

**Prisons &
Probation**

Ombudsman
Independent Investigations

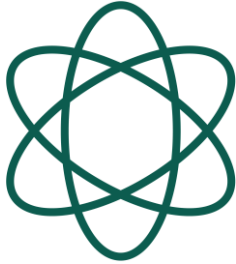
Independent investigation into the death of Mr George Gibbs, a prisoner at HMP Rye Hill, on 21 December 2020

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

OGL

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Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr George Gibbs died in hospital on 21 December 2020, while a prisoner at HMP Rye Hill. He was 72 years old. The cause of his death was COVID-19 infection. He also had underlying bile duct cancer which had spread to other parts of his body, paraplegia, diabetes and osteoarthritis. I offer my condolences to Mr Gibbs' family and friends.
4. Full details of the clinical findings are in the clinical reviewer's report. She identified several serious shortcomings in Mr Gibbs' clinical care at Rye Hill and concluded it was not equivalent to that he could have expected to receive in the community.
5. While acknowledging that Mr Gibbs was a challenging and complex patient, the clinical reviewer found that there was a lack of clinical leadership and oversight; GPs were not involved in multidisciplinary meetings; and there had been poor communication between healthcare and operational staff about an important missed appointment. The absence of a diagnosis further complicated Mr Gibbs' condition, leading to paraplegia and incontinence, and his chronic pain was not appropriately managed. We recast and repeat the clinical reviewer's recommendations directly related to Mr Gibbs' death.
6. We are also concerned that Mr Gibbs felt he was unable to receive adequate help from prison carers while shielding; officers escorting him in hospital were not fully compliant with the use of PPE; there were several missed telephone appointments with GPs; and healthcare staff did not take appropriate account of his state of health when completing security risk assessments for hospital visits.
7. We cannot say for certain where Mr Gibbs contracted COVID-19, as it was detected 14 days after he went into hospital (just within the accepted incubation period).

Recommendations

- The Director and Head of Healthcare should ensure that appropriate arrangements are made to facilitate prison carers when there are changes to a prisoner's regime or location.
- The Head of Healthcare should ensure that long-term conditions, such as diabetes, are managed in line with national guidance.
- The Head of Healthcare should ensure that there is dedicated clinical leadership for patients with complex medical conditions.

- The Head of Healthcare should ensure that GPs are involved in multidisciplinary team meetings, particularly when they are leading on a complex case.
- The Head of Healthcare should formally review the findings of the clinical review report with clinical managers and share the learning with all healthcare staff.
- The Head of Healthcare should ensure that healthcare staff use a pain assessment tool to objectively assess and document patients' reported pain and that referrals are made to specialist pain services, where necessary.
- The Director should ensure that escort officers are fully briefed on the requirement for PPE and how it should be worn.
- The Director and Head of Healthcare should develop a formal, auditable process to ensure that healthcare staff are immediately informed if a prisoner refuses to attend a clinical appointment.
- The Director and the Head of Healthcare should review the process for in-cell healthcare appointments to minimise missed calls and ensure prompt follow-up if a clinician is unable to make contact.
- The Director and Head of Healthcare should provide guidance to healthcare staff who complete security risk assessments to ensure that they understand the legal requirements and that they accurately reflect the current health and mobility of a prisoner.

The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Gibbs' clinical care at HMP Rye Hill.
9. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Gibbs' location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.
10. The investigator and clinical reviewer jointly interviewed two members of the healthcare department on 4 February 2021 and the investigator interviewed a residential manager on 5 February. The interviews were conducted by telephone due to the restrictions in place during the COVID-19 pandemic.
11. The PPO's family liaison officer wrote to Mr Gibbs' next of kin, his ex-wife, who asked for the following to be considered as part of the investigation:
 - Did Mr Gibbs have pressure sores because he was not helped to change his position?
 - Why was Mr Gibbs not transferred to a hospice, given the prison did not have the appropriate facilities?
 - What medication had been prescribed for Mr Gibbs?
 - Why was Mr Gibbs' diabetes not diagnosed in prison?
 - Why did prison officers not believe that Mr Gibbs had paralysis?
 - What social care did Mr Gibbs receive, as he had complained of lying in his urine and faeces?
12. These issues have been addressed in either the clinical review, or in this report.
13. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.
14. We sent a copy of our initial report to Mr Gibbs' ex-wife. She did not notify us of any factual inaccuracies.

Previous deaths at HMP Rye Hill

15. Mr Gibbs was the 13th prisoner at Rye Hill to die, since December 2018. There have been six further deaths. All the deaths were from natural causes, including three COVID-19 related deaths. We have previously raised concerns about multidisciplinary healthcare, missed clinical appointments, communication and restraints.

COVID-19 (coronavirus)

16. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.
17. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)
18. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners, or staff, who are clinically suspected, or have tested positive for COVID-19 within 14 days.) A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly-arrived prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

HM Inspectorate of Prisons

19. The inspectorate reported on a short scrutiny visit to Rye Hill in June 2020. Inspectors found that COVID-19 local operational delivery service plans were in place and there was good access to PPE. Patients had access to healthcare by telephone, triage was timely and patients could be seen on the wing, in their cells, or in the healthcare unit. Inspectors also noted that social care provision was maintained in line with care plans.

Key Events

20. Mr George Gibbs was remanded to HMP Liverpool on 31 October 2013. He was later convicted of sexual offences and sentenced to life imprisonment, with a minimum period to serve of ten years.
21. Mr Gibbs transferred to HMP Rye Hill on 11 June 2015. At his initial health screen, it was noted that he had asthma, high blood pressure and widespread osteoarthritis. He later developed diabetes (diagnosed on 12 April 2019), as well as persistent, severe back and hip pain.
22. Mr Gibbs often complained about his care and access to healthcare staff. As his health declined, his relationship with some staff became difficult, his behaviour was inappropriate at times and it was sometimes challenging to manage him. As a result of this, a lot of contact was recorded on body-worn cameras. A friend and Mr Gibbs' ex-wife also notified the prison of concerns about Mr Gibbs' care. They felt that a few prison staff either did not understand his needs or were deliberately unhelpful as they thought he was putting on an act and feigning the severity of his condition.
23. On 3 April 2020, the Head of Healthcare informed Mr Gibbs that he was clinically extremely vulnerable and at higher risk of complications if he contracted COVID-19. They discussed the risks and the options for shielding. In summary, these were: self-isolation with no external contact except for delivery of meals and medication and showers taken on his own; self-isolation, again with food and medication delivered, but taking exercise and showers with other higher risk prisoners; and continue as normal mixing with non-vulnerable men. Mr Gibbs chose option two and signed a compact.
24. In July, healthcare staff noted that Mr Gibbs had lost a lot of weight. After a discussion between the prison GP, medical director and Head of Healthcare, blood tests and an X-ray were requested. It was decided not to refer Mr Gibbs for investigation under the NHS pathway for suspected cancer, as his weight loss was thought to be intentional.
25. On 25 July, Mr Gibbs refused to attend an urgent pelvic X-ray, giving the pain and discomfort of being double handcuffed as his reason. Wing staff failed to tell healthcare that he had not attended. When clinical staff later found out, it was too late for the appointment to be rebooked, so Mr Gibbs had to be re-referred.
26. In the following months, Mr Gibbs refused to attend further planned hospital appointments. He annotated one of the disclaimers to say that he wanted to attend a scan but was in agony and could not use his legs. He added that the wheelchair supplied caused excruciating pain and he needed adequate transport.
27. A nurse reviewed shielding arrangements with Mr Gibbs on 11 August and Mr Gibbs decided to stop shielding. He signed a disclaimer, noting on the form that he was doing so "under duress", as it was impossible to be without a daily carer and by remaining on 'option two', he would only have a carer once a week. Nurses kept this under review and Mr Gibbs signed further disclaimers on 28 October and 2 November.

28. On 4 November, Mr Gibbs' ex-wife telephoned to say that Mr Gibbs' needs were not being met and that he was constantly left in a soiled and wet bed.
29. On 5 November, an entry in the wing observation book noted that Mr Gibbs had become immobile and doubly incontinent and that providing care was not within prison officers' remit, but staff should be understanding, supportive and telephone healthcare staff for assistance. On 12 November, help from the prison carer was stopped and external carers visited four times a day. (Mr Gibbs reported several falls during November.)
30. On 16 November, it was recorded that Mr Gibbs had been in contact with a carer who had tested positive for COVID-19. Mr Gibbs was isolated and a swab was taken for testing. He was given advice on reporting symptoms and received daily welfare checks. (The swab result returned as negative for COVID-19.)
31. At a welfare check on 18 November, the prison's paramedic found Mr Gibbs sleepy, confused and dehydrated, with low oxygen saturation levels. He called a code blue (a medical emergency code indicating that a person is unconscious or has difficulty breathing) and an ambulance was requested. Paramedics took Mr Gibbs to hospital, accompanied by two prison officers. No restraints were used.
32. The prison gave the hospital the contact details for Mr Gibbs' next of kin, in case doctors needed consent for resuscitation or other treatment. They later allowed him to telephone friends and family.
33. On 21 November, a CT scan revealed that Mr Gibbs had cancer of the liver, lungs and spine. He was given a life expectancy of three months. The spread to his spine had caused cord compression, paraplegia and double incontinence. He also had two spinal fractures, possibly caused by falls. A senior prison nurse visited Mr Gibbs to discuss his preferences and he asked to move to a hospice.
34. The prison appointed a family liaison officer on 24 November. She visited Mr Gibbs that day and, at his request, changed his next of kin to his ex-wife. On 25 November, she telephoned Mr Gibbs' ex-wife to introduce herself and offer support. The family liaison officer kept in touch throughout Mr Gibbs' illness.
35. On 2 December, Mr Gibbs tested positive for COVID-19. A hospital infection prevention nurse telephoned the prison to report that some of the escort officers had not been compliant with use of PPE and they were concerned that one of them had passed the infection to Mr Gibbs. A manager immediately went to speak to the escorts and carried out an investigation.
36. Over the next two weeks, prison and hospital staff discussed plans for discharging Mr Gibbs from hospital, including funding for equipment and how to facilitate overnight social care. An application for early release on compassionate grounds was submitted to the Prison Service on 14 December (but was still under consideration at the time of his death).
37. Mr Gibbs' condition deteriorated on 16 December and he was placed on end of life care. He died in hospital on 21 December.

38. As agreed with Mr Gibbs' next of kin, the prison arranged Mr Gibbs' funeral, which was held on 26 January. In line with national policy, the prison met the funeral expenses.

Cause of death

39. No post-mortem examination was held, as the coroner accepted the cause of death certified by the hospital as COVID-19 infection. Mr Gibbs also had underlying metastatic cholangiocarcinoma [bile duct cancer which had spread to other parts of the body], paraplegia, type 2 diabetes mellitus and osteoarthritis, which did not cause but had contributed to his death.

Findings

Clinical Findings

40. The clinical reviewer concluded that Mr Gibbs' care was not equivalent to that he could have expected to receive in the community. Full details of her findings and recommendations are in the clinical review report. The issues directly linked to Mr Gibbs' cause of death and the conditions that contributed to it are highlighted below.

Management of Mr Gibbs' risk of infection from COVID-19

41. Rye Hill provided detailed guidance to staff on managing and minimising the risks associated with COVID-19. In addition to formal guidance, we noted that the wing observation book had numerous entries giving advice to staff on expectations and new processes as they emerged.
42. Healthcare staff assessed Mr Gibbs as clinically extremely vulnerable at an early stage of the pandemic and, initially, he was appropriately shielded. His prison carer was advised to wear full PPE and spend the minimum amount of time in his cell. Mr Gibbs stopped shielding in August 2020, as he was unable to receive the required level of help from his prison carer if he continued.
43. We are concerned that Mr Gibbs' opportunity to shield was restricted by his care needs. Although there is no longer a requirement for the vulnerable to shield, consideration needs to be given to managing social care needs in similar circumstances in the future. We recommend:

The Director and Head of Healthcare should ensure that appropriate arrangements are made to facilitate prison carers when there are changes to a prisoner's regime or location.

Management of Mr Gibbs' diabetes

44. Mr Gibbs was not on healthcare's diabetes register. As a result, he was not routinely reviewed, in line with national guidance. The Head of Healthcare said she has taken steps to ensure that all long-term conditions are now included in disease management programmes. We recommend:

The Head of Healthcare should ensure that long-term conditions, such as diabetes, are managed in line with national guidance.

Clinical leadership and diagnosis of Mr Gibbs' cancer

45. Mr Gibbs had a number of symptoms over a period of six months, including increasingly severe back pain, appetite and weight loss, shoulder pain, abnormal blood tests, pressure ulcers, as well as left-sided weakness, resulting in paraplegia, incontinence and falls. Only one full examination took place during that time, other checks focussed on his lower limbs.
46. The clinical reviewer found several weaknesses in Mr Gibbs' clinical management, notably no clinical oversight, poor continuity of care, conflicting advice and a lack of

clinical curiosity. She also considered that there had been an over-reliance on X-rays and scans to try and obtain a diagnosis, rather than clinicians considering possible causes of the symptoms.

47. Although five prison GPs had been involved in Mr Gibbs' care, no one had been assigned to take the lead, so there was no overview of his presentation and symptoms. In addition, the GPs were not included in complex case meetings until a month before Mr Gibbs was admitted to hospital.
48. In response to our findings, the Head of Healthcare said that she has taken action to address these issues, including assigning a named nurse and a GP for each complex case. We recommend:

The Head of Healthcare should ensure that there is dedicated clinical leadership for patients with complex medical conditions.

The Head of Healthcare should ensure that GPs are involved in multidisciplinary team meetings, particularly when they are leading on a complex case.

The Head of Healthcare should formally review the findings of the clinical review report with clinical managers and share the learning with all healthcare staff.

Pain management

49. Mr Gibbs complained of persistent and worsening back pain and that his pain relief was no longer effective. Some staff felt that he was exaggerating his symptoms and deliberately choosing not to comply with advice, such as taking more exercise. The level of pain contributed to incontinence as Mr Gibbs could not get to the toilet quickly and to missed external appointments as he was in too much pain to attend. A GP arranged for additional pain relief to help him attend scans in October and November 2020, but there is no evidence that Mr Gibbs was aware of this, or that it was processed. The clinical reviewer said that if Mr Gibbs' cancer had been diagnosed earlier, he would have been offered palliative care. We recommend:

The Head of Healthcare should ensure that healthcare staff use a pain assessment tool to objectively assess and document patients' reported pain and that referrals are made to specialist pain services, where necessary.

Escort officers' use of PPE in hospital

50. We cannot say where or how where Mr Gibbs contracted COVID-19. The incubation period is thought to be between 2 and 14 days and Mr Gibbs tested positive on the cusp, 14 days after his admission hospital.
51. The hospital was concerned the escort officers had worn their face masks incorrectly and that this might have been the source of the infection. A prison manager went to the hospital immediately and the prison looked into the concerns. They established that the officers on duty at that time had no symptoms and were part of the staff testing programme. However, on further investigation, they found that escorts on duty two days before had not worn the correct PPE at all times. As a

result of this breach, the officers concerned were tested and immediately required to self-isolate. All test results were negative.

52. Rye Hill also said that although all escorts were given PPE and stocks were replenished during the daily managers' visits, they found inconsistencies in the handover of PPE information. A new process has since been implemented by the Head of Security to ensure that staff have a clearer understanding of requirements. The hospital was said to be content with the actions taken by the prison, and acknowledged that the location of Mr Gibbs' room next to the access doors for the COVID-19 ward and the resulting volume of passing hospital staff might also have made him more susceptible to infection.
53. We are pleased to note that Rye Hill took immediate action to rectify the problems using PPE and it would be helpful to have assurance that this has been formalised. We recommend:

The Director should ensure that escort officers are fully briefed on the requirement for PPE and how it should be worn.

Information sharing

54. Mr Gibbs refused to attend a key appointment for an urgent pelvic X-ray due to pain and the handcuffing arrangements. Operational staff did not tell the healthcare team about Mr Gibbs' refusal on the day. There was, therefore, no opportunity for healthcare staff to discuss with Mr Gibbs the importance of the appointment, or for healthcare and operational staff to jointly consider whether any adjustments could be made to accommodate him. We recommend:

The Director and Head of Healthcare should develop a formal, auditable process to ensure that healthcare staff are immediately informed if a prisoner refuses to attend a clinical appointment.

55. There were several entries in the medical record indicating that GPs had been unable to contact Mr Gibbs on his in-cell phone. When this was followed up in the early months of the pandemic, it was found that Mr Gibbs was sometimes out on exercise, so it is unclear whether he knew that a call was due. However, in the latter months when his physical condition deteriorated, it became more difficult for him to reach the phone. Mr Gibbs also complained that requests through wing officers to see healthcare staff were not actioned.
56. We consider that the failed calls should not have been treated as isolated incidents but identified as a pattern. Better communication between healthcare and operational staff, in consultation with Mr Gibbs, might have led to improved access for healthcare appointments.

The Director and the Head of Healthcare should review the process for in-cell healthcare appointments to minimise missed calls and ensure prompt follow-up if a clinician is unable to make contact.

Security risk assessments and the use of restraints

57. When prisoners travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public, but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking account of factors such as the prisoner's health and mobility.
58. Until August 2020, restraints were used when Mr Gibbs attended hospital appointments. The medical section of the risk assessment forms for August and October were contradictory - they recorded Mr Gibbs' limited mobility and wheelchair use, but also said that his condition did not restrict his ability to escape unaided. One nurse indicated no objections to the use of restraints, the other noted objections, but annotated the form to suggest the use of single handcuffs. The Head of Healthcare said that there was no guidance or training on completion of the risk assessment forms and it was left to individual judgement.
59. We are concerned that Mr Gibbs' missed medical appointments were partly due to the discomfort caused by restraints. We have made previous recommendations to Rye Hill about risk assessments and the use of restraints. Towards the end of Mr Gibbs' life, prison staff appear to have taken on board the relevant factors to be considered in assessing risk. However, the inconsistencies in the medical assessments and the Head of Healthcare's comments suggest a training need for healthcare staff, which will need to be addressed in consultation with the security team. We recommend:

The Director and Head of Healthcare should provide guidance to healthcare staff who complete security risk assessments to ensure that they understand the legal requirements and that they accurately reflect the current health and mobility of a prisoner.

**Sue McAllister CB
Prisons and Probation Ombudsman**

February 2022

Inquest

The inquest, held on 26 April 2023, concluded that Mr Gibbs died from natural causes.

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

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

T | 020 7633 4100