Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Semsettin Zihni, a prisoner at HMP Thameside, on 21 November 2019

A report by the Prisons and Probation Ombudsman

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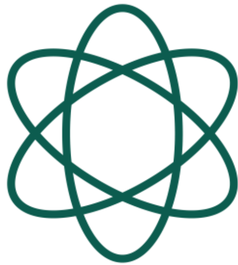
Our vision

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

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

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Semsettin Zihni died of miliary tuberculosis on 21 November 2019 while a prisoner at HMP Thameside. He was 55 years old. I offer my condolences to Mr Zihni's family and friends.

The investigation found that several aspects of Mr Zihni's care were not managed in line with national guidelines and there were weaknesses in continuity of care because healthcare staff did not obtain Mr Zihni's community records. Mr Zihni's blood pressure and diabetes were not monitored regularly, and nurses did not consistently use clinical assessment tools or create any care plans for him. The clinical reviewer also considered that healthcare staff needed further training and development in the management and handling of prisoners with complex long-term medical conditions.

The clinical reviewer therefore concluded that, overall, Mr Zihni's care was not equivalent to that which he could have expected to receive in the community. This is not the first time we have expressed concern about healthcare at Thameside and I am therefore copying this report to the Executive Director of Custodial Contracts at HMPPS and to the NHS Commissioner for London.

I am concerned that the decision to use restraints on Mr Zihni during his admission to hospital on 12 November was unjustified and did not take account of his deteriorating health or level of risk.

Our investigation also found that some facilities at the prison were in urgent need of repair and that this was negatively impacting on prisoners.

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 **December 2020**

Contents

Summary 1
The Investigation Process 4
Background Information 5
Key Events 7
Findings 10

Summary

Events

1. On 21 September 2019, Mr Semsettin Zihni was recalled to prison and was sent to HMP Thameside. He was charged with intent to kidnap and being in possession of an offensive weapon. His licence was revoked on 18 October.

2. Mr Zihni had a history of complex medical conditions which included kidney disease, a heart condition, diabetes, high blood pressure, iron deficiency, and arthritis, which reduced his mobility. He was also waiting for a knee replacement operation. Healthcare staff saw him frequently to prescribe his medication.

3. From November 2019, Mr Zihni's health began to deteriorate. He complained to a nurse that he had a cough. A prison GP prescribed an antibiotic.

4. On 11 November, Mr Zihni felt unwell and several healthcare staff visited him in his cell because the houseblock lift was not working and he was unable to get to the prison healthcare clinic. He could not be moved to the prison's inpatients unit because the water and electricity were not working in the only vacant cell.

5. On 12 November, Mr Zihni told staff he could not go for his dialysis appointment because he felt so unwell. Healthcare staff assessed him and found that his blood pressure and temperature were high. A nurse arranged for him to be transferred to hospital.

6. Mr Zihni was admitted to hospital where his condition deteriorated and he received life support. On 21 November, his life support was withdrawn and he died later that afternoon in hospital with his family present.

Findings

7. The clinical reviewer found that the arrangements put in place for Mr Zihni's dialysis appointments were appropriate and equivalent to that which he could have expected to receive in the community.

8. The clinical reviewer found that other aspects of Mr Zihni's care were disjointed and inconsistent. Healthcare staff did not obtain Mr Zihni's community records to ensure continuity of care, and they did not monitor his complex conditions or create any care plans to manage his conditions.

9. The clinical reviewer concluded that overall Mr Zihni's care was not equivalent to that which he could have expected to receive in the community. We have made similar findings in other investigations into deaths at Thameside in the last few years, and in April 2019 we escalated our concerns to the Executive Director of Custodial Contracts at HMPPS and to the NHS Commissioner for London.

10. The control room did not keep a log of when Mr Zihni left the prison in an emergency ambulance to attend hospital on 12 November.

11. We are concerned that, despite his poor health and limited mobility, prison managers decided that Mr Zihni should be restrained when he was admitted to

hospital on 12 November until 14 November. We are not satisfied that this was justified by fully considered risk assessments.

12. Mr Zihni had limited mobility and there were occasions when broken facilities at the prison impacted on his care.

Recommendations

- The Head of Healthcare should ensure that:
  - staff obtain and check community GP records and other relevant records; and
  - these are passed to prison GPs for clinical assessment to ensure continuity of healthcare.
- The Head of Healthcare should ensure that staff consistently use the Modified Early Warning Score (MEWS) system to assess and monitor patients with acute symptoms and to support clinical decision-making.
- The Head of Healthcare must ensure that full and detailed care plans are produced for prisoners with complex health needs such as diabetes and hypertension, in line with NICE guidelines.
- The Head of Healthcare should ensure that there are procedures in place and documented instructions for the long-term care of prisoners who are in the end stages of renal disease and receiving dialysis.
- The Head of Healthcare should ensure that all healthcare staff receive clear guidance and sufficient training to deal with monitoring complicated medical conditions effectively, including:
  - management and leadership training for staff expected to lead in the long-term care of prisoners with complicated medical conditions;
  - all staff are made aware of their roles and how to perform tasks assigned to them; and
  - all information must be recorded when conducting a cell visit.
- The Director should ensure that recategorisation after recall is completed promptly, in line with PSI 40/2011.
- The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Director should revise the risk assessment form for hospital escorts to make it clear that:
  - healthcare staff must provide information on the prisoner's current state of health and mobility; and
  - prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.

- The Director should ensure that:
  - prisoners with limited mobility are allocated suitable cells; and
  - lift breakdowns are quickly resolved to ensure the minimum disruption for prisoners with mobility issues.
- The Director should ensure that the control room keeps an accurate log when requests for an ambulance are made.
- The Director and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

The Investigation Process

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

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

15. The investigator interviewed one prison manager by telephone on 5 and 7 February 2020, and seven healthcare staff at HMP Thameside on 18 February.

16. NHS England commissioned a clinical reviewer firm to review Mr Zihni's clinical care at the prison. A clinical reviewer jointly interviewed healthcare staff with the investigator, and a second clinical reviewer completed the clinical review.

17. We informed HM Coroner for Inner South London of the investigation. The investigation was suspended from 3 December 2019 to 27 April 2020 as we waited for a copy of the post-mortem report. The coroner gave us the results of the post-mortem examination. We have sent him a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Zihni's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not raise any concerns.

19. Mr Zihni's family and solicitor received a copy of the initial report. They did not make any comments.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Thameside

21. HMP Thameside is a local prison which holds up to 1,232 male prisoners who have either been convicted or are on remand. It is managed by Serco. Healthcare is provided by Oxleas NHS Trust. A dedicated healthcare unit has inpatient facilities for 20 prisoners.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Thameside was in May 2017. Inspectors found that, overall, HMP Thameside was a relatively good prison and they identified an unusually high number of examples of good practice.

23. Inspectors reported that although a high number of prisoners were received into the prison, the reception processes were quick. They also noted that significant staff shortages had affected the delivery of health services, particularly in primary care. The regime and inefficiencies with the booking system delayed prisoner access to healthcare. There was an appropriate range of primary care services, but some waiting times were too long, especially to see the GP. The inpatient unit provided reasonably good care. Some patients experienced delays in receiving their medication, leading to potentially serious gaps in treatment.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to June 2019, the IMB reported that while there were still areas of concern, healthcare provision had improved, and that healthcare staffing levels had risen. The IMB reported that they received a concerning number of complaints about the quality of healthcare provision which included concerns about unexplained delays in treatment, referrals or test results, and non-provision of medication. The Board also noted that after a follow up Care Quality Commission inspection in May 2019, improvement was needed for personalised care planning for those diagnosed with long-term health conditions.

25. The IMB said that Thameside provided good quality modern accommodation. However, key facilities regularly broke down which had an adverse and unfair impact on prisoners: for example, it was rare to find a day without a lift being out of action, which impacted on the movements of disabled prisoners.

Previous deaths at HMP Thameside

26. Mr Zihni was the sixth prisoner to die at Thameside since November 2017. Of the previous deaths, two were from natural causes, two were drug-related, and in one case the cause of death is not yet known. There has been one self-inflicted death since Mr Zihni's death.

27. In four of our previous investigations, we have found that the prisoner’s healthcare was not equivalent to that which they could have expected to receive in the community, and in April 2019 we escalated our concerns to the Executive Director of Custodial Contracts at HMPPS and to the NHS Commissioner for London. We have also made previous recommendations about the use of restraints.

Key Events

28. On 4 May 2018, Mr Semsettin Zihni was released on licence from HMP Ford. He was recalled to prison on 21 September 2019, and was held on remand at HMP Thameside, facing charges of intent to kidnap and being in possession of an offensive weapon. His licence was revoked on 18 October, and formal notification of his recall was issued.

29. Mr Zihni had been previously diagnosed with kidney disease (for which he received dialysis in hospital three times a week), a heart condition, insulin dependent diabetes, high blood pressure, iron deficiency, and rheumatoid and osteo arthritis on his right knee which reduced his mobility. He was also waiting for a knee replacement operation. Due to his reduced mobility, Mr Zihni had a personal emergency evacuation plan (PEEP).

30. A nurse carried out Mr Zihni's reception health screen when he arrived at Thameside. The nurse checked Mr Zihni's observations including his blood pressure and weight. She noted that these were all stable and there were no significant physical concerns. She also noted his outstanding dialysis appointments. She referred him to a prison GP for review. She did not make any arrangements to create any care plans.

31. A prison GP reviewed Mr Zihni later that day. He noted that Mr Zihni's medical conditions were stable and that he had an arteriovenous (AV) fistula (an artery and vein connection for dialysis access) in his left wrist. He prescribed Mr Zihni's medications, arranged for the kitchen to provide a diabetic (no potassium) meal pack and asked healthcare administrators to facilitate his dialysis appointments. He noted that Mr Zihni had asked that handcuffs should not be placed on the AV fistula for any dialysis appointments. He did not make any arrangements to put any care plans in place for Mr Zihni.

32. On 22 September, a nurse completed a secondary reception screen. She checked Mr Zihni's observations, which were in the normal range. She noted that as well as a fistula, he had a peripherally inserted central catheter line (PICC). She did not note any information about the use or need for the PICC and did not arrange for any care plans to be put in place for Mr Zihni.

33. Mr Zihni was allocated a double cell on the upper floor of Houseblock 1. From 23 September, he attended his dialysis appointments three times a week. Healthcare staff saw him frequently.

34. On 6 November, a prison GP saw Mr Zihni on the houseblock as an emergency. Mr Zihni said that he had a cough for the past week and produced green sputum. The prison GP noted Mr Zihni's blood pressure was high. He diagnosed a lower respiratory tract infection and prescribed antibiotics (doxycycline).

35. Mr Zihni continued to feel unwell. He managed to attend his dialysis appointment on 9 November. On 10 November, he told a nurse that he had lost his appetite. His temperature and blood pressure were high. She gave him paracetamol and encouraged him to eat. She tasked nurses to monitor him. Later that evening, a nurse checked and found that his blood pressure and temperature were lower.

Events from 11 November 2019

36. On 11 November, a nurse checked on Mr Zihni. His temperature and blood pressure had increased. She noted he was poorly and that the duty GP needed to see him. Mr Zihni was not able to go to see the GP because the houseblock lift was out of service and he could not get to the clinic without a wheelchair.

37. An advanced nurse practitioner said that a prison GP was shadowing her that day. Together with the nurse, they all went to see Mr Zihni in his cell. At interview, the advanced nurse practitioner said that nurse completed the observations and the prison GP checked Mr Zihni's chest. After examination, she suspected a lower urinary tract infection and said that Mr Zihni should be admitted to the prison's inpatient unit for close monitoring. The inpatient unit staff said that there were no cells available because the only vacant cell had no electricity or water. She also noted that the houseblock lift was not working so any move would be difficult. Healthcare night staff arranged with prison staff to visit Mr Zihni's cell to monitor him during the night.

38. On 12 November, Mr Zihni was scheduled to attend his dialysis appointment. He felt so ill that he refused to go. A prison GP asked a nurse to arrange urgent blood and urine tests. The nurse was the first nurse to question why Mr Zihni had a central line in addition to the fistula (only one is needed for dialysis). She noted that both appeared clean. She checked Mr Zihni's blood pressure and noted it was high and that he was feeling dizzy. She noted that Mr Zihni should go to hospital.

39. Prison staff told the nurse that the escorting staff had said they could not transfer Mr Zihni from his bed to a wheelchair to get him to reception in order to transport him to hospital. The nurse called for an ambulance. She noted that the lift in Houseblock 1 was not working so help would be needed to transfer Mr Zihni to a stretcher and then down the stairs in the houseblock.

40. The ambulance arrived at 3.55pm. Ambulance and prison staff carried Mr Zihni down the stairs for transfer to the ambulance. He was escorted by two officers and was handcuffed for the journey to Queen Elizabeth Hospital, Woolwich.

41. Mr Zihni's condition deteriorated in hospital. He had a catheter and hospital staff arranged for him to have emergency dialysis. On 13 November, the prison transfer and discharge coordinator visited Mr Zihni and spoke to the nursing staff in the hospital. He noted that Mr Zihni was unable to communicate and was handcuffed to one of the escorts.

42. The prison transfer and discharge coordinator visited Mr Zihni again in hospital on 14 November. Mr Zihni had been transferred to the intensive therapy unit (ITU) and could not communicate, eat or drink. He was having dialysis and was on intravenous antibiotics as the consultant suspected he had an infection. The consultant said that Mr Zihni had both a fistula and a line in his wrist, when he should have only had one or the other. He suspected that the line had been in place for too long and could have been the starting point for the infection. Prison managers authorised Mr Zihni's handcuffs to be removed and they were not used again.

43. On 15 November, a member of staff from the prison healthcare team visited Mr Zihni and spoke to the hospital consultant. Mr Zihni was seriously ill and unable to

communicate. Tests were ongoing to try to establish the type of infection and diagnosis.

44. Prison healthcare staff rang the hospital daily for updates on Mr Zihni's condition.

45. A staff member from the prison healthcare team visited Mr Zihni and spoke to the hospital consultant again on 19 November. Mr Zihni was critically ill in a coma and investigations continued to try to identify the infection.

46. The prison transfer and discharge coordinator visited Mr Zihini on 21 November and spoke to the senior nurse who said that Mr Zihni was on life support and a brain assessment would be conducted later. If there was no activity, the life support would be switched off. The life support machine was switched off later that day with Mr Zihni's family present, and Mr Zihni died at 4.02pm.

Contact with Mr Zihni's family

47. On 13 November, the prison appointed a prison manager as the family liaison officer (FLO). He contacted Mr Zihni's mother to inform her that Mr Zihni was in hospital. He arranged to collect her and take her to the hospital to see her son. He accompanied her home after the visit.

48. On 19 November, the FLO spoke to Mr Zihni's mother after hospital staff had asked for Mr Zihni's next of kin to be contacted. He arranged another hospital visit and collected Mrs Zihni to see her son on 21 November. He also arranged for Mr Zihni's son (who was also a prisoner at Thameside) to be brought to the hospital to see his father.

49. Hospital doctors had discussions with Mr Zihni's mother and son and told them it was unlikely that he would survive. Mr Zihni's mother, brother and son were present when his life support machine was turned off.

50. After Mr Zihni died, the FLO telephoned Mr Zihni's mother and brother to offer advice and support.

51. In line with Prison Service guidance, Thameside offered a financial contribution to the cost of Mr Zihni's funeral.

Support for prisoners and staff

52. After Mr Zihni's death, a prison manager debriefed the escorting staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

53. The prison posted notices informing other prisoners of Mr Zihni'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 Zihni's death.

Post-mortem report

54. The Coroner concluded that Mr Zihni's cause of death was miliary tuberculosis (a rare form of TB where the tuberculosis bacilli spread to all parts of the body).

Findings

Clinical care

55. Mr Zihni died of miliary tuberculosis. The clinical reviewer noted that it is rare in the UK and is difficult to diagnose because its symptoms are non-specific. If untreated, it is likely to be fatal. There is nothing in Mr Zihni's medical records to suggest that it had been diagnosed before his death, and we cannot say how or when he had contracted the infection.

56. The clinical reviewer concluded that, overall, the healthcare Mr Zihni received at Thameside was not equivalent to that which he could have expected to receive in the community. She identified a number of concerns.

Community records

57. Prison Service Order (PSO) 3050, *Continuity of Healthcare for Prisoners*, describes the purpose of the reception health screen as "to identify any existing problems and to plan any subsequent care". The PSO also says that "efforts should be made to retrieve any information required from a prisoner's GP or other relevant service he/she has recently been in contact with". The aim is to enable continuity of healthcare between the community and prison, so a prisoner should not be disadvantaged in accessing and continuing treatment.

58. Given Mr Zihni's health conditions, the clinical reviewer considers that healthcare staff should have requested his previous GP records, and once received, a prison GP should have checked that information. It appears that only his medication summary was obtained. This meant that healthcare staff did not have the full clinical details about Mr Zihni's complex medical conditions. Although this did not directly impact on Mr Zihni's death, failure to ensure that prisoners continue to get the medical treatment they received in the community could prove critical. We make the following recommendation:

    The Head of Healthcare should ensure that:

    - **staff obtain and check community GP records and other relevant records; and**
    - **these are passed to prison GPs for a clinical assessment to ensure continuity of healthcare.**

Chronic disease management

59. Mr Zihni had complex medical conditions. His treatment options were limited to managing his symptoms, rather than curing his underlying illnesses. Appropriate management of life-long conditions in prison is important. The clinical reviewer noted that Mr Zihni's poorly controlled diabetes and his dialysis put him at increased risk of infection. She found that that there were no care plans to guide nurses and healthcare assistants in the day to day management of Mr Zihni's conditions. The care plans should have included management of the central line and the fistula.

60. The Early Warning Score System is a tool used to determine the degree of illness of a patient. The Modified Early Warning Score (MEWS) is calculated after recording blood pressure, heart rate, oxygen saturations, breathing rate, level of consciousness or new confusion and temperature. The clinical reviewer found that the use of MEWS was muddled and did not fulfil its function as a tool to aid objective assessment. We make the following recommendation:

The Head of Healthcare should ensure that staff consistently use the Modified Early Warning Score (MEWS) system to assess and monitor patients with acute symptoms and to support clinical decision-making.

Diabetes and hypertension

61. National Institute for Health and Care Excellence (NICE) guidelines on the management of hypertension emphasise the importance of regular monitoring and recording of blood pressure in hypertensive patients.

62. Mr Zihni's diabetes and hypertension were not well controlled and his medication was not reviewed as it should have been. His conditions could have been more effectively managed using care plans.

63. Although Mr Zihni's blood pressure was checked and on occasions it was high, healthcare staff did not implement any follow up care plans and there is no record of any blood tests to assess kidney function, cholesterol or blood sugar and no clear record of urine tests.

64. The clinical reviewer found that there was a lack of clarity around the storage and administration and even the dosage of Mr Zihni's insulin to manage his diabetes. She said that the approach to the checking of his blood glucose levels was intermittent and inconsistent.

65. There was further confusion when Mr Zihni was transferred to hospital because healthcare staff were unable to provide a summary of his care and treatment.

66. The clinical reviewer concluded that healthcare staff should monitor and treat chronic diseases in line with NICE guidelines. We make the following recommendation:

The Head of Healthcare must ensure that full and detailed care plans are produced for prisoners with complex health needs such as diabetes and hypertension, in line with NICE guidelines.

Dialysis

67. The clinical reviewer noted that the interviews with healthcare staff provided no certainty that staff had sufficient basic knowledge on the management and care for prisoners undergoing dialysis, and that this led to confusing advice about issues such as fluid intake and his fistula care. The clinical reviewer found no evidence to suggest that staff had a copy of the dialysis clinic's care plan for Mr Zihni's dialysis.

68. The long-term condition lead nurse said a care plan was not created for Mr Zihni as they relied on the hospital passing on any instructions. However, Mr Zihni never had any hospital outpatient clinic appointments, he only had his dialysis

appointments. The nurse accepted that there was no current system to share information about a prisoner's care because care plans were not created.

69. Managing a prisoner undertaking dialysis and being cared for in a prison environment has its challenges. The clinical reviewer was concerned that there was no oversight and consideration of Mr Zihni's risk of infection with a fistula and a central line. She considered that this was needed, given his shared cell and shared bathroom. We would have expected to see evidence that there was clear guidance about managing prisoners who are undertaking regular dialysis. We therefore recommend:

The Head of Healthcare should ensure that there are procedures in place and documented instructions for the long-term care of prisoners who are in the end stages of renal disease and receiving dialysis.

Healthcare reviews on 11 and 12 November

70. The clinical reviewer's report describes in detail the assessments and actions taken by healthcare staff on 11 and 12 November before Mr Zihni was taken to hospital. She considers that the assessment undertaken on 11 November was unsatisfactory because the examination findings and recordings of his history were incomplete, and there was not enough information to support the diagnosis of a urinary tract infection. Although healthcare staff considered transferring Mr Zihni to the prison's in-patient unit, when this proved impossible no thought was given to transferring him to hospital even though he was becoming increasingly unwell. Also, the written record was unclear about who had carried out the assessment and review.

71. We are also concerned that healthcare staff "advised" Mr Zihni's cellmate to monitor him. It is not clear what this meant and we do not consider that it was appropriate to delegate this task to another prisoner. Three healthcare staff visited Mr Zihni in his cell and noted that there should be close monitoring of his food and fluid intake. However, there is no evidence that this took place.

72. On 12 November, a prison GP visited Mr Zihni in his cell. There is no record of his actions or the decisions made about Mr Zihni's care. The clinical reviewer considers that healthcare staff should have requested Mr Zihni's transfer to hospital much sooner that day.

73. The clinical reviewer was satisfied, however, that these shortcomings did not adversely affect the outcome for Mr Zihni.

74. We make the following recommendations:

The Head of Healthcare should ensure that all healthcare staff receive clear guidance and sufficient training to deal with monitoring complicated medical conditions effectively, including:

- **management and leadership training for staff expected to lead in the long-term care of prisoners with complicated medical conditions;**
- **all staff are made aware of their roles and how to perform tasks assigned to them; and**
- **all information is recorded when conducting cell visits.**

75. The clinical reviewer has made some additional recommendations, which we have not repeated in this report but which the Head of Healthcare will need to address.

Restraints, security and escorts

76. When prisoners must travel outside the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public when escorting prisoners outside prison, but this must be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary in the circumstances and decisions should be based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

77. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. The judgement found that using handcuffs or other restraints on terminally ill or seriously ill prisoners was inhumane, unless justified by security considerations.

78. Thameside has a local security strategy and operating procedure, based on Prison Service Instruction (PSI) 33/2015, about escorts and risk assessments for the external movement of prisoners. This says that the risk assessment will consider a prisoner's medical condition and if in doubt, the medical officer's opinion should be obtained regarding the medical objections and the likelihood of escape unaided.

79. Mr Zihni had poor health, limited mobility and used a wheelchair to move around. He attended external dialysis appointments three times a week and was handcuffed for these appointments. He was seriously unwell when he went to hospital as an emergency on 12 November 2019.

80. The risk assessment for Mr Zihni's admission to hospital on 12 November wrongly recorded him as a Category B prisoner who was serving a lengthy prison sentence (which was incorrect because he had been recalled and his security categorisation had not been assessed). He was assessed as being medium risk to the public and a low risk of escape and hostage taking. There were no objections from medical staff to the use of restraints and they did not consider that Mr Zihni's condition restricted his ability to escape unaided. Two officers accompanied Mr Zihni to hospital, and he was restrained using double handcuffs (when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.)

81. We are surprised that healthcare staff considered that although Mr Zihni's blood pressure was raised, and he was feeling very ill and dizzy and had limited mobility, he had the ability to escape unaided from two escort officers. We accept that, faced with that advice, it was not unreasonable for prison managers to authorise that Mr Zihni should be restrained. We also accept that the decision on whether to use restraints rests with prison staff and not with healthcare staff. However, we are concerned that the member of healthcare who completed the healthcare section of the risk assessment form did not understand the legal position and their

responsibility to provide accurate information about Mr Zihni's current state of health to enable prison staff to make a justifiable decision.

82. When they arrived at the hospital, Mr Zihni complained that the handcuff was hurting his wrist where the fistula was. The duty manager gave permission for the escorts to change the handcuff to an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

83. The next day another escort risk assessment was completed when Mr Zihni had been admitted to hospital. It again wrongly recorded that Mr Zihni was a Category B prisoner with the same risk assessments, assessing him as being medium risk to the public and a low risk of escape and hostage taking. Prison managers reviewed the risk assessment and authorised the use of the escort chain because Mr Zihni was re-assessed as low risk because of his medical condition and hospital admission. A prison security manager visited the hospital and completed a management visit check and reviewed Mr Zihni's risk assessment. He appropriately authorised the escort chain to be removed. The handcuffs were removed on 14 November and Mr Zihni was not restrained again.

84. Ultimately, it is prison managers' responsibility to ensure that the process is managed properly, but Heads of Healthcare also need to ensure that healthcare staff understand their responsibilities and have appropriate input into the risk assessment process. We make the following recommendation:

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

The Director should revise the risk assessment form for hospital escorts to make it clear that:

- **healthcare staff must provide information on the prisoner's current state of health and mobility; and**
- **prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.**

Categorisation and recall

85. Prison Service Instruction 40/2011 outlines the process for the categorisation and recategorisation of prisoners. It says that recalled prisoners must be reviewed within four working days of the Parole Board or Justice Secretary's decision to recall. The normal categorisation paperwork should then be completed, taking into account the security category on release, the circumstances and number of recalls, length of time on licence and time to serve.

86. When Mr Zihni was remanded to Thameside on 21 September 2019, his security categorisation was recorded as 'unsentenced'. His recall paperwork was completed on 18 October, but no action was taken on his recategorisation.

87. Staff told us that caseworkers in the Catch 22 department provide offender management services. The caseworker for Mr Zihni said:

"[Mr Zihni] was released as unsentenced (without a category) as his NOMIS was not updated for us to be able to do the categorisation before he was admitted to hospital or recorded as 'out' on the system!"

88. Once recalled, Mr Zihni should have been recategorised. He was wrongly assessed as a Category B prisoner which impacted on the risk assessment decision making process for the use of restraints. Mr Zihni was not admitted to hospital until 12 November - more than seven weeks after his recall - so we consider that there was enough time for the recategorisation process to have been completed. We make the following recommendation:

The Director should ensure that recategorisation after recall is completed promptly, in line with PSI 40/2011.

Facilities

89. Mr Zihni's NOMIS records show that he had a PEEP, and prison staff should have been aware that he had reduced mobility. It was surprising to find that Mr Zihni was not allocated a larger cell, adapted for those with care and mobility problems.

90. The IMB report had reported that poor facilities at Thameside impacted on prisoners. In this case, Mr Zihni could not be admitted to the prison's inpatient unit because a cell was out of service due to electrical and water supply problems. We are also concerned that Mr Zihni had been unable to attend the healthcare clinic because the lift on his houseblock had been broken for several days.

91. There were further difficulties when Mr Zihni needed to go to hospital on 12 November. According to the London Ambulance Service record, Mr Zihni's transfer was delayed because the houseblock lift was out of service. The Ambulance Service and prison staff carried Mr Zihni down the stairs in a carry chair to the ambulance. We recommended:

The Director should ensure that:

- **prisoners with limited mobility are allocated suitable cells; and**
- **lift breakdowns are quickly resolved to ensure the minimum disruption for prisoners with mobility issues.**

Record keeping

92. The investigator asked the prison for details from the control room log about the timings of the ambulance arriving and leaving the prison on 12 November. Control room staff said that a medical emergency code was called at 9.27pm and the ambulance left the prison at 10.55pm (no name was mentioned). This was incorrect as the Ambulance Service log shows that Mr Zihni had left the prison in the ambulance at 5.09pm. We are concerned that the control room did not have a record of the movements of Mr Zihni and the escort officers when they left the prison to go to hospital. We therefore recommend:

The Director should ensure that the control room keeps an accurate log when requests for an ambulance are made.

Sharing of PPO reports

93. We consider that it is important for staff who were involved in Mr Zihni's care to see the findings of and learn lessons from our investigation. We make the following recommendation:

    The Director and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

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