



Independent investigation into the death of Mr Francis Graham, a prisoner at HMP Dovegate, on 4 April 2023

A report by the Prisons and Probation Ombudsman

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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Summary

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.
3. Mr Francis Graham died in hospital from lung cancer on 4 April 2023, while a prisoner at HMP Dovegate. He was 43 years old. We offer our condolences to Mr Graham's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Graham received at Dovegate was equivalent to that which he could have expected to receive in the community.
5. We found no issues of concern and make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Graham's death on 4 April 2023.
7. NHS England commissioned an independent clinical reviewer to review Mr Graham's clinical care at HMP Dovegate.
8. The PPO investigator investigated the non-clinical issues relating to Mr Graham's care.
9. The PPO family liaison officer wrote to Mr Graham's next of kin, his brother, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

Previous deaths at HMP Dovegate

11. Mr Graham was the 11th prisoner to die at Dovegate since April 2020. Of the previous deaths, seven were from natural causes, two were self-inflicted and one was drug related.

Key Events

12. On 1 February 2023, Mr Francis Graham was remanded to HMP Dovegate, charged with shoplifting and threats to shop staff. He was subsequently convicted and sentenced for these offences and a previously suspended sentence for assault and theft was activated, giving him a total of 24 weeks imprisonment.
13. Mr Graham had a long history of offending linked to drug addiction and homelessness. When he arrived at Dovegate, he said that he was spending £50 a day on heroin and was drinking alcohol daily. He tested positive for several illicit drugs. Staff put Mr Graham on an alcohol detoxification programme and a methadone programme to treat his opiate addiction.
14. As well as his substance misuse issues, Mr Graham had a number of long-term health conditions, including atrial fibrillation (a condition that causes the heart to beat irregularly), regular issues with deep vein thromboses (DVTs, blood clots in the deep veins of the body, a common condition in intravenous drug users, which can lead to dangerous lung problems) and hepatitis C (a viral infection that can cause serious liver disease). Mr Graham also had burns to his face and body from a house fire in November 2019.
15. On 3 February, Mr Graham told staff he thought he had a chest infection. Healthcare staff took samples for testing and a GP at Dovegate prescribed antibiotics. The tests came back negative for an infection. Blood tests results in mid-February were slightly abnormal and so further blood samples were scheduled. However, Mr Graham refused his blood test on 23 March, and signed a disclaimer, but it is not clear why.
16. On 20 March Mr Graham said he had a sore and swollen throat, and on 24 March, he saw a GP complaining of a cough again. He did not have any breathlessness or problems with walking up the stairs. The GP prescribed antibiotics and steroids and scheduled to review Mr Graham in a month's time.
17. A week later, Mr Graham said that he had been struggling to breathe and was seen by a nurse in the morning and then by a GP later the same day. The GP noted that although there was no immediate cause for concern, healthcare staff should visit Mr Graham daily to check his clinical observations.
18. Following difficulty breathing on 1 April, and a deterioration in his observations, healthcare staff requested an ambulance to take Mr Graham to hospital. He left the prison early in the afternoon.
19. The hospital initially indicated that Mr Graham would return to prison on the same day but delayed sending him back until X-rays had been examined. Following this, the hospital said it was not happy for Mr Graham to return to prison, as it appeared that he had possible lung cancer.
20. The following day, Mr Graham became critically unwell and was transferred to the hospital's intensive care unit. He remained there until his death on 4 April.

Post-mortem report

21. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Graham's cause of death as respiratory failure (the lungs stopped working), caused by metastatic lung cancer (advanced lung cancer which has begun to spread). They gave intravenous drug use (injection of illicit drugs) and atrial fibrillation as factors which contributed to the death but did not cause it.

Findings

22. Mr Graham had poor health as a result of his lifestyle and drug use and from the effects of serious burns sustained in a house fire. He was an ex-smoker. Although he had a cough at Dovegate, there were no signs of significant deterioration in his health prior to his transfer to hospital on 1 April, and the subsequent discovery of lung cancer. The clinical reviewer concluded that Mr Graham's healthcare at Dovegate was equivalent to that which he could have expected to receive in the community.

23. We make no recommendations.

**Adrian Usher
Prisons and Probation Ombudsman**

September 2023

Inquest

The inquest, held on 30 November 2023, concluded that Mr Graham died from natural causes.



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