Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Graham Gregory, a prisoner at HMP Hull, on 15 April 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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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Summary

1. 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.

2. Our office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Graham Gregory, who was 83 years old, died of acute renal failure and bronchopneumonia on 15 April 2019 while a prisoner at HMP Hull. We offer our condolences to Mr Gregory's family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Gregory received at Hull was not of the required standard and therefore not equivalent to that which he could have expected to receive in the community. She has made five recommendations about clinical issues.

5. The prison did not contact Mr Gregory's next of kin until four days after his admission to hospital, when his health had already seriously declined.

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

Recommendations

- The Head of Healthcare should ensure that staff make themselves available for interviews to allow for accurate reporting of events.
- The Head of Healthcare should ensure that healthcare staff complete second stage screening in line with NICE guidance NG57 and ensure that regular audits are undertaken to monitor compliance.
- The Head of Healthcare should ensure that all healthcare personnel are aware of the NICE guidance for chronic health needs and that appropriate assessments are completed in a timely manner and ongoing health needs are met.
- The Head of Healthcare should ensure that all staff are aware of the NMC record keeping guidelines so that there is ongoing assessment, planning and continuity of care.
- The Head of Healthcare should review the waiting lists and requested investigations process and ensure that they are completed in a timely manner.
- The Governor should ensure that a family liaison officer is appointed when a prisoner is assessed as seriously ill and that appropriate and timely arrangements are made for early contact with families.

Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Gregory's clinical care at HMP Hull. The clinical review is attached to this report as annex 1.

8. The PPO has investigated the non-clinical issues in Mr Gregory's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. We wrote to Mr Gregory's next of kin to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They responded with some matters they wanted the investigator to consider. These have been addressed in this report and in the clinical review.

10. Mr Gregory's next of kin received a copy of the draft report. Mr Gregory's next of kin also raised several questions that did not impact on the factual accuracy of this report and has been addressed through separate correspondence.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out no factual inaccuracies. The action plan has been annexed to this report.

Previous deaths at Hull

12. There have been nine deaths from natural causes at Hull in the last two years. There are no similarities between our findings in the investigation of Mr Gregory's death and the other deaths.

Key Events

13. In 2017, Mr Graham Gregory was diagnosed with prostate cancer and bone metastases (spread of cancer to the bone tissue) while in the community. He also had chronic lymphatic leukaemia, high blood pressure, high cholesterol and previously had had a stroke.

14. On 28 March 2018, Mr Gregory was sentenced to four years in prison for historic sexual offences. On 29 June, he was transferred to HMP Hull.

15. Following a review of Mr Gregory's risk and health needs in November, prison managers decided that he should not be restrained for any hospital appointments or hospital admissions.

16. In February 2019, Mr Gregory's health began to deteriorate. He saw a prison GP and complained of shortness of breath and back pain. The GP prescribed stronger pain relief and Mr Gregory was sent to hospital for an ECG and a chest x-ray on 4 March.

17. The results showed that Mr Gregory had bilateral pulmonary fibrosis (a respiratory disease in which scars are formed in the lung tissues and leads to serious breathing problems).

18. Mr Gregory's health continued to deteriorate. His mobility was reduced, he was incontinent of urine, and had increased back pain. On 14 March, he was moved to the prison's palliative care suite.

19. On 18 March, Mr Gregory was transferred to hospital for end of life care.

20. On 15 April, it was confirmed that Mr Gregory had died.

21. Because Mr Gregory's health had declined so quickly, prison staff did not apply for compassionate release on his behalf before he died.

22. The post-mortem examination gave Mr Gregory's cause of death as 1a) acute renal failure, 1b) bronchopneumonia due to, 1c) chronic obstructive pulmonary disease, contributed to by 2) disseminated carcinoma of the prostate.

Non-clinical findings

Contact with Mr Gregory's Next of Kin

23. PSI 64/2011 on safer custody requires prisons to communicate with the next of kin of prisoners who are seriously or terminally ill. The prison appointed a family liaison officer on 21 March, four days after Mr Gregory became very unwell and was sent to hospital as an emergency.

24. On 20 March, hospital staff told a nurse from the prison's healthcare team, that Mr Gregory was very ill and his kidneys were not working. However, Mr Gregory's next of kin were not told about his condition until the next day. When Mr Gregory's next of kin visited him in hospital, they said that he was confused and he did not recognise them.

25. The Head of Healthcare told the investigator that while Mr Gregory was showing some signs of confusion, he did have full capacity to make decisions about his

care and treatment when he was taken to hospital on 18 March. She also said that hospital staff continually assessed Mr Gregory's capacity and liaised with the prison about his condition.

26. Once a prison family liaison officer was appointed, Mr Gregory's family received appropriate support. However, we consider that prison staff should have told Mr Gregory's family of his deteriorating condition much sooner. We make the following recommendation:

The Governor should ensure that a family liaison officer is appointed when a prisoner is assessed as seriously ill and that appropriate and timely arrangements are made for early contact with families.

Sue McAllister CB
Prisons and Probation Ombudsman **February 2020**