

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Andrew Rubery a prisoner at HMP Lindholme on 11 March 2018

**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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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 Andrew Rubery died on 11 March 2018 at HMP Lindholme. The cause of death was recorded as drug (psychoactive substance) toxicity. Mr Rubery was 27 years old. I offer my condolences to his family and friends.

I am satisfied that Mr Rubery received good support from the substance misuse team. He said he had stopped using drugs some months before he died and he applied to be a peer mentor to support other prisoners who wanted to stop.

I am, however, concerned about the availability of drugs at Lindholme. Like many prisons, Lindholme faces significant problems controlling the supply of and demand for synthetic cannabinoids (also known as psychoactive substances, or PS). Lindholme has a local drug strategy that it is working to implement but I am concerned that individual prisons are being left to develop local strategies to reduce the supply and demand for drugs. In my view there is now an urgent need for national guidance on the best measures to combat this serious problem and we have made a recommendation to this effect to the Chief Executive of HM Prison and Probation Service in a previous investigation. We have also written to the Prisons Minister setting out our concerns at the number of drug-related deaths in custody.

I am also concerned that, despite previous recommendations by this office, control room staff did not request an ambulance as soon as a medical emergency response code was called.

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**

**January 2019**

## Contents

Summary .....	1
The Investigation Process .....	3
Background Information .....	4
Key Events .....	6
Findings.....	9

# Summary

## Events

1. In February 2015, Mr Andrew Rubery was remanded in custody. He was later sentenced to nine years imprisonment, and was transferred to HMP Lindholme in March 2017.
2. In May, prison staff found Mr Rubery under the apparent influence of psychoactive substances (PS). They referred him to the prison's substance misuse team. Mr Rubery was suspected of using PS twice more, in June and July, but afterwards began working with the substance misuse team and said he had stopped using drugs. Staff no longer suspected Mr Rubery of using PS, and his cellmate said that Mr Rubery had not used drugs for several months before his death. Mr Rubery applied to be a peer mentor to other prisoners who used drugs. He completed his work with the substance misuse team in December.
3. At around 6.00am on 11 March 2018, prison staff found Mr Rubery collapsed on the floor of the communal bathroom of his spur. They called for assistance and began chest compressions but paramedics confirmed Mr Rubery's death at 6.52am.

## Findings

### Substance misuse support offered to Mr Rubery

4. Mr Rubery worked well with the substance misuse team, and completed all of the work asked of him. He maintained that he had stopped using drugs, and had applied to support others who wanted to stop. We found that he received appropriate support from the substance misuse team at Lindholme.

### Psychoactive substances at HMP Lindholme

5. We are concerned at the availability of PS at Lindholme. Despite having taken positive steps to reduce the supply and demand of PS, it is clear that more needs to be done. In our view there is now an urgent need for HMPPS to issue national guidance on this to prisons, rather than leaving individual establishments to develop their own local strategies on a piecemeal basis.

### Emergency response

6. Prison staff appropriately radioed a medical emergency response code. However, there was a delay of four minutes before the control room telephoned the ambulance service, contrary to local and national instructions. There was also a delay bringing a defibrillator to Mr Rubery's wing, and staff were not deployed to the gate to deploy paramedics to the wing as soon as they arrived.

## Recommendations

- **The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:**
  - **control room staff request an ambulance as soon as an emergency code is called;**
  - **there are no delays in directing ambulances to the relevant location; and**
  - **the locations of defibrillators are clearly labelled and all staff are made aware of their location.**

## The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Lindholme informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Rubery's prison and medical records.
9. The investigator interviewed two prisoners in March 2018, and four members of staff in May.
10. NHS England commissioned a clinical reviewer to review Mr Rubery's clinical care at the prison.
11. We informed HM Coroner for South Yorkshire East District of the investigation. We have sent the Coroner a copy of this report.
12. The investigator wrote to Mr Rubery's parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Rubery's parents later spoke to one of the Ombudsman's family liaison officers. They asked for details of what happened on the morning of his death. Mr Rubery's parents also said that he had twice been caught in possession of drugs in prison and asked for further details of these incidents.
13. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.
14. We also shared the initial report with Mr Rubery's family. His mother raised some questions that do not impact on the factual accuracy of our report and have been addressed through separate correspondence.

# Background Information

## HMP Lindholme

15. HMP Lindholme is a medium security prison near Doncaster, which holds around 1,000 men. Care UK provides healthcare services and healthcare staff are on duty between 7.30am and 7.30pm every day.
16. In August 2018, the prisons minister, Rory Stewart MP, announced those prisons participating in the '10 Prisons Project'; HMP Lindholme is one of the named establishments. The project (with the aid of a £10 million funding injection) seeks to improve safety, security and decency at the prisons by focussing on living conditions, preventing drugs entering the establishments and enhancing leadership training available to Governors and their staff.

## HM Inspectorate of Prisons

17. HM Inspectorate of Prisons (HMIP) inspected Lindholme in October 2017. Inspectors found that more than two thirds of prisoners found it easy to get drugs at Lindholme. They found that PS was a serious problem at Lindholme and contributed significantly to the 41 per cent positive mandatory drugs test rate. Inspectors also found that there was no detailed supply reduction action plan.

## Independent Monitoring Board

18. 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 ending January 2017, the IMB reported that substance misuse remained an ongoing issue. They reported that the amount of PS found in the prison had declined, although commented that the extent of its use was difficult to monitor and it remained a huge challenge to the prison.

## Previous deaths at HMP Lindholme

19. Mr Rubery was the fourteenth prisoner to die at Lindholme since April 2015. In our investigation into the death of a prisoner in November 2015, we expressed concern about the availability of illicit drugs at Lindholme. In February 2018, a prisoner died at Lindholme as a result of the effects of taking PS. In several of our investigations, we have found that there was a delay before control room staff requested an ambulance after an emergency radio message.

## Psychoactive Substances (PS)

20. PS (formerly known as 'new psychoactive substances' (NPS) 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 PS precipitating or exacerbating the deterioration of mental health, and they are linked to suicide or self-harm.

21. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time, NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.
22. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

# Key Events

## Background

23. On 24 February 2015, Mr Andrew Rubery was remanded in custody to HMP Leeds. He had served several short prison sentences beforehand. Mr Rubery did not report any history of physical or mental ill health on arrival at Leeds, and said he did not use drugs.
24. In September, Mr Rubery was sentenced to seven years in prison for burglary. In October, another prisoner told prison staff that he thought Mr Rubery was dealing 'mamba' and 'spice', both PS, in prison.
25. In November, Mr Rubery was transferred to HMP Lindholme. In May 2016, another prisoner told staff that Mr Rubery was in possession of various illicit items, including spice. It is not recorded whether Mr Rubery's cell was searched afterwards. On 25 August, he was transferred to HMP Doncaster for an upcoming court appearance.
26. On 6 September, Mr Rubery told an officer that he did not want to return to Lindholme because he was under threat for being in debt for spice. He repeated these concerns to another officer in November.
27. On 12 January 2017, Mr Rubery was transferred to Lindholme. On arrival, he told an officer that he had made up the threats from other prisoners to try to block a transfer as he was unhappy at having to move prisons.
28. On 20 February, Mr Rubery was transferred to Leeds for a court appearance. The next day, he was convicted of another offence of burglary. Two years were added to his previous sentence length.

## HMP Lindholme

29. On 7 March, Mr Rubery was transferred back to Lindholme. At an initial health screen, he told a nurse that he had used cocaine in the past.
30. On 23 May, prison staff found Mr Rubery swaying, and with slurred speech. They suspected that he had used drugs and referred him to the substance misuse team.
31. On 26 May, a substance misuse practitioner, assessed Mr Rubery. She recorded that Mr Rubery said that he occasionally smoked PS. She recorded that they discussed some of the dangers of using PS, after which Mr Rubery said he thought he would stop using the drugs as he did not want to take any chances. She put Mr Rubery on the waiting list for PS awareness sessions.
32. On 10 June, prison staff found Mr Rubery under the apparent influence of PS. This happened again on 14 July, when he was reportedly swaying and slurring his words.
33. On 20 July, Mr Rubery attended a PS awareness session. A substance misuse practitioner recorded that Mr Rubery appeared ambivalent about PS use and said boredom contributed to his motivation to use drugs. Mr Rubery recalled

times he had used drugs which he found amusing but when other prisoners in the group challenged him, he said that he wanted to stop.

34. On 16 August, Mr Rubery attended another PS awareness session. The substance misuse worker recorded that he appeared to have made real progress since the last session and said that he had significantly reduced his PS use.
35. The next day, Mr Rubery had an introductory meeting with a nurse, his keyworker. She recorded that Mr Rubery was very positive, and said that he had stopped using PS and felt much better for it.
36. On 19 September, Mr Rubery had a one to one session with his keyworker. He said that he had not used PS for two months and felt much healthier as a result. Mr Rubery also said that he felt better able to cope since he completed the PS awareness course, and he wanted to apply to be a peer mentor (supporting other prisoners who are undertaking drug and alcohol work). Mr Rubery's keyworker recorded that, because of the length of time since he had used drugs, she discussed tolerance issues and the risk of overdose with Mr Rubery.
37. On 1 November, Mr Rubery had another session with his keyworker. She reminded him to complete an application to be a peer mentor, which he was still keen to do. She also gave him some worksheets to complete.
38. On 7 November, Mr Rubery moved to F Wing. This is a smaller wing for well-behaved prisoners, and consists of eight spurs with eight prisoners on each spur. Each prisoner has a key to their cell and there is a communal association area and communal bathroom on each spur. The spur is locked at night but the prisoners can move around it as they please.
39. On 15 November, Mr Rubery told his keyworker that he had now written a letter to support his application to be a peer mentor. She recorded that they discussed the detrimental effect that PS use in prison had on other people.
40. On 18 December, Mr Rubery attended his final session with his keyworker. She recorded that Mr Rubery had completed all the work in his programme and had now withdrawn from the service. She also recorded that Mr Rubery was on the waiting list for an interview for a peer mentor role. Mr Rubery's keyworker told us that Mr Rubery was very articulate about the dangers of using PS and she thought that he was helping and encouraging other prisoners to stop using drugs.
41. On 26 February 2018, Mr Rubery's personal officer recorded that he had recently done a good job cleaning the spur. The officer told us that Mr Rubery was a very lively person who always ensured that any job he was asked to do was done properly. He said that Mr Rubery had told him that he had used drugs in the past but had now stopped. Mr Rubery's personal officer told us that Mr Rubery had worked hard to give up drugs and had been doing his best not to use again. He did not think Mr Rubery had any issues or problems on F Wing.
42. Mr Rubery shared a cell. His cellmate told us that Mr Rubery had previously used spice in prison but had stopped several months before his death. A prisoner who lived on the same spur, also said that Mr Rubery had not used drugs for several months before he died.

## Events of 10-11 March 2018

43. The cellmate told us that Mr Rubery appeared as normal on 10 March. He said that they stayed up until around 4.00am on the night of 10-11 March, playing video games. The cellmate said that Mr Rubery did not use any drugs or complain of feeling unwell during this time. He said that they both went to bed at this point, and he went straight to sleep.
44. Mr Rubery's mother told us that he made video calls to several family members on an illicit mobile telephone until around 3.00am on 11 March. Mr Rubery's mother said that Mr Rubery had been laughing and appeared well during these calls.
45. At around 6.00am, two officers arrived on F Wing to conduct a routine count of prisoners. When they checked Mr Rubery's cell, they found only his cellmate present. (He was asleep at the time.) One officer checked the bathroom and found Mr Rubery lying on the floor. She told us that Mr Rubery had vomited, appeared cold when she touched him and was not breathing. She asked the night patrol officer on F Wing to radio a medical emergency code blue, indicating a life-threatening situation. The control room operator recorded this message at 6.03am.
46. An officer and the Night Patrol Officer began chest compressions. At 6.07am, the control room operator telephoned for an ambulance. When the first paramedic arrived at 6.20am, the two officers went to the gate to escort them to F Wing. The Supervising Officer (SO) fetched the nearest defibrillator from G Wing. He did not use it as the paramedics were arriving on F Wing when he returned. At 6.52am, the paramedics confirmed that Mr Rubery had died.

## Contact with Mr Rubery's family

47. The Governor visited Mr Rubery's parents on 11 March, and informed them of his death. Lindholme contributed to the costs of the funeral in line with Prison Service instructions.

## Support for prisoners and staff

48. After Mr Rubery's death, an operational manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
49. The prison posted notices informing other prisoners of Mr Rubery's death, and offering support. The Head of Safety and Equality spoke to the prisoners on Mr Rubery's spur and offered them support.

## Post-mortem report

50. Toxicology tests identified that Mr Rubery had used PS at some point before his death. The post-mortem report recorded that his death was caused by drug (psychoactive substance) toxicity.

# Findings

## Substance misuse support offered to Mr Rubery

51. Mr Rubery was appropriately referred to the substance misuse team the first time that he was found under the influence of PS at Lindholme. He initially continued to use PS but after working with the substance misuse service, he said that he no longer used drugs. Mr Rubery maintained his stance that he had stopped using drugs, and this was supported by his cellmate and a friend on his wing. He successfully completed all of his work with the substance misuse team, and had applied to be a peer mentor for other prisoners hoping to stop using drugs.
52. The clinical reviewer found that the care Mr Rubery received was of a very good standard. She found that a clear plan of care was in place to support Mr Rubery to stop using drugs. We consider that Mr Rubery received appropriate support and advice on the dangers of PS use at Lindholme.

## Psychoactive substances at HMP Lindholme

53. In their inspection of October 2017, HMIP found that more than two thirds of prisoners said that it was easy to get drugs at Lindholme. They found that PS was a significant problem at the prison.
54. The PPO's Learning Lessons Bulletin on PS, issued in July 2015, highlighted that PS was then a source of increasing concern in prisons. Not only does PS use have a profoundly negative impact on physical and mental health, but trading these substances can lead to debt, violence and intimidation. Mr Rubery's death is a clear example of how dangerous PS is, and illustrates why prisons must do all they can to eradicate its use.
55. Lindholme's substance misuse strategy, issued August 2017, includes various actions intended to support those known to use PS, plus additional disciplinary measures to deter drug use. While the strategy includes some action points to reduce the supply of PS, HMIP found that there was no detailed supply reduction action plan. Since their inspection, Lindholme has introduced further measures to reduce the supply of PS, including adding additional fences between the wings and outer wall and preventing prisoners accessing parts of the grounds that are more vulnerable to thrown packages.
56. We are satisfied that Lindholme has responded proactively to the evolving challenges of PS supply and demand. Nevertheless, evidence that we and HMIP have obtained indicates that the use of PS continues to be high. It is clear, therefore, that more needs to be done to reduce both the supply and the demand for PS.
57. Lindholme is not alone in facing this problem – it is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, in the PPO's view there is now an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works.

58. In a recent investigation, we recommended that the Chief Executive of HM Prison and Probation Service (HMPPS) should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of deaths she was investigating that were due, or linked, to the use of PS. The Chief Executive has told us that HMPPS plan to issue a national drug strategy in the autumn of 2018. We therefore make no recommendation.

## Emergency response

### *Calling an ambulance*

59. PSI 03/2013 on Medical Emergency Response Codes sets out the actions staff should take in a medical emergency. It contains mandatory instructions for Governors and Directors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure that there are no delays in calling an ambulance and it should not be a requirement for a member of the healthcare team or a manager to attend the scene before calling an ambulance.
60. This is incorporated at Lindholme by Notice to Staff 75/2017 (issued in June 2017), which states that on receipt of an emergency code, the control room operator “will immediately call for an ambulance using the 999 system”. The Notice to Staff also states that this has been agreed with the Yorkshire Ambulance Service NHS Trust, who have said they will always immediately despatch an ambulance even if some details (such as the name or age of the patient, or their specific symptoms) are not known.
61. The officers who discovered Mr Rubery promptly and appropriately radioed a code blue medical emergency. However, it was another four minutes until the control room operator telephoned the ambulance service. The operator, told us that she called the ambulance as soon as she had spoken to a member of staff on F Wing to obtain further details of the prisoner and incident. Local and national instructions are that she should have telephoned the ambulance immediately and obtained details later.
62. In several of our previous investigations at Lindholme, we found that there was a delay before control room staff requested an ambulance after an emergency radio message. It is apparent that there is still work to do to ensure staff are aware of their responsibilities in a medical emergency.

### *Escorting the ambulance to F Wing*

63. Notice to Staff 75/2017 states that, at night, the Orderly Officer (the most senior officer on site overnight) must ensure that extra staff are deployed to the gate immediately to ensure the ambulance has unobstructed entry and is taken directly to the area required. The two officers were not sent to the gate until after

the ambulance had arrived. This led to a delay in the paramedics attending to Mr Rubery.

*Collecting a defibrillator*

64. One officer told us that there was some confusion about the location of the nearest defibrillator to F Wing. SO Eccleshall collected one from G Wing but it was not applied because he arrived at Mr Rubery's spur at around the same time that the paramedics arrived on the wing. This was around 20 minutes after staff first found Mr Rubery collapsed.
65. We cannot say whether any of these delays affected on the outcome for Mr Rubery. Nevertheless, it is important that prison staff understand their roles in a medical emergency as early intervention when someone is found unconscious might save their life. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:**

- **control room staff request an ambulance as soon as an emergency code is called;**
- **there are no delays in directing ambulances to the relevant location; and**
- **the locations of defibrillators are clearly labelled and all staff are made aware of their location.**

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