Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Grimes, a prisoner at HMP Isle of Wight, on 26 February 2022

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

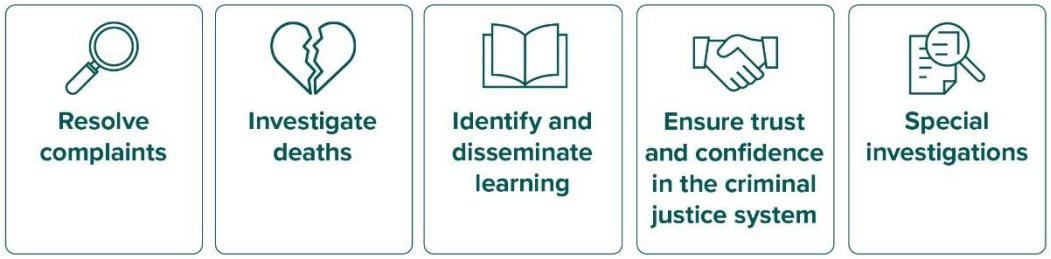
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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 Michael Grimes died of congestive cardiac failure (where the heart is unable to pump blood around the body properly) caused by an enlarged heart, ischaemic heart disease and high blood pressure, on 26 February 2022, at HMP Isle of Wight. He was 74 years old. I offer my condolences to his family and friends.

Mr Grimes had a number of significant long-term health conditions, and I am satisfied that these were managed appropriately by prison healthcare staff. However, I am concerned that the officers who found Mr Grimes unresponsive on 26 February did not commence cardiopulmonary resuscitation in the minutes before healthcare staff arrived at his cell.

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 **March 2023**

Contents

Summary 1

The Investigation Process.....3

Background Information.....4

Key Events.....5

Findings 8

Summary

Events

1. On 27 September 2017, Mr Michael Grimes was sentenced to 28 years in prison for sex offences. On 20 February 2019, he was transferred to HMP Isle of Wight.

2. Mr Grimes had many long-term health conditions including Type 2 diabetes, high blood pressure, atrial fibrillation (an irregular and often fast heartbeat) and heart failure. On arrival at Isle of Wight, healthcare staff recorded that his blood sugar levels were too high and that he was obese. Mr Grimes declined to participate in the prison's healthy lifestyle programme.

3. On 28 August, a vascular nurse specialist reviewed Mr Grimes because he had a long history of pain in his calves and his mobility had deteriorated. The nurse found that Mr Grimes was likely to have superficial femoral artery disease caused by atherosclerosis (a condition where arteries become clogged with fatty substances).

4. On 17 January 2020, a consultant vascular surgeon reviewed Mr Grimes. He noted that further tests confirmed that Mr Grimes had atherosclerosis. The consultant suggested that the best options for treatment were weight loss with a gradual increase in exercise.

5. On 2 February 2022, a pharmacist, noted that she had a higher than expected stock of insulin pens which suggested that Mr Grimes was not taking his insulin as prescribed or at the dose recommended. The pharmacist asked for details of Mr Grimes' glucose levels and the administering of his insulin doses to enable a review and dose optimisation of his insulin.

6. On 22 February, a nurse saw Mr Grimes who arrived in healthcare in a wheelchair. The nurse noted that Mr Grimes had unstable diabetes, increased anxiety and digestion and abdominal issues possibly related to poor and reduced mobility. The nurse asked for a GP to review him in a week's time.

Events of 26 February 2022

7. At 10.18am on 26 February, an officer found Mr Grimes lying on the floor of his cell with his head and torso partially under the bed. He went into the cell and found that Mr Grimes was not breathing. The officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or having difficulty breathing).

8. A custodial manager and another officer went to Mr Grimes' cell. The officers moved Mr Grimes out from under the bed and turned him onto his back. They attached a defibrillator but did not begin cardiopulmonary resuscitation.

9. A healthcare assistant and a nurse arrived at Mr Grimes' cell three minutes later. The healthcare assistant began chest compressions, and the nurse gave Mr Grimes oxygen.

10. Paramedics arrived and chose to transfer Mr Grimes to hospital. They moved Mr Grimes to the ambulance but at 11.36am, before they had left the prison, they confirmed that Mr Grimes had died.

Findings

Clinical care

11. The clinical reviewer found that the clinical care that Mr Grimes received at Isle of Wight was of a good standard and was equivalent to that which he could have expected to receive in the community.

Emergency response

12. The officer who found Mr Grimes unresponsive promptly radioed a medical emergency code blue. Officers applied a defibrillator but did not commence cardiopulmonary resuscitation (CPR) including chest compressions in the three minutes before healthcare staff arrived at the cell.

Recommendations

- The Governor should ensure that all staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity and that staff first on the scene of an emergency provide basic life support until qualified health professionals arrive.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Isle of Wight 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 Grimes' prison and medical records.

15. The investigator interviewed seven members of staff at HMP Isle of Wight on 18 and 19 May 2022, and a member of staff by video on 27 June.

16. NHS England commissioned a clinical reviewer to review Mr Grimes' clinical care at the prison.

17. We informed HM Coroner for the Isle of Wight of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's family liaison officer wrote to Mr Grimes' stepdaughter to explain our investigation. Mr Grimes' stepdaughter asked what time he should have been released from his cell on the day that he died and asked if prison staff had completed a personal emergency evacuation plan (PEEP).

19. We shared the initial report with the Prison Service. There were no factual inaccuracies.

20. We shared the initial report with Mr Grimes' stepdaughter. She did not respond.

Background information

HMP Isle of Wight

21. HMP Isle of Wight is an amalgamation of two former prisons, Parkhurst and Albany, and holds approximately 1,100 men, mainly convicted of sex offences. Practice Plus Group provides healthcare services at the prison. There is an inpatient healthcare unit (IHU) at the former Albany site, providing 24-hour care for prisoners. There are two palliative care suites on the IHU to accommodate end of life prisoners. The prison is opposite the island's hospital.

HM Inspectorate of Prisons

22. The most recent full inspection of HMP Isle of Wight was in May 2019. Inspectors reported that healthcare was very good at the prison, and that health services were delivered by a conscientious team who knew their patients well. They said there was good oversight of the implementation of healthcare recommendations from deaths in custody reports and evidence of learning from serious incidents. The inspectors reported that in-possession medication risk assessments were completed and reviewed, and spot checks of in-possession medication took place according to the policy. They also said that relationships between prison staff and prisoners were good. The report noted that 40 per cent of the prison population were over 50 years old and that a significant proportion were elderly.

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 latest annual report for the year to 31 December 2020, the IMB found that the health provision had been excellent. They noted that prisoner representatives spoke positively about the role of healthcare.

Previous deaths at HMP Isle of Wight

24. There have been thirteen deaths from natural causes at HMP Isle of Wight in the two years before Mr Grimes' death, four of which were related to COVID-19. There have also been three self-inflicted deaths and a drug related death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

25. On 27 September 2017, Mr Michael Grimes was sentenced to 28 years in prison for sex offences. On 20 February 2019, he was transferred to HMP Isle of Wight.

26. Mr Grimes had Type 2 diabetes, which caused diabetic neuropathy (nerve damage caused by high levels of sugar in the blood). He was also diagnosed with high blood pressure, atrial fibrillation, heart failure, high cholesterol, peripheral vascular disease (a blood circulation disorder), cellulitis (a skin infection), chronic obstructive pulmonary disease (COPD - a lung disease), obesity, obstructive sleep apnoea and depression. In 2016, Mr Grimes experienced a 'mini stroke'.

27. On 21 February 2019, a prison nurse recorded that Mr Grimes' blood sugar levels were too high and that he was obese. Healthcare staff created care plans for high blood pressure and heart concerns, diabetes, asthma/COPD, anxiety and depression. Mr Grimes declined to participate in the healthy lifestyle programme and refused an abdominal aortic aneurysm screening (to check if there is a bulge or swelling in the aorta blood vessel).

28. On 28 August, a vascular nurse specialist reviewed Mr Grimes because he had a long history of pain in his calves and his mobility had deteriorated. She found that Mr Grimes was likely to have superficial femoral artery disease caused by atherosclerosis (the thickening or hardening of the arteries). She said that further tests should be carried out.

29. On 17 January 2020, a consultant vascular surgeon reviewed Mr Grimes. He noted that further tests showed that Mr Grimes had atherosclerosis. He suggested that the best options for treatment were weight loss with a gradual increase in exercise.

30. On 23 November, prison staff completed a Personal Emergency Evacuation Plan (PEEP) for Mr Grimes.

31. Over the following months, healthcare staff frequently saw and reviewed Mr Grimes.

32. On 24 April 2021, a consultant cardiologist reviewed Mr Grimes and suggested a change in his medication to treat heart disease, high blood pressure and heart failure.

33. On 18 October, a nurse saw Mr Grimes in his cell because he said that he had shortness of breath and a chesty cough with sputum. A prison GP noted that Mr Grimes looked a little grey and sweaty but that he had no chest pain and was maintaining his blood oxygen saturation. The GP and a nurse decided that he should be sent to the healthcare inpatient unit for observation and treatment for an acute exacerbation of COPD.

34. On 26 October, a prison GP noted that Mr Grimes had recovered well and was able to return to a normal prison wing.

35. On 22 November, a nurse saw Mr Grimes, who said that he felt horrible, was breathless on the slightest exertion, pale, had difficulty in breathing and intermittent chest pains. She noted that Mr Grimes had some oedema (fluid in the limbs) and that she was unable to perform an ECG. She sent him to hospital as a non-urgent

admission. Later that day, Mr Grimes returned to the prison having been prescribed antibiotics.

36. On 2 February 2022, a pharmacist noted that she had a greater stock of insulin pens than expected, which suggested that Mr Grimes was not taking his insulin as prescribed or at the dose recommended. She asked for Mr Grimes to provide regular glucose levels to enable a review and dose optimisation of his insulin.

37. On 22 February, a nurse saw Mr Grimes, who arrived in healthcare in a wheelchair. He noted that most of Mr Grimes' symptoms were likely to be linked to unstable diabetes, increased anxiety, and digestion and abdominal issues possibly related to poor and reduced mobility. He asked for a GP review in a week's time.

Events of 26 February 2022

38. At about 9.10am on 26 February, Officer A spoke to Mr Grimes in his cell. He saw Mr Grimes wrapped up with blankets. Mr Grimes told him that he was "all right".

39. At 10.18am, Officer A went back to Mr Grimes cell to unlock his cell door for his domestic period. He found Mr Grimes lying on the floor with his head and torso partially under the bed. He tried to gain a response from Mr Grimes, who did not respond. He went into the cell and checked for signs of life. Mr Grimes was not breathing. He radioed a medical emergency code blue and called for assistance.

40. A Custodial Manager (CM) and Officer B went to Mr Grimes' cell. Officer A and Officer B moved Mr Grimes out from under the bed and turned him onto his back. Officer A saw that his face was purple, that his blood had pooled and that his face and body were cold. The CM passed a defibrillator to Officer B, who attached it to Mr Grimes. No one began cardiopulmonary resuscitation.

41. Around three minutes after the code blue message, a Healthcare Assistant (HCA) and a nurse arrived at Mr Grimes' cell. The HCA inserted an airway and commenced chest compressions. The nurse gave Mr Grimes oxygen. The nurses changed positions and continued life support. The defibrillator advised not to shock.

42. At around 10.28am, ambulance paramedics arrived at the cell and asked the prison staff to move Mr Grimes onto the landing. Ambulance paramedics gave Mr Grimes adrenalin and amiodarone (given as an attempt to reverse a cardiac arrest). The paramedics also delivered shocks from their defibrillator. The paramedics recognised some cardiac output so decided to transfer Mr Grimes to hospital.

43. The paramedics lifted Mr Grimes onto a stretcher and carried him to the ambulance which was outside the wing. At 11.36am, in the ambulance before leaving the prison, they confirmed that Mr Grimes had died.

Contact with Mr Grimes' family

44. A family liaison officer (FLO) was appointed. After Mr Grimes died, the FLO telephoned his stepdaughter and left a message. Later that day, Mr Grimes' stepdaughter telephoned the FLO, who told her that he had died. Mr Grimes' funeral took place on 28 April. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

45. After Mr Grimes' death, the Head of Security and Intelligence 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.

46. Prison staff posted notices informing other prisoners of Mr Grimes' 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 Grimes' death.

Post-mortem report

47. A post-mortem examination established that Mr Grimes died from congestive cardiac failure (heart failure) as a result of cardiomegaly (an enlarged heart), ischaemic heart disease and hypertension (high blood pressure).

Inquest

48. The inquest into Mr Grimes' death concluded on 25 July 2025, and returned a verdict of natural causes.

Findings

Clinical care

49. The clinical reviewer found that the clinical care that Mr Grimes received at HMP Isle of Wight was of a good standard and was equivalent to that which he could have expected to receive in the community.

50. The clinical reviewer found that Mr Grimes was well supported by healthcare staff for his long-term conditions and underlying co-morbidities. She found that Mr Grimes made choices about engagement with healthy lifestyle options which were not always conducive to good diabetes control and his other health needs.

51. The clinical reviewer has made two recommendations which are not directly related to Mr Grimes' death which the Head of Healthcare will need to address.

Emergency response

52. When Officer A found Mr Grimes unresponsive, he promptly radioed a medical emergency code blue. Officer B applied a defibrillator, but the officers did not commence cardiopulmonary resuscitation (CPR) or chest compressions. When the HCA and nurse arrived at Mr Grimes cell, around three minutes later, they commenced chest compressions and inserted an airway. The HCA said that she would have expected the officers to have commenced CPR and did not know why they hadn't.

53. Officer B told us that after they had applied the defibrillator "it started to count down or it was telling [us] to wait". He said that Officer A told him that he thought that they should carry out chest compressions and as he was "sinking into the situation" the healthcare staff arrived. He agreed that chest compressions should have been carried but that healthcare staff then arrived at the cell.

54. Officer A said that he did not know why they did not start chest compressions but said that "healthcare staff were there pretty quickly".

55. There was a delay of around three minutes from when the officers went into Mr Grimes' cell until healthcare staff began CPR. We recognise that it can be difficult for staff in such situations to make instant decisions but when there is a potentially life-threatening situation, it is essential to act quickly. We cannot say that earlier intervention would have made a difference to the outcome for Mr Grimes, but there is a chance that it might. We make the following recommendation:

    The Governor should ensure that all staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity and that staff first on the scene of an emergency provide basic life support until qualified health professionals arrive.

Prisons & Probation Ombudsman
Independent Investigations

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