Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jeffrey Griffiths, a prisoner at HMP Whatton, on 23 July 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Jeffrey Griffiths died from a brain haemorrhage on 23 July 2015 while a prisoner at HMP Whatton. He was 71 years old. I offer my condolences to Mr Griffiths' family and friends.

Mr Griffiths had a number of chronic health conditions and had frequent contact with the prison healthcare and hospital staff. I am satisfied that Mr Griffiths received a good standard of care at Whatton. While it did not affect the outcome, I am concerned that prison staff did not follow local policy and use an emergency medical code immediately they suspected Mr Griffiths had suffered a stroke. There is a need for better staff awareness of the symptoms of a stroke and how to respond, particularly in a prison like Whatton with a high proportion of older prisoners and no 24- hour healthcare cover.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2016**

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Summary

Events

1. In August 2008, Mr Jeffrey Griffiths received an indeterminate prison sentence for sexual offences. He had been at HMP Whatton since July 2011. Mr Griffiths had a number of chronic health conditions, including an irregular heartbeat, high blood pressure, and poor mobility.

2. Healthcare staff at Whatton saw Mr Griffiths frequently to monitor his conditions. Referrals, treatment, and medication were appropriate and timely. He attended regular hospital outpatient appointments and was occasionally admitted for treatment.

3. At about 8.10am on 22 July 2015, Mr Griffiths told the officer unlocking his cell that he felt sick. His speech was slurred, he slumped over to one side, and he appeared confused. The officer went to get help from another officer. They suspected that Mr Griffiths might have suffered a stroke and radioed for urgent medical help. A supervising officer arrived and, after telephoning a nurse for advice, radioed a medical emergency code. The control room then called an ambulance. Nurses reached Mr Griffiths' cell at 8.25am and examined him.

4. At 8.45am, paramedics arrived took over Mr Griffiths' treatment. His condition improved slightly and he became more alert. Paramedics took him by ambulance to hospital but his condition deteriorated. He died in hospital the next day. A post-mortem examination found that Mr Griffiths had died of a brain haemorrhage.

Findings

5. We are satisfied that the care Mr Griffiths received at Whatton was equivalent to that he could have expected to receive in the community. The officers who found Mr Griffiths unwell on 22 July suspected that he might have suffered a stroke but were unsure of the symptoms. They did not call a medical emergency code, which would have led to an ambulance being called immediately. The clinical reviewer did not consider this affected the outcome for Mr Griffiths, but it is important, particularly in a prison with a high proportion of older prisoners that staff recognise the symptoms of a stroke and understand that they should call an ambulance immediately. Although Mr Griffiths was initially restrained by an escort chain when he went to hospital, this was removed very shortly afterwards.

Recommendations

- The Governor and Head of Healthcare should ensure that staff are informed of the common symptoms of a stroke and call an emergency medical code immediately when a stroke is suspected.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Whatton informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

7. The investigator obtained copies of relevant extracts from Mr Griffiths' prison and medical records.

8. The investigator interviewed five members of staff and a prisoner at Whatton on 16 September 2015.

9. NHS England commissioned a clinical reviewer to review Mr Griffiths' clinical care at the prison.

10. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Griffiths' brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He asked if Mr Griffiths had hit his head when he collapsed, how long it was before staff discovered him and whether the response was appropriate.

12. Mr Griffith's brother received a copy of the initial report. He pointed out some factual inaccuracies and this report has been amended accordingly.

13. We shared the initial report with the Prison Service, who pointed out some factual inaccuracies, and this report has been amended accordingly. The prison submitted an action plan and this has been appended to this report.

Background Information

HMP Whatton

14. HMP Whatton in Nottinghamshire is a medium security category prison holding up to 841 men convicted of sex offences.

15. Nottinghamshire Healthcare Foundation Trust provides healthcare services at the prison. The prison healthcare centre is open seven days a week from 7.30am to 6.30pm on weekdays and 8.30am to 1.30pm at weekends. There is an out of hours service. There are specialist clinics for older prisoners and those with chronic conditions. There are no inpatient beds.

HM Inspectorate of Prisons

16. The most recent inspection of Whatton was in February 2012. The Inspectorate found the prison was safe and decent. They judged that health services were generally good and the staff were polite and responsive to prisoners' needs. Primary care was well organised and access to nurse-led GP and dental services was good. There was a wide range of chronic disease clinics to meet the needs of the population.

Independent Monitoring Board

17. 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 May 2015, the IMB reported that the number of daily escorts to hospital affected the prison regime. There was an increasing demand for healthcare services, the result of a higher proportion of elderly prisoners. There were good mental health initiatives, including for those with dementia.

Previous deaths at HMP Whatton

18. Mr Griffiths' death was the thirteenth from natural causes at Whatton since the beginning of 2013. There were no significant similarities circumstances with the circumstances of the previous deaths, but we have previously made a recommendation about medical emergency codes.

Key Events

19. On 15 August 2008, Mr Jeffrey Griffiths was convicted of sexual offences and received an indeterminate sentence for public protection, with a minimum term to serve of 12 months. He had been at HMP Whatton since 6 July 2011. The Parole Board had never considered him suitable for release.

20. When he arrived at Whatton, Mr Griffiths had a number of health conditions including atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate) and hypertension (high blood pressure). He had a history of myocardial infarction (heart attack). His mobility was poor.

21. Doctors prescribed medication for high blood pressure and to reduce cholesterol. They also prescribed warfarin, an anticoagulant, used to thin the blood and reduce the risk of stroke for people with atrial fibrillation. Mr Griffiths had regular blood tests to check that the anticoagulant medication continued to be effective.

22. Mr Griffiths continued to smoke, against healthcare staff advice. In November 2011, he was diagnosed with chronic obstructive pulmonary disease (COPD - a collection of lung diseases, including chronic bronchitis and emphysema).

23. Healthcare staff continued to manage Mr Griffiths' ongoing medical problems, with appropriate and timely assessment and treatment. A nurse saw him daily to give him his medication and for brief healthcare interventions. He had regular face-to-face assessments and tests, including blood tests. The results were discussed with him to keep him fully informed about his health.

24. Mr Griffiths had regular mobility assessments from community based occupational therapists. On 21 June 2012, an occupational therapist noted Mr Griffiths found it difficult to walk very far. He used a walking frame to go small distances and relied on others to push him in a wheelchair if he needed to go further.

25. On 20 August 2012, a prison GP reviewed Mr Griffiths following a letter from his vascular consultant, which said he should reduce his risk factors, one of which was smoking. Mr Griffiths remained adamant that he would not give up smoking.

26. Throughout 2013 and the first six months of 2014, Mr Griffiths' condition remained relatively stable. He continued to have regular reviews, assessments and treatment in line with his care and management plans.

27. On 18 July 2014, a nurse examined Mr Griffiths, who had fallen in his cell and hit his head. Another prisoner said Mr Griffiths had not eaten since the previous day, had drunk very little and that he had appeared confused. The nurse spoke to a prison GP, who advised that Mr Griffiths should go to hospital.

28. Mr Griffiths was taken to hospital. Hospital staff diagnosed a chest infection, which they treated with antibiotics. His condition gradually improved and, on 21 August, he returned to Whatton to a specially adapted cell. The prison GP noted that, while Mr Griffiths was in hospital, a doctor had diagnosed peripheral vascular disease (a build-up of fatty deposits in the arteries restricting blood

supply to leg muscles). Mr Griffiths had had stents inserted into the arteries of his legs to improve circulation.

29. Nurses continued to see Mr Griffiths daily to give him medication and manage his care, including treating bedsores he had developed in hospital. The sores were difficult to manage as Mr Griffiths frequently refused to take antibiotics, loosened or removed dressings and had poor personal hygiene.

30. Mr Griffiths remained relatively stable over the next year, apart from occasional shortness of breath due to COPD. Healthcare staff continued to take blood tests regularly and to review his medication. He still refused to stop smoking.

31. On 23 June 2015, a consultant psychiatrist examined Mr Griffiths as healthcare staff had been concerned about his memory. The psychiatrist diagnosed vascular dementia (caused by problems in the supply of blood to the brain, typically by a series of minor strokes). He explained the condition could not be cured but stressed the importance of keeping vascular risk factors under control, in particular the need to cut down or stop smoking. Despite this advice, Mr Griffiths continued to smoke.

32. Shortly after 7.00am on 22 July, an officer checked Mr Griffiths in his cell and said he was breathing normally and snoring quietly. At 8.10am, she began unlocking the cells. When she got to Mr Griffiths' cell, he was on the bed with his head over the side 'retching', as if about to be sick. Mr Griffiths told her he felt sick and she gave him a bin in case he vomited. She told him that she had to unlock the rest of the cells but would come back.

33. The officer came back a few minutes later. Mr Griffiths had not moved and continued to retch and cough phlegm into the bin. His speech was slurred and did not make sense. She said that she often found Mr Griffiths slumped over and his speech was generally unclear, so was not too concerned about him. However, she went to get another officer to take a look at him.

34. The officer came back very quickly with a colleague. The officers sat Mr Griffiths in a chair but he continued to retch and spit into the bin. Another prisoner, who had come to help, suggested Mr Griffiths might have suffered a 'TIA' (Transient Ischaemic Attack, or 'mini stroke'). The officers asked Mr Griffiths to stick his tongue out, which they believed was a way of telling if someone had had a stroke. The officer radioed for healthcare staff to attend 'as soon as possible.' She did not use a medical emergency code.

35. A Supervising Officer (SO) went to Mr Griffiths' cell about a minute later. Mr Griffiths was coughing and retching and the officer explained that they thought he might have had a stroke. One of the officers asked Mr Griffiths to raise his arms in front of him but he could only raise one of them.

36. Another SO went to the wing office and telephoned to check whether healthcare staff were on their way. She told a nurse that they thought Mr Griffiths might be having a stroke and the nurse advised her to call a code blue medical emergency code, which should alert the control room to call an ambulance immediately. The SO immediately radioed the code blue and then telephoned the control room with Mr Griffiths' details for the ambulance crew.

37. At approximately 8.25am, two nurses arrived at Mr Griffiths' cell. An officer, who was first-aid trained, was with the other officers. A nurse noted that Mr Griffiths was sitting in a chair leaning to his right and that the right side of his face had drooped. He had slurred speech and could not raise his right arm. He knew where he was and told her he felt sick. He continued to cough large amounts of green and white sputum. She noted Mr Griffiths' blood pressure was high but his other clinical observations were within normal limits. He said he was not in pain.

38. At 8.45am, paramedics arrived, by which time Mr Griffiths' condition had started to improve. He became more alert and a nurse gave him his usual morning medication. At 9.31am, the ambulance took Mr Griffiths to hospital. Two officers escorted him and restrained him with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

39. At 10.15am, one of the escort officers removed the escort chain, at the request of a hospital nurse, as Mr Griffiths became unconscious. At 1.35pm, a senior manager reduced the escort staff from two to one. An officer was the prison's family liaison officer and contacted Mr Griffiths' brother, his next of kin, to let him know he was in hospital. The officer explained his role and offered support. Mr Griffiths' brother said he planned to visit him in hospital the next day.

40. Mr Griffiths' brother went to the hospital on 23 July. Mr Griffiths' condition declined in hospital and his brother was with him when he died that day. The officer spoke to him the next day to offer his condolences and to discuss funeral arrangements. Mr Griffiths' funeral was on 12 August. The prison contributed towards the costs in line with national instructions.

Support for prisoners and staff

41. A prison manager debriefed the staff who had been involved when Mr Griffiths had been unwell on 22 July and offered his support and that of the staff care team. A senior manager subsequently spoke to the staff who had been unable to attend.

42. The Governor issued a notice to prisoners and staff informing them of Mr Griffiths' death and of the support available, if needed. Staff reviewed the cases of all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by his death.

43. The prison held a memorial service for Mr Griffiths on 3 August.

Post-mortem report

44. A post-mortem report concluded that Mr Griffiths had died of cerebellar haemorrhage (bleeding in the brain).

Findings

Clinical care

45. The clinical reviewer noted that Mr Griffiths had a number of chronic health conditions. Prison healthcare staff and hospital staff saw him frequently to manage his medical conditions. The clinical reviewer considered that the care Mr Griffiths received at Whatton was appropriate, comprehensive and equivalent to that he could have expected to receive in a community setting. We are satisfied that Mr Griffiths received a good standard of healthcare at Whatton.

Emergency response

46. Although Mr Griffiths died of a brain haemorrhage, he initially presented with symptoms of a stroke (which can be similar). Although the officers who initially attended considered that he might be having a stroke, they were unsure of the symptoms and did not use an emergency medical code. Using an emergency code would have resulted in the control room calling an ambulance immediately.

47. Prison Service Instruction (PSI) 03/2013 about medical emergency response codes requires prison staff to use a code blue when a prisoner has chest pain, difficulty in breathing, is unconscious, is choking, fitting or concussed, has a severe allergic reaction or has a suspected stroke. This replicates NHS guidance for calling ambulances in the community,

48. In September 2014, Whatton issued a Notice to Staff about using emergency code procedures when a prisoner needs immediate medical assistance. In May 2015, two months before Mr Griffiths died, the prison published a protocol on the same subject. Both documents list suspected stroke as an example of when staff should call a code blue.

49. The clinical reviewer said it was unlikely that the short delay in calling an ambulance would have affected the eventual outcome for Mr Griffiths. However, we are concerned that in other circumstances such a delay could be crucial. The clinical reviewer noted that prison staff would benefit from some awareness of the symptoms of stroke and we agree that this is important, especially in a prison like Whatton, which has a high proportion of older prisoners, more at risk of stroke. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that staff are informed of the common symptoms of a stroke and call an emergency medical code immediately when a stroke is suspected.

Restraints

50. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. A judgment in the High Court in 2007 found that the level of restraints used should be necessary in all the circumstances and based on a risk assessment, which takes into account medical opinion about the prisoner's health and mobility at the time.

51. A risk assessment completed before Mr Griffiths went to hospital on the morning of 22 July, concluded that Mr Griffiths should be escorted by two officers and restrained by an escort chain. The assessment was based on security information that Mr Griffiths had tried to grab a female doctor when he was semi-conscious after a heart attack. It did not record the date of this incident, which was in August 2008. It also noted that Mr Griffiths "exposes himself". The medical section was completed by a nurse who knew Mr Griffiths well but was not one of the nurses who was with him that morning and therefore not in a position to comment on how his condition at the time affected his risk of escape.

52. As the escort chain was removed very quickly after Mr Griffiths arrived at hospital, we do not make a formal recommendation about this. However, we note the need for risk assessments to be based on up to date information about the prisoner's actual risk at the time, including his current state of health and mobility.

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