Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Viktor Grebenkin, a prisoner at HMP Chelmsford, on 27 July 2019

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 Viktor Grebenkin died on 27 July 2019 of heart failure at HMP Chelmsford. He was 57 years old. I offer my condolences to those who knew him.

I am concerned that, although Mr Grebenkin spoke little English, interpreting services were not used consistently to communicate with him.

I am not satisfied that the healthcare Mr Grebenkin received at Chelmsford was equivalent to that which he could have expected to receive in the community. Our investigation found that staff did not complete a reception screen when he arrived at Chelmsford, and that when he was transferred to the prison's healthcare unit, there were no care plans to monitor and try to determine the reasons for his behaviour.

When staff found Mr Grebenkin collapsed in the shower area, they responded quickly and made commendable efforts to assist him, as well as immediately calling an ambulance.

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, CB
Prisons and Probation Ombudsman **January 2020**

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Summary

Events

1. On 24 June 2019, Mr Viktor Grebenkin was remanded into custody for burglary and sent to Chelmsford. He had only been in the UK for two weeks and was homeless.

2. There is no record of a completed reception health screen. Mr Grebenkin was agitated and could not speak English. Staff moved him to a general wing. There was no change to his behaviour.

3. When a nurse was unable to complete an assessment, he arranged for Mr Grebenkin to be admitted to healthcare. An older person's care plan was created. Mr Grebenkin remained unsettled in healthcare. Sometimes he was aggressive and disruptive.

4. Around 12.00pm on 27 July, officers found Mr Grebenkin unresponsive on the floor of the shower room. An officer radioed a code blue medical emergency code and the control room called an ambulance. Prison and healthcare staff began resuscitation attempts. Paramedics arrived and continued to try to resuscitate Mr Grebenkin, but they pronounced him dead at 12.50pm.

Findings

5. The clinical reviewer considered that the care Mr Grebenkin received at Chelmsford was not equivalent to that which he could have expected to receive in the community. We agree with the clinical reviewer as Mr Grebenkin never received any substantial treatment at Chelmsford. Staff did not consistently use interpreting services to communicate with Mr Grebenkin.

6. Healthcare staff did not complete a reception health screen with Mr Grebenkin. He was transferred to healthcare without the rationale for this decision being clearly recorded. We also found there were no care plans for Mr Grebenkin to try to identify the reasons behind his behaviour and there were missed opportunities to discuss his problems with him.

7. Mr Grebenkin died from heart disease. There was a lack of primary care management. Entries in his records focused on recording his poor behaviour.

8. When staff found Mr Grebenkin unresponsive in the shower area, the emergency response was timely and appropriate.

Recommendations

- The Governor and Head of Healthcare should ensure that foreign national prisoners are informed of the availability of the telephone interpreting service and accredited interpreting services are used for prisoners who do not understand English well.
- The Head of Healthcare should ensure that all newly arrived prisoners have an appropriate health screen that reviews their medical history and identifies any relevant conditions.

- The Head of Healthcare should ensure that there is a clearly defined procedure for transferring prisoners to healthcare.
- The Head of Healthcare should ensure that when prisoners are admitted to healthcare staff create condition-specific management plans in place in line with NICE guidelines and recommendations.
- The Head of Healthcare should ensure that clinical staff assess and manage prisoners effectively to enable good standards of care, including that:
    - all treatment and care is fully documented in prisoners' medical records to allow effective continuity of care; and
    - clinical staff are aware of the triggers for escalation and when to organise further investigations.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Chelmsford informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator obtained copies of relevant extracts from Mr Grebenkin's prison and medical records.

11. The investigator interviewed two members of staff at Chelmsford on 4 September. NHS England commissioned a clinical reviewer to review Mr Grebenkin's clinical care at the prison.

12. We informed HM Coroner for Essex of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

13. We were unable to contact Mr Grebenkin's family to inform them of the investigation. They had no contact with him while he was in prison.

14. 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 Chelmsford

15. HMP Chelmsford is a local prison that takes prisoners directly from the courts. It holds nearly 730 men. Essex Partnership University NHS Foundation Trust (EPUT) was commissioned to provide 24-hour healthcare until 1 April 2019, when Castle Rock Group (CRG) Medical took over the contract. The prison has a twelve-bed inpatient unit.

16. Between 3 May 2018 and 2 July 2019, Chelmsford was under special measures. This means that HM Prisons and Probation Service had determined that it needed additional, specialist support to improve its performance.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Chelmsford in June 2018. Inspectors said that aspects of healthcare provision needed attention, leadership needed to be stronger and significant staffing shortages in healthcare affected service delivery and leadership. They reported that waiting times for some aspects of care were too long and mental health services were very stretched, with prisoners waiting weeks for an assessment, and that services were reactive.

18. HMIP also recommended that there should be a better focus on the issues raised by the PPO in relation to deaths in custody.

19. In April 2019, HMIP reviewed Chelmsford's progress against the main recommendations. Inspectors found that there had been reasonable progress in the provision of care and that the new provider had already begun to address many of their concerns. For example, the health application appointment process had been revised and the high failure-to-attend rate had since decreased. Waiting times for primary care services had reduced and were now within acceptable timescales. They said that positive partnership working between the new provider and the prison was evident, with several examples of proactive joint strategic and operational work. There was now strong leadership, and the new senior health team was visible to patients and accessible to health and prison staff.

20. HMIP also said that PPO recommendations relating to health care were monitored well, and there had been good progress in this area. However, not all the recommendations were actively reviewed to ensure that progress was made or sustained.

Independent Monitoring Board

21. 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 31 August 2018, the IMB reported that there were significant healthcare staff shortages and lengthy delays in mental healthcare provision.

Previous deaths at HMP Chelmsford

22. Mr Grebenkin was the eleventh prisoner to die at Chelmsford since July 2017. Two of these previous deaths were due to natural causes, three deaths were drug related and five were self-inflicted. There has been one self-inflicted death since that of Mr Grebenkin. There were no similarities between the circumstances of the previous deaths and that of Mr Grebenkin.

Key Events

23. On 24 June 2019, Mr Viktor Grebenkin was remanded into custody for burglary. He was sent to Chelmsford. He had only been in the UK for two weeks and was homeless.

24. On arrival at Chelmsford, healthcare staff did not conduct a reception medical screen. Reception staff noted that he did not speak English and appeared agitated. He told staff he was from Uzbekistan. Staff tried using Google translate and Russian speaking prisoners but Mr Grebenkin was abusive to them.

25. Staff tried again to complete the reception medical screen on 25 June when they had transferred Mr Grebenkin to a cell on B wing. A mental health nurse spoke to Mr Grebenkin but noted that he was unable to understand English.

26. Wing staff arranged for a mental health assessment to be completed as they described Mr Grebenkin as having "very odd behaviour" and mood swings as he struggled with the language barrier. Mr Grebenkin rang his cell bell constantly. When staff went to speak to him he was rude and abusive. The only person who could communicate with Mr Grebenkin was a visiting Russian Orthodox priest who said that Mr Grebenkin spoke Russian and was Russian Orthodox.

27. Mr Grebenkin remained frustrated. Wing staff recorded numerous instances of him ringing his cell bell all night, kicking the cell door, smashing his kettle and television against the cell door and shouting.

28. On 1 July, a mental health nurse attempted to complete a mental health review with Mr Grebenkin. However, she was unable to complete it as Mr Grebenkin started shouting at her and kicking his cell door. She noted he was very aggressive, difficult to engage, there was a language barrier and she was unable to complete an assessment of his mental state.

29. Later that day, an Immigration Officer tried to interview Mr Grebenkin, but the interview was terminated as Mr Grebenkin was disruptive. A mental health nurse also tried to complete a mental health review but noted he was unable to complete the assessment as Mr Grebenkin was difficult to engage with. He noted that Mr Grebenkin would require a period of assessment in healthcare to rule out any psychosis or underlying mental health issue. He noted Mr Grebenkin was not fit to remain on the wing given his presentation and the state of the cell. He arranged for his transfer to healthcare and said there should be a follow up psychiatric assessment.

30. On 5 July, Mr Grebenkin moved to the healthcare unit for observation and psychiatric assessment. Staff described him as erratic and dangerous. However, there is no evidence that healthcare staff referred him to or discussed him with a psychiatrist.

31. On 8 July, A nurse noted that Mr Grebenkin was agitated but due to the language barrier it was not possible to discover why. The nurse noted that a nurse manager told her that as Mr Grebenkin had been in prison for two weeks, alcohol withdrawal was unlikely as he did not have any of the typical symptoms.

32. The nurse decided that she would complete a referral to Full Circle (which provides integrated support for older people and people with learning disabilities, substance misuse issues and mental health problems across criminal justice settings in Essex) for psycho-social intervention. A nurse created an Older Person's care plan to assess Mr Grebenkin's health needs although there is no record that she included Mr Grebenkin in this or that it was subsequently reviewed.

33. On 12 July, a prison GP noted that he had seen Mr Grebenkin on the wing and there were "no new issues".

34. On 25 July, a mental health nurse assessed Mr Grebenkin using an official interpreter. However, Mr Grebenkin was abusive and provided unclear information about his life and medical history. He denied any alcohol or illicit drug use and any mental or physical health issues. He said that he had been in Lithuania and was registered disabled in his country.

35. On 26 July, a mental health nurse noted that she deemed Mr Grebenkin medically fit for court. However, there is no documentation relating to this or how it was assessed and decided without the use of an interpretation service.

Events on 27 July 2019

36. An officer told the investigator that Mr Grebenkin asked him if he could have a shower just after 11.30am on 27 July. The officer said he could and went with him to collect a clean towel and then left him in the shower room. No other prisoners were present in the shower area.

37. At around 12.00pm, three officers began locking prisoners into their cells at lunchtime. They went to the shower area to collect Mr Grebenkin and found him lying on the floor on his back. An officer asked him if he was okay but he did not respond. The officer told the investigator that it appeared that Mr Grebenkin had started to change to get into the shower and had collapsed. An officer checked for a pulse, said there was not one and immediately began Cardio Pulmonary Resuscitation (CPR).

38. At 12.06pm, an officer radioed a "code blue" medical emergency (indicating a life-threatening incident involving breathing difficulties). Staff in the communications room immediately telephoned for an ambulance. Two nurses and a prison GP responded to the emergency call.

39. When a nurse arrived, an officer was doing chest compressions. The nurse immediately used the defibrillator, which did not detect a shockable heart rhythm. He then helped staff with the resuscitation attempt.

40. Records show that the ambulance arrived at 12.15pm. The paramedics reached the shower area at 12.21pm and continued emergency treatment. At 12.50pm, a paramedic declared that Mr Grebenkin had died.

Contact with Mr Grebenkin's family

41. Prison staff were unable to contact any of Mr Grebenkin's family when he died. Mr Grebenkin had not named anyone as his next of kin, had never received any visits and had had no known contact with any family members. The Uzbekistan Embassy told prison staff that they were unable to trace any relatives.

42. The prison arranged and paid for Mr Grebenkin's funeral, which was held on 9 September.

Support for prisoners and staff

43. After Mr Grebenkin's death a senior 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.

44. The prison posted notices informing other prisoners of Mr Grebenkin'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 Grebenkin's death.

Post-mortem report

45. The Coroner gave the cause of death as haemopericardium (blood in the sac which contains the heart and vessels) caused by a ruptured myocardial infarct (tissue death of the heart muscle due to a tear of one of the blood vessels). Mr Grebenkin also had coronary artery thrombosis (a clot in the blood vessel of the heart) which did not cause but contributed to his death.

Findings

Communication with prisoners who speak little or no English

46. It was evident that Mr Grebenkin spoke and understood very little English. As with all prisons, Chelmsford has a contract with a professional telephone interpreting service, yet prison and healthcare staff did not consistently use the service. The Prison Service's policy on foreign national prisoners states:

> "Language barriers obviously make all other problems worse. Staff should not assume that prisoners with some comprehension of English have completely understood what is being said to them. Poor communication between staff and prisoners may have implications for things like risk of self-harm and good order and discipline."

47. Mr Grebenkin was a difficult prisoner to manage. More consistent use of the interpreting service may have enabled Mr Grebenkin to explain his feelings and actions, as well as allowing healthcare staff to assess whether he had any ongoing clinical needs. We make the following recommendation:

The Governor and Head of Healthcare should ensure that foreign national prisoners are informed of the availability of the telephone interpreting service and accredited interpreting services are used for prisoners who do not understand English well.

Clinical care

48. The clinical reviewer found that Mr Grebenkin's clinical care at Chelmsford was not satisfactory and therefore not equivalent to that he could have expected in the community.

49. The clinical reviewer concluded that the main issue was that Mr Grebenkin's physical and mental health were not assessed and most actions taken had been due to presumptions made by staff.

Reception screening

50. A reception health screen is important for a nurse to note any ongoing healthcare issues that require a referral to a specialist. On arrival at Chelmsford, staff noted that Mr Grebenkin had a poor command of English and they tried to use unofficial interpreters to assist (asking a prisoner to assist and using an online translation service). However, despite noting that the reception process was not completed and an interpreter should be arranged, there was no follow up action for this. Mr Grebenkin may have had an underlying medical problem, including heart and circulatory problems which required ongoing treatment and management. However, this was not known or attended to, as staff focused on his behaviour. We therefore recommend:

The Head of Healthcare should ensure that all newly arrived prisoners have an appropriate health screen that reviews their medical history and identifies any relevant conditions.

Transfer to healthcare

51. The clinical reviewer considered that there were some weaknesses in managing Mr Grebenkin's care as staff did not monitor his behaviour to help manage his triggers and disruption. Mr Grebenkin presented as having complex needs. When a nurse referred him to healthcare for a period of assessment, he did not document the clinical reasons for this, only that Mr Grebenkin's cell was flooded and he was malodourous and agitated. We agree with the clinical reviewer that his care at this stage was not equivalent to community care. We make the following recommendation:

The Head of Healthcare should ensure that there is a clearly defined procedure for transferring prisoners to healthcare.

Care plans

52. Although there were communication problems, the clinical reviewer concluded that if Mr Grebenkin had been assessed using an interpretation service, information could have been gathered that may have indicated that there was an existing problem that required ongoing monitoring. The post-mortem concluded that the cause of death was historical heart disease which led to eventual sudden cardiac arrest.

53. Staff did not compare possible triggers for Mr Grebenkin's behaviour to track any increase in poor behaviour and often did not record observations about him, which made it difficult for the staff involved in his care to note any improvement or deterioration.

54. Except for an older person's care plan, Mr Grebenkin did not have any care plans in place. We agree with the clinical reviewer that when Mr Grebenkin arrived in healthcare there should have been a plan for his care, with good, clear, holistic care plans, which were well communicated within the healthcare team. We therefore make the following recommendation:

The Head of Healthcare should ensure that when prisoners are admitted to healthcare, staff create condition-specific management plans in line with NICE guidelines.

Clinical assessment

55. Given the findings of the post mortem, including that Mr Grebenkin had heart disease, we are concerned that possible symptoms of heart failure were never explored. There are no records of any blood pressure checks or blood tests which may have prompted further investigations in relation to the management of potential heart conditions. We recommend:

The Head of Healthcare should ensure that clinical staff assess and manage prisoners effectively to enable good standards of care, including that:

- **all treatment and care is fully documented in prisoners' medical records to allow effective continuity of care; and**
- **clinical staff are aware of the triggers for escalation and when to organise further investigations.**

Emergency response

56. Records indicate that officers began cardiopulmonary resuscitation when they found Mr Grebenkin collapsed. They continued this, with assistance from healthcare staff, until the paramedics arrived. All staff worked hard and professionally and this should be commended.

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