

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Graham Fisher, a prisoner at HMP Stafford, on 4 June 2024

A report by the Prisons and Probation Ombudsman

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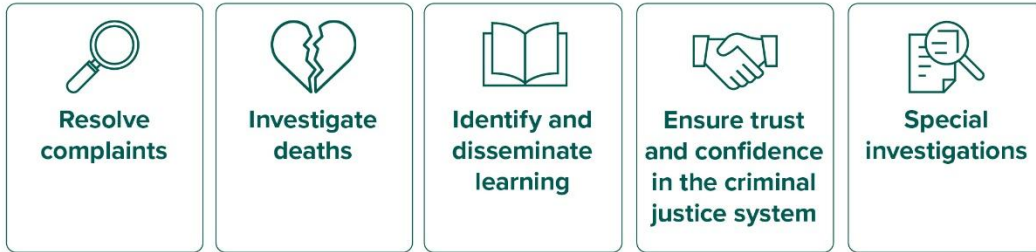
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OUR VISION

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



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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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
1. In July 2018, Mr Graham Fisher was sentenced to 17 years in prison for sexual offences. He died in hospital of acquired pneumonia (a lung infection) on 4 June 2024, while a prisoner at HMP Stafford. Lung cancer, chronic obstructive pulmonary disease (COPD - a lung disease), dementia and heart failure were listed as contributory factors in his death. He was 84 years old. We offer our condolences to those who knew Mr Fisher.
2. The Ombudsman's office wrote to Mr Fisher's next of kin, his wife, to explain the investigation and to ask if they had any matters they wanted us to consider. She asked for a copy of our report and raised questions which has been addressed in separate correspondence.
3. NHS England commissioned an independent clinical reviewer to review Mr Fisher's clinical care at HMP Stafford. The clinical reviewer's report is attached as Annex 1.
4. The clinical reviewer concluded that the clinical care Mr Fisher received at Stafford was of a very good standard and equivalent to that which he could have expected to receive in the community. She found that palliative care was provided in a timely manner. She also noted that Mr Fisher received all possible and recommended care for his health conditions and palliative care needs.
5. The PPO investigator investigated the non-clinical issues relating to Mr Fisher's care. We did not identify any significant non-clinical learning related to Mr Fisher's death and we make no recommendations.
6. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy within the clinical review report which has been amended accordingly.
7. Mr Fisher's family received a copy of the draft report. They did not make any comments.

Adrian Usher
Prisons and Probation Ombudsman

January 2025

Inquest

At the inquest held on 21 May 2025, the Coroner concluded that Mr Fisher died from natural causes.

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