Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Austin, a prisoner at HMP Long Lartin, on 1 December 2024

A report by the Prisons and Probation Ombudsman

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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

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 David Austin died from a thrombotic stroke (a blood clot in the brain) on 1 December 2024, while a prisoner at HMP Long Lartin. He was 58 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Austin received at Long Lartin was equivalent to that which he could have expected to receive in the community. She made a recommendation about the management of Mr Austin's compliance with his medication which the Head of Healthcare said they had addressed after Mr Austin's death.

5. We found that Mr Austin was inappropriately restrained when he was escorted to hospital on 23 November. While escort staff complied with the escort risk assessment, Mr Austin's medical condition and mobility severely deteriorated from the time it was completed to when the restraints were applied.

Recommendations

The Governor should ensure that:

- **if a prisoner's condition and mobility deteriorate so that restraints are no longer appropriate in line with the Graham judgment, escort staff should ask for restraints to be removed; and**

- **staff use the appropriate escort risk assessment template, as outlined in Annex H of the Prevention of Escape – External Escorts Policy Framework.**

The Investigation Process

6. HMPPS notified us of Mr Austin's death on 1 December 2024.

7. NHS England commissioned an independent clinical reviewer, to review Mr Austin's clinical care at Long Lartin.

8. The PPO investigator investigated the non-clinical issues relating to Mr Austin's care. She interviewed four members of staff from Long Lartin between 25 January and 11 February 2025.

9. The Ombudsman's office wrote to Mr Austin's next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at HMP Long Lartin

11. Mr Austin was the ninth prisoner to die at Long Lartin since 1 December 2021. Of the previous deaths, four were from natural causes, three were self-inflicted and one was drug related. There are no similarities between the findings in our investigation into Mr Austin's death and the findings from our investigations into the previous deaths.

Key Events

12. On 8 January 2007, Mr David Austin was remanded to HMP Pentonville, charged with murder. He later received a life sentence.

13. On 19 May 2010, Mr Austin was transferred to HMP Long Lartin.

14. On 25 July, a paramedic, saw Mr Austin as he was short of breath. His medical records indicated that there were 'no red flags at present' and she referred him to the prison GP.

15. On 2 August, a GP operating at Long Lartin, reviewed Mr Austin. He reported that he was short of breath when walking but had no chest pains.

16. On 6 August, Mr Austin attended hospital for a CT scan of the thorax, abdomen and pelvis which showed evidence of multiple thromboses (which occur when blood clots block the blood vessels). He was referred to the accident and emergency department (A&E) for a respiratory review but discharged himself from the hospital before this took place. He was deemed to have the mental capacity to make this decision.

17. On 9 August, a GP reviewed Mr Austin and gave him anti-coagulant medication (to help prevent blood clots) which the hospital had prescribed.

18. On 19 August, a nurse reviewed Mr Austin as he was short of breath. Paramedics were called and advised that Mr Austin should attend hospital. He was sent to A&E. An officer contacted Mr Austin's wife to tell her that he was in hospital. While in hospital, Mr Austin was referred to the cardiology department for potential heart failure.

19. On 25 August, when Mr Austin returned to Long Lartin from hospital, a nurse reviewed him. However, he declined physical observations and said he wanted to return to the wing. He had been diagnosed with stage three chronic kidney disease while in hospital and the nurse arranged for him to be monitored frequently.

20. On 24 October, a nurse saw Mr Austin at the medication hatch, and he reported shortness of breath. She advised him to consider further assessment at hospital but he declined and said he would not go to hospital. Mr Austin was deemed to have the mental capacity to make this decision.

21. On 25 October, a nurse saw Mr Austin who reported that he felt better. He declined observations and further support and confirmed he knew how to contact the healthcare team if he felt unwell.

22. On 12 November, Mr Austin attended a hospital appointment and was admitted to the acute respiratory unit.

23. On 15 November, a nurse called the hospital. The doctor said that Mr Austin's shortness of breath was caused by heart failure. He said that they were going to discuss a care plan for his chronic kidney disease but Mr Austin had a severe heart attack that night so the kidney disease treatment was put on hold. The doctor also advised that Mr Austin had a chronic clot in his aorta (the main artery that carries

blood away from the heart to the rest of the body). He said that Mr Austin needed surgery to clear his arteries and after this, they would treat the chronic kidney disease.

24. On 16 November, a nurse contacted the hospital. They told her that Mr Austin had discharged himself from the coronary care unit, where he should have remained for cardiac monitoring. The hospital said that Mr Austin was aware of the risks of discharging himself. The nurse reviewed Mr Austin on his return to prison who told her he had not been taking some of his anti-coagulant medication. The nurse told prison staff to check on him every hour and alert the healthcare team if they had concerns.

25. On 17 November, a nurse saw Mr Austin and explained the importance of taking the correct medication at the correct time. Mr Austin handed back approximately 20 boxes of medication.

26. On 18 November, a nurse saw Mr Austin for observations. She noted that he promised he was taking his medication and realised the importance of it.

27. On 20 November, a GP reviewed Mr Austin's medication.

28. On 23 November, a nurse reviewed Mr Austin who reported dizziness, an intense headache, vomiting and blurred vision. He was admitted to hospital. Before he left, an escort risk assessment was completed and signed by the Head of Residence, who was the duty governor that day. The escort risk assessment stated that double cuffs (where the prisoner's hands are handcuffed together and a second pair of handcuffs are applied attaching the prisoner to a prison officer) should be used. However, she told us she approved the use of single cuffs (a handcuff on one wrist, attached to an officer). There were no medical objections to the use of restraints.

29. When the ambulance crew arrived, Mr Austin could not walk unaided and was taken to the ambulance in a stretcher. He also became unresponsive. The escort officers told us that Mr Austin was restrained with double cuffs and an escort chain (a long cable attached at one end to the prisoner and at the other to a prison officer) just before he was moved into the ambulance.

30. At 8.40pm, the hospital asked the escort staff to remove Mr Austin's restraints for emergency treatment. An officer contacted the control room, and this was authorised. The restraints were removed and reapplied after treatment.

31. At 9.30pm, the hospital asked escort staff to remove the double cuffs for emergency treatment. They did so but the escort chain remained in place.

32. At 10.00pm that evening, all restraints were removed as Mr Austin was in an induced coma.

33. On 24 November, a nurse called the hospital. They told him that Mr Austin had had a stroke at the base of the brain and was in an induced coma on a ventilator. His wife and daughter were with him.

34. On 25 November, the hospital told a nurse that there were no changes in Mr Austin's presentation.

35. On 26 November, a nurse contacted the hospital. They confirmed that Mr Austin had been diagnosed with a brain stem cell stroke, and they withdrew all care for him as he had shown no signs of improvement. He was transferred to a hospice for palliative care.

36. On 28 November, a nurse attended the hospice and met Mr Austin's wife. Mr Austin was unable to move any part of his body independently.

37. On 29 November, an officer spoke to Mr Austin's wife. She said that she would stay with him until he died and confirmed she was aware that she could contact prison staff if needed.

38. On 1 December, the hospice called a nurse and told her that Mr Austin had died.

Post-mortem report

39. A hospice doctor established that Mr Austin died from a thrombotic stroke. He also had heart failure and hypertension which did not cause but contributed to his death. The Coroner accepted this cause of death and no post-mortem examination was carried out.

Inquest

40. At an inquest held on 29 September 2025, the Coroner concluded that Mr Austin died of natural causes.

Findings

Clinical findings

41. The clinical reviewer concluded that the care Mr Austin received at Long Lartin was of a good standard and was equivalent to that which he could have expected to receive in the wider community. She found that the healthcare team consistently explained to Mr Austin the importance of complying with his medication but that at times, he chose not to comply or to attend hospital appointments.

42. The clinical reviewer was concerned about the management of Mr Austin's medication compliance. On 17 November, Mr Austin handed back approximately 20 boxes of medication that he had not taken. This medication was critical to treat his heart and kidney disease. The Head of Healthcare told the clinical reviewer that since Mr Austin's death, a local operational procedure had been put into place to monitor in-possession medication compliance. She also said that procedures had been put in place to document any medication handed back and ensure a medication review was requested.

Use of restraints

43. 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 (the Graham judgment) 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 he has a serious medical condition. It said that medical opinion about a prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

44. The escort risk assessment completed on 23 November 2024 stated that Mr Austin should be double cuffed. At this point, Mr Austin was confused, had a headache, was vomiting and had blurred vision. A CM told us that she contacted the Head of Residence and asked for Mr Austin to be double cuffed, with an escort chain applied (rather than a short chain to an officer) and this was approved.

45. A nurse told us that after the escort risk assessment had been completed and paramedics had arrived at Long Lartin, Mr Austin's presentation deteriorated. An officer confirmed that Mr Austin was unable to move and staff had to carry him down the stairs and put him onto a stretcher.

46. We have received conflicting information about the type of restraints used. The officer and CM told us that double cuffs and an escort chain were applied just before Mr Austin was taken into the ambulance. This account aligns with the entry in Mr Austin's prisoner escort record (PER). The Head of Residence said that she authorised the use of single cuffs and then an escort chain once Mr Austin deteriorated. There is no evidence of this in the escort risk assessment or PER.

47. Long Lartin should have used the current hospital escort risk assessment template outlined in the Prevention of Escape – External Escorts Policy Framework (Annex H) dated July 2023. The version they used caused confusion about the type of restraints used.

48. The officer and CM confirmed that the process used to ask for restraints to be removed was to contact the duty governor to authorise this. They said that they did not the Head of Residence to ask for this for Mr Austin as they considered that restraints were still appropriate. The officer and CM told us that they would ask for restraints to be removed if paramedics said they were impeding a prisoner's medical treatment. Consideration should also be given to removing restraints for prisoners whose medical condition and mobility severely deteriorated during an escort.

49. Although the officer and CM told us that they were familiar with the Graham judgment as it was written on the escort risk assessment template, its principles had not been applied as Mr Austin's deteriorating medical condition and mobility had not been taken into consideration when applying the restraints.

50. The officer told us that he knew Mr Austin well, he had no security concerns about his risk of escape or risk to staff and there had been no incidents during previous escorts. In light of this and Mr Austin's presentation, there was no reason for restraints to be used.

51. While we note that the restraints were removed once Mr Austin was in an induced coma, restraints were inappropriately used during the transport to hospital and the first few hours of his admission. At the point the restraints were applied, Mr Austin was immobile and unable to communicate with staff. We make the following recommendation:

The Governor should ensure that:

- **If a prisoner's condition and mobility deteriorate so that restraints are no longer appropriate in line with the Graham judgment, escort staff should ask for restraints to be removed; and**

- **staff use the appropriate escort risk assessment template, as outlined in Annex H of the Prevention of Escape – External Escorts Policy Framework.**

Adrian Usher **September 2025**
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