Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Moffett, a prisoner at HMP Preston, on 6 August 2019

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

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.

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.

Mr Thomas Moffett died of cardiac tamponade (a heart condition) on 6 August 2019 at HMP Preston. Mr Moffett was 56 years old. I offer my condolences to his family and friends.

The clinical care that Mr Moffett received at Preston was generally good. However, the care he received on the day of his death was not equivalent to that which he could have expected to receive in the community.

I am concerned that Mr Moffett did not have an electrocardiogram (ECG – a test used to detect the heart's rhythm and electrical activity) when he first collapsed on 6 August, and that a prison manager did not accept a prison paramedic's assessment that an ambulance should be called, and instead sought a second opinion. I am also concerned that we have been unable to establish the chronology of events on 6 August accurately because the paramedic's entries in Mr Moffett's medical records were significantly different to a statement, she submitted to the PPO five months later.

We cannot say whether the outcome for Mr Moffett might have been different if an ECG had been conducted earlier or if the ambulance had arrived more quickly.

I am also concerned that two officers inappropriately used a medical emergency code to request a medical review for Mr Moffett and that the level of restraints used was inappropriate when Mr Moffett was urgently transferred to hospital.

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 **April 2025**

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Summary

1. On 14 February 2017, Mr Thomas Moffett was released from prison on licence. He was recalled to prison on 3 July 2019 and was sent to HMP Preston.

2. Mr Moffett had a history of chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease) and substance misuse, both of which were appropriately treated.

3. In early August 2019, Mr Moffett had diarrhoea and was vomiting. Healthcare staff reviewed him frequently. His vital signs were in the normal range.

4. On 5 August, an officer radioed healthcare staff to request a medical emergency code blue for Mr Moffett. A nurse responded immediately and found that Mr Moffett continued to vomit and have diarrhoea. She reviewed Mr Moffett, who was conscious and alert, and his vital signs remained within the normal range. Mr Moffett was reviewed again the next day as his symptoms continued. His vital signs remained normal.

5. Later that day, at about 2.30pm, an officer radioed healthcare staff to request a medical emergency code blue as Mr Moffett had fallen. Mr Moffett told the prison paramedic who responded that he had collapsed but had not lost consciousness, and that he was vomiting less. The paramedic completed another set of observations and found that his blood glucose level had increased. She advised him to see healthcare staff if his symptoms worsened.

6. Later that day, the paramedic reviewed Mr Moffett who was lying on the floor by the medication hatch after collapsing again. She noted that his observations were getting worse, he had increased difficulty breathing and his oxygen saturation levels were lower. She assessed that he needed to go to hospital and told a prison manager that an ambulance should be called.

7. The prison manager wanted a second opinion from a GP. There were no GPs available so a nurse prescriber agreed that an ambulance should be called.

8. At 5.25pm, a non-urgent ambulance was called but they could not say when they would attend.

9. Sometime between 5.30 and 6.30pm, the paramedic completed an ECG which showed that Mr Moffett had a possible pericardial effusion (an abnormal accumulation of fluid around the heart which affects the function of the heart). Prison staff updated the ambulance service and contacted them four more times to ask when the ambulance would arrive. Mr Moffett's condition continued to deteriorate and at 9.13pm, the control room requested an emergency ambulance.

10. At 9.26pm, an ambulance arrived, and Mr Moffett was transferred to hospital, restrained by double cuffs. These were removed at 11.15pm to allow hospital staff to try to resuscitate him. They were unable to do so, and Mr Moffett died at 11.35pm.

Findings

11. Although the clinical care Mr Moffett received at HMP Preston was generally good, the care he received on 6 August 2019 was not equivalent to that which he could have expected to receive in the community. He did not have an ECG after his first unexplained collapse on 6 August.

12. There was a delay in an ambulance being called because a prison manager wanted a second opinion from a GP after a prison paramedic said that that an ambulance should be called.

13. We are concerned that a prison paramedic's entry in Mr Moffett's medical record was not timely, detailed or accurate as it should have been.

14. Prison officers inappropriately radioed a medical emergency response code twice to ask healthcare staff to assess Mr Moffett.

15. Mr Moffett was inappropriately restrained when he was transferred to hospital on 6 August.

Recommendations

- The Head of Healthcare should ensure that an ECG is undertaken promptly if a prisoner collapses without clear explanation, regardless of his physical presentation.
- The Governor should ensure that an ambulance is called promptly if a qualified clinical professional says that one is required.
- The Head of Healthcare should ensure that healthcare staff make detailed, timely and accurate entries in prisoners' medical records in line with the Nursing and Midwifery Council's Code and the Health and Care Professions Council's Standards of Conduct.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 on medical emergency codes so that staff accurately and appropriately communicate the nature of a prisoner's medical condition.
- The Governor and Head of Healthcare should ensure that all staff undertaking and reviewing risk assessments for prisoners taken to hospital understand the legal position, that assessments fully take into account prisoners' health and are based on the actual risk they present at the time.

The Investigation Process

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

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

18. NHS England commissioned a clinical reviewer to review Mr Moffett's clinical care at the prison. After she had produced her initial clinical review report, we received an undated and unsigned statement from a prison paramedic in January 2020 which differed in some respects from the details she had recorded in Mr Moffett's medical records on the day of his death. The clinical reviewer and the Death in Custody lead for Spectrum Community Health interviewed the paramedic on 19 February 2020. Details of the interview are included in the revised clinical review.

19. We informed HM Coroner for Preston and West Lancashire of the investigation. He gave us the results of the post-mortem examination and we have sent him a copy of this report.

20. The initial report was originally issued in December 2020. In response, the Governor of HMP Preston asked for a prison manager, to be interviewed. After several attempts, it has not been possible to interview him. On 3 June 2021, he did, however, send the investigator an email about his recollection of events. We have amended our report to include his comments.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

22. One of the Ombudsman's family liaison officers contacted Mr Moffett's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Moffett's son responded on her behalf and raised concerns about Mr Moffett's medication and treatment. The clinical reviewer has addressed these concerns in her report. Mr Moffett's family received a copy of the draft report.

Background Information

HMP Preston

23. HMP Preston is a Category B local prison serving the courts in Lancashire and Cumbria. It holds up to 811 adult male prisoners. At the time of Mr Moffett's death, Spectrum Community Health CIC provided primary healthcare services 24 hours a day, seven days a week. GPs provide daytime cover between 8.00am and 9.00pm, Monday to Friday and 3.00pm to 5.30pm on Saturdays. Outside these hours a Registered General Nurse is on duty. An out of hours service is provided by GTD Healthcare, and there is a 28-bed recovery wing for those with addiction problems.

HM Inspectorate of Prisons

24. The most recent report on a scrutiny visit to HMP Preston was in August 2020. Inspectors noted that, due to the Covid-19 pandemic, primary and mental health services were stretched, and there were long waits for routine and some urgent assessments. Healthcare staff were working hard to improve matters and there were early signs of recovery, as staff who had been shielding returned to work.

25. The most recent unannounced inspection of HMP Preston was in March 2017. Inspectors noted that healthcare provision had deteriorated. Care for prisoners with long-term conditions was inconsistent and care plans were inadequate. Inspectors found that the standard of care in the inpatient unit was generally good.

Independent Monitoring Board

26. 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.

27. In the IMB report for the year to March 2021, they reported that at the start of the lockdown, due to the COVID-19 pandemic, medication was delivered but due to staff shortages, this took between three and four hours instead of forty minutes. In August, the provision of services started to improve, but in October, for the second time, Preston was declared an outbreak prison. Disruption to the healthcare (HC) services did take place but not as much as during the first lockdown. By the end of the year, HC was functioning well with no prisoner out of date with any routine vaccination. The normal regime of blood sampling and routine appointments was in place, and substance misuse reviews took place after five days and 13 weeks. The discharge reviews were also taking place. All waiting lists were comparable with those in the community.

Previous deaths at HMP Preston

28. Mr Moffett was the fourth prisoner to die at Preston since August 2017. The previous deaths were from all from natural causes. Since Mr Moffett's death until 1 April 2025, there have fourteen more deaths at Preston, four of which were self-inflicted and the other ten which were from natural causes.

29. Following a death in November 2018, we made a recommendation about the inappropriate use of restraints. The prison agreed to issue a Staff Information Notice about the appropriate use of restraints when prisoners are escorted to hospital. It is, therefore, disappointing that this remained a concern in our investigation into Mr Moffett's death.

Key Events

30. On 14 February 2017, Mr Thomas Moffett was released from prison on licence. He was recalled into custody on 3 July 2019 for reoffending and sent to HMP Preston.

31. At Mr Moffett's initial health screen, it was noted that he was underweight and that he had a history of chronic obstructive pulmonary disease (COPD) and substance misuse. Mr Moffett said that he had recently been treated for hepatitis C and had plates above his eye and in his jaw as the result of an assault. Mr Moffett did not know what medication he was taking and had not brought any with him to prison. He said that he had used drugs recently and was prescribed methadone as an opioid substitute. A nurse assessed that Mr Moffett had mild withdrawal symptoms, and he was placed in the Substance Misuse Assessment Unit and prescribed methadone.

32. On 4 July, a nurse completed Mr Moffett's second health screen. Mr Moffett told her that he had outstanding hospital appointments. An administrator later found out that Mr Moffett was on the waiting list for a follow-up appointment with the Neurology Department.

33. The nurse assessed that Mr Moffett continued to have mild withdrawal symptoms. A prison GP reviewed the summary from Mr Moffett's medical record. He noted Mr Moffett's substance misuse concerns and that he was extremely underweight. He prescribed him nutritional supplements and medication to treat a vitamin deficiency.

34. On 9 July, Mr Moffett moved from the Substance Misuse Assessment Unit to a standard wing.

35. On 18 July, a pharmacist referred Mr Moffett to the prison GP after she assessed that he was at risk of developing heart disease, an osteoporotic fracture and hip fracture within ten years. Later that day, a prison GP reviewed Mr Moffett. He noted that he had previously been diagnosed with osteoporosis, that he was underweight and on steroids. He prescribed Mr Moffett medication to treat osteoporosis.

Events of 4 and 5 August

36. On 4 August, Mr Moffett went to the medication hatch and said that he felt sick, was unable to keep anything down and thought he was dying. A nurse noted that his respiratory rate was normal, his skin was a normal colour, and he was able to communicate without difficulty. She gave him pain relief and told him to see healthcare staff if his symptoms got worse.

37. At 12.06pm, a nurse reviewed Mr Moffett in his cell as he had been vomiting. She noted that he was chatty and bright and reported normal bowel movements. She told him to drink plenty of water, to eat when he felt able and to see healthcare staff if he continued to be sick.

38. At 7.47am on 5 August, a nurse reviewed Mr Moffett as he continued to vomit and have diarrhoea. He checked Mr Moffett's vital signs, which were normal, and noted that he may have a viral infection. He told Mr Moffett to drink plenty of fluids and to contact healthcare staff if his condition changed.

39. At 9.46am, an unidentified officer on Mr Moffett's wing radioed a nurse to ask her to respond to a medical emergency code blue (used when a prisoner has chest pains, difficulty with breathing, is choking or having a suspected stroke) for Mr Moffett, as he continued to vomit and have diarrhoea.

40. The nurse went to Mr Moffett's cell immediately. She noted that he was lying on his bed and was conscious and alert. She checked Mr Moffett's vital signs and noted that they were within the normal range. Mr Moffett asked her if he could go to the medication hatch to collect his methadone. She told him that he should do so if he felt able.

Events of 6 August

41. At 10.59am on 6 August, a pharmacist asked healthcare staff to review Mr Moffett as he had not been to the medication hatch to collect his methadone and wing officers had told her that he had been unwell for a few days.

42. At 11.15am, a prison paramedic reviewed Mr Moffett. He told her that he had had diarrhoea and vomiting for three weeks and had lost weight in the last 18 months. He said that he had a history of COPD, that he felt tired and lethargic but that he was able to move around without any difficulty. He said that he had collected his medication from the medication hatch.

43. The paramedic completed a full set of observations, and a healthcare assistant took his blood. She found that he was alert, and his breathing was normal. He had low blood pressure, but his temperature and blood glucose level were normal. She advised Mr Moffett to sip fluids and to try to eat. She told him to see healthcare staff if he felt worse and that she would review him later that day.

44. We have found it difficult to establish the exact chronology of the events that followed as the paramedic has given two different accounts: one in Mr Moffett's electronic medical record (SystmOne), which was written after Mr Moffett had been taken to hospital, and one in an undated and unsigned statement which we received in January 2020.

45. It appears that at 2.30pm, an unidentified officer on Mr Moffett's wing radioed the paramedic to ask her to respond to a medical emergency code blue for Mr Moffett as he had had a fall.

46. The paramedic said she went to Mr Moffett's cell immediately, accompanied by two healthcare assistants (HCAs). Mr Moffett said that he had become unsteady on his feet and collapsed but had not lost consciousness, and that he was vomiting less. He said that he had managed to drink a cup of tea. The paramedic completed another set of observations and found that his blood glucose level had increased. She advised Mr Moffett to see healthcare staff if his symptoms got worse. An ECG was not completed.

47. At 4.00pm, the paramedic asked HCA 1 to review Mr Moffett again and complete another set of observations.

48. At 4.15pm, the paramedic contacted a nurse in the medication hatch to ask if Mr Moffett could be given his methadone. The nurse told her that Mr Moffett was lying

on the floor at the medication hatch but had not collapsed. The paramedic contacted HCA 1, who told her that she was on her way to review him.

49. At 4.25pm, HCA 1 contacted the paramedic and told her that she had not been able to take Mr Moffett's blood pressure and thought that he needed to go to hospital. The paramedic said she responded immediately and was also unable to take Mr Moffett's blood pressure reading. She noted that his observations were getting worse, he had increased difficulty breathing and that his oxygen saturation levels were lower. She said that she assessed that Mr Moffett needed to go to hospital urgently and told a prison manager that an ambulance should be called. The manager told us that at no time did she tell him that Mr Moffett needed to go to hospital urgently.

50. The paramedic told us that the manager wanted a prison GP to review Mr Moffett first before an ambulance was called, but one was not available. A nurse prescriber, therefore, gave a second opinion and agreed that Mr Moffett should be transferred to hospital.

51. The manager requested an ambulance at 5.23pm. He told us that the paramedic was aware that the ambulance was given a low priority.

52. At 5.25pm, an ambulance was called. The Ambulance Service log records that the call was allocated a low priority with a 4-hour waiting time.

53. The paramedic told us that prison officers helped Mr Moffett to walk to a clinical room so that she could monitor him. She gave him oxygen, checked his observations and completed an ECG which showed that he had a possible pericardial effusion (an abnormal accumulation of fluid around the heart which affects the function of the heart). She gave control room staff the results of the ECG, and they updated the Ambulance Service at 6.39pm.

54. At 6.50pm, prison staff contacted the ambulance service again to update them about Mr Moffett's condition and to check when the ambulance would arrive. They could not give an estimated time of arrival.

55. At 7.50pm, the paramedic handed over to a nurse, who continued to monitor Mr Moffett.

56. At 8.18pm, 8.28pm and 8.49pm, prison staff contacted the ambulance service to check when the ambulance would arrive, but they could not give an estimated time of arrival.

57. Mr Moffett's condition continued to deteriorate, and at 9.13pm, an emergency ambulance was called.

58. At 9.26pm, an ambulance arrived at the prison and Mr Moffett was transferred to Royal Preston Hospital at 9.45pm. He was restrained using double cuffs and escorted by Officer A and another officer.

59. At 10.25pm, Officer A told a prison manager that Mr Moffett's condition had deteriorated and asked if his restraints could be removed. The manager refused and told the officer only to remove the restraints as a last resort.

60. Mr Moffett went into cardiac arrest and at 11.15pm, the restraints were removed to allow hospital staff to carry out cardiopulmonary resuscitation (CPR), but, at 11.35pm, he was pronounced dead.

Contact with Mr Moffett's family

61. Shortly after Mr Moffett died, the on-call chaplain was appointed as the family liaison officer and went to Royal Preston Hospital, where the police told him that it would not be practical to break the news to Mr Moffett's mother, his named next of kin, in the early hours of the morning.

62. At 9.30am on 7 August, the on-call chaplain and a Governor visited Mr Moffett's mother, but there was no answer. A probation officer told them that Mr Moffett's mother could only be contacted in the afternoon and agreed to accompany them.

63. At 2.30pm, Imam Ingar, the Governor and the probation officer broke the news of Mr Moffett's death to his mother and brother and offered their condolences and support. They were told that the police had already told them.

64. Mr Moffett's funeral took place on 20 August 2019, and the prison contributed to its cost in line with national policy.

Support for prisoners and staff

65. The prison posted notices informing other prisoners of Mr Moffett'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 Moffett's death.

Post-mortem report

66. A Digital Autopsy Radiology Report concluded that on the balance of probability, the suggested cause of Mr Moffett's death was cardiac tamponade (a build-up of fluid around the heart which impairs the heart's ability to pump blood), caused by hemopericardium (an accumulation of blood in the pericardial sac around the heart).

Inquest

67. At an inquest held on 14 January 2022, the Coroner concluded that Mr Moffett died as a result of cardiac arrest brought on by metabolic acidosis as a result of prolonged diarrhoea and vomiting exacerbated by failings that caused inappropriate delays in him getting appropriate treatment.

68. Following the inquest, the Coroner issued a regulation 28 report, which required HMP Preston to take action to prevent future deaths within 56 days.

Findings

Clinical findings

69. The clinical reviewer found that Mr Moffett's initial and secondary health screens took place promptly when he arrived at Preston in July 2019. She found that when issues needed to be clarified, healthcare staff did so promptly and recorded accurate information. She also found that Mr Moffett was signposted appropriately to substance misuse and mental health services, and that his medical record suggested appropriate and timely information sharing across the different services involved.

70. The clinical reviewer was satisfied that the substance misuse team assessed Mr Moffett promptly and that all interventions were detailed and appropriate. She found that he received consistent and quality care on the Substance Misuse Assessment Unit. She found that Mr Moffett's withdrawal symptoms were assessed consistently.

71. However, the clinical reviewer concluded that the care that Mr Moffett received at Preston on 6 August 2019 was not of a good standard and was not equivalent to that which he would have expected to receive in the community.

72. She was concerned that Mr Moffett did not have an ECG after his unexplained collapse at 2.30pm, as he should have done. An ECG was not done until between three to four hours later when it showed that he had a possible pericardial effusion.

73. We cannot say what the results of an ECG at 2.30pm would have been, but failure to complete an ECG promptly may have meant a delay in diagnosing the possible cause of Mr Moffett's collapse. This in turn may have led to a delay in calling an ambulance. The clinical reviewer was unable to say whether there might have been a different outcome for Mr Moffett if an ECG had been conducted earlier. We make the following recommendation:

    The Head of Healthcare should ensure that an ECG is undertaken promptly if a prisoner collapses without clear explanation, regardless of his physical presentation.

Requesting an ambulance

74. On 6 August 2019, a prison paramedic assessed Mr Moffett and told a prison manager that he needed to be transferred to hospital. However, the manager wanted a second opinion from a GP before doing so. In the absence of a GP, a nurse prescriber agreed that Mr Moffett should be transferred to hospital. The manager told us that "The asking for the GP to see the prisoners is literally seconds of a conversation" and that an ambulance was called when requested. The paramedic said that she went to speak to the nurse prescriber, who agreed that if she believed Mr Moffett should attend hospital, then he should be sent. She returned to the manager and told him that Mr Moffett needed to go to hospital and that the nurse prescriber supported her decision.

75. We appreciate that taking a prisoner to hospital has staffing implications for a prison. For that reason, we think it is reasonable for prison staff to ask healthcare

staff how urgent the issue is and whether the escort to hospital can wait. However, if healthcare staff say that a prisoner needs to go to hospital, prison staff need to accept their clinical judgement. In this case, a second opinion was not necessary as the prison paramedic was a trained paramedic and qualified to make that judgement. We are concerned that the manager did not accept her professional assessment, which delayed an ambulance being called for Mr Moffett. Although this does not appear to have caused a significant delay, it was unnecessary and could have serious consequences for prisoners in future medical emergencies. We make the following recommendation:

The Governor should ensure that an ambulance is called promptly if a qualified clinical professional says that one is required.

Record keeping

76. The Nursing and Midwifery Council Code 2018 and the Health and Care Professions Council's Standards of Conduct state that medical records should be clear and accurate at all times.

77. The clinical reviewer found that the prison paramedic's written statement of January 2020 about events on 6 August 2019 did not correspond with the detail she recorded in Mr Moffett's medical record at the time, and that the new information she provided suggested a different sequence of events. The clinical reviewer also found that she did not make it clear that her entries in Mr Moffett's medical record on 6 August were written retrospectively, which gave the impression that events had occurred later than they had. (The clinical reviewer did, however, find that other entries in Mr Moffett's medical record were in keeping with the Nursing and Midwifery Council's Code and the Health and Care Professions Council's Standards of Conduct.)

78. We are very concerned that the inaccurate and misleading entries made by the prison paramedic have made it impossible to be certain of the chronology of events on 6 August. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff make detailed, timely and accurate entries in prisoners' medical records in line with the Nursing and Midwifery Council's Code and the Health and Care Professions Council's Standards of Conduct.

Non-clinical findings

Medical emergency response codes

79. Prison Service Instruction (PSI) 03/2013 on medical emergency response codes says that an emergency code should only be called in a medical emergency. The codes are designed to ensure that all available healthcare staff attend the emergency as quickly as possible with the correct equipment, and to trigger the control room to call an ambulance immediately.

80. We are concerned that officers used the code blue inappropriately on 5 and 6 August 2019. They radioed healthcare staff to "request a code blue" (by which they seem to have meant that they wanted a member of healthcare to see Mr Moffett urgently), but Mr Moffett's condition at the time did not justify the use of an

emergency code. If communication with healthcare staff is a person-to-person call, it would not go through the communication suite. Healthcare staff recorded both calls in Mr Moffett's medical record as 'code blues', but it was not recorded in the control room log. This indicates that they were person-to-person calls.

81. We are concerned that this misled healthcare staff about the seriousness of Mr Moffett's condition and the need for an urgent response. If emergency codes are misused in this way, they will cease to have any meaning when a real emergency occurs.

82. We are also concerned that the medical emergency response code was communicated to healthcare staff alone. In a medical emergency, an emergency response code should be radioed to all staff to ensure that the control room requests an ambulance immediately. While this may not have had an impact on the outcome for Mr Moffett, it may have serious consequences for prisoners in other circumstances.

83. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 on medical emergency codes so that staff accurately and appropriately communicate the nature of a prisoner's medical condition.

Restraints, security and escorts

84. 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.

85. 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.

86. Mr Moffett was restrained with double cuffs when he was transferred to hospital on 6 August 2019. In the escort risk assessment, a prison manager, assessed that Mr Moffett posed a 'normal' risk of harm to the public, of hostage taking, danger to staff and of escape. He noted that he had absconded from prison in 2014. The manager told us that, "As is normal practice, the risk assessment for escorts is completed before healthcare complete their section. At no point did the nurse suggest to me that he should not be cuffed. The risk assessment was completed well in advance of the prisoner's condition deteriorating and could have been revised by another duty manager after I had completed my shift".

87. The prison paramedic noted that Mr Moffett's medical condition was a possible pleural effusion, and that he was generally unwell. She noted that he had a heart or other condition that may require immediate lifesaving treatment but concluded that she had no medical objections to the use of restraints.

88. The Head of Operations authorised that two officers should escort Mr Moffett using double-cuff restraints. He noted that as an unsentenced prisoner, Mr Moffett should be treated as a Category B prisoner.

89. We are concerned that the level of restraints used on Mr Moffett was inconsistent with the provisions of the High Court judgement. While we accept that it was reasonable for Preston to restrain Mr Moffett, we do not consider that double cuffs were appropriate. None of his risks were high and his health was poor. We do not consider in these circumstances that the restraints used on Mr Moffett were proportionate to the risk he posed, especially as he was also escorted by two officers, and we are concerned that the restraints were not removed promptly when his condition deteriorated in hospital. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking and reviewing risk assessments for prisoners taken to and admitted to hospital understand the legal position, that assessments fully take into account prisoners' health and are based on the actual risk they present at the time.

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