Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bernard Grace, a prisoner at HMP Forest Bank, on 25 March 2024

A report by the Prisons and Probation Ombudsman

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 deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Bernard Grace died in hospital of ischaemic bowel (blocked blood flow to the bowel) on 25 March 2024, while a prisoner at HMP Forest Bank. He was 73 years old. We offer our condolences to Mr Grace's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Grace received at Forest Bank was of a good standard and was equivalent to that which he could have expected to receive in the community. The clinical reviewer made one recommendation which the Head of Healthcare will wish to address.

5. We found delays in prison staff notifying Mr Grace's next of kin when he became seriously ill in hospital. We bring this to the Director's attention.

The Investigation Process

6. HMPPS notified us of Mr Grace's death on 26 March 2024.

7. NHS England commissioned an independent clinical reviewer to review Mr Grace's clinical care at HMP Forest Bank.

8. The PPO investigator investigated the non-clinical issues relating to Mr Grace's care.

9. The Ombudsman's office contacted Mr Grace's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She raised no issues but requested a copy of our report.

10. We shared our initial report with HMPPS and with the prison's healthcare provider, Spectrum Community Health CIC. They found no factual inaccuracies.

11. We sent a copy of our initial report to Mr Grace's sister. She responded with some comments about the report but did not notify us of any factual inaccuracies.

Previous deaths at HMP Forest Bank

12. Mr Grace was the 17th prisoner to die at Forest Bank since March 2021. Of the previous deaths, 12 were from natural causes, two were self-inflicted and two were drug related. We found no similarities between the findings from our investigation into Mr Grace's death and the findings from our investigations into the previous deaths.

Key Events

13. On 12 May 2023, Mr Bernard Grace was sentenced to eight years imprisonment for sexual offences. He was sent to HMP Forest Bank.

14. Mr Grace had significant health conditions including kidney failure, high blood pressure, and peripheral vascular disease (a build-up of fatty deposits in the arteries that restricts blood supply to the legs). In 2016, he had undergone an above the knee amputation of his right leg due to this condition. Mr Grace attended hospital for kidney dialysis three times a week.

15. On 6 March 2024, during a dialysis appointment, Mr Grace had a cardiac arrest and was successfully resuscitated. He remained in hospital until 16 March when he returned to Forest Bank.

16. On the evening of 24 March, healthcare staff saw Mr Grace after he complained of chest pains. After an electrocardiogram (ECG – a test to check the heart's rhythm) showed abnormal readings, healthcare staff sent Mr Grace by ambulance to Salford Royal Hospital. Subsequent tests showed that Mr Grace had a blockage of a blood vessel in his stump.

17. At 9.45am on 25 March, the escorting staff at the hospital told the prison that Mr Grace needed a transfer to Manchester Royal Infirmary within the hour.

18. At 10.15am, Mr Grace left Royal Salford Hospital and travelled to Manchester Royal Infirmary by blue light ambulance. According to the escorting officers, Mr Grace vomited a black liquid and his condition deteriorated during the journey.

19. At 11.45am, hospital staff asked the escorting officers for Mr Grace's next of kin details. They contacted the prison who provided the details for Mr Grace's sister.

20. Later that afternoon (time unknown), the prison appointed a prison chaplain as the family liaison officer (FLO). She arrived at Manchester Royal Infirmary at around 6.45pm. Shortly after she arrived, she was told that Mr Grace had died (at around 6.50pm).

21. Prison records show that when Mr Grace's sister was contacted at 6.53pm, she was on her way to the hospital (from Scotland). It is unclear whether it was the hospital or the prison who had told her that Mr Grace was in hospital, or at what time contact was made. Mr Grace's sister arrived at the hospital shortly before 11.00pm, after Mr Grace had died, and met the FLO there.

Post-mortem report

22. The post-mortem report concluded that Mr Grace died of ischaemic bowel (blocked blood flow to the bowel) caused by severe aortic atherosclerosis (narrowing of the arteries caused by the build-up of fatty deposits). Chronic kidney failure was listed as a contributory factor.

Non-Clinical Findings

Liaison with Mr Grace's family

23. Prison Rule 22 says that if a prisoner becomes seriously ill, the Governor or Director should notify their next of kin at once.

24. We accept that when Mr Grace was initially taken to hospital on the evening of 24 March, it was not apparent that he was seriously ill. However, by 10.00am the next morning, it was clear that Mr Grace was seriously unwell as he required an emergency transfer to Manchester Royal Infirmary. We consider that the prison should have contacted Mr Grace's next of kin at that point. Instead, it seems nothing happened until the hospital asked for next of kin details at 11.45am, and the prison did not appoint a family liaison officer until sometime that afternoon.

25. We consider that prison staff should have contacted the next of kin much earlier, and the record keeping around contact with the next of kin was poor in this case. We bring this to the Director's attention.

Adrian Usher
Prisons and Probation Ombudsman **August 2024**

Inquest

The inquest, held on 27 November 2024, concluded that Mr Grace died from natural causes.

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