

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dean Gabay, a prisoner at HMP Lowdham Grange, on 1 August 2020

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 Dean Gabay died on 1 August 2020 of the toxic effects of synthetic cannabinoids while a prisoner at HMP Lowdham Grange. He was 30 years old. I offer my condolences to Mr Gabay's family and friends.

The clinical reviewer concluded that the healthcare Mr Gabay received at Lowdham Grange was equivalent to that which he could have expected to receive in the community.

I am concerned that Mr Gabay was able to obtain illicit drugs at Lowdham Grange with apparent ease. The prison needs to continue its efforts to prevent the supply of and demand for illicit substances. The prison has updated its drugs strategy and now needs to ensure this is implemented fully, to reduce the serious harm caused by drug use, and ensure that staff are vigilant for signs of drug use.

I am also concerned that there was a delay in the emergency response because Mr Gabay had covered his observation panel without being challenged to remove it and because staff did not immediately enter Mr Gabay's cell or call a medical emergency code when he was seen unresponsive on his bed. I cannot say whether the delay affected the outcome for Mr Gabay, but we know that in an emergency situation, a delay of a few minutes may be critical.

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

July 2021

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Summary

Events

1. In September 2012, Mr Dean Gabay was remanded into prison custody charged with murder. In August 2013, he received a life sentence with a minimum tariff of 24 years. He spent time at a number of prisons.
2. In late 2017, Mr Gabay was found under the influence of psychoactive substances (PS) on three occasions but there are no further references in his medical or prison records to him using drugs.
3. On 26 April 2019, Mr Gabay transferred to HMP Lowdham Grange. A prison nurse carried out an initial health screen and recorded that he had a history of illicit substance misuse. She referred him to the prison's drug treatment team and mental health team, but he declined to engage with them and said he was drug-free.
4. On 1 August 2020, an officer was asked by a prisoner to take some DVDs to Mr Gabay in his cell at about 6.00pm. When she arrived at Mr Gabay's cell, she opened the observation panel to speak to him, but it was covered from the inside. She called to him but, due to the noise on the wing, she was unsure if he responded. She slid the DVDs under the cell door and carried on with her duties.
5. Just after 10.00pm, another officer was conducting an evening roll and welfare check. When he went to check Mr Gabay, he found that the observation panel was covered up. He called to Mr Gabay but got no response. He and the other officer looked into the cell through the opening for inserting a fire hose and saw Mr Gabay lying face down on his bed and unresponsive. The officer contacted the Night Orderly Officer and asked for permission to enter the cell to check on his wellbeing. He agreed.
6. When they entered the cell, they found Mr Gabay unresponsive. They radioed an emergency code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Prison and healthcare staff arrived and began cardiopulmonary resuscitation (CPR) until paramedics arrived at 10.32pm. The paramedics took over emergency treatment and instructed staff to continue with CPR. At 10.43pm, the paramedics confirmed that Mr Gabay had died.
7. A post-mortem examination concluded that Mr Gabay died from the toxic effects of PS.

Findings

Mr Gabay's PS use

8. There is no evidence that staff at Lowdham Grange had ever seen Mr Gabay under the influence of drugs or were aware that he was using drugs. We cannot say if he was using drugs regularly or if doing so on the day of his death was a rare event.

Obstructed observation panel

9. When Mr Gabay covered the observation panel of his cell door on 1 August, staff did not ask him to remove the obstruction. This later caused a delay in Mr Gabay being found unresponsive in his cell.

Emergency response

10. Prison staff did not immediately use an emergency medical code or consider entering the cell as they should have done when Mr Gabay was found unresponsive in his cell. This meant that there was a delay in calling an ambulance. We cannot say whether the delay made a difference to the eventual outcome for Mr Gabay.

Clinical care

11. The clinical reviewer concluded that the clinical care Mr Gabay received at Lowdham Grange was equivalent to that which he could have expected to receive in the community.
12. However, the clinical reviewer found that when Mr Gabay returned to Lowdham Grange in October 2019 (after a month away at HMP Thameside for accumulated visits), he did not have an initial health screen or a secondary health screen as he should have done. This was a missed opportunity to ask him about his drug use.

Sharing of PPO reports

13. We consider that it is important for staff who were involved in Mr Gabay's care to see the findings of our investigation.

Recommendations

- The Director should ensure that observation panels in cell doors are kept clear to enable safe observations and that staff actively challenge prisoners who cover them.
- The Director should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies. In particular staff should:
 - enter a cell where there appears to be immediate danger to life, subject to a dynamic risk assessment; and
 - use an emergency code immediately there are serious concerns about the health of a prisoner to alert control room staff to call an ambulance immediately.
- The Director should ensure that staff are vigilant for signs of drug use and take appropriate action when a prisoner appears to be under the influence of drugs.
- The Head of Healthcare should ensure that that all newly arrived prisoners receive an initial health screen and be offered a secondary health screen within seven days in accordance with NICE guidance.

- The Director should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Lowdham Grange informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
15. Due to restrictions in response to the COVID-19 pandemic, the investigator was unable to visit Lowdham Grange. He obtained copies of relevant extracts from Mr Gabay's prison and medical records by email and conducted interviews with two staff by telephone.
16. NHS England commissioned an independent clinical reviewer to review Mr Gabay's clinical care at the prison.
17. We informed HM Coroner for Nottingham City and Nottinghamshire Coroners Service of the investigation. The coroner gave us the results of the post-mortem investigation and toxicology results. We have sent the coroner a copy of this report.
18. Mr Gabay's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Lowdham Grange

20. HMP Lowdham Grange is a medium security prison, managed by Serco, which holds a maximum of 888 men, the majority of whom are serving sentences of 10 years or more. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services, which includes 24-hour nursing cover.

HM Inspectorate of Prisons (HMIP)

21. The most recent full inspection of HMP Lowdham Grange was in August 2018. Inspectors noted that 49% of prisoners surveyed said that it was easy to obtain illicit drugs and 46% said that it was easy to obtain alcohol.
22. Inspectors noted that the prison's strategic approach to drugs had improved. There had been regular finds of illicit substances (including the interception of psychoactive substances (PS) impregnated into mail sent to prisoners), leading to a reduction in the number of positive random drug test results. However, inspectors considered that not enough suspicion led drug tests had been carried out.
23. Inspectors noted that all new arrivals needing substance misuse treatment were identified at reception and received appropriate prescribing. They considered the prescribing of treatment was flexible and that prisoners underwent regular reviews. They noted that prisoners also benefitted from individualised and audited care plans. Substance misuse teams delivered a good range of individual and group psychological interventions and person-centred clinical treatment. Inspectors also found that the team worked effectively with partners to support the prison's revised drug strategy.
24. In January/February 2021, HMIP carried out a scrutiny visit to Lowdham Grange to look at the conditions and treatment of prisoners during the COVID-19 pandemic. They found that the prison had been active in easing the COVID regime restrictions when this became possible and had been able to reopen several key work activity areas during the summer. However, they noted that wider national restrictions and a serious COVID-19 outbreak in September 2020 had subsequently stalled progress, and prolonged periods locked in cells were clearly taking their toll on prisoners' wellbeing.

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 July 2020, the IMB reported that the inappropriate use of illicit substances, particularly PS, by prisoners had continued to be a cause for concern. However, the Board noted that the prison was using Rapiscan equipment which had enabled them to disrupt the supply of drug-impregnated mail to prisoners, principally PS and cocaine, with on average between 40-50 drug finds each month.

Previous deaths at HMP Lowdham Grange

26. Mr Gabay was the seventh prisoner to die at Lowdham Grange since August 2018. Of the previous deaths, two were self-inflicted deaths, two were from natural causes, and two were drug-related. There has been one further death (from natural causes) since Mr Gabay's death.
27. Following some of our previous investigations we have made recommendations about taking action when prisoners cover their observation panels, about failings in the emergency response and about the availability of drugs.

Psychoactive Substances (PS)

28. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a significant 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 precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
29. There are many types of PS, including synthetic cannabinoids, often referred to as "Spice".

Key Events

30. On 17 September 2012, Mr Dean Gabay was remanded into prison custody charged with murder and was sent to HMP Wormwood Scrubs. On 16 August 2013, Mr Gabay received a life sentence with a minimum tariff (period to serve in prison) of 24 years. Over the next few years, Mr Gabay spent time at HMP Belmarsh, HMP Swaleside and HMP Dovegate.
31. In October and December 2017, Mr Gabay's medical and prison records contain references to him being found under the influence of psychoactive substances (PS). In October, he had an adverse reaction to PS and a code blue emergency response was called. His medical notes recorded that he was in a very agitated state all night and describe him as being a "habitual user" at that time. Although there was intelligence to indicate he was involved in the prison's drug culture, there are no further recorded instances of PS or other drug use in his records.

In April 2018, Mr Gabay transferred to Dovegate. A nurse carried out an initial health screen and noted that Mr Gabay had refused a referral to the prison's substance misuse team. In June 2018, Mr Gabay saw a member of the prison's mental health in-reach team (MHIRT). He told the mental health nurse that although he had engaged with the MHIRT at Belmarsh, he did not want to engage at Dovegate.

HMP Lowdham Grange

32. On 26 April 2019, Mr Gabay transferred to Lowdham Grange after allegedly being involved in a fight with other prisoners at Dovegate. A nurse carried out an initial health screen. She recorded that Mr Gabay had a history of illicit substance misuse and admitted that he had used drugs in the last three months. She referred him to the prison's substance misuse team and the prison's mental health team.
33. On 8 May, Mr Gabay saw a nurse from the prison's MHIRT team. Mr Gabay told him that he had previously engaged with the MHIRT at Belmarsh because he had been hearing voices which he believed were coming from the television. The nurse asked him if he had considered that the voices were related to his previous PS use. Mr Gabay said no and that he thought the voices were as a result of his struggle to cope with receiving a long prison sentence. He said he had not taken PS since 2016. The nurse concluded that Mr Gabay would not benefit from any further input from the MHIRT.
34. On 24 May, Mr Gabay saw a substance misuse worker. He told her that he had been drug-free for over a year and that he had no cravings or urges to use illicit substances while at Lowdham Grange. She told him that he could refer himself for assistance and/or support to the team at any time should he feel the need to. Mr Gabay had no further contact with the prison's substance misuse team.
35. For the first few years of his prison sentence, Mr Gaby's behaviour had been poor: the records indicate that he did not comply with the regime and was aggressive to staff and other prisoners. However, he appeared to settle at Lowdham Grange and gained Enhanced regime status (under the IEP scheme which is designed to incentivise positive behaviour) and got a job as a wing cleaner. He had regular key

worker sessions and engaged well with staff. He said he wanted to use his sentence to obtain qualifications and in due course to do an Open University degree. Although he did not have visits because of the distance from his family, he said he enjoyed good support from his mother and grandmother and that he spoke to his mother on the phone most days.

36. In September/October, he spent a month at HMP Thameside for accumulated visits and an officer there described him as “polite and respectful” to staff and as being helpful and having a positive attitude.
37. When he returned to Lowdham Grange on 14 October, there is no evidence in his medical records that he had a reception health screen on arrival or that he received a secondary health screen. Mr Gabay had little further significant contact with healthcare staff.
38. Mr Gabay lost his job as a wing cleaner at Lowdham Grange when he went to Thameside and remained unemployed until his death. This meant that he spent more time in his cell than he would otherwise have done. He raised his frustrations about this regularly during his key worker sessions but, although he said on 16 March 2020, that he was “desperate” for a job, he also said he was fussy about which jobs he would be willing to do. Apart from Mr Gabay’s concerns about being unemployed, staff recorded that he said he was happy on the wing, felt safe there and had no issues with debts or drugs, and that he enjoyed going to the gym.
39. However, on 21 April, Mr Gabay was given a behaviour warning for using inappropriate language to a female officer and the following day, he was placed on the Basic regime after exposing himself to a female officer and throwing food over the railings. In May, staff recorded that Mr Gabay was continually flouting the restricted regime imposed in response to the COVID-19 pandemic, and on 12 May, he was given a behaviour warning after refusing to lock up and being aggressive to staff. On 11 May, he was told that he would remain on the Basic regime until his behaviour improved.
40. Throughout June and July staff recorded that Mr Gabay repeatedly said that he was “frustrated”, “bored” and “sick of the regime” and asked about getting a job, and that he did not always want to talk when they checked on his wellbeing. However, they also recorded that he always said he was “fine” and coping, and staff noted that he was “generally always in good spirits” (28 June), “in a good mood” (13 July) and “in good spirits (21 July).

Events of 1 August 2020

41. On the morning of 1 August, an officer went to see Mr Gabay for a key worker session. She recorded that he was “in high spirits”. He did not want a key worker session as he said nothing had changed since his last one, but he told her he was “doing good” and that, apart from wanting a job, he said “everything is all good”.
42. At 5.59pm, an officer was asked by a prisoner to pass some DVDs to Mr Gabay. She said that, after checking the contents, she went to Mr Gabay’s cell, knocked on the cell door and opened the observation panel, but it was covered up from the inside. The officer told the investigator that due to music playing and noise on the wing, she could not hear his response, so she shouted to Mr Gabay that she was putting the DVDs under his door. She also said that she could hear prisoners talking

to each other through the windows and assumed that Mr Gabay was one of them but could not be sure. She slid the DVDs under the cell door and told him that they were on the floor. She then left the cell to carry on with her duties.

43. At 10.00pm, while carrying out an evening roll check and welfare check, an officer arrived at Mr Gabay's cell door. He opened the observation panel and saw that it was covered from the inside. He knocked on the cell door while calling Mr Gabay's name. Mr Gabay did not respond. He then called to another officer and told her that he could not see into the cell. She told him to keep trying, and that she would help him once she had finished her checks. The officer told the investigator that they both finished checking the landing, which took less than one minute, then went to Mr Gabay's cell together. They tried to gain a response from him, but he did not respond.
44. The officers left the cell and went to the wing office to get a key to open the inundation point (a small hatch in the cell door used for a fire hose in case of a cell fire). They opened it and looked inside the cell. They saw Mr Gabay lying face down on his bed in what they considered to be an unnatural position.
45. At 10.08pm, one of the officers radioed the Night Orderly Officer and asked for permission to enter the cell to check on Mr Gabay's welfare. He agreed they could do so as long as they considered it was safe.
46. The officers immediately entered the cell and checked Mr Gabay for signs of a pulse or breathing, but there were none. An officer radioed an emergency code blue (indicating a prisoner is unresponsive or having difficulty breathing). Staff in the prison control room telephoned for an emergency ambulance immediately.
47. At 10.10pm, the Night Orderly Officer arrived at the cell with three officers and a nurse. They moved Mr Gabay to the floor and the Night Orderly Officer began CPR while the nurse attempted to take his clinical observations.
48. The nurse recorded Mr Gabay's temperature which indicated that he was suffering from severe hypothermia. He tried to take a sample of Mr Gabay's blood in order to check his blood sugar level but was unable to get a sample. He gave Mr Gabay a glucose injection, in case he had collapsed due to low blood sugar, but Mr Gabay did not respond. The nurse attached a defibrillator to Mr Gabay's chest, and an oxygen mask to his face. The defibrillator did not find a shockable rhythm and there were no signs of life. The Night Orderly Officer continued with CPR.
49. At 10.25pm, the emergency ambulance arrived. Paramedics reached the cell at 10.32pm. They attempted to insert an airway into Mr Gabay's throat but they were unsuccessful. They then attached a defibrillator to Mr Gabay's chest, but no shockable rhythm was found. At 10.41pm, they told staff to stop CPR and at 10.43pm paramedics confirmed that Mr Gabay had died.

Information received after Mr Gabay's death

50. Police officers searched Mr Gabay's cell on 1 August and found a bottle, cigarettes and a bed sheet with fluids on. A second bottle was found on the window sill outside Mr Gabay's cell window. Information received by the police suggested that a prisoner might have supplied Mr Gabay with illegal drugs on the day of his death.

Contact with Mr Gabay's family

51. On 2 August, the prison appointed a family liaison officer.
52. A senior manager tried to telephone Mr Gabay's next of kin, his grandmother, to inform her of his death but there was no answer. She then telephoned Mr Gabay's mother and informed her of her son's death. She told Mr Gabay's mother that ordinarily she would have gone to her home in person to break the news, but due to the COVID-19 restrictions, she was unable to do so. She offered her condolences and support.
53. The prison's family liaison officer remained in contact with Mr Gabay's mother and grandmother until his funeral, which was held on 22 September. The prison contributed to the funeral costs in line with national instructions.

Support for prisoners and staff

54. The prison posted notices informing other prisoners of Mr Gabay'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 his death.
55. After Mr Gabay's death, the staff involved in the incident were given the opportunity to discuss any issues arising and were also offered support by the staff care team.

Post-mortem report

56. Toxicology tests showed that Mr Gabay had taken PS before he died. The toxicologist noted that the effects of PS are unpredictable and can include abnormal heart rhythms, seizures, respiratory depression and coma.
57. The post-mortem report concluded that the most likely cause of Mr Gabay's death was to PS toxicity.
58. The clinical reviewer commented that the post-mortem found that Mr Gabay's heart, brain and lungs were structurally normal, apart from a minor bleed to the brain. She said it seemed most likely that he died from an acute heart rhythm problem as a result of PS use which caused a sudden and unpredictable cardiac arrest.

Inquest into Mr Gabay's death

59. The inquest into Mr Gabay's death was held on 20 April 2023 and a verdict of death by drug and alcohol use was recorded.
60. The coroner concluded Mr Gabay's death was due to drug toxicity.

Findings

Mr Gabay's PS use

61. Mr Gabay's death was caused by PS use. After his death, the police found a number of drug-related items in Mr Gabay's cell and intelligence suggested that a prisoner had passed Mr Gabay some illicit drugs on the day of his death. We have therefore considered whether Mr Gabay had a problem with substance misuse and whether the prison should have done more to support him to tackle his drug use.
62. We cannot say whether Mr Gabay used PS regularly at Lowdham Grange or whether the use on the day of his death was a rare event. Prison staff were not aware that Mr Gabay was using drugs. He told both healthcare and prison staff that he was drug-free, he did not test positive for drugs and was not found under the influence of drugs at Lowdham Grange and there was no intelligence to suggest that he was using drugs.
63. However, there is evidence that Mr Gabay did not always tell the truth about his drug use and that he was adept at concealing his drug use from staff. For example, when he arrived at Lowdham Grange in April 2019, Mr Gabay admitted to the reception nurse that he had used drugs in the last three months, although staff at his previous prison had not been aware of this. In May 2019, Mr Gabay told a nurse from the prison's mental health team that he had not used PS since 2016, which was not correct as there are records of him using drugs at Belmarsh in late 2017. In the same month he told a substance misuse worker that he had been drug free for over a year, which does not match with his earlier admission of drug use in the previous three months.
64. We are satisfied that Mr Gabay gave staff no reason to suspect that he was using drugs at Lowdham Grange. We are also satisfied that Lowdham Grange offered Mr Gabay support for potential substance misuse issues and that he declined help.
65. However, we note that mandatory drug tests did not take place for the last five months of Mr Gabay's life because of the COVID-19 restrictions, and that it may also have been easier for drug use to go unnoticed when prisoners were spending long periods in their cells because of the restricted regime. It is possible that prisoners may be more tempted to use drugs during the lockdown because of boredom. We make the following recommendation:

The Director should ensure that staff are vigilant for signs of drug use and take appropriate action when a prisoner appears to be under the influence of drugs.

Availability of psychoactive substances (PS) at Lowdham Grange

66. We are concerned that Mr Gabay was able to obtain the PS which caused his death at Lowdham Grange. Both HMIP and the IMB have expressed concern about the availability of PS at Lowdham Grange, although they also noted that the prison was taking steps to tackle the problem.
67. The use of PS is a concern across the prison estate and has a profoundly negative impact on the physical and mental health of prisoners, as well as being associated

with debt and bullying. Mr Gabay's death is an example of the dangers of PS and illustrates why prisons must do all they can to eradicate its use.

68. In April 2019, HM Prison and Probation Service published the National Drug Strategy. It set out their plans to reduce substance misuse in prisons by providing detailed guidance for prisons to help them identify issues and share best practice. It required each prison to develop their own local drug strategy, taking account of their specific needs and issues.
69. In June 2020, Lowdham Grange implemented a new substance misuse strategy that focused on reducing the supply of and demand for drugs and in building recovery for those who use illicit substances. The Head of Security told us that the policy is reinforced through dedicated monthly meetings that make use of security intelligence, and that some of the recent initiatives have included new procedures for identifying suspicious incoming mail (using x-ray machines and drugs dogs); ensuring that healthcare staff are told when a prisoner's incoming mail has tested positive for drugs so they can start any drug intervention needed with prisoners much sooner; and from January 2021, they will have a body scanner for use when prisoners enter the prison.
70. We consider that the prison has taken positive steps to address the supply and demand of drugs at Lowdham Grange, and we therefore make no recommendations. However, it is important that the prison continues its efforts to prevent the supply of and demand for illicit substances. The prison needs to ensure that its updated drugs strategy is implemented fully and that staff are vigilant for signs of drug use.

Obstructed observation panel

71. We are concerned that when Mr Gabay covered his observation panel on 1 August, An officer did not ask him to remove the obstruction, even though she was not sure if she had got a response from him or not. We consider that it is dangerous to allow prisoners to cover their observation panels and that the officer should have challenged Mr Gabay and asked him to remove the obstruction. The fact that staff could not see into the cell caused a delay in Mr Gabay being found unresponsive later. We cannot say whether this delay impacted on the eventual outcome for Mr Gabay, but a similar delay may prove critical in other cases.
72. We note that after Mr Gabay's death, a senior manager gave the officer advice and guidance about what to do when a prisoner covers up the cell door observation panel.
73. We make the following recommendation:

The Director should ensure that observation panels in cell doors are kept clear to enable safe observations and that staff actively challenge prisoners who cover them.

Emergency response

74. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol which ensures an ambulance is called automatically in a life-threatening emergency. It says that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies.
75. PSO 24/2011, *Management and Security of Nights*, says that under normal circumstances, authority to unlock a cell at night must be given by the Night Orderly Officer (NOO) and no cell will be opened unless a minimum of two/three members of staff are present, one of whom should be the NOO. However, the PSO goes on to say that the preservation of life must take precedence and that where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the NOO, and an individual member of staff may enter the cell on their own. However, night staff should not take action that they feel would put themselves or others in unnecessary danger.
76. While an officer was carrying out an evening roll and welfare check on 1 August, he opened Mr Gabay's observation panel and saw that it was covered from the inside and he did not get a response from Mr Gabay. He told another officer that he could not see into the cell. We are concerned that both officers then carried on checking other cells on the landing before going back to Mr Gabay's cell. They both then left the cell and went to the wing office to get a key to open the cell inundation point. Although they both said that this took less than a minute, we are concerned that the officers did not respond with any sense of urgency when Mr Gabay did not respond to the officer's calls.
77. Once they had opened the inundation point and seen Mr Gabay was unresponsive, we consider that they should have immediately called an emergency medical code blue to indicate Mr Gabay was unconscious. They should also have considered whether it was safe for them to enter the cell together to provide immediate assistance to Mr Gabay. Instead, they radioed the NOO and asked for his permission to enter the cell. Once the NOO gave permission, the officers entered the cell and tried to rouse Mr Gabay, but he was still unresponsive. One of the officers then called an emergency code blue, which meant that there was a further delay between her first seeing Mr Gabay lying unresponsive on his bed and the ambulance being called.
78. Although we cannot say whether the delay affected the outcome for Mr Gabay, we know that in an emergency situation, a delay of a few minutes may be critical. We make the following recommendation:

The Director should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies. In particular staff should:

- **enter a cell where there appears to be immediate danger to life, subject to a dynamic risk assessment; and**
- **use an emergency code immediately there are serious concerns about the health of a prisoner to alert control room staff to call an ambulance immediately.**

Clinical care

79. The clinical reviewer found that that the healthcare Mr Gabay received at Lowdham Grange was of a good standard and equivalent to that which he could have expected to receive in the community.
80. The clinical reviewer did, however, identify some concerns.
81. She noted that when Mr Gabay returned to Lowdham Grange on 14 October 2019, he did not have an initial health screen. We consider that this was a missed opportunity to review his substance misuse needs and consider whether a referral to the substance misuse team was necessary.
82. The National Institute for Health and Care Excellence (NICE) also recommends that prisoners should be offered a secondary health screen within seven days of entering a prison, to explore any health conditions and to ensure they receive appropriate treatment and support. However, there is no evidence in Mr Gabay's medical records that he was offered a secondary healthcare screen when he returned to Lowdham Grange on 14 October 2019. We consider that this was another missed opportunity to review Mr Gabay's substance misuse needs and consider referring him to the substance misuse team for support if needed. We recommend:

The Head of Healthcare should ensure that that all newly arrived prisoners receive an initial health screen and are offered a secondary health screen within seven days in accordance with NICE guidance.
83. The clinical reviewer made several other recommendations which the Head of Healthcare at Lowdham Grange, Thameside and Belmarsh will need to address.

Sharing of PPO reports

84. We consider that it is important for staff who were involved in Mr Gabay's care to be aware of the findings of our investigation. We make the following recommendation:

The Director should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

**Prisons &
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