Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Oxley, a prisoner at HMP Lindholme, on 9 June 2019

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*

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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 Michael Oxley died in hospital on 9 June 2019, while a prisoner at HMP Lindholme. The post-mortem concluded that he died from a brain injury caused by epilepsy. He was 39 years old. I offer my condolences to Mr Oxley's family and friends.

Mr Oxley frequently used illicit drugs in prison and his symptoms were initially attributed to his use of psychoactive substances. When he suggested to a prison GP that he might be having seizures, she immediately referred him to a consultant neurologist. Although I am concerned that Mr Oxley was not referred to the prison's lead epilepsy nurse for advice and help to manage his symptoms, I am satisfied that, overall, he received prompt and supportive treatment and care, which was equivalent to that which he could have expected in the community.

The emergency response when Mr Oxley was found unresponsive and not breathing on 4 June was not well-handled. I am concerned that there were significant delays in requesting an ambulance; providing vital basic information to enable the call handler to prioritise the emergency; and allowing the ambulance to leave the prison promptly.

I am very concerned that after intensive resuscitation procedures in prison which restarted Mr Oxley's heart and breathing, he was restrained during the journey to hospital and for an hour after he was admitted. This was unacceptable and does not reflect well on the prison. The investigation also found unacceptable irregularities in the security risk assessment completed on the night of the emergency and in the general process for obtaining medical input to such assessments.

I am also concerned that, although Mr Oxley's condition was clearly life-threatening, the prison did not immediately inform his family that he was in hospital.

Finally, after the initial incident and Mr Oxley's death a few days later, prison managers did not debrief staff and some felt inadequately supported.

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

Sue McAllister CB
Prisons and Probation Ombudsman **March 2020**

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Summary

Events

1. Mr Michael Oxley was serving an extended sentence of nine years for arson and had been at HMP Lindholme since 17 November 2016. He had a history of substance misuse and mental health problems, but had reported no physical health problems during reception health assessments.

2. Mr Oxley was initially on methadone maintenance and frequently used illicit psychoactive substances in prison. At times, he displayed symptoms of being under the influence of drugs, but insisted that he had not taken anything. In November 2018, Mr Oxley suggested that he might be having seizures and a prison GP referred him to a neurologist. The neurologist requested tests and prescribed medication to control Mr Oxley's seizures. Mr Oxley continued to report frequent seizures, but they were not witnessed as he was in a single cell.

3. At around 6.30pm on 4 June, an officer looked for Mr Oxley, but could not find him. A few minutes later, a prisoner told the same officer that Mr Oxley needed a code blue emergency. Mr Oxley was in another prisoner's cell, unresponsive and not breathing. Officers and nurses performed cardiopulmonary resuscitation and paramedics gave advanced life support. Mr Oxley's heart restarted and he began breathing.

4. Mr Oxley was taken to hospital just after 7.30pm and placed on a ventilator. He did not regain consciousness and died on 9 June. The post-mortem report concluded that Mr Oxley died from a hypoxic brain injury, caused by epilepsy.

Findings

5. The investigation found that Mr Oxley had regular health reviews and, overall, his clinical care was equivalent to that which he could have expected to receive in the community.

6. Mr Oxley was referred to a neurology specialist promptly when he suspected that he might be having seizures. However, he was not referred to the prison's lead epilepsy nurse, so did not benefit from specialist attention and advice within the prison.

7. There was a delay in requesting an ambulance when Mr Oxley was discovered unresponsive and, after calling the Ambulance Service, it took several minutes to provide his personal details and basic information about his condition.

8. Although Mr Oxley was unconscious and in a life-threatening condition, there was a delay in allowing the ambulance to leave the prison and he was restrained for the journey to hospital and for a period after his admission.

9. Irregularities were found in the completion of the medical section of the security risk assessment, as well as the general process for handling such assessments. In particular, the medical portion of the assessment was purportedly written by a clinician, but none of those on duty had been asked to complete it. It also came to light that the Head of Healthcare's electronic signature and the annotation "no

cuffing restrictions" were routinely added to risk assessments, without her knowledge.

10. Prison staff were not debriefed, or offered structured support after the emergency incident, or Mr Oxley's death.

11. Although Mr Oxley was in a critical condition, the prison delayed informing his family until the morning after he had been admitted to hospital.

Recommendations

- The Head of Healthcare should ensure that prisoners diagnosed with, or undergoing investigations for epilepsy are referred to the prison's lead nurse for epilepsy.

- The Governor should ensure that an ambulance is requested immediately after a medical emergency code is called and that essential information about the prisoner's symptoms is promptly given to the Ambulance Service.

- The Governor and Head of Healthcare should ensure that all operational and healthcare staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that escort arrangements are proportionate to risk, notably:
    - Staff who complete and authorise risk assessments should take full account of the prisoner's medical condition in decisions on the continuing use of restraints.
    - The medical assessment must set out the extent to which the prisoner's current state of health and mobility may impact on his ability to escape.
    - The medical assessment must be completed and signed by a clinician.
    - In a life-threatening emergency, prison managers should allow an ambulance to leave the prison urgently, if necessary, without the risk assessment form.
    - Restraints should not be used during serious or invasive treatment, unless there are exceptional reasons for doing so.
- The Governor and Head of Healthcare should investigate the actions of those responsible for completing the security risk assessment for Mr Oxley's journey on 4 June and review the process for completing the medical information on the form.

- The Governor should ensure that, in line with national policy, prison staff, healthcare staff and prisoners are offered appropriate and timely support after a serious incident or a death in custody.

- The Governor should ensure, in line with Prison Rule 22, that prison staff inform the next of kin of seriously ill prisoners immediately of their admission to hospital.

The Investigation Process

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

13. The investigator visited Lindholme on 17 June 2019. She spoke to prison managers, staff and prisoners and viewed CCTV footage. She also obtained copies of relevant extracts from Mr Oxley's prison and medical records.

14. NHS England commissioned an independent clinical reviewer to review Mr Oxley's clinical care at the prison.

15. The investigator held a telephone interview with a member of staff on 24 July. They jointly interviewed six members of staff at Lindholme on 31 July. The investigator conducted further interviews by telephone on 5 and 16 September.

16. Our investigation was suspended between 21 October and 2 December, while waiting for the cause of death.

17. We informed HM Coroner for South Yorkshire (East District) of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Oxley's next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Oxley's next of kin had no specific questions.

19. Mr Oxley's next of kin received a copy of the initial report. He made no comments.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies an accepted our recommendations. The HMPPS action plan has been annexed to this report.

Background Information

HMP Lindholme

21. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1,000 men. Care UK provides healthcare services, with healthcare staff on duty between 7.30am and 7.30pm every day.

22. In August 2018, Lindholme was selected to be part of the “10 Prisons Project”, which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Lindholme was in October 2017. Inspectors noted that the range of primary care services available at the prison was appropriate with nurses promptly assessing prisoners before referring them to a GP for review, if needed.

24. A dedicated lifelong condition nurse, supported by healthcare colleagues, ensured that those prisoners with long-term and complex conditions were identified when they arrived at the prison, and were reviewed regularly. Healthcare staff dealt with a large number of emergencies related to drug intoxication, which had put a significant strain on health resources.

Independent Monitoring Board

25. 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 January 2019, the IMB found that staffing levels within the healthcare department were of concern. They were also concerned that the high level of PS use was a major challenge to the healthcare and substance misuse teams and the security of the prison.

26. The Board reported that a Prison Healthcare Operational Group, comprising the senior prison management team and the healthcare team, had been set up. An IMB monitor attended. They met monthly to conduct a systematic review of staffing, performance, the action plan and risk register.

Previous deaths at HMP Lindholme

27. Mr Oxley was the 13th prisoner to die at Lindholme since June 2017. Two of the previous deaths were from natural causes, four were self-inflicted and six were drug-related. There has since been a further death, but the cause is not yet known. We have previously made recommendations about emergency response procedures; debriefing staff and offering support; and contact with prisoners’ next of kin.

Psychoactive Substances (PS)

28. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

Key Events

Remand to HMP Doncaster

29. On 29 August 2016, Mr Michael Oxley was remanded to HMP Doncaster. He was later convicted of arson and possession of heroin. On 10 November 2016, Mr Oxley was given an extended sentence of nine years, with a custodial term of five years and an extension period of four years on licence.

30. At an initial health screen, a nurse noted that Mr Oxley had a history of substance misuse and had been prescribed methadone in the community. He also had a history of anxiety, depression and other mental health problems, but declined a referral for a mental health assessment. The next day, he was seen by the substance misuse team and a clinical management plan was agreed. A prison GP placed him on methadone maintenance therapy and continued his prescription for pregabalin, for generalised anxiety. During his time at Doncaster, Mr Oxley self-referred to the substance misuse service and attended several courses. Due to the nature of his offence, he was allocated to a single cell.

Transfer to HMP Lindholme

31. On 17 November 2016, Mr Oxley was transferred to HMP Lindholme. A nurse carried out physical and mental health assessments and referred Mr Oxley to the substance misuse clinic. Mr Oxley reported no physical health problems. Over the next few weeks, he had further mental health and substance misuse assessments. He decided that he wanted to remain on methadone and did not want to reduce the dosage.

32. From April 2017, Mr Oxley was frequently found under the influence of psychoactive substances (PS), often being treated as a medical emergency. He was said to use it daily, with short periods of abstinence. In November 2017, the substance misuse team placed Mr Oxley on weekly support with a mental health nurse, for crisis and anxiety management and motivation to help him to stop using PS. He engaged with the substance misuse team and was allocated a keyworker, who was a senior nurse, but he continued to use PS.

33. Mr Oxley was usually open about his drug use when challenged. However, from June 2018, there were occasions when he adamantly denied it. Security intelligence reports suggested that he was dealing and selling prescription medication.

34. On 15 November 2018, Mr Oxley had an appointment with a prison GP. Mr Oxley said that staff had called code blue medical emergencies when he had not taken PS and a recent urine test had only been positive for methadone (which he had been prescribed). (A code blue is a medical emergency indicating that a prisoner is unconscious, or has breathing difficulties.) He thought his symptoms might be due to seizures, but no one had witnessed them as he was in a single cell. The prison GP referred Mr Oxley to a neurologist.

35. Mr Oxley completed detoxification of methadone in January 2019. On 24 January, a prison GP noted that Mr Oxley had to be weaned off pregabalin for safety reasons, due to the risk of accidental death. Recently issued guidance on

safer prescribing in custody had advised that patients with a history of substance misuse should not take it. (Pregabalin is also highly tradable within prisons and often misused.) Alternative medication was prescribed, but Mr Oxley was dissatisfied with this.

36. On 1 February, Mr Oxley slashed his throat in a serious attempt to kill himself and spent three days in hospital. He had little recollection of the incident, but said he did it because his medication had been stopped. Prison staff managed him under the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm (known as ACCT) until 5 March.

37. On 15 February, a wing officer told a substance misuse worker, that Mr Oxley's medication appeared to be too strong, as she had to kick his bed and make a concerted effort to rouse him at times. A nurse confirmed that Mr Oxley was not on any medication that would have that effect.

38. Mr Oxley was suspected to be under the influence of PS on 23 February, but he later denied he had taken anything. On 5 March, he told staff that a mandatory drug test (MDT) taken on 28 February would prove that he had not been misusing drugs recently. Later that day, the MDT result was recorded as negative. (A further test on 11 April was also negative.)

39. On 15 April, Mr Oxley saw a consultant neurologist, at a hospital. She prescribed lamotrigine (a medication to treat epilepsy) to try to control Mr Oxley's seizures and she requested a brain scan. (Mr Oxley began the medication the next day but, due to side effects, it was replaced by carbamazepine on 3 May.) Mr Oxley was also given a form to be completed by any witnesses to his seizures, or by healthcare staff post-seizure.

40. A prison nurse spoke to Mr Oxley after his hospital appointment. Mr Oxley said that he no longer took drugs and was concerned about the number of code blue emergency calls following seizures, as he thought it might affect his eligibility for parole. A few days later, Mr Oxley told a substance misuse worker that he had been diagnosed with epilepsy and had no recollection of his seizures when he recovered.

41. On 30 April, Mr Oxley had appointments with a psychiatrist and a prison GP. He reported continuing seizures, but admitted to the psychiatrist, that he had used PS. The doctors discussed with each other the neurologist's recommendation to prescribe carbamazepine (for epilepsy) and Mr Oxley's wish to restart pregabalin. The prison GP concluded that Mr Oxley's episodes were both seizures and illicit drug use, so it was not appropriate to re-prescribe pregabalin.

42. In May, Mr Oxley was reported to have taken PS several times. On 17 May, he had a brain MRI scan (which revealed no abnormalities). The hospital arranged an electroencephalogram (EEG – a test of brain activity) for 6 June.

43. On 22 May, Mr Oxley told a nurse that the medication was not helping with his seizures and he was keeping a diary. After an appointment on 28 May, a locum prison GP noted that Mr Oxley was having seizures three or four times a week. On 30 May, it was noted that an MDT was negative.

Emergency response on 4 June

44. At around 6.30pm on 4 June, during the prisoners' association time, an officer went to speak to Mr Oxley. She looked around the yard and landing and then looked into a prisoner's cell, 1-04, where Mr Oxley usually socialised with friends. Three prisoners were in the cell and said they had not seen him. CCTV shows that at 6.36pm, another prisoner ran into the wing office. He told the officer that a code blue was needed for Mr Oxley. The officer immediately went back to cell 1-04 and saw Mr Oxley on one of the beds. He was not breathing and his eyes were wide open.

45. The officer called a code blue emergency. Two other officers arrived at 6.37pm. Prisoners helped the officers to lift Mr Oxley from the bed to the floor. An officer could not find a pulse and saw that Mr Oxley's lips, tongue and gums were blue. He and an officer initially tried to put Mr Oxley into the recovery position, but quickly realised that it was more serious and began cardiopulmonary resuscitation (CPR). The communications room asked for an update and an officer said that an emergency ambulance was required.

46. Two nurses arrived at 6.40pm and continued CPR, in rotation with the officer. They attached a defibrillator, which gave one shock. A nurse gave an injection of naloxone (a medication to block the effect of opioids) but this had no effect.

47. A first responder arrived at 6.58pm and an ambulance at 7.04pm. The paramedics gave advanced life support. Mr Oxley's heartbeat restarted and he began to breathe but did not regain consciousness. At 7.34pm, the paramedics took Mr Oxley to hospital, where he was admitted to the critical care unit. Mr Oxley was escorted by two prison officers using restraints, which were removed in the hospital's resuscitation unit at 8.50pm.

48. Prison healthcare staff contacted the hospital every day and a nurse visited. Mr Oxley remained on a ventilator, in an induced coma. On 9 June, the hospital switched off the ventilator and Mr Oxley died a few minutes later.

Additional information given to staff after the incident

49. Just after the emergency response, a prisoner told an officer that Mr Oxley had taken PS. The next day, a prisoner admitted to the officer that Mr Oxley had been in the cell when she had first looked in, but they had hidden him as he was heavily under the influence of PS and they did not want him to be reported and disciplined. A prisoner said he had been concerned about Mr Oxley during association, as he was sticky and grey, with a very faint heartbeat and no breaths. He was then pushed out of the cell and he went to alert officers. Another prisoner said that Mr Oxley had been dealing PS for around two weeks, he had previously bought some from him and Mr Oxley had received a batch that day.

Contact with Mr Oxley's family

50. At 10.40am on 5 June, an officer was appointed as the prison's family liaison officer (FLO). Just after 11.00am, he informed Mr Oxley's next of kin that Mr Oxley was in hospital. At midday, he spoke to Mr Oxley's next of kin and gave her the visiting times for the hospital. At 4.00pm, the FLO met the family at the hospital and gave them information. In the following days, he made further calls

to provide information and updates. Several family members and friends visited Mr Oxley in hospital.

51. At 1.45pm on 9 June, the escort officers informed the prison of Mr Oxley's death. The FLO arrived at the hospital at 2.10pm, but Mr Oxley's family had already left. He telephoned Mr Oxley's next of kin shortly afterwards to offer condolences and support. The FLO kept in touch with him and gave further support by liaising with the Coroner's office and funeral directors.

52. Mr Oxley's funeral was held on 27 June and the FLO represented the prison. In line with national policy, the prison contributed to the funeral expenses.

Support for prisoners and staff

53. No formal debrief was held after the emergency on 4 June, but a custodial manager, commended the staff and asked if they were all right. An officer was particularly affected and spoke, at length, to a prison manager.

54. After Mr Oxley's death, the prison manager telephoned the escort officers at the hospital. They were based at other prisons and did not want to attend Lindholme for a formal debrief. He reminded them of the support services available, including the care teams, employee support services and Trauma Risk Management (TRIM) practitioners.

55. A Custodial Manager (CM) telephoned an officer at home to inform her of Mr Oxley's death. The prison noted that the staff care team was asked to speak to the staff involved in the original emergency.

Post-mortem report

56. The post-mortem report concluded that the cause of Mr Oxley's death was a hypoxic brain injury (lack of oxygen to the brain) caused by epilepsy. The pathologist noted:

> "The history provided and the realities of the case point to hypoxic brain injury in relation to his background epilepsy. The levels of anti-epileptic drugs are less than the therapeutic ranges in life, although post-mortem realities may be applicable in this case. There is no evidence of toxicity of these drugs or indeed any other drugs of abuse."

57. The toxicology report noted there was no evidence of PS in Mr Oxley's system at the time of death (although we note that he died five days after he collapsed).

Findings

Clinical care

58. Mr Oxley received thorough, responsive and timely healthcare and substance misuse support throughout his time at Lindholme. On reception, prison healthcare staff had completed the required health assessments. They subsequently carried out regular mental health and medication reviews and the substance misuse team provided consistent support. Mr Oxley developed good and trusting relationships with healthcare staff. When he reported to a GP that he thought that some of his episodes might be due to seizures rather than the effects of drugs, he was promptly referred to a neurologist.

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

Investigation of Mr Oxley's epilepsy

60. Mr Oxley was under the care of a consultant neurologist, who was investigating his symptoms and had prescribed medication to help reduce his epileptic fits. He had attended hospital for a brain scan, which had shown no abnormalities and he was due to have another investigative test two days after his death.

61. The investigation found that although the prison had a lead nurse for epilepsy, Mr Oxley had not been referred to her. He did not, therefore, have the opportunity to access advice or have his care coordinated by a specialist within the prison. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners diagnosed with or undergoing investigations for epilepsy are referred to the prison's lead nurse for epilepsy.

62. The clinical reviewer identified a problem with the suction machine which the Head of Healthcare will wish to resolve.

Emergency response

63. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, and Lindholme's Notice to Staff 40/2018, *Medical Emergency Response Code Protocol*, set out the actions staff should take in a medical emergency. They contain mandatory instructions on efficiently communicating the nature of a medical emergency and stipulate that if an emergency code is called over the radio, an ambulance must be called immediately.

64. The communications room log noted that the code blue emergency was called at 6.42pm. However, the Ambulance Service records indicate that the request for an ambulance was received at 6.45pm. CCTV footage shows an officer going into the cell at 6.36pm, so it is possible that the code was actually called sooner than 6.42pm. At best, the ambulance was called three minutes after the code blue and at worst, nine minutes.

65. From the audio recording of the telephone call, there was clearly an additional significant delay in providing enough substantive information for the Ambulance

Service to prioritise the call and despatch paramedics. While speaking to the call handler, it was several minutes before the officer in the communications room could say whether Mr Oxley was breathing and around seven minutes before he provided personal details, such as his name and age. The prison rang the Ambulance Service again at 6.56pm to give additional details about Mr Oxley's condition.

66. We are concerned that the cumulative delays in calling an ambulance and providing key information prevented Mr Oxley from receiving prompt specialist treatment. We make the following recommendation:

The Governor should ensure that an ambulance is requested immediately after a medical emergency code is called and that essential information about the prisoner's symptoms is promptly given to the Ambulance Service.

Security risk assessment and the use of restraints

67. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. 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.

68. A judgment in the High Court in 2007 (the *Graham* judgement) 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.

69. Mr Oxley was a category C prisoner. The escort risk assessment for his journey to hospital, completed by a CM, noted that he was a high risk to the public due to his index offence and a low risk on all other factors, including risk of escape. Additionally, there was no history of escape, or violence and no warnings from the police. A prison manager authorised the risk assessment and concluded that Mr Oxley should be restrained with single handcuffs. The Person Escort Record noted that staff used an escort chain (a long chain with a handcuff at each end, one attached to the prisoner and the other to an officer).

70. Although Mr Oxley was unconscious when he left the prison and did not regain consciousness before his death, he was restrained on the way to hospital and for around an hour after his admission to the resuscitation and critical care units. The Head of Security told the investigator that she had spoken to the custodial manager responsible for completing the risk assessment and the rationale for the assessment was that Mr Oxley was breathing and alive. She said, at that time, the prison's risk assessment form contained no prompts specifically on the *Graham* judgment, but this had since been changed.

71. The Head of Healthcare said that nurses did not necessarily know about the *Graham* judgment and were not always aware of the implications of different handcuffs. She had recently shared information with the nurses about the

different types of handcuffs, where they are applied and how they might impact on a prisoner.

72. Restraining a comatose man, whose heart had been restarted minutes before, shows a poor attitude to dignity and decency and we are not satisfied that staff at Lindholme understand the rationale for completing risk assessments before deciding to restrain prisoners going to hospital. In particular, risk should not be assessed solely on a prisoner's index offence, but should take account of the prisoner's current state of health and mobility.

Delay in completing the security risk assessment

73. An officer expressed several concerns after the emergency, including his view that there had been an excessive delay in allowing the ambulance to leave the prison due to the completion of the security risk assessment. He said that the paramedics had asked to leave three times and were extremely frustrated while waiting. He felt that, as the situation was time critical and it was imperative to get Mr Oxley to hospital, a member of staff could have delivered the assessment once it had been authorised.

74. The Head of Security said that in the event of a life-threatening situation, managers can exercise discretion to send the prisoner to hospital without the risk assessment form, which could be sent afterwards.

Irregularities in the risk assessment

75. The investigation found irregularities in Mr Oxley's risk assessment. The medical section of the form indicated that there was no objection to the use of restraints and various other boxes in the medical section had been ticked, but there was no signature on that part of the form. Although the medical section of the form appeared to have been completed by a nurse, those on duty that evening said they had not seen it and would not have endorsed normal cuffing in those circumstances.

76. We also found that the Head of Healthcare's electronic signature had been routinely printed on security risk assessments and they were consistently annotated "no cuffing restrictions" without her knowledge or input. She was understandably concerned about this.

77. We are very concerned about the decision-making on Mr Oxley's risk assessment. This is one of the worst risk assessments we have seen and we do not consider that the use of restraints was justified. We are also very concerned about the poor practices and irregularities discovered during the investigation. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all operational and healthcare staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that escort arrangements are proportionate to risk, notably:

- **Staff who complete and authorise risk assessments should take full account of the prisoner's medical condition in decisions on the continuing use of restraints.**

- **The medical assessment must set out the extent to which the prisoner's current state of health and mobility may impact on his ability to escape.**
- **The medical assessment must be completed and signed by a clinician.**
- **In a life-threatening emergency, prison managers should allow an ambulance to leave the prison urgently, if necessary, without the risk assessment form.**
- **Restraints should not be used during serious or invasive treatment, unless there are exceptional reasons for doing so.**

The Governor and Head of Healthcare should investigate the actions of those responsible for completing the security risk assessment for Mr Oxley's journey on 4 June and review the process for completing the medical information on the form.

Support for staff and prisoners

78. PSI 64/2011, *Safer Custody*, requires prisons to hold a 'hot debrief' after all deaths in custody. This should be led by a senior manager and all staff directly involved in the incident, including healthcare staff, should be invited. The instruction also sets out the expectation that prisoners should be offered support.

79. No debrief was held after the emergency. Staff continued their shifts, some working beyond the normal hours expected due to the emergency. A custodial manager asked the operational staff if they were all right and commended them on their actions. Healthcare staff went back to the healthcare centre and immediately documented the incident.

80. A custodial manager telephoned an officer at home to inform her that Mr Oxley had died. She said no formal support was offered at any time.

81. A prisoner whose cell Mr Oxley collapsed in, said that he learned of Mr Oxley's death in the prison yard and was not told personally. He added that he had asked for support, but had not received it and it was probably too late.

82. We acknowledge that the escort officers at the hospital were debriefed and offered support. However, we are concerned that staff involved in the emergency response and key prisoners were not offered structured support. We were unable to verify that the staff care team was asked to contact staff after Mr Oxley's death. We make the following recommendation:

    The Governor should ensure that, in line with national policy, prison staff, healthcare staff and prisoners are offered appropriate and timely support after a serious incident or a death in custody.

Contact with Mr Oxley's family

83. Prison Rule 22 instructs that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. Mr Oxley was taken to hospital just after 7.30pm on 4 June, immediately admitted to the critical care unit and placed on a

ventilator. The prison assigned an officer as family liaison officer the following morning and he informed Mr Oxley's family of his condition.

84. Given the gravity of Mr Oxley's condition, there must have been doubt as to whether, or for how long he would survive. We consider that Mr Oxley's family should have been told sooner that he had been admitted to hospital. We make the following recommendation:

    The Governor should ensure, in line with Prison Rule 22, that prison staff inform the next of kin of seriously ill prisoners immediately of their admission to hospital.

85. We are satisfied that after Mr Oxley's death, his family was well supported by the FLO.

Substance misuse

86. One of Mr Oxley's close friends told the investigator that Mr Oxley had stopped taking drugs for a long time, but had decided to have a "day out" (that is, get 'high' on drugs) on 4 June. He said that Mr Oxley had taken drugs throughout the day and had received a supply of PS "from the yard". He named the drugs taken as Subutex, gabapentin, pregabalin, "DFs - little blue tablets" and lots of PS. Several other prisoners also said that Mr Oxley had used drugs on the day of the emergency. However, the post-mortem examination and toxicology tests detected no drugs of abuse in his system at the time of his death.

87. The information gathered during the investigation about Mr Oxley's drug taking on 4 June appeared credible. We note that Mr Oxley died five days after he collapsed, which may explain why no drugs were detected in his system at the time of his death.

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