Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Emlyn Francis, a prisoner at HMP Dovegate, on 18 July 2022

## A report by the Prisons and Probation Ombudsman

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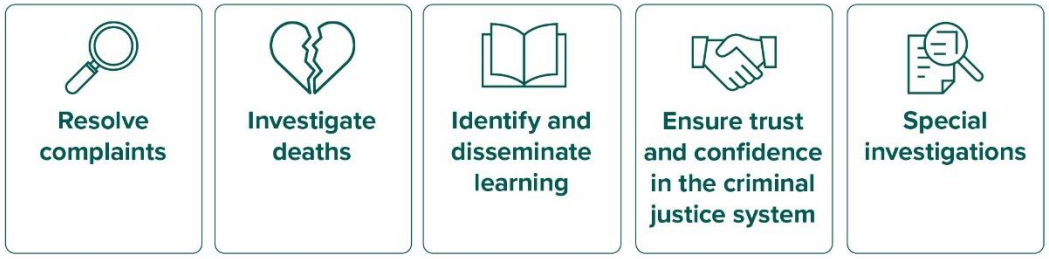
## OUR VISION

**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, detained individuals in immigration centres, and people recently released from prison.

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 Emlyn Francis died in hospital from a heart attack on 18 July 2022, while a prisoner at HMP Dovegate. He was 65 years old. I offer my condolences to Mr Francis's family and friends.

Prison healthcare staff requested an ambulance for Mr Francis on the afternoon of 16 July when he became unwell. However, when the ambulance had not arrived five hours later, Mr Francis said he no longer wanted to go to hospital as he was feeling better. Healthcare staff did not check on him again until the next morning, by which time he was seriously ill. He was taken to hospital but less than 24 hours later, he had a heart attack and died.

The clinical reviewer concluded that the clinical care that Mr Francis received at Dovegate was variable and some aspects were not equivalent to that which he could have expected to receive in the community.

She was concerned that healthcare staff did not check on Mr Francis for over 14 hours after he decided he did not want to go to hospital. She considered that if they had monitored Mr Francis overnight, they might have detected a deterioration in his condition earlier.

The clinical reviewer also found that staff had not put a care plan in place for Mr Francis's risk of cardiovascular disease and there had been a long delay in prescribing one of his medications for kidney disease. The delay in medication did not appear to have a detrimental effect on Mr Francis but it was nevertheless concerning that it had not been prescribed earlier.

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** **February 2023**

# Contents

# Summary

## Events

1. On 20 January 2022, Mr Emlyn Francis was recalled to prison custody and sent to HMP Dovegate.

2. Mr Francis had several health conditions, including Type 2 diabetes, hypertension (high blood pressure), hypercholesteremia (high cholesterol in the blood), Parkinson's disease and chronic kidney disease.

3. In the early hours of 12 July, Mr Francis complained of breathlessness. Healthcare staff checked on him but had no concerns.

4. On the morning of 16 July, Mr Francis again experienced breathing difficulties. Healthcare staff checked on him and found that his blood oxygen levels were low, so they requested an ambulance. After waiting several hours for an ambulance, Mr Francis said he was feeling better and did not want to go to hospital. Healthcare staff suggested that he should move to the healthcare unit overnight so he could be monitored, but he said he wanted to stay in his own cell. He signed a disclaimer to say he was aware this was against medical advice.

5. Mr Francis was not checked again by healthcare staff for over 14 hours. By the time healthcare staff saw him on the morning of 17 July, he was seriously ill. He was taken to hospital. He subsequently had a heart attack in hospital and died in the early hours of 18 July.

## Findings

6. The clinical reviewer found that the care Mr Francis received was variable and some aspects were not equivalent to that which he could have expected to receive in the community.

7. Although healthcare staff put care plans in place for Mr Francis's serious health conditions, they did not put a care plan in place to manage his risk of cardiovascular disease, which was high.

8. Due to an oversight, healthcare staff did not prescribe one of Mr Francis's kidney medications when he arrived at Dovegate. It was not prescribed until July, over six months later. While it appears that this had no adverse effect on Mr Francis, this medication should not have been missed.

9. We are concerned that healthcare staff did not check on Mr Francis during the night of 16/17 July. A nurse tried to contact Mr Francis on his in-cell phone at around 8.45pm and was subsequently told by wing staff that he was sleeping. No further attempts were made to check on him during the night. The clinical reviewer considered that if healthcare staff had monitored Mr Francis overnight, they might have identified a deterioration in his condition earlier.

## Recommendations

- The Head of Healthcare should ensure that staff create care plans for prisoners at risk of cardiovascular disease.
- The Head of Healthcare should investigate why one of Mr Francis's medications was not prescribed when he arrived at Dovegate and introduce any changes necessary to prevent a recurrence of this issue.
- The Head of Healthcare should ensure that prisoners who are unwell and require clinical monitoring are reviewed overnight.

# The Investigation Process

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

11. The investigator obtained copies of the relevant extracts from Mr Francis's medical and prison records.

12. NHS England commissioned an independent clinical reviewer to review Mr Francis's clinical care at Dovegate.

13. We informed HM Coroner for Staffordshire South of the investigation. He provided us with the cause of death. We have sent the Coroner a copy of this report.

14. The Ombudsman's family liaison officer contacted Mr Francis's son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

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

# Background Information

## HMP Dovegate

16. HMP Dovegate is a Category B prison in Staffordshire, managed by Serco. The main prison holds around 930 remanded and sentenced adult prisoners. There is also a therapeutic community, separate to the main prison, which holds up to 220 prisoners. Practice Plus Group provides 24-hour healthcare services. South Staffordshire and Shropshire Foundation Trust provides mental health services.

## HM Inspectorate of Prisons

17. The most recent inspection of HMP Dovegate was in September and October 2019. Inspectors found that healthcare provision was reasonably good overall. They said that since their last inspection in 2017, the management of patients with long-term conditions had improved, and that there were plans for staff to develop care planning. They said that the recruitment and retention of pharmacy staff continued to be a challenge.

## Independent Monitoring Board

18. 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 September 2021, the IMB reported that during that period, measures taken to combat the COVID-19 pandemic had impacted the prison in several ways, including waiting times for all healthcare services.

## Previous deaths at HMP Dovegate

19. Mr Francis was the ninth prisoner to die at Dovegate since July 2020. Of the previous deaths, six were from natural causes, one was self-inflicted, and one was drug related. In a previous investigation, we found that one of the prisoner's medications was missed and there was a long delay before the error was noticed, as was the case for Mr Francis.

# Key Events

20. On 22 July 2013, Mr Emlyn Francis was sentenced to ten years imprisonment for sexual offences. He was released from prison on licence on 1 March 2018.

21. On 20 January 2022, Mr Francis was recalled to prison after committing further offences. He was sent to HMP Dovegate. He was subsequently sentenced to 16 months imprisonment.

22. When Mr Francis arrived at Dovegate, he was taking medications for a range of health conditions, including Type 2 diabetes (the inability of the body to regulate sugar in the blood), hypertension (high blood pressure), hypercholesteremia (high cholesterol in the blood), Parkinson's disease (a disease of the brain which affects body movements) and chronic kidney disease (a long-term condition where the kidneys do not work properly).

23. Healthcare staff prescribed all Mr Francis's medications, apart from sevelamer, a medicine used to treat kidney disease, which was missed. It was not re-prescribed until July when the mistake was noticed.

24. Healthcare staff created care plans for Mr Francis for his diabetes, Parkinson's disease, hypertension and kidney disease. However, they did not create a care plan for his risk of cardiovascular disease which, due to his health conditions, was high.

25. In the early hours of 12 July, wing staff asked healthcare staff to see Mr Francis as he was breathless. His observations were within normal range and a follow-up check from a prison GP later that day gave no cause for concern.

## Events of 16-18 July

26. On the morning of 16 July, officers asked healthcare staff to check Mr Francis as he was having breathing difficulties again. At around 10.30am, a nurse took Mr Francis's clinical observations and found that his blood oxygen level was at the lower end of normal and his blood pressure was slightly high. She said she would check on him again later.

27. Around four hours later, the nurse checked on Mr Francis again and noted that his blood oxygen level had fallen below the normal range. She gave him oxygen. Although his blood oxygen level rose to a normal level, staff decided that given Mr Francis's medical conditions, they would send him to hospital.

28. The prison called for an ambulance shortly after 3.00pm. The ambulance service said that there would be a three to five hour wait as Mr Francis was not acutely unwell. Shortly before 8.00pm, Mr Francis said he was feeling a bit better and did not want to go to hospital. Staff suggested that he should move to the healthcare wing so he could be monitored overnight but he said he wanted to stay in his cell with his cellmate. He signed a disclaimer to say that he understood that he was doing this against medical advice.

29. At around 8.45pm, a nurse tried to call Mr Francis on his in-cell phone but got no reply. Wing staff subsequently told her that Mr Francis was sleeping. Healthcare staff made no further checks overnight.

30. At 10.40am on 17 July, a nurse saw Mr Francis and took his clinical observations. The nurse noted that his blood oxygen levels were low, his breathing rate was high, he was pale and clammy and found it painful to breathe. Healthcare staff requested an ambulance, which arrived at the prison at 11.10am and left with Mr Francis at 12.19pm to take him to hospital.

31. In the early hours of 18 July, Mr Francis said that he did not feel well, and he was having breathing problems again. He was taken to the resuscitation unit, and while investigations were being undertaken by doctors, Mr Francis had a heart attack and died.

## Contact with Mr Francis's family

32. Mr Francis had no personal contacts on his phone list, and he was estranged from his family. He had no named next of kin and therefore, the prison had no opportunity to contact anyone in the short period between him becoming ill and when he died. Staff at Dovegate were able to contact family members following information they received from the police, and at the request of the family, Dovegate made the funeral arrangements.

## Support for prisoners and staff

33. After Mr Francis's death, a prison manager carried out a full debrief for the staff involved once the bedwatch officers had returned to the prison. A member of the Care Team attended and offered support to the staff. The member of the Care Team also later spoke to those who had not been able to attend the debrief.

34. The prison also posted notices informing other prisoners of Mr Francis's death, and offering support.

## Cause of death

35. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Francis's cause of death as myocardial infarction (a heart attack), which was caused by myocardial degeneration (a deterioration in the ability of the heart to function normally). Type 2 diabetes, Stage 4 chronic kidney disease and Parkinson's disease were given as underlying conditions, which contributed to but did not cause Mr Francis's death.

# Findings

36. Although the clinical reviewer highlighted some areas of good clinical practice in her report, she found that the care that Mr Francis received was variable and some aspects were not equivalent to that which he could have expected to receive in the community.

37. Mr Francis's medical conditions, his hypertension, hypercholesteremia, diabetes and kidney disease, put him at risk of cardiovascular disease. However, healthcare staff at Dovegate did not create a cardiovascular care plan for Mr Francis. This meant that an annual review for cardiovascular disease did not take place.

38. When Mr Francis arrived at Dovegate, he was not prescribed one of his kidney medications (sevelamer). Staff noted that he took this medication but due to an oversight, it was not prescribed to him until July, over six months later. The clinical reviewer acknowledged that this did not appear to cause him harm. However, we have commented on a similar oversight in another recent case at Dovegate, and we consider that this is potentially a serious matter which needs to be addressed.

39. The clinical reviewer was concerned that healthcare staff did not check on Mr Francis during the night of 16/17 July. She considered that had they done so, they might have identified a deterioration in his condition earlier.

40. We recommend:

    **The Head of Healthcare should ensure that staff create care plans for prisoners at risk of cardiovascular disease.**

    **The Head of Healthcare should investigate why one of Mr Francis's medications was not prescribed when he arrived at Dovegate and introduce any changes necessary to prevent a recurrence of this issue.**

    **The Head of Healthcare should ensure that prisoners who are unwell and require clinical monitoring are reviewed overnight.**

## Inquest

41. The inquest, held on 11 January 2023, concluded that Mr Francis died from natural causes.

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