Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Grimes a prisoner at HMP Hull on 15 May 2016

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 Michael Grimes died on 15 May 2016 from small bowel ischaemia (reduced blood supply to the small intestine) at HMP Hull. He was 63 years old. I offer my condolences to Mr Grimes' family and friends.

I agree with the clinical reviewer that Mr Grimes' care at the prison was generally good. However, there are some areas for improvement, such as the need for healthcare staff to better identify early warning signs that a prisoner's condition has deteriorated. I am concerned that there was a missed opportunity to refer Mr Grimes for emergency intervention in the days leading to his death.

I am also concerned that after the police notified Mr Grimes' family of his death, there was a significant delay before prison staff contacted them to offer condolences and support.

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 **November 2016**

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Summary

Events

1. In September 1997, Mr Michael Grimes was sentenced to life imprisonment for a sexual offence and attempted murder. He had been at HMP Hull since August 2011.

2. Mr Grimes had a number of chronic health problems, including a non-functioning kidney, constipation, high blood pressure and anorexia. Healthcare staff monitored him frequently, prescribed relevant medication and implemented appropriate care plans.

3. On 23 May 2015, Mr Grimes was admitted to hospital and treated for constipation after he complained of abdominal pain. On 8 June, after further severe abdominal pain, a prison doctor again sent him to hospital, where he had surgery to correct a bowel obstruction.

4. On 12 May 2016, a prison doctor sent Mr Grimes to hospital after he reported severe pain. Hospital staff diagnosed constipation and prescribed laxatives. They discharged him the same day. Mr Grimes' abdominal pain continued for the next two days and he vomited brown fluid. Healthcare staff reviewed Mr Grimes frequently and encouraged him to take his laxatives, but they did not always take his clinical observations, or consider that he might have a further or continuing bowel obstruction.

5. Just after 2.00am on 15 May, a night patrol officer found Mr Grimes unresponsive in his cell. After alerting a colleague, they contacted a prison manager, who radioed a medical emergency code. Within minutes, a prison officer and a nurse went to Mr Grimes' cell and performed cardiopulmonary resuscitation (CPR), until paramedics arrived and took over. The resuscitation attempts were unsuccessful and the paramedics confirmed that Mr Grimes had died at 2.46am.

Findings

6. The clinical reviewer noted that, although much of Mr Grimes' care was good, healthcare staff should have monitored his deteriorating condition more closely, using a formal early warning assessment tool. In addition, they should have arranged for an emergency assessment by a prison or hospital doctor, after he showed symptoms of a bowel obstruction. We are satisfied that the emergency response was prompt and appropriate.

7. We are concerned that, after the police notified Mr Grimes' sister of his death, there was a delay of seven days before the prison contacted her to offer support.

Recommendations

- The Head of Healthcare should ensure that healthcare staff receive training to help detect and treat early warning signs of deterioration in prisoners with chronic conditions, take and record observations as required and record actions and decisions about their ongoing care in their medical records.

- The Governor should ensure that the prison complies with Prison Service guidance about contacting the families of deceased prisoners. Where it has not been possible for prison staff to inform the prisoner's family, a visit should be arranged as soon as possible afterwards.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Hull 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 Grimes' prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Grime's clinical care at the prison. The investigator and clinical reviewer interviewed five members of staff at HMP Hull on 22 June 2016. The investigator interviewed another member of staff by telephone on 1 July.

11. We informed HM Coroner for Hull of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers wrote to Mr Grimes' sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She 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.

14. Background Information

HMP Hull

15. HMP Hull is a local prison, which holds up to 1055 men in ten wings. City Healthcare Partnership provides health services at the prison. The prison closed its healthcare inpatient unit in October 2014, and it became a wellbeing unit to support and progress prisoners with complex needs, which are difficult to meet in the normal prison environment. The unit includes a specialist palliative care cell. GP surgeries are held four days a week, with an out-of-hours service at other times.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Hull was in October 2014. Inspectors reported that health services were good, and most prisoners were reasonably satisfied with the quality of and access to healthcare. They found that the prison offered a wide range of primary care clinics and healthcare screening programmes, and prisoners could usually see a GP within three days.

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 most recent annual report, for 2015, the IMB at Hull noted that the outpatient clinics managed prisoners' long term medical conditions. The Board had received many complaints, mostly concerning medication and prescribing issues.

Previous deaths at HMP Hull

18. There have been nine deaths from natural causes, at Hull, since January 2014. There were no significant similarities between the circumstances of Mr Grimes' death and those we have already investigated.

Key Events

19. On 5 September 1997, Mr Michael Grimes was sentenced to life imprisonment for a sexual offence and attempted murder. He spent time at a number of prisons and moved to HMP Hull on 11 August 2011.

20. Mr Grimes suffered from a number of chronic health conditions including a non-functioning kidney, hydronephrosis (a condition where one or both kidneys stretch and swell due to the build up of urine), constipation, high blood pressure and anorexia. Healthcare staff monitored Mr Grimes' chronic conditions, prescribed medication and nutritional drinks to stabilise his weight. His kidney and constipation caused him long-term abdominal pain and doctors prescribed tramadol (a painkiller) and lactulose (a laxative) when required.

21. On 23 May 2015, a nurse examined Mr Grimes on the wing and noted that he was kneeling on the floor in pain and had difficulty breathing. She sent him to hospital as an emergency and hospital staff treated him with enemas for constipation. Mr Grimes returned to Hull on 26 May and a nurse reviewed him. He noted that Mr Grimes was due a follow-up consultation with a consultant in four to six weeks, though this did not take place until after further abdominal problems in June.

22. On 8 June, Mr Grimes reported severe abdominal pain to a prison GP. He said that he had been sick and had not opened his bowels for two weeks. Suspecting intestinal obstruction, the GP sent Mr Grimes to hospital, where he had an operation to correct a bowel obstruction. On 21 June, Mr Grimes was discharged from hospital and healthcare staff monitored him frequently. Doctors reviewed his medication and prescribed laxatives and pain relief when required.

23. Mr Grimes did not complain of any abdominal pain from June 2015 to May 2016.

Events from 12 to 15 May 2016

24. On 12 May, a nurse reviewed Mr Grimes on the wing after he reported severe abdominal pain to prison staff. As Mr Grimes was in significant pain and unable to lie flat, she sent him to the healthcare centre. A prison GP examined him and sent him to hospital as an emergency. Before Mr Grimes left the prison, staff completed a security risk assessment. As he was reasonably mobile, two prison officers escorted him, using 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.) Hospital staff diagnosed constipation and discharged Mr Grimes the same day. A nurse reviewed Mr Grimes when he returned to prison and later told wing staff that he needed to wait for his medication to work, after he reported ongoing pain.

25. The next morning, a nurse reviewed Mr Grimes in his cell and noted that he felt generally unwell and nauseous. She completed a National Early Warning Score assessment (NEWS – a scoring system to assess clinical deterioration in patients) and, based on Mr Grimes' observations, she scored him '0' (low clinical risk). She also spoke to a prison GP about increasing Mr Grimes' laxatives, but he did not feel this was necessary. He prescribed a suppository, which a nurse issued later that day.

26. At 10.00am on 14 May, prison staff asked a nurse to review Mr Grimes in his cell. Mr Grimes complained of stomach pain and said that he had not opened his bowels for three days. She noted that his blood pressure (110/60), pulse rate (88bpm) and oxygen saturation levels (97%) were all within normal limits and issued tramadol. At 4.31pm, she checked Mr Grimes again. She noted that he had vomited brown fluid and gave him additional laxatives (lactulose and a glycerol suppository). At 5.03pm, Mr Grimes had still not had a bowel movement and she advised him to wait for the medication to start working. She consulted the senior nurse on duty, who confirmed that this was the correct action.

27. At approximately 9.00pm, Mr Grimes reported stomach pain to an Operational Support Grade (OSG) A. The OSG offered to get a nurse, but Mr Grimes declined. As he knew that Mr Grimes did not feel well, he checked him hourly, while conducting ACCT observations on another prisoner. He last saw Mr Grimes alive at 1.00am.

28. At around 2.05am, on 15 May, OSG A noticed that Mr Grimes was kneeling on the floor of his cell with his head on his bed. At interview, he said that Mr Grimes did not look as though he had collapsed, but it was difficult to tell as he could only see his back, not his face. He thought Mr Grimes might have got into a comfortable position to relieve his stomach pain and then fallen asleep. However, concerned for his welfare, the OSG asked OSG B to double check. After failing to get a response from Mr Grimes, OSG B radioed a prison manager to inform him of their concern. At 2.08am, the manager radioed an emergency code blue (which indicates that a prisoner is unconscious or not breathing) and went to collect a nurse from the healthcare department. The control room called for an ambulance at 2.10am.

29. Shortly after hearing the emergency code, an officer arrived at Mr Grimes' cell and tried to get his attention by banging on the door. As Mr Grimes failed to respond, she radioed the prison manager and obtained his permission to use OSG A's emergency key. She entered Mr Grimes' cell at approximately 2.09am, and attempted to rouse him. At interview, she said that she had checked for a pulse and started cardiopulmonary resuscitation (CPR). In the meantime, the nurse arrived and set up the defibrillator, which issued one shock. She told the investigator that when she went into the cell, she had instructed the officer to start CPR, and they continued the resuscitation attempts together. At 2.20am, paramedics arrived and took over CPR until confirming at 2.46am that Mr Grimes had died.

Contact with Mr Grimes' family

30. Mr Grimes had not had any contact with his family for over 14 years. He had nominated his father as his next of kin, but despite help from the police and the Probation Service, the prison could not locate him. The police eventually obtained an address for Mr Grimes' sister and they informed her of his death on 19 May. On 26 May, a prison manager spoke to Mr Grimes' sister and offered her condolences. Mr Grimes' sister said that she thought that he had died some years earlier, so did not want to be involved in the funeral arrangements.

31. Mr Grimes' funeral took place on 15 June 2016. The prison arranged and paid for the funeral, in line with national Prison Service policy.

Support for prisoners and staff

32. After Mr Grimes' death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

33. The prison posted notices informing other prisoners of Mr Grimes' 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 Grimes' death.

Post-mortem report

34. The coroner confirmed that Mr Grimes died of small bowel ischaemia caused by an internal abdominal hernia.

Findings

Clinical care

35. The clinical reviewer considered that much of Mr Grimes' care in prison was of a good standard. Healthcare staff monitored his chronic conditions frequently, issued appropriate medication and made timely specialist referrals when required.

36. On 13 May, a nurse reviewed Mr Grimes and subsequently sought advice from a prison GP about his ongoing constipation. Although the GP did not see Mr Grimes in person, he reviewed his discharge letter issued by the hospital the previous day and prescribed a suppository in addition to his laxatives. A nurse issued Mr Grimes with a suppository later the same evening, but did not record his clinical observations or provide any detail about his general presentation. The clinical reviewer considered that, as a full set of clinical observations were not completed, Mr Grimes did not receive adequate monitoring.

37. The clinical reviewer considered that there was a missed opportunity to arrange an emergency GP appointment, or hospital admission on 14 May, following signs that Mr Grimes' health had deteriorated further. He had not opened his bowels despite taking laxatives and had vomited brown fluid. A nurse did use the NEWS score to assess him following her clinical observations (she had not received the training). She told the investigator that she was not concerned that Mr Grimes' vomit was faecal liquid (a sign of bowel obstruction), because it had the same appearance as the drink in his mug. While it was clear that she checked on Mr Grimes frequently and encouraged him to take his laxatives, a more thorough assessment might have provided a clearer picture of the extent of his deterioration.

38. The clinical reviewer concluded that healthcare staff failed to manage Mr Grimes' deteriorating condition appropriately in the last few days of his life and that more comprehensive monitoring might have led to further intervention to try and prevent his death. In particular, she noted that healthcare staff did not always complete clinical observations in full and their use of a NEWS score was inconsistent. While we recognise that there might not have been the opportunity to monitor Mr Grimes' declining condition in the community, in prison, where healthcare staff are available, a robust system of monitoring should be used to ensure the effective identification of life-threatening conditions. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff receive training to help detect and treat early warning signs of deterioration in prisoners with chronic conditions; take and record observations as required; and record actions and decisions about their ongoing care in their medical records.

Emergency response

39. As Mr Grimes felt unwell, OSG A used his initiative to check on him during the night. He acted quickly when he became concerned that Mr Grimes was lying in an unusual position and consulted OSG B as he was unsure whether he was in a deep sleep. We are satisfied that there was sufficient doubt to warrant a further

check before calling a code blue. The prison manager used the correct emergency medical code and the control room called an ambulance in line with Prison Service instructions. The officer responded promptly, allowing for swift access to Mr Grimes. Although there are conflicting accounts as to whether she immediately started CPR, the nurse was shortly behind, so there was no significant delay in starting the resuscitation attempt. The clinical reviewer considered that the resuscitation attempt was good, with evidence of a timely response, effective communication and the correct CPR technique. We are satisfied that prison and healthcare staff did all they could to try and resuscitate Mr Grimes.

Family contact

40. Prison Rule 22 states that if a prisoner dies or becomes seriously ill then the governor should 'at once' inform a prisoner's spouse or next of kin and also any other person who the prisoner may reasonably have asked should be informed. PSI 64/2011 requires that wherever possible, the family liaison officer and another member of staff visit the next of kin or nominated person to break the news of the death. The instruction also states that if the prisoner's next of kin is not informed in person, or is told by another prison or the police, a follow-up visit by the prison must be arranged as soon as practicable.

41. Prison staff quickly tried to identify Mr Grimes' next of kin, but were unable to do so. The police traced and notified Mr Grimes' sister four days after his death. We are concerned that the prison did not contact Mr Grimes' sister to offer information and support until a further seven days had passed. We make the following recommendation:

The Governor should ensure that the prison complies with Prison Service guidance about contacting the families of deceased prisoners. Where it has not been possible for prison staff to inform the prisoner's family, a visit should be arranged as soon as possible afterwards.

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