Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Griffiths a prisoner at HMP Parc on 14 October 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 Peter Griffiths died on 14 October 2016 at HMP Parc, of respiratory failure and pneumonia caused by AIDS (acquired immune deficiency syndrome). Mr Griffiths was 56 years old. I offer my condolences to Mr Griffith's family and friends.

I consider that the standard of care Mr Griffiths received at Parc was well below that which he could have expected to receive in the community. There were no adequate procedures for dealing with positive blood test results, and a lack of urgency and determination to locate Mr Griffiths after he was bailed to the community. I am also concerned that Mr Griffiths' positive HIV test was not detected on his return to Parc, and for over two months afterwards. It is also of concern that Mr Griffiths failed to receive timely medical treatment when he requested it.

If Mr Griffiths had been diagnosed earlier, it is possible his condition might not have deteriorated and his immune system could have been restored. Moreover, this delay in diagnosing Mr Griffiths' as positive for HIV put the health of people in the community, other prisoners and prison staff at risk.

I am also concerned that officers continued to restrain Mr Griffiths after he was admitted to the intensive treatment unit at the hospital.

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 **July 2017**

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Summary

Events

1. On 6 January 2016, Mr Peter Griffiths was remanded to HMP Parc after being charged with historic sex offences.

2. Mr Griffiths' initial health screen revealed no concerns about his physical health. He had a secondary health screen on 13 January and a dry blood spot sample was taken to be tested for blood-borne viruses. On 22 January, the laboratory sent electronic confirmation to Parc that the blood sample tested positive for HIV and they requested further blood samples to confirm the diagnosis. The laboratory telephoned Parc the same day, to inform them of this result. This result was not entered on to Mr Griffiths' medical records until 8 February.

3. Mr Griffiths was bailed and released from Parc on 3 February without knowing the result of this test. Prison healthcare staff did not locate Mr Griffiths in the community and he was not told of the result.

4. On 11 July, Mr Griffiths was convicted and sentenced to 14 years and eight months in prison, and returned to Parc. He had a reception health screen the same day, but no outstanding health issues were recorded.

5. The HIV results remained undetected for a further two months despite a number of healthcare and GP appointments.

6. On 12 September, a prison GP reviewed Mr Griffiths' records due to concerns about his symptoms and noticed the positive HIV result. The GP did not tell Mr Griffiths about the positive test, but ordered blood tests electronically. The GP did not discuss these findings with anyone else at Parc.

7. Mr Griffiths' condition worsened from 16 September, and he was taken to hospital as an emergency admission on 19 September. The following day, the hospital formally diagnosed Mr Griffiths with HIV.

8. Mr Griffiths' condition deteriorated quickly, and he died at 3.55pm on 14 October.

Findings

9. Overall, we found that the standard of clinical care Mr Griffiths received at Parc fell well below that which he could have expected to receive in the community. Following a positive HIV screening result in January 2016, the prison did not process the result for over two weeks by which time he had been released on bail. The prison did not take sufficiently proactive steps to locate Mr Griffiths in the community to inform him of this result and they, critically, failed to spot the positive result when Mr Griffiths returned to custody in July or for a further two months. We are concerned that these missed opportunities seriously reduced Mr Griffiths' ability to receive timely treatment which may have prevented his death. We are also concerned that by not diagnosing Mr Griffiths' positive HIV result sooner, the prison put the health of people in the community, other prisoners and prison staff at risk.

10. We are concerned about the delays Mr Griffiths experienced in getting GP appointments in the prison, especially given his deteriorating health. This also fell below the standard he could have expected in the community.

11. We are concerned that Mr Griffiths was restrained after being moved to the hospital's intensive care unit. There was a risk assessment completed when he first went into hospital but no further assessments appear to have been completed prior to them being removed. We are not satisfied that prison staff followed, or were aware of, legal precedent on the appropriate use of restraints as a prisoner's health deteriorates.

Recommendations

- The Head of Healthcare should ensure that clinicians promptly and appropriately review and follow up abnormal blood test results, especially where the results reveal a significant diagnosis.
- The Head of Healthcare should ensure that reasonable steps are taken to pass on significant medical test results when prisoners have been released from custody, or transferred to another establishment.
- The Head of Healthcare should ensure that all important information about prisoners' health is entered on SystmOne and that healthcare staff adequately review newly arrived prisoners' SystmOne records to ensure appropriate continuity of care.
- The Head of Healthcare should ensure that prisoners get timely access to a GP when applications are made.
- The Director 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 Investigation Process

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

13. Another investigator obtained copies of relevant extracts from Griffith's prison and medical records.

14. Healthcare Inspectorate Wales (HIW) reviewed Mr Griffiths' clinical care at the prison.

15. The investigator and HIW interviewed six members of staff at HMP Parc on 24 November 2016.

16. We informed HM Coroner for Bridgend and Glamorgan Valleys of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Griffiths' friend to explain the investigation and to ask if he had any matters they wanted the investigation to consider. Mr Griffiths' friend asked us to consider the procedures for getting GP appointments at Parc. He was also concerned that officers restrained Mr Griffiths in hospital, while he was ill and had limited mobility.

18. Mr Griffith's friend received a copy of the initial report. He 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 did not find any factual inaccuracies.

Background Information

HMP Parc

20. HMP Parc is a medium security private prison run by G4S, which holds around 1,600 convicted men and young adults on remand or convicted. It also has a unit for around 60 young people under 18.

21. Integrated Services, a branch of G4S, provides 24-hour primary general and mental healthcare services at Parc and St John's Medical Practice provides 24-hour GP cover.

HM Inspectorate of Prisons

22. The most recent inspection of Parc was in January 2016. Inspectors found that chronic recruitment and retention problems affected secondary health screening. They said there were easily accessible automated defibrillators, which ensured prompt emergency care. In their survey of prisoners, significantly fewer prisoners than in comparator prisons said the quality of health provision was good. Inspectors noted that support for prisoners with complex health needs, including life long conditions was generally good.

Independent Monitoring Board

23. 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 February 2016, the IMB found that the prison was well managed. The Board said that the HMIP survey results about health provision could be explained by a lack of access to healthcare services rather than the quality of the service.

Previous deaths at HMP Parc

24. Mr Griffiths was the fifth prisoner to die of natural causes at HMP Parc since January 2016. There were no similarities between the circumstances of Mr Griffiths' death and the previous deaths at the prison.

Public Health Wales' HIV screening programme

25. Public Health Wales operates a programme to screen prisoners on their entry to prison, for a variety of blood borne viruses, including HIV.

26. Human immunodeficiency virus (HIV), commonly called a retrovirus, attacks certain white blood cells which form an essential part of the immune system. If untreated the immune system weakens so that the body cannot defend against bacteria, viruses and other germs. If detected early, HIV can be treated with antiretroviral therapy which enables people to live active, healthy lives.

27. Acquired immunodeficiency syndrome (AIDS) is a term used to explain the range of infections and illnesses which can result from a weakened immune system caused by HIV. Because antiretroviral treatment can now treat HIV, this is often referred to as 'late-stage HIV'.

Key Events

Time on remand in January 2016

28. Mr Peter Griffiths was remanded to HMP Parc on 6 January 2016, after being charged with historic sex offences.

29. When he arrived at Parc, a nurse reviewed Mr Griffiths at an initial health screen. Mr Griffiths had no physical health concerns at this time.

30. On 13 January, Mr Griffiths had an extended secondary health screen, where a dry blood spot specimen was taken. This was sent to the hospital to be tested for a number of blood borne viruses (BBV), including HIV.

31. The hospital analysed Mr Griffiths' blood and found that it was positive for HIV. They sent the result electronically to Parc, on 22 January, and requested further blood samples to confirm the diagnosis and to measure the viral load and baseline resistance (the severity of the infection). The laboratory telephoned Parc the same day to inform them of this result, but there is no record of this call on Mr Griffiths' medical records. Public Health Wales were informed the same day of a positive HIV test result at Parc, but the prisoner's identity was not disclosed to them.

32. The procedure at Parc for BBV results was for them to remain in an electronic inbox until they were processed and filed into the prisoner's individual electronic medical records. Nurse A had overall responsibility for BBV results at Parc, but this task was assigned to a nurse to perform in a clinic which operated three days each week. There was a delay in processing these results.

33. On 29 January, a doctor from Public Health Wales emailed Nurse A regarding two unidentified prisoners with positive HIV results at Parc and whether there was a link to a prisoner with HIV who had previously been at Parc. The nurse confirmed in interview that she had received an email regarding a second positive HIV test for a prisoner, but that she was only told it was Mr Griffiths after he was released from prison.

34. Mr Griffiths was released on bail from Parc on 3 February. A release from custody form was sent to Parc confirming his bail, with the condition of an electronically monitored curfew.

The period between February and July 2016

35. On 3 February, a nurse spoke to a doctor about requiring further blood samples to confirm the results for Mr Griffiths. He also noted that Mr Griffiths had a nurse appointment booked on 10 February for 'bloods to be done'.

36. On 8 February, Mr Griffiths' HIV test results were filed by a nurse on his prison medical notes, marked as requiring 'no further action'.

37. Nurse A emailed the doctor on 8 February and informed her that the person with a positive HIV test had been released by the court. She enquired as to the procedure in this situation.

38. On 10 February, the doctor arranged a meeting to discuss the issues arising from recent HIV screening results, particularly 'contact tracing'. The prison's clinical manager and Nurse A attended this meeting on 3 March. The next day, the doctor sent an email, marked 'High Importance', to the clinical manager and Nurse A, confirming that is was agreed that Mr Griffiths should be referred to his local clinic in Aberdare. The doctor further mentioned that the clinical manager had agreed to telephone the clinic to make sure this was done, and to follow this up with an email. There is no record of any telephone call or email.

39. On 6 April, the doctor emailed Nurse A to request contact details for Mr Griffiths because Public Health Wales were unable to locate him. Two days later, the nurse provided by email his home address, his GP's address and the address for Mr Griffiths' registered next of kin. Despite these addresses, Mr Griffiths was not traced while he was in the community.

Mr Griffiths return to prison in July

40. On 11 July, Mr Griffiths was convicted and sentenced to 14 years and eight months in prison and returned to Parc.

41. At Mr Griffiths' reception health screen the same day, the worker from the community health service recorded that he had no outstanding health issues or appointments. A prison GP confirmed in interview that a prisoner's medical notes are not automatically available to healthcare staff at reception health screens.

42. The next day, a prison GP saw Mr Griffiths to review his anxiety medication. She noted that a review of his notes would be needed before any further changes, but confirmed in interview that this referred to the notes relating to his mental health, not those relating to blood tests.

43. Mr Griffiths failed to attend a 72 hour extended screening appointment on 25 July, but no reason is noted and this appointment was not rescheduled. Mr Griffiths did attend a mental health assessment the same day.

44. On 2 August, Mr Griffiths was seen by a nurse due to abdominal pain, rectal bleeding and a chesty cough. It was noted that he had previously suffered irritable bowel syndrome and that he should be referred to a GP.

45. A prison GP saw Mr Griffiths on 15 August, and discussed his mental health issues, an ongoing cough and bleeding from his rectum. He examined Mr Griffiths and noted that his observations were stable, but that he should be reviewed in three weeks if his symptoms persisted. He did not review Mr Griffiths' medical notes during this consultation.

46. Mr Griffiths applied to see a GP on 22 August, complaining of a painful chesty cough and rectal bleeding. Eight days later, Mr Griffiths again applied to see a GP, and was told that an appointment was already booked.

47. During September, Mr Griffiths' health deteriorated significantly with reports of him coughing a lot. He was prescribed antibiotics for a chest infection on 1 September. On 8 September, healthcare staff noted that he had just completed

a course of antibiotics, and that a nurse noted his chest sounded ‘a little crackly’. Two days later, he was examined by a nurse for nausea, vomiting and diarrhoea.

48. There is no record of Mr Griffiths seeing a GP until 12 September, when a prison GP saw him. She noted that Mr Griffiths had a widespread rash and was concerned about his weight loss and loss of appetite. She stated in interview that her suspicions became aroused so she reviewed Mr Griffiths’ medical records and noticed the positive HIV test result. She was not sure whether Mr Griffiths knew about this so enquired about his lifestyle and asked whether he had been tested before. Mr Griffiths told her about the test in January but said he had not been told the result. She ordered more blood tests and a chest X-ray electronically, and confirmed in interview that she thought the blood tests would happen the next day. She did not discuss her findings with anyone at the prison, and these blood tests were not completed.

49. On 15 September, a healthcare assistant saw Mr Griffiths in his cell, who said that his chest and head hurt, he felt lethargic, was losing weight and could not eat much. She reviewed his electronic medical records and noticed the HIV result. She booked him in for urgent blood tests the next day and handed over to the senior nurse on duty. Later that day, a support worker examined Mr Griffiths in his cell before handing over to night staff.

50. A nurse saw Mr Griffiths in his cell in the early hours of Friday 16 September. She recorded that Mr Griffiths was unwell, and had a cold and a cough for some time. She noted Mr Griffiths’ positive HIV test result from January, and that he was booked in for emergency blood tests in the morning. She recorded that Mr Griffiths was also to be reviewed by a GP in the morning, with a nurse to chase this up.

51. Later that day, a nurse realised that Mr Griffiths was the prisoner with the positive result from January, who they had been unable to trace, and discussed this with a prison GP. The nurse further noted that blood samples were taken from Mr Griffiths that morning, but that further blood tests were booked in for the clinic on 19 September. She also recorded the GP’s advice that Mr Griffiths should be taken straight to hospital if he became ill over the weekend.

52. Mr Griffiths’ condition worsened over the weekend, and healthcare staff were unable to take blood samples on 19 September. At 10.55am that day, paramedics took Mr Griffiths to hospital, accompanied by two officers and restrained with an escort chain.

53. The hospital formally diagnosed Mr Griffiths with HIV on 20 September. Mr Griffiths remained in hospital while waiting for a bed at the Singleton GUM Clinic (Genitourinary Medicine - GUM involves the investigation and management of sexually transmitted infections and HIV).

54. On 2 October, Mr Griffiths suffered a collapsed lung and had a drain inserted. He was moved to the intensive care unit the next day, and described as poorly but not critical. Early in the morning on 4 October, Mr Griffiths was connected to a machine to assist with his breathing. Mr Griffiths was later declared unfit to transfer to the Singleton GUM Clinic. The escort chain was removed at 10.45am that day.

55. Mr Griffiths deteriorated further over the next ten days, and he died at 3.55 pm on 14 October.

Contact with Mr Griffiths' next of kin

56. Mr Griffiths' friend was his nominated next of kin. On 20 September, Mr Griffiths asked if his friend could be informed that he was in hospital. This was done the same day by the prison.

57. On 4 October 2016, the prison appointed a prison chaplain as the family liaison officer for Mr Griffiths. She called Mr Griffiths' friend and told him that Mr Griffiths was in the intensive care unit. Mr Griffiths' friend said he saw Mr Griffiths on the previous Saturday and was concerned that he was still wearing cuffs, given how ill he was.

58. At 8.15am on 14 October, a prison chaplain spoke to Mr Griffiths' friend, who confirmed he was happy to be called in the event of Mr Griffiths' death. The chaplain called him at 4.25pm to confirm Mr Griffiths' death and to offer his condolences and support. Mr Griffiths' friend said he already knew having spoken to a bedwatch officer. The chaplain provided ongoing support to Mr Griffiths' friend.

59. Mr Griffiths' funeral was held on 3 November and the prison contributed to the cost of the funeral, in line with national instructions.

Support for prisoners and staff

60. After Mr Griffiths' death, a senior manager had a meeting with the bedwatch staff on duty to discuss any issues arising, and to offer support. The staff care team also offered follow up support.

61. The prison posted notices informing other prisoners of Mr Griffiths' death, and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Griffiths' death.

Post-mortem report

62. There was no post mortem in this case, but a referral form sent to the coroner concluded that Mr Griffiths' immediate cause of death was respiratory failure, caused by pneumocystis jirovecii pneumonia (a form of pneumonia uncommon in the lungs of healthy people, but which can cause a lung infection in people with a weak immune system). This was all caused by acquired immune deficiency syndrome (AIDS).

Findings

Clinical care

63. Healthcare Inspectorate Wales (HIW) concluded that Mr Griffiths would have received better treatment in the community than he did at HMP Parc. While the coroner has concluded that Mr Griffiths' death was due to pneumonia related to AIDS, HIW consider that the prison's failure to take timely action on Mr Griffiths' HIV diagnosis and to ensure he received the appropriate antiretroviral treatment increased the likelihood that he would die. HIW observed that there were poor procedures and inadequate systems at Parc for dealing with the results of positive HIV tests, which led to Mr Griffiths' positive blood test being missed for such a long time.

64. There was a catalogue of failures prior to Mr Griffiths being released on bail, which meant nobody became aware of his positive HIV result before he was released. There was no system in place to immediately flag up important results when they came in, and the telephone call made by the laboratory was not noted or acted upon. There were at least four scheduled BBV clinics during this period, but the test result was not processed and filed onto Mr Griffiths' records until after he was released. Five days before Mr Griffiths was released on bail, a doctor emailed Nurse A to query the positive result at Parc, and although Mr Griffiths was not named there was no urgency on the part of healthcare staff to identify the prisoner involved.

65. A nurse stated in interview that emergency calls took priority over tasks in clinics, which explained the delay in processing Mr Griffiths' BBV results. The prison confirmed there were 61 emergency codes during January and 51 during February, compared to a normal level of between two and three calls per week. The increase mainly related to emergencies caused by prisoners using new psychoactive substances.

66. After Mr Griffiths was released on bail, we share HIW's concerns that healthcare staff made insufficient effort to trace him in the community. No one appeared determined enough to locate Mr Griffiths, despite there being several options open to staff at Parc. A number of the GPs interviewed confirmed that a patient can easily be traced in the community by obtaining their registration details from the 'Business Services Centre'. HIW observed that a simple phone call could have traced Mr Griffiths' current GP to convey the result of his HIV test.

67. Mr Griffiths was also on an electronically monitored curfew after his release from custody, which meant he had to be at a specified property during certain hours every day. The release from custody form given to the prison by the court had this address on it, and Nurse A clearly knew this address when she gave it to the doctor on 10 April. This address was in fact Mr Griffiths' home address so we are perplexed that nobody at Parc thought to send him a letter or to contact the court from which he had been bailed or the electronic monitoring service provider, with whom the prison would have regular and frequent contact given their broader responsibilities.

68. We consider that the prison could have easily contacted Mr Griffiths to inform him of this result during the period he was on bail. As such, Mr Griffiths would have

been in a position to access medical assistance from his GP and healthcare professionals in the community.

69. We share HIW's concerns that no alert was placed on Mr Griffiths' electronic medical records. This meant that his positive HIV result did not show up during Mr Griffiths' reception health screen when he returned to Parc in July, despite it having been filed on his medical records in February. Healthcare staff missed this result during several appointments held between July and September, and it was not noticed until healthcare staff fully reviewed Mr Griffiths' notes. Healthcare staff and GPs confirmed when interviewed that there was no cause to review his medical records during their consultations with Mr Griffiths. We would have expected some form of alert to have been on Mr Griffiths' medical records, especially given the seriousness of this condition.

70. We are concerned that healthcare staff did not review Mr Griffiths' records as his health deteriorated throughout the summer. Healthcare staff saw Mr Griffiths on several occasions with various health concerns, many of which did not appear to be improving. We therefore agree with HIW that there were missed opportunities to review his notes and detect his underlying condition, or to request blood tests in their own right.

71. It is of concern that Mr Griffiths requested a GP appointment on 22 August and 30 August, but was not seen until 12 September. This was a delay of almost a month at a time when Mr Griffiths was becoming increasingly poorly.

72. When Mr Griffiths finally saw a GP on 12 September, a prison GP quickly realised that Mr Griffiths had a positive HIV result on his records which required confirmatory blood tests. The GP made an electronic task request for further blood tests, but did not discuss her findings with anyone. We share HIW's concern that this request for a blood test was not processed straight away, and that it was a further four days before they were actually performed.

73. Finally, we are concerned that by not formally diagnosing Mr Griffiths with HIV sooner, the prison put the health of people in the community, other prisoners and prison staff at risk. We make the following recommendations:

The Head of Healthcare should ensure that clinicians promptly and appropriately review and follow up abnormal blood test results, especially where the results reveal a significant diagnosis.

The Head of Healthcare should ensure that reasonable steps are taken to pass on significant medical test results when prisoners have been released from custody, or transferred to another establishment.

The Head of Healthcare should ensure that all important information about prisoners' health is entered on SystmOne and that healthcare staff adequately review newly arrived prisoners' SystmOne records to ensure appropriate continuity of care.

The Head of Healthcare should ensure that prisoners get timely access to a GP when applications are made.

Restraints, security and escorts

74. 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.

75. An officer completed a risk assessment for Mr Griffiths prior to his visit to hospital, on 19 September. Mr Griffiths was assessed as violent, though no specific intelligence supports this. He was also assessed as a risk to children due to his index offence. At this stage, healthcare staff made no objections to restraints for Mr Griffiths on the grounds of his mobility or poor health. He was restrained with double cuffs during transit and an escort chain at hospital.

76. On 4 October, Mr Griffiths' next of kin spoke to a prison chaplain about Mr Griffiths being restrained when he visited three days earlier. Mr Griffiths' friend was concerned that this was unnecessary given Mr Griffiths' poor medical condition and limited mobility. The chaplain raised this issue during her visit.

77. At 8.00am on 4 October, it was noted that Mr Griffiths was unconscious and on a ventilator. A nurse asked for the cuffs to be removed for treatment, but worked around them when told that the prison had to give authority. Bedwatch staff spoke to the prison about this at 8.35 am, and they were removed at 10.45 am. There is no evidence of any further risk assessments being completed for Mr Griffiths, prior to the restraints being removed.

78. We do not consider that the initial risk assessment was adequate. Notwithstanding the nature of the index offence and the absence of evidence to justify the assertion of violence, the lack of consideration of the impact of Mr Griffiths' evidently very poor health on his risk suggests that the requirements set out in the Graham case were not met. We also find that once Mr Griffiths' health deteriorated and his mobility became limited, the use of restraints should have been reviewed. Whenever restraints are used, the risk assessments must accurately reflect the risk posed at that time to ensure proportionality and to maintain human dignity. We make the following recommendation:

    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.

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