Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Vasile Moisa, a prisoner at HMP Altcourse, on 17 January 2026

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



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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. 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 Vasile Moisa, a Romanian national, died of a hypoxic brain injury due to a heart attack on 17 January 2026, while a prisoner at HMP Altcourse. He was 51 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Moisa received at Altcourse was partially equivalent to that which he could have expected to receive in the community. She found that healthcare staff had not complied with the requirement in national guidance to identify Mr Moisa's communication needs during his health screens and this had impaired his clinical and medication management.

5. We found that despite Mr Moisa's limited English, staff did not use an interpreting service for important discussions, or refer him to the equality and inclusion team, in line with the prison's Foreign National Strategy. Record keeping was poor in many areas, impairing the reception and induction process, family contact and documenting wing staff's involvement in the emergency response when Mr Moisa became unresponsive.

6. There are conflicting accounts of whether Mr Moisa was placed in restraints for the journey to hospital and the investigation was unable to resolve this. We are particularly concerned that the prison submitted a second, apparently altered version of the escort risk assessment when challenged about the use of restraints.

Recommendations

- The Head of Healthcare should ensure that the weaknesses identified in the clinical review are addressed and there is an auditable process to monitor implementation of specific actions.

- The Director and Head of Healthcare should ensure that staff use interpreting services for interviewing and assessing prisoners who have limited conversational English.

- The Director should ensure that the Foreign National Strategy is dated, reviews are documented and that there is an auditable record of prisoners referred to the Equality and Inclusion Team.

- The Director and Head of Healthcare should put in place a robust quality assurance process to monitor the use of restraints on external escorts, ensuring that it would identify the issues raised by this investigation.

- The Director should review the escort risk assessment forms submitted to this investigation to determine the reasons for the discrepancies and consider whether disciplinary action is warranted.

- The Director should ensure that staff fully document prisoners' personal details, as well as significant events and interactions, and that there is a robust and auditable process to monitor record keeping.

The Investigation Process

7. HMPPS notified us of Mr Vasile's death on 17 January 2026.

8. NHS England commissioned an independent clinical reviewer, to review Mr Moisa's clinical care at HMP Altcourse. The clinical review is attached as Annex 1.

9. The PPO investigator investigated the non-clinical issues relating to Mr Moisa's care. The clinical reviewer and the investigator interviewed eight members of staff from Altcourse between 17 February and 6 March, via Microsoft Teams. The investigator also spoke to a prisoner who had responded to the notice inviting those with relevant information to contact her.

10. The Ombudsman's office wrote to Mr Moisa's next of kin to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

11. The initial report was shared with HMPPS and the healthcare provider. They found no factual inaccuracies and accepted the recommendations.

Previous deaths at HMP Altcourse

12. Mr Moisa was the 17th prisoner to die at HMP Altcourse since January 2023. Of the previous deaths, eight were from natural causes and six were self-inflicted and two were drug related. There are no similarities between the findings in our investigation into Mr Moisa's death and the findings from our investigations into the previous deaths. As of 31 May 2026, there had been no further deaths at Altcourse.

Key Events

13. Mr Vasile Moisa, a Romanian national, was remanded to HMP Altcourse, on 9 December 2025, charged with burglary. It was his first time in prison.

14. Nurse A, a registered mental health nurse, completed a reception health screen, noting that Mr Moisa did not need an interpreter as he spoke some English. Mr Moisa reported his medical conditions as type 2 diabetes and a stroke the previous year. He said he had been prescribed metformin (for diabetes), as well as two medications that Nurse A did not recognise and thought might be Romanian names. (This was not followed up.)

15. On 10 December, the multidisciplinary *Early Days in Custody Daily New Arrivals Meeting* (a healthcare forum to discuss new prisoners) discussed Mr Moisa's clinical needs.

16. At a second stage health screen on 11 December, Nurse B recorded that Mr Moisa had diabetes, heart problems and asthma. She referred him to the long-term conditions clinic (and an appointment was made for 13 January 2026). Substance misuse and mental health assessments were held on 10 and 11 December and no issues were identified.

17. During his first few days in prison, Mr Moisa had reception and induction interviews with prison staff and signed various compacts. On the induction sign-off form, there was a reminder that prisoners with vulnerabilities or additional needs should be assessed for an enhanced induction. On 10 December, it was ticked and signed off to indicate that Mr Moisa did not need this.

18. Part one of Mr Moisa's basic custody resettlement screen (to identify immediate vulnerabilities) was completed on 12 December. His preferred spoken language was noted as, 'other' and the box to indicate whether an interpreter was required was left blank. The answers to whether he found understanding, speaking and reading English easy were ticked as 'no' and writing English 'yes'. It was further annotated, "…speaks limited English, but enough to answer questions for this assessment". (The second stage of this screening on 18 December noted that Mr Moisa had a limited understanding of English which had impacted the amount of detail given.)

19. After his education induction, also on 12 December, staff placed Mr Moisa on the waiting list for an English for Speakers of Other Languages (ESOL) class. He was listed to attend between 14 and 19 January 2026.

20. On 15 December, a wing officer conducted a wellbeing check after Mr Moisa attended a court hearing. She noted there was a language barrier as he "didn't speak good English". Other than cell moves, nothing was recorded in Mr Moisa's personal records over the next four weeks.

Events of 12 January 2026

21. The following account has been drawn from staff and prisoner interviews, a brief entry in the Duty Director's log, as well healthcare department and ambulance records.

22. Just before 9.00am on 12 January 2026, Mr Moisa went to the medication hatch and requested paracetamol for a headache. Ms A, a pharmacy technician dispensed two tablets. A prisoner, who was a friend of Mr Moisa said that he looked very unwell at that time and when he suggested that Mr Moisa needed to be examined by healthcare staff, he was told that he had to submit an application. Due to his concern, the prisoner checked Mr Moisa just after 5.00pm and was concerned about his appearance. He told a prison officer (who he described but did not know her name), who went into the cell briefly, but took no further action.

23. At around 5.15pm, Mr Moisa returned to the medication hatch with his cell mate and asked for more paracetamol. Ms A saw that Mr Moisa looked pale and spoke to a prison officer about getting a nurse to check him. Mr Moisa then collapsed to the floor. At 5.20pm, an officer radioed a code blue medical emergency (which indicates that a prisoner is unresponsive or has breathing difficulties) and an ambulance was requested.

24. Nurse C arrived at 5.25pm, followed by other healthcare staff. While healthcare staff were examining Mr Moisa, he stopped breathing and they could find no pulse. Staff performed cardiopulmonary resuscitation (CPR), using a defibrillator which gave three shocks, and inserted an intravenous cannula for medication.

25. Paramedics arrived at 5.36pm. They continued the resuscitation attempts and Mr Moisa's heartbeat restarted at 5.45pm. They took him to hospital, where he was admitted to the critical care unit and sedated. Mr Moisa was accompanied by two prison officers. (It is unclear whether restraints were used, discussed in the findings section of this report.)

26. The prison sought regular updates from the hospital, who said that the prognosis was poor and they were likely to withdraw care on 15 January.

27. Details of Mr Moisa's next of kin were not in his personal records and the police were unable to find any contact information. The prison obtained a telephone number for a possible next of kin in Romania, through the family of another Romanian prisoner. The family liaison officer tried unsuccessfully to call several times. On 14 January, at the request of the family liaison officer, the Romanian prisoner asked his relatives to tell Mr Moisa's family to contact the prison. On 15 January, Mr Moisa's son telephoned the prison and was informed of his father's condition.

28. The hospital consultant agreed to delay the withdrawal of life support and set a deadline of 17 January, as Mr Moisa's son was said to be desperate to visit. However, he was unable to get a visa in time. On 17 January, the prison allowed a cousin in the UK to visit Mr Moisa and facilitated a video call with his son. Mr Moisa died at 9.05pm that evening.

29. In line with national policy, Altcourse contributed to costs of Mr Moisa's funeral and paid for his body to be repatriated to Romania.

Post-mortem report

30. A post-mortem examination was held. The report concluded that the cause of Mr Moisa's death was hypoxic brain injury due to a myocardial infarction (heart attack). He also had underlying diabetes, which contributed to but did not cause his death.

Inquest

31. At an inquest held on 6 February 2026, the Coroner concluded that Mr Moisa died of natural causes.

Findings

Clinical findings

32. The clinical reviewer found several shortcomings in Mr Moisa's clinical management. Full details are in the clinical review report, but key concerns are summarised below.

33. NHS interpreting guidance states that even a person with good fluency in English might not be able to understand health-related information. Mr Moisa's reception and second-stage health screens did not adhere to national guidance as staff did not meet the requirement to actively identify his communication needs. The clinical reviewer felt it would have been prudent for healthcare staff to use a translation service to determine Mr Moisa's level of comprehension and a more thorough assessment might have led to better verification of his medication and diabetic management.

34. Mr Moisa's medicines reconciliation (the process to accurately list medications) was not completed promptly, nor carried out face-to-face as it should have been. Also, the pharmacy technician wrote contradictory statements as to whether it had been completed and did not seek advice on the difficulties completing it.

35. The clinical reviewer acknowledged that the healthcare provider had completed a thorough investigation, identifying several actions to share learning and improve areas of weakness. These included training staff to use the language interpreting service; recirculating guidance on the management of diabetes; and a full audit of the early days in custody process, with particular emphasis on health screening, record keeping, the importance of following up actions and accountability at the new arrivals meeting.

36. The clinical reviewer concluded that Mr Moisa's clinical care was of a mixed standard and only partially equivalent to that which he could have expected to receive in the community. We recommend:

    The Head of Healthcare should ensure that the weaknesses identified in the clinical review are addressed and there is an auditable process to monitor implementation of specific actions.

Non-clinical findings

Foreign National Strategy and the use of interpreting services

37. HMP Altcourse has a Foreign National Strategy. It is undated, with no indication as to when it was implemented, or updated but the Head of Safety, Ms B, said it was reviewed annually.

38. The strategy states that all foreign nationals should have their language of choice established at admission/induction and those whose first language is other than English should be referred to the Equality and Inclusion Team. There is no evidence that Mr Moisa was referred to the team and the Head of Safety said there was no formal mechanism for recording such information.

39. Several documents, including the Prisoner Escort and Custody Services (PECS) form for Mr Moisa's transfer from court to prison, reception and induction forms and medical records referred to Mr Moisa's main language as Romanian. Staff gave varying accounts of Mr Moisa's understanding of English, but no healthcare, or prison staff used interpreting services during their interactions with him.

40. A prison friend of Mr Moisa described his level of English as limited to a few words, such as painkiller and food, but he made hand signals for other items such as vapes. Without prompting, the prisoner said he knew there was a "translation line" (meaning interpreting services) and felt it should have been used on the day Mr Moisa was unwell.

41. During the investigation, it came to light that Prison Custody Officer (PCO) A, a Romanian speaking wing officer had helped Mr Moisa considerably during the first week, but this had not been documented in either personal or prison records. She said that she had interviewed Mr Moisa when he arrived and had helped him with several issues, such as showing him how to use the case management system (CMS) to make requests, helping him to order items from the prison shop, requesting a diabetic food pack from the catering department and asking for him to be moved to a wing where there were several other Romanian prisoners.

42. When asked why she had not noted her actions, PCO A told the Head of Safety that she felt she was just doing her job. While we appreciate that she acted conscientiously and in Mr Moisa's best interests, significant contact with prisoners should be fully recorded and the Head of Safety has given advice to the officer about the importance of doing so.

43. In response to the investigator's concerns that the failure to provide enhanced induction might be systemic, the Head of Safety provided statistics showing the type of inductions conducted for new prisoners between January 2025 and February 2026. 1,242 prisoners (just under one in six of the total) had received enhanced induction. Allowing for the high number of the remaining prisoners who had a fast-track induction, having returned to Altcourse after a short period, the ratio of those who had received enhanced induction rose to around one in three. We are therefore satisfied that staff are aware of and regularly use the enhanced induction process.

44. We consider that both healthcare and prison staff should have used the interpreting service to ensure that Mr Moisa fully understood the prison regime, rules, procedures and the compacts that he signed. It would also have been beneficial to get a better understanding of his healthcare needs and clarity around the prescribed medications that the reception nurse could not decipher. We recommend:

The Director and Head of Healthcare should ensure that staff use interpreting services for interviewing and assessing prisoners who have limited conversational English.

The Director should ensure that the Foreign National Strategy is dated, reviews are documented and that there is an auditable record of prisoners referred to the Equality and Inclusion Team.

Escort risk assessment and the use of restraints

Legal position and HMPPS policy

45. 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.

46. 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. These requirements are reflected in the HMPPS' *External Escorts Policy Framework*, implemented on 5 January 2026.

Healthcare information

47. The healthcare section of the risk assessment for Mr Moisa's transfer to hospital indicated that there were no objections to the use of restraints and his current state of health did not affect his ability to escape. Given he had to be resuscitated from a cardiac arrest and given intravenous treatment at the prison, this suggests that the clinician who completed it did not understand the rationale for doing so.

Risk assessment and authority to use restraints

48. Other parts of the risk assessment form were largely incomplete, for example individual risk factors and level of restraints, but we understand that the prison did not want to delay Mr Moisa's journey to hospital. National policy makes provision for the assessment to be completed retrospectively in such circumstances, so we are not critical of this action.

49. However, we are concerned about the possible use of restraints, contradictory statements surrounding this and the provision of two risk assessment forms purportedly relating to the escort but with different assessments.

50. The overall security assessment, completed by the Duty Operations Manager, Mr A, stated, "Uncuffed at this time due to potential heart attack. To be reviewed as and when he regains consciousness." However, the authorisation section, completed by the Duty Director, Mr B, indicated that restraints should be used and they could be removed for treatment or emergencies, only with the Duty Director's authority. In the reason for the decision section, Mr B recorded, "emergency escort … for possible cardiac arrest. Cuffs removed for treatment staff informed to reapply once treatment finished."

51. The escort authority form (which authorised taking Mr Moisa out of the prison) was countersigned by Mr B. It was annotated "1st escort, treat with caution" and specified the handcuffing arrangements as "escort chain". (An escort chain is a long

chain with a handcuff at each end, one attached to the prisoner and the other to a prison officer.) There were no references to restraints in either the Person Escort Record (PER) or the bedwatch logs.

52. The investigator tried to explore the reasons for the apparent use of restraints. The prison asserted that no restraints had been used and provided another copy of the security risk assessment. Sections of the form which were previously blank (eg levels of risk and use of restraints) were marked with a highlighter pen to indicate 'normal' risk of escape and to the public, and no restraints. (The annotated information and signatories were the same.) When the investigator challenged the variation in the form and its validity, the prison could provide no explanation for the alteration and who had amended it.

53. There are conflicting accounts about the use of restraints. The Duty Director, Duty Operations Manager and one of the PCOs who escorted Mr Moisa insisted that no restraints were used. (The other escort officer did not reply to the enquiry.) The Duty Director said that he was fully aware of the seriousness of Mr Moisa's condition as he had spoken to the senior paramedic and would not have instructed staff to use restraints. He suggested that the comments on the form might have been misinterpreted.

54. The pharmacy technician at the emergency vividly remembered an escort chain on Mr Moisa. The nurse could not remember whether she had seen the escort chain but distinctly recalled the Duty Operations Manager saying that an escort chain would be applied as it was an emergency (taken to mean instead of handcuffs).

55. The weight of evidence suggests that an escort chain was applied at some point, as the Duty Director had noted that 'cuffs' had been removed. It is conceivable that they were withdrawn before Mr Moisa left the prison, but this cannot be substantiated. At best, there was an initial intention to use restraints despite a cardiac arrest barely an hour before, as well as continuing intravenous treatment. At worst, restraints were used and the modification of the form was a ploy to conceal this. Either way, the judgements were flawed and cast doubt on whether healthcare and wing staff fully understand their responsibilities in completing risk assessments. We recommend:

The Director and Head of Healthcare should put in place a robust quality assurance process to monitor the use of restraints on external escorts, ensuring that it would identify the issues raised by this investigation.

The Director should review the escort risk assessment forms submitted to this investigation to determine the reasons for the discrepancies and consider whether disciplinary action is warranted.

Contacting Mr Moisa's next of kin

Recording next of kin details

56. Prison Service Instruction (PSI) 07/2015 *Early Days in Custody* contains a mandatory instruction that prisons must record a next of kin or nominated emergency contact during the reception or induction process. Additionally, Prison Rule 22 and HMPPS' national policy states that prisoners' next of kin should be

informed immediately if a prisoner becomes seriously ill, or if there is unpredicted or rapid deterioration in their physical health.

57. Mr Moisa's family did not know that he was in prison as he had been arrested in the airport on his way home and, without his mobile phone, he had no access to their phone numbers or addresses. PCO A asked a Romanian prisoner to ask his family to message Mr Moisa's relatives via social media, to get their contact details. The prisoner obtained a telephone number that PCO A added to the prisoner telephone system, but no name was recorded. The prisoner was also instrumental in obtaining Mr Moisa's contact details while he was in hospital.

58. We acknowledge that staff took these steps as a last resort. However, we question the propriety of using a prisoner in this way, exposing them to sensitive and upsetting information and the inherent risk of disclosing personal details. There is no evidence that the staff offered Mr Moisa the opportunity of consular access when he arrived or that they contacted consular officials, the obvious and appropriate way of seeking his family's contact details when he became ill.

59. The consequent delay in contact caused distress to Mr Moisa's family and deprived them of the opportunity to have meaningful contact before he died.

60. The omissions identified are no reflection on the prison's family liaison officer who made every effort to obtain the required details and then provided a high level of support to Mr Moisa's next of kin, with detailed entries in the family liaison log.

Record keeping

61. Poor record keeping was a recurrent theme during this investigation, adversely impacting on several areas of Mr Moisa's management, including important personal details; clinical and medication needs; induction in the prison regime and potential contact with his family. Apart from the clinical records and brief entries in the security and Duty Director's log, there was no proper record of the emergency response, details of the prison staff and their involvement, or staff statements. No debrief was held for the wing staff who witnessed the emergency.

62. Accurate information sharing in medical and personal records is essential to determine the immediate needs of newly arrived prisoners, who can be particularly vulnerable. It is also a vital method of communicating risks to staff and ensuring consistent management of a prisoner. The records suggested poor engagement with Mr Moisa and little observation of his language requirements. However, he received some support that might have been overlooked due to limited record keeping. We recommend:

The Director should ensure that staff fully document prisoners' personal details, as well as significant events and interactions, and that there is a robust and auditable process to monitor record keeping.

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