Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Muhamed Alkubaisi a prisoner at HMP Wormwood Scrubs on 18 November 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Muhamed Alkubaisi died on 18 November 2016 of a brain aneurysm in hospital. He was 45 years old. I offer my condolences to Mr Alkubaisi's family and friends.

I agree with the clinical reviewer that Mr Alkubaisi received a good standard of health care for his ongoing heart condition and that, when he collapsed, staff made a coordinated effort to help him.

However, I am concerned that staff used the highest level of restraints on Mr Alkubaisi when he was unconscious, which was clearly unjustified. In addition, record keeping was poor.

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 **October 2017**

Contents

Summary

Events

1. On 19 April 2016, Mr Muhamed Alkubaisi was sentenced to18 months in prison for fraud and sent to HMP Wormwood Scrubs.

2. Mr Alkubaisi had a history of heart disease and depression. He told a nurse he had a heart attack a few years before and had a stent inserted. Prison GPs re-prescribed medication for Mr Alkubaisi, including aspirin, atorvastatin (cholesterol lowering medication), bisoprolol (a beta blocker for high blood pressure), ramipril (for high blood pressure), and venlafaxaine (an antidepressant). Healthcare staff regularly monitored his blood pressure and pulse.

3. Mr Alkubaisi collapsed in his cell on 18 November. His cellmate raised the alarm. Mr Alkubaisi was conscious and told the nurse that he had a headache. His observations were within the normal range, but the nurse noted Mr Alkubaisi was vomiting, clammy and looked pale. She diagnosed food poisoning. However, a short while later Mr Alkubaisi's condition deteriorated and he became unresponsive. The nurse asked the prison officers to call for an ambulance.

4. Paramedics attended and took Mr Alkubaisi to hospital. It appears he went to hospital under double-cuffed restraint. Hospital doctors found he had an aneurysm and he never regained consciousness. Mr Alkubaisi died at 9.00pm on 18 November.

Findings

5. Overall, we are satisfied that that the clinical care offered to Mr Alkubaisi was good and equivalent to that he could have expected to receive in the community.

6. When Mr Alkubaisi went to hospital, he was escorted by two officers and the highest level of restraints was used. He never regained consciousness. The decision to use double handcuffs appears unjustified.

7. The prison's record keeping was poor and inaccurate. Despite the escort risk assessment stating it had been completed prior to the journey, it was in fact a retrospective entry after Mr Alkubaisi's hospital admission. The prison also conceded that the information entered in their family liaison log was incorrect.

8. We make five recommendations.

Recommendations

- The Governor should ensure that all escorting staff are made aware of their responsibilities during medical emergencies and ensure they adhere to the information in the escorting risk assessments. The use of double handcuffs for category C prisoners should be exceptional and fully justified in writing.
- The Governor should ensure that a member of Prison Service staff informs the next of kin of seriously ill prisoners as soon as possible, in line with national guidance.

- The Governor should ensure that all staff fully understand that alteration of documents, including retrospective entries, can amount to a serious disciplinary matter.
- The Governor should ensure that all staff maintain accurate and contemporaneous prisoner records, so that there is an effective record of events, issues, concerns, decisions and action taken.
- The Governor should ensure that staff are aware of their responsibilities, set out in PSI 58/2010, to provide all relevant material to the Ombudsman.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator obtained copies of relevant extracts from Mr Alkubaisi's prison and medical records.

11. The investigator interviewed three members of staff and one prisoner at Wormwood Scrubs on 11 and 17 January 2017.

12. NHS England commissioned a clinical reviewer to review Mr Alkubaisi's clinical care at the prison. She conducted joint interviews with the investigator with prison and healthcare staff.

13. We informed HM Coroner for West London of the investigation who gave us the results of the cause of death. We have sent the coroner a copy of this report.

14. The investigator contacted Mr Alkubaisi's next of kin, to explain the investigation and to ask if he had any matters they wanted the investigation to consider. We did not receive a response.

15. The initial report was shared with the Prison Service as part of the consultation process. The Prison Service pointed out two typing errors and this report has been amended accordingly.

16. The Prison Service also provided further information about the decision to restrain Mr Alkubaisi when he was taken to hospital. We have amended our report to acknowledge and take account of that further information.

Background Information

HMP Wormwood Scrubs

17. HMP Wormwood Scrubs is a local prison in west London, holding over 1,200 men, either convicted or remanded by courts in the local area. It is also a designated resettlement prison for London prisoners. On 1 April 2016, Care UK took over the healthcare contract for primary care and several other health services. Mental health services are subcontracted to Barnet, Enfield and Haringey Mental Health Trust. There is 24-hour healthcare cover and an inpatient unit with 17 beds.

HM Inspectorate of Prisons

18. The most recent inspection of Wormwood Scrubs was in December 2015. Inspectors had a number of concerns about the prison, but found that the quality of health services was reasonable with an adequate range of primary care services. The management of long-term conditions was mostly reasonable but few prisoners with long-term or complex conditions had care plans. The inpatient unit was a good environment. Most inpatients had severe mental health problems or other complex needs but there were often too few beds available to meet demand. The prison cancelled too many external hospital appointments due to a shortage of prison staff to take prisoners to hospital and this had a detrimental effect on prisoners' health.

Independent Monitoring Board

19. 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 May 2015, the IMB noted that healthcare services had received a commendable inspection report from the Care Quality Commission. The IMB was concerned that too many prisoners had hospital appointments cancelled, often due to a shortage of prison staff to take them.

Previous deaths at HMP Wormwood Scrubs

20. Mr Alkubaisi was the fourth prisoner to die at Wormwood Scrubs from natural causes since January 2014. There has been one further death since. We have made recommendations on the disproportionate use of restraints on two other occasions.

Key Events

21. On 19 April 2016, Mr Muhamed Alkubaisi was sentenced to18 months in prison for fraud and sent to HMP Wormwood Scrubs.

22. At his initial medical reception, Mr Alkubaisi told a nurse that he suffered from depression but had not taken medication for this. The nurse arranged for Mr Alkubaisi to see a prison GP.

23. Later that evening, Mr Alkubaisi told a prison GP that four years ago he had had a heart attack and had a stent inserted, and that he had high cholesterol. He said he did not drink but was a smoker. He declined help to stop smoking. The GP issued a prescription for Mr Alkubaisi to continue taking aspirin, atorvastatin (cholesterol lowering medication), bisoprolol (a beta blocker for high blood pressure), ramipril (for high blood pressure), and venlafaxaine (an antidepressant).

24. On 17 May, Mr Alkubaisi had a blood test, which showed that his cholesterol was raised (6.06mmol/L). He saw a prison GP to discuss the blood test results. Mr Alkubaisi said he had left sided chest pain and was having difficulty breathing. The GP arranged for Mr Alkubaisi to have an electrocardiogram (ECG – tests the electrical rhythm of the heart) and made a referral for the rapid access chest pain clinic. He also prescribed ezetimbe to lower his cholesterol. The ECG showed no concerns, and Mr Alkubaisi's blood pressure (122/84) and pulse (73 beats per minute) were within normal range.

25. Mr Alkubaisi first complained of a headache on 27 May. A nurse gave him two paracetamol tablets.

26. On 19 July, Mr Alkubaisi attended the rapid access chest pain clinic and completed an exercise tolerance test. The results were normal, so no further action was planned.

27. On 26 July, Mr Alkubaisi had another cholesterol blood test. His level had lowered to 3.4mmol/L, within normal range.

28. The second time Mr Alkubaisi complained of a headache on 11 September, a nurse gave him two paracetamol tablets.

29. On 30 September, 6 October and 13 October an assistant practitioner checked Mr Alkubaisi's blood pressure. A nurse checked it on 26 October. Each result was within the normal range.

30. When Mr Alkubaisi told the nurse that he was having headaches on 5 November, she made an appointment for him to see the GP. A prison GP examined Mr Alkubaisi on 7 November. He reported having intermittent headaches, which were worse at night. He had a tight feeling around the front of his head. The GP diagnosed tension type headaches.

31. Mr Alkubaisi had a standard double cell on a residential wing at Wormwood Scrubs. His cellmate slept on the top bunk and Mr Alkubaisi was on the bottom.

32. The cellmate said that Mr Alkubaisi slept for long periods each day. On Thursday 17 November, he said that Mr Alkubaisi woke up around 4.00pm. They both left their cell and collected their evening meal and brought it back to the cell. Mr Alkubaisi did not eat his meal immediately. They watched television together and, by 9.00pm, Mr Alkubaisi had eaten his meal. He said they both dozed on and off.

Events from Friday 18 November 2016

33. At approximately 1.00am on 18 November, the cellmate said Mr Alkubaisi told him that he was going to the toilet to wash and then come back to pray. He heard Mr Alkubaisi making a strange noise. He shouted to him asking if he was ok and he got out of his bunk and knocked on the toilet door. There was no response so he pushed the door open and found Mr Alkubaisi on the floor. He said Mr Alkubaisi appeared to be in pain and conscious. He asked him if he was ok and he turned his head to the side to help his breathing. He rang the cell bell to call staff for help.

34. Records show the cellmate rang the cell bell at 1.38am. An operational support officer (OSG) responded and the cellmate told him that Mr Alkubaisi was unwell. The OSG could not see Mr Alkubaisi from the cell door. At 1.40am, he radioed to the control room for officers to come to the cell, as a prisoner was unwell.

35. A nurse heard the radio call and immediately went to the cell and found officers were already in the cell by the toilet area. She said that Mr Alkubaisi was sitting on the floor vomiting into a bin. The officers helped Mr Alkubaisi out of the cell into the corridor. She asked the cellmate if Mr Alkubaisi had taken any drugs. He told her that Mr Alkubaisi did not take any drugs and only smoked his own cigarettes. Mr Alkubaisi told her he had a headache and she noted he was sweating, clammy, cold, very pale, vomiting and needing to use the toilet. She checked Mr Alkubaisi's observations. His blood pressure (128/76), pulse (86 beats per minute), and blood glucose levels (5.5mmol) were all within normal range. She diagnosed food poisoning and told Mr Alkubaisi to rest and take plenty of fluids. An officer helped him to get to the toilet and then back to his bed. Mr Alkubaisi began snoring very loudly.

36. The nurse left the cell but almost immediately officers called her back. Mr Alkubaisi was unresponsive on the bed. His pupils were dilated and his heart rate was very high (148 beats per minute) and irregular. She told the officers to call for an ambulance. Records show that an officer radioed a code blue emergency at 2.12am, which indicates a prisoner is unconscious or has breathing difficulties. The control room immediately called an ambulance.

37. Paramedics arrived at 2.23am and took Mr Alkubaisi to hospital at 3.33am. Two officers escorted him and restrained him with double handcuffs. (This means a prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.)

38. In hospital, officers removed the handcuffs for Mr Alkubaisi to have a CT scan. Restraints were not reapplied. Mr Alkubaisi did not regain consciousness and died at 9.00pm with his family present.

Contact with Mr Alkubaisi's family

39. When Mr Alkubaisi was in hospital, hospital staff asked prison staff for his family details. Hospital staff arranged for the police to bring the family to the hospital.

40. On 18 November, the prison appointed an officer as the family liaison officer. At 9.55am, she and the prison Imam went to the hospital and met Mr Alkubaisi's family. Mr Alkubaisi's cousin was his next of kin and was present at the hospital. The officer offered advice and support.

41. The officer rang Mr Alkubaisi's cousin on 19 November to offer her condolences. She remained in contact with him until after Mr Alkubaisi's funeral, held on 1 December. The prison contributed towards the costs, in line with national policy.

Support for prisoners and staff

42. After Mr Alkubaisi's death, a hot debrief was not held because staff involved in responding to Mr Alkubaisi becoming unwell were at the end of their shift. A prison manager scheduled a debrief when the escort officers and healthcare staff were next on duty to ensure they had the opportunity to discuss any issues arising, and to offer support.

43. The prison posted notices informing other prisoners of Mr Alkubaisi's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Alkubaisi's death. Staff moved the cellmate to another cell and he said he felt supported.

Cause of death

44. The Coroner confirmed that the cause of Mr Alkubaisi's death was a subarachnoid haemorrhage (stroke) and a ruptured intracerebral artery aneurysm (brain haemorrhage).

Findings

Clinical care

45. The clinical reviewer said that the circumstances of Mr Alkubaisi's death were not predictable. High blood pressure and smoking are both risk factors for a stroke, and although Mr Alkubaisi smoked cigarettes he did not have a history of high blood pressure.

46. The prison doctors correctly monitored Mr Alkubaisi's cardiac condition. The clinical reviewer judged the nurse's emergency response on 18 November as structured and detailed, including objective measures of assessment. Her approach to establish the situation was practical and appropriate.

47. We agree with the clinical reviewer that Mr Alkubaisi's care was equivalent to what he could have expected to receive in the community.

Use of restraints

48. 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 the 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 prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

49. On 18 November, when Mr Alkubaisi was unconscious and leaving the prison in the ambulance, a prison manager wrote in the wing log book and in Mr Alkubaisi's prison record that Mr Alkubaisi was drifting in and out of consciousness and was going to hospital as an emergency. In the prisoner escort log, he noted that double handcuffs were applied. The investigator was unable to interview him (who had authorised the use of double handcuffs), as he no longer works at the prison.

50. An escort risk assessment was completed and dated 18 November 2016. This said that the destination was the hospital. The escort risk assessment stated that Mr Alkubaisi's security file had been accessed on 18 July 2016 and noted "victim contact", that there were no indications that a victim may be at risk or any known unresolved domestic issues. The risk assessment showed that the prison considered him a low risk in all areas including hostage taking and escape. Healthcare staff noted on the medical section that there was no need for any restraints. The assessment indicated that two officers were to escort Mr Alkubaisi to hospital unrestrained. A prison manager signed and dated the form.

51. Double handcuffing is usually required for moving high-risk prisoners in security categories A or B, in good health. When, exceptionally, double cuffs are used for a category C prisoner like Mr Alkubaisi, the Prison and Probation Service

instructions require that reasons should be recorded in writing. There is no contemporary record to justify this exceptional decision.

Comments received after the initial report

52. The Prison Service explained that the risk assessment had not been completed until after Mr Alkubasi was in hospital, notwithstanding that the assessment is recorded as completed for travel to hospital on 18 November, with no indication that this was in fact a retrospective decision.

53. The prison stated that the priority of staff at the time was to ensure Mr Alkubaisi was able to access emergency medical assistance as soon as possible. PSI 33-2015 (emergency escorts) states:

> 5.12 *In an emergency situation, an escort of at least 2 officers must be supplied. Restraints must be used unless there are medical objections from a qualified medical professional. A full escort risk assessment must be completed as soon as is practicable, but in any event within 24 hours of the prisoner leaving the establishment.*

54. The Prisoner Escort Record (PER) does not address the need for restraint. Mr Alkubaisi was double cuffed for a total of 42 minutes. The records also show that an ambulance was called at 2.12am, but did not leave the prison until 3.33am. We conclude there was sufficient time to make the necessary security and medical assessments to consider the appropriate level of restraint.

55. We note in particular that, when the nurse completed the medical record, she noted that Mr Alkubaisi was unresponsive. In the wing log and his prison notes, the prison manager described him as drifting in and out of consciousness. It appeared that Mr Alkubaisi's condition deteriorated quickly while he was in prison. This was apparent to the nurse and paramedics in attendance who noted Mr Alkubaisi went from conscious and alert to seriously ill. Paramedics noted Mr Alkubaisi's Glasgow Coma Scale (GCS) was 6 at 03.15 and 03.40. Six indicates a severe brain injury. The clinical reviewer notes:

> "Mr Alkubaisi did have some responses to movement but he was unconscious. In my opinion there would have been no reasonable risk of him running off with a sustained GCS of 6."

56. We are concerned that Mr Alkubaisi was restrained when he was unconscious. By this time, he was critically ill and immobile.

57. We are concerned that the escort risk assessment did not make it clear this was a retrospective decision. We found the prison's approach to the investigation, in particular the provision of supporting documentation and explanation of the identified deficits to the investigator, disappointing. We make the following recommendation:

The Governor should ensure that all escorting staff are made aware of their responsibilities during medical emergencies and ensure they adhere to the information in the escorting risk assessments. The use of double

handcuffs for category C prisoners should be exceptional and fully justified in writing.

Contact with Mr Alkubaisi's family

58. We were told that by the prison that the contents of the family liaison log about contacting Mr Alkubaisi's family were incorrect and incomplete. They said that when a prison manager arrived in the prison in the early hours of 18 November, he arranged for the police to go to Mr Alkubaisi's home address to get the next of kin information and arrange for the son and brother to visit the hospital.

59. Regardless, Prison Rule 22 requires that when a prisoner is seriously ill, the governor should tell the prisoner's next of kin "at once". Wormwood Scrubs should have contacted his next of kin as soon as he was taken to hospital. We make the following recommendation:

The Governor should ensure that a member of staff informs the next of kin of seriously ill prisoners are informed as soon as possible, in line with national guidance.

Record keeping

60. It is clear that there was very poor record keeping in this case. The prison provided conflicting information about family contact, the escort risk assessment and the use of double handcuffs. We therefore make the following recommendations:

The Governor should ensure that all staff maintain accurate and contemporaneous prisoner's records, including making clear where retrospective decisions are made, so that there is an effective record of events, issues, concerns and action taken.

The Governor should ensure that staff are aware of their responsibilities, set out in PSI 58/2010, to provide all relevant material to the Ombudsman.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141