Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mardan Halimi, a prisoner at HMP Pentonville, on 10 March 2025

A report by the Prisons and Probation Ombudsman

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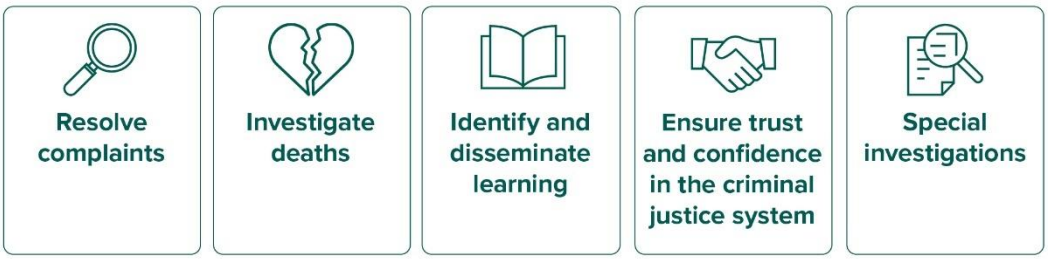
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Mardan Halimi died in hospital of hospital acquired pneumonia caused by metastatic pancreatic cancer (pancreatic cancer that has spread to other parts of the body) on 10 March 2025, while a prisoner at HMP Pentonville. He was 46 years old. We offer our condolences to his family and friends.

4. The clinical reviewer found that the clinical care Mr Halimi received at Pentonville was equivalent to that he could have expected to receive in the community.

5. Mr Halimi spent the last two and a half weeks of his life as a hospital inpatient. We found that, for much of this time, restraints were used on Mr Halimi without due consideration for his increasingly poor mobility and difficulty breathing.

Recommendations

- The Governor should ensure that all prison staff undertaking management checks during hospital bedwatches understand the legal position on the use of restraints and that:
    - Managers fully consider the prisoner's current health and mobility and base their decision on the actual risk the prisoner poses at the time.
    - A robust quality assurance process is implemented to check that these measures are in place and effective.

The Investigation Process

6. HMPPS notified us of Mr Halimi's death on 10 March 2025.

7. NHS England commissioned an independent clinical reviewer, to review Mr Halimi's clinical care at HMP Pentonville. The clinical review is attached as Annex 1.

8. The PPO investigator investigated the non-clinical issues relating to Mr Halimi's care.

9. The Ombudsman's office wrote to Mr Halimi's brother to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Halimi's brother said that he emailed and phoned Pentonville several times to highlight concerns about his brother's health.

10. We also shared the initial report with Mr Halimi's family. They did not make any comments.

11. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is an additional annex to this report.

Previous deaths at HMP Pentonville

12. Mr Halimi was the seventh prisoner to die at Pentonville since March 2022. Of the previous deaths, one was from natural causes, two were drug related deaths and three were self-inflicted. There are no significant similarities between the findings in our investigation into Mr Halimi's death and the findings from our investigations into the previous deaths.

Key Events

13. On 25 September 2024, Mr Mardan Halimi was sentenced to two years in prison for drugs offences. On 28 November, he was released on licence. On 2 December, Mr Halimi was arrested for rape, strangulation and actual bodily harm. On 4 December, he was admitted to HMP Pentonville on licence recall and on remand for the new offences.

14. A nurse completed a reception health screen assessment, at which Mr Halimi said that he had high blood pressure and cholesterol. The nurse referred him to a GP.

15. On 19 February 2025, Mr Halimi told prison staff that he had pain in his kidney and his head, and said that he had felt unwell for three days. A nurse assessed him, and Mr Halimi said that he had not opened his bowels for five days and had pain in the right side of his stomach with a loss of appetite. A urine test was completed and identified a presence of urobilinogen (excess urobilinogen in urine may indicate liver diseases, such as viral hepatitis, cirrhosis, or liver damage). Mr Halimi's clinical observations identified an elevated pulse rate. He had an electrocardiogram (ECG - test that records the electrical activity of your heart, including the rate and rhythm) completed which identified sinus tachycardia (heart is beating faster than normal) and it was planned to discuss Mr Halimi with a GP. It was also planned to repeat blood tests, and these were requested.

16. On the same day, a GP saw Mr Halimi and described him as appearing to be in obvious discomfort, appearing slightly dehydrated and holding his right side in pain. The GP prescribed codeine to help with the pain and recorded that there was a low threshold to send Mr Halimi to hospital if his symptoms had not improved later that day. Mr Halimi was also prescribed a course of antibiotics.

17. Staff asked Mr Halimi about the pain in his head. Mr Halimi stated that over a year ago while in the community he had hit himself over the head with an ashtray until it smashed. He stated he had been waiting for an MRI to see what was wrong.

18. On 20 February, a nurse reviewed Mr Halimi. He said that he still felt unwell, was holding his right side, and said the pain was getting worse. Mr Halimi's clinical observations showed an ongoing elevated pulse rate. He had a NEWS2 (determines degree of illness of a patient and prompts critical care intervention) score of two, which indicated a low clinical acute risk.

19. Shortly afterwards, Mr Halimi experienced severe pain and staff arranged for him to be taken to hospital by ambulance. Before transfer to hospital, a nurse completed the healthcare section of the escort risk assessment and did not object to the use of restraints. A senior prison officer authorised double cuff restraints on Mr Halimi, to be removed only for life threatening emergencies. (Double cuffs is when the prisoner's hands are cuffed together with one set of handcuffs and a second set of cuffs is used to cuff one of the prisoner's wrists to an officer's wrist.) Mr Halimi remained in hospital on bedwatch (with two officers present) and did not return to prison.

20. On 28 February, bedwatch officers considered completing another risk assessment on Mr Halimi to assess whether he should still be restrained. They contacted the

prison and the duty operational manager called the hospital for an update on Mr Halimi's health. The consultant treating Mr Halimi was present when the duty manager called. He said that Mr Halimi was not "imminently dying". After this no further action was taken and Mr Halimi remained in restraints. There was no consideration for his mobility, ongoing treatment and wider health, including that by this stage he was receiving oxygen therapy due to difficulty breathing and required personal care in bed and assistance to use a commode.

21. On 4 March, staff recorded that Mr Halimi was fairly immobile and a physiotherapist was helping him to practice walking. He had difficulty breathing and continued to receive oxygen (which remained for the rest of his hospital stay). Mr Halimi also now had a catheter in place. He remained in handcuffs.

22. On 6 March, hospital staff contacted the Deputy Head of Healthcare to make them aware that Mr Halimi was still being restrained despite his frail and poor clinical condition. This was raised with the duty operational manager and the restraints were removed the next day.

23. On 7 March, Mr Halimi was admitted to the hospital intensive care unit. Hospital staff informed the prison that Mr Halimi had been diagnosed with metastatic pancreatic cancer, and he was not for active treatment and had a poor prognosis. Mr Halimi continued to deteriorate in hospital.

24. On 7 March also, prison staff contacted court staff and asked to speak with the Judge handling Mr Halimi's current case (the outstanding offences for which he had been remanded). They wanted to ask if bail could be granted to Mr Halimi so that prison and healthcare staff could issue release on temporary licence (ROTL, a means by which prisoners can temporarily be released to spend time in the community, usually for resettlement purposes but also for essential medical treatment) in case he needed end of life care. A court hearing was scheduled for 12 March.

25. On 8 March, Mr Halimi's brother visited him in hospital.

26. At 9.18am on 10 March, Mr Halimi died.

Cause of death

27. A hospital doctor gave Mr Halimi's cause of death as hospital acquired pneumonia caused by metastatic pancreatic cancer (pancreatic cancer that has spread to other parts of the body).

Findings

Clinical findings

28. The clinical reviewer concluded that the clinical care Mr Halimi received at Pentonville was equivalent to that which he could have expected to receive in the community. She made one recommendation on medication reconciliation, not related to Mr Halimi's death, which the Head of Healthcare will wish to address.

Release on Temporary Licence

29. Once it was established that Mr Halimi had a poor prognosis, healthcare and prison staff attempted to facilitate release on temporary licence (ROTL) for him. This could be approved by the Governor if Mr Halimi was granted bail by the court for his outstanding offences.

30. The clinical reviewer found evidence of good practice from healthcare staff in their work to support Mr Halimi's bail application once his poor prognosis became clear. Prison staff quickly applied to the court and a hearing was promptly listed, but Mr Halimi died before his case was heard.

Use of restraints

31. 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 the prisoner's health and mobility. 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.

32. The Prevention of Escape – External Escorts policy framework says there should be management checks initially within the first 24 hours of a bedwatch, and then at least every 72 hours to include looking at the prisoner's medical condition and whether restraints are inappropriate.

33. On 20 February, Mr Halimi was taken to hospital. Before he was transferred a nurse completed the healthcare section of the escort risk assessment and did not object to the use of restraints. This decision appeared clinically appropriate on the day as, while Mr Halimi was experiencing significant pain, he was a middle-aged prisoner who retained mobility. Mr Halimi was also on remand for very serious offences and a duty manager appropriately authorised the use of restraints.

34. By 28 February, Mr Halimi's health had deteriorated. He was now receiving oxygen therapy due to difficulty breathing and was considerably less mobile. A duty manager considered the use of restraints, but this appeared to consist solely of a conversation with a hospital consultant who said that Mr Halimi was not "imminently

dying". After this no further action was taken and Mr Halimi remained in restraints. There was no consideration therefore for his mobility, poor health and ongoing treatment.

35. By 4 March, Mr Halimi was much more immobile and a physiotherapist was helping him to practice walking. He continued to receive oxygen therapy (which remained for the rest of his hospital stay). He was also given personal care by nurses in bed or had to be helped to use a commode, and had a catheter fitted. There was no apparent reconsideration of his risk assessment and whether restraints were still appropriate.

36. The restraints were eventually removed on 7 March, after hospital staff questioned their use.

37. The prison records showed that bedwatch staff conducted management checks every 72 hours, in line with policy requirements. However, they did not properly consider Mr Halimi's health during this time and he remained in restraints longer than was appropriate.

38. We are not satisfied that prison staff complied with the High Court judgement or that they fully considered Mr Halimi's risk in light of his poor and deteriorating physical health. Although his restraints were removed on 7 March, this was initiated by hospital staff raising their concerns with the prison. There had been no proper prior consideration for Mr Halimi's current and long-term health or his current circumstances, treatment and mobility.

39. It is important that Pentonville properly considers the prisoner's health, mobility and treatment when determining the appropriate level of restraints during bedwatch management checks.

40. We make the following recommendation:

The Governor should ensure that all prison staff undertaking management checks during hospital bedwatches understand the legal position on the use of restraints and that:

- **Managers fully consider the prisoner's current health and mobility and base their decision on the actual risk the prisoner poses at the time.**
- **A robust quality assurance process is implemented to check that these measures are in place and effective.**

Inquest

41. The inquest into Mr Halimi's death concluded on the 9 September 2025. The coroner confirmed that Mr Halimi died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman **June 2026**

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