Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Graham Gilbert a prisoner at HMP Haverigg on 30 June 2016

A report by the Prisons and Probation Ombudsman
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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 Graham Gilbert died on 30 June 2016 of ischaemic heart disease and synthetic cannabinoids toxicity at HMP Haverigg. Mr Gilbert was 55 years old. I offer my condolences to Mr Gilbert's family and friends.

This investigation found that the clinical care Mr Gilbert received was equivalent to that he could have expected to receive in the community. However, it identified a need for better information sharing between the different healthcare sections and closer monitoring of prisoners who return from hospital.

Haverigg's problems with New Psychoactive Substances (NPS) are clear and the prison should have done more to prevent Mr Gilbert's continuing abuse of them. It is troubling that officers did not enter his cell as soon as it was apparent that something was wrong. It is also disappointing that I have to highlight again the need to call an ambulance immediately, when an emergency code is radioed.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2017**

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Summary

Events

1. Mr Graham Gilbert was remanded into prison in September 2012, and received an extended sentence of 12 years and 6 months imprisonment on 12 December. He spent time in several prisons before he was sent to HMP Haverigg on 25 November 2015.

2. Mr Gilbert reported a family history of heart disease, and neurofibromatosis (a genetic condition that causes tumours to grow around nerves). He also had a history of bipolar disorder. A doctor prescribed medication for these conditions. He had a history of taking illicit substances, which on one occasion while in another prison had caused him to stop breathing. There were a number of occasions when healthcare staff reported that Mr Gilbert was under the influence of a substance while in Haverigg. He sometimes admitted to having taken a new psychoactive substance (NPS).

3. A psychiatrist, a mental health worker and doctors reviewed Mr Gilbert for his various conditions while he was in Haverigg. He had electrocardiograms (ECG – to test the electrical rhythm of the heart), none of which showed concerns. Staff monitored Mr Gilbert.

4. On 29 June 2016, during lunchtime unlock, officers found Mr Gilbert to be unwell, but conscious and responsive. They radioed for healthcare assistance, and nurses attended to review him. The prison called an ambulance when Mr Gilbert's health deteriorated and he became unresponsive. In hospital, Mr Gilbert was monitored for the effects of NPS. He was returned to the prison that evening and was located back to his cell.

5. Two operational support grade workers (OSG) spoke to Mr Gilbert on the evening of 29 June and checked on him twice over the night. On the second occasion, in the early hours of 30 June, an OSG noticed Mr Gilbert had not changed position and tried to get a response, but could not. He called for help at around 4.05 am. After a custodial manager and other officers arrived, they entered the cell at around 4.20 am. They found Mr Gilbert was not breathing and began CPR. An ambulance was called some ten minutes after Mr Gilbert was found unresponsive. CPR continued until paramedics pronounced him dead at 4.40am.

Findings

6. The clinical care that Mr Gilbert received was equivalent to that he could have expected to receive in the community. The investigation found that communication between primary and mental healthcare workers was not always effective, and this was compounded by the amount of activity in the prison.

7. Mr Gilbert clearly was a habitual user of NPS. The prison broadly managed him appropriately within their NPS drug supply reduction strategy. But clearly those efforts were insufficient and the challenge of NPS at Haverigg remains significant.

8. During the investigation it became apparent that when an emergency code is radioed, the control room do not immediately call an ambulance as they should have done, in line with PSI 03/2013. Officers did not enter the cell as soon as they should have done in line with national and local policy, when they had concerns for Mr Gilbert's welfare.

9. The investigation found that Mr Gilbert was not monitored as thoroughly as he should have been when he returned from hospital on 29 June. The observation log was not detailed, and staff working during the night shift did not know how serious Mr Gilbert's illness had been that day. It is also apparent, that despite suspecting drug use, the prison did not search Mr Gilbert's cell for drugs or drug apparatus.

Recommendations

- The Governor and Head of Healthcare should ensure that prison and healthcare staff work together effectively, through regular multi-disciplinary team meetings and appropriate record keeping to ensure accurate and up to date information is available.
- The Governor should ensure that significant incidents are logged and shared, and that prisoners are appropriately monitored when they return from hospital after having been seriously unwell.
- The Governor and Head of Healthcare should ensure that the strategy to reduce the supply of and demand for new psychoactive substances is consistently implemented, and that staff are vigilant for signs of their use and are briefed how to respond when prisoners appear to be under the influence of such substances.
- The Governor should ensure that the drug supply reduction strategy includes intelligence led searching.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and ensures there are no delays in calling ambulances.
- The Governor should ensure that all prison staff are made aware of PSI 24/2011 and Local Security Strategy 2.77 and that they understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Haverigg informing them of the investigation and asking anyone with relevant information to contact her. No one responded. She obtained copies of relevant extracts from Mr Gilbert's prison and medical records.

11. The investigator visited HMP Haverigg on 4 August 2016. She interviewed eight members of staff and spoke to two prisoners.

12. NHS England commissioned a clinical reviewer to review Mr Gilbert's clinical care at the prison. She interviewed with the investigator on 4 August.

13. The investigation was suspended while police conducted an investigation into recent deaths at HMP Haverigg. We regret the subsequent delay in publishing the report.

14. We informed HM Coroner for the North and West Cumbria District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Gilbert's mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She wanted to know more information about Mr Gilbert's general health, and the circumstances around Mr Gilbert's death, including procedures in prison around poor health and hospital stays. She also asked how Mr Gilbert was monitored once he returned from hospital the day before he died. She asked about the use of NPS, and security procedures. Mr Gilbert's mother also gave us more information around his health in the years before he died.

16. Mr Gilbert's family received a copy of the initial report. They pointed out a factual inaccuracy. This report has been amended accordingly. Mr Gilbert's family also raised a number of issues that do not impact on the factual accuracy of this report.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Haverigg

18. HMP Haverigg is a medium secure prison, which can hold 644 sentenced men. Cumbria Partnership NHS Foundation Trust provides healthcare services at the prison. The Gables Medical Practice provides GP services. Cumbria on-call medical service provides out-of-hours GP cover.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Haverigg was in April 2017, but has not been published yet. Haverigg had responded satisfactorily to most of the PPO's previous recommendations. In the inspection published in January 2014, inspectors reported that there was a shortage of healthcare staff which impeded primary care. Prisoners were more dissatisfied then previously about the quality of healthcare services, however there was a good range of clinics and treatments. There was better support for prisoners with substance misuse issues, although liaison between the substance misuse and the mental health teams was ad hoc. Drug availability continued to be a problem, although the prison were testing prisoners for drugs and increasing perimeter checks as the prison was particularly vulnerable to packages being thrown over the wall.

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 November 2015, the IMB reported that there was a continuing disjunction between primary and mental health care. Assaults and the use of New Psychoactive Substances (NPS) were increasing problems. More prisoners were collapsing under the influence of NPS, which was impacting on healthcare delivery.

Previous deaths at HMP Haverigg

21. Mr Gilbert was the fourth prisoner to die at HMP Haverigg since January 2014. Two were natural causes, and there has been one further death related to drugs since. We have twice commented on the need to call an ambulance when an emergency code is called.

New psychoactive substances (NPS)

22. New psychoactive substances, previously known as 'legal highs' are an increasing 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. At the time Mr Gilbert died, drug testing did not identify the presence of NPS in a person's system. Prisoners under the influence of NPS 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 precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

23. In July 2015, we published a Learning Lessons Bulletin about the use of 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 NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

24. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

25. Mr Graham Gilbert was remanded into prison in September 2012, and received an extended sentence of 12 years and 6 months imprisonment on 12 December. He spent time in several prisons and was admitted into HMP Haverigg on 25 November 2015.

26. At his initial health screening, a prison GP noted that Mr Gilbert had a family history of heart disease and neurofibromatosis (a genetic condition that causes tumours to grow around nerves). He had at least one operation previously to remove a tumour from his spine, and Mr Gilbert was on the waiting list to have another tumour removed. He also had a history of bipolar disorder (a mental health issue which causes manic and low moods). The GP prescribed pregabalin (for pain relief), depakote (for bipolar disorder), simvastatin, propranolol and ramipril (for heart disease) and valproic acid (used to treat convulsions).

27. A prison GP reviewed Mr Gilbert on 26 November. He noted that Mr Gilbert had a history of using new psychoactive substances (NPS), and in March 2015 had suffered a respiratory arrest (stopped breathing) as a result of using NPS. He noted that the dose of pregabalin needed to be reduced because it increased the possibility of another respiratory arrest. Mr Gilbert declined to take valproic acid and depakote until he had seen the psychiatrist. The GP told him this may take up to six months.

28. On three occasions in December, while Mr Gilbert was collecting his medications, nurses reported he appeared to be under the influence of a substance. A test for detectable drugs on 20 January 2016 was negative. The next day Mr Gilbert saw a psychiatrist. Instead of depakote medication, the psychiatrist prescribed Mr Gilbert sodium valproate, with a 1mg dose of haloperidol twice a day to treat the bipolar disorder. He noted that it should not affect Mr Gilbert's heart function. He asked for an electrocardiogram (ECG- tests the electrical rhythm of the heart) - the results came back as normal on 26 January. He had other ECG tests at regular intervals, which showed no concerns. Mr Gilbert told him that he had recently taken NPS, but after moving to a drug free wing wanted to remain drug free.

29. When re-prescribing Mr Gilbert's medications, a prison GP noted on 22 January that he had concerns with prescribing haloperidol and pregabalin together as they were both medications that could slow the heart and affect its rhythm. He wrote to a hospital consultant twice, asking for advice on prescribing pregabalin, but did not receive a response until May 2016. Mr Gilbert remained taking pregabalin.

30. On 28 January, officers noted that Mr Gilbert appeared to be under the influence of a substance while he was in his workplace. He vomited, and an officer recorded that he did not pass any sobriety tests. The prison placed him on basic regime (the lowest level of the incentive scheme, which aims to encourage and reward responsible behaviour) on 4 February for 28 days, as a result of using NPS.

31. Mr Gilbert frequently saw a mental health nurse for mental health reviews. From 28 March, he raised concerns about his mental health. Officers also noticed some bizarre behaviour (strange conversations for example). Mental health staff monitored him closely and, on 14 April, the psychiatrist saw him and recorded that Mr Gilbert was stable and well. He denied using any illicit substances. In response to the prison GP's concerns of prescribing haloperidol and pregabalin at the same time, he recorded that, in his opinion, there was no issue because the haloperidol dose was low.

32. On 5 May, Mr Gilbert had an operation in hospital to remove a tumour as a result of the neurofibromatosis and he was returned to prison the next day. He had an external appointment to review how he was healing on 13 May.

33. A nurse saw Mr Gilbert for his annual hypertension review on 15 June. His recent blood results were fine and he reported no chest pains. He was prescribed ramipril (for high blood pressure) and simvastatin (to lower cholesterol levels). His blood pressure (129/84) was slightly high and she assessed Mr Gilbert as having a 27.19% risk of developing heart problems within the next ten years (this is classed as a high risk).

34. On 28 June, Mr Gilbert asked for a psychiatric review, and the mental health nurse referred him.

29 June – 30 June 2016

35. On the afternoon of 29 June, Officer A was one of two officers on the unit unlocking prisoners after lunch. He unlocked Mr Gilbert's cell. He thought that Mr Gilbert seemed unsteady on his feet and unwell, although he said he was OK. He called the other officer unlocking cells on the unit to come and give his opinion. Officer B knew Mr Gilbert and asked if he was OK. Mr Gilbert responded that he was, but the officer saw he was unsteady on his feet and asked another prisoner to help Mr Gilbert onto his bed. When the prisoner began to help him, Mr Gilbert sank to his knees on the floor and Officer B called a code blue (an emergency code that indicates a prisoner has collapsed or has trouble breathing). This was at 1.48pm.

36. A nurse attended. She noted that Mr Gilbert was initially alert, but his oxygen level dropped to 74%. She gave him oxygen but he became unresponsive. She attempted to insert an airway but could not. She then requested an ambulance, which the control room called at 1.56pm. Paramedics arrived at 2.04pm, Mr Gilbert recovered consciousness, and they took him to hospital. In hospital, he recovered and received no treatment, but doctors observed him. They discharged him and he was returned to prison at about 6.30pm that evening. A note was written in the wing observation log that Mr Gilbert had gone out to hospital, but there were no plans in place to monitor him any more closely then usual.

37. An OSG spoke to Mr Gilbert at about 9.10pm, when he found him lying on the cell floor. He was aware Mr Gilbert had been to hospital. Mr Gilbert got up off the floor and said that he was sleeping on the floor because he had a bad back. The OSG checked on him at 1.00am, and noticed he was sleeping on the floor and looked to be breathing. Again, he checked Mr Gilbert at 4.05am, he

appeared to be in the same position. This time he could not get a response after banging on the door and shouting through the observation panel.

38. The OSG radioed for the prison manager on duty, stating that he could not get a response from Mr Gilbert, and explained that Mr Gilbert had said he may sleep on the floor. He did not make an urgent request for assistance. She took about two minutes finishing what she was doing and attended with an officer and another OSG at 4.15am. Another officer then also attended at about 4.20am, when the three officers then entered the cell. It was at this point they asked the control room to call an ambulance (recorded as 4.25am) and began CPR.

39. The paramedics arrived at 4.35am and checked Mr Gilbert. They said that he had rigor mortis and that CPR was futile. They pronounced him dead at 4.40am.

Contact with Mr Gilbert's family

40. The family liaison officer went with a chaplain to Mr Gilbert's mother's address to inform her that he had died. They offered ongoing support. The funeral was held on 19 July, and the prison paid towards the costs, in line with national policy.

Support for prisoners and staff

41. After Mr Gilbert's death a governor 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.

42. The prison posted notices informing other prisoners of Mr Gilbert's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Gilbert's death.

Post-mortem report

43. The post-mortem report concluded that Mr Gilbert died of ischaemic heart disease and synthetic cannabinoid toxicity. Ischaemic heart disease could have caused his death at any time, but because of the documented effects of cannabinoid toxicity this also contributed to his death.

Findings

Clinical care

44. The clinical reviewer concluded that the care Mr Gilbert received was equivalent to what he could have expected to receive in the community. Healthcare staff frequently monitored Mr Gilbert's blood pressure as it was often high and he had annual hypertension reviews.

45. However, the investigation found that communication between physical and mental health staff was strained, and there was not time for in depth handovers and meetings. The number of prisoners that needed healthcare support was high and so the services were further stretched. The clinical reviewer also highlighted the need for closer monitoring of prescribing pregabalin to known illicit drug users. The Head of Healthcare will need to address these issues.

Mental health treatment

46. Mr Gilbert received mental health treatment through medication and input from mental health staff. Mr Gilbert had a dedicated mental health nurse that he saw often, and a psychiatrist he saw occasionally. Doctors prescribed and reviewed medications appropriately. The clinical reviewer concluded that the mental health care Mr Gilbert received was good.

47. A prison GP raised a concern that haloperidol could affect the functioning of Mr Gilbert's heart, but the psychiatrist felt that it was a small dose that would not negatively affect Mr Gilbert. When taking medication like haloperidol, electrocardiograms (ECG – tests the electrical rhythm of the heart) are used to measure the heart function. Mr Gilbert received these tests appropriately and they showed no concerns.

Drug management

48. At the time of Mr Gilbert's death, there was a drug supply reduction policy in place in Haverigg, specifically for tackling NPS. The policy includes managing prisoners through the IEP process to restrict their access to association with other prisoners, placing them on report, and referring them to the drug misuse services called Unity. Intelligence reports must also be submitted.

49. Various healthcare staff reviewed and treated Mr Gilbert, and they discussed his substance misuse and the dangers associated with it, and mixing it with prescribed medication. Mr Gilbert self-referred himself to Unity, and saw a worker on at least once. On at least one occasion, the prison placed him on basic regime, as a disciplinary measure for being under the influence of NPS. Prison and healthcare staff recorded when they suspected Mr Gilbert was under the influence of a substance, which sometimes he admitted, in line with the local supply reduction strategy.

50. Mr Gilbert was managed consistently within the policy framework but the actions taken were insufficient to reduce the risks NPS posed to him. We make the following recommendation:

The Governor and Head of Healthcare should ensure that the strategy to reduce the supply of and demand for new psychoactive substances is consistently implemented, and that staff are vigilant for signs of their use and are briefed how to respond when prisoners appear to be under the influence of such substances.

51. There were occasions when Mr Gilbert's suspected NPS use and reported bizarre behaviour was not shared with all staff. The psychiatrist noted that Mr Gilbert was doing well on 14 April, when two weeks before that prison staff had noted Mr Gilbert was behaving bizarrely. As a visiting psychiatrist once every two weeks, he (and other healthcare staff) said they rarely had the time to review medical notes. He was not aware of Mr Gilbert's bizarre behaviour and told the investigator that when he worked at Haverigg he did not have time to review records in great depth and relied on more recent medical record entries, or permanent staff telling him significant information about prisoners

52. We agree with the clinical reviewer that healthcare staff and prison staff need to be able to share information easily and effectively. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prison and healthcare staff work together effectively, through regular multi-disciplinary team meetings and appropriate record keeping to ensure accurate and up to date information is available.

53. On 29 June, the observation log records:

'Gilbert currently out at FGH, he was found unresponsive during unlock, code blue called, ambulance escorted him to hospital'

and then later at 6.00pm:

'Gilbert – packed lunch in cell…returned from FGH Escort now located back in cell'

54. Prison staff that night were aware Mr Gilbert had gone to hospital, but the notes in the wing observation log were all the information that they had about Mr Gilbert's health. There was no record it may be a result of taking a substance. We would have expected a more detailed handover, and for staff to consider reviewing Mr Gilbert more closely during the night. We make the following recommendation:

The Governor should ensure that significant incidents are appropriately logged and shared, and that prisoners are appropriately monitored when they return from hospital after having been seriously unwell.

55. It is also apparent that once Mr Gilbert was suspected of collapsing from drug use on 29 June that a cell search was not completed. After his death, drugs and drug paraphernalia were found in his cell.

56. There is no reference within the local Approach and Strategy for Tackling NPS to searching cells after suspected drug use. Mr Gilbert's cell was not searched on 29 June. After his death, NPS was found in his cell and nearby outside. Mr

Gilbert had been returned straight to his cell from hospital that day, and more could have been done to limit his access to the drug. We make the following recommendation:

The Governor should ensure that the drug supply reduction strategy includes intelligence led searching.

Emergency response

57. Prison Service Instruction (PSI) 3/2013 requires prisons to have a medical emergency response code protocol, which states how staff communicate the nature of a medical emergency, and that the control room calls an ambulance immediately when a code is used. It also ensures healthcare staff bring the correct medical equipment to the scene. The PSI makes it clear that it must not be a requirement for a member of the prison healthcare team or a manager to attend the scene before emergency services are called. Haverigg re-issued their local protocol which reflects national guidance, on 4 November 2015.

58. Mr Gilbert collapsed on 29 June, and was sent to hospital as an emergency. Initially he was conscious when he collapsed. Officer B called a code blue (an emergency radio call which indicates that a prisoner is unconscious or having difficulties breathing) when this happened. Healthcare staff arrived to assess him, and then Mr Gilbert became unresponsive, which is when healthcare staff asked for an ambulance. This was eight minutes after the emergency code had been called. Control room staff explained that this is their practice because an ambulance may not be needed and they wait for staff on scene to confirm this.

59. On 30 June, when Mr Gilbert was found unconscious, staff did not immediately call a code blue, and instead asked for assistance. The OSG thought Mr Gilbert might be asleep and so told the prison manager over the radio that he could get no response, but did not clarify that it was an emergency. Officers requested that the control room call an ambulance once they entered the cell.

60. Practice at Haverigg is not in line with the national policy or local instructions on the use of emergency codes. An ambulance should be called immediately, when a code blue is called. A code blue would have ensured the prison manager knew the situation was an emergency. It would also have alerted the control room staff to call an ambulance rather than wait for officers to attend, enter the cell and then request an ambulance. It would not have changed the outcome for Mr Gilbert, but it could in other circumstances. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and ensures there are no delays in calling ambulances.

61. It was the prison manager's first night shift. She and the OSGs gave the reason for not entering the cell immediately because of local protocol. They understood that three officers needed to be present, and that OSGs did not count as within that required number. The local policy (LSS 2.77) states (in line with Prison Service Instruction 24/2011 Management and Security of Nights) that officers must not put their lives at risk but can enter the cell if:

‘Staff dealing with incidents such as deaths in custody or suicide may request to enter a cell to deal with the incident or offer initial life saving treatment… Under normal circumstances, no cell will be opened unless two members of staff are present, the only exception to this may be in the circumstances outlined above.’

62. There is no acceptable reason that staff had to wait for three officers to be present to enter the cell. It is apparent that staff misunderstood the requirements of their local protocol, and of the PSI. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of PSI 24/2011 and Local Security Strategy 2.77 and that they understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life.

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