

**Prisons &
Probation**

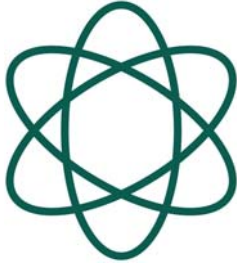
Ombudsman
Independent Investigations

**Independent investigation into the
death of Mr Terence Mitchell,
a prisoner at HMP/YOI Doncaster,
on 23 April 2022**



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

OGL

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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 Terence Mitchell died of hyperosmolar diabetic coma (a coma caused by very high blood glucose levels) in hospital on 23 April 2022, while a prisoner at HMP Doncaster. He was 73 years old. We offer our condolences to Mr Mitchell's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Mitchell received at Doncaster was equivalent to that which he could have expected to receive in the community and that his diabetes was managed in line with National Institute for Health and Care Excellence guidelines. The clinical reviewer made no recommendations.
5. We found no non-clinical issues of concern.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Mitchell's clinical care at Doncaster.
7. The PPO investigator investigated the non-clinical issues relating to Mr Mitchell's care, including Mr Mitchell's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Mitchell's next of kin, his wife, to explain the investigation and to ask if she had any matters, she wanted us to consider. She had questions about his mental health care, his physical health care and the communication between herself and the prisons. The questions regarding Mr Mitchell's healthcare have been addressed in the clinical review. The questions regarding non-clinical issues have been addressed in this report or in separate correspondence.
9. Mr Mitchell's family received a copy of the draft report. They did not make any comments.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

Previous deaths at HMP Doncaster

11. Mr Mitchell was the 18th prisoner to die at Doncaster since April 2020. Of the previous deaths, ten were from natural causes, four were self-inflicted and three were drug related. Since Mr Mitchell's death, two more prisoners have died. One death was self-inflicted, and the other was from natural causes. There are no similarities between our findings in the investigation into Mr Mitchell's death and our investigation findings for the previous deaths.

Key Events

12. On 26 August 2016, Mr Terence Mitchell was sentenced to 15 years for sexual offences.
13. On 16 June 2021, Mr Mitchell transferred to HMP Moorland. At his initial health screening, healthcare staff noted that Mr Mitchell had diabetes, mobility issues and required a wheelchair.
14. On 25 June Mr Mitchell moved to a cell on house block seven, where there were no stairs, and he was paired with a buddy (a prisoner who had volunteered to assist Mr Mitchell with his daily needs). On 5 July, a social worker and an occupational therapist visited Mr Mitchell to assess whether he needed any further support. They concluded that he needed additional living aids and thirty minutes worth of social care assistance per day, which they put in place.
15. Staff observed a decline in Mr Mitchell's presentation and contacted the occupational health team on 6 August. On 9 August, an occupational therapist assessed Mr Mitchell again and concluded that his buddy was going above and beyond his duties. They concluded that Mr Mitchell needed social care support during the night. They noted that Moorland did not have 24-hour social care available and emailed the social worker and the Head of Healthcare to suggest a transfer to another prison.
16. On 17 August, a nurse emailed HMP Doncaster to ask if they had space for Mr Mitchell. Between August 2021 and January 2022, staff at Moorland regularly chased the transfer request while trying to secure funding for temporary night-time social care. They were unable to secure the funding.
17. On 25 January 2022, Mr Mitchell was transferred to HMP Doncaster social care unit because a place had become available. The security team authorised an open-door policy so that healthcare staff could provide care whenever Mr Mitchell required it.
18. On 10 February, an advanced nurse practitioner completed Mr Mitchell's annual diabetes review. They checked his blood sugar levels and his feet for any diabetes-related issues and found no cause for concern. Healthcare assistants were asked to check Mr Mitchell's blood sugar levels daily, and quarterly reviews were put in place.
19. On 6 April, a nurse saw Mr Mitchell for a mental health assessment. The nurse recorded that Mr Mitchell had a low mood, low energy and did not want to engage. She assessed that Mr Mitchell might have depression with Alzheimer's disease (a brain disorder that slowly destroys memory) and requested blood tests to rule out any physical causes for his mental ill-health.
20. On 7 April, Doncaster assigned a family liaison officer (FLO).
21. On 8 April, a consultant psychiatrist assessed Mr Mitchell and recorded that his gradual cognitive decline was likely to be caused by Alzheimer's disease. The psychiatrist prescribed anti-depressants to help manage Mr Mitchell's low mood.

On 20 April, Mr Mitchell failed a memory test and a prison GP referred him to the hospital memory clinic.

22. At 3.00pm on 22 April, a healthcare assistant took Mr Mitchell's blood sugar levels and found that they were high. They notified the lead nurse, who recorded that Mr Mitchell was alert and felt well. She asked the healthcare assistant to remove Mr Mitchell's sugary snacks, give him a cup of water and retest the blood sugar levels one hour later. The healthcare assistant returned at 4.15pm, but Mr Mitchell was eating his evening meal so they planned to try again later.
23. At 4.35pm on 22 April, a healthcare assistant found Mr Mitchell unresponsive in his cell. They called a code blue (the emergency radio code used when a prisoner is not breathing) and started CPR. Paramedics arrived at 4.48pm and took Mr Mitchell to hospital. The FLO contacted Mr Mitchell's family and they made their way to hospital.
24. On 23 April 2022, Mr Mitchell died in hospital with his family present.

Post-mortem report

25. The post-mortem report concluded that Mr Mitchell died of a hyperosmolar diabetic coma (a coma caused by high blood glucose levels) and diabetes.

Tallulah Frankland
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February 2023

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