Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Samuel Omar, a prisoner at HMP Stafford, on 15 October 2025

A report by the Prisons and Probation Ombudsman

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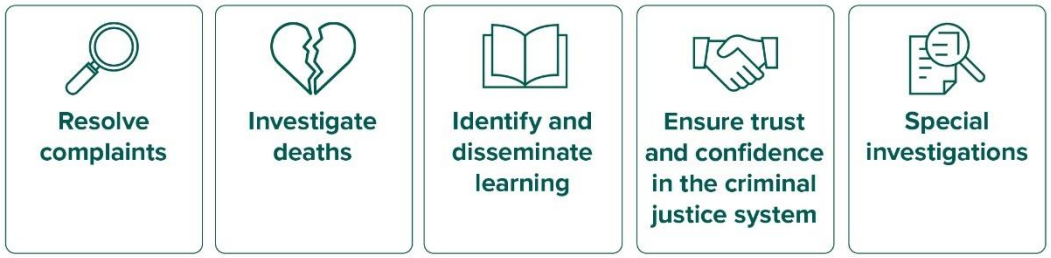
OUR VISION

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 Samuel Omar died in a hospice of pneumonia caused by chronic obstructive pulmonary disease (COPD, lung disease) on 15 October 2025, while a prisoner at HMP Stafford. He was 77 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Omar received at Stafford was of a good standard and equivalent to that which he could have expected to receive in the community. She found there had been a joined-up approach to Mr Omar's care which ensured high-quality treatment.

5. Mr Omar was inappropriately restrained during two emergency hospital transfers on 8 and 9 October, after he fell during the night. As a frail, 77-year old man with poor mobility and a terminal illness, he posed no risk of escape and there was no justification for applying restraints.

6. We have previously made recommendations to Stafford about the inappropriate use of restraints on frail, terminally ill prisoners. The prison told us that the risk assessment process had been amended but this case shows that poor decision making around use of restraints persists.

Recommendations

- The Governor and Head of Healthcare should:
    - Ensure that all healthcare professionals informing escort risk assessments provide clear, accurate details of a prisoner's current health and mobility.
    - Review how effective previous work to educate managers about the risk assessment process and the Graham judgement has been and provide additional measures, including additional training, where necessary.
    - Consider reintroducing a 'non-cuffing' list.

The Investigation Process

7. HMPPS notified us of Mr Omar's death on 15 October 2025.

8. NHS England commissioned an independent clinical reviewer, to review Mr Omar's clinical care at HMP Stafford.

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

10. The prison was unable to trace a next of kin for Mr Omar. Therefore, the Ombudsman's office did not contact anyone about this investigation.

11. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies. HMPPS provided an action plan, which is annexed to this report.

Previous deaths at HMP Stafford

12. Mr Omar was the 27th prisoner to die at Stafford since October 2022. Of the previous deaths, 23 were from natural causes and three were self-inflicted. Up to the end of January 2026, there have been no further deaths.

13. During our investigation into a previous death at Stafford, we found that restraints had been used inappropriately on a terminally ill, category D prisoner who was receiving palliative chemotherapy. In March 2025, the prison told us that the risk assessment process had been amended to ensure that decisions were made in line with the Graham judgment. Restraint risk assessments had also been added to the agenda for preventing future death (PFD) meetings with security to ensure a prisoner's current health was considered when assessing their risk.

Key Events

14. On 20 September 2012, Mr Samuel Omar was given an imprisonment for public protection (IPP) sentence for sexual offences, with a tariff (minimum term he had to serve before he could be considered for release by the Parole Board) of three years.

15. Mr Omar had chronic obstructive pulmonary disease (COPD, a lung condition that restricts airflow and causes breathing difficulties). He also had type 2 diabetes and had multiple falls due to frailty and poor mobility.

16. At around 6.30am on 3 September 2025, an officer found Mr Omar on the floor of his cell. Mr Omar said he had fallen while trying to get to the toilet. A nurse attended and assessed him for injuries. She observed his speech was slurred, he was unable to move and had weakness down his left side, which indicated he might have had a stroke. The nurse checked his blood oxygen levels, which were very low, and gave him oxygen and a salbutamol nebuliser (a machine that helps someone breathe more easily), but his oxygen levels continued to fall. An ambulance arrived and took him to hospital. Mr Omar was not handcuffed for his transfer to hospital as his risk assessment stated he had mobility issues and needed walking aids.

17. At the hospital, Mr Omar had a CT scan which confirmed he had had a stroke. Hospital staff continued to give him oxygen as his blood oxygen levels remained low. He also had a CT scan of his lungs, which showed suspected lung cancer. Due to Mr Omar's poor health, doctors agreed with him that he would not start treatment.

18. Mr Omar remained in hospital until his blood oxygen levels were stable. On 12 September, he was discharged back to Stafford.

19. On 22 September, staff at Stafford submitted an application for Mr Omar's Early Release on Compassionate Grounds (ERCG) to the Public Protection Casework Section (PPCS) of HMPPS. PPCS did not make a decision before Mr Omar died.

20. On 23 September, Mr Omar saw a doctor at the lung cancer clinic. He was not handcuffed for the transfer to hospital as his risk assessment stated he was an elderly category C prisoner with poor health and mobility. The doctor told Mr Omar that the mass on his lungs was likely lung cancer, but due to his severe COPD and poor health after a stroke, they would not do any further tests. They referred him to the community palliative care nurses for supportive care.

21. At around 1.30am on 8 October, Mr Omar fell in his cell and pressed his wrist alarm to call for help. An officer radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff to attend and the control room to call an ambulance) and a nurse responded. The nurse took Mr Omar's clinical observations and calculated a NEWS2 score of two, due to his blood oxygen being low and his heart rate being high. (The National Early Warning Score (NEWS2) is a tool used to assess clinical deterioration. A score is calculated from the clinical observations taken and the higher the score, the higher the risk. A score of two is low risk.). Mr Omar was complaining of chest pain but was not breathless. As Mr Omar had hit his head and was on blood thinning medication, the nurse decided he needed to go to hospital for further assessment. A

prison manager completed the escort risk assessment and decided to apply an escort chain (a long cable with cuffs at either end, attached at one end to the prisoner and at the other to a prison officer) to Mr Omar. He was taken to hospital and returned to Stafford later that day.

22. At around 1.12am on 9 October, a nurse found Mr Omar on the floor of his cell. He was unable to sit up and was complaining of back and neck pain. The nurse took his clinical observations and calculated a NEWS2 score of six (medium to high risk). He observed that Mr Omar's blood oxygen levels were low and he had a crackling sound in his chest. The nurse arranged for an ambulance which took Mr Omar to hospital for further assessment. The same prison manager as the night before completed the risk assessment and decided to apply an escort chain to Mr Omar. Mr Omar returned to the prison later that day.

23. At around 9.26pm on 10 October, a nurse and healthcare assistant went to Mr Omar's cell to help him into bed. He was sitting in his chair, and they struggled to get a response from him. They radioed a code blue and took his clinical observations while awaiting the ambulance. They calculated a NEWS2 score of 10, which indicates high risk, and gave him oxygen. An ambulance arrived and the paramedics assessed Mr Omar. They gave him a salbutamol nebuliser and he became more alert. They advised that he could have another nebuliser at 3.00am if needed, and for a GP to prescribe antibiotics the next day.

24. At around 3.00am, a nurse checked on Mr Omar. He was asleep and breathing well, so did not need another nebuliser.

25. At around 7.50am, Mr Omar's carer found him slumped on his bed struggling to breathe. They alerted a nurse who saw he was short of breath, radioed a code blue and gave him oxygen. A paramedic responded and helped take Mr Omar's observations. They calculated a NEWS2 score of eight, which indicated high risk. The ambulance arrived and the paramedic at Stafford said they were concerned that he was not taken to hospital during the night despite having a NEWS2 score of 10. The ambulance crew agreed to take him to hospital.

26. On 12 October, a nurse at Stafford phoned the hospital and spoke to a nurse on Mr Omar's ward. The hospital nurse said that Mr Omar had not improved and he was struggling to breathe when they tried to reduce his oxygen levels. They were giving him intravenous antibiotics and continued oxygen.

27. On 14 October, a palliative care consultant told the healthcare team at Stafford that Mr Omar had deteriorated and would be transferred to a hospice for end-of-life care.

28. At 1.45pm on 15 October, Mr Omar died.

Cause of death

29. The Coroner accepted the cause of death provided by a hospice doctor and no post-mortem examination was carried out. The doctor gave the cause of death as pneumonia caused by COPD.

Findings

Clinical findings

30. The clinical reviewer concluded that the care Mr Omar received at Stafford was of a good standard and equivalent to that which he could have expected to receive in the community.

31. The clinical reviewer found the joined-up approach to Mr Omar's care between the complex care team, safer custody, and palliative care team, ensured he had proactive care and treatment. She made one recommendation about healthcare staff input to escort risk assessments which we have addressed in our recommendations.

Use of restraints

32. 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 (known as the Graham judgement) 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. It said 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.

33. Mr Omar was taken to hospital on 8 and 9 October after he had fallen in his cell. Staff applied an escort chain to Mr Omar for his transfer to hospital, despite him being a 77-year-old man who was terminally ill with very poor mobility. Also, he had not had restraints applied for previous hospital transfers due to his frailty.

34. The nurse who completed the medical section of both escort risk assessments indicated that Mr Omar was a wheelchair user with limited mobility and serious illness but did not include any details of his medical conditions, as they did in the Person Escort Record (PER).

35. The investigator spoke to the Head of Security at Stafford, who said that the authorising manager for both restraints decisions was a custodial manager (the senior prison officer in charge at night), rather than a duty governor, as both transfers took place during the night shift. (Prisons operate with minimal staff during the night and no governors are on site.)

36. The authorising manager had decided to apply an escort chain to Mr Omar on 8 October as they were concerned that he had had an unwitnessed fall during the night (when far fewer staff are on duty so the security risks of moving prisoners are greater) and had asked whether he would be handcuffed. The following evening, Mr Omar had a second unwitnessed fall during the night. The authorising manager decided to apply an escort chain and submitted an intelligence report as Mr Omar had asked several times why he was being handcuffed. The manager spoke to the

ambulance crew and asked if there was any medical reason why Mr Omar should not be handcuffed, and they said no.

37. The Head of Security at Stafford reflected that if Mr Omar had gone to hospital during the daytime, then due to his health and mobility issues, he likely would not have been restrained, as there would not be the same security concerns as during the night.

38. The Head of Security at Stafford told us that there was no longer a 'non-cuffing' list at Stafford. There used to be an approach where no one over the age of 65 was handcuffed. However, this had since changed to a dynamic risk assessment based on an individual's health, age and overall risk, as they found that this varied across the age group.

39. While we appreciate that a 'non-cuffing' list for all prisoners over the age of 65 would not be appropriate, it would seem sensible for there to be a list of prisoners for whom restraints should not be applied due to their negligible risk of escape due to their health and mobility. This would mean that regardless of the time of day or night that they are taken to hospital, the authorising manager would know not to apply restraints.

40. In a previous investigation into a death at Stafford, we found that a terminally ill category D prisoner had been inappropriately handcuffed when receiving palliative chemotherapy. We were told in March 2025 that the escort risk assessment process had been amended to ensure that decisions are made in line with the Graham judgment and risk assessments were discussed at preventing future deaths (PFD) meetings with security to reinforce the importance of balancing a prisoner's risk with their current health.

41. There was an inconsistent approach to Mr Omar's cuffing arrangements that seemed to be based on the time of the transfer, and the grade of the authorising manager, as opposed to the risk he posed. Mr Omar was not handcuffed for daytime hospital transfers on 23 September and 2 October on the grounds of his poor mobility and terminal illness. There was no justification for applying restraints on 8 and 9 October when if anything, Mr Omar's risk of escape had decreased even further. We recommend:

The Governor and Head of Healthcare should:

- **Ensure that all healthcare professionals informing escort risk assessments provide clear, accurate details of a prisoner's current health and mobility.**
- **Review how effective previous work to educate managers about the risk assessment process and the Graham judgement has been and provide additional measures, including additional training, where necessary**.
- **Consider reintroducing a 'non-cuffing' list**.

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

Inquest

42. At the inquest, held on 26 May 2026, the Coroner concluded that Mr Omar died from natural causes.

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