Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Grass, a prisoner at HMP Garth, on 20 October 2021

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

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 Peter Grass, who was 67 years old, died from cancer on 20 October 2021, at HMP Garth. We offer our condolences to Mr Grass's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Grass received at Garth was of a good standard and was equivalent to that which he could have expected to receive in the community. She found that he received quality care and compassion. She made one recommendation.

5. We are concerned that when Mr Grass was taken to hospital in September, he was double handcuffed (his wrists were handcuffed together and he was attached to an officer using an escort chain). The decision was based on his security category alone and did not take account of his current state of health and mobility as it should have done. We consider that the level of restraints used was disproportionate to the risk posed by Mr Grass.

Recommendations

- The Head of Healthcare should ensure that a falls risk assessment and falls risk assessment management plan are completed and added to the prisoner's medical record, following an incident where a person has fallen, irrespective of injury.

- 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, in all cases:

    - healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and

    - authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Grass's clinical care at HMP Garth.

7. The PPO investigator has investigated the non-clinical issues in Mr Grass's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered. The investigator interviewed a prison manager.

8. The PPO's family liaison officer wrote to Mr Grass's next of kin, his cousin, to explain the investigation and ask if she had any questions for the investigator. She did not respond.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

Previous deaths at HMP Preston

10. Mr Grass was the ninth prisoner to die at Garth since October 2019. Four of the previous deaths were from natural causes, two were drug related and two were self-inflicted. There are no similarities between our findings from our investigation into the death of Mr Grass and our findings from the previous deaths.

Key Events

11. On 8 December 2006, Mr Peter Grass was sentenced to life imprisonment for murder with a minimum tariff of 26 years. He was sent to HMP Garth on 24 September 2007.

12. Mr Grass experienced significant health problems in his latter years, including chronic obstructive pulmonary disease (COPD - the term for a group of serious lung diseases), type 2 diabetes, circulation problems and heart disease. He became increasingly reliant on a wheelchair towards the end of his life.

13. On 3 June 2021, Mr Grass experienced severe shortness of breath and was taken to hospital, where he stayed until 15 June. The doctors considered his existing COPD to be the primary cause for his condition but arranged follow up investigations.

14. On 9 July, Mr Grass had a scan which indicated that it was likely that he had lung and bone cancer. This was subsequently confirmed, and he was told that the condition was inoperable. The emphasis in Mr Grass's treatment became palliative care (care with the focus on optimising the quality of life and reducing suffering).

15. On 20 August, staff at Garth referred Mr Grass to the local hospice. Prison and healthcare staff worked closely with the hospice and, in September, Mr Grass had a meeting with hospice staff and discussed his thoughts about his illness.

16. Mr Grass said he did not want to move to HMP Preston even though it had a hospital wing which Garth did not. He said he would prefer to stay in Garth where he had been for many years, with his friends and the staff he knew. Exceptionally, Garth was able to accommodate his wishes.

17. On 21 September, the hospice doctor who reviewed Mr Grass recorded that he could only mobilise very short distances without his wheelchair.

18. Early in the morning on 23 September, prison officers helped Mr Grass back into bed as he could not manage it by himself. Later in the day, an officer called a code blue (a medical emergency radio code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and prompts the control room to call an ambulance), after they found Mr Grass having breathing difficulties. However, after nurses made an initial assessment, they stood down the ambulance and took Mr Grass to the healthcare unit in his wheelchair and asked a prison GP to review him. The GP decided that Mr Grass should go to hospital for further checks, which Mr Grass reluctantly agreed to.

19. Mr Grass was admitted to hospital and only returned to Garth on 4 October. When he came back, healthcare staff reviewed him four times a day and prison officers checked him every half hour.

20. Mr Grass's condition deteriorated significantly on 17 October. At this time he was on a constant watch with a dedicated officer at night, and his cell door was left open. On 18 October, prison and healthcare staff met with nurses from the local hospice, to discuss the most suitable location for Mr Grass. Although it was unusual not to move such an ill prisoner out of Garth, the hospice nurses said that

the care Mr Grass was receiving was equivalent to that in the hospice, and given that his wish was to remain at Garth, the decision was made to respect that wish.

21. At around 6.30am on 20 October, the officer dedicated to Mr Grass's night cover, called healthcare staff to attend as Mr Grass had become unresponsive. They assessed that Mr Grass had died, and this was formally confirmed by a doctor at 8.40am.

Cause of death

22. There was no post-mortem examination as the coroner accepted the cause of death provided by a prison doctor, who recorded that Mr Grass had died from metastatic cancer (cancer which has spread from an original site to other parts of the body) of unknown origin.

Non-Clinical Findings

Use of restraints

23. When prisoners leave prison (for example, to go to hospital), staff complete a risk assessment to determine the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public which must be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's health and mobility.

24. 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.

25. A nurse saw Mr Grass with a prison GP on the afternoon of 23 September, when he was brought to the healthcare unit after being found unwell by officers. She filled out the clinical part of the risk assessment form for Mr Grass's transfer to hospital. In response to the questions: "Are there any medical objections to restraints being used?", and "Removal of restraints for treatment/ consultation?" she circled "No" to both. In answer to the question: "Any other medical conditions likely to influence the escort?", she circled "Yes", and in the comments below relating to the removal or otherwise of restraints, she wrote: "Peter has a DNAR (do not attempt resuscitation order) in place".

26. The authorising manager - the Acting Head of Security and Intelligence - wrote, "To be double cuffed with standard "D" cuffs at all times. Mr Grass is a category B prisoner and handcuffing is in line with the minimum NSF [National Security Framework] requirements". He indicated that he had taken account of the healthcare input, and wrote, "Mr Grass has a Do Not Resuscitate in place. Should his condition deteriorate and handcuffing needs to deviate from this then the Duty Governor must be contacted to assess the risk..." He also indicated that if the visit to the hospital turned into an admission, the restraint should be changed to an escort chain (a length of chain linking a prisoner to a prison officer).

27. At interview, the authorising manager said that Mr Grass was changed from double handcuffs to an escort chain when he was admitted to hospital on 23 September. He said that he visited the hospital while Mr Grass was there, and he was able to make his own way to the toilet and so did not see any problem with the level of restraints used. However, he did say that he was unaware that Mr Grass was a wheelchair user.

28. The healthcare section of the risk assessment for 23 September was not completed properly. There was no mention of Mr Grass's mobility issues, and beyond saying that there was a DNAR in place, there was no mention of Mr Grass's health conditions. It is important that the level of restraint is not automatically determined by a prisoner's security category and should be in line with the actual level of risk. Mr Grass was 67 years old with very limited mobility and in the end stages of

cancer, accompanied by two prison officers. We consider that the level of restraints used on Mr Grass was not proportionate to the risk he posed. We recommend:

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 in all cases:

- **healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and**

- **authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.**

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