

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terence Grigg a prisoner at HMP Hull on 26 August 2018

A report by the Prisons and Probation Ombudsman

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 Terence Grigg died in hospital on 26 August 2018 of multiple organ failure caused by a heart attack while a prisoner at HMP Hull. Mr Grigg was 84 years old. I offer my condolences to his family and friends.

Mr Grigg was an elderly man who arrived at Hull less than three weeks before he died with several long-term conditions. Prison healthcare staff did not review him after he received his sentence, did not complete an adequate secondary health screen and failed to monitor his long-term conditions and deteriorating health condition appropriately. The clinical reviewer found that the care that Mr Grigg received at Hull was not equivalent to that which he could have expected to receive in the community.

I am also concerned that when Mr Grigg was taken to hospital, he was restrained with an escort chain. Mr Grigg was elderly, in poor health and with limited mobility. In this context, I consider that the use of restraints was not justified. We have raised this issue with Hull before. In October 2018 (that is, after Mr Grigg's death) the prison committed to improving its risk assessment process to ensure that the level of restraint used is proportionate to the risk posed by the prisoner. I have not, therefore, made another recommendation on this occasion but will do so if the problem recurs.

The investigation also found deficiencies in family contact which the prison will need to address.

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

Sue McAllister
Prisons and Probation Ombudsman

September 2019

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Summary

Events

1. On 8 August 2018, Mr Terence Grigg was convicted of sexual offences and was sent to HMP Hull. He had several long-term health conditions, including diabetes, high blood pressure, chronic kidney disease and heart disease. At an initial reception screen, a nurse assessed Mr Grigg as suitable to keep and administer his medication himself.
2. On 9 August, Mr Grigg was sentenced to 12 years in prison and returned to Hull.
3. On 10 August, a prison GP examined Mr Grigg and made an urgent cardiology referral after noting that he had a pacemaker in need of a battery change.
4. At 5.15pm on 23 August, a nurse reviewed Mr Grigg at the request of prison staff. Mr Grigg said that he had pacemaker failure and had been incontinent of urine and faeces. The nurse took his clinical observations, which were in the normal range. At 6.58pm, another nurse recorded that Mr Grigg had a low pulse rate and a low blood pressure reading.
5. At 10.49am on 24 August, a nurse conducted an ECG on Mr Grigg. At 11.02am, a nurse noted that the ECG result was abnormal but that this was expected due to his medical history. The nurse requested urgent blood tests and discussed Mr Grigg's symptoms with a GP at HMP Humber. The GP told her to wait for the blood test results and arrange for his admission to the elderly assessment unit at Hull Royal Infirmary as soon as possible. At 4.47pm, she phoned a community GP service to discuss Mr Grigg's abnormal blood test results but a GP was not available. Healthcare staff continued to monitor Mr Grigg overnight.
6. At 8.55pm on 25 August, Mr Grigg was sent by prison minibus to Hull Royal Infirmary. Two officers went with him and restrained him using an escort chain. Hospital staff diagnosed multiple organ failure and treated Mr Grigg with fluids and antibiotics. However, Mr Grigg's condition deteriorated rapidly and he died at 9.17pm on 26 August.
7. The post-mortem report concluded that Mr Grigg died of multiple organ failure, caused by a heart attack and underlying heart disease.

Findings

8. The clinical reviewer considered that the clinical care that Mr Grigg received at Hull was not equivalent to that which he could have expected to receive in the community. Healthcare staff should have assessed Mr Grigg when he returned from court on 9 August, completed a secondary health screen, created relevant care plans and managed his deteriorating condition more appropriately.
9. Mr Grigg was elderly and in poor health. In this context, we consider that the decision to use restraints on Mr Grigg when he was taken to hospital on 25 August was unjustified. We have previously raised concerns with Hull about the unjustified use of restraints. In October 2018, the prison committed to improving

its escort risk assessment process to ensure that the use of restraints is proportionate to the risk posed by the prisoner.

10. We are also concerned that the prison did not notify Mr Grigg's next of kin of his death in line with Prison Service instructions.

Recommendations

- The Operational Manager for Offender Health should ensure that healthcare staff:
 - appropriately assess prisoners returning to prison from court following a change in status;
 - offer all prisoners a full general health screen within a week of their arrival in line with PSO 3050;
 - manage prisoners with long-term health conditions in line with National Institute of Clinical Excellence guidelines and create appropriate care plans; and
 - receive training to help detect and treat early warning signs of deterioration in prisoners with long-term health conditions.
- The Governor should ensure that a member of Prison Service staff informs a prisoner's next of kin of their death in line with national instructions.

The Investigation Process

11. 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.
12. The investigator obtained copies of relevant extracts from Mr Grigg's prison and medical records.
13. The investigator interviewed one member of staff by telephone on 19 October 2018.
14. NHS England commissioned a clinical reviewer to review Mr Grigg's clinical care at the prison. The clinical reviewer and a Spectrum community interest company (CIC) death in custody manager interviewed three members of healthcare staff at Hull on 14 December.
15. We informed HM Coroner for East Riding and Kingston-Upon-Hull of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
16. The investigator contacted Mr Grigg's friend, his named next of kin, to explain the investigation and to ask if he had any matters he wanted us to consider. Although he did not have any concerns, he agreed for us to speak to another friend of Mr Grigg who had contacted us directly and wanted to know:
 - more about the care he received;
 - why he went to hospital in restraints; and
 - why nobody was told that Mr Grigg had been taken to hospital.We have addressed these issues in this investigation report.
17. Mr Grigg's friend received a copy of the initial report. He raised two issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Hull

19. HMP Hull is a local prison which holds up to 1,056 men in ten wings. City Healthcare Partnership provides health services at the prison. The prison has 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.
20. In August 2018, Hull was selected to be part of the "10 Prisons Project" which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering prisons and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Hull was in April 2018. Inspectors found that health provision was reasonable and governance was mostly effective, but some health services had deteriorated since the last inspection. They noted that staff in the wellbeing unit provided compassionate support to prisoners but, although joint working with health services was good, the diverse mix of prisoners meant it was not sufficiently therapeutic. Care for patients with palliative or end of life needs was excellent.

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 2015, the IMB noted that the prison was effectively run, provided a safe environment for all and had benefited from the strong leadership of the Governor and Management Team.
23. The IMB noted that there was a full health screen at reception, which identified immediate risks, and outpatient clinics to manage long-term medical conditions. However, the IMB had received many complaints, mostly about medication and prescribing issues. The IMB reported that inpatient care was provided in the wellbeing unit and that a terminal care suite had been adapted to manage the rising population of older prisoners.

Previous deaths at HMP Hull

24. Mr Grigg's death was the seventeenth at Hull since August 2015, 11 of which were from natural causes. There have been three deaths since, two of which were self-inflicted and the other was from natural causes. We have previously made recommendations in a number of investigations about ensuring that staff properly justify the use of restraints on prisoners taken to hospital. The inappropriate use of restraints is yet again an issue in this case.

Key Events

25. On 8 August 2018, Mr Terence Grigg was convicted of sexual offences and was sent to HMP Hull. He was 84 years old and had several long-term health conditions, including diabetes, high blood pressure, chronic kidney disease and heart disease. Mr Grigg's community medical record shows that his GP reviewed and monitored his health conditions regularly.
26. At an initial reception screen, a nurse recorded that Mr Grigg had a history of heart problems and a pacemaker. He noted that Mr Grigg took several medications, could attend to his personal care needs and did not have any health concerns. He assessed that Mr Grigg was suitable to keep his medication in his cell and to administer it himself.
27. On 9 August, a nurse reviewed Mr Grigg before he went to court and recorded that he did not report any concerns. Later that morning, a prison pharmacist carried out medication reconciliation (a process where medications that a person should be prescribed are matched against those that are prescribed). Mr Grigg was sentenced to 12 years in prison and returned to Hull. There is no record that healthcare staff reviewed him or re-assessed his suitability to keep and administer his medication.
28. On 10 August, a prison GP examined Mr Grigg and made an urgent cardiology referral as his pacemaker was nine years old and required a battery change. However, there is no record that healthcare staff conducted a secondary health screen or created care plans for Mr Grigg's health conditions.
29. On 16 August, Mr Grigg told a prison paramedic that he had a painful tongue. She recorded that she could not do much as it was late at night but would ask healthcare staff to see him in the morning.
30. At 7.09am on 17 August, a nurse reviewed Mr Grigg and noted that he appeared settled. At 11.25pm, an Operational Support Grade (OSG) responded to Mr Grigg's cell bell and he reported feeling shaky and cold. A nurse examined him, took his clinical observations and completed a National Early Warning Score assessment (NEWS – a scoring system to assess clinical deterioration in patients). Based on his observations, she scored him 2 (a low clinical risk). 45 minutes later, Mr Grigg pressed his cell bell and told the OSG that he had diarrhoea. A nurse attended and arranged for prison staff to move him to Hull's wellbeing unit for monitoring.
31. At 5.44am, on 18 August, the nurse reviewed Mr Grigg and he reported feeling much better. She took his observations and recorded a news score of '1' (low clinical risk). Healthcare staff continued to monitor Mr Grigg frequently and he returned to his own cell the next day.

Events between Thursday 23 and Sunday 26 August

32. At 5.15pm, on 23 August, a nurse reviewed Mr Grigg in his cell following a request from prison staff. She noted that he had reported 'pacemaker failure' and had been incontinent of urine and faeces due to not having enough energy to make it to the toilet. She recorded that Mr Grigg had a good colour, was sat

calmly in his chair and could talk in full sentences. She took his observations and recorded a NEWS of '0' (a low clinical risk).

33. At 6.58pm, a nurse noted that Mr Grigg had a low pulse rate of 59 bpm (normal is between 60 and 100 bpm) and a low blood pressure reading of 96/52 mmHg (normal is between 120/80 mmHg and 140/90mmHg). She recorded a NEWS of '2', but there is no record that staff considered additional monitoring or an electrocardiogram (ECG - to monitor the electrical rhythms of the heart).
34. At 10.49am on 24 August, a nurse conducted an ECG on Mr Grigg. At 11.02am, a nurse reviewed him and noted that although the ECG result was abnormal, this was expected due to his medical history. She recorded that he had an irregular pulse rate and that she could not exclude the possibility of sepsis. She requested urgent blood tests and discussed Mr Grigg's symptoms with a GP at HMP Humber, who told her to wait for the blood test results and, as a precaution, to arrange for his admission to the elderly assessment unit at Hull Royal infirmary, as soon as possible.
35. At 4.47pm, a nurse contacted a community GP service to discuss Mr Grigg's blood test results as they had come back abnormal but a GP was not available. At interview, she told the clinical reviewer that healthcare managers at the prison had provided her with the details of the GP service and said that a GP would be available if she needed support. She asked healthcare staff to take Mr Grigg's observations every four hours and to call an ambulance if his condition deteriorated. She also recorded that prison staff would take Mr Grigg to hospital in the morning, when escort staff became available. Healthcare staff moved Mr Grigg to the wellbeing unit, created a care plan and took his observations, as directed.
36. At 5.20am, on 25 August, a nurse reviewed Mr Grigg in his cell and noted that he reported feeling "a little better". He took his observations and recorded a low oxygen saturation level of 87% (normal is between 95-100%) and a low breathing rate of 10 breaths per minute (normal for resting adults is between 12 and 20 breaths per minute). He completed a NEWS assessment and scored Mr Grigg '4' (medium clinical risk).
37. At 8.55am, Mr Grigg was sent by prison minibus to Hull Royal Infirmary. Two officers went with him and restrained him using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). Hospital staff diagnosed multiple organ failure and treated Mr Grigg with fluids and antibiotics. Escort records show that at 7.00pm, a hospital doctor informed Mr Grigg that he was very unwell and that his treatment may not work. Shortly afterwards, the doctor told Mr Grigg that hospital staff would not try to resuscitate him if his heart or breathing stopped.
38. At 3.44pm, on 26 August, a nurse contacted the hospital for an update and recorded that Mr Grigg had multiple organ failure. She noted that he had a poor prognosis and that hospital staff planned to treat him for two to three days to see if he improved. However, Mr Grigg's condition deteriorated rapidly and he died at 9.17pm.

Contact with Mr Grigg's family

39. At 10.15am on 25 August, the prison appointed a Supervising Officer (SO) as the family liaison officer. She noticed that Mr Grigg had not named a next of kin and tried to contact his local priest, who had previously enquired about a visit. She did not get an answer, so she decided to speak to Mr Grigg that evening when she took over as one of his escort officers. At 6.00pm, Mr Grigg named a friend as his next of kin and provided her with an address. He could not remember his friend's phone number but said that his priest might know.
40. At 10.00pm on 26 August, a prison manager informed the SO that Mr Grigg had died. She updated him about her attempt to obtain a contact number for his next of kin and left the prison. At 7.45am on 27 August, he told her that he had been unable to obtain a phone number for Mr Grigg's next of kin. Shortly afterwards, she told another prison manager that she could ask a prison close to Mr Grigg's next of kin's address in Northampton or the local police to break the news. He advised her to ask the police to attend.
41. On 28 August, the SO recorded that despite several attempts the police were unable to make contact with Mr Grigg's next of kin. She subsequently spoke to a prison chaplain who contacted a friend of Mr Grigg's who had enquired about a visit and provided a phone number for his next of kin. At 11.10am, she phoned Mr Grigg's next of kin to break the news and to offer support.
42. The SO provided support to Mr Grigg's next of kin until his funeral which a prison manager and a prison chaplain attended on 24 September 2018. The prison contributed towards the cost in line with national instructions.

Support for prisoners and staff

43. After Mr Grigg's death, a prison manager debriefed the staff present at the hospital to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
44. The prison posted notices informing other prisoners of Mr Grigg'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 Grigg's death.

Post-mortem report

45. A post-mortem report found that Mr Grigg died of multiple-organ failure caused by a heart attack which in turn was caused by a build-up of plaque in the coronary arteries and an enlarged heart. The report found that a build-up of fatty deposits caused the coronary arteries to narrow and impaired the heart's ability to pump effectively.
46. Microscopic analysis of Mr Grigg's heart suggested a progressive heart attack and the pathologist raised the possibility that it was a heart attack that had caused Mr Grigg's symptoms between 16-24 August. The report concludes that although it remains uncertain whether an earlier diagnosis would have prevented Mr Grigg's death, it would not be a surprise if such a major cardiac insult would have caused his death irrespective of medical treatment. Chronic kidney disease, high blood pressure and diabetes were also given as contributory factors.

Findings

Clinical care

47. The clinical reviewer found that the care Mr Grigg received at HMP Hull was not equivalent to that which he could have expected in the community.

Medical assessment following a change of circumstance

48. We are concerned that healthcare staff did not review the decision to allow Mr Grigg to keep and administer his medication or carry out a full medical assessment when he was returned to Hull on 9 August. Prison policy set out in Prison Service Instruction (PSI) 07/2015 on early days in custody states that when a prisoner returns to prison after a temporary absence, a medical assessment is required where the prisoner falls into one of several categories or where reception staff have any other concerns about their health. We consider that Mr Grigg fell into one of these categories, given that his status had changed due to receiving a sentence of 12 years.

Healthcare for newly arrived prisoners

49. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners requires that newly arrived prisoners should be offered a general health assessment in the week after first reception. This assessment is expected to be equivalent to a primary care assessment when registering with a new GP in the community. The operational manager for offender health told the clinical reviewer that Mr Grigg's GP appointment on 10 August should have been recorded as a secondary health screen but appears to have been overlooked. However, the screening template on the prison's electronic medical record was not completed and the clinical reviewer considered that the information that the GP provided was not sufficient to amount to a secondary health screen.

Management of long-term health conditions

50. The clinical reviewer considered that due to Mr Grigg's age and long-term health conditions, healthcare staff should have identified his risks and planned his care accordingly. However, the operational manager said that healthcare staff would only complete care plans for long-term health conditions if they were uncontrolled. Mr Grigg's pacemaker battery was nearing the end of its life and his medical record shows that his community GP monitored all his long-term health conditions frequently. The clinical reviewer concluded that healthcare staff should have referenced Mr Grigg's care against the relevant National Institute of Care Excellence (NICE) guidelines and created care plans to replicate this level of monitoring in prison.

Assessing and monitoring clinical deterioration

51. The clinical reviewer considered that healthcare staff should have conducted an ECG on 23 August. This would have clarified whether Mr Grigg had an acute problem with his heart. While we recognise that healthcare staff conducted an

ECG the next morning, they should have conducted an ECG immediately if there were concerns about Mr Grigg's pacemaker. We are also concerned that despite a NEWS score of '2' at 6.58pm, healthcare staff did not review Mr Grigg again until the next morning. The clinical reviewer considered that a NEWS score of '2' required monitoring every four to six hours.

52. The clinical reviewer was not wholly satisfied with the decision to monitor Mr Grigg overnight on 24 August and transfer him to hospital the next morning. She noted that although his observations indicated that he was stable, his blood results were abnormal and his ECG was irregular. She concluded that healthcare staff did not manage Mr Grigg's deteriorating condition as well as they could have done and we consider that a hospital transfer would have been more appropriate. Although we recognise that there might not have been the opportunity to monitor Mr Grigg's declining health in the community, in prison, where healthcare staff are available, it is important that staff effectively identify life-threatening conditions. We make the following recommendation:

The Operational Manager for Offender Health should ensure that healthcare staff:

- **appropriately assess prisoners returning to prison from court following a change in status;**
- **offer all prisoners a full general health screen within a week of their arrival, in line with PSO 3050;**
- **manage prisoners with long-term health conditions in line with National Institute of Clinical Excellence guidelines and create appropriate care plans; and**
- **receive training to help detect and treat early warning signs of deterioration in prisoners with long-term health conditions.**

Restraints, security and escorts

53. 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.
54. 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.
55. When Mr Grigg was taken to hospital on 25 August, a prison manager reviewed his risk assessment and authorised two officers to escort him using an escort chain. His risk of escape was assessed as low and there were no medical objections to the use of restraints. However, a CM appears to have completed the medical section of the assessment. The person escort record (PER) states

that Mr Grigg was transported by wheelchair but there is no record of this in the risk assessment.

56. A prison manager told the investigator that although it looked as though the CM had completed the medical section, it was likely that he would have obtained the information from healthcare staff. He said that when he made the decision to use restraints, he took into account that Mr Grigg was assessed as a medium risk to the public and a risk to children. At 8.00pm, on 26 August, he visited Mr Grigg in hospital, reviewed his risk assessment and authorised the removal of restraints.
57. While we are satisfied that the prison manager appropriately decided to remove the restraints shortly before Mr Grigg died, we are concerned that Mr Grigg went to hospital restrained by an escort chain and that he remained restrained for so long after his hospital admission. Mr Grigg was an elderly and frail man who, at the time, had limited mobility and was clearly seriously ill. The risk assessment appears to have been based primarily on his offence, with little consideration of his actual risk or how his health affected this risk, as the 2007 High Court judgment requires. Whenever restraints are used, the risk assessments must accurately reflect the risk posed at that time to ensure proportionality and to maintain human dignity.
58. We have previously expressed concerns about the inappropriate use of restraints on very sick and elderly prisoners at HMP Hull, and the prison has committed on each occasion to address these failings. In October 2018, we drew our concerns to the attention of the Prison Group Director (PGD) for Yorkshire. In response, Hull said that they would review the escort risk assessment form and remind all relevant staff of the legal position on the use of restraints. They also said that they would monitor the use of restraints on a monthly basis and provide the PGD with the new risk assessment to test compliance. In December, we expressed concern about the inappropriate use of restraints on a prisoner who died on the same day as Mr Grigg. We did not make a recommendation on the basis that the prison had made appropriate changes since that death and we do the same in Mr Grigg's case.

Informing Mr Grigg's next of kin

59. Prison Rule 22 requires that the Governor informs families at once when a prisoner dies. Prison Service Instruction (PSI) 64/2011 says that wherever possible, the family liaison officer and another member of staff should visit the next of kin or nominated person to break the news of the death. It notes that time will be of the essence to try to ensure that the family do not find out about the death from another source. If the next of kin live a long distance away, consideration must be given to requesting the assistance of a family liaison officer from the nearest prison.
60. Mr Grigg's next of kin lived approximately 134 miles from the prison. A prison manager told the investigator that he could not remember being told that a next of kin had been identified and was therefore not aware of an address. He said that if he had known, he would have arranged for the next of kin to be informed. Another prison manager told us that he decided to ask the police to break the news to Mr Grigg's next of kin as he thought asking a family liaison officer from a nearby prison would take too long.

61. We are satisfied that the family liaison officer appropriately broke the news to Mr Grigg's next of kin. However, we consider that the prison should have acted more promptly after they clarified Mr Grigg's next of kin's address and asked a nearby prison for assistance before contacting the police. We make the following recommendation:

The Governor should ensure that a member of Prison Service staff informs a prisoner's next of kin of their death in line with national instructions.

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