Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Ahmed a prisoner at HMP Manchester on 29 July 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr John Ahmed died on 29 July 2015, while a prisoner at HMP Manchester. Mr Ahmed was 42 years old. I offer my condolences to Mr Ahmed's family and friends.

Mr Ahmed had misused drugs and alcohol, and was overweight. When he arrived at Manchester, medical staff found that he had fluctuating blood pressure readings, but the clinical reviewer found that these indications of a possible underlying health issue were not monitored and managed optimally.

Some weeks later, Mr Ahmed became unresponsive while being restrained during a search after he had apparently concealed a contraband package in his mouth. While the restraint appeared necessary and the techniques employed by staff appeared to be in line with their training, the risks inherent in using them do not appear to have been fully understood or mitigated. In particular, Mr Ahmed was repeatedly kept in the prone position with his arms behind his back and even handcuffed while prone, without staff recognising his specific risk factors or, until it was too late, the distress he was in.

However, the post-mortem examinations have not definitively determined the cause of Mr Ahmed's death and, therefore, we cannot know conclusively what roles the restraint or any pre-existing medical conditions played in his death. It is possible that a more considered and risk-aware approach on the part of prison staff might have avoided Mr Ahmed's sudden death.

I am satisfied that, as soon as they realised there was a problem, prison officers stopped physically restraining Mr Ahmed and staff began appropriate emergency treatment to a good standard. Although there was a slight delay calling an ambulance I do not consider that this affected the outcome.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2017**

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Summary

Events

1. On 14 July 2015, Mr John Ahmed was remanded to HMP Manchester. He had served a sentence at the prison before. Mr Ahmed had a history of drug abuse and mental health problems, and received medication for these conditions. Staff began Prison Service suicide and self-harm prevention procedures because he had made a comment about harming himself but the next day they decided that further monitoring was unnecessary. He had appropriate initial health screens, including an ECG test, which identified no heart abnormality. Some blood pressure readings taken shortly after he arrived were high but monitoring did not continue and not all requested tests were carried out. On 16 July, he was given an incorrect dose of subutex for opiate dependency but healthcare staff monitored him and were satisfied that he had suffered no ill-effects.

2. On the morning of 29 July, Mr Ahmed and a friend were in the prison exercise yard, when staff saw them picking up a package from an out-of-bounds area. Two prison officers took them into the wing. They took Mr Ahmed into a side room to search him and found he had a small package containing tobacco and a tablet in his pocket. He began to resist the search and the officers called for help. Another officer pressed the general alarm bell and went into the room to assist. Other prison officers and a nurse arrived. Two of the officers went into the room while the other staff remained outside.

3. The officers restrained Mr Ahmed until he agreed to comply. They then began to walk him to the segregation unit in handcuffs. He resisted again but then complied with instructions and walked to the unit. The nurse accompanied them and had no concerns about Mr Ahmed's wellbeing. When they got to the segregation unit, segregation unit staff took Mr Ahmed into a cell to search him and Mr Ahmed resisted again and what looked like a small silver package emerged from his mouth.

4. Staff restrained him using approved techniques and brought Mr Ahmed under control but he became unresponsive. The nurse, who was still observing the officers' actions, assessed him and could not find a pulse. He immediately began cardiopulmonary resuscitation. Other healthcare staff arrived and helped with the emergency treatment. Paramedics arrived and took Mr Ahmed to hospital but he was pronounced dead shortly afterwards.

Findings

5. Mr Ahmed had been at Manchester just over two weeks before he died. We are satisfied that he received appropriate initial health screens. Healthcare staff confirmed his medication with his community GP and a prison GP represcribed sertraline and risperidone, the latter with a slightly reduced dosage. He had an appropriate mental health assessment. Despite one occasion when he was given a higher dose of subutex than prescribed, overall he received good treatment for opiate dependency. Mr Ahmed had a number of high blood pressure readings. Although a GP considered his blood pressure was

reasonable, some further requested tests did not happen. His blood pressure was not monitored further.

6. On 29 July, when prison officers saw Mr Ahmed pick up a package in the exercise yard, we are satisfied that it was reasonable to search him. Staff appear to have used recognised control and restraint techniques. The other prisoner who was with Mr Ahmed on the exercise yard said that he subsequently saw approximately ten prison officers restrain Mr Ahmed, but we found no evidence of this from CCTV records. (CCTV shows that no more than four officers were in the room at one time.) Nor was there evidence to corroborate the other prisoner's claim that Mr Ahmed had said he was unable to breathe at any time during the restraint.

7. Although we are satisfied that Mr Ahmed's continued aggression and resistance to being searched made his restraint by staff necessary, we are concerned that he was repeatedly restrained in the face-down (prone) position and an officer placed his hands in ratchet handcuffs behind his back while prone on two occasions. While it is permissible for prisoners to have handcuffs applied in this way while lying prone, the risk of positional asphyxia arising from this approach requires continual observation and prison service guidelines make clear that a prisoner must never be kept in this position with handcuffs on. The risks do not appear to have been fully understood or mitigated by staff. The supervisor and team did not appear to have sought advice from healthcare staff who should have been actively monitoring the condition of a restrained person and engaged in any decision to apply handcuffs, especially when these are applied to a subject in a prone position. A recognition of the risks and a closer monitoring of the medical warning signs presented by Mr Ahmed before and during his restraint might have produced a reduced or postponed response by officers.

8. There is a need for better understanding of national guidance about the risk of restraining prisoners, and the use of pain compliance techniques, particularly in a case such as Mr Ahmed, who had a number of significant risk factors which were seemingly overlooked by staff.

9. We are satisfied that when Mr Ahmed became non-responsive, staff immediately stopped restraining him. A nurse who was directly outside the cell assessed him immediately and began emergency first aid. Other healthcare staff responded quickly and assisted but no one used a medical emergency code. This meant that the control room did not call an ambulance until a second nurse arrived and asked for one. As the first nurse had begun cardiopulmonary resuscitation very quickly, this slight delay is unlikely to have affected the outcome for Mr Ahmed and we consider he received appropriate emergency treatment.

10. The post-mortem examination and other tests were unable to conclude what caused Mr Ahmed's death and, therefore, we cannot know conclusively what roles the restraint or pre-existing medical conditions played in his death. The cardiology report concludes that while Mr Ahmed's death was due to multiple factors, he was unlikely to have died when he did had he not been subject to the stresses he was under at that time. Mr Ahmed had been exercising immediately before he was restrained, and it appears that the prison officers were reasonable in their decisions to restrain him However, it is possible that a more considered

and risk aware approach on the part of prison staff might have avoided Mr Ahmed's sudden death.

Recommendations

- The Head of Healthcare should ensure that healthcare staff manage possible hypertension in line with current NICE guidance and that all identified tests are carried out and recorded.
- The Governor should ensure that there is clear guidance and training for all staff on the safe use of force, including pain compliance techniques, and in particular on all risk factors in using these techniques, especially in relation to positional asphyxia.
- The Head of Healthcare should ensure that healthcare staff are fully trained in relation to control and restraint guidelines, and in particular all risk factors, especially in relation to positional asphyxia, and are empowered to intervene when they feel the need to do so.
- The Governor should ensure that staff use the appropriate emergency medical code immediately in a life threatening situation, which alerts other staff to bring appropriate emergency equipment and the control room to call an ambulance without delay.

The Investigation Process

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

12. In line with our terms of reference and protocol with the police, the investigation was suspended until the police completed enquiries. We regret the consequent delay in issuing this report. Following their investigation, the police took the view that it was not appropriate to bring criminal proceedings against either the prison itself or any staff member. The investigator was eventually able to begin the investigation in December 2015. He visited the prison on 21 December 2015, and obtained copies of relevant extracts from Mr Ahmed's prison and medical records.

13. The investigator interviewed one member of prison staff by telephone and a former prisoner by video link in December 2015. He interviewed four members of staff at Manchester in December 2015.

14. NHS England commissioned a clinical reviewer to review Mr Ahmed's clinical care at the prison.

15. We informed HM Senior Coroner for Manchester (City) Area of the investigation, who gave us the inconclusive post-mortem report. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Ahmed's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Ahmed's mother and her legal representatives said that Mr Ahmed had been keeping fit and was not using drugs at the time of his death. They said he had high blood pressure and was due to have an ECG. They had been told that up to 13 prison officers had been involved in restraining Mr Ahmed and wanted to know if the restraint and removal to the segregation unit had been conducted properly. When they saw him after he had died he had injuries to his face and they wanted to know how he had got them. They asked us to consider whether prison staff had informed Mr Ahmed's mother of his death appropriately. Mr Ahmed's family received a copy of the initial report, and did not make any further comments.

Background Information

HM Prison Manchester

17. HMP Manchester operates both as a high security prison and as a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 men. Manchester Mental Health and Social Care Trust provide 24-hour nursing care and the healthcare centre includes an inpatient unit.

18. There are two main residential buildings, with wings radiating from a central hub. Because of a slight slope between the buildings, A, B, C, D and E Wings (including the segregation unit) are known colloquially as 'the bottom jail', and G, H and I Wings are known as 'the top jail'.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Manchester was conducted in November 2014. Inspectors reported good relationships between staff and prisoners. Security procedures were generally well managed and proportionate. A well-attended supply reduction committee oversaw efforts to reduce the availability of illegal drugs. Prisoners reported that it was easy to get illicit drugs in the prison but there were few finds and the positive random mandatory drug testing rate was very low. Opiate substitution prescribing and administration were safe. The mental health team provided dual diagnosis support for prisoners with both substance misuse and mental health issues. Use of force was low compared to other prisons and well supervised. Inspectors found no evidence that force was used unnecessarily or as a first resort when dealing with difficult and violent behaviour. Inspectors noted that officers in the segregation unit engaged positively with prisoners and dealt patiently and calmly with difficult situations.

20. The standard of healthcare services was generally good. All new arrivals received an initial health assessment in reception, and appropriate referrals were made. Nurses with specialist training ran regular clinics for lifelong conditions, and GPs supported more complex cases.

Independent Monitoring Board

21. 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. In its latest annual report, for the year to 28 February 2015, the IMB reported that the health and welfare of prisoners was given a high priority. The IMB noted that healthcare staff saw all new prisoners within 24 hours of reception to identify any ongoing problems and that when indicated, prisoners had a further early assessment with the mental health in-reach team The IMB was concerned about general staffing levels in the prison and considered that there were insufficient segregation unit staff to ensure a safe and stable environment.

Previous deaths at HMP Manchester

22. Mr Ahmed was the sixth prisoner from HMP Manchester to die since the beginning of 2014. In a report issued in August 2014 we made a recommendation about emergency codes. There have been three further deaths

at the prison since that of Mr Ahmed. There were no significant similarities with the circumstances of Mr Ahmed's death and those of other prisoners.

Training Guidelines for Control & Restraint Instructors (C & R)

23. Guidance is provided for C & R instructors and prison staff on the principles to be applied in the appropriate use of force when violent situations arise in the course of their duties. These guidelines state that force must be necessary, reasonable and proportionate in the circumstances. They also address the personal safety of prison staff and the continued wellbeing of the prisoner. The purpose of the guidelines is to ensure that any prison response is appropriate and that levels of risk to staff and prisoner are monitored and reduced. HM Prison Service Training and Development Group's *Use of Force Training Manual*, published in 2006, was the relevant document at the time of Mr Ahmed's death. The mandibular angle technique (MAT) is an approved form of pain compliance.

24. Guidance is also provided by prison policy documents Prison Service Order (PSO) 1600, *Use of Force*, and Prison Service Instruction (PSI) 30/2015, *Amendments to Use of Force Policy,* which should be read in conjunction with one another. Situations that require particularly close monitoring include periods when a prisoner is or has been laid in the prone position. Paragraph 4.42 of PSO 1600 explicitly states that while ratchet handcuffs can be applied to a prisoner who is in the prone position, the prisoner must **never** (their emphasis) be kept in this position with handcuffs on.

25. Paragraph 4.41 states that the physical condition of the prisoner is another consideration in deciding whether or not handcuffs should be applied or their application continued. Over the course of an incident in which a prisoner is offering violence to prison staff, officers involved and those supervising are instructed to look out for a number of medical warning signs. These include: physical exhaustion, exceptional or unexpected strength, abnormally high tolerance of pain, noisy or laboured breathing, coughing or foaming from the mouth. The guidance explicitly states that the presence of one or more warning signs must alert staff that they need to be particularly vigilant in monitoring the prisoner's responses and they must be prepared to treat the incident as a medical emergency.

26. Restraining a prisoner in a position that compromises the airway or expansion of the lungs (ie. in the prone position) may seriously impair that individual's ability to breathe and can lead to positional asphyxia. No prisoner should be restrained face down for longer than absolutely necessary to gain control and there should be continuous observation of a prisoner following relocation in the prone position until such time as the prisoner is no longer laying face down. The guidelines are explicit in warning that the risk of positional asphyxia and sudden death is increased with an overweight prisoner.

27. The roles of the C & R supervisor and of healthcare staff during a C & R intervention include monitoring the condition of the prisoner during the incident with particular regard to any warning signs. The supervisor must make a decision as to whether to apply ratchet handcuffs and the team must be prepared to release the prisoner from all C & R holds immediately if it becomes necessary to do so on medical grounds. The role of healthcare staff includes providing

clinical advice to the supervisor and / or team in the event of medical emergency. All staff should be aware that they have a duty of care to both staff and prisoners.

Key Events

28. On 14 July 2015, Mr John Ahmed was remanded to HMP Manchester charged with rape and sexual assault. He had been in prison before, including at Manchester and had last been released on licence from a sentence for burglary in March 2015. He had a history of drug use and was prescribed buprenorphine (subutex) to help manage his addiction to heroin. He also had a history of mental health problems, including schizophrenia, personality disorder, anxiety and depression.

29. Before Mr Ahmed arrived at the prison, a member of court staff had phoned a nurse to alert prison staff that Mr Ahmed was tearful and had said he had thoughts of hanging himself because of the charges against him. He had said that he was prescribed risperidone (for schizophrenia), sertraline (for depression) and subutex (for opiate dependence). She noted that she would inform the detoxification team that Mr Ahmed was returning to the prison. She also made a note that the reception nurse should consider beginning ACCT procedures. (Assessment, Care in Custody and Teamwork procedures, the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm.)

30. When Mr Ahmed arrived, his escort papers referred to his mental health and drug problems and included a suicide and self-harm warning form noting that Mr Ahmed had said that if he was remanded to prison he would kill himself. At an initial health screen, Mr Ahmed told a nurse that he had not harmed himself or been in a psychiatric hospital in the last six months, but had previously received inpatient treatment. He said he had tried to kill himself in 2005 after a domestic row.

31. The nurse recorded that Mr Ahmed was 19st 2lbs and his blood pressure and pulse were in the normal range. He said he had no allergies, smoked and had no recent injuries. He had no concerns about his physical health. He did not appear to be mentally unwell, but said that he suffered from schizophrenia and would take his own life if he did not get his medication. Mr Ahmed said that he did not drink and had not used illicit drugs. A drug test was positive for subutex, tranquilisers and opiates. Mr Ahmed said that this must have been the medication he had taken in police custody to combat his withdrawal symptoms. He had no physical withdrawal symptoms at the time.

32. The nurse began ACCT procedures and noted that he claimed to be innocent of the crime he was accused of, and had said he would hang himself if he did not receive his medication that night. Officers telephoned Mr Ahmed's mother to allow him to speak to her, but the number was engaged and they were unable to get through. They offered him the support of a Listener (a prisoner trained by the Samaritans to support other prisoners in distress). Officers were asked to check Mr Ahmed at least four times during the day and four times at night.

33. A locum GP assessed Mr Ahmed in reception and noted that he did not appear confused or mentally unwell. He noted that when Mr Ahmed had been discharged from prison in March, he had been taking mirtazapine (an

antidepressant) and risperidone (an antipsychotic). Mr Ahmed said that his psychiatrist had since changed his medication to sertraline and risperidone. The GP did not see any signs of drug withdrawal so said he would prescribe risperidone but no other medication until he had confirmed his medications with Mr Ahmed's community GP. After initially refusing, Mr Ahmed agreed he would take the risperidone but when the GP told him that he would not receive any subutex, he became angry and left. The GP asked healthcare staff to obtain a copy of Mr Ahmed's GP records, so he and the substance misuse team could assess Mr Ahmed the next day.

34. Mr Ahmed told officers he did not want to be designated as a vulnerable prisoner and kept apart from the general population because of his charges. He said that he was annoyed he had not been prescribed subutex that night, but once that had been sorted out he would no longer need ACCT monitoring. He was given a cell on I Wing, the detoxification wing, and said he had no concerns.

35. The next morning, 15 July, a member of healthcare staff obtained his medical records from his community GP and a doctor prescribed him sertraline. The doctor requested blood tests and an ECG (electrocardiogram) test to check the heart's rhythm.

36. A nurse from the substance misuse team assessed Mr Ahmed and took his blood pressure and pulse, both of which were in the normal range at the time. He was advised to reduce his alcohol intake, declined any help to give up smoking and did not want to be screened for hepatitis C.

37. An officer assessed Mr Ahmed as part of ACCT procedures. Mr Ahmed told him he was worried about the charges he was facing and had made the remark about taking his own life in haste when he was under a great deal of stress. He said that prison staff knew him, and he had never harmed himself or attempted suicide. He said he was angry about his situation but he was not depressed or suicidal. He had good external support and knew how to get help in prison.

38. A Supervising Officer (SO), an officer and a nurse from the mental health team held an ACCT case review. Mr Ahmed said that the last time he had attempted suicide was some years earlier and he had no current thoughts of harming himself. He had strong family ties and would work with the detoxification team and the mental health team. The review assessed his risk as low and agreed that he did not need ACCT support.

39. The nurse noted in Mr Ahmed's medical record that he appeared in low spirits but denied any thoughts of self-harm. She noted that he would continue to work with the drug and alcohol recovery service team, known as Lifeline, and would have a psychiatric review. She also noted that he was due to have blood tests and an ECG. A locum GP noted in Mr Ahmed's medical record that he was being treated for a personality disorder and possible schizophrenia.

40. At 15.12pm, a nurse from the substance misuse team saw Mr Ahmed. She took his blood pressure and noted that his pulse was high. Mr Ahmed said that he was anxious because he had not had any subutex for two days and she gave him some.

41. Shortly after this, a nurse from the substance misuse team noted that Mr Ahmed should have been given 4mg of subutex but had taken 14mg. She told Mr Ahmed what had happened, and he said that he usually took 14mg outside prison and felt okay. She checked his pulse and blood pressure, which were both lower than they had been 20 minutes previously. She told him to alert staff if he felt unwell, and that a nurse would check him that evening. A nurse reported this to one of the prison doctors, and he did not suggest any further action. The nurse checked Mr Ahmed that evening. His pulse was slightly high, but he was alert and lucid, and said he felt fine.

42. The following morning, 16 July, the nurse saw Mr Ahmed again. She noted his high pulse but recorded no concerns. She noted that staff should continue to monitor Mr Ahmed's blood pressure.

43. Later that morning a specialist nurse noted that Mr Ahmed was sweating and reported feeling very stressed and anxious, as he had not had his sertraline. She recorded that his blood pressure was raised, possibly due to stress and anxiety and because he was overweight. His pulse rate was also raised. He said he had no chest pain or other problems. She referred him for an ECG test, noted he had been prescribed sertraline, and recorded a clinical plan to monitor his blood pressure and pulse rate.

44. That afternoon a healthcare assistant recorded his blood pressure at 126/95 and his pulse at 90bpm, which were both raised. Mr Ahmed told her that he felt better.

45. A worker from the Lifeline project also saw Mr Ahmed for an initial assessment. He said that although he had used heroin, crack, cannabis and cocaine in the past, he had not used illicit drugs since he had been released from prison earlier that year, and had been prescribed subutex. They discussed overdose awareness and tolerance levels.

46. The next morning, on 17 July, Mr Ahmed had an ECG test because of his high blood pressure readings. A healthcare assistant noted that although his blood pressure was high, there were no symptoms from the ECG suggesting any problems. She referred the ECG results to a cardiac interpretation service for analysis, which reported that his heart had a normal rhythm. A prison GP noted in Mr Ahmed's medical record that the ECG results were normal.

47. The healthcare assistant saw Mr Ahmed again that afternoon. She noted on SystmOne, the prison medical record system, that a doctor should assess Mr Ahmed in view of the fluctuations in his blood pressure.

48. Mr Ahmed did not collect his sertraline on 17, 18 or 19 July and said he preferred to take it in the evening as he had done outside prison. From 20 July, Mr Ahmed received his sertraline in the evening.

49. On 20 July, one of the prison GPs noted in Mr Ahmed's medical record that his blood pressure seemed reasonable and was only sometimes classed as hypertensive (high). He noted that Mr Ahmed could be assessed in the GP clinic.

50. On 22 July, Mr Ahmed refused to move to K Wing and an officer gave him a negative behaviour warning. On 24 July, a SO reviewed Mr Ahmed's Incentive

and Earned Privileges Scheme level (IEPS, which is used to encourage and reward responsible behaviour) and moved Mr Ahmed down to the basic level. This meant he lost privileges such as extra visits and a television, and spent more time locked in his cell.

51. On 24 July, Mr Ahmed told a nurse from the mental health team that he was unhappy about staff trying to move him to a different wing. He believed he was not being treated fairly because of his mental health problems and asked for a medication review. She had no concerns about his mental health at the time and advised him to discuss this with the psychiatrist at his scheduled appointment on 30 July.

52. On 26 July, Mr Ahmed's personal officer recorded that Mr Ahmed had no concerns.

53. On 28 July, Mr Ahmed's recovery coordinator in the Lifeline team was on the wing to see another prisoner and spoke to Mr Ahmed while she was there. Mr Ahmed told her that he had found out he was next due in court in October. His licence had been revoked on 24 July and his release date had been changed. Mr Ahmed said that he was having violent thoughts, and needed to see someone from the mental health team urgently. She told him to put in an application to see someone and, in the meantime. she would try to contact the mental health team. She said she phoned the Lifeline office and asked a member of the administrative team, to make a SystmOne request for a member of the mental health team to see Mr Ahmed but there is no record of the referral. She made a note in the wing observation book and told wing officers what Mr Ahmed had said.

Events of 29 July

54. At 8.24am on 29 July, Mr Ahmed telephoned his mother and told her that he had been put on the basic regime because he had refused to move wings. He said he did not feel stable and wanted to come off subutex but the mental health team had told him he should continue with it as it was a stressful time for him.

55. After he had telephoned his mother, Mr Ahmed and Prisoner A went out onto the exercise yard. They took off their jackets and tracksuit trousers and began to run around the yard in shorts. Two officers were on duty in the exercise yard and, when asked, told them they had about 20 minutes exercise time remaining. They continued running around the yard.

56. Prisoner A told the investigator that he and Mr Ahmed did not have any tobacco but Mr Ahmed had said he had a friend on H Wing who would be able to get them some. Mr Ahmed had arranged that his friend would throw out a package of tobacco from one of the windows of H Wing during the exercise period. The exercise yard has a painted line around the perimeter which prisoners are not permitted to cross. As they walked past the windows to H Wing, Prisoner A crossed the line and picked up a package from the ground.

57. Officer A saw Prisoner A and shouted to him to stop, but he and Mr Ahmed turned and walked away. He shouted again, and said he saw Prisoner A pass something to Mr Ahmed, although he could not see what it was. Both officers followed the prisoners to where they had left their outer clothing and told them to

get dressed as they were going to take them inside and search them. While they were walking towards the building, Officer A said that Mr Ahmed said to him, "Oh come on, it's only a smoke". Officer B went ahead with Mr Ahmed and Officer A followed with Prisoner A. While they were walking across the yard, both prisoners tried several times to put their hands down their trousers, which made the officers think they were trying to hide something. A prisoner who was present as they entered I wing told the police that he saw Mr Ahmed appear to put something into his underwear. CCTV footage of I Wing shows that they came onto the wing at 9.38am.

58. The laundry room, which officers usually used for searches, was out of action, so the officers decided to use a former cell that had been converted into a passageway between I Wing and the exercise yard. This was not overlooked and would allow privacy. Officer B and Officer C took Mr Ahmed there to search him. CCTV shows that they went into the room at 9.39am and closed the door. Officer A waited outside with Prisoner A.

59. Officer B told the police that as soon as they went into the search area Mr Ahmed, who had been calm, began to swear and question why he was being searched. He kicked his shoes off, and seemed agitated. He told him to slow down and asked him to empty his pockets. Officer C looked at the items that Mr Ahmed had produced from his pockets and noted that one was a folded tobacco package and a tablet wrapped up tightly together in cellophane. (Tests later showed that the pouch contained tobacco and the tablet was pregabalin, which Mr Ahmed had not been prescribed. Pregabalin is prescribed for various uses, including epilepsy and neuropathic pain, but often misused in prisons to get a high.) Officer B said that Mr Ahmed would have been familiar with the search procedures and believed he was trying to disrupt the process. He had kicked off his shoes. Searches always begin at the head and work down. He thought that Mr Ahmed was trying to dictate the pace of the search and change the usual routine.

60. Officer B said he had asked Mr Ahmed to open his mouth and that Mr Ahmed then became aggressive and closed in on him, which he felt was an attempt to intimidate him into not completing the search. He said Mr Ahmed was waving his arms around and getting closer to him. He said he feared that Mr Ahmed was going to assault him and decided that he needed to restrain him. He said he used an approved Prison Service technique and put his arms around Mr Ahmed and drew his head towards him. Officer C said he saw Mr Ahmed's right arm was flailing and grabbed it, in case he hit Officer B. The officers said that Mr Ahmed resisted them and Officer C could not get his arm into an arm lock. Mr Ahmed was still sweaty from running around the yard, which Officer C said made it difficult to keep a grip on his arm. Officer C shouted for help. Prisoner A said that he could hear Mr Ahmed telling the officers to get off him, and saw him trying to get out of the room but being dragged back in. There is CCTV footage but it does not have sound. The CCTV footage of the door does not shows any sign of Mr Ahmed trying to get out of the room or the officers dragging him back.

61. Officer A pressed the general alarm button at 9.40am. He then went into the room and said Mr Ahmed was crouched over, with his arms tucked under his head, while the officers were trying to restrain him. Officer C was on the right

and Officer B in front of him. Officer A said he could not get a hold on one of Mr Ahmed's arms and shouted to the other officers that they should take him to the floor. He then used his forearms to push into Mr Ahmed's back in order to take him to the floor. He told the police that he had to do this two or three times before they got him on the floor. The officers manoeuvred Mr Ahmed into a prone position, lying him face down on the floor. Mr Ahmed continued to resist, and despite being asked to release his arms, kept them tucked beneath him. Officer A said he managed to pull Mr Ahmed's left arm out and hold it behind his back but Mr Ahmed kept his fist closed. Officer C did the same with his other arm, while Officer B held Mr Ahmed's head, in line with Prison Service control and restraint techniques. Officer B said he turned Mr Ahmed's head to the side and tried to calm him down and de-escalate the situation, but Mr Ahmed would not engage with him and continued to resist the officers. Officer B told the police that, while restraining prisoners, officers are aware of the possibility of positional asphyxiation, and they took care not to put any of their own bodyweight on Mr Ahmed's back. He said he had no concerns about Mr Ahmed's breathing at the time. Officer A also said that he was aware of the possibility of positional asphyxia making it harder for a prisoner held in this position to breathe.

62. The CCTV shows that other staff arrived within a minute of Officer A going into the room. One of these was a nurse responsible for responding to general alarms that day. His role was to monitor but not to become involved in the restraint unless there was a specific medical need. He stood at the doorway, looking into the room and said that he had no concerns about Mr Ahmed's health at this stage.

63. Staff responded to the alarm and joined the officers. Prisoner A said that he saw eight to ten officers go into the room, but CCTV shows that only two more officers went in, and one, Officer A, subsequently came out. Others looked into the room but did not go in. At 9.41am, a prison officer locked Prisoner A in a nearby cell.

64. An SO put handcuffs on Mr Ahmed's wrists behind his back while he was still lying prone. Another SO who had also responded to the alarm asked if any of the officers restraining Mr Ahmed needed to be relieved. Officer A did, and another officer replaced him in holding Mr Ahmed's arm. Officer A then took no further part in the restraint. At 9.43am, the officers outside the room began to disperse. The nurse remained observing from the doorway. At 9.44am, another SO went into the room. He said that Mr Ahmed was still struggling, but the staff had control and he decided that they should take Mr Ahmed to the segregation unit. A prison manager radioed the segregation unit to let the staff know.

65. The officers who were restraining Mr Ahmed said they told him to bring his knees up to his chest. After initially refusing he complied and the officers said they lifted him by his arms into a standing position and continued to hold him by the arms. He was bent forward and Officer B guided his head. They left the room at 9.45am and staff accompanied them.

66. The staff walked Mr Ahmed approximately 30 feet down the wing towards the exit. Prisoner A was back in his cell. He told the police that he had shouted to Mr Ahmed and asked if he was all right and Mr Ahmed said that he could not breathe. As they reached the door, Mr Ahmed told the officers that he could not

walk in that position as he could not see where he was going. He tried to push his head up and Officer B told him to stop. The staff said that Mr Ahmed did not appear to be in distress and had made no complaints about having any trouble breathing, but as they got towards the end of the wing, he dropped his weight. The officers took him to the floor as safely as they could, again placing him in a prone position, and said that they protected his head while they did this. They told him that if he refused to walk they would have to carry him. Mr Ahmed then agreed to walk and the officers brought him back to his feet.

67. The staff took Mr Ahmed through the wing treatment room, across the rotunda central hub (sometimes referred to as 'the under centre'), along a corridor and out of the building. From there, it was an outdoor walk down the hill to the segregation unit. Mr Ahmed began to shift his weight again. An SO told Mr Ahmed that they would allow him to walk upright if he would comply. Mr Ahmed agreed, Officer B released his head and Mr Ahmed stood up. The officers either side of him put a hand on each shoulder to support him in case he fell. When they got to the segregation unit a custodial manager was leaving the unit. He knew Mr Ahmed and made a light- hearted remark to him. Mr Ahmed responded cheerfully and the officers thought that he had calmed down.

68. The officers walked Mr Ahmed to a holding room (E1 H01) and the unit manager told Mr Ahmed that segregation unit officers would search him. Mr Ahmed agreed to comply with the search and the officers took him into the room. The nurse said that Mr Ahmed seemed orientated and alert, and looked well. He had no concerns about him. An SO removed the handcuffs and noted there was some blood on Mr Ahmed's left hand, on the cuffs, and on his own hand. He went away to wash the cuffs and his hands. The unit manager noticed a red mark on the right side of Mr Ahmed's back. Officer D said that Mr Ahmed was red and sweating heavily.

69. The unit manager told Mr Ahmed to walk to the back of the room, and officers released his arms and stepped out to allow segregation unit officers to search him. Mr Ahmed walked further into the room and then span around continuing to resist officers by thrashing his arms around. Officer E thought Mr Ahmed was about to assault him, and grabbed his right arm. Officer D grabbed his left arm, and they tried to restrain him. Mr Ahmed was bare-chested, as he had removed his t-shirt earlier. He was slippery with sweat and the officers said they had difficulty in holding him. The unit manager came into the room to assist.

70. The staff said Mr Ahmed aggressively resisted all attempts to restrain him, but eventually they took him to the floor, again in a prone position. The unit manager said that this was to reduce the risk of injury both to Mr Ahmed and to members of staff trying to control him. Officer E held Mr Ahmed's right arm, the unit manager his left, while Officer D controlled his head to protect it. Mr Ahmed continued to resist and a SO, who was watching from the doorway, said that they would have to take him to one of the special cells. (These are unfurnished cells used for short periods for unruly prisoners.)

71. The unit manager told the police that at this point Mr Ahmed was sweating hard and breathing heavily. The officers had brought him to his feet again and began to walk towards the door, when Mr Ahmed resisted again by dropping his

bodyweight. The unit manager told the police that it was unclear whether this was a deliberate act intended to make it more difficult for staff to move him out of the cell or due to Mr Ahmed's inability to remain standing. Staff said that Mr Ahmed began struggling again with what he called an unnatural level of aggression and strength, and in the struggle Officer D lost his grip on Mr Ahmed, and they fell to the floor. Although initially falling backwards, Mr Ahmed ended up being placed in a prone or semi-prone position and continued trying to prevent the officers from restraining him. Officer E managed to restrain his left arm and the unit manager his right arm. Mr Ahmed was kicking out, so another officer came in and restrained his legs. Officer D did not have enough space to get full control of Mr Ahmed's head. He had blood on his glove, but said he could not see where it was coming from. The unit manager said he noticed that Mr Ahmed was bleeding from a small cut on his forehead. Another officer came in, took over from Officer D and restrained Mr Ahmed's head.

72. The unit manager said that despite repeated attempts by officers to engage Mr Ahmed in conversation in an attempt to calm him down, he continued to display high levels of aggression. He therefore told Mr Ahmed that unless he stopped resisting he would apply pressure to the nerves in his jaw in an approved form of pain compliance technique called the mandibular angle technique (MAT). Mr Ahmed continued to resist and he said that despite using the MAT several times Mr Ahmed had no reaction to this application of pain. He said this was the first time he had found this technique to be ineffective.

73. The unit manager said that Mr Ahmed continued to resist aggressively so he asked an officer to handcuff Mr Ahmed and he placed his wrists in ratchet cuffs behind his back. Mr Ahmed was still lying prone and an officer was holding Mr Ahmed's head to the floor to try to control his movements. The unit manager said that he began to gurgle and froth at the mouth and a small silver package was retrieved. (Tests later showed this to be silver-backed paper, with no traces of controlled drugs.) An officer took the package and passed it out of the room. An SO said that at this point he noticed that Mr Ahmed had gone pale. He also had a small cut above his eyebrow. Mr Ahmed stopped resisting and became unresponsive. An officer also noted that his face had changed colour from ruddy to pale. He felt Mr Ahmed's neck and was unable to find a pulse so the unit manager shouted for the nurse.

74. The nurse had seen Mr Ahmed stop resisting and go limp and, when the officer called him, he went straight in. He said there was a small amount of blood on the floor and a small cut over Mr Ahmed's right eyebrow but no other obvious injuries. Mr Ahmed was breathing, but only slowly, and was unconscious. An SO removed the handcuffs at the nurse's request. The nurse asked the officers to put Mr Ahmed in the recovery position. The SO and Officer E kept a grip on his arms in case he was pretending. The nurse could find no neck pulse and noted that Mr Ahmed's lips had turned blue. He shouted to the officers to summon the emergency healthcare responder. This was at 10.00am. The officers placed Mr Ahmed on his back and the nurse began cardiopulmonary resuscitation.

75. The emergency response nurse and a healthcare assistant arrived and she was asked to call for an ambulance. She radioed for one at 10.02am and also asked the duty doctor to attend. They then joined the first nurse in trying to resuscitate

Mr Ahmed. They applied a defibrillator but it found no shockable heart rhythm. A prison GP arrived and together they continued to try to revive Mr Ahmed until paramedics arrived at 10.20am, and took over emergency treatment. At 10.57am, the paramedics took Mr Ahmed to hospital in an ambulance. Mr Ahmed did not recover and, at 11.22am, shortly after they arrived at the hospital, a doctor pronounced him dead.

Contact with Mr Ahmed's family

76. An officer from the safer custody team was appointed as the prison's family liaison officer and she and the chaplain went to Mr Ahmed's mother's home to inform her of his death. They arrived at 1.15pm but there was nobody in. They confirmed they had the correct address and went back again 50 minutes later, but there was still no one at home. They contacted the prison and said that they would wait to break the news in person. At 5.37pm the officer contacted the prison to see if there were any alternative next of kin contact details but there were not. The prison contacted the police to see if they could help, but they had no other information. They remained outside Mr Ahmed's mother's house.

77. At 7.52pm, Mr Ahmed's former partner contacted the prison and the officer phoned her to ask for Mr Ahmed's mother's phone number. She would not give it but said she would call back. At 8.08pm, Mr Ahmed's mother phoned the officer. She said she had been driving but had pulled into a service station when she had got a call from Mr Ahmed's former partner. She said she had heard a rumour that her son had died. The officer asked if she could come and meet her but his mother was not sure where she was. The officer said that she was concerned that she was alone and driving, but Mr Ahmed's mother asked her to tell her what had happened. She decided it was not appropriate to delay informing her any longer and told Mr Ahmed's mother that he had died that morning and offered her condolences.

78. The officer visited Mr Ahmed's mother at her home the next morning to offer condolences and support in person. In line with national Prison Service policy, the prison contributed to the costs of the funeral.

Support for prisoners and staff

79. After Mr Ahmed's death the Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

80. The prison posted notices informing other prisoners of Mr Ahmed's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Ahmed's death.

Post-mortem report

81. A post-mortem examination was unable to determine the cause of Mr Ahmed's death. The pathologist noted that Mr Ahmed had an enlarged heart, and had been at risk of sudden death at any time. This can be caused by high blood pressure but, while he had recorded some high blood pressure readings while he was in prison, he had not been diagnosed with high blood pressure. Alcohol and drug abuse can also cause an enlarged heart, and Mr Ahmed had a history of

both. He was overweight and had been exercising, which would have put an additional strain on his heart. The pathologist also suggested he would have experienced a surge of adrenaline after being caught with contraband, and because of being restrained when he resisted being searched.

82. Mr Ahmed had been taking prescribed medication and blood tests also showed the presence of cannabis, although it could not be determined how recently he had taken it. Tests found no evidence that he had taken new psychoactive substances (sometimes called 'legal highs'). It was not possible to determine whether Mr Ahmed had developed a condition known as 'excited delirium', which can affect people with schizophrenia and can sometimes cause death during restraint.

83. Mr Ahmed had a cut and a small abrasion above his right eye, two abrasions and bruising above his left eye. The post-mortem report described these as minor injuries. There was also bruising to Mr Ahmed's limbs. The pathologist noted that Mr Ahmed's physical injuries were in keeping with the restraint described by the prison officers, and that it was surprising there were no further injuries. The pathologist was unable to conclude what effect, if any, the restraint had on Mr Ahmed's death.

84. After the inconclusive post-mortem examination, the coroner requested more specialised cardiology tests. The cardiologist concluded that Mr Ahmed was predisposed to cardiac problems. There were a number of factors that contributed to his death, but it was not likely to have occurred when it did without the presence of the various stresses upon him at that time.

Findings

Physical Healthcare

85. When Mr Ahmed arrived at the prison he had an appropriate initial health screen and said he had no health concerns. Although he was very overweight, his blood pressure and pulse rate were normal at the time.

86. On 17 July, Mr Ahmed had an ECG test. The results were analysed and did not identify any problems. On 20 July, a prison GP reviewed Mr Ahmed's blood pressure readings and noted that although some had been raised overall his blood pressure appeared reasonable. He noted that this could be assessed and managed in the GP clinic However, there is no record that he saw a GP after that or that there were any further blood pressure checks. Hypertension (high blood pressure) was never diagnosed.

87. While the pathologist was unable to establish the cause of Mr Ahmed's death, she noted that he had an enlarged heart, which can be caused by high blood pressure. However, Mr Ahmed had other factors such as a history of alcohol and drug abuse which can also cause an enlarged heart. He was very overweight and had been exercising, which would have put extra strain on his heart at the time.

88. While Mr Ahmed's blood pressure was monitored during his time in prison, the clinical reviewer noted that this was not managed in line with best practice National Institute for Health and Care Excellence (NICE) guidelines. The clinical reviewer said it is best practice to offer all people with hypertension a urine test for the presence of protein, although as noted Mr Ahmed had never formally been diagnosed with hypertension.

89. The clinical reviewer noted that there were entries in Mr Ahmed's medical record requesting blood tests. However, there is no record of what these were intended for or that they ever took place.

90. Mr Ahmed's death was sudden and unexpected and without knowing the cause we cannot say definitively what, if anything, could have been done to prevent it. However, there is a need to ensure that there is better management and monitoring of prisoners with possible hypertension and other cardiovascular risk factors. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff manage possible hypertension in line with current NICE guidance and that all identified tests are carried out and recorded.

Substance misuse treatment

91. When the doctor assessed Mr Ahmed in reception he noted his previous drug use. Mr Ahmed had no signs of withdrawal symptoms when he first arrived so the doctor did not prescribe subutex for his first night but asked the substance misuse team to assess him the next day.

92. On 15 July, when Mr Ahmed was given a higher dose of subutex than intended, nurses quickly recognised the mistake and dealt with it immediately. They

monitored him, advised him to report if he felt unwell, and informed a doctor. Mr Ahmed did not seem to suffer any adverse effects and said the dose was what he usually received in the community. We are satisfied that this medication error was handled properly. The clinical reviewer considered that Mr Ahmed's substance misuse problems were properly identified and managed appropriately.

Mental healthcare

93. At his initial health screen Mr Ahmed's previous mental health problems were noted. The doctor who assessed Mr Ahmed in reception did not consider he was mentally unwell, but a nurse appropriately began ACCT suicide and self-harm procedures as the court had warned that he had threatened to kill himself if he was remanded to prison. The next day, staff at a multidisciplinary meeting decided that Mr Ahmed's risk was low and he did not need monitoring. We are satisfied that this was reasonable.

94. Mr Ahmed had a mental health assessment and was referred to the mental health team. His medications for mental health were confirmed and prescribed promptly, with a minor variation. He was allocated a mental health nurse who did not have any concerns about him. When he wanted a medication review Mr Ahmed agreed he would discuss this with his consultant psychiatrist.

95. On 28 July, Mr Ahmed told his recovery co-ordinator from the Lifeline team that he was having violent thoughts and wanted to see someone from the mental health team. She told officers on Mr Ahmed's wing what he had said, made a note in the wing observation book, and asked an administrator to request a member of the mental health team to see him. While this does not seem to have happened before he died, it is unlikely that anyone from the team would have seen him so soon, even if the referral had been made immediately. She did not consider that Mr Ahmed was in crisis and that he needed to speak to someone immediately.

96. We consider that Mr Ahmed received appropriate mental health support at the prison.

Control and Restraint

97. All the prison officers involved in restraining Mr Ahmed had Prison Service training in C & R techniques. Apart from Officer A and Officer C, all the staff involved had completed refresher training within the previous 12 months. Prison officers who have not had refresher training within the previous 12 months are not allowed to participate in a planned restraint of a prisoner, but can participate in spontaneous incidents, such as this. The accounts of the restraint from the officers involved are broadly consistent.

98. CCTV footage of the area of I Wing, where Mr Ahmed was first searched on 29 July, does not show the search itself but we are satisfied from the statements of the officers and Prisoner A that Mr Ahmed resisted when officer started to search him. Mr Ahmed had already been found in possession of contraband (the folded tobacco pouch and tablet) a few moments earlier and we are satisfied that it was reasonable to use force when he physically resisted a further search. The officers tried to restrain him, and other prison staff and a nurse arrived in

response to a general alarm. Mr Ahmed was taken to the floor by officers and placed in a prone position. While in this position his hands were handcuffed behind his back. Apart from a single period of a few seconds when officers first responded to the alarm, no more than four prison officers were in the room with Mr Ahmed at any time. The nurse who had responded to the original alarm and arrived within a minute stood in the doorway and observed the restraint.

99. Prisoner A told the police that about 30 seconds after the officers took Mr Ahmed into the room to be searched, he heard Mr Ahmed shouting, telling the officers to get off him. He claimed he could see Mr Ahmed's arms and head through the door, and an officer kneeling on the back of his neck. He said later that Mr Ahmed was shouting that he could not breathe. However, CCTV footage of I wing shows that Mr Ahmed and the officers remained inside the search room until staff brought him out to take him to the segregation unit. He would not have been able to see into the room from where he was standing or see what was happening inside. Although we find that Mr Ahmed continued struggling after the application of the handcuffs, both an officer and the nurse stated that Mr Ahmed gave no appearance of having any difficulty breathing and neither could recall him complaining about being unable to breathe. They said they had no concerns at that time that he was in distress. The nurse, who had responded to the alarm, remained with Mr Ahmed until he later collapsed in the segregation unit.

100. On his way to the segregation unit, after he dropped his bodyweight, Mr Ahmed was taken to the floor by officers and placed in a prone position a second time. The handcuffs were still in place, restraining his hands behind his back.

101. On arrival in the segregation unit, after he agreed to comply with being searched, the handcuffs were removed from Mr Ahmed's wrists. The nurse stated that at this stage Mr Ahmed was alert, well-orientated and had no trouble breathing. However, one of the officers on the unit stated that he was red in the face and sweating heavily. When Mr Ahmed began resisting being searched again, officers restrained him again. We do not consider that this was an unreasonable response to his aggression and we accept that it was done to reduce the risk of injury both to Mr Ahmed and staff members. However, Mr Ahmed was taken to the floor and placed in a prone position a third time. Even after he was taken to the floor, we find that Mr Ahmed aggressively continued to resist officers' attempts to restrain him. He was sweating hard and breathing heavily.

102. After being brought to his feet by officers, Mr Ahmed dropped his weight again. In the ensuing scuffle he ended up on the floor and lying in a prone position a fourth time. He aggressively continued to resist attempts to restrain him.

103. The unit manager employed the MAT pain compliance technique to end Mr Ahmed's resistance. This was unsuccessful. He then asked an SO to handcuff Mr Ahmed, and the SO cuffed Mr Ahmed's hands behind his back while he was lying prone. This was the fourth occasion that Mr Ahmed lay prone on the floor and the second time that he had had his hands cuffed behind his back in this position in around twenty minutes.

104. Although they noted that Mr Ahmed was hot and sweaty after his run around the exercise yard, none of the staff involved or other officers observing said they had any concerns about the restraint techniques used. No one, including the nurse

who had observed the restraint from the outset, said they spotted anything to indicate concerns about Mr Ahmed's wellbeing until he suddenly became unresponsive.

105. However, we find that although Mr Ahmed's intentional resistance and deliberate aggression gave the officers grounds to employ control and restraint techniques, the officers and the nurse overlooked a number of warning signs indicating that Mr Ahmed was at risk.

106. Mr Ahmed exhibited risk characteristics from the outset of which his obesity and physical exhaustion at the time of restraint were evident. Being placed repeatedly in a prone position with his hands cuffed behind his back - which the C & R guidance specifically identifies as extremely high risk - preceded a number of identifiable warning signs described in officers' statements, namely his heavy breathing, exceptional strength, abnormally high tolerance of pain and, ultimately, frothing from the mouth. All of these risk factors were recorded by officers on the segregation unit and ought to have been acknowledged as such.

107. All staff should be aware that they have a duty of care towards prisoners and should monitor their welfare throughout the course of any incident. Although the unit manager had a particular responsibility for monitoring Mr Ahmed's condition with regard to risk characteristics and warning signs, he seemingly failed to recognise these. (In mitigation, he had witnessed events only from the point of Mr Ahmed's arrival on the segregation unit, and only seen him taken to the floor twice - the earlier two occasions being on I wing and en route to the segregation unit.) The role of healthcare staff in C & R explicitly includes providing clinical advice to officers over the course of an incident. Although the officers' restraint was in response to Mr Ahmed's behaviour, he was placed in prone position too frequently and within the context of the presence of various risk characteristics and warning signs. Although the nurse said he saw no sign of Mr Ahmed being in difficulty, he had witnessed him placed prone with his hands cuffed behind his back repeatedly. It is the responsibility of the healthcare staff to intervene when warning signs are displayed.

108. While it cannot be established definitively whether, or to what extent, the restraint played a part in Mr Ahmed's sudden death, had the nurse intervened and recommended, for example, that officers withdraw temporarily, it is possible Mr Ahmed's sudden death might have been avoided. On the other hand, the fact that Mr Ahmed had a small package concealed in his mouth meant that withdrawing would have allowed him to swallow, or otherwise dispose of, the package which would have removed the whole basis for the search.

109. As soon as the officers noticed that Mr Ahmed had stopped resisting, they immediately stopped restraining him and called the nurse for medical assistance.

110. The post-mortem report indicated that Mr Ahmed had minor facial injuries including one bruise. There is nothing to suggest that Mr Ahmed had any injuries when he first came off the exercise yard so it appears they were sustained subsequently. Officer E said that when Mr Ahmed arrived in the segregation unit he had a cut to his eye or head, and red marks on the back of his body. Officer C noticed a cut above Mr Ahmed's eye when he put him into the recovery position. The ambulance records refer to the injury being caused by Mr Ahmed

hitting his head on a wall. It appears that Mr Ahmed was injured sometime during the course of his protracted scuffle with prison officers. However, there is nothing about the injuries that conclusively indicates that excessive force was used.

111. The pathologist noted that some people, particularly those with serious mental illnesses, can suffer from a phenomenon known as 'exited delirium syndrome' when people die under restraint. However, there is no evidence of this. The cardiologist concludes that Mr Ahmed's death was due to multiple factors, but that he would have been unlikely to have died when he did without the stresses on his heart at that time.

112. While we accept that the decision to use force was reasonable, we are concerned that staff did not appear to fully understand or mitigate the inherent dangers in the techniques they used, particularly given Mr Ahmed's specific risks. In particular, staff did not seem to appreciate the grave risks involved in handcuffing a prisoner who was already lying prone. We therefore make the following recommendations:

The Governor should ensure that there is clear guidance and training for all staff on the safe use of force, including pain compliance techniques, and in particular on all risk factors in using these techniques, especially in relation to positional asphyxia.

The Head of Healthcare should ensure that healthcare staff are fully trained in relation to control and restraint guidelines, and in particular all risk factors, especially in relation to positional asphyxia, and are empowered to intervene when they feel the need to do so.

Emergency Response

113. PSI 03/2013 requires prisons to have a medical emergency response code protocol, with a two level code system that differentiates between a blood injury and all other injuries, and that ensures that an ambulance is called automatically in a life-threatening medical emergency. The protocol should ensure that staff communicate the nature of a medical emergency and take the correct emergency equipment to the incident.

114. Manchester's local guidance is not strictly in line with the national instruction as it does not have a two level code system and says that a Priority One code indicates a life-threatening emergency such as when a prisoner is unconscious, has breathing difficulties, or suffers severe blood loss. However, our concern is that no one used the emergency Priority One code immediately when Mr Ahmed became unresponsive.

115. As a nurse was already with Mr Ahmed, there was no delay in medical assistance and other healthcare staff arrived quickly. The clinical reviewer considered that the emergency medical aid Mr Ahmed received when he became unresponsive was good. There were no delays in reacting and all the necessary equipment was quickly available.

116. However, because no one used an emergency code, the control room did not call an ambulance immediately, although the emergency response nurse requested

one after she arrived about two minutes later. It is unlikely that this short delay made any difference as a nurse was on hand immediately to administer emergency treatment. However, it is important that all staff are familiar with the emergency code system and use the appropriate code to prompt the control room to call an ambulance immediately in a life threatening situation. In other cases, any delay in calling an ambulance could be critical. We make the following recommendation:

The Governor should ensure that staff use the appropriate emergency medical code immediately in a life threatening situation, which alerts other staff to bring appropriate emergency equipment and the control room to call an ambulance without delay.

Family Liaison

117. PSI 64/2011, gives guidance on breaking the news of a prisoner's death to his or her family. The guidance says that wherever possible the family liaison officer and another member of prison staff must visit the next of kin in person. If this is not possible then a follow-up visit must be arranged as soon as practicable.

118. The prison's family liaison officer and a prison chaplain went to Mr Ahmed's mother's house quickly to inform her of his death. She was not there but they waited for seven hours to try to ensure that they could tell her in person. They made efforts to establish whether there were alternative next of kin contact details but there were none.

119. When Mr Ahmed's mother's phoned the family liaison officer, she asked her to tell her what had happened as she had heard that Mr Ahmed might have died. The family liaison officer wanted to go to Mr Ahmed's mother but she asked her to tell her what had happened. The family liaison officer knew that Mr Ahmed's mother was alone in her car, but she believed that she had parked and decided that she had little option but to tell her. The solicitor for Mr Ahmed's family said that his mother was driving at the time of the telephone call, but the family liaison officer's notes show that she thought that his mother had told her that she had pulled into a service station and was not actually driving at the time.

120. We consider that the family liaison officer and the chaplain made commendable efforts to inform Mr Ahmed's mother of her son's death in person, but were unable to do so. When Mr Ahmed's mother contacted the family liaison officer she was in a difficult position. His mother pressed her for information and the family liaison officer decided that by this stage it was not appropriate to withhold the news of Mr Ahmed's death any longer. It is possible that she had misunderstood and believed that Mr Ahmed's mother was no longer driving, but in the circumstances, while evidently not ideal, we do not consider that her decision was unreasonable.

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