Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bislim Zejnullahi, a prisoner at HMP Bedford, on 18 November 2021

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

Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Bislim Zejnullahi died of COVID-19 pneumonia and cirrhosis of the liver on 18 November 2021 while a prisoner at HMP Bedford. He was 51 years old. I offer my condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Zejnullahi received at HMP Bedford was partially equivalent to that which he could have expected to receive in the community. She found that the lack of a secondary health assessments and clinical assessments made elements of his care not equivalent. She made several recommendations, some of which we repeat below.

5. We found that there were delays in arranging for Mr Zejnullahi to call his family in Kosovo. We also found that not all the staff involved in Mr Zejnullahi's care were contacted for support following his death.

Recommendations

- The Head of Healthcare should ensure that there is a robust process in place for arranging secondary health assessments and all prisoners are offered a Blood Borne Virus (BBV) test as part of this assessment.
- The Head of Healthcare should ensure that healthcare staff consistently complete clinical observations, including NEWS-2 assessments, when requested by a doctor.
- The Governor and the Head of Healthcare should ensure that prison and healthcare staff use interpreting services when discussing residential, care and health matters with prisoners with limited or no English.
- The Governor should ensure that prisoners with family abroad are able to call their relatives in a timely way.
- The Governor should ensure that when a prisoner dies, all key staff who were actively involved in a prisoner's care are correctly identified and offered support.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Zejnullahi's clinical care at HMP Bedford.

7. The PPO investigator has investigated non-clinical issues, including the prison's response to COVID-19 and shielding prisoners, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. The clinical reviewer and the investigator interviewed two members of staff on 10 and 17 December. The interviews were conducted by telephone due to the restrictions imposed in response to the COVID-19 pandemic.

9. We wrote to Mr Zejnullahi's next of kin, his brother, to explain the investigation. He did not respond to our letter.

10. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Previous deaths at HMP Bedford

11. Mr Zejnullahi was the sixth prisoner to die at HMP Bedford since November 2019. Of the previous five deaths, two were from natural causes (one of which was from COVID-19) and three were self-inflicted.

COVID-19 (coronavirus)

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

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

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

main population. Other measures include social distancing and the use of personal protective equipment (PPE).

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

Key Events

16. On 22 February 2021, Mr Bislim Zejnullahi was remanded to HMP Bedford charged with drug offences.

17. Healthcare staff completed an initial health screening. They did not identify any health issues. To prevent the spread of COVID-19, Mr Zejnullahi was placed in isolation for 14 days.

18. On 1 March, Mr Zejnullahi's key worker saw him. She noted that his English was poor which made communication difficult. He asked to contact his brother in Kosovo. She gave him an application form for international calls.

19. On 2 March, Mr Zejnullahi was moved on to a main prison wing after he tested negative for COVID-19. He had no health conditions that made him vulnerable to COVID-19 and at that time, he did not meet the criteria for shielding.

20. Mr Zejnullahi should have had a secondary health assessment within seven days of the initial health screening. The secondary health assessment offers blood tests for a range of diseases including hepatitis. There is no evidence that Mr Zejnullahi had a secondary health assessment.

21. On 15 March, a prison GP saw Mr Zejnullahi for constipation. The GP prescribed a laxative and advised him that if his constipation did not improve, he should make an appointment to see a GP.

22. On 27 March, another prison GP saw Mr Zejnullahi. Mr Zejnullahi told him that he had not had a bowel movement and had vomited. The GP noted that Mr Zejnullahi's stomach was tense and bloated. He sent him to hospital for review. Mr Zejnullahi returned to the prison the following day.

23. On 8 April, the same prison GP saw Mr Zejnullahi, and used an over-the-phone interpreting service. Mr Zejnullahi was concerned that he was gaining weight, his stomach was bloated, and his urine was dark in colour. The GP tested his urine which was normal. He noted that Mr Zejnullahi had swelling in his feet. He prescribed medication to treat the swelling and set a review for a week's time.

24. On 12 April, Mr Zejnullahi showed signs of liver failure. The prison sent him to hospital, and he was diagnosed with decompensated liver cirrhosis and hepatitis B.

25. Mr Zejnullahi told one of the prison officers escorting him that he had not spoken to any of his family since he arrived at the prison. He said that the application form he was given was in English. An international telephone number was later added to his PIN phone account.

26. On 7 May, Mr Zejnullahi was discharged from hospital with medication to treat his hepatitis and liver cirrhosis. Hospital doctors asked that he have a blood test every other day and they referred him to the hospital's liver clinic for review. Mr Zejnullahi returned to the prison's healthcare unit. Healthcare staff started a personalised care plan for his conditions and added him to the Complex Case Register, which meant that his condition was discussed at a weekly multi-disciplinary team meeting. The prison correctly identified Mr Zejnullahi as being clinically vulnerable.

27. On 19 May, another key worker saw Mr Zejnullahi. She noted that he spoke limited English and that this impacted their conversation. He told her that he wanted his phone credit for domestic calls transferred to international calls.

28. On 26 May, Mr Zejnullahi was sentenced to 18 months imprisonment for drug offences.

29. On 28 June, healthcare staff noted that Mr Zejnullahi was lethargic and had slurred speech. They were concerned that he was showing signs of hepatic encephalopathy (a loss of brain function due to levels of toxins in the blood). Over the next three weeks, Mr Zejnullahi was taken to hospital three times for review.

30. On 26 July, the prison's lead GP asked healthcare staff to calculate NEWS-2 scores (NEWS-2 is a tool to measure clinical deterioration in adult patients) for Mr Zejnullahi every time they completed his observations. She also asked that they calculate his abdominal girth every other day. Healthcare staff did not complete these assessments consistently.

31. On 28 July, Mr Zejnullahi was taken to hospital. Blood test results showed that his liver function was deteriorating, he was gaining weight and had a raised pulse. He was also assessed for a liver transplant. He was discharged from hospital and returned to the prison on 2 August. However, on 9 August, he was taken back to hospital because he had abdominal pain and had vomited bile and blood. He stayed in hospital until 20 August and was referred to the Liver Transplant Team at Addenbrookes Hospital, Cambridge. He was discharged back to the prison's healthcare unit.

32. On 25 August, Mr Zejnullahi had his first dose of the COVID-19 vaccine. His second dose was due in late November.

33. On 20 October, Mr Zejnullahi was taken to hospital for a set of blood tests. Two prison officers escorted him and restrained him using a single handcuff. After he had the blood tests, he fainted. The hospital admitted him as an inpatient.

34. On 2 November, Mr Zejnullahi tested positive for COVID-19. His condition worsened and he was diagnosed with COVID-19 pneumonia. He was moved to the respiratory ward and placed on a CPAP machine (a device that supplies air via a mask).

35. The prison appointed a Family Liaison Officer (FLO). The FLO rang Mr Zejnullahi's next of kin, his brother, and two of his friends in the UK.

36. At around 1.00pm on 18 November, the hospital confirmed that Mr Zejnullahi had died.

37. The FLO rang Mr Zejnullahi's brother to inform him of Mr Zejnullahi's death. In line with policy, the prison contributed to the cost of returning Mr Zejnullahi's body to his family in Kosovo.

Cause of death

38. The Coroner accepted the cause of death provided by a hospital doctor and there was no post-mortem examination was carried out. The doctor gave Mr Zejnullahi's cause of death as COVID-19 pneumonia and decompensated liver cirrhosis (an acute deterioration in liver function) caused by hepatitis B (a liver infection spread through blood and other bodily fluids).

Findings

Clinical Findings

39. The clinical reviewer concluded that the care Mr Zejnullahi received at HMP Bedford was partially equivalent to that which he could have expected to receive in the community.

Management of Mr Zejnullahi's risk of infection from COVID-19 and risk to others

40. The clinical reviewer considered that it was likely Mr Zejnullahi contracted COVID-19 in hospital. He had been in hospital for 13 days when he tested positive.

41. She found that the prison complied with HMPPS and Public Health England (PHE) guidance to mitigate Mr Zejnullahi's risk of contracting COVID-19. This was particularly important once he was diagnosed with liver cirrhosis and hepatitis B which made him vulnerable to COVID-19.

42. When he returned from hospital on 7 May, Mr Zejnullahi was located in a single cell on the healthcare unit which ensured he was separated from the main prison population. On return from his overnight hospital stays, he was separated from other prisoners in the healthcare unit to prevent the spread of COVID-19 to other prisoners.

43. The clinical reviewer found that healthcare staff had enough supplies of personal protective equipment (PPE) and that it was worn in line with PHE guidance.

44. Once Mr Zejnullahi tested positive for COVID-19, escorting prison officers were provided with PPE equipment. As he became more unwell, his restraints were removed, and the escorting officers sat outside the ward to reduce their risk of infection.

Secondary health screenings and Blood Borne Virus (BBV) testing

45. NICE guidance, NG57 physical healthcare for prisoners, requires that every prisoner has an initial health screening and a secondary health assessment a number of days later. The primary care manager at HMP Bedford said that routine practice was for the secondary health assessment to be scheduled during the initial assessment. It is also routine practice for Blood Borne Virus (BBV) tests to be offered during the secondary health assessment. We cannot say that Mr Zejnullahi would have accepted the BBV test, but by not having a secondary health assessment he was not offered this choice. Had he opted for a BBV test, it would have increased the chances of earlier diagnosis and treatment. We make the following recommendation:

    The Head of Healthcare should ensure that there is a robust process in place for arranging secondary health assessments and all prisoners are offered a Blood Borne Virus (BBV) test as part of this assessment.

Clinical observation and assessment

46. The clinical reviewer was concerned that healthcare staff did not consistently follow up the lead GP's request for NEWS-2 scores to be calculated every time they completed a set of observations on Mr Zejnullahi, and to calculate his abdominal girth every other day. She considered that these observations were key in monitoring any sign of Mr Zejnullahi's health deteriorating. The clinical reviewer acknowledged that the lead GP did not feel Mr Zejnullahi's health was compromised as a result of this, but that this might not be the case for another prisoner. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff consistently complete clinical observations, including NEWS-2 assessments, when requested by a doctor.

Use of interpreting services

47. All prisoners should be able to access primary health care services in a way that ensures their language and communication requirements do not prevent them from receiving the same quality of care as others. Mr Zejnullahi's first language was Albanian. NHS England guidance says that a professional interpreter should be offered where language is a barrier to discussing health.

48. Clinicians at Bedford said that Mr Zejnullahi's English was such that he could understand 'everyday" English and could communicate well. However, the clinical reviewer found interpreting services were used intermittently, and there is evidence that Mr Zejnullahi refused treatment in June 2021 because he did not understand why he was having this treatment.

49. We reviewed Mr Zejnullahi's prison record and found multiple instances where staff found it hard to communicate with him due to his limited English. This included discussions on his potential early release and maintaining family ties. There is no evidence that using interpreting services was considered by prison staff at any point during Mr Zejnullahi's sentence. We consider that this was an omission.

50. We asked the prison whether they had assessed Mr Zejnullahi's level of English. The prison could not find a record of an English assessment being completed. We make the following recommendation:

    The Governor and the Head of Healthcare should ensure that prison and healthcare staff use interpreting services when discussing residential, care and health matters with prisoners with limited or no English.

51. The clinical reviewer made a recommendation about symptom management which we do not repeat in this report but which the Head of Healthcare will need to address.

Non-Clinical Findings

Maintaining family ties

52. The Prison Service's Strengthening Prisoner Family Ties Policy Framework published in January 2019 provide instruction and guidance on supporting foreign national prisoners to maintain family ties. Section 4.27 of the Framework covers services for foreign national offenders (FNOs). It says:

> "It is important to facilitate a FNO's contact with family who reside overseas.
>
> FNOs are more likely to have family abroad which is an impediment to ongoing family visits. Governors must consider ways to mitigate this disadvantage e.g., through additional provision for phone calls, additional visits when family are in the UK etc".

53. Mr Zejnullahi arrived in prison on 22 February 2021. It took nearly a month for an international telephone number to be added to his PIN phone account. It may not have been helped that the prison had provided him with an application form in English for international telephone calls, which it appears he struggled to understand. We note that in May, a prison officer completed another application on Mr Zejnullahi's behalf, presumably due to his limited written English. We make the following recommendation:

The Governor should ensure that prisoners with family abroad are able to call their relatives in a timely way.

54. National guidance on family liaison and communicating with prisoners' families during the pandemic states that if a prisoner is either diagnosed with, or suspected of contracting, COVID-19, they should be given the opportunity for someone to be informed.

Staff support

55. The Prison Service Instruction (PSI) 02/2018 – *Post Incident Care* sets out the policy on supporting staff following a serious incident (such as the death of a prisoner). This includes having a local Care Team that provides peer support and signposting to professional services. The policy covers care in the immediate aftermath of serious incident as well as in the following days and weeks.

56. The prison held a debrief, in line with the policy on 18 November for the escort staff who were with Mr Zejnullahi when he died in hospital. The prison's safety manager then arranged for the prison's Care Team to see all key staff involved in his care to see if they needed support.

57. However, Mr Zejnullahi's Prison Offender Manager (POM) had not been identified and included on the list of people to be seen. This was an oversight. The POM, who had been involved in arranging elements of Mr Zejnullahi's immigration bail and release planning, had to identify herself to the Safety Manager. We make the following recommendation:

The Governor should ensure that when a prisoner dies, all key staff who were actively involved in a prisoner's care are correctly identified and offered support.

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Prisons and Probation Ombudsman **June 2022**

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