Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mohammed Omar a prisoner at HMP Oakwood on 24 March 2018

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 I oversee can improve their work in the future.

Mr Mohammed Omar died in hospital on 24 March 2018 of a heart attack while a prisoner at HMP Oakwood. He was 42 years old. I offer my condolences to Mr Omar's family and friends.

I am satisfied that the clinical care Mr Omar received at Oakwood was equivalent to that which he could have expected to have received in the community. He had no significant health concerns and there was no indication that he had an underlying condition which could have been picked up earlier.

I am concerned that the officer who performed the unlock on Mr Omar's cell failed to check on his welfare but I am satisfied that the prison has subsequently taken steps to address this.

I am also concerned that radio transmission problems at Oakwood meant that an emergency call was not transmitted when Mr Omar was found unresponsive and that there was, therefore, a delay of at least three minutes before an ambulance was called.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **November 2018**

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Summary

Events

1. On 21 December 2017, Mr Mohammed Omar was committed to custody. On 31 January 2018, he was transferred to HMP Oakwood.

2. A health screen on his reception at Oakwood revealed no health concerns. For the next couple of months, Mr Omar had no significant health concerns.

3. Mr Omar's cellmate said that Mr Omar had been unwell during the week beginning 19 March, but that he did not tell healthcare staff and continued to attend a course he was taking. He said that on the evening of 23 March, Mr Omar said he felt unwell and went to sleep early.

4. On 24 March, at approximately 8.10am, an officer unlocked Mr Omar's cell. He did not open the door or look inside. Sometime later, Mr Omar's cellmate spoke to Mr Omar who was lying on the top bunk. Mr Omar appeared lifeless so he called for help.

5. An officer responded, called an emergency on her radio and pressed her personal alarm. The emergency call did not transmit but officers and a nurse responded to her personal alarm, attended and started cardiopulmonary resuscitation.

6. A first line manager requested more assistance and extra healthcare staff arrived. Only then, at approximately 9.45am, did a senior officer confirm it was a medical emergency, and an ambulance was called. Staff continued resuscitation attempts until the ambulance arrived.

7. The ambulance crew took Mr Omar to New Cross Hospital in Wolverhampton, where, at 11.02am, he was pronounced dead.

Findings

Clinical care

1. The clinical reviewer concluded that the care Mr Omar received at Oakwood was equivalent to that which he could have expected to receive in the community.

Unlock procedure and welfare checks

2. When Mr Omar was unlocked at approximately 8.10am, the officer did not open the door or look inside the cell to check on the welfare of its occupants. Although we cannot say whether a welfare check on Mr Omar at this point would have prevented his death, a more thorough check may have triggered an emergency response sooner. We note the steps the prison has taken, both disciplinary and procedural, to address this issue since Mr Omar's death.

Emergency response

3. When Mr Omar was discovered to be unresponsive, the emergency response was delayed due to a failure of the radio network to transmit the emergency code. We accept that the officer made an emergency call, and note that

Oakwood has significant technical issues with radio reception. However, we are concerned that as a result, emergency radio calls may not be successfully transmitted.

4. We are also concerned that the first line manager who responded to the personal alarm did not call an emergency code for a further three minutes, even though she was aware that no emergency call had been transmitted.

Contact with Mr Omar's family

5. We are satisfied that the prison conducted its contact with Mr Omar's family appropriately. The family liaison officer at the prison respected Mr Omar's wife's wishes regarding contact, and liaised separately with Mr Omar's blood relatives. We also recognise the efforts of the family liaison officer and the coroner to ensure that Mr Omar's body was released as soon as possible to enable his family to hold his funeral promptly.

Recommendations

- The Director should ensure that staff are aware of the need to confirm that emergency radio calls have been received and actioned.
- The Director should ensure that all staff are reminded of the procedures they must follow in a medical emergency, as set out in Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*.

The Investigation Process

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

7. The investigator visited Oakwood on 3 April 2018. He obtained copies of relevant extracts from Mr Omar's prison and medical records.

8. The investigator interviewed four members of staff and three prisoners at Oakwood on 3 April 2018.

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

10. We informed HM Coroner for Staffordshire South of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Omar's wife to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She had no specific observations at that time, but wanted to be kept updated about the investigation.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

13. Mr Omar's wife received a copy of our initial report. She did not comment on the factual accuracy of the report and raised no further concerns.

Background Information

HMP Oakwood

14. HMP Oakwood is managed by G4S and is one of the largest prisons in England and Wales, providing places for around 2,100 male prisoners. Care UK provides the healthcare services, which include a daily GP clinic, some specialist services and out-of-hours GPs.

15. Oakwood is made up of several house blocks which are subdivided into wings. The main residential blocks have eight wings: A-D upper and A-D lower. Mr Omar was located on Cedar House Block B, upper wing, on the lower landing.

HM Inspectorate of Prisons

16. The last inspection of HMP Oakwood was conducted in January and February 2018. Inspectors reported that health services had improved considerably since their last inspection and, overall, were reasonably good. The range of services was appropriate and the management of prisoners with lifelong or complex health needs was very good, although staff shortages had led to a backlog of nurse reviews. Inspectors found that the healthcare rooms were well equipped and staff created appropriate care plans. However, there were often delays in arranging external hospital appointments because of the high demand and insufficient escort staff.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board made up 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 March 2017, the IMB reported that the transition from the previous healthcare provider to Care UK went well, without major problems. Care UK had introduced clinics led by nurses on some wings due to the uncertainty arising from the change of healthcare provider. There were also a high number of professional vacancies and the use of agency staff had lowered continuity of care.

Previous deaths at HMP Oakwood

18. Mr Omar was the fifteenth prisoner to die at Oakwood since January 2016, and the fourteenth to die from natural causes.

19. We have previously made recommendations about the unlock procedure at Oakwood. We have also previously recognised the issues with radio contact at Oakwood, but have not made a formal recommendation about this in the past.

Mr Omar's history

20. While he was in prison, Mr Mohammed Omar was known as Omar Sharif, which was the name used on his sentence documentation. His family, however, refer to him as Mohammed Omar, and that is the name used by HM Coroner on his post-mortem and death certificate.

Key Events

21. On 21 December 2017, Mr Mohammed Omar was committed to custody for non-payment of a confiscation order and was ordered to serve 511 days imprisonment. He was initially sent to HMP Birmingham. On 31 January 2018, Mr Omar was transferred to HMP Oakwood.

22. A nurse reviewed Mr Omar at a health screen on his reception at Oakwood. She recorded that he had no ongoing physical health concerns and was fit for a normal cell location and work.

23. Mr Omar had few health concerns at Oakwood. On 8 February, a nurse saw him after complaints of urinary incontinence. He noted that Mr Omar had previously been prescribed medication for this, and reinstated it. On 17 February, a nurse examined Mr Omar after he complained of a sore chest. She observed that his chest was sore but not painful, so gave him paracetamol but took no further action.

24. Mr Omar's cellmate said in interview that on Monday 19 March, Mr Omar became poorly but that he had improved by Thursday of that week. He said that Mr Omar did not see healthcare staff and continued to attend a course he was taking. He said that on Friday 23 March, Mr Omar did not eat his tea and had said that he was ill. He then watched TV from his bed and went to sleep early. His cellmate said that during the night, he heard a noise but thought nothing of it. He recalled that at some point in the morning, Mr Omar had asked for some water and seemed to say that something had happened but his cellmate said he was still half asleep so could not be sure.

The events of 24 March

25. On 24 March at approximately 8.10am, an officer unlocked Mr Omar's cell. He did not open the door or enter the cell, and did not engage with the occupants.

26. In interview, Mr Omar's cellmate said that at some point after the cell was unlocked he noticed some dirt on the floor and looked at Mr Omar to ask about it. He said that Mr Omar was "leant on the side of his bed with his body back but his head forward – his legs were hanging over the side of the bed. His neck/head was hanging forward". He said Mr Omar looked lifeless. He said that a lot of water was coming out of his eyes and nose. At that point he left the cell to get help.

27. An officer was working on Cedar B wing uppers, supervising from the second-floor landing. She said that Mr Omar's cellmate shouted up to her and pointed towards his cell. She walked down and entered the cell. In interview, she said that there was a smell as she entered and she saw faeces on the floor. She observed Mr Omar "lying on the top bunk, head towards the door facing in towards the cell". She said he was unresponsive and had no signs of life.

28. The officer said she then stepped out of the cell and called a code blue emergency on her radio. (A code blue call is an emergency radio code which indicates someone is unconscious or having problems breathing and immediately alerts healthcare staff and the control room to call for an ambulance.) She also

pressed her personal alarm as she felt more officers would be needed to deal with the number of prisoners on the landing. The control room log records that the officer's personal alarm was pressed at 9.41am.

29. The officer then went back into Mr Omar's cell and attempted to get him off the top bunk with the help of another prisoner from the next cell. She quickly realised that it would take more than two of them but by that time more officers had arrived.

30. A First Line Manager (FLM) was the duty manager on Cedar B wing uppers. In interview, she said she heard the officer's personal alarm, but did not hear a code blue call on the radio. The FLM went to where the officer was stationed and saw a crowd outside Mr Omar's cell. The officer informed her that Mr Omar was not breathing. The FLM said she immediately requested healthcare assistance on her radio – at 9.41am according to the control room log - but did not call a code blue. She said that while waiting for healthcare staff, officers lifted Mr Omar down onto the floor of his cell. They put him on a blanket because of the faeces on the floor, and an officer attempted to start cardio-pulmonary resuscitation (CPR). The FLM said that at this point a member of healthcare and another manager arrived.

31. A FLM was the duty manager on Cedar B wing lowers. He said in interview that he heard the officer's personal alarm, but did not hear a code blue call. He went to Mr Omar's cell, and saw that several officers were already there. He said that it was very tight in the cell and CPR could not be performed properly, so he ordered the other prisoners on the landing to be locked in their cells. The control room log records that he requested staff assistance at 9.43am, that the FLM confirmed it was a code blue emergency on the radio at 9.44am and that an emergency ambulance was called at the same time.

32. A nurse recorded in Mr Omar's medical notes that she heard a code blue call at approximately 9.45am, and arrived within a couple of minutes. She told the clinical reviewer that she initially heard an officer request healthcare assistance on a personal alarm, followed by a senior officer requesting urgent healthcare assistance and took the emergency bag with her. She was located nearby, so arrived quickly. The nurse said that when she arrived, Mr Omar was on the floor in the recovery position, he was not breathing and was unresponsive. An officer started CPR at her request. She noted that the cell was tight so, after they had locked up the other prisoners, officers moved Mr Omar onto the landing. The nurse assessed Mr Omar and inserted a tube into his airway to administer oxygen. An officer also fetched a defibrillator. This was attached to Mr Omar but, during the time healthcare staff worked on him, it did not detect the conditions to administer a shock.

33. The senior nurse on duty that day did not respond to the initial radio call because she knew healthcare staff on the wing were attending. Shortly afterwards, she heard a nurse call for extra healthcare staff and responded immediately. On her arrival, she did a series of chest compressions to allow other staff a break, and then organised staff to rotate CPR. She then looked into Mr Omar's cell to see if she could find anything, particularly drug paraphernalia, to indicate what might

have caused his collapse. She said that she found a part pack of ibuprofen, but nothing untoward.

34. The senior nurse evaluated Mr Omar's observations and noted that his blood sugar level was a little low. She sent a colleague to collect the paramedic bag, which contained glucose and other medications which she was qualified to administer. She said that the ambulance crew had arrived by the time she had the bag so she did not administer anything. She added that while CPR was being performed, Mr Omar was "peripherally shutting down… we kept on trying but clinically he didn't look very good".

35. The control room log records that the first ambulance crew arrived on scene at 10.03am and the second ambulance arrived at 10.12am.

36. The ambulance crew took over Mr Omar's care, while staff continued to assist with CPR. They inserted a cannula into Mr Omar so they could administer fluids, including glucose to treat his low blood sugar levels. They then transferred him to New Cross Hospital in Wolverhampton.

37. At 11.02am, Mr Omar was pronounced dead by the hospital.

Contact with Mr Omar's family

38. Mr Omar's next of kin was his wife. At 11.25am on 24 March, the prison appointed a senior manager as his family liaison officer (FLO).

39. At 2.15pm, the FLO and the Muslim chaplain arrived at Mr Omar's marital home. Mr Omar's wife was not there but Mr Omar's sister was. She contacted Mr Omar's wife who returned home shortly afterwards. The FLO informed Mr Omar's wife, sister and other family members of his death, and offered support. Mr Omar's family asked whether the FLO and the chaplain could also speak to Mr Omar's father who lived nearby. They visited him immediately and informed him of his son's death.

40. On Monday 26 March, the FLO spoke to the coroner's office on behalf of Mr Omar's family, to ask when his body could be released. They wanted to have his funeral as soon as possible in accordance with the practices of their Muslim faith. The coroner was unaware of Mr Omar's death at this point, as he had died over the weekend but Mr Omar's post mortem was expedited and his body released a few days later.

41. Mr Omar's wife initially gave her consent for the FLO to liaise with one of Mr Omar's brothers for family contact. She also asked the FLO to liaise with her via Mr Omar's sister, who acted as a translator. In April, Mr Omar's wife decided to have direct liaison with the prison and withdrew her consent for primary liaison to be conducted with Mr Omar's brother. She also requested direct liaison with the prison rather than via her husband's sister. The FLO agreed and had direct liaison with Mr Omar's wife. She held separate liaison with Mr Omar's family.

42. Mr Omar's funeral was held on 29 March 2018. The prison offered to contribute to the cost in line with national guidance but the family declined this and arranged the funeral themselves.

Support for prisoners and staff

43. After Mr Omar's death, a senior manager 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.

44. The prison posted notices informing other prisoners of Mr Omar'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 Omar's death.

Post-mortem report

45. The post-mortem report concluded that Mr Omar's cause of death was myocarditis. This is an inflammation of the heart muscle causing degeneration or death of heart muscle cells. Due to the nature of Mr Omar's death, toxicology was performed but these results came back as clear.

Findings

Clinical care

46. We agree with the clinical reviewer that the clinical care Mr Omar received at Oakwood was equivalent to that which he could have expected to have received in the community. He had no significant health concerns and rarely sought help from healthcare staff during his time at the prison. There was no indication that he had an underlying condition which could or should have been picked up earlier.

Unlock procedure and welfare checks

47. Prison Service Instruction (PSI) 75/2011, *Residential Service*, states that "there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock". Oakwood has its own local instruction which states: "It is important to check on the welfare of prisoners at unlock. Staff must satisfy themselves that the prisoner is well."

48. When the officer unlocked Mr Omar's cell on the morning of 24 March, he did not open his door or look inside the cell to perform a welfare check. We cannot say whether a welfare check on Mr Omar at this stage would have affected the outcome but, if the officer had checked on his welfare as directed, there is every chance that an emergency response would have been triggered sooner.

49. The prison has since informed us that disciplinary action was taken in this case, and we consider that to be appropriate. We have also been told that House Block managers have briefed staff about their responsibilities when unlocking prisoners, and that they have reissued the local instruction on welfare checks. Officers are now additionally required to sign to confirm that they have checked on the welfare of prisoners when they unlock cells, and managers are tasked to perform spot checks to confirm that this has been done.

50. We acknowledge the steps Oakwood have taken and therefore make no recommendation.

Emergency response

51. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two-code medical emergency response system in place. A code blue should be used to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger healthcare staff to attend as a matter of urgency, and the control room to call an ambulance.

52. While we accept that the officer believed she had called a code blue when she first discovered Mr Omar was unresponsive in his cell, this call clearly did not transmit over the radio network at Oakwood.

53. Oakwood told us that metal plates were built into the walls of the prison as a security feature when it was constructed. This has caused significant radio reception issues, which were recognised by HMPPS some years ago. Oakwood

has subsequently installed extra antennae to minimise this issue, but certain radio blind spots remain. Senior management at Oakwood told us that staff are advised about this problem and are instructed to move to areas where radio reception can be achieved.

54. We are satisfied that Oakwood have done all they reasonably can technically to solve the issues with radio reception at the prison. However, we are concerned that the officer who found Mr Omar was not aware that the code blue call did not transmit. She should have realised that it had not transmitted when she did not receive an acknowledgement.

55. We are also concerned that the FLM did not initially radio a code blue call when she arrived, although she knew that no call had been transmitted, and did not do so for another three minutes.

56. We recognise that the officer pressed her personal alarm when she discovered Mr Omar unresponsive and that a nurse and two managers responded immediately. We also recognise that the FLM requested urgent healthcare assistance on the radio when she arrived. However, there was a delay of at least three minutes, and possibly more, before a code blue emergency was triggered. If the emergency code had been called earlier, the emergency ambulance would have been requested earlier and the senior nurse on duty would also have arrived more quickly. The failure to call a code blue sooner is a cause for concern, and falls short of the requirements of the prison instruction.

57. We cannot say whether an earlier call would have changed the outcome for Mr Omar. However, if had a code blue had been called earlier, there is every chance that an emergency response would have been triggered sooner. We therefore make the following recommendations:

The Director should ensure that staff are aware of the need to confirm that emergency radio calls are received and actioned.

The Director should ensure that all staff are reminded of the procedures they must follow in a medical emergency, as set out in Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*.

Contact with Mr Omar's family

58. We are satisfied that the prison conducted its contact with Mr Omar's family appropriately and sympathetically. Mr Omar was recently married and had several close relatives living in the area. The FLO promptly informed Mr Omar's wife in person, and then informed Mr Omar's father and other family members. She respected Mr Omar's wife's wishes, by initially liaising through Mr Omar's sister, and then directly with her. The FLO appropriately liaised separately with Mr Omar's blood relatives.

59. The FLO also liaised with the coroner on behalf of Mr Omar's wife and family to ensure his body was released as quickly as possible to enable his family to hold his funeral. We also recognise the efforts made by the coroner to release Mr Omar's body in such a short time.

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