue was. He noted that Mr Shiri was to be admitted and that the prison had been informed.

109. At 7.30pm, Officer B noted that Mr Shiri had been moved into his permanent room for the night. He was located in the High Dependency Unit, but this was not recorded in the bed watch log and there is no evidence that it was reported to the prison.

13 April – 14 April

110. On 13 April, at 7.50am, a CM and Officer C took over the bedwatch. Officer C told us that they were 20 minutes late arriving as he was given the wrong location for Mr Shiri and that the prison had to contact the bedwatch staff to find out where he was.

111. At 8.51am, Officer C noted that Mr Shiri would be moving from the High Dependency Unit to the Intensive Care Unit (ICU), and that he was moved at 9.20am. There is no record that this was reported to the prison.

112. At 10.19am, Officer C noted that he had contacted the prison to ask for Mr Shiri's approved telephone numbers to be brought to the hospital. At 10.50am, Officer C noted that a consultant had checked Mr Shiri and recommended a procedure that would save Mr Shiri's life. He noted that the prison had been made aware. (Hospital records show that Mr Shiri was put into a medically induced coma to assist his breathing. A tube was inserted into his lungs to help him breathe and he was ventilated.)

113. Officer C contacted the prison for authorisation to remove the restraints for the procedure. The CM said that they were told that the restraints could not be removed until a manager had been to the hospital to do a risk assessment, and that the doctor said that he would work around them. He told us that he would have removed the restraints if the doctor had told him to.

114. At 11.50am, Officer C noted that the doctor had finished the procedure and that Mr Shiri was unconscious but breathing.

115. Mr Shiri's mother told us that she went to visit her son at Chelmsford at 9.00am. She said that she was told that he was in hospital, but staff refused to tell her which hospital. Mr Shiri's mother said that she then was told that she would not be able to see her son without a visit warrant, and that as it was the weekend, she would have to wait until Monday (15 April) to make a booking to see him. She said that she told the staff that she was Mr Shiri's next of kin and that it was her right to see him in hospital. She told us that a member of staff said, "Don't you dare try to visit him without a warrant".

116. Mr Shiri's mother told us that when she arrived at the ICU, Mr Shiri was in an induced coma and chained to the bed (indicating that she arrived after 10.50am, when the procedure began). She said that officers told her that she needed a court order to be allowed in, and that she was escorted to a waiting room for an hour and a half, and not given any information about her son. She said that she was told by the officers that they were waiting for clearance from the prison to allow her to see Mr Shiri, and that she waited another hour before she was allowed to see him (at 1.20pm). She said that during this time, she called her brother and niece for support, who went to the hospital and waited with her.

117. The CM told us that he was unable to remember what time Mr Shiri's mother arrived at the hospital, and it was not recorded in the bed watch log. He also did not know what time they contacted the prison to report that she was at the hospital but said that he would "like to think" that it was at the same time that they asked whether the restraints could be removed (10.50am). He told us that they were told that Mr Shiri's mother could not visit him until a manager had been to the hospital and assessed the situation.

118. Mr Shiri's mother said that as she was waiting, a doctor said that he thought she should have been allowed in to see him as he was in a critical condition. She said that the doctor told her that Mr Shiri had been put into a medically induced coma as he was very unwell on admission and some organs had begun shutting

down. She said that the doctor appeared to be disturbed when he learned that she had been trying to gain access to her son, and that he explained it was a critical time, when she could have been providing his medical history which could have informed his treatment.

119. The Duty Governor on that day told us that Mr Shiri's location was not disclosed to his mother, and authorisation was not given for her to visit him straight away, as she had been told by bedwatch staff on the morning of 13 April, that Mr Shiri was sitting up, chatting and asking about his canteen (purchases from the prison shop), and that there were no major concerns for his health. According to the bedwatch log, however, the escort officers told the prison at 10.50am that Mr Shiri was critically ill and needed a procedure to save his life.

120. The Duty Governor told us that if a prisoner goes to hospital, prison staff have 72 hours to authorise visitors from the time a prisoner is admitted to hospital, to make sure that is safe and secure for staff and prisoners for them to attend. She told us that the bedwatch staff contacted her to say that Mr Shiri's mother was at the hospital, and wanted to see him, and that it was around this time she learnt that Mr Shiri's health had deteriorated. She said that it was very difficult to understand what was going on at the hospital, so she sent a CM to the hospital to speak to Mr Shiri's mother and the medical staff.

121. At 12.54pm, Officer C noted that the CM had been to the hospital to assess the situation. The Duty Governor told us that following this, she gave authorisation for Mr Shiri's mother to visit him. She said that, with hindsight, she could have potentially authorised the visit sooner.

122. At 1.20pm, Officer C noted that Mr Shiri's restraints had been removed to facilitate a family visit but that bedwatch staff had been told by the CM that the restraints should be reapplied after the visit. However, Mr Shiri's mother did not leave, and he remained uncuffed. At 7.45pm that evening, approval was given for Mr Shiri to remain permanently unrestrained.

123. Mr Shiri did not regain consciousness, and he died at 1.10am on 14 April, with his family present.

Contact with Mr Shiri's family

124. On 14 April, an officer was appointed as the Family Liaison Officer (FLO). An SO was appointed as the Deputy Liaison Officer. At 9.40am, the Deputy Liaison Officer telephoned Mr Shiri's mother and they arranged to visit her at home at 11.00am that morning. The FLO and Deputy Liaison Officer visited Mr Shiri's family, as planned, and offered their condolences and support. The FLO remained in contact with Mr Shiri's mother and arranged for the family to visit the prison. The prison offered a contribution to the cost of Mr Shiri's funeral, in line with national policy.

Support for prisoners and staff

125. After Mr Shiri's death, the Deputy Governor 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.

126. The prison posted notices informing other prisoners of Mr Shiri'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 Shiri's death.

Post-mortem report

127. The post-mortem said that that Mr Shiri died from disseminated cryptococcal infection, a fungal infection that is often found in people with the HIV infection (which compromises the immune system). The pathologist concluded, "*It is highly likely that the failure to administer the anti-retroviral agents has led to significant immunosuppression resulting in the acquisition and multi-organ dissemination of Cryptococcus.*"

128. The consultant explained that Cryptococcus "*rarely causes problems to people with normally functioning immune systems but can cause a severe infection in those who are immunosuppressed. It tends to enter the body through the chest (by inhalation) but normally causes a meningitis rather than a disseminated infection as in Mr Shiri. This suggests that he was very severely immunocompromised and had been so for some time."*

Findings

Clinical issues

129. The clinical reviewer found a catalogue of systematic failings in the healthcare provided to Mr Shiri and concluded that the care he received at Chelmsford was sub-standard. She found that in view of the post-mortem report, and the failure to administer the necessary HIV medications, Mr Shiri's care was not equivalent to that which he could have expected to receive in the community. The clinical reviewer concluded that there was a failure by Essex Partnership University NHS Foundation Trust (EPUT) to protect Mr Shiri by ensuring he received his life saving anti-retroviral medication.

Medication

130. Mr Shiri's anti-retroviral medication was initially prescribed on 10 October 2018 but was not given to him as the pharmacy was waiting for the hospital to send it as HIV medication is not stocked at the prison. The clinical reviewer found that the prescribing of these medications was not chased up by any members of the healthcare team and that Mr Shiri did not receive his medication until 26 March 2019, five months after he arrived at HMP Chelmsford. The reasons for the delay are unclear. The clinical reviewer concluded that this was not timely prescribing and did not provide continuity of care. The clinical reviewer also found that EPUT did not make links with the local HIV service until 26 March 2019.

131. It is a cause for very significant concern that, although healthcare staff at Chelmsford were aware of Mr Shiri's HIV status, they did not ensure that he received his essential medication. It is deeply troubling that this lack of action most likely led to Mr Shiri's death. We make the following recommendations:

The Head of Healthcare should ensure that all patients with HIV are referred to the appropriate external sexual health service and sexual health link nurse from the local hospital and their medication is obtained to provide continuity of treatment.

NHS England's Regional Director for the East of England should refer Nurse A to the nursing and Midwifery Council with a view to an investigation to determine why Mr Shiri did not receive his anti-retroviral medication for five months.

Pathways and care plans for prisoners with long-term conditions

132. The clinical reviewer identified that there were no long-term conditions or HIV care plans for Mr Shiri and found no reference to National Institute for Health and Care Excellence (NICE) guidelines in relation to his HIV care. She found that healthcare staff did not liaise with Mr Shiri's community GP practice about his HIV status, and that locum GPs did not escalate their concerns to permanent members of staff or the Head of Healthcare. She also found that there was no multi-disciplinary approach to Mr Shiri's care until March 2019.

133. We are very concerned that there was no plan of care or multi-agency approach in relation to Mr Shiri's HIV status. He had a serious long-term condition and should have had a specialised care plan to address his healthcare needs. We make the following recommendations:

The Head of Healthcare should ensure that patients with immuno-supressing illnesses have access to any specialised care required in accordance with NICE guidelines.

The Head of Healthcare should ensure that all patients with long-term conditions are seen in the long-term conditions' clinic and a plan of care is documented within their medical records.

National Early Warning Score (NEWS) 2

134. The clinical reviewer found that there was a lack of National Early Warning Score (NEWS) 2 scoring at Chelmsford and there were numerous missed opportunities to escalate Mr Shiri to secondary care. She found that from 29 March to 11 April 2019, Mr Shiri was seen repeatedly by healthcare staff, a GP and a pharmacy technician. The pharmacy technician escalated Mr Shiri's health issues to healthcare staff each time, but no healthcare staff took a full set of physical observations and no staff used the NEWS 2 scoring tool, which may have identified that Mr Shiri's condition was deteriorating and that he needed secondary care in hospital.

135. The clinical reviewer identified that if the NEWS 2 scoring tool had been used on 7 April 2019 by a healthcare support worker, who told us that she was accompanied by a nurse, she would have found that Mr Shiri needed to be escalated for medical review. She concluded that Mr Shiri should have been sent out to hospital for an urgent review. Instead, Mr Shiri was listed to see the GP for an urgent review, which was in two days' time. The clinical reviewer found that a GP did not complete a full set of physical observations at this review, despite the previous set of observations being in Mr Shiri's medical record.

136. We are concerned that healthcare staff did not use the NEWS 2 scoring system to escalate health issues to secondary care. This led to Mr Shiri not being referred for secondary care, as he should have been. The clinical reviewer has found that Chelmsford is now using the NEWS 2 scoring system, but to ensure that this practice is embedded in practice at Chelmsford, we make the following recommendation:

The Head of Healthcare should ensure that all physical observations are undertaken in full, and NEWS 2 scoring guidance is used to inform ongoing care, interventions, monitoring and escalation pathways.

Blood tests

137. The clinical reviewer found that the follow up of blood test results at Chelmsford was poor. She found that there was no system for reviewing and communicating blood test results, or of following up blood tests that needed to be repeated.

138. The clinical reviewer identified that on 19 October 2018, Mr Shiri had blood taken to check his CD4 count and viral load. She found that the blood sample was sent to be tested in the wrong bottle and on the wrong day, which resulted in them needing to be repeated. The clinical reviewer identified that this was not followed up until 4 March 2019, by which time Mr Shiri was very immunosuppressed. She concluded that as a result, it was unclear what Mr Shiri's baseline CD4 count, and viral load were when he arrived at Chelmsford and that this was a missed opportunity.

139. We are concerned not only that healthcare staff at Chelmsford sent Mr Shiri's blood for testing in the wrong bottle and on the wrong day, but also that they did not repeat this test for over four months. We make the following recommendation:

The Head of Healthcare should ensure that there is a systematic process in place for reviewing blood test results, and that they are done in a timely manner and clearly documented within the medical records with a plan of care.

Documenting healthcare referrals

140. The clinical reviewer found that there was no clear recording process for custodial staff to follow when passing information on to healthcare staff about unwell prisoners. The clinical reviewer also found that there was no documentation process in the healthcare department to show that healthcare staff had been told by custodial staff about unwell prisoners.

141. On 7 April 2019, Mr Shiri told Officer A that he was struggling to breathe and needed to go to hospital. The officer told Mr Shiri that he would ask healthcare staff to see him, but they did not. There is no evidence that the officer contacted healthcare and they did not attend until the next day. In the absence of a clear process for documenting such requests and it is impossible to for us to know whether the officer made this request. We make the following recommendation:

The Governor and Head of Healthcare should ensure that custodial staff and healthcare staff clearly document when custodial staff refer prisoners to healthcare.

Communicating emergency concerns to healthcare

142. The consultant tried to call prison healthcare staff to communicate urgent concerns about Mr Shiri, but she could never get through to the healthcare department. This is unacceptable.

143. The Head of Prisons for CRG Medical told us that a doctor would be able to contact healthcare staff by dialling the main switchboard and being transferred to healthcare. However, she told us that healthcare had been experiencing some challenges with the telephone system, and that there had been some issues raised with staff being unable to contact healthcare directly and not being able to

leave a voicemail. She told us that healthcare is currently working with the prison to address the issue and that she is hopeful that this will be resolved soon.

144. We are very concerned that Mr Shiri's specialist consultant was unable to speak to the healthcare department to communicate her concerns about Mr Shiri's health. Medical practitioners in the community should be able to contact the health department at Chelmsford without difficulty. We make the following recommendation:

The Head of Healthcare should ensure that medical practitioners in the community can contact the healthcare department at Chelmsford by telephone to communicate emergency concerns about a prisoner's health.

145. The clinical reviewer has also made recommendations about an out of hours doctors service and record keeping that we have not repeated in this report.

146. We are so concerned about the very poor standard of healthcare that Mr Shiri received that we make the following recommendation:

NHS England's Regional Director for the East of England should write to the Ombudsman setting out what she has done to satisfy herself that effective action has been taken to address the serious healthcare failings identified in this report.

Non-clinical issues

Emergency response codes

147. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes,* sets out the framework for calling a medical emergency consistently over the establishment radio network in all prisons. The intention is to ensure a timely, appropriate and effective response to medical emergencies and so maximise the likelihood of a positive outcome for the prisoner.

148. In line with PSI 03/2013, Officer A should have used a medical emergency code on 7 April when Mr Shiri told him that he could not breathe and needed to go to hospital. This would have triggered the control room to call an ambulance immediately. Instead, the officer told us that he contacted healthcare to let them know that Mr Shiri was unwell, and Mr Shiri was not reviewed by a nurse until lunchtime the next day. We would have expected the officer to have recorded in Mr Shiri's electronic record or the wing observations book that Mr Shiri had been sufficiently ill for him to have contacted healthcare.

149. Officer A told us that he did not hear Mr Shiri say that he could not breathe and that if he had heard this, he would have called a code blue. However, part of his conversation with Mr Shiri can be heard on the recording of Mr Shiri's telephone call with his mother. This shows that Mr Shiri told him that he could not breathe and that the officer responded, "You can't breathe?"

150. The clinical reviewer said that it is not possible to know whether paramedics would have assessed that Mr Shiri needed to go to hospital that evening, or whether he would have had a different outcome if he had gone to hospital. However, using a medical emergency code can be critical in medical emergencies and we make the following recommendations:

The Governor should ensure that all staff are aware of PSI 03/2013 and radio a medical emergency code appropriately.

Contacting the prison

151. Chelmsford's website says that if family or friends have any concerns about a prisoner they should "feel free" to contact the safer custody team helpline, a confidential answerphone. It says that messages are checked daily but that if the concerns are urgent, you should speak to staff in the visitor's centre or call the main switchboard.

152. The safer custody hub manager told us that at weekends, an officer from the safer custody department is required to check the hotline twice a day – in the morning and the afternoon. She told us that safer custody staff follow-up matters raised and respond to the caller with an update. The answerphone message tells the caller, "If your concern is about immediate risk to life please do not leave a message. Please hang up and call the main Chelmsford number and ask to speak to the Duty Manager".

153. On the night of Sunday 7 April, Mr Shiri's mother telephoned the safer custody prison helpline and left a message. The prison tried to contact her the next day at 00.36am. Mr Shiri's mother tried to return the call four times before 9.41am but got no answer. (It is not known whether she called the safer custody hotline or the main prison number.) Although safer custody staff responded promptly to Mr Shiri's mother's answerphone message and tried to contact her shortly after midnight, there is no evidence that anyone made any further attempt to speak to her at a more convenient time when she did not answer the phone.

154. Two days later, on the afternoon of 9 April, Mr Shiri's mother telephoned the main prison number, and was transferred to the safer custody helpline, where she left a message. She was not contacted by Chelmsford until the afternoon of 11 April.

155. We are not satisfied that Chelmsford responded appropriately to the messages Mr Shiri's mother left on the safer custody helpline. We consider that someone should have tried to speak to her in response to her message of 7 April, and that they should have responded more promptly to her message of 9 April. We recommend:

The Governor should ensure that staff respond promptly to messages left on the safer custody helpline.

Bedwatch, informing next of kin, and visits

156. Prison Rule 22 says that when a prisoner becomes seriously ill, the governor should "at once inform the prisoner's spouse or next of kin". This is reflected in PSI 64/2011, which requires prisons to contact the next of kin of prisoners who are seriously ill.

157. Chelmsford's local policy says that next of kin will be informed by the Security/Duty Manager within 48 hours of a prisoner going to hospital, and that it will be made clear to the next of kin that visitors are not permitted until 72 hours after this, unless their condition is critical. This gives security time to collate the approved visitors list and check any public protection concerns.

158. Local policy also states that all important events must be recorded in the bedwatch log, such as details of visitors to the prisoner, details of the prisoner's behaviour, including change of medical condition, and records of all reports to the prison.

159. In this case, Mr Shiri was taken to hospital by emergency ambulance on the morning of 12 April and was admitted at 4.00pm. He was then transferred to the High Dependency Unit (HDU) at 7.30pm that evening, indicating that he was seriously ill. Bed watch staff should have reported this to the prison and recorded their communication with the prison in the bed watch log but there is no evidence that they did so. As a result, it appears that prison managers did not know that Mr Shiri was in the HDU. We recommend:

The Governor should ensure that bedwatch staff record all important events in the bed watch log, and immediately report significant changes in a prisoner's condition to the Duty Governor.

160. The fact that the prison did not know that Mr Shiri had been moved to the HDU, and therefore did not know where he was in the hospital, is worrying from a security point of view. But it also meant that Mr Shiri's mother was not told that he was critically ill in hospital, as she should have been. We consider that she should have been informed when he was admitted to hospital at 4.00pm, and certainly when he was transferred to the HDU that evening.

161. If this had happened, she would have had the opportunity to visit him before he was placed in a medically induced coma. We are very concerned that she was not told that Mr Shiri was seriously ill in hospital and that she only found out by chance when she went to the prison to visit him at 9.00am the following day. This was not acceptable.

162. We are also concerned about the lack of sensitivity with which Mr Shiri's mother was treated by prison staff when she arrived for her visit on the morning of 13 April. We recognise that poor communication between the bedwatch officers and the prison meant that the staff she spoke to were not aware that Mr Shiri was critically ill, but we would have expected someone to have taken the time to find out what was happening and explain it to Mr Shiri's mother when she found out that Mr Shiri was in hospital. If her account is correct – and we have no reason to believe it is not – she was simply told she would not be allowed to visit him in

hospital for two days and was not treated with the sensitivity we would have expected in this situation.

163. In fact, Mr Shiri was moved the Intensive Care unit (ICU) at 9.20am on 13 April while his mother was speaking to staff at the prison. At 10.20am, staff first recorded in the bedwatch log that the prison had been told that Mr Shiri was in a critical condition. The prison should certainly have contacted Mr Shiri's mother at this point to tell her he was seriously ill, but this did not happen. As a result, Mr Shiri's mother only learnt that he was critically ill when she arrived at the hospital, by which time Mr Shiri was in the ICU in a medically induced coma and never regained consciousness.

164. Given Mr Shiri's serious condition we consider that the prison should also have allowed Mr Shiri's mother to visit him as a matter of urgency when he was admitted to the HDU on the evening of 12 April. While it is important that the prison maintains security procedures when prisoners are admitted to hospital, it is also important that they act promptly to authorise family visits to seriously ill prisoners. Instead, Mr Shiri's mother was left waiting at the hospital for two and a half hours before she was allowed to see her son on the morning of 13 April. This was very poor practice.

165. The Duty Governor told us that when a prisoner is admitted to hospital, prison staff "have 72 hours to authorise visitors" to make sure that is safe and secure for staff and prisoners for them to attend. We recognise that security needs to be maintained when prisoners are hospital. However, while a 72-hour timescale may be appropriate for a routine hospital admission, we consider that staff need to act with urgency when a prisoner is seriously ill. We are concerned that she did not appear to appreciate this.

166. The Duty Governor also told us that it was necessary for a CM to go to the hospital to assess the situation before a visit could be authorised. We do not understand why this was necessary when there were two bedwatch officers with Mr Shiri, one of whom was himself a CM, who should have been updating prison managers on Mr Shiri's condition. According to the bedwatch log, the prison was told at 10.20am that Mr Shiri was critically ill and had been admitted to the ICU, and we consider that this should have been sufficient information to authorise a visit by his mother.

167. We make the following recommendation:

The Governor should ensure that when a prisoner is in hospital in a critical condition, their next of kin is informed at once and authorised to visit, without delay.

Restraints, security and escorts

168. 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 a prisoner's health and mobility.

169. 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 he has 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.

170. PSI 33/2015, *External escorts*, says that prisons must undertake a risk assessment to decide whether restraints should be used when a prisoner is taken to hospital, and that under normal circumstances all prisoners will be restrained and escorted by two officers. It goes on to say that prisoners at Category C or below will be single cuffed unless the individual risk assessment indicates that double cuffing is required and is proportionate.

171. Mr Shiri was double cuffed when he was taken to hospital by ambulance on 12 April. He was a Category C prisoner and there is nothing in the risk assessment by a CM to explain why double cuffing was thought to be necessary. We do not consider that double cuffing was appropriate.

172. After his admission, Mr Shiri's restraints were changed from a double cuff to an escort chain, to allow him to have tests. We consider that this was appropriate.

173. However, we are very concerned that the restraints were not removed when Mr Shiri was moved to the ICU and placed in a medically induced coma at 10.50am on 13 April. Although the restraints were removed at 1.20pm to allow a family visit, the CM instructed that the restraints should be reapplied when the family left. Mr Shiri's restraints were not reapplied as his mother did not leave, but it was not until 7.45pm that evening that approval was given for Mr Shiri to remain unrestrained permanently.

174. It is very difficult to understand why the CM thought it was necessary and proportionate to restrain Mr Shiri when he was in a medically induced coma. The decision gave no consideration to Mr Shiri's health and mobility and the fact that, in this condition, he clearly presented no risk at all to the public or of escape. We consider that the use of restraints was completely unnecessary, and that Mr Shiri was not treated with dignity and humanity when he was seriously ill.

175. In addition, we do not understand why the Duty Governor thought it was necessary for a CM to visit the hospital to make a decision about Mr Shiri's restraints when another CM was at the hospital as an escorting officer and should have been keeping prison managers informed of Mr Shiri's condition. We are concerned that, despite his rank, this CM was "happy" to take a back seat and let the other bedwatch officer take the lead. We consider that this contributed to the confused situation in which key events were not noted in the bedwatch log or communicated promptly to the Duty Governor.

176. We expressed similar concerns about the inappropriate use of restraints following the death of a prisoner at Chelmsford in 2017. Our recommendation on the subject was accepted and noted as completed in April 2018, yet staff are still not making appropriate risk assessments. We make the following recommendations:

The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners taken to and admitted to hospital understand the legal position on the use of restraints, and that assessments fully take in to account a prisoner's health and are based on the actual risk he presents at the time.

177. We are so concerned about the failings in Mr Shiri's care that we make the following recommendations:

The Governor should ensure that a copy of this report is shared with staff named in this report.

The Prison Group Director for Hertfordshire, Essex and Norfolk should write to the Ombudsman setting out what he has done to satisfy himself that effective action has been taken to address the serious failings identified in this report.

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