

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

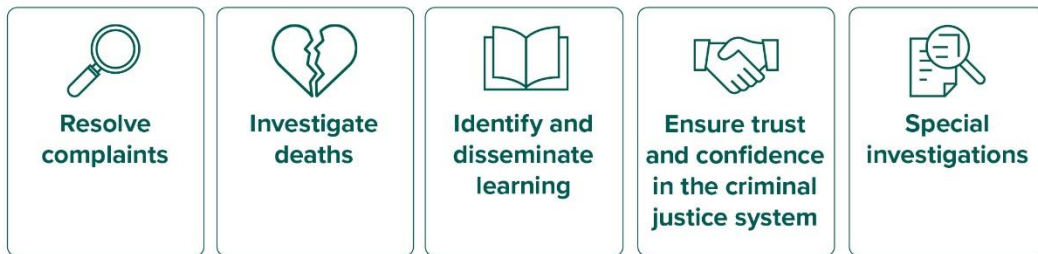
# **Independent investigation into the death of Mr Michael Copley, a prisoner at HMP Altcourse, on 14 March 2023**

**A report by the Prisons and Probation Ombudsman**

## OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

## WHAT WE DO



## WHAT WE VALUE



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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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. Mr Michael Copley died in hospital on 14 March 2023 of multi organ failure while a prisoner at HMP Altcourse. He was 48 years old. We offer our condolences to Mr Copley's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Copley received at Altcourse was partially equivalent to what he could have expected to receive in the community. She made recommendations about adherence to NICE guidelines (evidence based health and care recommendations), checking clinical observations and escalating mental capacity concerns, which are not repeated in this report, but which the Head of Healthcare will wish to address.
5. There were no non-clinical issues of concern.

## The Investigation Process

6. HMPPS notified us of Mr Copley's death on 14 March 2023.
7. NHS England commissioned an independent clinical reviewer to review Mr Copley's clinical care at Altcourse.
8. The PPO investigator investigated the non-clinical issues relating to Mr Copley's care.
9. The PPO family liaison officer wrote to Mr Copley's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not have any questions but asked for a copy of this report.
10. Mr Copley's family received a copy of the initial report. They did not make any comments.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Previous deaths at HMP Altcourse

12. Mr Copley was the fifteenth prisoner to die at Altcourse since March 2021. Of the previous deaths, eight were from natural causes, five were self-inflicted and one was drug related. There are no similarities between our findings in the investigation into Mr Copley's death and our investigation findings for the previous deaths.

## Key Events

13. On 15 February 2023, Mr Michael Copley was remanded to HMP Altcourse charged with sexual offences. This was not his first time in prison. He was scheduled to attend court on 15 March to face further charges.
14. Mr Copley had a medical history of alcoholic liver disease, anxiety, depression, hiatus hernia, gastro-oesophageal reflux disease and hepatic encephalopathy (changes in the brain that occur in patients with advanced, acute (sudden) or chronic (long-term) liver disease).
15. On arrival at Altcourse, a nurse completed Mr Copley's first reception screen. Mr Copley said that he did not have any alcohol, drug or mental health issues. The nurse did not complete any clinical observations or a urine drug screen. She noted that Mr Copley had long COVID. (There is no record of any assessments or diagnosis of this.) Healthcare staff did not complete a secondary health screen as they should have done.
16. On 18 February, Mr Copley had a seizure in his cell. He was confused and drowsy, with extremely high blood pressure and high heart rate. It was only at this point that he told staff that he was an alcoholic. Healthcare staff sent him to hospital, and he was admitted as an inpatient. Two officers escorted him, and he was handcuffed using 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) for the journey. The records noted Mr Copley was compliant and there were no issues.
17. In hospital on 19 February, escorting prison staff noted that Mr Copley was agitated by the handcuff on his wrist, and he kept fiddling with it. Staff noted that he had tried to remove the cuff. The officers contacted the prison duty manager for a review of the handcuffing arrangement. The prison duty manager authorised the use of double handcuffs (when the prisoner's hands are handcuffed in front of them, and one wrist is attached to a prison officer by an additional set of handcuffs). Mr Copley then tried to escape from the officers. He jumped out of the hospital bed and attempted to run down the corridor. The officers and hospital security staff had to restrain him. After repeated attempts to bite off his handcuffs and kicking out at the escorting prison staff, hospital doctors sedated Mr Copley. Mr Copley suffered several seizures throughout the day. Escorting staff noted he continued to be aggressive, violent and unpredictable. The prison escort staff level was increased to three officers.
18. On 22 February, the officers with Mr Copley rang the prison to discuss whether the handcuffs on Mr Copley's bruised wrist could be removed. It was agreed that a medical report was needed to justify removing the handcuffs. At this time, Mr Copley was compliant with no concerns or issues. Hospital staff highlighted concerns about a wound on his right wrist due to wearing tight handcuffs. Hospital staff took pictures of the bruising and arranged for a tissue viability nurse to examine him. Prison managers authorised the use of handcuffs over Mr Copley's bandaged wrists, then permission was given to use the handcuff on one wrist only.
19. At a meeting on 24 February, and after two security managers and a nurse from the prison visited Mr Copley in hospital, managers authorised the handcuffs to be

removed, as the nurse noted that there was significant infection around both Mr Copley's wrists, which the hospital nurses said had been a direct result of being handcuffed. Prison managers authorised plastic handcuffs to be used for Mr Copley's return journey to prison.

20. That day, Mr Copley returned to Altcourse and was admitted to the prison's inpatients unit. The hospital discharge summary noted that hospital staff had treated Mr Copley for hepatic encephalopathy, cellulitis on his right wrist (an infection of the deeper layers of skin and underlying tissue) and anaemia. Nurses at the prison noted that Mr Copley had settled and there were no concerns.
21. On 26 and 27 February, nurses at Altcourse noted that Mr Copley was confused and disorientated. None of the nurses completed any clinical observations because Mr Copley initially refused. A GP at the prison conducted an inpatient review and noted that staff should continue with frequent observations, which they did.
22. At approximately 5.00am on 28 February, a nurse at the prison noted that Mr Copley had another unsettled night and refused to engage with staff. The nurse did not escalate this to clinical staff. Later that morning, another nurse noted that Mr Copley was unkempt, confused but alert and was still refusing to have any clinical observations checked. Mr Copley complained of abdominal pain. After consulting with a GP at the prison, the nurse arranged for an ambulance to take Mr Copley to hospital for an assessment. The healthcare section of the escort risk assessment noted that there were medical objections to the use of restraints and that removal of restraints would be needed for treatment/consultation. The prison manager authorised two officers to escort Mr Copley, and he was handcuffed (using plastic handcuffs). On admission to hospital the escort officers removed the handcuffs, and they were never reapplied.
23. Doctors at the hospital placed Mr Copley in an induced coma and on a ventilator as his agitation was unmanageable and they conducted further tests. Mr Copley's mother visited him in hospital.
24. Mr Copley's condition continued to deteriorate in hospital, and he died there on 14 March 2023.

## **Inquest**

25. The inquest was held on 22 March 2023. The Coroner concluded that Mr Copley died from natural causes. Mr Copley died of multi organ failure, caused by pneumonia, decompensated alcoholic liver disease and spontaneous bacterial peritonitis (a bacterial infection linked to cirrhosis).

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**January 2024**

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