

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martin Mousah, a prisoner at HMP Leyhill, on 27 March 2022

A report by the Prisons and Probation Ombudsman



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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Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Martin Mousah died from bleeding from the intestine caused by acute myeloid leukaemia (aggressive cancer of the white blood cells) on 27 March 2022 at HMP Leyhill. He was 65 years old. I offer my condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Mousah received at HMP Bristol and Leyhill was equivalent to that which he could have expected to receive in the community. The clinical reviewer has made a recommendation which does not directly related to Mr Mousah's death, but which the Head of Healthcare at Bristol will need to address.
5. We found that Mr Mousah was inappropriately restrained when he went to hospital with deteriorating health from Bristol on 20 January and 21 January. After Mr Mousah died prison staff did not hold a hot debrief.

Recommendations

- The Governor and Head of Healthcare at HMP Bristol should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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 at HMP Leyhill should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody and that all those involved in the incident, including healthcare staff, are invited to attend.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Mousah's clinical care at Bristol and Leyhill.
7. The PPO investigator has investigated the non-clinical issues, including Mr Mousah's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The Ombudsman's family liaison officer wrote to Mr Mousah's sister to explain our investigation. She did not respond.
9. We shared the initial report with the Prison Service. There was one factual inaccuracy, and this report has been amended accordingly.

Previous deaths at HMP Leyhill

10. In the two years before Mr Mousah's death, five prisoners died from natural causes at Leyhill. There has been one death from natural causes at Leyhill since Mr Mousah's death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

11. On 1 November 2021, Mr Martin Mousah was remanded to HMP Bristol.
12. At the time of his imprisonment, Mr Mousah was diagnosed with neutropenia (low white blood count which causes a weakened immune system) and myelodysplasia (a rare type of blood cancer) which had progressed to acute myeloid leukaemia (an aggressive cancer of the white blood cells, diagnosed in September 2020). He was also diagnosed with Type 2 diabetes, Hepatitis B, chronic kidney disease, schizophrenia (a severe, long-term mental health condition), an antisocial personality disorder, cerebellar ataxia (a condition that affects coordination, balance and speech) and drug and alcohol dependency.
13. On 2 November, a prison GP contacted staff at the Bristol Haematology and Oncology Centre to discuss Mr Mousah's diagnosis of acute myeloid leukaemia and to establish a joint plan regarding the treatment that prison healthcare staff could carry out.
14. On 4 November, Mr Mousah moved to the Brunel Unit (for prisoners with complex mental health and physical needs) and a cell which had been deep cleaned because of the risk to him if he contracted an infection.
15. On 9 November, Mr Mousah went to hospital for a bone marrow biopsy.
16. On 13 January 2022, Mr Mousah was convicted of assault, breach of suspended sentence order and possession of a controlled drug and was sentenced to 20 months in prison.
17. On 17 January, hospital staff told Mr Mousah that the bone marrow biopsy suggested that he had relapsed acute myeloid leukaemia (some patients reach remission and then have a return of leukaemia cells in the bone marrow and a decrease in normal blood cells).
18. On 20 January, Mr Mousah saw a consultant haematologist to discuss his treatment options. Mr Mousah decided to have a course of palliative cytarabine (for acute myeloid leukaemia).
19. Before Mr Mousah went to hospital, prison staff completed an escort risk assessment. A nurse completed the medical section of the risk assessment and did not object to the use of restraints. A Custodial Manager (CM) completed Mr Mousah's security assessment and noted that he posed a low risk to the public, a low risk of escape, a medium risk to a known adult and a medium risk to females as he had previously assaulted his girlfriend. He noted that Mr Mousah should be escorted by two officers and should be double cuffed with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). The Head of Security authorised that as Mr Mousah was an unsentenced prisoner, he should be restrained with a double cuff. (As noted, Mr Mousah had been sentenced a week earlier.) We do not know if Mr Mousah was restrained when he went to hospital, but the escort risk assessment indicates that he was.

20. On 21 January, after Mr Mousah became unwell, healthcare staff sent him back to hospital because oncology staff at the hospital thought that he had febrile neutropenia or neutropenic sepsis (a fever or a serious infection linked to a low white blood count).
21. Before Mr Mousah went to hospital, prison staff again completed an escort risk assessment. A nurse completed the medical section of the risk assessment and did not object to the use of restraints. A CM completed Mr Mousah's security assessment and noted that he posed a low risk to the public, a low risk of escape, a medium risk to a known adult and a medium risk to females as he had previously assaulted his girlfriend. The CM recommended that Mr Mousah be escorted by two officers and restrained by a single cuff. The Head of Security recorded that Mr Mousah was an unsentenced prisoner, but that due to ill health a single cuff was appropriate. When he went to hospital, Mr Mousah was restrained by a single handcuff.
22. On 1 February, while Mr Mousah was in hospital, prison staff completed an escort risk assessment. The Head of Security noted that Mr Mousah had COVID-19, was undergoing chemotherapy, was very frail and barely mobile. She noted that Mr Mousah did not represent an escape risk and should not be restrained. The handcuffs were therefore removed.
23. On 9 February, Mr Mousah went back to Bristol.
24. The following day a prison GP sent Mr Mousah back to hospital because he was concerned with an abscess that Mr Mousah had in his left arm. We requested escort risk assessment and bedwatch logs for this inpatient stay in hospital, but these were not provided. (Staff at Bristol told us that the records were transferred to HMP Leyhill. Staff at Leyhill said that they did not receive the records.) We do not therefore know whether restraints were used.
25. On 15 March, Mr Mousah left hospital and was sent to HMP Leyhill, where he lived in the palliative care unit.
26. On 26 March, Mr Mousah died at Leyhill. His family was with him.

Support for prisoners and staff

27. Leyhill did not hold a hot debrief after Mr Mousah's death, and staff were not given the opportunity to discuss the incident or discuss any issues arising, or for managers to offer support.

Post-mortem report

28. There was no post-mortem examination. A prison GP recorded that Mr Mousah died from an upper gastrointestinal bleed (the organs that food and liquids travel through when they are swallowed) as a result of acute myeloid leukaemia.

Non-Clinical Findings

Use of restraints

29. 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 a prisoner's health and mobility.
30. A judgement in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit, including the risk to the public in the event of an escape, and the prisoner's risk when he has 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. The judgement found that using handcuffs or other restraints on terminally ill or seriously ill prisoners was inhumane, unless justified by security considerations.
31. We are concerned that when Mr Mousah went to hospital as an outpatient on 20 January, and inpatient on 21 January, he was restrained. On 20 January, the Head of Security incorrectly noted that Mr Mousah was an unsentenced prisoner so should be double cuffed. (Mr Mousah was convicted and sentenced the week before this escort.) The following day she again noted that Mr Mousah was an unsentenced prisoner, but that due to ill health a single cuff was appropriate.
32. HM Prison and Probation Service (HMPPS) PSI 33/2015, Prevention of Escape - External Escorts, provides establishments with the information and guidance needed to maintain high levels of security, seek to prevent escape or abscond, and maintain a secure and stable environment for all. The policy states that remand prisoners will be assessed on a case-by-case basis to determine the appropriate level of restraint. The Head of Security appears to have based her judgement on the fact that Mr Mousah was an unsentenced prisoner, which was not correct. At the same time, Mr Mousah's health was failing, and we are also concerned that healthcare staff did not object to the use of restraints even though they would have been aware that he had leukaemia and that his health was deteriorating. It was not until 1 February, when Mr Mousah had been an inpatient for over a week, that she authorised that Mr Mousah should not be restrained. We see no justification for the use of a restraint for the escorts of 20 and 21 January, and it is disappointing that judgements were made based on incorrect information and without proper consideration of Mr Mousah's health at the time. We make the following recommendation:

The Governor and Head of Healthcare at HMP Bristol should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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.

Staff support

33. PSI 64/2011 sets out the actions that should be taken following a death in custody. This includes holding a hot debrief immediately after a death in custody and inviting all staff directly involved in the incident, including healthcare staff, to attend.
34. No debrief took place. We are concerned that the staff involved were given no opportunity to discuss any concerns that arose and were not offered support services. We make the following recommendation:

The Governor at HMP Leyhill should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody and that all those involved in the incident, including healthcare staff, are invited to attend.

Inquest

35. The inquest, heard on 7 February 2023, concluded that Mr Mousah died from natural causes.

Mark Judd
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November 2022

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