

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Umbar Ali a prisoner at HMP Humber on 12 December 2015

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## 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*



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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 Umbar Ali died of a brain haemorrhage in hospital on 12 December 2015. He was 41 years old. I offer my condolences to Mr Ali's family and friends.

Mr Ali had high blood pressure but stopped taking his medication at Humber and did not attend healthcare appointments. Mr Ali was advised about the risks and I am satisfied that he received a good standard of healthcare. Healthcare staff responded promptly when he collapsed and gave appropriate emergency treatment. There was a delay calling an ambulance, but there is no evidence this affected the outcome for Mr Ali and I do not consider that prison staff could have prevented his death.

I am concerned that prison staff initially restrained Mr Ali when they took him to hospital, even though he was unconscious. It is also unfortunate that the prison did not inform his family promptly that he was seriously ill in hospital.

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

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

**July 2016**

**Contents**

Summary ..... 1  
The Investigation Process ..... 3  
Background Information ..... 4  
Key Events ..... 5  
Findings ..... 8

# Summary

## Events

1. On 23 January 2015, Mr Umbar Ali was sentenced to four years and nine months in prison, and sent to HMP Leeds. Mr Ali had high blood pressure and chronic obstructive pulmonary disease (COPD – the name for a collection of long-term progressive lung diseases including chronic bronchitis and emphysema). He received medication for these conditions.
2. On 12 February, Mr Ali was transferred to HMP Humber. Leeds had given him a month's supply of medication and, at an initial health screen at Humber, a nurse explained how to apply for repeat prescriptions when he needed more. Mr Ali did not attend an appointment on 4 March for a more detailed health assessment and made no requests for medication over the following months.
3. In early October, a member of healthcare staff noted that Mr Ali's blood pressure was very high, referred him to the GP and arranged for him to be closely monitored. However, Mr Ali did not attend the monitoring appointments.
4. At a stop smoking clinic on 28 October, a healthcare assistant again noted Mr Ali's high blood pressure and advised him about his lifestyle choices. A doctor examined him, prescribed medication and arranged blood tests. In spite of several reminders, Mr Ali did not attend.
5. At 10.15am on 11 December, during a religious class, Mr Ali suddenly became unwell and lost consciousness. A chaplain called for healthcare assistance but no one used an emergency medical code. A prison doctor and nurses treated Mr Ali until paramedics arrived and took him to hospital. Mr Ali's condition deteriorated but it was not until later that afternoon that the prison notified his family that he was seriously ill. Mr Ali died at 1.10am on 12 December. His family were with him at the time.

## Findings

6. Mr Ali had longstanding high blood pressure but did not comply with attempts by healthcare staff to monitor and treat this. We are satisfied that the staff made appropriate efforts to monitor his condition, but as in the community, Mr Ali had the choice whether to engage in treatment. There was no indication that he lacked mental capacity to make such decisions. We consider that Mr Ali received an appropriate standard of care at the prison equivalent to that he could have expected to receive in the community. Prison staff could not have prevented his death.
7. When Mr Ali collapsed, no one used an emergency medical code, as should have happened. This meant that there was a delay in calling an ambulance. While there is no evidence this affected the outcome for Mr Ali, such a delay in other cases could be critical.
8. We are concerned that, although Mr Ali was unconscious and not a high security risk, prison managers decided he should be restrained for the journey to hospital

and after he was admitted. The medical section of the security risk assessment did not fully reflect Mr Ali's poor condition and incapacity at the time.

9. We are also concerned that there was a delay of some hours before the prison informed Mr Ali's family that he was seriously ill in hospital.

## **Recommendations**

- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies. Staff should use an emergency code immediately there are serious concerns about the health of a prisoner to alert control room staff to call an ambulance automatically. There should be no unnecessary delays in ambulances entering and leaving the prison.
  
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
  
- The Governor should ensure that, in line with Prison Rule 22, when a prisoner becomes seriously ill staff notify their next of kin quickly so that they are able to visit them in hospital without undue delay.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Humber informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Ali's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Ali's clinical care at the prison.
13. The investigator interviewed five members of staff and a prisoner at Humber on 10 and 11 February 2016. The clinical reviewer joined her for interviews with healthcare staff on 11 February 2016.
14. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation, who gave us the cause of Mr Ali's death. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Ali's sister to explain the investigation and to ask if she had any matters they wanted the investigation to consider. Mr Ali's family were concerned about the delay in notifying them that Mr Ali was seriously ill and had been taken to hospital. They asked if there had been a delay in him going to hospital. They also wanted to know if he had been injured in a fight, two weeks before he died and, if so, whether this was linked to his death.
16. Mr Ali's family received a copy of the initial report. The solicitor representing the family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
17. The prison considered our initial report and recommendations, which they have accepted. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

# Background Information

## HMP Humber

18. HMP Humber is made up of two former prisons, HMP The Wolds and HMP Everthorpe. The two prisons formally merged in April 2014. Humber holds up to 1,062 prisoners.
19. City Health Care Partnership provides healthcare services. There are healthcare staff on duty at all times.

## HM Inspectorate of Prisons

20. The most recent inspection of Humber was in July 2015. Inspectors reported that a new health provider had begun to make positive changes and services were generally safe and responsive. There was good prioritisation of urgent cases. Care for prisoners with long-term conditions needed further development to match community standards.

## 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 annual report for the year to December 2015, the IMB reported that the healthcare provider had changed in June and was delivering a good service. The IMB noted that there was a good focus on health education and wellbeing clinics, such as smoking cessation and well man sessions, which reflected community provision.

## Previous deaths at HMP Humber

22. Mr Ali was the second prisoner to die from natural causes at HMP Humber since it was formed in 2014. There has been one death since. We have previously made a recommendation about the use of restraints.

## Key Events

23. Mr Umbar Ali was remanded to HMP Leeds on 1 January 2015. (On 23 January, he was sentenced to four years and nine months in prison, for dangerous driving and other serious offences.)
24. At an initial health screen, a nurse noted that Mr Ali had a long history of high blood pressure and chronic obstructive pulmonary disease. Later that day, a prison GP prescribed salbutamol and fostair inhalers (to widen the airways), ramipril and timolol (for high blood pressure), tiotropium bromide and carbocisteine (for COPD), and eye drops. Mr Ali had smoked for a long time and had never been able to give up. He had previously used heroin and crack cocaine and had completed a drug treatment programme at Leeds.
25. On 12 February, Mr Ali moved to HMP Humber. Healthcare staff at Leeds gave him one month's supply of medications to take with him and sent a list of them to Humber. At an initial health screen, a nurse recorded that his blood pressure was high. Mr Ali did not report his medical conditions and she had no immediate concerns about his health. She told him how to make a healthcare appointment and how to apply for a repeat prescription when he needed further medication. She booked an appointment for 4 March, for a more detailed health assessment but Mr Ali did not attend.
26. Over the following months, Mr Ali saw healthcare staff frequently for minor ailments, but he did not request any further medication. A nurse said that prisoners were expected to take responsibility for their own medication and, as in the community, prison healthcare staff do not send reminders about repeat prescriptions.
27. On Friday 2 October, Mr Ali told a nurse that he had blood pressure problems. She took a reading and found it was 194/146mmHg (very high). His pulse was 118 (high). She arranged for his blood pressure to be checked daily over the weekend, but Mr Ali did not attend the appointments. On 6 October, Mr Ali's blood pressure was 167/118 and on 7 October 178/110. Healthcare staff made an urgent appointment for a GP review on 8 October, but Mr Ali did not attend this or subsequent appointments sent to him on 13, 20, and 27 October.
28. On 28 October, Mr Ali attended a stop smoking session. A healthcare assistant took his blood pressure and noted that it was very high. Mr Ali told her that he used to take ramipril, but had not bothered to renew his prescription. She warned him of the risks and asked the doctor to see him immediately. A GP reviewed Mr Ali and prescribed ramipril again. He also arranged blood tests to check Mr Ali's risk factors for heart disease, diabetes and thyroid function, and planned to review him. Healthcare staff sent Mr Ali several appointments for blood tests over the next few weeks, but he did not attend any of them.

### Events on Friday 11 December 2015

29. A prisoner told the investigator that, from approximately 8.15am on Friday 11 December, he had been in the chapel at a religious class with Mr Ali and several other prisoners. Sometime after 10.00am, they were having a hot drink during a break. Mr Ali put his cup down and his head tilted back and his eyes were closed.

He called Mr Ali's name, but he did not respond. He had been trained in first aid and put Mr Ali on the floor in the recovery position. He checked his pulse, which was weak. He shouted for the imam to call healthcare staff. He said nurses and a doctor arrived quickly.

30. A nurse said that he was in healthcare centre when he heard a radio call for healthcare staff to go to the chapel. He rang the communications room to clarify the nature of the problem and was told that a prisoner had had an asthma attack. He told the control room staff that someone should have called an emergency code blue (this indicates circumstances such as when a prisoner is unconscious, not breathing or is having breathing difficulties). He then went to the chapel with a senior nurse.
31. When the nurse arrived at the chapel at around 10.15am, Mr Ali was in the recovery position, breathing but unconscious. Initially, the nurses thought it was an asthma attack, but soon realised it was more serious and Mr Ali appeared to be having small tremors. The senior nurse called for a doctor to assist them and a GP arrived.
32. The GP diagnosed chronic seizures and gave Mr Ali oxygen, salbutamol and diazepam (a muscle relaxant). His blood pressure was high and he remained unconscious. The GP asked if anyone had called an ambulance. The nurse then radioed an emergency code blue at 10.31am and asked the control room to call an ambulance immediately. He asked for all gates to be opened so the ambulance could get through quickly.
33. Paramedics arrived at the prison at 10.52am, but did not reach the chapel until 11.00am. At 11.30am, they took Mr Ali to hospital. Before they left the prison, staff completed a security risk assessment and a prison manager decided that he should be accompanied by two officers using double handcuffs. (Double handcuffing means the prisoner has his hands cuffed in front of him and then has one wrist attached to a prison officer by an additional set of handcuffs.) After difficulty trying to double handcuff Mr Ali in the ambulance, the despatching officer decided that the escort officers should use an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) The restraints were removed in hospital at 1.35pm.
34. Mr Ali remained unresponsive and his condition deteriorated. He died in hospital, with his family at his bedside, at 1.10am on 12 December.

### **Contact with Mr Ali's family**

35. Mr Ali's family said that, at around 10.15am on 11 December, another prisoner's family had told them that Mr Ali had collapsed at the prison. One of Mr Ali's sisters rang the prison healthcare department to find out what had happened. She asked someone to call her back, but no one returned her call. There is no record of this in the prison log. Mr Ali's family lived a long distance from the prison and did not know how serious his condition was. They set off to travel to Hull, intending to go to the prison.

36. Around 2.30pm, hospital doctors diagnosed a catastrophic bleed on the brain and asked prison staff to inform Mr Ali's family. The prison appointed an officer as the family liaison officer and, at 3.40pm, he arrived at the hospital with one of the prison imams. At 3.55pm, the imam spoke to Mr Ali's sister to tell her that Mr Ali was in hospital. She told him that his family were already on their way to Hull and would divert to the hospital. She asked about the nature of Mr Ali's illness. The imam said he could not disclose details, but Mr Ali was quite ill. At 5.00pm, a prison doctor considered that Mr Ali might die within 45 minutes. Mr Ali's mother, sisters and other family members arrived at the hospital at around 6.20pm.
37. The officer and imam met Mr Ali's family when they arrived at the hospital and after his death. On 14 December, the two prison imams conducted Mr Ali's funeral. The prison contributed to the funeral costs, in line with national guidance.

### **Support for prisoners and staff**

38. After Mr Ali's death, a prison manager debriefed the escort staff and offered her support and that of the staff care team.
39. The prison posted notices informing other prisoners of Mr Ali'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 Ali's death. Staff told the prisoner who had initiated first-aid personally and offered specialist support if he needed it.

### **Cause of death**

40. The coroner confirmed that the cause of Mr Ali's death was a large intercranial haemorrhage (brain haemorrhage) due to hypertension.

# Findings

## Clinical care

41. Mr Ali arrived at Humber with a month's supply of medication for high blood pressure, but he did not request a repeat prescription when this ran out. In October 2015, a prison doctor re-prescribed the medication and planned to review him, but Mr Ali did not attend appointments arranged to monitor his condition. As in the community, this was his choice, and staff made a number of attempts to allow him to engage in treatment. The healthcare manager told us that since Mr Ali's death, healthcare staff follow up prisoners who miss appointments to establish the reason why they did not attend, which we welcome.
42. Mr Ali's family was concerned that his death was possibly associated with injuries he might have received two weeks before he died, when he was involved in a fight. His records show that he was reportedly involved in a fight on 21 October, but we have found no evidence of any injury at the time or any links between this and his death.
43. Mr Ali's brain haemorrhage was caused by high blood pressure. The clinical reviewer noted that his failure to take his prescribed medication and attend appointments was significant; it is possible his blood pressure had been high and uncontrolled for several months.
44. The clinical reviewer told the investigator that Mr Ali had suffered a catastrophic brain bleed due to high blood pressure. In her opinion, the delay in calling an ambulance would not have affected the outcome and he received appropriate treatment from the GP at the scene.
45. We are satisfied that Mr Ali received an appropriate standard of care at the prison, equivalent to that he could have expected to receive in the community. He had responsibility for taking his own decisions about his health and had been told of the risks and his lifestyle choices.

## Emergency response

46. PSI 03/2013 requires prisons to have a medical emergency response code protocol, which ensures an ambulance is called automatically in a life-threatening emergency. It states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. The PSI makes it clear that there should be no delay in admitting and discharging an ambulance. The Governor issued a notice to staff in February 2015, briefly describing the procedures.
47. When Mr Ali collapsed, staff in the chapel should have called a code blue to indicate he had difficulty in breathing or was unconscious. Instead, they rang the control room to ask for healthcare assistance, without using an emergency code, which meant that healthcare staff were not aware of the nature of the emergency. Even after healthcare staff arrived, it was at least another 15 minutes before anyone called a code blue and the control room called an ambulance.

48. During the emergency, a prisoner acted commendably by placing Mr Ali in the recovery position and he and other prisoners also helped paramedics move him from the chapel on the first floor down narrow stairs to the ambulance.
49. Although a nurse asked for gates to be opened, the paramedics reported that it took them eight minutes to reach Mr Ali and that there was a further delay leaving the prison due to security procedures. While there is no evidence this delay affected the outcome for Mr Ali, such a delay in other cases could be critical. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies. Staff should use an emergency code immediately there are serious concerns about the health of a prisoner to alert control room staff to call an ambulance automatically. There should be no unnecessary delays in ambulances entering and leaving the prison.**

### **Restraints, security and escorts**

50. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
51. Mr Ali's risk assessment concluded that his risk to the public, of hostage taking, escape potential and likelihood of outside assistance were all low. It did not record that he was unconscious and in a very poor condition. The prison manager, who authorised officers to restrain Mr Ali with double handcuffs, said that the medical section of the risk assessment indicated that there were no medical objections to the use of restraints. We were unable to identify who completed the medical section of the risk assessment. Two medical staff said that they would not have said that Mr Ali should be restrained.
52. When interviewed, the manager said that in the ambulance the despatching officer decided not to use double cuffs, as they were too restrictive. The paramedic noted in his report that the security issues delayed their departure.
53. We are concerned that anyone decided that it would be appropriate to use double handcuffs for Mr Ali. Double cuffing is usually required for moving category A or category B prisoners in good health. Mr Ali was a category C prisoner. When, exceptionally, double cuffs are used for a category C prisoner like Mr Ali, the Prison Service requires that reasons should be recorded in writing. There is no evidence to support this decision and we can see no reason why it would be justified. It is difficult to see how the assessment concluded that an unconscious man had the ability to escape unaided from two escort officers.

54. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. We are not satisfied that there was appropriate and considered healthcare input into the risk assessment, or that managers appropriately considered his condition at the time and how this affected his risk. We make the following recommendation:

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

### **Family liaison**

55. Prison Rule 22 requires that the governor should inform families at once if a prisoner becomes seriously ill. Prison Service Instruction (PSI) 64/2011, requires prisons to have in place procedures to do this.
56. Mr Ali's family said that they found out that Mr Ali had taken ill through another prisoner and the prison did not return their call when they asked for information about his condition. Although Mr Ali had been unconscious since he collapsed shortly after 10.00.am that morning, there is no evidence that the prison attempted to inform his family until the hospital requested this at 2.30pm. A prison imam spoke to Mr Ali's sister almost an hour and a half later, but accounts differ as to who initiated the call. By then, Mr Ali's family were already on their way to Hull and were able to see Mr Ali in hospital before he died. We are concerned that the prison did not comply with the requirement to notify Mr Ali's family immediately that he was seriously ill. We make the following recommendation:

**The Governor should ensure that, in line with Prison Rule 22, when a prisoner becomes seriously ill staff notify their next of kin quickly so that they are able to visit them in hospital without undue delay.**

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