Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Gamble, a prisoner at HMP Forest Bank, on 26 April 2017

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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 Lee Gamble died on 26 April 2017 of heart disease and a pulmonary embolism at HMP Forest Bank. He was 51 years old. We offer our condolences to Mr Gamble's family and friends.

We are not satisfied that the care Mr Gamble received was equivalent to that which he could have expected to receive in the community. Staff did not follow up on incomplete health screens or apply a cardiac risk assessment tool correctly. Mr Gamble was clearly mentally distressed and his behaviour very challenging and while we recognise that staff did their best to transfer him to a psychiatric facility, we have concerns about their management of his dirty protests and food refusal.

Although these shortfalls had no direct bearing on the cause of death, staff did not interact meaningfully with Mr Gamble for 13 hours prior to his death, despite his obvious distress and the fact that he had not eaten or taken any fluids for at least two and a half days. This is not acceptable.

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 **January 2018**

Contents

Summary

Events

1. On 23 December 2014, Mr Lee Gamble was remanded into custody and was sent to HMP Liverpool. On 18 June 2015, he was sentenced to four years imprisonment for arson. Mr Gamble received an additional sentence of 14 days for attempted criminal damage on 25 September 2015, and a further sentence of 14 months on 7 February 2017, for malicious wounding, an offence he committed against a member of staff while at HMP Liverpool.

2. Mr Gamble had a history of schizophrenia, personality disorder and other mental health problems. Between 1 June 2016 and 6 September 2016, he was held at a medium secure psychiatric facility, the Edenfield Centre. He was transferred to HMP Forest Bank on 6 September, as psychiatrists did not believe he was suffering from an enduring mental illness.

3. When he arrived at Forest Bank, Mr Gamble did not participate in the first night screening process. He demanded to be located in the segregation unit because he said he was worried that there were prisoners on the wings who wanted to harm him and he said he would refuse food. Staff agreed to place him in the segregation unit and managed Mr Gamble under suicide and self-harm prevention procedures known as ACCT (Assessment Care In Custody Teamwork). Staff did not complete a first night screen or offer a standard second screen.

4. When he arrived in the segregation unit, Mr Gamble immediately started to smear faeces on his body and in his cell and on 29 September a prison psychiatrist asked the mental health unit staff to reassess him. On 6 October, the psychiatrist from the mental health unit visited Mr Gamble but did not think he needed to go back to hospital or that he needed medication. The psychiatrist agreed that Forest Bank staff could keep in touch with him if Mr Gamble's behaviour changed.

5. On 28 October, Mr Gamble's behaviour calmed down and he agreed to leave the segregation unit but refused to go onto the normal wing. Staff located Mr Gamble in a cell in healthcare and put him on a separate regime so he did not have to mix with other prisoners. A psychiatrist prescribed antipsychotic medication (quetiapine) and arranged for an electrocardiogram (ECG measures electrical activity in the heart) to check Mr Gamble was physically suitable for that particular medication. The results were satisfactory.

6. On 21 November, a prison GP identified that Mr Gamble had raised cholesterol. He saw him again on 6 December and assessed Mr Gamble for his likely risk of developing heart disease. The results showed that the prediction was just over 10%. This should have prompted a formal review but staff did not take action to address Mr Gamble's high cholesterol levels.

7. On 3 January 2017, Mr Gamble had been due to appear in court by video link. He took an overdose of quetiapine and was taken to hospital. He was discharged from hospital the same day and continued to be managed under the ACCT process.

8. On 6 February, Mr Gamble refused to have a 50-70 year-olds' health assessment and refused the assessment again on two further occasions. On 17 April, he refused his migraine medication (propanalol).

9. On 2 March, staff decided to stop the ACCT procedures because Mr Gamble took all his medication, was not expressing any thoughts of suicide or self-harm, had an adequate diet including fluids, was physically well and staff had not reported any concerns about him.

10. On 23 April, Mr Gamble started a dirty protest and refused a meal. An officer opened a dirty protest log and informed the duty director who had already visited Mr Gamble that day. The officer also noted in the dirty protest log that he had informed the Independent Monitoring Board and a duty manager. Staff did not consider opening an ACCT.

11. Mr Gamble continued to refuse meals and fluids on 24 and 25 April, did not engage with staff and maintained his dirty protest. The prison psychiatrist saw Mr Gamble in his cell on 25 April but Mr Gamble did not respond to him. The prison psychiatrist questioned Mr Gamble's behaviour and whether the sudden change in his presentation was due to him taking illicit drugs. The psychiatrist asked staff whether the segregation unit would be a more suitable location for him due to his continued dirty protest and asked staff to find out when Mr Gamble was last referred to the Edenfield Centre. At 6.00pm, an officer noted that Mr Gamble would not engage with him.

12. On the morning of 26 April, between 7.00am and 7.10am, an officer went to Mr Gamble's cell to give him his breakfast but received no response from Mr Gamble. When he passed the cell again, he was alarmed to see that Mr Gamble had not moved position. Staff attended the cell and put on protective suits and a nurse was called for. Two officers and a nurse entered the cell at approximately 7.20am and the nurse asked someone to call an emergency code blue, which they did. The nurse concluded that Mr Gamble was dead. Paramedics arrived at 7.45am and confirmed that Mr Gamble had died.

Findings

13. The clinical reviewer concluded that the care Mr Gamble received was not equivalent to that which he could have expected to receive in the community, but that there was nothing in his medical records to suggest Mr Gamble displayed any obvious symptoms of either a deep vein thrombosis or an embolism. Mr Gamble had become extremely challenging to manage and in the last few days of his life he did not report any physical issues.

14. Mandatory health initial and second health screens were not completed and the cardiac assessment completed on 6 December was not completed correctly.

15. Staff failed to manage Mr Gamble's deteriorating mental health, associated dirty protest and food refusal in line with local policy. There is no evidence that prison managers checked Mr Gamble or that staff engagement, when it occurred, offered strategies for ending his dirty protest or food refusal.

16. There is no record to indicate that staff attempted any meaningful engagement with Mr Gamble between 6.00pm on 25 April and 7.00am on 26 April. Although there were roll checks (prisoner headcounts), this represented 13 hours where staff did not try to speak to a man who was clearly distressed and had not taken any food or liquids for two and a half days.

Recommendations

- The Director and the Head of Healthcare should ensure that, in line with PSO 3050, staff complete full initial and secondary health screens.

- The Director and the Head of Healthcare should ensure that QRisk assessments are conducted thoroughly and follow up action takes place.

- The Director and the Head of Healthcare should ensure that, in line with PSI 64 2011 and associated Department of Health guidance, staff are aware of the correct procedures to follow when a prisoner refuses food.

- The Director should ensure staff are aware, in line with PSI 75/2011, of the importance of gaining a response from prisoners at unlock and that, where a prisoner refuses to communicate, officers should log what they have observed as signs of life.

The Investigation Process

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

18. NHS England commissioned an independent clinical reviewer to review Mr Gamble's clinical care at the prison.

19. We informed HM Coroner for Milton Keynes of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. One of the Ombudsman's family liaison officers contacted Mr Gamble's sister to explain the investigation and to ask if she had any matters she wished to raise. She raised a number of concerns that are outside the remit of this investigation but some of which the clinical review has covered. She also wished to know whether Mr Gamble's inactivity because of his limited regime and/or food refusal might have contributed to the cause of death.

21. Mr Gamble's sister received a copy of the initial report. The solicitor representing her indicated that she was satisfied with the findings.

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

Background Information

HMP Forest Bank

23. Forest Bank is a local prison in Salford, serving courts in the North West. It holds 1,460 remanded and sentenced men. The prison is managed by Sodexo Justice Services. Sodexo provides primary health care services. There is a 20-bed inpatient unit with 24-hour nursing cover. An agency provides GP services with doctors available from 9.00am to 9.00pm Monday to Friday, 1.00pm to 5.00pm Saturday and 9.00am to 12.00pm Sunday. There is out of hours cover at other times.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Forest Bank was in February 2016. Inspectors reported that most areas of health provision were reasonable but some areas required considerable improvement. Some aspects of local governance required attention, including access to staff supervision and emergency equipment checks. Prisoners had access to an appropriate range of primary care services, with mostly acceptable waiting times, and long-term conditions were well managed

Independent Monitoring Board

25. 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 31 October 2016, the IMB reported that Forest Bank was a well-performing prison. Challenges arose from a growing number of incidents of violence, possibly linked to the increased usage of New Psychoactive Substances (or NPS, drugs formerly known as legal highs).

Previous deaths at HMP Forest Bank

26. Mr Gamble was the fifth person to die at Forest Bank of natural causes since the beginning of 2015. There are no significant similarities with those cases.

Key Events

27. On 23 December 2014, Mr Lee Gamble was remanded into custody and was sent to HMP Liverpool. On 18 June 2015, he was sentenced to four years imprisonment for arson. Mr Gamble received an additional sentence of 14 days for attempted criminal damage on 25 September 2015, and a further sentence of 14 months on 7 February 2017, for malicious wounding, an offence he committed against a member of staff while at HMP Liverpool.

28. Mr Gamble had a previous history of schizophrenia, personality disorder and other mental health problems.

29. On 1 June 2016, Mr Gamble was transferred to a medium secure psychiatric unit, the mental health unit. On 6 September 2016, he was transferred back to prison and sent to HMP Forest Bank. The psychiatrist at the mental health unit did not believe Mr Gamble had an enduring mental illness and disputed his historical diagnosis of schizophrenia. He would not prescribe antipsychotic medication and felt Mr Gamble demonstrated traits of a personality disorder.

30. On his arrival at Forest Bank, Mr Gamble demanded staff place him in the segregation unit because he said that other prisoners wanted to harm him. Mr Gamble would not engage with the reception process and said that he would refuse food. A nurse saw Mr Gamble in the segregation unit and assessed him as suitable to be segregated and started ACCT procedures.

31. On 29 September 2016, Mr Gamble smeared faeces over his body and cell because he said that people were trying to harm him. The mental health team at Forest Bank wanted to re-refer Mr Gamble back to the mental health unit but were worried that another move would destabilise him. A prison psychiatrist made the referral to the mental health unit team for Mr Gamble to be reassessed with a view to trialling medication to see if it helped.

32. On 7 October, a prison psychiatrist visited Forest Bank to assess Mr Gamble. He did not change his opinion about diagnosis or need for medication. The team at Forest Bank agreed to make daily entries about Mr Gamble's presentation, and to alert the prison psychiatrist if there were any changes.

33. On 28 October, Mr Gamble was moved from the segregation unit to the healthcare centre. Mr Gamble seemed calmer, was pleasant to staff but would not associate with other prisoners. The prison psychiatrist decided to prescribe Mr Gamble quetiapine (an antipsychotic) because healthcare staff described Mr Gamble as experiencing ‘paranoia’ about other prisoners wanting to harm him. Staff developed a separate regime for Mr Gamble. While he spent long periods in his cell, Mr Gamble was still able to exercise and shower daily and be involved in therapeutic activities with a teacher**.**

34. On 11 November, Mr Gamble had an electrocardiogram (ECG measures electrical activity in the heart. ECG and blood pressure readings are taken for patients prescribed quetiapine because of the links between antipsychotics and heart rhythms.) The results showed a normal rhythm and showed no decrease in blood

flow and oxygen to the heart muscle. On 4 November, Mr Gamble's blood pressure was normal. (A reading of 120/80 or below is good.)

35. On 17 January 2017, Mr Gamble's blood pressure reading was partially elevated at 141/73. There is no record that staff investigated this further. By April, Mr Gamble's blood pressure had returned to normal.

36. On 21 November, a prison GP recorded that Mr Gamble's cholesterol levels were elevated at 9.1 mmol/L (millimoles per litre. A normal range is less than 5mmol/L). He assessed Mr Gamble again on 6 December 2016, using a tool called 'QRisk & QRisk2'. The tool uses a scoring system looking at traditional risk factors for cardiovascular disease. Mr Gamble's QRisk2 results predicted that he had a rounded down 10% risk of developing heart disease in the next ten years (the actual score was 10.82 %). He did not record in the medical records whether he had included Mr Gamble's height, weight or blood pressure as part of the assessment. He did not arrange a further review even though a score of over 10% would warrant this. He gave Mr Gamble smoking and diet advice but did not record whether he had considered offering Mr Gamble statins (a medication) to reduce his cholesterol. Mr Gamble declined any smoking cessation assistance.

37. The mental health team continued to monitor Mr Gamble regularly but on 3 January 2017, in the lead up to a video-link court appearance for assaulting a staff member at a previous prison, Mr Gamble took an overdose of quetiapine. He was sent to hospital for treatment and was returned to Forest Bank the same day. On his return to Forest Bank Mr Gamble refused to go to a normal wing but his behaviour eventually calmed.

38. On 6 February, Mr Gamble would not attend his 50-70 year-old health screen (designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes and dementia). Mr Gamble also refused to attend his health screens on 13 February and 11 April.

39. On 2 March 2017, staff decided to close the ACCT that had been open since 6 September 2016. A nurse noted that this was because Mr Gamble was compliant with all his medication, was not expressing any thoughts of suicide or self-harm, had an adequate diet including fluids, was physically well and staff had not reported any concerns about him.

40. On 7 April, Mr Gamble complained of having migraines. On 17 April, he would not accept his propanalol medication (commonly used to treat heart conditions but also migraines), complaining that it was making his hands swell. A nurse told the in-reach team and made an appointment for Mr Gamble to see a GP.

41. On 18 April, Mr Gamble told a mental health nurse that he did not want to take propanalol because it was making the joints in his hands and knees swell. She noted that his hands did seem to be swollen. She spoke to an unnamed GP who said that swelling was not a known side effect of propanalol but Mr Gamble still refused to take it.

42. On 19 April, Mr Gamble reported to a prison GP that he had intense headaches that lasted for 5 days at a time. He prescribed amitriptyline (an antidepressant which also helps nerve pain).

43. On 23 April, at 3.55pm, an officer noted in the log book that he went to Mr Gamble's cell to give him his evening meal and that Mr Gamble had started a dirty protest. He opened a dirty protest log, and noted that Mr Gamble had accused him of 'being bent' and said that 'the police had been informed'. He also noted that he had submitted all relevant paperwork to the duty manager, the duty director and informed the Independent Monitoring Board.

44. At 7.13pm, a mental health nurse noted in the medical records that Mr Gamble had refused his antipsychotic medication and had started a dirty protest. He said that Mr Gamble had expressed delusional beliefs that the protest would protect him against people who were trying to kill him. He reported the change in Mr Gamble's mental state to the inreach team. A community mental health nurse noted this information, including that Mr Gamble was on restricted officer unlock because of his paranoid ideation and the risk this had presented to staff in the past, because of his violent behaviour towards members of prison and healthcare staff at HMP Liverpool. She said she would inform the psychiatrist the next day. Staff recorded that Mr Gamble was present in his cell at roll count (to make sure that a prisoner is present in their cell) that evening and at 5am the next morning.

45. On 24 April, at 7.00am, an officer logged that the observation panel to Mr Gamble's cell was jammed and he could not serve Mr Gamble's breakfast or medication. At 11.40pm, Mr Gamble refused his dinner.

46. At 1.14pm, a mental health nurse noted in the medical records that he had had very limited interaction with Mr Gamble when he had tried to carry out mental state, behaviour and psychosocial function observations. He also noted that that Mr Gamble had smeared faeces to such an extent the observation panel would not open. At 3.00pm, an officer offered Mr Gamble a shower but Mr Gamble refused.

47. On 24 April at 4.03pm, the Inreach community mental health nurse noted in the medical records that the primary community mental health team had told her that Mr Gamble was on a dirty protest, was non-complaint with his antipsychotic medication and there were no obvious patterns to his behaviour. She noted that she would tell the psychiatrist about the sudden change in Mr Gamble's presentation at the next day's psychiatry clinic. At 4.30pm, an officer logged that Mr Gamble refused to engage and take any food. Staff conducted roll checks that evening and at 5.00am the next morning.

48. On 25 April, an officer made entries throughout the day. At 7.00am he recorded that he had asked Mr Gamble if he wanted breakfast. Mr Gamble did not respond, although an officer recorded that Mr Gamble was breathing. At 11.30am, he asked Mr Gamble if he wanted dinner but again, Mr Gamble did not respond and he noted that Mr Gamble was breathing. There is no evidence that staff considered opening an ACCT to help manage Mr Gamble's food refusal.

49. At 3.11pm, a community mental health nurse noted in the medical records that the prison psychiatrist had seen Mr Gamble at his cell door. Mr Gamble did not engage and the doctor noted in the medical notes that he wondered if illicit substances were the reason for Mr Gamble's sudden change in behaviour. He considered whether the segregation unit might be a more suitable environment if Mr Gamble's dirty protest continued. He asked the inreach team to find out when Mr Gamble had last been referred to the mental health unit.

50. At 4.20pm, an officer recorded in the log that when he asked Mr Gamble if he wanted his tea, Mr Gamble did not respond but was breathing.

51. On 25 April 2017, at 4.28pm, the Mental Health Clinical Lead Nurse noted in the medical records he had seen Mr Gamble to complete his mental state, behaviour and psychosocial observations. Mr Gamble would not answer questions about his medication, so he noted that Mr Gamble had not been not compliant with medication and continued to be on a dirty protest. At 6.00pm, an officer recorded in the log that Mr Gamble refused to engage with him.

52. At 10.00pm that night, an officer started the night roll call. Mr Gamble had smeared faeces over some of the glass on the observation panel of his cell and she had to shine her torch into the cell to see him. She said that Mr Gamble appeared to be asleep but was sitting up in bed. At 5.00am, she started the next roll call and observed that Mr Gamble was in the same position as when she checked him before. She said she assumed he was asleep. She did not complete the dirty protest log on either occasion but made an entry in the healthcare observation book, noting the time and confirming that she had completed a roll check.

Emergency Response

53. Between 7.00am and 7.10am on 26 April, an officer went to Mr Gamble's cell to offer him breakfast. Mr Gamble was sitting on his bed but did not respond to him. He did not complete the dirty protest log or any other log and continued giving out breakfast to other prisoners. On his way back, he looked into Mr Gamble's cell again and was alarmed to see he had not moved from his previous position. He told a Senior Officer (SO) that they needed to go into the cell, and two other colleagues, gathered outside the cell and put on protective suits.

54. At 7.15am, a nurse was checking equipment in healthcare when she received a call to go to the healthcare wing. It is not clear who made this call as the staff statements differed. She went immediately, arriving in approximately 30 seconds alongside an officer, who also put on a protective suit.

55. An officer went into the cell at 7.20am, with another officer and the nurse. As the nurse went into the cell, she called to an officer to call an emergency code blue. (An emergency code blue indicates a prisoner is unconscious, not breathing or is having breathing difficulties.) The officer did so and an ambulance was called at 7.22am. The nurse and the officer checked Mr Gamble's vital signs and concluded that he was dead.

56. Paramedics arrived at 7.39am, they put on protective suits and went in Mr Gamble's cell at 7.45am and confirmed that Mr Gamble had died.

Contact with Mr Gamble's family

57. At 7.50am, on the morning of Mr Gamble's death, the prison appointed the prison manager, as the family liaison officer and the chaplain as her deputy. They visited Mr Gamble's brother and his brother's partner at 9.15am and gave them the news of Mr Gamble's death, and offered advice and support. They also maintained contact with other family members who wanted to be involved.

58. Mr Gamble's funeral was held on 5 June 2017. Prison staff did not attend at the family's request but contributed to the costs of the funeral in line with national guidance.

Support for prisoners and staff

59. After Mr Gamble's death, a prison manager 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.

60. The prison posted notices informing other prisoners of Mr Gamble'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 Gamble's death.

Post-mortem report

61. The coroner concluded that the cause of Mr Gamble's death was ischaemic heart disease and pulmonary thromboembolism from a deep vein thrombosis. Toxicology tests did not detect any illicit substances. Levels of quetiapine were detected, which were above the level associated with normal therapeutic use but not at a level comparable to quetiapine-associated deaths.

Findings

Clinical care

62. Mr Gamble died unexpectedly of natural causes. He had heart disease and a pulmonary embolism caused by a deep vein thrombosis. The clinical reviewer found that there was nothing in his records to suggest he displayed any obvious symptoms. Joint swelling is not a side effect of a deep vein thrombosis, and there is no record of Mr Gamble exhibiting any of the classic symptoms (for example a heavy ache in an affected area, or warm skin in the area of the clot). The clinical reviewer also noted that there are no reported symptoms of a pulmonary embolism, such as breathlessness or chest pain, noted anywhere in Mr Gamble's record, although his constant refusal to engage would have made assessment very difficult. Nevertheless, mandatory health screens were not completed and a cardiac assessment on 6 December 2016 was not thorough.

63. PSO 3050, chapter 2.6, says that the purpose of the health screen which should take place before the prisoner's first night is to detect any immediate physical or mental health concerns, significant drug or alcohol abuse and risk of suicide and self-harm. Chapter 2.12 stipulates that in the week following that first reception, staff should offer a general assessment. Although the second assessments are not standardised, they should be seen as an opportunity for gathering further medical information, checking how the prisoner is settling in, and providing health education in the form of information and health promotion.

64. When Mr Gamble arrived at Forest Bank on 6 September 2016, he refused to engage with the initial health screen process. It is not clear whether the health screen had been fully completed but the policy states that prisons should routinely offer a second reception health screen within 7 days of arriving at an establishment. There is no evidence to indicate that Forest Bank attempted to offer Mr Gamble a second health screen.

65. Healthcare staff identified that Mr Gamble had high cholesterol and a prison GP conducted an assessment tool to examine his likely risk of developing heart disease. He did not record that he took into account Mr Gamble's weight, height or blood pressure when he completed the assessment or that he considered statin therapy or any other way to reduce Mr Gamble's cholesterol. The QRisk2 assessment predicted Mr Gamble had a 10.82% likelihood of developing cardio vascular disease over the next ten years. This should have prompted a further review but there is no evidence that one took place.

66. The post-mortem findings showed that Mr Gamble's coronary arteries were partially blocked, that there was evidence he had had a heart attack in the past and that he had had cardiovascular disease for at least months but probably years.

67. Although the toxicology report says that venous thromboembolisms are recognised as a potential risk associated with antipsychotics, the post mortem report says that Mr Gamble's obesity, smoking, relative immobility, possible dehydration and antipsychotic medication might have all contributed, but that each factor's contribution cannot be quantified. Mr Gamble did not engage with general attempts by staff to help him and specifically refused smoking cessation advice.

68. We agree with the clinical reviewer that the overall care Mr Gamble received was not equivalent to that which he could have expected in the community. We make the following recommendation:

The Director and the Head of Healthcare should ensure that, in line with PSO 3050, staff complete full initial and secondary health screens.

The Director and the Head of Healthcare should ensure that QRisk assessments are thoroughly conducted and, where necessary, follow up action takes place.

Management of Mr Gamble's dirty protest

69. Prison Service Order 1700 'Segregation', chapter 11, covers national policy on dirty protests. The PSO says that the local policy should cover who is to be informed when a prisoner starts a dirty protest and that these should include the wing or unit manager, the Director or duty director, a doctor or nurse, the security department (who should record the incident on their reporting system), the Independent Monitoring Board and an ACCT case manager. Forest Bank's local policy reflects these requirements but did not apart from the requirement to inform the wing or unit manager.

70. The investigation identified a number of failings in the management of Mr Gamble's dirty protest. There is no evidence that the security department and an ACCT manager were informed of Mr Gamble's dirty protest, no record that a duty director or other prison managers visited Mr Gamble, that he was encouraged to end his protest, that events were accurately recorded, or that staff had a conversation with Mr Gamble after 6.00pm on 25 April. Staff entered his cell approximately 13 hours later, the next morning, to find that he had died.

71. The investigation found that staff did not manage Mr Gamble in line with the national and local policy. However, as the events surrounding the dirty protest do not directly relate to Mr Gamble's death, we make no recommendation.

Management of Mr Gamble's food refusal

72. Mr Gamble was refusing food from 23 April 2017. Prior to his death, he had not taken any food or liquids for two and a half days. Prison Service Instruction 64/2011 'Management of prisoners at risk of harm to self, to others and from others (Safer Custody)' says that prisons should manage prisoners who are refusing food and/or fluids in line with the the Department of Health guidance, *Guidelines for the clinical management for people refusing food in Immigration Removal Centres and Prisons.*

73. The Department of Health guidance states it is critical that a thorough assessment of a person's mental capacity and nutritional status is undertaken immediately and there should be regular reassessments of the person's physical and mental state. Healthcare staff should have initiated and adhered to an appropriate protocol as soon as they were made aware of Mr Gamble's refusal to eat and drink. We recognise it would have been difficult to record Mr Gamble's weight, temperature, pulse, blood pressure and respiration rate while he was not engaging and was on a

dirty protest. However, it is unacceptable that healthcare staff did not record Mr Gamble's level of food and fluid intake.

74. The PSI also says that many prisons have in place a food refusal log. We were not provided with the food refusal log for Mr Gamble but note that officers noted that Mr Gamble was refusing food on the dirty protest log.

75. Although food and liquid refusal is not considered in law to be a form of self-harm, PSI 64/2011 states that an ACCT may provide a useful way of recording the care offered and facilitate information sharing. Although staff opened an ACCT when Mr Gable arrived at the prison and refused to go on the normal wing and threatened to refuse food, there is no evidence that staff considered opening an ACCT to facilitate management of Mr Gamble's food refusal on 23 April.

76. We note that staff did not check in any meaningful way on a very vulnerable man for 13 hours prior to his death. This would not have been the case if Mr Gamble had been on an ACCT – although it is not possible to say whether this would have made any difference to the outcome.

77. We make the following recommendation:

The Director and the Head of Healthcare should ensure that, in line with PSI 64/2011 and associated Department of Health Guidance, staff are aware of the correct procedures to follow when a prisoner refuses food.

Unlock procedures

78. At unlock, officers should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual says, "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response, you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

79. Prison Service Instruction 75/2011 'Residential Services' states that:

> "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...
>
> "[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

80. The requirement to 'gain a response' was difficult for officers because Mr Gamble was not communicating with anyone at the time. However, on previous occasions when an officer had taken a Mr Gamble a meal, he logged that he had seen movement or seen Mr Gamble breathing. Although he told police he took Mr

Gamble his breakfast on the morning of 26 April between 7.00am and 7.10am, he did not evidence in the log that he had sought to check Mr Gamble's welfare. We reiterate the importance of doing so.

The Director should ensure staff are aware, in line with PSI 75/2011, of the importance of gaining a response from prisoners at unlock and that, where a prisoner refuses to communicate, officers should log what they have observed as signs of life.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100