Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Grindon, a prisoner at HMP Stoke Heath on 4 October 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 Richard Grindon died of a heart attack at hospital, while in the custody of HMP Stoke Heath. Mr Grindon was 52 years old. I offer my condolences to Mr Grindon's family and friends.

The risk assessment process regarding the restraint and escorting arrangements to hospital was confused, and the authorising manager did not consider Mr Grindon's particular circumstances in deciding the appropriate level of restraints to be used.

At the hospital, there was an avoidable delay in releasing Mr Grindon from his restraints when hospital staff needed to apply a defibrillator. I note the views of the experts who have reviewed the clinical impact of the delay, which do not suggest that the delay was necessarily material. It was, however, very regrettable. I understand that the prison has since amended its local policy with regards to keys and cuffs to reduce the possibility of this happening again. However, the Governor needs to ensure all staff are aware of the changes.

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 **March 2017**

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Summary

Events

1. On 21 July 2015, Mr Richard Grindon was convicted of possession of an offensive weapon and drugs and sentenced to six months imprisonment. He was sent to HMP Altcourse and was transferred on 3 August 2015 to HMP Stoke Heath.

2. At Mr Grindon's initial health screen at Stoke Heath, a nurse noted that he smoked cigarettes, was overweight, and was a heavy drinker. His blood pressure was slightly outside the normal range. He said he did not have a history of chest pains. He had previously reported a family history of cardio vascular disease. The nurse offered access to smoking cessation services (which he declined) and gave him healthy living advice.

3. On 4 October, at approximately 2.45pm, Mr Grindon told an officer he had chest pains and the officer phoned for a nurse to attend. Before she arrived, Mr Grindon decided he wanted some air and he was taken outside where he met the responding nurse. She took him to the healthcare unit for an electrocardiogram reading (ECG – which measures heart rhythms) and sent one of the readings to an automated tele-med service. The service advised her to call an ambulance for Mr Grindon and another nurse asked the control room staff to do this straight away.

4. Prison staff carried out risk assessments for the escorting arrangements which were incomplete (whole sections were blank) and confused (two Person Escort Forms were completed, one with incorrect timings). An officer reported that the authorising prison manager told him to restrain Mr Grindon by a single handcuff in the ambulance as there had been a number of recent prisoner escapes at other establishments.

5. When they arrived at hospital, at approximately 4.34pm, escorting staff changed the single cuff to an escort chain and hospital staff assessed Mr Grindon. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) Hospital staff discussed giving Mr Grindon an X-ray and transferring him to another hospital. Mr Grindon was sitting up and talking although he was in some pain. One of the escorting officers foresaw that the escorting shift might be significantly extended and, as Mr Grindon seemed in a reasonable condition, went to get some refreshments. In accordance with the Local Security Strategy, he took the key to the handcuffs with him and left his colleague attached to Mr Grindon.

6. At 5.25pm, shortly after the officer had left, Mr Grindon had a heart attack and nurses took him to the resuscitation room. They wanted to use a defibrillator (which delivers electric shocks to the heart through the chest), but could not because Mr Grindon was still attached to the other officer. It took 11 minutes to find the officer with the key and remove the restraints. Hospital staff tried to resuscitate him manually in the meantime, during which time he suffered two further cardiac arrests. When hospital staff were able to use the defibrillator, they administered four shocks and adrenaline to Mr Grindon, successfully reviving him.

However, he continued to arrest and be resuscitated a number of times. A doctor pronounced him dead at 6.16pm.

7. A specialist examined Mr Grindon's heart but was unable to say conclusively to what extent the 11 minute gap had diminished Mr Grindon's chances of survival.

Findings

8. The clinical reviewer concluded that primary care healthcare appropriately addressed Mr Grindon's risk of heart disease by offering lifestyle advice. When he initially presented with chest pains, the officer and nurses at Stoke Heath dealt with him effectively.

9. We found deficiencies with the local emergency response protocol which was not in line with national Prison Service instructions. Prison officers and nurses were under the impression that only healthcare staff could call for an ambulance, even if officers used an emergency medical code.

10. The risk assessment process for the use of restraints was incomplete, incorrect and the authorising prison manager did not address the specific risk Mr Grindon presented at the time. His reported focus on the number of recent escapes by prisoners from other establishments was not relevant. He authorised the use of a single handcuff for transit. We consider that the decision making process regarding restraints was flawed and needed to take account of Mr Grindon's specific circumstances.

11. The officer who left Mr Grindon's bedside, taking the cuff key with him just before Mr Grindon had a heart attack, was following the prison's local policy. We understand that the prison's Local Security Strategy has been amended to reduce the possibility of this happening again. The Governor should ensure all staff are aware of this change.

Recommendations

- The Governor should ensure that local emergency protocol properly reflects the requirements of PSI 03/2013.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should ensure that where a prisoner is cuffed and attending hospital, escorting staff are aware of the contingencies in place.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Stoke Heath informing them of the investigation and asking anyone with relevant information to contact her. One person responded.

13. The investigator visited Stoke Heath on 13 October. She obtained copies of relevant extracts from Mr Grindon's prison and medical records.

14. The investigator interviewed three members of staff at the prison on 4 December 2015.

15. NHS England commissioned a clinical reviewer to review Mr Grindon's clinical care at the prison. She also interviewed staff with the investigator on 4 December. She submitted two clinical reviews. One, dated 10 March 2016, and a subsequent review (written after the pre-inquest review) dated 16 February 2017, which retracted an earlier recommendation.

16. We informed HM Coroner for the Mid and North Shropshire District of the investigation who gave us results of the post-mortem examination. We have sent the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Grindon's niece, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.

18. Mr Grindon's niece received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

19. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Stoke Heath

20. HMP Stoke Heath is a medium security prison in Shropshire holding up to 782 adult and young adult men. It is in the process of becoming a resettlement prison for Wales and about 60% of its prisoners are from Wales. Primary care services are provided by Shropshire Community Health NHS Trust and secondary mental health services by South Staffordshire NHS Foundation Trust.

HM Inspectorate of Prisons

21. The most recent inspection of Stoke Heath was in April 2015. Inspectors found that not all new arrivals received an initial health screen and their follow up was inadequate. They also considered management of long term conditions was underdeveloped. Emergency resuscitation equipment and automated defibrillators were only available in the health care centre and had to be collected from there before responding to an incident, which could lead to delays. All nursing staff had undertaken mandatory training in this area but no custody staff were trained to use defibrillators.

Independent Monitoring Board

22. 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 April 2016, the IMB reported that the healthcare unit continued to be very busy dealing with acute and chronic medical issues. A patient forum group has been set up with wing representatives and a healthcare member appointed to help support prisoners and help cut down on missed appointments.

Previous deaths at HMP Stoke Heath

23. Mr Grindon's was the first natural cause death at Stoke Heath since the Ombudsman began fatal incidents investigations in 2004.

Key Events

24. On 21 July 2015, Mr Richard Grindon was convicted of possession of drugs and an offensive weapon and sentenced to six months imprisonment. He was sent to HMP Altcourse before being transferred to HMP Stoke Heath on 3 August 2015.

25. On 3 August, a nurse completed Mr Grindon's first night health screen at Stoke Heath. She noted Mr Grindon had completed an alcohol detoxification programme in Altcourse, and said he had taken antidepressants. She also noted Mr Grindon was a moderate smoker of cigarettes (he declined her offer of smoking cessation advice), was overweight (body mass index was 31.97 – over 30 is considered obese). His blood pressure was slightly outside the normal range at 120/84 (the normal range is between 90/60 and 120/80), but the clinical reviewer did not raise any concerns and Mr Grindon did not report any previous or current history of chest pains. She deemed Mr Grindon fit for the gym and talked to him about healthy lifestyle choices.

26. A prison GP reviewed Mr Grindon on 10 August and prescribed citalopram (an antidepressant). Mr Grindon saw the mental health team on 24 August and, on 29 September, a prison GP referred him to a specialist to investigate a lump on his jaw - the precise cause of which was not determined before he died.

27. On the evening of 3 October, Mr Grindon told his cell mate that he had heartburn. The cellmate had some first aid experience and asked Mr Grindon if he had any tingling sensations or a stiff neck, but he did not. The next day, at about 2.45pm, Mr Grindon told his cellmate that his chest felt a bit stiff and went to tell an officer.

28. An officer was in the wing office when Mr Grindon came to speak to him. The officer told the investigator that Mr Grindon was very pale and sweaty, and told him that he had a pain in his chest. He telephoned the healthcare unit and spoke to a nurse and asked her to come over. He asked Mr Grindon if he had any pains in his arms (he said he had not) and he examined his pupils to see if they were dilated (they were not) to rule out substance misuse. Mr Grindon then asked if he would take him outside for some air. The healthcare unit was next to the wing, and they went out the way the nurses would have to come in. When they got outside they met two nurses. He told them what Mr Grindon's symptoms were and the nurses took him to the treatment room in the healthcare unit.

29. The nurses took his blood pressure, pulse and oxygen levels which were within normal range. They decided to do an ECG as well because of his chest pains. When Mr Grindon took his jumper off, so they could do the ECG, the nurses noticed that his skin was mottled and purple. One nurse believed the results showed he had an atrial flutter (abnormally fast heart rhythm), and they decided to do another ECG on a portable machine which could telephone the results to a cardiac specialist. She phoned the results through and the specialist advised her to call for an ambulance. Another nurse requested control room staff do this and they called the ambulance straight away at 3.07pm.

30. A prison manager authorised a two person escort and to restrain Mr Grindon by a single cuff. The paramedics arrived at 3.15pm and took Mr Grindon to hospital in Staffordshire at 4.15pm. He was handcuffed to an officer by a single cuff and

another officer had the keys. An officer said he asked the manager if they could use an escort chain for the journey instead, but the manager said that there had been a number of escapes across the prison estate recently and he did not want to take any risks. The manager's unsigned police statement says he cannot recall what conversations he had with escorting staff.

31. The ambulance arrived at the hospital at 4.34pm. At 4.45pm, a hospital doctor examined Mr Grindon in a cubicle and the officers said they changed the cuffing arrangement from single cuffs to an escort chain to make it more comfortable. The Local Security Strategy gave them flexibility to do this once they had reached their destination although Mr Robb said one of the officers telephoned him to ask. An officer went outside to use the prison mobile and inform his wife that his shift had changed.

32. A nurse completed an ECG, showed it to a doctor and faxed it to another hospital, as they have specialist heart surgeons there and the local hospital frequently transfers patients to them. Medical staff discussed the possibility that they might transfer Mr Grindon to another hospital after an X-ray.

33. One officer thought that the escorting duties could turn into a bedwatch and therefore a longer shift, so he decided he would get some food from the hospital café. Mr Grindon was sitting up talking, although he appeared to be in some pain.

34. The officer swapped places with his colleague (handcuffing him to Mr Grindon) and left the cubicle to go and buy some food, taking the key to the escort chain handcuffs. This appears to be in accordance with the Local Security Strategy which was current at the time.

35. At 5.25pm, Mr Grindon had a heart attack and a hospital nurse sounded the emergency alarm and secured his airway. Hospital staff moved him into the resuscitation unit, still attached to the officer. In the resuscitation unit, hospital staff attached Mr Grindon to a defibrillator which advised them to 'shock' the patient and a nurse told all staff to stand clear so she could administer the shock. The officer told her that he could not stand clear because he was attached via the escort chain to Mr Grindon and his colleague had the key. (There was a concern that the electric shock could go through the escort chain to the other person.)

36. A healthcare assistant went to find the other officer. Hospital staff performed CPR (cardio pulmonary resuscitation - an emergency procedure that combines chest compression often with artificial ventilation) on Mr Grindon in the meantime. A total of three opportunities to shock Mr Grindon with the defibrillator were missed.

37. The officer was located after approximately 11 minutes. The healthcare assistant had run to the hospital café but he was not there. He had returned to the cubicle after purchasing food and when no one was there he went to the X-ray department, presuming after earlier discussions that was where everyone would be. The healthcare assistant used a phone to put a 'fast bleep' out for security to find him and get him to resuscitation department. On her way back, she saw him in the X-ray department.

38. The healthcare assistant and the officer ran to the resuscitation unit. The officer removed the handcuff from his colleague and then Mr Grindon. At 5.36pm, the defibrillator delivered the first shock of four and staff administered adrenaline which revived Mr Grindon. At 5.57, Mr Grindon's pulse stopped again and hospital staff gave him three further shocks and more adrenalin. At 6.04pm, Mr Grindon had another heart attack and staff revived him after CPR. His heart stopped twice more, at 6.12pm and 6.14pm, and staff gave him further shocks but ultimately he did not revive. At 6.16pm, a hospital doctor pronounced Mr Grindon dead.

Contact with Mr Grindon's family

39. Mr Grindon had not given the prison any next of kin details. The prison manager started to make enquiries that evening and appointed a family liaison officer the next morning. On 5 October, after making various enquiries through prison records and an offender supervisor, the family liaison officer asked the police for help. They traced Mr Grindon's brother but only told her about this as they approached his address. As a result, the police - not the prison - broke the news to him at 12.20am on 5 October.

40. It is unclear when, but very soon afterwards before the family liaison officer had an opportunity to contact the family, Mr Grindon's niece contacted her to discuss matters. She continued to offer advice and support.

41. Mr Grindon's funeral was held on 12 September 2016. No prison staff attended as they had not been informed that Mr Grindon's body had finally been released. In line with national policy, the prison is making a contribution towards the funeral costs in line with national policy.

Support for prisoners and staff

42. After Mr Grindon's death, the prison manager went to the hospital and debriefed the officers to ensure they had the opportunity to discuss any issues arising, and to offer support. The prison nurses told the investigator that they were also offered support.

43. The prison posted notices informing other prisoners of Mr Grindon's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Grindon's death.

Post-mortem report

44. The post-mortem report concluded that Mr Grindon died of coronary artery atheroma and thrombosis with ischaemic heart disease.

Findings

Clinical care

45. The clinical reviewer concluded that, the information Mr Grindon received with regards to managing his heart disease risk was appropriate and the care Mr Grindon received on the day he presented with chest pains was good**.**

Emergency response

46. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called automatically in a life-threatening medical emergency. The PSI explicitly states that when a medical emergency is called over the radio network, an ambulance must be called immediately and local procedures should ensure this. There should be no requirement for control room staff to check with managers, healthcare staff or others at the scene before calling an ambulance, but they should wait for updates and keep the ambulance service informed. The PSI notes that it is better to act with caution and request an ambulance that can be cancelled later if it is not needed.

47. On 4 October, the officer did not call a code blue. When interviewed, the officer thought that healthcare staff would have to ask the control room to call an ambulance once they had assessed the patient. Two nurses also thought it was healthcare staff's decision to ask for an ambulance.

48. Stoke Heath's local protocol covering emergency codes, at the time of Mr Grindon's death, did not instruct control room staff to call an ambulance immediately an emergency was called. An updated protocol was issued in April 2016 which sets out the circumstances in which an emergency code should be used and details the codes to be used, but says that on hearing them any member of staff should call an ambulance. The PSI says that staff in the control room should call the ambulance.

49. The fact officers did not use a code and therefore there was a delay in calling for an ambulance did not make a difference to the outcome for Mr Grindon. However, it is clear that the Governor needs to update the latest protocol to comply with the PSI, specifically in relation to the role of the control room, as it could make a difference in other circumstances.

    The Governor should ensure that local emergency protocol properly reflects the requirements of PSI 03/2013.

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. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's

risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

51. On 4 October, staff called an emergency ambulance to treat Mr Grindon as he had chest pains. A nurse completed the medical portion of the risk assessment indicating she had no objections to restraints being used on Mr Grindon. She also said that Mr Grindon's condition did not prevent him escaping. A section for wing staff and the security portion was not completed at all. A custodial manager recommended Mr Grindon be accompanied by two officers, restrained by a single cuff or an 'escort chain through ambulance'. She specified that staff should not remove restraints for treatment or in an emergency other than with the prior knowledge of the Duty Governor. A prison manager authorised the risk assessment but specified that escorting staff should refer to the Local Security Strategy and that restraints should remain on unless the duty governor authorised their removal. An officer reported that he also said that because of recent escapes across the prison estate, Mr Grindon had to wear a single cuff.

52. The 'details of current and relevant risk' portion of the accompanying 'Person Escort Record' (PER) specified a domestic violence risk to females, harassment risk and generalised views regarding racial and homophobic motivation - but it was not signed or dated. A nurse completed the medical portion of the PER form. She ticked that Mr Grindon had no known medical risks but added that he was known to mental health. She signed this at 2.20pm, which is before the estimated time that Mr Grindon even told the officer that he felt unwell, so was presumably an error. A second PER was also completed. An officer signed off the risk details section of the second PER at 3.25pm having listed the following: 'risk to custody staff, domestic violence, will drink any alcohol and racist marker'. This PER does not appear to have been taken to the hospital by officers as the section where they document significant events is blank, whereas the other has been completed.

53. We are concerned that the risk assessment process was confused and did not take into account the risk that Mr Grindon presented at the time, as the High Court judgment requires. The ECG had confirmed that Mr Grindon was unwell enough to require emergency medical attention but his degree of ill health and its impact on his possible risk does not appear to have been taken into account as it should have been. Additionally, the prison manager seemed to base his decision making on recent national events and not Mr Grindon's position at the time. We consider that the risk assessment process was confused and judgements based on factors that were not directly relevant. We are therefore unable to conclude whether restraints were appropriate.

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Delay in removing the escort chain

54. Hospital staff assessed Mr Grindon and officers heard them discuss taking him for an X-ray and possibly transferring him to another hospital. One escort officer told police that, in his opinion, it sounded as if the escort could turn into a much longer shift and he wanted to get some refreshments. Mr Grindon was sitting up and talking at the time so he swapped the escort chain cuff with his colleague. He went to the hospital café, taking the cuff key with him in accordance with local instructions. Shortly after this, Mr Grindon had a heart attack and required resuscitation using a defibrillator, but this could not be applied for 11 minutes because he was attached by the metal restraining chain to the other officer.

55. While the consequences were very regrettable, it is not possible to conclude that the officer disregarded any local instructions or policies in going to the café and taking the keys with him. Indeed, Mr Grindon's health at that point had appeared stable and he had been sitting up and talking. The expected X-ray could also go ahead while Mr Grindon was still restrained. The other officer had also left the scene with the keys earlier on to telephone his wife.

56. The officers had only one mobile phone between them. When Mr Grindon had a heart attack the officer had no way of contacting his colleague to request his immediate return.

57. It would have been prudent for the escorting officers to make hospital staff aware that they were taking keys away with them and that there was no other way of getting the escort chain off. It seems that hospital staff were unaware of the key and cuffing arrangements. This is an area where prison and hospital communication could have been better. The prison have issued a revised instruction to staff which includes giving more flexibility with regards to arrangements for cuff keys, including the potential to leave the key with the cuffed officer. This change needs to be communicated to all staff.

    The Governor should ensure that where a prisoner is cuffed and attending hospital, escorting staff are aware of the contingencies in place.

The clinical consequences of delay

58. The clinical reviewer did not comment on whether the delay in removing restraints adversely affected the outcome for Mr Grindon as it was a matter for a suitably qualified expert.

59. A consultant in histopathy (the examination of surgical specimens) who also specialises in cardiovascular pathology examined Mr Grindon's heart and said in a statement:

    '…it is understood that not all possibilities of medical support therapy were available to this individual, and consequently the chances of survival would be necessarily reduced. This does not mean that Mr Grindon's survival would have been guaranteed. Rather, it simply means that survival following a cardiac arrest/occlusion of one of the three major coronary arteries will be lower if not all medical therapies are available to treat an affected individual. The lessening of survival probability cannot be quantitated [sic] from the pathology, although expert cardiologist opinion may assist on this matter.'

60. Further to this, a consultant cardiologist submitted a report which said:

'…the 11 minutes of delayed defibrillation while maintaining basic life support, one could assume that the patient suffered 33-44 per cent reduction in the chances of survival. Another difficult to calculate negative factor was the delay to giving the intravenous Adrenaline which was not at all related to the issue of the cuffs, but to difficulties in establishing venous access. Thirdly, it is vital to reiterate that the best survival rate for someone with ECG monitoring who receives immediate resuscitation is not more than 60 per cent. Therefore, while the delay in applying defibrillation must have caused some compromise to the chances of survival; no one could possibly claim that had there been instantaneous defibrillation that he would necessarily have survived the cardiac arrest.'

65. Based on the expert evidence, it is not possible to conclude that the delay in defibrillation – while regrettable – was necessarily material.

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