Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Gavin Short a prisoner at HMP Hatfield on 15 December 2017

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

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

## 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 we oversee can improve their work in the future.

Mr Gavin Short died on 15 December 2017 of coronary artery disease at HMP Hatfield. He was 50 years old. I offer my condolences to Mr Short's family and friends.

I am satisfied that the clinical care Mr Short received was equivalent to that which he could have expected to receive in the community.

I am disappointed, however, that a roll check carried out one hour before Mr Short was discovered, failed to identify any concerns for his welfare, despite it being highly likely that he was dead at that time.

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**
**Acting Prisons and Probation Ombudsman** **October 2018**

## Contents

# Summary

## Events

1. On 12 December 2006, Mr Gavin Short was given an Imprisonment for Public Protection (IPP) sentence with a minimum tariff of five years and 268 days. He was sent to HMP Altcourse.

2. On 30 October 2012, Mr Short was transferred to HMP Thorn Cross, a Category D open prison. On 20 June 2013, after a period of home leave, Mr Short failed a drugs test and was returned to closed conditions. Between June 2013 and September 2015, he was moved from open to closed conditions on two further occasions, after being found under the influence or failing a drugs test after a period of home leave.

3. Mr Short was transferred to HMP Hatfield, an open prison, on 23 January 2017. During an initial health screen, a nurse noted Mr Short's previous drug misuse. She also referred him to the prison's stop smoking support service.

4. On 8 February, Mr Short was diagnosed with high cholesterol and his QRISK2 score was calculated at 9.81%. (A QRISK2 score indicates the risk of developing cardiovascular disease. A score of 10% or more indicates a need for intervention to lower risk such as lifestyle change and/or medication.) On 8 May, Mr Short told staff he had stopped smoking and was eating a healthy diet. On 5 and 25 May, Mr Short declined a NHS Health Check.

5. Mr Short was granted a period of home leave between 11 to 13 December. He returned to Hatfield at 3pm on 13 December.

6. At 7.30am on 16 December, an officer conducted a roll check and saw Mr Short lying on his bed. At 8.40am, another officer went to Mr Short's cell after he heard prisoners banging on the cell door. He could not get a response so he opened the cell and went in. He found Mr Short cold to the touch and stiff. Healthcare staff attended but did not attempt resuscitation because they thought Mr Short was dead. At 8.59am, an ambulance paramedic confirmed that Mr Short had died.

7. The cause of death shown in the post-mortem report was coronary artery disease. Toxicology tests found pregabalin and buprenorphine in Mr Short's system at therapeutic levels. He had not been prescribed either drug.

## Findings

8. Healthcare staff at Hatfield assessed Mr Short's risk of cardiovascular disease and discussed with him how he could lower his overall risk. We are satisfied that the care provided to Mr Short was equivalent to that which he could have expected to receive in the community.

9. When he was discovered, Mr Short had rigor mortis, which indicated that he had been dead for some time. We are troubled that no concerns were identified for Mr Short's welfare at the roll check an hour earlier, as it is highly likely that he was dead at that time.

10. Mr Short was found dead less than three days after he had returned from home leave on 13 December. He had a history of drug misuse, particularly following periods of home leave. Medication was found in his system that he had not been prescribed. While Mr Short evidently took illicit medication shortly before he died, there is no evidence that this contributed to his death.

## Recommendations

- The Governor of HMP Hatfield should ensure that staff completing roll checks are aware of their responsibilities and that they satisfy themselves all prisoners are present and correctly accounted for, that they have not escaped, and are not ill or dead.

# The Investigation Process

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

12. The investigator interviewed five members of staff and three prisoners at HMP Hatfield on 28 February and 8 March 2018.

13. NHS England commissioned a clinical reviewer to review Mr Short's clinical care at the prison. She attended all interviews at the prison.

14. The investigation was suspended on 15 February 2018 while we awaited toxicology results and the cause of death. The investigation was resumed on 9 May 2018.

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

16. The investigator sent a letter to Mr Short's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. We did not receive a reply.

17. 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.

# Background Information

### HMP Hatfield

18. HMP Hatfield is an open resettlement prison which holds up to 338 men who are due to complete their sentence within two years. Healthcare is provided by Care UK who run clinics from 7.30am to 5.30pm Monday to Friday. A weekend and bank holiday service is provided from 7.30am to 9.30am.

### HM Inspectorate of Prisons

19. The most recent inspection of HMP Hatfield was in August 2015. Inspectors reported that healthcare was good and improving. Prisoners were very positive about the healthcare provided and the attitude of healthcare staff. There was an appropriate and improving range of services provided. The misuse of drugs and alcohol was not a significant issue, and substance misuse services were good. The substance misuse team was effective in preparing prisoners for release, providing suitable harm reduction, overdose and relapse prevention information according to individual needs.

### Independent Monitoring Board

20. 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 February 2017, the IMB reported that the healthcare service at Hatfield continued to be delivered by a multidisciplinary team which included a GP, nurses, pharmacy technician and healthcare assistants. The priority for the next year was health promotion in line with national campaigns to support prisoners through resettlement into community services.

### Previous deaths at HMP Hatfield

21. Mr Short was the third prisoner to die at HMP Hatfield since December 2014. There are no similarities between Mr Short's death and those of the other two prisoners.

# Key Events

22. On 12 December 2006, Mr Gavin Short was given an Imprisonment for Public Protection (IPP) sentence with a minimum tariff of five years and 268 days. (Offenders sentenced to an IPP are set a minimum term (tariff) which they must spend in prison. After they have completed their tariff they can apply to the Parole Board for release.) He was sent to HMP Altcourse.

23. Mr Short had a history of drug use and on arrival at Altcourse told a nurse that he used heroin and cocaine on an almost daily basis. He started a drug detoxification programme.

24. On 30 October 2012, Mr Short was transferred to HMP Thorn Cross, a Category D Open prison. (An open prison is any prison in which the prisoners are trusted to serve their sentences with minimal supervision and security and are often not locked in their cells.)

25. On 20 June 2013, after a period of home leave, Mr Short failed a drugs test and was returned to closed conditions at HMP Risley.

26. Between 20 June 2013 and 7 September 2015, Mr Short had two further periods in an open prison, but after either being found under the influence or failing a drugs test after a period of home leave, he was returned to closed conditions.

27. In 2014, Mr Short worked with DISCOVER, the drug and alcohol recovery service. In June 2015, he was advised of the risks of smoking psychoactive substances (PS) after being found under their influence.

28. Mr Short was transferred to HMP Liverpool on 7 September 2015. On 27 July 2016, a member of the prison's Offender Management Unit emailed the Head of Healthcare asking them to assess Mr Short's suitability for residential rehabilitation on his release from prison. Mr Short was not interested in rehabilitation and said that he had completed extensive drug work over the past ten years in prison and felt that going back over this would have a negative impact on him. He wanted to move forward with his recovery and concentrate on getting released and finding employment.

29. Mr Short was transferred to HMP Hatfield, an open prison, on 23 January 2017. During an initial health screen, a nurse noted Mr Short's previous drug misuse. Mr Short was a smoker and the nurse referred him to the prison's stop smoking support service. He had no concerns for his health.

30. On 8 February, Mr Short saw a prison GP to assess and calculate his QRISK2 score. (QRISK2 is a risk assessment tool to estimate a person's 10-year risk of developing cardiovascular disease. Factors taken into account include age, gender, weight, family history, smoking status and pre-existing health conditions.) A score of 10% or more indicates a need for intervention to lower risk such as lifestyle change and/or medication. Mr Short's QRISK2 score was 9.81%.

31. On 1 March, Mr Short saw a prison GP to discuss a prescription of champix, a medication to treat nicotine addiction. He was keen to stop smoking and found that nicotine patches did not work. Mr Short had raised cholesterol and the GP

explained that he could possibly avoid having to take medication to lower this if he quit smoking. Mr Short said that since moving to Hatfield he was exercising and eating a much healthier diet. The GP prescribed champix and said she would review his cholesterol in six months' time if he still smoked.

32. Mr Short attended a stop smoking support session on 6 March. He provided a carbon dioxide breath test of 18ppm (a level of 10ppm or more shows recent exposure to carbon monoxide from smoking). Mr Short attended stop smoking sessions on a weekly basis.

33. On 5 May, Mr Short declined a NHS Health Check. The NHS Health Check is offered to all adults in England aged 40-74. It is designed to spot early signs of stroke, kidney and heart disease, type 2 diabetes and dementia by looking at the person's family history, lifestyle, weight, blood pressure and cholesterol levels.

34. Mr Short attended a stop smoking support session on 8 May. He had now stopped smoking and a carbon dioxide breath test confirmed this.

35. In May, a member of the prison's substance misuse team sent all prisoners information about future courses the prison would be offering. Mr Short responded on 18 May, asking to attend relapse prevention group sessions. This course did not run as not enough people were interested. Mr Short's name was added to a waiting list to attend the relapse prevention course when next available.

36. On 25 May, Mr Short again declined a NHS Health Check. He did, however, agree to have his blood pressure checked, which was normal.

37. Mr Short was granted a period of home leave between 11 to 13 December. He returned home to see his mother, returning to Hatfield at 3pm on 13 December.

38. A fellow prisoner spoke to Mr Short at teatime on 15 December. He said that Mr Short told him that he had taken five pregabalin tablets. The prisoner saw Mr Short again at 11pm. He said Mr Short did not appear to be unwell or under the influence on either occasion.

39. Prisoners on Mr Short's wing were required to be in their cells overnight from 10pm until 7.30am. They had their own keys and were allowed to access the toilets overnight. The night operational support grade on the wing did not report any concerns overnight. An officer arrived on duty at 7am and started his roll check at roughly 7.30am. He said that Mr Short was lying on his back on his bed, in his boxer shorts. He could not remember if Mr Short was awake or sleeping.

40. At 8am, another officer arrived on the wing. At 8.30am, a message was received over the prison radio network asking officers to send prisoners to work. At 8.40am, the officer heard banging and found two prisoners banging on Mr Short's door. One of them said that he could not get a response from Mr Short.

41. The officer looked through the panel in the door and saw Mr Short lying on his bed with his eyes slightly open with the sound of the TV in the background. He could not get a response so entered the room using his own key. He said that when he entered the cell it was clear immediately that something was wrong, and

at 8.42am he called a code blue (an emergency medical call indicating that a prisoner is unconscious, not breathing or is having breathing difficulties) over his radio. He told the investigator Mr Short "was absolutely freezing" and he was unable to find a pulse. He tried to lay Mr Short flat on the bed to start cardiopulmonary resuscitation (CPR) but found his joints were stiff.

42. A nurse was already on the wing when she heard the code blue. She arrived at the cell to find Mr Short on the bed with vomit visible on the pillow and under his head. Mr Short was not breathing, had no pulse and his muscles were stiff indicating rigor mortis. (Rigor mortis is the stiffening of the body after death.) She did not start CPR as it appeared Mr Short had been dead for some time. An ambulance arrived at 8.59am and a paramedic confirmed that Mr Short had died.

43. After Mr Short's death, intelligence was received to say that he had taken a quantity of pregabalin tablets that had not been prescribed to him the night before his death.

### Contact with Mr Short's family

44. On 15 December, a prison family liaison officer travelled to Mr Short's mother's address arriving at 1pm. He passed on his condolences and offered support. He kept in regular contact with Mr Short's mother. Mr Short's funeral was on 23 January 2018. The prison contributed to the cost of the funeral in line with national prison policy.

### Support for prisoners and staff

45. After Mr Short's death, the Head of Offender Management 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.

46. The prison posted notices informing other prisoners of Mr Short's death, and offering support.

### Post-mortem report

47. The cause of death shown in the post-mortem report was coronary artery disease. The pathologist said that the autopsy had shown significant coronary atheroma (fatty deposits in the inner lining of an artery) at a level where it might be implicated in a sudden dysrhythmic death. Toxicology tests found pregabalin and buprenorphine were present, but levels were both within the therapeutic range. Neither drug had been prescribed to Mr Short.

# Findings

### Clinical Care

48. Healthcare staff at Hatfield assessed Mr Short's risk of cardiovascular disease and discussed options with him, including suggestions on how to lower his overall risk. Mr Short told healthcare staff that since moving to Hatfield he had improved his diet and stopped smoking. There is no evidence that he reported chest pain or anything that would have raised concern. He did not engage with the NHS Health Checks offered.

49. We consider that the care Mr Short received was of a good standard and was equivalent to that which he could have expected to receive in the community.

### Roll checks

50. An officer completed a roll check on the wing at 7.30am on 15 December. He told the investigator that he was not required to get a response from every prisoner, and that he just had to check that all prisoners were accounted for.

51. Prison Service guidance shows that the purpose of a roll check is to ensure all prisoners are accounted for, they have not escaped, and they are not ill or dead. The Head of Offender Management confirmed that procedures at Hatfield (despite being an open prison) do not differ to the Prison Service National Security Framework that instructs staff to complete a full roll check in the morning.

52. Mr Short had rigor mortis when he was found at 8.40am, which indicated that he had been dead for some time. While we cannot say for certain, it is highly likely that he was dead at 7.30am. We are concerned therefore, that the morning roll check failed to identify any concerns for Mr Short's welfare. We make the following recommendation:

    **The Governor of HMP Hatfield should ensure that staff completing roll checks are aware of their responsibilities and that they must satisfy themselves all prisoners are present and correctly accounted for, that they have not escaped, and are not ill or dead.**

### Emergency response

53. An officer immediately called a code blue on discovering Mr Short unresponsive in his cell. A nurse was already on the wing when she heard the code blue. She attended the cell without delay. CPR was not attempted. This was appropriate as Mr Short appeared to have been dead for some time and this decision was in accordance with Resuscitation Council guidance (2016) which states that resuscitation is inappropriate and should not be attempted when there is clear evidence that it will be futile.

### Substance misuse

54. Pregabalin and buprenorphine were found in Mr Short's system after his death. Neither had been prescribed to him. Pregabalin is a prescription-only medication used to treat epilepsy, anxiety and nerve pain. It can produce feelings of relaxation and euphoria and can enhance the euphoric effects of other drugs, like

opiates. It is not a controlled drug and can be held by prisoners in-possession. Buprenorphine (also known as Subutex) is an opioid painkiller that can be used to treat opioid dependency. It is a controlled drug and would not be prescribed to be held in-possession in prisons. Both drugs are illicitly traded by prisoners.

55. In-possession drug audits at Hatfield are completed by a pharmacy technician on a monthly basis. The date the prescription was given and how many tablets they should have left on a given day is checked. The Deputy Head of Healthcare said that a medication audit of all prisoners on Mr Short's wing who had been prescribed pregabalin was completed on 18 December. One prisoner on Mr Short's wing failed this audit and he was returned to closed conditions.

56. Although it is clear that Mr Short took illicit medication shortly before he died, there is no evidence that it caused or contributed to his death. Mr Short died from coronary artery disease. The clinical reviewer noted that this is a long-term condition that would have developed over several years and is linked to lifestyle (smoking, diet, exercise) and family history. The clinical reviewer considered it unlikely that pregabalin would have made this condition worse and noted that in cases where pregabalin overdose caused death, respiratory failure was the usual cause. Pregabalin has been linked to heart failure (a different heart condition that would have caused swelling in the legs and breathing difficulties) but Mr Short had none of these symptoms.

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