Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jonathan Groman, a prisoner at HMP Wormwood Scrubs, on 11 November 2021

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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 Jonathon Groman died of pneumonia on 11 November 2021 while a prisoner at HMP Wormwood Scrubs. He was 45 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the healthcare that Mr Groman received at Wormwood Scrubs was equivalent to that which he could have expected to receive in the community.

However, the clinical reviewer was concerned that healthcare staff failed to document fully Mr Groman's clinical observations or include his National Early Warning Score (a tool to detect clinical deterioration) in his medical record.

Mr Groman's family complained that following Mr Groman's death, they had difficulty obtaining information and answers to their questions from the prison in a timely manner. The Governor should satisfy himself that family liaison officers have the time and resources needed to support bereaved families promptly and effectively.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **May 2023**

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Summary

Events

1. On 2 July 2021, Mr Jonathan Groman was charged with stalking and sentenced to two years imprisonment. He was sent to HMP Wormwood Scrubs.

2. Mr Groman had several pre-existing medical conditions, including asthma and high blood pressure. On his arrival at Wormwood Scrubs, healthcare staff completed his initial health screens. They noted his medical conditions and created care plans to manage his care. Mr Groman received appropriate medication for his conditions.

3. On 4 November, a healthcare nurse saw Mr Groman because he had swelling to both of his feet. The nurse advised him to rest in bed and to keep his feet elevated. A couple of days later, another nurse saw him and noted that there was no reduction in the swelling. The nurse referred him to a GP for review.

4. A prison GP saw Mr Groman later that day. He noted that both of Mr Groman's feet were oozing watery fluid and that the swelling in his legs had spread up to his mid-thigh area. He considered that Mr Groman could be at risk of a heart attack or stroke. Mr Groman was taken to hospital by emergency ambulance.

5. Hospital staff carried out some tests and the results showed that Mr Groman had a blood clot in the artery of his thigh. He was admitted to hospital as an inpatient, and hospital staff referred him to the hospital's vascular clinic. He was discharged from hospital and went back to the prison the following day.

6. On 9 November, a prison GP saw Mr Groman after he complained of shortness of breath and excessive sweating. He took a note of Mr Groman's observations which were outside the normal range. He also noted that Mr Groman had an increased erratic heart rate. He considered that Mr Groman could be at risk of heart failure. Mr Groman was again taken to hospital by emergency ambulance. He was admitted to hospital as an inpatient and placed on oxygen therapy to help him breathe.

7. Mr Groman's condition continued to deteriorate in hospital, and he died at 8.05pm on 11 November. A hospital doctor immediately confirmed his death.

8. The post-mortem report gave Mr Groman's cause of death as pneumonia. He also had heart failure, raised blood pressure, methicillin-resistant staphylococcus aureus (MRSA, an infection) and obesity which did not cause but contributed to his death.

Findings

9. The clinical reviewer concluded that the healthcare that Mr Groman received at Wormwood Scrubs was equivalent to that which he could have expected to receive in the community.

10. She was, however, concerned that although healthcare staff took Mr Groman's observations and National Early Warning Score (NEWS2, a tool used to identify clinical deterioration), they did not always fully document Mr Groman's clinical

observations and NEWS2 results in Mr Groman's medical record as they should have done.

11. There was a delay of two days in notifying Mr Groman's family that he had been taken to hospital and was seriously unwell.

12. Mr Groman's family expressed concern that following Mr Groman's death, they had difficulty in obtaining information from the prison or answers to their questions.

Recommendations

- The Head of Healthcare should ensure that clinical observations are fully documented, and where appropriate, include a NEWS2 score.

- The Governor should ensure that:

  - staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

  - the nominated family liaison officer is available to take calls from family members, and if they are unavailable, alternative arrangements are put in place to maintain effective support for the families.

  - all contact with a next of kin is recorded in the family liaison contact log to provide continuity of support.

The Investigation Process

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

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

15. NHS England commissioned a clinical reviewer to review Mr Groman's clinical care at the prison.

16. We informed the Coroner for London West of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.

17. 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.

18. Mr Groman's family received a copy of the initial report. They pointed out a factual inaccuracy and this report has been amended accordingly.

19. Mr Groman's family also raised a number of issues that are not within the remit of this report but have been addressed through separate correspondence.

Background Information

HMP Wormwood Scrubs

20. HMP Wormwood Scrubs is a local prison in West London, which can hold up to 1,300 men. The prison holds men on remand from West London courts and London prisoners serving short sentences or coming to the end of long sentences. Practice Plus Health Group Health and Rehabilitation Services Limited is contracted to provide primary care and several other health services at Wormwood Scrubs.

HM Inspectorate of Prisons (HMIP)

21. The most recent inspection of HMP Wormwood Scrubs was in June 2021. Inspectors considered that healthcare services were led by a strong management team. The management of long-term health conditions had improved, but support for some patient groups was not sufficient and care plans were not sufficiently personalised.

22. The healthcare inpatient unit was noted to provide a good standard of care and prisoners with social care needs were found to be well supported. However, inspectors were concerned that the local authority were slow in responding to requests for social care support.

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 report for the year to May 2021, the IMB noted that there had been changes to the management structure in the healthcare department, including a new Head of Healthcare and Matron.

24. The IMB was pleased to note that the lead GP in the healthcare department had organised weekly complex care meetings with other members of the healthcare team to discuss inpatients, with a view to ensuring that their care needs were met.

Previous deaths at HMP Wormwood Scrubs

25. Mr Groman was the seventh prisoner to die at Wormwood Scrubs since November 2019. Of the previous deaths, two were from natural causes and four were self-inflicted. There are no similarities between our findings in the investigation into Mr Groman's death and our investigation findings for the previous deaths.

Key Events

26. On 2 July 2021, Mr Jonathan Groman was charged with stalking and was sentenced to two years imprisonment. He was sent to HMP Wormwood Scrubs.

27. Mr Groman had several pre-existing medical conditions, including asthma and high blood pressure. He had previously undergone a hernia mesh repair (a surgical procedure to strengthen the weakened area of the abdomen wall). Mr Groman also had a long history of alcohol and substance misuse.

28. On his arrival at Wormwood Scrubs, a prison GP completed Mr Groman's initial health screens and noted his medical conditions. He created care plans to manage Mr Groman's care and prescribed appropriate medications. He also referred him to the prison's substance misuse team.

29. On 18 July, a prison GP saw Mr Groman after he complained of a high temperature, severe abdominal pain and blood in his urine. The prison GP sent him to hospital by emergency ambulance. In hospital, Mr Groman was diagnosed inflammation of the intestines and sepsis. He was admitted to hospital as an inpatient and was discharged to the prison on 22 July. Prison healthcare staff updated his care plans and reviewed him regularly over the following months.

30. On 11 October, a nurse saw Mr Groman after he complained that he had had swelling and pain in his legs and feet since the previous day. She noted his observations which were all within a normal range. She advised him to rest and to keep his legs elevated to try and reduce the swelling. She referred him to a prison GP for a further review. A couple of days later, a prison GP reviewed the nurse's notes from 11 October, and asked for blood tests be carried out. He reviewed the test results on 18 October and noted that they were within a normal range.

31. On 19 October, Mr had a chest exam which revealed some crackles (usually fluid or mucous) on the right lung. He was treated with antibiotics.

32. On 25 October, a nurse saw Mr Groman after he complained that he had had stomach pain for the previous two days. The nurse noted that his stomach was swollen and painful. He prescribed him pain relief medication and referred him to a prison GP.

33. The following day, a prison GP saw Mr Groman who told him that while he had been mopping his cell floor, he had felt tearing in the area of his previous hernia repair. The prison GP sent him to hospital by emergency ambulance. Mr Groman had a computerised tomography (CT) scan which showed that he had bleeding in the tendon around the abdominal muscles. He was admitted to hospital as an inpatient and on 27 October, he was discharged to Wormwood Scrubs and advised to rest in bed.

    On 4 November, a nurse saw Mr Groman after he again reported swelling to both of his feet. He told her that he did not have any chest pain or shortness of breath (often an early indicator of heart disease if coupled with swelling of the feet). She advised him to continue to rest in bed and to keep his feet elevated. Two days later, a nurse reviewed Mr Groman. She noted that there was no reduction in the

swelling. He told her he had also had difficulty urinating. She referred him for a GP review.

34. Later that day, a prison GP saw Mr Groman. He noted that both of his feet were oozing serous fluid (a clear or pale watery fluid found in the spaces between organs and membranes in the body) and that the swelling in his legs had spread up to his mid-thigh area. The prison GP noted his observations and recorded that his blood pressure was within a normal range but that his oxygen saturation was low. He also noted that Mr Groman had gained seven kilograms in weight in twelve days. He considered that Mr Groman could be at risk of a heart attack or stroke and sent him to hospital by emergency ambulance.

35. Hospital staff carried out a CT scan which showed that Mr Groman had a blood clot in an artery in his thigh. He was admitted to hospital as an inpatient, and hospital staff referred him to the hospital's vascular clinic. He was discharged to the prison the following day. A prison GP saw Mr Groman when he arrived at the prison. He noted the adjustments to Mr Groman's prescribed medications and the vascular referral that hospital staff had made.

36. On 6 November, Healthcare staff noted in Mr Groman's medical record that there was crackles on the right lung.

37. On 9 November, a prison GP saw Mr Groman again after he complained of shortness of breath and excessive sweating. He noted Mr Groman's observations, including that his oxygen saturation level was low. He also noted that Mr Groman had an increased erratic heart rate and that he could be at risk of heart failure. He sent Mr Groman to hospital by emergency ambulance. He was admitted to hospital as an inpatient and placed on oxygen therapy to help him breathe.

38. Mr Groman's condition continued to deteriorate in hospital.

39. At 7:30pm on 11 November, Mr Groman told the staff accompanying him that he was unable to breathe. Shortly afterwards, he had a heart attack. Hospital staff tried to resuscitate him but were unsuccessful. At 8.05pm, a hospital doctor confirmed that Mr Groman had died.

Contact with Mr Groman's family

41. At 7.42pm on 11 November, the Deputy Governor telephoned Mr Groman's next of kin, his father and his ex-partner to inform them that Mr Groman was seriously ill in hospital. He encouraged Mr Groman's family to attend the hospital as soon as possible. However, Mr Groman died before they arrived.

42. The Deputy Governor met Mr Groman's family at the hospital to offer support and to answer any questions about Mr Groman's death. The following day, the prison appointed a Senior Officer (SO) as the prison's family liaison officer (FLO). She telephoned Mr Groman's father and offered her support. He asked if a Rabbi who had offered Mr Groman religious support in prison, could contact him. She gave him Mr Groman's father's contact details.

43. Mr Groman's funeral was paid for by members of his community.

44. As it was not necessary for the prison to contribute to the funeral, the Deputy Governor inquired if the prison could instead contribute towards Mr Groman's headstone.

45. The business hub manager at the prison, advised him that would not be possible, and would in fact be a breach of Prison Service Instruction 64/2011, (Managing prisoner safety in custody) which states contributions to the costs of a funeral do not include headstones.

Support for prisoners and staff

46. After Mr Groman's death, a prison manager debriefed the staff who were involved in his care to give them the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.

47. The prison posted notices informing other prisoners of Mr Groman'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 his death.

Post-mortem report

48. The post-mortem report gave Mr Groman's cause of death as pneumonia. Congestive cardiac failure (heart failure), hypertension (raised blood pressure), methicillin-resistant staphylococcus aureus (MRSA, an infection) and obesity were also listed as contributory factors.

Findings

Clinical care

49. The clinical reviewer concluded that the care that Mr Groman received at HMP Wormwood Scrubs was of an acceptable standard and equivalent to that which he could have expected to receive in the community. She considered that Mr Groman had received prompt reviews and that he was appropriately transferred to hospital as his condition deteriorated. She also considered that appropriate blood tests were carried out and the results reviewed in a timely manner.

50. However, the clinical reviewer identified some shortcomings in Mr Groman's care. She was concerned that a healthcare nurse did not see Mr Groman in person on 11 October after he complained of swelling to his lower legs and feet. However, the clinical reviewer was satisfied that he was appropriately reviewed and subsequently transferred to hospital on other occasions.

51. The clinical reviewer found that although healthcare staff recorded his observations and NEWS2 score on the clinical assessments, there were occasions when they failed to note these observations in Mr Groman's medical record. We recommend:

    The Head of Healthcare should ensure that clinical observations are fully documented and, where appropriate, include a NEWS2 score.

Liaison with Mr Groman's family

52. Prison Rule 22 says that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. PSI 64/2011 on safer custody says that if a prisoner's physical health deteriorates unexpectedly or rapidly, a member of prison staff should contact their next of kin to provide information and support. If a prisoner's health deteriorates, a family liaison officer should be appointed immediately and the prisoner's next of kin should be contacted.

53. Mr Groman's next of kin's details were recorded in his prison records. Mr Groman's family were not told that he was seriously ill in hospital until 7.42pm on 11 November, two days after he arrived in hospital. It was clear that Mr Groman was seriously ill when he was taken to hospital because prison healthcare staff were concerned that he was at risk of heart failure. We therefore consider that there was too long a delay in contacting his family.

54. Following his death, Mr Groman's father and ex-partner said that they had difficulty getting responses to their requests for information from the prison.

55. The family liaison officer told us that that the main reason why the family might have had difficulty in getting prompt responses was that her mobile phone had to be replaced so the family would not have been able to contact her outside of working hours. She told us that she gave the family her email address and told them when she would be able to respond. The family liaison officer told us that she had since responded to all the family's enquiries. However, the prison was unable to provide us with an up-to-date copy of the prison's family liaison log. As a result, we were

unable to establish how long Mr Groman's family waited for a response to their enquiries.

56. Bereaved families go through a very difficult process emotionally and may understandably rely on family liaison officers for support and information. It is therefore essential that they maintain effective contact with the bereaved family. We are not satisfied that effective contact was maintained with Mr Groman's family, and make the following recommendation:

The Governor should ensure that:

- **staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.**
- **the family liaison officer is available to take calls from family members and if the nominated family liaison officer is unavailable, alternative arrangements are put in place to maintain effective support for the families.**
- **all contact with a next of kin is recorded in the family liaison contact log to provide continuity of support**

Kimberley Bingham
Acting Prisons and Probation Ombudsman **May 2023**

Inquest

The inquest, held on 9 January 2024, concluded that Mr Groman died from natural causes.

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