

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Shaun Grove a prisoner at HMP Elmley on 25 November 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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 Shaun Grove died in hospital from pneumonia on 25 November 2016, while a prisoner at HMP Elmley. He was 56 years old. I offer my condolences to Mr Grove's family and friends.

Mr Grove had a number of chronic health conditions, including hepatitis C and alcoholic liver disease. He was often an uncooperative patient, but healthcare staff managed his illnesses as well as they could and reviewed him frequently. I am satisfied that Mr Grove received a good standard of healthcare at Elmley, equivalent to that he could have expected to receive in the community.

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

May 2017

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Summary

Events

1. Mr Shaun Grove had been at HMP Elmley since December 2015. In February 2016, he was sentenced to 12 months imprisonment, for assault and breach of the Sexual Offences Act 2003. He had a number of chronic health conditions, including hepatitis C and alcoholic liver disease. He had a history of drug misuse.
2. At an initial reception screen, Mr Grove told a nurse that he had problems with his liver and that he had previously had fluid drained from his stomach. A nurse noticed that his stomach appeared distended and admitted him to the prison's inpatient unit for monitoring. Mr Grove displayed challenging behaviour while an inpatient and did not always engage with staff. Over the next four months, healthcare staff saw Mr Grove when they could but he often failed to attend appointments.
3. Mr Grove was released from prison on 24 June. He was sent back to Elmley nine days later for breaching his licence conditions. Over the next five months, healthcare staff monitored his deteriorating health and arranged for him to have fluid drained from his stomach on a number of occasions. They saw him in his cell when required but his poor compliance with appointments continued. Doctors reviewed Mr Grove's medication frequently and prescribed appropriate pain relief, but there is no record that they considered a do not attempt resuscitation order.
4. On 19 November, a prison GP examined Mr Grove after he told a nurse that he felt unwell and sent him to hospital as an emergency. Evidence suggests that he frequently displayed verbally abusive behaviour to escort officers and healthcare staff. Four days later a prison nurse met hospital doctors, who informed her that Mr Grove had liver failure that had impacted on his kidneys and his prognosis was poor. Mr Grove's condition deteriorated further and a doctor recorded that he died on 24 November, at 6.33am.

Findings

5. Mr Grove frequently refused treatment for his conditions and often did not attend healthcare appointments, despite encouragement from staff. Although this made it difficult to manage his conditions effectively, the clinical reviewer found that his care was equivalent to that he could have expected to have received in the community. However, despite satisfactory care, there was no documented evidence that healthcare staff sought Mr Grove's wishes regarding resuscitation.
6. Officers restrained Mr Grove with an escort chain when he went to hospital on 19 November. Prison managers reviewed his escort risk assessment and appropriately removed restraints as his condition deteriorated.
7. We are concerned that that a prison manager did not debrief the escort staff on duty at the hospital when Mr Grove died.

Recommendations

- The Head of Healthcare should ensure that healthcare staff are reminded of the importance of having a discussion and recording the outcome of conversations about resuscitation with prisoners with terminal conditions.
- The Governor should ensure that a debrief is held promptly after the death of a prisoner and that all of the staff involved are offered effective support.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Grove's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Grove's clinical care at the prison.
11. We informed HM Coroner for Mid Kent and Medway District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. The investigator wrote to Mr Groves' brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.
13. The initial report was shared with the prison service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Elmley

14. HMP Elmley is a local prison on the Isle of Sheppey, which serves the courts in Kent. It holds more than 1,200 men in five wings, with a mixture of single, double and triple cells. Integrated Care 24 Ltd (IC24) provides primary healthcare services, with input from Minster Medical Group. The prison's healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Elmley was in November 2015. Inspectors reported that healthcare services at the prison had improved since the last inspection in June 2014 and were generally good. The inpatient unit provided good care for prisoners with the most acute needs, though general access to healthcare services remained a problem. They also found that prisoners sometimes missed routine external hospital appointments because of competing prison priorities for escort staff.

Independent Monitoring Board

16. 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 October 2016, the IMB reported concern that the inpatient department was housing more prisoners with mental health issues than physical health problems. They were also concerned that the number of prisoners who did not attend healthcare appointments remained a problem, although new systems were starting to improve the situation.

Previous deaths at HMP Elmley

17. Mr Grove was the sixth person to die from natural causes at Elmley since January 2015. We have made a recommendation on the need to consider prisoners' resuscitation wishes before.

Key Events

18. On 24 December 2015, Mr Shaun Grove was remanded to HMP Elmley, charged with assault and breach of the Sexual Offences Act 2003. (He was subsequently convicted and, on 17 February 2016, sentenced to 12 months imprisonment.) Mr Grove had a number of chronic health conditions, including hepatitis C and alcoholic liver disease. He also had history of substance misuse.
19. At an initial reception screen, Mr Grove told a mental health nurse that he had problems with his liver and that he had recently had fluid drained from his stomach at hospital. The nurse noted that Mr Grove had a history of drug and alcohol misuse, appeared frail and had difficulty walking. A nurse manager reviewed Mr Grove and admitted him to the prison's inpatient unit, concerned that his stomach appeared distended.
20. On 25 December, a prison GP examined Mr Grove and recorded that he had massive ascites (a build up of fluid in the abdomen) and pedal oedema (swollen feet due to fluid accumulation). He requested Mr Grove's hospital discharge summary and suggested that he remain in the inpatient unit until they confirmed his diagnosis. He also asked for blood tests and twice weekly weight monitoring.
21. Over the next week, healthcare staff created inpatient department care plans and monitored Mr Grove frequently. Evidence suggests that they could not take his blood or complete a secondary reception screen due to his persistent rude and abusive behaviour. His hospital discharge letter confirmed a diagnosis of chronic liver disease but there is no record of his weight was documented. On 31 December, a prison GP assessed Mr Grove as fit for discharge from the inpatient unit and he moved to normal location.
22. On 17 February 2016, a mental health nurse saw Mr Grove for a review and recorded that he looked physically well in comparison to when he first came in to prison. Over the next four months, healthcare staff issued appropriate medication and examined Mr Grove on the wing when required. Doctors requested blood tests and reviewed the results when they could, but Mr Grove often failed to attend appointments or refused to engage.
23. On 24 June, a mental health nurse reviewed Mr Grove prior to his release on licence and recorded that he looked calm and relaxed. Mr Grove did not report any issues but refused to confirm whether he had a community GP.
24. On 3 July, Mr Grove was recalled to prison for breach of his licence conditions and was moved directly from hospital to the inpatient unit at Elmley. Later that day, Mr Grove told a prison GP that hospital staff had discharged him due to his behaviour and reported severe abdominal pain. She suspected an incarcerated hernia and arranged for an ambulance to take him to hospital, but he refused to go. Mr Grove remained in the prisons inpatient unit for monitoring until a prison GP assessed him as fit for discharge, four days later. (The prison received a hospital discharge letter on 25 July, stating Mr Grove had been treated in hospital for an upper gastrointestinal bleed, caused by enlarged veins in his throat.)
25. On 17 July, prison staff noticed that Mr Grove's legs were swollen and leaking a small amount of fluid. A nurse saw him for review, recorded that his clinical

observations were normal and gave him pads to place under his legs. Healthcare staff continued to monitor Mr Grove's deteriorating condition frequently and prison GPs prescribed appropriate pain relief. On 4 August, Mr Grove attended an appointment at hospital to have excess fluid drained from his stomach. He had the same procedure again on 8 August.

26. Over the next two months, healthcare staff saw Mr Grove when they could but he frequently failed to attend appointments. Evidence suggests that healthcare staff often told prison staff about Mr Grove's medical appointments so they could remind him and encourage him to attend. Prison GPs continued to review his prescriptions regularly and prescribe appropriate medication as required. Despite records indicating that Mr Grove was aware that his deteriorating condition was life limiting, there is no evidence that healthcare staff discussed a do not attempt cardio pulmonary resuscitation order (DNACPR) with him. A DNACPR means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made.
27. On 10 October, Mr Grove attended triage and reported concern about his swollen stomach to a nurse. A prison GP saw him for a review and noted that he presented as jaundiced (a yellow discoloration of the skin) with a distended stomach. She liaised with doctors at the hospital and arranged for him to have fluid drained from his stomach on 12 October. When he returned to prison, a nurse recommended an admission to the inpatient unit for monitoring but he declined. Mr Grove failed to attend a number of appointments over the next four weeks, although healthcare staff did see him when he permitted.
28. On 19 November, a nurse reviewed Mr Grove in his cell and he reported feeling very unwell. She noted that he presented as jaundiced with a distended stomach and arranged for an urgent GP review. Within 15 minutes, a prison GP examined Mr Grove and sent him to hospital by ambulance. Two officers escorted him and restrained him with an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to a prison officer). Evidence suggests that Mr Grove frequently displayed verbally abusive behaviour towards escort officers and hospital staff.
29. On 22 November, a nurse manager spoke to a nurse from the hospital, who informed her that Mr Grove's vital signs were stable and that he was alert and orientated. The escort chain was removed that evening. On 23 November, a hospital nurse told a prison nurse that Mr Grove was very unwell and that he was likely to be treated with palliative care (a specialist type of care that aims to treat or manage pain for people nearing the end of life). Later that afternoon, the nurse attended the hospital and met two junior doctors, who told her that Mr Grove had liver failure that had impacted on his kidneys and his prognosis was poor.
30. At around 6.20am, on 24 November, one of the escort staff noticed that Mr Grove had stopped breathing. She notified a nurse, who confirmed that he was no longer breathing and asked for a doctor to verify death. A hospital doctor later confirmed that Mr Grove had died at 6.33am.

Contact with Grove's family

31. On 22 November, the prison appointed an officer as the family liaison officer. He noted that Mr Grove did not have a next of kin listed in his prison record and arranged for escort officers to request the details. However, Mr Grove refused to nominate anyone. When escort officers asked him again the next day, he still refused to provide them with a name. On 24 November, he went to the hospital to speak to Mr Grove in person, but he had died earlier that morning.
32. On 29 November, Mr Grove's brother contacted the prison's managing chaplain stating that the police had notified him of Mr Grove's death. He transferred the call to the officer, who explained the next steps and arranged to visit him the following day. The chaplain attended with him and they offered their condolences and support. Both the officer and the chaplain remained in contact with Mr Grove's family.
33. The prison contributed to the costs of Mr Grove's funeral, which was held on 3 January, in line with national policy.

Support for prisoners and staff

34. The prison posted notices informing other prisoners of Mr Grove'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 Mr Grove's death.
35. After Mr Grove's death, there was no record that managers debriefed the escort officers present at the hospital to review what had happened and to support them.

Post-mortem report

36. The post-mortem examination found that Mr Grove's had died from pneumonia and fluid accumulation on the lungs. Cirrhosis of the liver was a contributory factor.

Findings

Clinical care

37. Mr Grove suffered from several complex chronic health conditions and healthcare staff reviewed him when they could, usually for symptoms associated with his liver disease. However, he often refused to accept treatment or attend appointments. The clinical reviewer considered that despite Mr Grove often displaying challenging behaviour, healthcare staff clearly documented the deterioration in his health, prescribed appropriate medication, and referred him to hospital when required. The clinical reviewer concluded that Mr Grove's overall care in prison was at least equivalent to that he could have expected to have received in the community. We are satisfied that the level of care Mr Grove received at Elmley was of a good standard.
38. However, there is no indication that healthcare staff discussed a DNACPR with Mr Grove. The clinical reviewer considered that Mr Grove had a terminal condition and that it would have been clinically inappropriate to have started resuscitation if he suffered a cardiac arrest in the last weeks of his life. Making and recording a decision about CPR for prisoners with terminal conditions in advance and communicating it to those who need to know can help to ensure that inappropriate CPR is avoided. While we recognise that this did not affect the outcome for Mr Grove, in other circumstances, it could be crucial. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff are reminded of the importance of having a discussion and recording the outcome of conversations about resuscitation with prisoners with terminal conditions.

Support for staff

39. PSI 64/2011 requires a manager to hold a debrief after a prisoner's death, for all staff involved, including healthcare staff. It does not specify where the death took place or differentiate between prison and hospital deaths. The purpose is to offer support, allow staff to support each other and to discuss any lessons from how the situation was handled.
40. Our investigation confirmed that a prison manager did not hold a debrief following Mr Grove's death. We make the following recommendation:

The Governor should ensure that a debrief is held promptly after the death of a prisoner and that all staff involved are offered effective support.

Restraints, security and escorts

41. When prisoners have to travel outside 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 into account factors such as the prisoner's health and mobility. Decisions should be kept under review as circumstances change.

42. When Mr Grove was taken to hospital on 19 November, a prison manager decided that an escort chain instead of a single handcuff should restrain him. A full risk assessment indicated that he presented a medium risk to the public and had a history of challenging behaviour during escorts. The medical section highlighted that he had limited mobility and objected to the use of double handcuffs. Prison staff kept his risk assessment under review and although Mr Grove displayed difficult behaviour, a prison manager decided to remove his restraints due to his increasingly ill health on 22 November. We are satisfied that the prison appropriately considered the use of restraints.

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