Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Graham Daggett, a prisoner at HMP Lincoln, on 3 April 2024

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 l 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.

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 Graham Daggett died in hospital of necrotising fasciitis (a bacterial infection of the soft tissues), caused by a perianal abscess and metastatic pancreatic cancer (cancer that has spread from the pancreas) on 3 April 2024, while a prisoner at HMP Lincoln. He was 56 years old. We offer our condolences to Mr Daggett's family and friends.

Mr Daggett had been in severe pain and had abnormal blood tests before he went to prison. Healthcare staff did not consult his community clinical record until his condition drastically deteriorated the day before he died. It is unclear whether Mr Daggett required support in making healthcare appointments since, despite being in considerable pain, he had not applied to see healthcare staff as advised. The clinical reviewer found that Mr Daggett's healthcare was partially equivalent to that he would have received in the community.

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 **January 2025**

Contents

Summary

Events

1. Mr Graham Daggett had complained about severe pain to community GPs in the months before going to prison. On 23 February 2024, Mr Daggett was sentenced to 6 months imprisonment and taken to HMP Lincoln. This was his first time in prison.

2. Mr Daggett had two healthcare screening appointments when he arrived in Lincoln, but he did not report any pain other than knee pain. After that, he reported to feeling in pain to different members of staff.

3. Healthcare staff saw Mr Daggett a few times and noted that his clinical observations were normal.

4. On 3 April, Mr Daggett became unwell, staff called an ambulance and paramedics took him to hospital. He was restrained with an escort cable which was removed early the next morning. Mr Daggett died a few hours later of a bacterial infection and cancer that had spread from his pancreas.

Findings

5. The clinical reviewer concluded that the clinical care Mr Daggett received at Lincoln was partially equivalent to that which he could have expected to receive in the community. The clinical reviewer made recommendations about the process of making appointments with healthcare, checking a prisoner's community clinical record and record keeping.

6. Despite being in considerable pain, Mr Daggett had not tried to schedule an appointment with healthcare staff. It is unclear whether he needed support to do this, but we have concluded that he had opportunity to raise this with staff if he was struggling to do so.

Recommendations

- The Head of Healthcare should carry out an audit to ensure that healthcare staff appropriately consult prisoners' full medical records when they raise concerns about their health.

The Investigation Process

7. HMPPS notified us of Mr Graham Daggett's death on 3 April 2024. The investigator issued notices to staff and prisoners at HMP Lincoln informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

8. The investigator obtained and reviewed copies of relevant extracts from Mr Daggett's prison and medical records.

9. NHS England commissioned an independent clinical reviewer to review Mr Daggett's clinical care at Lincoln. The investigator and clinical reviewer interviewed five members of staff in May and June.

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

11. The Ombudsman's office wrote to Mr Daggett's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She told us that Mr Daggett had filled in a complaint form, which he never submitted, and that he told staff he was in severe pain. She asked why he had not been given pain medication or diagnostic tests, and why information about his symptoms had not been pieced together. These questions have been addressed in this report and the clinical review.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy, and this report has been amended accordingly.

13. Mr Daggett's family received a copy of the draft report. They did not make any comments.

Background Information

HMP Lincoln

14. HMP Lincoln holds remanded and convicted men, in four residential wings. It serves the courts of Lincolnshire, Nottinghamshire, and Humberside. Nottinghamshire Healthcare NHS Trust provides health services, with 24-hour nursing cover.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Lincoln was in December 2019 and January 2020. Inspectors reported that Lincoln was a much safer prison since the previous inspection in 2017.

16. Inspectors noted that there had been an increase in healthcare staff, with regular clinical supervision and training, as well as a systemic approach to learning lessons. New prisoners received a comprehensive health screen and appropriate specialist referrals.

Independent Monitoring Board

17. 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, from February 2023 to January 2024, the IMB reported that reception and induction assessments were in place. They also found that prisoners were treated fairly and humanely. The IMB noted that most of the concerns reported to them were about healthcare management issues. They noted that there was a shortage of healthcare staff and although waiting lists could be long, those with urgent needs were assessed sooner.

Previous deaths at HMP Lincoln

18. Mr Daggett was the fifth prisoner to die at HMP Lincoln since April 2021. Of the previous deaths, two were from natural causes and two were self-inflicted. There were no similarities between the findings in our investigation into these previous deaths and Mr Daggett's death. Since Mr Daggett's death and up to the end of October 2024 there have been two further deaths. One of these was self-inflicted and the cause of the other one is so far unascertained.

Key Events

Background

19. In January 2024, Mr Graham Daggett's medical record notes that he had several appointments with different community GPs (as he was of no fixed abode). He said he had been very unwell for 18 months, was in pain, felt sick and thought something was wrong with his digestive system. Examinations revealed a lump in his abdomen, and blood tests were abnormal and required follow up tests for cancer. Due to staff not being able to contact Mr Daggett or him moving area these tests did not occur. Mr Daggett's pre-sentence report, completed on 20 February 2024, notes that Mr Daggett said he was in constant agony and rated his pain as ten out of ten.

HMP Lincoln

20. On 23 February, Mr Daggett was sentenced to six months imprisonment for assault. He was taken to HMP Lincoln. It was his first time in prison. During his initial healthcare screening, he did not tell staff about any health concerns other than knee pain for which he was given ibuprofen (a painkiller).

21. On 28 February, Mr Daggett attended his second healthcare screening with a nurse. Again, he only spoke about his chronic knee pain. The nurse told Mr Daggett how he could make healthcare appointments. In interview, the nurse said that Mr Daggett did not tell him that he had recently seen his GP or had tests. He said that he would have read his community medical record had he been aware of this.

22. On 4 March, prison staff called healthcare staff to see Mr Daggett as he said he was in pain and short of breath. A nurse assessed Mr Daggett and did not identify any urgent concerns. His physical observations were normal. She noticed that the room was hot and Mr Daggett was wearing a jumper and she advised him to take off the jumper and open the window. She noted that she would put him on the nurses' list to be seen later that day. (After he died, a complaint form was found in Mr Daggett's cell relating to this interaction. He claimed that he had been called 'a lying hypochondriac' and that at the time he was seen, he was feeling cold. Mr Daggett had also written that he had been in excruciating pain for the previous 20 months. He did not submit the complaint.)

23. Later that day, a paramedic who worked in the prison assessed Mr Daggett and noted that he got up without difficulty, was breathing normally and had a good skin colour. His physical observations were normal. Mr Daggett told him that he had had dull aches all over his body for nearly two years and he had seen several community GPs but had not received a diagnosis. The paramedic consulted Mr Daggett's summary care record (SCR – a database containing clinical information about a patient such as medications and allergies) but this did not contain information about his recent GP appointments or blood tests. He told Mr Daggett to request a GP appointment.

24. On 6 March, Mr Daggett told a chaplain from the chaplaincy department that he was in pain in his upper body and needed medication to relieve this. The chaplain sent an email to healthcare staff and to the wing managers. He also spoke to an officer on the wing, who said he would get Mr Daggett to the medication hatch. On 7

March, healthcare staff emailed the chaplain to say that Mr Daggett had been seen by a nurse. There is no note in Mr Daggett's medical record that he attended the hatch, was seen by healthcare staff or received any pain medication.

25. On 17 March Mr Daggett met his keyworker for the first time. He said he had not been feeling well since arriving at Lincoln and was waiting for healthcare to follow up with appointments for his treatment. She told Mr Daggett that it may take a little while, but if healthcare staff did not contact him soon he should submit a healthcare application or use the red phone (a phone which can be used by prisoners to call healthcare).

26. In interview, the Clinical Matron told us that there was no record of Mr Daggett using the red phone to contact healthcare, nor was there any record that he had submitted applications to make healthcare appointments during his time at Lincoln.

27. On 19 March, Mr Daggett did not feel well enough to attend work. An entry on the prison system says that a staff contacted healthcare staff on his behalf, but there is no record of what was discussed.

28. On 21 March, the keyworker had a second key worker session with Mr Daggett. She noted that there was no change in his circumstances and he had no further concerns.

29. On 27 March, healthcare staff gave Mr Daggett two paracetamol. There is no reason recorded as to what this was for. He later told his keyworker that he felt constantly sick and had not been going to education as he could not manage the stairs. He said he had tried to book appointments with healthcare but had not heard back yet. They spoke about his release. He said he needed to speak to his sister but had no money for telephone credit to call her. There is no recorded follow up action from this conversation and Mr Daggett only made one 43 second call in early March. He did not have any telephone credit when he died. Lincoln explained that prisoners are given at least £2.50 every week which they can use towards phone credit. They can also send free letters to their family. This is explained to prisoners during induction.

30. On 2 April at 3.41am, Mr Daggett fell out of his bed. Healthcare staff attended and he reported always feeling dizzy. A nurse noticed that his hand was swollen and had some signs of jaundice. Mr Daggett's pulse and respiratory rates were raised. After seeing Mr Daggett, the nurse reviewed his past medical record and noted that Mr Daggett had some abnormal blood test results when he was in the community. He booked an urgent GP assessment for later that day and requested that Mr Daggett had urgent blood tests. Mr Daggett was seen four times that day by medical staff but not by a GP as there was none available. Mr Daggett had urgent blood tests done.

31. At 8.30pm, prison staff found Mr Daggett on the floor of his cell. He told them he had fallen. Prison staff asked for healthcare support urgently. Two nurses went to see Mr Daggett and struggled to get a definitive reading of his blood pressure and oxygen saturation. During their assessment, prison staff were called to a different location to deal with an emergency. Both nurses had to leave the cell as they could not remain inside without prison staff present. They remained at the cell door and continued to observe Mr Daggett through the observation panel.

32. Prison staff returned ten minutes later. They unlocked the cell and the nurses further assessed Mr Daggett. His blood pressure was normal but his oxygen saturation was low. They administered oxygen and noted that his pulse was also slow. Mr Daggett's National Early Warning Score (NEWS2 – used to determine the urgency of response needed) was eight, which meant that Mr Daggett needed an urgent response. A nurse asked officers to urgently request an ambulance.

33. The ambulance arrived prison at 9.58pm, paramedics assessed and treated Mr Daggett and took him to hospital at around 11.00pm.

34. As part of the process for Mr Daggett to leave prison, a Custodial Manager (CM) completed an emergency escort risk assessment. He had seen Mr Daggett in his cell and then left to complete the risk assessment. He noted that Mr Daggett's health situation did not have an impact on his mobility to escape and that there were no medical objections to the use of restraints. In interview, he explained that Mr Daggett's health situation was unclear. A nurse said in interview that she did not input in the risk assessment (there is no space on the form for her to do so). She said that since she did not know what was wrong with Mr Daggett, she did not know if his condition would improve or deteriorate and would not have objected to the use of restraints in any case. Due to time constraints, the CM did not have any security information, so he assessed that Mr Daggett should be escorted by two officers and restrained by a single cuff (when a standard handcuff has one end attached to the prisoner's wrist and the other is attached to a prison officer).

35. When the CM saw Mr Daggett being taken to the ambulance on a stretcher, he thought that he would need paramedics to treat him in the ambulance, so he decided to authorise the use of an escort cable instead (a long cable with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

36. Once Mr Daggett arrived hospital, staff removed his restraints at 2.15am for ten minutes because Mr Daggett needed a CT scan.

37. At 2.52am on 4 April, Mr Daggett went into cardiac arrest. The officers with him removed the restraints so that medical staff could treat Mr Daggett. At 11.10am, Mr Daggett died.

Contact with Mr Daggett's family

38. The CM contacted Mr Daggett's next of kin once Mr Daggett went to hospital. Hospital staff also contacted the next of kin to discuss Mr Daggett's condition. Mr Daggett's family arrived at the hospital at 5.30am and were with him when he died.

39. The CM appointed a family liaison officer, who went to the hospital before Mr Daggett's death and stayed in contact with the family in the weeks afterwards. In line with national instructions, the prison contributed to the cost of Mr Daggett's funeral.

Support for prisoners and staff

40. After Mr Daggett's death, staff involved in the emergency response were not offered a debrief to ensure they had the opportunity to discuss any issues arising, and to offer support. The prison posted notices informing staff and other prisoners of Mr Daggett's death and offering support.

Post-mortem report

41. The post-mortem report concluded that Mr Daggett died of necrotising fasciitis caused by perianal abscess and metastatic pancreatic cancer.

Findings

Clinical Care

42. The clinical reviewer concluded that Mr Daggett's care was partially equivalent to that he which he would have received in the community. She concluded that healthcare screenings occurred according to guidelines. She also found that when nurses became aware that Mr Daggett was acutely unwell on 2 April, they read his previous medical records, ordered urgent blood tests and ultimately requested his transfer to hospital.

43. However, healthcare staff were unaware of Mr Daggett's abnormal blood tests and interactions with community GPs before coming into prison until they read his records when he became acutely unwell on 2 April. The Head of Healthcare said that this was appropriate unless there was a reason to review these records. The clinical reviewer concluded that the prison paramedic should have reviewed Mr Daggett's record on 4 March when he said he had been suffering pain for a long time. However, she recognised that Mr Daggett did not appear to be acutely unwell during this assessment and he was advised to see a GP. We endorse and recast the clinical reviewer's recommendation that:

    The Head of Healthcare should carry out an audit to ensure that healthcare staff appropriately consult prisoners' full medical records when they raise concerns about their health.

44. The clinical reviewer also raised concerns in relation to communication between healthcare and prison staff which we discuss further below. She made further recommendations about record keeping which the Head of Healthcare will wish to address.

Making healthcare appointments

45. Before receiving his prison sentence, Mr Daggett had, over a period of months, reported considerable pain to community healthcare staff and required urgent further tests. He also told the probation practitioner who completed his pre-sentence report. However, he did not report this pain to nurses who completed both his health screenings when he arrived at Lincoln. We do not know why Mr Daggett did not tell the nurses about his history of pain but as a result, and in line with local practice, the nurses did not check his community GP records - where they would have been able to see recent abnormal blood tests and follow ups that were outstanding.

46. During his time in prison, Mr Daggett said he was in pain to several staff. He was told to schedule healthcare appointments. His keyworker also explained he could use the red phone to call the healthcare department, if he did not hear from them.

47. On 6 March, chaplaincy staff told healthcare staff and wing staff that Mr Daggett was in pain. On 7 March, healthcare staff responded that Mr Daggett he had been seen by nurses. There is no record of him seeing healthcare staff that day and it is unclear if this referred to an earlier interaction he had with healthcare staff.

48. On 19 March, Mr Daggett told prison staff he was in pain. They noted that they told healthcare staff but this is not noted on the clinical record nor was there any follow-up action. On 27 March, Mr Daggett told his keyworker that he constantly felt sick and had asked for healthcare appointments, but that he had not heard back from them. The CM told us that the role of key workers is to signpost prisoners to services, and he would not expect keyworkers to routinely schedule healthcare appointments.

49. Various staff had explained to Mr Daggett how to book healthcare appointments and there is no specific information suggesting he required extra support in scheduling these. However, healthcare staff had not received any applications for appointments from Mr Daggett. It is unclear whether Mr Daggett genuinely thought he had requested healthcare appointments and therefore did not properly understand the process that had been explained to him, or whether he was aware that he had not. Either way, we conclude that he had opportunity to raise any concerns he had about making appointments with staff and we are satisfied that they supported him appropriately.

Governor and Head of Healthcare to note

Staff debrief

50. Both prison and healthcare staff said that they were not given the opportunity to attend a debrief after Mr Daggett died. We bring this to the Governor and Head of Healthcare's attention.

Adrian Usher
Prisons and Probation Ombudsman **January 2025**

Inquest

The inquest hearing was held on 22 January 2025. The Coroner concluded that Mr Daggett died of natural causes.

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 l 020 7633 4100