Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dean Graham, a prisoner at HMP Northumberland, on 11 April 2023

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.

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.

Mr Dean Graham died of acute cardiorespiratory failure (sudden failure of the heart and lungs) on 11 April 2023 at HMP Northumberland. He was 42 years old. I offer my condolences to Mr Graham's family and friends.

Mr Graham, who had previously had throat cancer, underwent further surgery on his throat on 30 March. He was discharged back to Northumberland on 7 April.

The clinical reviewer found that the care Mr Graham received in respect of his discharge planning from hospital and subsequent care was not of the required standard. Mr Graham was not appropriately reviewed by healthcare staff when he returned to Northumberland and instructions in the hospital discharge summary were not followed.

The investigation found that there was a delay of over 15 minutes between Mr Graham being found unresponsive and an ambulance being called. The prison carried out an internal investigation and took disciplinary action against the member of staff concerned.

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

Adrian Usher
Prisons and Probation Ombudsman **May 2024**

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Summary

Events

1. On 30 June 2022, Mr Dean Graham was sentenced to six years and ten months imprisonment for sexual offences. On 19 July, he was moved to HMP Northumberland.

2. Mr Graham had previously had cancer of the larynx (part of the throat) and a partial laryngectomy (removal of the larynx). He was obese and in December 2022, was diagnosed with hypertension (high blood pressure).

3. On 30 March 2023, Mr Graham attended hospital for surgery to remove excess tissue in his throat. Due to complications with his breathing, Mr Graham remained in hospital as an inpatient for a week following his surgery. He was discharged back to Northumberland unexpectedly on 7 April, after most prison healthcare staff had left for the day. A nurse stayed late to see Mr Graham on his return and noted there were no issues. There was subsequently no handover to day staff and despite the hospital discharge summary saying that Mr Graham's dressing should be changed daily, this did not happen.

4. At 4.12am on 11 April, Mr Graham rang his cell bell. An operational support officer (OSO) responded one minute later and found Mr Graham unresponsive on the floor of his cell. The OSO called the senior prison custody officer (SPCO) for support, who arrived at the cell between 10 and 15 minutes later with two prison officers. An officer called a medical emergency code at 4.30am.

5. The SPCO and officers entered the cell and found that Mr Graham was cold to the touch and showing clear signs of death. They did not start CPR. At 4.50am, ambulance paramedics pronounced that Mr Graham had died.

6. The post-mortem report found that Mr Graham died from cardiorespiratory failure caused by heart disease. Obesity was listed as a contributory factor.

Findings

7. The clinical reviewer found that while some aspects of Mr Graham's care were of the required standard, including the care he received for his laryngeal cancer and his obesity, his discharge planning from hospital and subsequent care were not of the required standard.

8. The clinical reviewer also found that staff had not put a care plan in place for Mr Graham's hypertension.

9. The OSO who responded to Mr Graham's cell bell and found him unresponsive on the floor, failed to call a medical emergency code as she should have done. This resulted in a delay of over 15 minutes before an ambulance was called, during which time Mr Graham died. The Director commissioned an internal investigation and disciplinary action was taken against the OSO.

Recommendations

- The Head of Healthcare should ensure that there are robust processes in place for communicating with hospitals to ensure that information is appropriately shared and discharge planning is completed.
- The Head of Healthcare should review the process of sharing information between one shift and the next.
- The Head of Healthcare should ensure that care plans are initiated when clinically indicated, including for hypertension.

The Investigation Process

10. HMPPS notified us of Mr Graham's death on 11 April 2023.

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

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

13. NHS England commissioned an independent clinical reviewer to review Mr Graham's clinical care at the prison. The investigator and clinical reviewer jointly interviewed four members of staff.

14. Another investigator subsequently took over the investigation.

15. We informed HM Coroner for Newcastle of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Graham's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She had concerns about whether Mr Graham should have been discharged back to Northumberland following his stay in hospital. This has been addressed in the clinical review.

17. We shared our initial report with HMPPS and with the prison's healthcare provider, Spectrum Community Health CIC. They found no factual inaccuracies. Spectrum Community Health CIC provided an action plan which is annexed to this report.

18. We sent a copy of our initial report to Mr Graham's mother. She did not notify us of any factual inaccuracies.

Background Information

HMP Northumberland

19. HMP Northumberland is a large resettlement prison which holds up to 1,348 male prisoners. The prison is managed privately by Sodexo. Healthcare is provided by Spectrum. Nurses are on duty between 7.30am and 7.30pm from Monday to Thursday; between 7.30am and 5.30pm on Fridays; and between 8.00am and 5.30pm on weekends.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Northumberland was December 2022. Inspectors reported that overall Northumberland was a reasonably decent prison with capable leadership. Positively, they saw that cell bells were answered promptly more often than in other similar prisons.

21. However, they reported that a shortage of healthcare staff impacted on their capacity to meet prisoner needs, and that the lack of 24-hour healthcare further limited access. They noticed poor communication between healthcare workers and prison officers, but overall found that prisoners were receiving acceptable care.

Independent Monitoring Board

22. 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 2022, the IMB reported that the healthcare provision at Northumberland had been uneven due to staffing issues. They noted that there had been some improvement with the recruitment of more healthcare staff.

Previous deaths at HMP Northumberland

23. Mr Graham was the nineteenth prisoner at Northumberland to die since April 2020. Of the previous deaths, 11 were from natural causes, six were self-inflicted, and one was drug related.

24. We have previously made recommendations to Northumberland about care plans and monitoring long-term conditions. We were told that two senior nurses had been employed in January 2023 to manage long-term conditions and a clinical lead now oversaw the process, including auditing referral times and quality of care plans.

Key Events

25. On 5 May 2022, Mr Dean Graham was remanded in prison, charged with sexual offences, and sent to HMP Durham.

26. On 30 June, Mr Graham was sentenced to six years and ten months imprisonment. He was moved to HMP Northumberland on 19 July.

27. When Mr Graham arrived at Northumberland, he told healthcare staff that he had previously had cancer in his larynx (part of the throat), which was diagnosed in the community in 2018, and as a result, had had a partial laryngectomy (removal of the larynx). He also had high blood pressure and obesity. Mr Graham was offered advice on how to manage his obesity but was not agreeable to this.

28. On 4 October, a GP at Northumberland saw Mr Graham after he said he was experiencing 'noisy breathing'. The GP referred Mr Graham for an MRI scan on 11 October to investigate this issue further.

29. On 13 October, Mr Graham attended Freeman Hospital to discuss the MRI results with an ear, nose, and throat (ENT) specialist. The ENT doctor told Mr Graham that his noisy breathing was caused by excess tissue in his throat following his previous surgery in 2018. Mr Graham was placed on a non-urgent waiting list to have a micro-laryngoscopy (surgical removal of the excess tissue).

30. On 18 November, healthcare staff noted that Mr Graham's blood pressure was high. On 23 November, staff checked his blood pressure again and recorded that it was above the normal range. An ECG (test to check the heart's rhythm and electrical activity) was done which returned normal results.

31. On 15 December, a nurse reviewed Mr Graham's blood pressure and diagnosed him with hypertension (high blood pressure). She offered him advice on how to manage his weight and prescribed him medication to treat his hypertension. A follow up appointment was arranged for 28 December however Mr Graham did not attend. The appointment was then rescheduled for 6 January 2023.

32. Mr Graham attended his appointment on 6 January, and his blood pressure was still high. Staff increased his medication dose and scheduled a further review for 27 January. Mr Graham attended appointments to monitor his blood pressure on 27 January, 1 March, and 10 March.

33. On 10 March, a GP reviewed Mr Graham's medication because his blood pressure remained high. The GP prescribed Mr Graham a different medication to try instead. He scheduled a follow up appointment for 27 March.

34. On 27 March, Mr Graham did not attend his appointment for reasons unknown.

35. On 30 March, Mr Graham attended Freeman Hospital for his micro-laryngoscopy. Mr Graham was expected to return to Northumberland after his procedure that day, however following the operation there were complications with his breathing. As a result, Mr Graham was admitted to the Intensive Care Unit (ICU) and given a tracheostomy (a tracheostomy is an opening made in the throat through which a tube is fitted to assist with breathing)

36. On 3 April, Mr Graham was discharged from ICU and placed on an ENT ward to recover from his operation. On 6 April, his tracheostomy tube was removed.

37. While Mr Graham was in hospital, Northumberland healthcare staff held multi-disciplinary team (MDT) meetings to plan for Mr Graham's return to prison. They first met on 5 April but did not yet have an expected discharge date. They met again on 7 April to discuss Mr Graham's discharge, which they expected to take place the next day. They noted that a member of the healthcare team would contact the hospital to discuss the discharge details but there is no evidence that this was done.

38. During the late afternoon of Friday 7 April, which was a bank holiday, Mr Graham was discharged back to Northumberland. Healthcare staff at the prison were not expecting his discharge until the next day, and healthcare services had already closed for the day. A nurse volunteered to stay on past her shift and saw Mr Graham in reception at approximately 5.50pm. She looked over his hospital discharge letter, which stated that Mr Graham needed the dressing on his tracheostomy wound to be changed daily, and that Mr Graham would be reviewed in hospital in two to three months' time. She did not complete any physical observations as Mr Graham appeared medically fit.

39. On 8 April, Mr Graham attended the medication hatch in the morning to request his prescribed pain relief medication. The nurse at the medication hatch told him that his medication was not available, which agitated Mr Graham. The nurse then arranged for his medication to be prescribed and Mr Graham received it at 2.20pm that day.

Events of 10 to 11 April 2023

40. At around 8.30pm on 10 April, an Operational Support Officer (OSO) conducted a roll check (a check that each prisoner was in their cell). The OSO stated in interview that she checked Mr Graham's cell at approximately 9.00pm and had no concerns. No information had been handed over to the OSO about Mr Graham's recent discharge from hospital, so she was not aware of his health issues.

41. At 4.12am on 11 April, Mr Graham pressed his cell bell to alert staff that he needed assistance. Cell bell records indicate that the OSO responded to the bell by attending Mr Graham's cell at 4.13am. The OSO said that on arrival, she looked into Mr Graham's cell through the observation panel and saw him lying on the ground with his upper body under his bed and his legs sticking out. She knocked on the door and called out to him repeatedly, but he did not respond. The OSO said that she saw Mr Graham moving his legs while she was knocking.

42. At approximately 4.14am, the OSO called the Senior Prison Custody Officer (SPCO) who was in charge that night. She told him that Mr Graham was lying on the floor, that his legs were moving, but that he was not responding to her. The SPCO told the OSO that he would attend Mr Graham's cell and asked her to go and wait in the main office. He then called two prison officers and asked them to meet him at Mr Graham's cell, while he made his way there from the reception unit in a prison van.

43. Between 4.25 and 4.30am, the SPCO and the two officers arrived at Mr Graham's cell. They found him lying on the floor, unresponsive. They felt that he was cold to

the touch, and they could not feel a pulse or see any breathing. They also saw post-mortem staining (purple coloration of the skin which becomes visible from approximately 30 minutes following death).

44. At 4.30am, one of the officers called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties).

45. While waiting for the ambulance to arrive, the prison officers did not attempt to resuscitate Mr Graham due to clear signs that he was already dead. The ambulance arrived at Northumberland at 4.38am. The paramedics logged the post-mortem staining visible on Mr Graham's body and pronounced Mr Graham deceased at 4.50am.

Contact with Mr Graham's family

46. On the morning of 11 April, the prison appointed a SPCO as the family liaison officer (FLO) and a PCO as his deputy. They attended the home of Mr Graham's mother to inform her of his death. They offered their condolences and support, and explained what would happen next. Following the visit, the FLO remained in contact with Mr Graham's mother to support with funeral arrangements.

47. Mr Graham's funeral took place on 4 May and the prison contributed to the cost, in line with national policy.

Support for prisoners and staff

48. Despite several requests for Northumberland to share evidence that they debriefed staff who were involved in the emergency response, to ensure that they had the opportunity to discuss any issues arising and to offer support, no evidence was provided.

Post-mortem report

49. The post-mortem report concluded that Mr Graham died of acute cardiorespiratory failure (sudden failure of the heart and lungs) caused by left ventricular hypertrophy (thickening of the wall within the heart). Raised body mass index (obesity) was listed as a contributing factor.

50. The pathologist noted that there was no evidence to suggest that the cancer Mr Graham had received treatment for some years before had reoccurred, nor was there anything to suggest that the recent procedures he had undergone in hospital were connected to his death.

Findings

Clinical care

51. The clinical reviewer found that some of the care Mr Graham received was of the required standard, in particular his ongoing care for laryngeal cancer, multi-agency working and care received for his obesity. However, the care Mr Graham received regarding his discharge planning from hospital and subsequent care was not of the required standard and was only partially equivalent to the care he could have expected to receive in the community.

52. The Head of Healthcare confirmed during interview that healthcare staff were responsible for contacting the hospital and coordinating a discharge plan. This did not happen. Mr Graham arrived back at the prison unexpectedly in the late afternoon of 7 April. He was seen in reception by a nurse who volunteered to stay on past her shift, but the nurse did not draw up a formal plan in relation to Mr Graham's ongoing care or provide any handover to day staff who would arrive the following morning. Mr Graham's discharge letter stated that he would need to have the dressing on his tracheostomy wound changed daily, however no appointments were arranged to do this so his dressing remained unchanged. We recommend:

    The Head of Healthcare should ensure that there are robust processes in place for communicating with hospitals to ensure that information is appropriately shared and discharge planning is completed.

    The Head of Healthcare should review the process of sharing information between one shift and the next.

53. The clinical reviewer found that Mr Graham did not have a care plan for his hypertension and his QRisk2 score (calculation of risk of heart attack/stroke) was not updated after his diagnosis of hypertension. The Head of Healthcare said that this was due to not having a permanent member of the healthcare team to complete long term conditions care. He said that a long-term conditions nurse had recently been employed and they would review implementation of care plans. We recommend:

    The Head of Healthcare should ensure that care plans are initiated when clinically indicated, including for hypertension.

Emergency response

54. The OSO responded quickly to Mr Graham's cell bell but when she got to the cell and saw Mr Graham unresponsive on the floor, she called for assistance from the night SPCO rather than calling a medical emergency code. The code was not called until the SPCO and two officers arrived around 15 minutes later.

55. The OSO said in interview that she did not immediately call a code blue because she saw Mr Graham's legs moving and took this as a sign that he was not unconscious. She also said that she had experienced a similar situation with a different prisoner two weeks earlier, where the prisoner had been faking an emergency as he was under the influence of illicit substances.

56. We acknowledge that the OSO had not been told that Mr Graham had recently been discharged from hospital following an operation and a period of treatment on the ICU. During her interview, the OSO said that had she known about Mr Graham's medical condition, she probably would have called a code blue herself.

57. In response to this incident, the Director promptly launched an internal investigation into staff actions during the emergency response. The investigation found that the OSO's delay in calling an emergency code amounted to misconduct, and she was subject to disciplinary proceedings. In light of Northumberland's swift action on this matter, we make no recommendation.

Good practice

58. Since Mr Graham's death, the Director of Northumberland has reviewed the processes at Northumberland for when a prisoner is discharged from hospital. They have since introduced a requirement for staff to note any recent hospital discharges in the observation book. This allows all staff, including night prison staff, to identify any prisoners who may be vulnerable as a result of recent medical treatment. We consider this to be a positive change in response to learning from this incident.

Inquest

59. At the inquest, held on 14 October 2024, the jury concluded that Mr Graham died from natural causes.

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