Investigation into the circumstances surrounding the death of a man at HMP & YOI Altcourse in December 2009

Report by the Prisons and Probation Ombudsman for England and Wales

September 2010

This report considers the circumstances surrounding the death of a man at HMP Altcourse in December 2009. He collapsed in the admissions area of the prison shortly after 6.00pm. He had just returned to Altcourse after being discharged from hospital. He was 64 years old. A post-mortem examination found that he died from multiple pulmonary emboli (blockages of the main artery of the lung) caused by deep venous thrombosis (a blood clot).

I offer my sincere condolences to all those who knew him.

The investigation was conducted by my investigator on my behalf. I would like to thank the Director and the Controller for their co-operation. I also extend thanks to the liaison for the Ombudsman's office. In addition, I thank the clinical reviewer who conducted a review of the man's clinical care. I apologise for the delay in issuing this report, and any additional distress it may have caused his family family.

The man was remanded to Altcourse on 29 June 2009 and sentenced to 16 years imprisonment on 30 October. Other than going into hospital, he remained at Altcourse until the time of his death.

This is the eighth death from natural causes at Altcourse since 2004, when the Ombudsman's office began investigating all deaths in custody. I have examined various aspects of the man's clinical care, though I do not make any recommendations. The National Offender Management Service (NOMS) saw a draft version of this report but did not make any comments.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman **September 2010**

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SUMMARY

The man appeared at Magistrates' Court on 29 June 2009, charged with serious sexual offences, and was remanded to HMP Altcourse. A short medical assessment was undertaken and said he had seen a doctor recently for chest pain and diabetes.

Having initially stayed on the healthcare unit, he saw a doctor on 30 June and a nurse from the mental health team. He said he was depressed due to his circumstances, but there were no major concerns about his mental health. He remained in healthcare until 4 July. He was placed on a review list for patients with chronic heart disease or blood pressure problems.

He moved to the prison's first night centre (where prisoners usually spend their very first night in prison) on 4 July until 15 July, when he moved to a unit for vulnerable prisoners. On 19 July, he appeared unwell, and saw a doctor the next day. He said he had been suffering from back pain for a week, and the doctor noted that there was slight curvature of the upper spine and limited range of spinal movement. He was prescribed an anti-inflammatory drug and offered a review at the hospital if his condition had not improved within two months.

During late July and August, the man failed to attend a number of appointments with healthcare staff. He attended several appointments in early September and requested a walking stick due to his history of spinal injury. He fell in his cell on 21 September whilst trying to climb to the top bunk but did not sustain any visible injuries.

On 25 September, he was convicted at Crown Court and returned to Altcourse to await sentencing. He saw a nurse the next day and complained again of back pain. He saw a physiotherapist on 15 October and explained that he had suffered spinal problems for 30 years after being injured whilst playing rugby. He said that when at home, he used a motorised wheelchair and a walking stick. The physiotherapist issued him with a walking stick.

The man was sentenced to 16 years imprisonment on 30 October. When he returned to Altcourse, he saw a mental health nurse who thought he appeared philosophical about his sentence. The next day, he saw a doctor about his back problems but declined admission to the healthcare unit.

On 18 November, he attended the healthcare unit after vomiting and feeling dizzy. He was prescribed glucose tablets but declined admission, saying he would monitor his own blood sugar levels. At 2.00am the following morning, a nurse was called to see him, who appeared unwell and incoherent. He was weak, clammy, and disorientated. After being given sweetened milk, he regained strength and was able to communicate coherently. He was admitted to the healthcare unit later the same morning for observation.

The man was seen by a doctor on 21 November, and was anaemic, dizzy, pale and unsteady on his feet. He was admitted to hospital where he remained for two nights. He returned to Altcourse on 23 November but was taken back to hospital after falling in the prison's admissions area.

On this occasion, he remained in hospital for nine nights and commenced insulin treatment for diabetes. He was discharged from hospital on the evening of 2 December and returned to Altcourse.

Shortly after returning to the prison, he was taken ill and collapsed in the admissions area. Members of staff started cardio-pulmonary resuscitation (CPR) which was continued when the paramedics arrived. He was taken to hospital but died later the same evening. A post-mortem found that he died from multiple pulmonary emboli (blockages of the main artery of the lung) caused by deep venous thrombosis (a blood clot). Further contributory factors were ischaemic heart disease (characterised by reduced blood supply to the heart) and diabetes mellitus (a condition resulting in high blood sugar levels).

In conjunction with the clinical reviewer, I have investigated the medical care. I do not make any recommendations.

THE INVESTIGATION PROCESS

1. One of my senior investigators opened the investigation on 3 December 2009. At HMP Altcourse, he met the PPO's liaison officer. He facilitated access to all of the records regarding the man's period in custody, including his clinical record.

2. My senior family liaison officer (FLO) wrote to the man's son to explain the purpose of the investigation and offer his family the opportunity to raise any questions or concerns. At the time of writing, there has been no reply. The family will have the opportunity to read the draft version of this report and make comments on it, should they wish to do so.

3. The local Primary Care Trust (PCT) appointed a clinical reviewer to conduct a review of the man's clinical care whilst in custody. (The purpose of a clinical review is to examine the medical care that a prisoner received whilst in custody, which should be of an equivalent standard to what might have been expected in the community.) His findings are summarised in this report and the full clinical review is included as an annex. The investigator received the clinical review in July 2010. The delay receiving the review inevitably delayed issuing my own report.

4. During the course of the investigation, the investigator interviewed three members of Altcourse's staff, all of whom responded when the man collapsed. The clinical interviewer interviewed five additional members of the healthcare staff.

HMP ALTCOURSE

5. Altcourse is located near Liverpool. It is contracted out by the National Offender Management Service (NOMS) and run by G4S, a private company. It serves the courts from Merseyside, Cheshire and North Wales, and holds up to 1324 sentenced and unsentenced adults and young offenders. There are seven residential units and a separate healthcare unit.

6. Healthcare services at Altcourse are commissioned by the local PCT and delivered by G4S. An outpatients clinic is available every weekday, and the inpatients unit involves 24-hour staffing by nurses. Additionally, doctors are on call 24 hours a day for more serious incidents.

Performance

7. The Ministry of Justice provides quarterly figures for all prisons in England and Wales. Every establishment is given a rating between 1 and 4 based on 34 agreed performance indicators. During quarter 3 of 2009-2010 (October, November and December 2009), Altcourse received the maximum rating of 4, indicating exceptional performance. The most recently available figures are from quarter 4 of 2009-2010 (January, February and March 2010). For this period, Altcourse received a rating of 3. This indicates good performance, but nevertheless represents a drop in rating from the previous quarter.

8. An Independent Monitoring Board (IMB) is made up of volunteers from the community in which a prison is located. IMBs must satisfy themselves as to the humane and just treatment of people held in custody, and they report to the Justice Secretary annually. At the time of writing, the most recently available IMB report for Altcourse covered the period July 2008 to June 2009. It was, overall, a “most pleasing report”. The IMB noted some concerns about the way in which healthcare services were contracted out, and the way in which day to day services could be better managed, but also said G4S were committed to improving the situation.

9. The then HM Chief Inspector of Prisons inspected Altcourse on 15-22 January 2010, some six weeks after the man’s death. Her report was generally positive, finding that time spent out of cell was “outstanding, and for much of that time prisoners were engaged in purposeful activity”. Healthcare staffing was generally good, but some areas of the healthcare unit were run-down or untidy. Inpatients had little structured activity to occupy their time.

Previous deaths at Altcourse

10. The Ombudsman’s office has been responsible for investigating deaths in custody since April 2004. Prior to the man’s death, seven prisoners have died from natural causes whilst in the care of Altcourse. Two of these deaths were heart-related, four were from cancer, and in one case a cause of death could not be identified. There were few similarities between these previous cases and his death.

KEY FINDINGS

11. The man appeared at Magistrates' Court on 29 June 2009, and was subsequently remanded into custody at Altcourse.

12. At 9.30pm, an initial health screening was completed by Nurse A. (The initial health screening is a short medical assessment, and is completed for every newly arriving prisoner. Screenings usually take place in the prison's admission area, and are primarily based on information provided by the prisoner.) She noted that the man did not drink alcohol or smoke, and had not sustained any physical injuries in the few days prior to his admission. He had, however, seen a doctor in the preceding few months for chest pain and diabetes. His weight was recorded as 70kg. He was assessed as fit for normal cell location and work.

13. A cell sharing risk assessment (CSRA) was completed when he arrived. This is intended to identify any risks associated with prisoners sharing a cell. There were no concerns that he posed a danger to other prisoners, and as a result he was assessed as low risk. However, the Prison Custody Officer (PCO), who completed the form, noted that he requested vulnerable prisoner status due to the nature of his offence. (Prisoners can be considered vulnerable for various reasons, including the nature of their offences. Prison Rule 45 allows Governors or Directors to remove prisoners from normal association with others, to maintain good order or discipline, or in prisoners' own interests. Prisons usually have a separate unit for those considered vulnerable.) The PCO made a note in his wing history record that he had been accepted for vulnerable prisoner status and would be moved to the care and separation unit (CSU) until there was a space on the vulnerable prisoners' unit.

14. The man was not, however, initially accommodated on the CSU, but instead was admitted to the healthcare unit for observation and assessment. Nurse B wrote in his clinical record that he was admitted to maintain his safety and comfort, and that he would be reviewed when he had seen a doctor the next morning. She noted that he had heart-related problems, Type II diabetes (a metabolic disorder characterised by high blood glucose, and insulin resistance and deficiency) and glaucoma (a condition involving damage to the optic nerve; it leads to progressive and irreversible loss of vision). Additionally, she noted that he seemed settled in healthcare.

15. The following day, 30 June, he saw the Prison Doctor A at the morning surgery. His medical history was reviewed. The doctor noted that he had a kidney disorder, damage to his spine, and hearing problems that were alleviated by the use of a hearing aid. He was considered fit for normal cell location.

16. On the afternoon of the same day, the man went to an appointment with Nurse C from Altcourse's mental health team. He was referred to the service because it was his first time in prison. She wrote in the clinical record that he appeared settled in mood and manner, engaged freely in conversation, and

said he had no previous issues regarding his mental health. He said he felt depressed due to his circumstances, but had no suicidal thoughts. She advised him how he could contact the mental health team if required.

17. The man continued to live on the healthcare unit for the next few days. Observations were noted in his clinical record but there was nothing untoward. On 3 July, a healthcare assistant spoke to his general practitioner (GP) who faxed the most recent entries of his medical history to the prison.

18. On 4 July, he moved from the healthcare unit to the first night centre. (This is where most prisoners spend their very first night in prison, though by this time he had spent five nights in the healthcare unit.) On the same day, Prison Doctor B noted that his blood pressure was not well controlled. He was placed on the chronic heart disease/blood pressure review list, and was prescribed 4mg of Doxazosin, a drug used to treat high blood pressure.

19. Rather than just a single night, the man remained in the first night centre until 15 July. It is unclear why this was the case, though the first night centre may have been considered a more suitable interim location than the CSU for a vulnerable prisoner. Officer A completed an induction interview with him on 7 July but noted that he was "standoffish, aggressive and extremely demanding". On 10 July, he attended Crown Court and was remanded back to Altcourse. Four days later, he saw Nurse D because he was experiencing stabbing lower back pain that had grown worse over the last few days. The nurse referred him to Prison Doctor A.

20. The man moved to the Reynoldstown unit (for vulnerable prisoners) on the following day, 15 July. On the same morning, he saw Prison Doctor A and said he had experienced lower back pain since travelling to court in a prison escort vehicle. He was prescribed paracetamol and tramadol for pain relief.

21. Four days later, he saw Nurse E, who thought he was unwell, lethargic and unmotivated. An appointment was made to see the doctor the following day. Prison Doctor C noted in the clinical record on 20 July that he had been suffering from back pain for a week, though there was no referred pain in other areas. He also complained of some nausea whilst taking tramadol. The doctor noted slight thoracic kyphosis (curvature of the upper spine) and limited range of spinal movement. He was prescribed 50mg Diclofenac (an anti-inflammatory and painkilling drug) twice daily, and offered a review at the hospital if his condition had not improved within two months.

22. On 27 July, the man asked to see a doctor for pain relief medication, and the following day some of his medication was changed following information from his community GP. During late July and August, he failed to attend a number of appointments with healthcare staff. On 30 August, Nurse E made an appointment for him to see a doctor after noticing that he appeared unwell, looked jaundiced, and reported pain in his right foot. Two days later, he saw Prison Doctor A, who noted in his clinical record that, four months previously, he had undergone tests to investigate his iron deficiency anaemia, though no

cause was found. The doctor also noted that he had a fungal infection in his right foot.

23. During early September, he attended several appointments complaining of constipation. He also had a corn on his right foot, and requested a walking stick due to his history of spinal injury. On 14 September, Prison Doctor B noted that his blood test showed low serum iron, and he was prescribed folic acid.

24. Officer B made a note in the man's wing history record on 21 September that he had fallen whilst trying to climb to the top bunk of his bed. The officer wrote that no visible injuries were sustained and that he had not hurt himself. However, he had been sick afterwards. It seems that this incident was not reported to healthcare staff as there is no mention of it in his clinical record.

25. Three days later, he saw Prison Doctor A and reported that he had a history of vomiting in the mornings, and was due to attend court the following day. He was prescribed 10mg domperidone, a medication used to suppress nausea and vomiting, three times daily.

26. On 25 September, he was convicted at Crown Court and returned to Altcourse to await sentencing. The following day, he saw Nurse F and complained of back pain after a fall. She noted that unit staff said he had become more unstable, and listed him for a review appointment with a doctor. On 28 September, he attended an appointment with Prison Doctor A. He was diagnosed with helicobacter pylori serology (a common bacteria in the stomach) and prescribed 500mg amoxicillin (an antibiotic) three times daily, 400mg metronidazole (an antibiotic) three times daily, and 20mg omeprazole (a medication to reduce gastric acid) once daily.

27. The man attended an appointment with a physiotherapist on 15 October. He explained that he had a 30 year history of spinal injury after suffering damage to his vertebrae whilst playing rugby. This had put pressure on the spinal cord. He said he used a motorised wheelchair and a walking stick when at home. Although he was walking on the unit, he had fallen twice and feared he might do so again. As a result of the appointment, the physiotherapist issued him with a walking stick.

28. On 30 October, he appeared at Crown Court and was sentenced to 16 years imprisonment. Upon his return to Altcourse, he saw Nurse G from the mental health team. The nurse noted that, whilst he was upset about the length of his sentence, he seemed "philosophical in mood and manner". He firmly denied any thoughts of suicide or self-harm, and was offered admission to the healthcare unit which he declined to take up. The next day, he saw Prison Doctor A, who also noted that he declined admission to healthcare. The doctor recorded that he had been complaining of backache for several months and that the pain was not well controlled. He had curvature of the upper spine but no tenderness. His medical care plan involved a weekly bath in the healthcare unit, a blood and renal liver test, and an X-ray of his thoracolumbar

spine (a full spinal X-ray). His tramadol prescription was increased to 150mg twice daily.

29. The man saw Nurse G again on 1 November for a follow-up appointment. The nurse noted in the clinical record that he appeared calm and rational, with no thoughts of self-harm or suicide.

30. On 18 November, he attended the healthcare unit and saw Nurse H, as he had been vomiting and feeling dizzy. He was prescribed glucose tablets and referred to the doctor. He saw Prison Doctor A the same day, who advised that he should be admitted to the healthcare unit so that his blood sugar level could be monitored. However, he declined admission to healthcare, saying he would monitor his own blood sugar levels and take dextrose tablets as required.

31. At 2.00am the following morning, Nurse I was called to Reynoldstown unit to see the man, who appeared unwell and incoherent. She noted that he seemed weak, clammy and disorientated to time, place and person. He was given some sweetened milk and, after a few minutes, appeared to gain strength and was able to communicate coherently. At 7.00am, she spoke with unit staff who reassured her that he had recovered well.

32. Later the same morning, the man was admitted to the healthcare unit for observation and assessment. He also saw Prison Doctor A. At 6.00am on 20 November, Nurse I checked him and gave him a glucose drink. He saw Prison Doctor B the same day, who noted that he appeared well. The doctor suggested that he could return to Reynoldstown unit the next day if his diabetes was well controlled.

33. On 21 November, he again saw Prison Doctor B, who was concerned about his well-being. The doctor noted in the clinical record that he reported feeling very anaemic and dizzy, appeared unsteady on his feet and was very pale. He admitted him to hospital due to poorly controlled anaemia.

34. The man remained in hospital for two nights. He was on a medical assessment unit and received a blood transfusion to treat his anaemia. Although he returned to Altcourse on the afternoon of 23 November, he was very quickly re-admitted to hospital after falling in the prison's admissions area. The clinical reviewer interviewed Nurse J, who saw him in the admissions area. He recalled that his colour had improved, but he still seemed confused. He was in a wheelchair. He said he did not seem any better than when he had been admitted to hospital, but neither did he appear worse. After falling, he was taken to the healthcare unit and appeared disorientated. The on-call registrar at the hospital was contacted so that he could be re-admitted to the medical assessment unit. However, as there were no free beds in the unit, he was taken to the accident and emergency department.

35. The man remained in hospital for nine nights and commenced insulin treatment for his diabetes. On 30 November, Nurse K noted in the clinical

record that she had received a telephone call from the hospital, advising that he should remain in the prison's healthcare unit after discharge so that his diabetes could be monitored. He was discharged on the evening of 2 December and returned to Altcourse.

36. He arrived at the prison shortly after 5.30pm. PCO B was working in the admissions area at the time and, during interview with my investigator, recalled his arrival. He explained that when prisoners have been out of the prison for a number of days, as was the case with the man, they must be searched before returning to their home unit. The PCO was responsible for searching prisoners on the evening of 2 December, and he told my investigator that he searched him without incident.

37. Following his search, he was moved to a holding booth (a waiting area in admissions). The PCO telephoned the healthcare unit, where he was to be based, and asked someone to collect him. Nurse J left the healthcare unit and made his way to the admissions area for this purpose. In an entry he later made in the clinical record, the nurse recalled that this was at approximately 6.00pm. During interview, he said that when he arrived at admissions, he looked well. He had seen him after his last discharge, when he appeared confused and unwell, and thought he looked considerably better on this occasion.

38. In order to assess the man's level of mobility, Nurse J asked him to walk with the aid of his stick. However, after he had taken around 30 steps, the nurse realised that he would not be capable of walking to the healthcare unit. He left him sitting in a chair in the admissions area, and returned to the healthcare unit to collect a wheelchair. This, he said during interview, took a maximum of 15 minutes.

39. PCO B went into an office to complete paperwork, telling the investigator that the man was in his line of sight at all times. He recalled during interview that, as the nurse returned with a wheelchair, the man slumped to one side. The admissions manager told my investigator that he heard the officer shouting that he had collapsed.

40. Nurse J moved the man to the floor, into the recovery position and checked for signs of breathing and a pulse. He asked the admissions manager to summon assistance using a 'Code 2'. (This is a specific radio call sign indicating that someone has collapsed or suffered a fit.) The man regained consciousness and the nurse asked him if, with assistance, he would be able to stand up and get in the wheelchair. He agreed that he could do this. The nurse and the PCO helped him into the wheelchair. Although he initially remained conscious, the nurse, PCO and admissions manager all recalled during interview that he deteriorated very quickly, turning very pale.

41. The nurse asked one of the officers to collect a blood pressure cuff from the nurses' station in the admissions area. He told my investigator that, as he was taking the man's blood pressure, he suddenly slumped forward and stopped breathing. By this time, Nurse L had arrived, and she decided to start

cardio-pulmonary resuscitation (CPR). He was laid on the floor, and Nurse J asked the admissions manager to call a 'Code 1' over the radio. This code indicates a medical emergency involving a person who is not breathing.

42. Nurse L began chest compressions, and Nurse J performed mouth to mouth breaths. During interview, he recalled that other members of staff arrived very quickly with various items of medical equipment, including a ventilator bag and mask attached to an oxygen cylinder. This is a more efficient means of administering artificial breaths to a patient, and so Nurse J used this instead of mouth to mouth breaths. A defibrillator was also attached to the man. This is a piece of medical equipment that monitors a patient's heart rhythm and delivers an electrical shock if necessary. In this case, no shockable rhythm was detected.

43. Paramedics arrived in the admissions area shortly before 6.30pm. They continued CPR and left the prison with the man in an ambulance at 6.45pm. He was alive when he left Altcourse. The ambulance arrived at the hospital at 6.50pm and he was taken into the accident and emergency department. Staff at the hospital continued to work on him, but assessed him as critically ill and thought it unlikely that he would survive. They asked for his next of kin to be informed of his condition. The decision was taken for North Wales Police to contact his ex-wife and son to minimise any delays. He died at 8.50pm the same evening.

44. The next day, a family liaison officer from Altcourse spoke to the man's son. His ex-wife declined any contact. The prison continued to liaise with the son over the next few days, arranging to return his property and contributing towards the funeral expenses.

45. A post-mortem examination took place on 7 December, and concluded that he died from multiple pulmonary emboli (blockages of the main artery of the lung) caused by deep venous thrombosis (a blood clot). Further contributory factors were ischaemic heart disease (a disease characterised by reduced blood supply to the heart muscle) and diabetes mellitus (a condition resulting in high blood sugar levels).

ISSUES

Clinical care

General

46. The clinical reviewer noted in his clinical review that the man received his initial health screening at Altcourse in a timely manner. He saw a nurse and a doctor, and was admitted to the healthcare unit for observation and assessment. His history of diabetes, anaemia, high blood pressure, kidney disease, poor sight and back pain were identified at an early stage.

47. He did not have a history of mental health problems. Nevertheless, he was seen on a number of occasions by the mental health team at Altcourse during periods that were potentially stressful, such as his initial reception into custody and after his sentencing. This is good practice on the part of the healthcare team.

48. The clinical reviewer found that the standard of medical notes held by Altcourse about him was satisfactory, and the entries were made in a logical manner. He also noted that communication regarding his care and treatment was timely, efficient and effective.

49. I endorse these findings.

Chronic disease management

50. The clinical reviewer noted that the man was known to have Type II diabetes when he arrived at Altcourse. He was relatively stable until the middle of November 2009, after which he suffered from episodes of hypoglycaemia (a lower than normal level of blood sugar). The reviewer concluded that he was treated appropriately and he was admitted to the healthcare unit for an evaluation of his diabetic control.

51. Upon his second admission to hospital he started a course of insulin. He had not previously been prescribed this medication to control his diabetes at Altcourse. The reviewer noted this in his clinical review, but concluded that the actions taken by staff at Altcourse were appropriate.

Weight loss

52. In his clinical review, the clinical reviewer noted that the man's weight when he arrived at Altcourse on 29 June 2009 was 70kg. On 14 September, his weight was recorded at 62kg. There was no indication of his weight being recorded on any other occasion, nor is there anything to suggest that the weight loss was noted as an issue by staff.

53. The clinical reviewer discussed the matter with Prison Doctor A, who said the weight loss could be explained by the fact that the man was an elderly patient, and that elderly patients do not adapt well to prison conditions and tend to

have poor appetite. The reviewer thought that, whilst this was a reasonable explanation, it should only be relied upon after organic causes of weight loss had been excluded. He did undergo a number of tests that could have contributed to a search for a cause, though this was never stated to be the aim.

54. The clinical reviewer took the view that, although the man's weight loss was not monitored, recorded and assessed more carefully, it did not expose him to any risk or contribute to his death. Nevertheless, the head of healthcare will wish to consider my findings and decide whether prisoners such as him should be weighed regularly.

Discharge from hospital

55. The man was admitted to hospital on two occasions. He was initially discharged on 23 November 2009, and appeared confused and disorientated upon his arrival at Altcourse. After falling in the admissions area, he was taken to the healthcare unit and then re-admitted to hospital.

56. The clinical reviewer examined his discharge record. He found that he had been seen by a doctor the day before his discharge. An early morning entry in his hospital record on 23 November stated that he was to be discharged and that he was confused. The record did not state whether his fitness was assessed, and his status at the time of his discharge was not recorded.

57. After being re-admitted to hospital on 23 November, he was discharged on 2 December. He collapsed in the admissions area at Altcourse, which ultimately led to his death. The clinical reviewer asked Nurse J about his appearance and condition before he was taken ill, and the nurse said he seemed much better in mobility, colour and speech. On the basis of this evidence, the reviewer concluded that he was in a reasonable state of health at the time of his discharge, taking into account his age and medical history. He also noted that the cause of his sudden collapse was due to pulmonary emboli caused by deep venous thrombosis. This was, therefore, an independent event and not directly related to a pre-existing condition.

CONCLUSION

58. The man arrived at Altcourse on 29 June 2009. It was the first time he had been in prison. From his arrival, he suffered from a number of chronic medical conditions which were managed on an ongoing basis.

59. On 2 December, he was discharged from hospital and, only minutes after arriving at Altcourse, suffered a collapse which led to his death. I acknowledge the clinical reviewer's conclusion that the cause of the collapse was a new medical event which was independent of his ongoing problems. Undoubtedly this was a shock to prison staff, who expected him to be well enough to return to prison life. The hospital's decision to discharge him from their care is outside my remit and so I have not considered whether it was appropriate. No doubt the coroner's inquest will assess whether the hospital doctors took the correct decision.