

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Graham, a prisoner at HMP Littlehey, on 7 March 2022

A report by the Prisons and Probation Ombudsman



Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity



© Crown copyright, 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Edward Graham died of coronary artery thrombosis in Hinchingsbrooke hospital on 7 March 2022, while a prisoner at HMP Littlehey. He was 71 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 Littlehey was of a good standard and was equivalent to that which he could have expected to receive in the community. She made no recommendations.
5. We are satisfied that Mr Graham was appropriately supported and found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Graham's clinical care at HMP Littlehey. The clinical reviewer's report is attached as Annex 1.
7. The PPO investigator investigated the non-clinical issues relating to Mr Graham's care, including Mr Graham's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Graham's next of kin to explain the purpose of the investigation and to ask if they had any matters they wanted us to consider. They did not have any questions but requested a copy of our report.
9. Mr Graham's family received a copy of the draft report and indicated that they were satisfied with the findings.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Previous deaths at HMP Littlehey

11. There were 30 deaths at Littlehey in the two years prior to Mr Graham's death. Of the previous deaths, 29 were from natural causes and one was self-inflicted. There have been six further deaths since Mr Graham died, five of which are suspected to be from natural causes and one self-inflicted death. There are no similarities across our investigation findings.

Key Events

12. On 10 November 2014, Mr Edward Graham was given a 14-year prison sentence and sent to HMP Chelmsford. He spent time at a number of prisons and transferred to HMP Littlehey on 8 May 2017.
13. When Mr Graham arrived at Littlehey, healthcare staff noted his complex medical needs, including type 2 diabetes (a condition causing too much sugar in the blood), ischaemic heart disease (where the blood vessels to the heart are narrowed or blocked), high blood pressure, atrial fibrillation (a condition causing an irregular heartbeat) and cirrhosis (scarring of the liver caused by long term damage). In 2020, he had a pacemaker inserted into his heart (a small device that helps maintain a regular heartbeat). The appropriate care plans were put in place to support these conditions.
14. When staff identified potential signs of liver disease, Mr Graham was referred to a specialist at the local hospital. He met with the specialist on 3 May 2019, who organised for a biopsy to be taken. The biopsy appointment was delayed due to the COVID-19 pandemic. On 7 November, Mr Graham was told by hospital staff that he was not well enough to have it, due to his heart condition.
15. In November 2019, a prison GP met with Mr Graham to discuss low levels of iron in his blood. He referred him for further investigation and he was diagnosed with a polyp (non-cancerous lump) on his liver.
16. In March 2020, Mr Graham was due for an ultrasound appointment to review the growth on his liver. Between March and November 2020, three of Mr Graham's ultrasound appointments were cancelled by Cambridge University Hospital. He was offered another appointment on 14 December 2020, which had to be conducted over the phone due to COVID restrictions. The specialist arranged a review and ultrasound appointment to take place three months later.
17. On 8 January, Mr Graham met with another prison GP. A routine blood test showed that the level of sugar in his blood was high. The test results also indicated fibrosis of the liver. The prison GP noted that Mr Graham was still awaiting an ultrasound and requested that this was brought forward by the hospital.
18. Mr Graham had his next ultrasound on 20 January and the findings triggered a range of follow up investigations.
19. On 19 March, a scan confirmed that Mr Graham had liver cancer. A consultant in palliative medicine told Mr Graham that they would be unable to operate on the cancer due to the risks associated with his multiple health conditions.
20. On 5 July, Mr Graham spoke with the consultant about his care plan and said that he did not want to be resuscitated if his heart or breathing stopped. He signed an agreement to that effect (DNACPR). The consultant told Mr Graham he had up to 20 months of life left, but that the period might change.
21. On 12 July, Mr Graham experienced chest pains and was admitted to Royal Papworth hospital where he was diagnosed with heart failure. He had surgery

to put stents in his heart (a short wire mesh tube that acts like scaffolding to keep the artery open).

22. On 5 August, a custodial manager was allocated as the family liaison officer for Mr Graham. With consent, he regularly updated Mr Graham's family on his health and involved them in care planning.
23. On 13 August, Mr Graham had a heart attack and was admitted to hospital, where he was monitored until 22 August.
24. On 15 September, Mr Graham had an appointment with a consultant medical oncologist. He advised that liver treatment options were limited due to the risks associated with Mr Graham's heart problems but that supportive treatments such as pain management could be explored.
25. On 20 September, the consultant met with Mr Graham to discuss his end-of-life care. He told him that his prognosis had reduced to around three months and advised that the prison could support him with an application for early release on compassionate grounds (these procedures can be used where prisoners have a prognosis of three or less months to live). On 4 October, once the relevant information had been gathered, the application was submitted to the Public Protection Casework Section (PPCS) of Her Majesty's Prison and Probation Service (HMPPS) in line with policy. This was supported by prison and probation offender managers and the Governor of Littlehey.
26. On receipt of the application, PPCS sought further risk information from the police. The application was refused on 6 January, on the grounds of risk not being sufficiently reduced. They noted that while Mr Graham was very unwell, he was still fully mobile and independent.
27. On 16 February, Mr Graham told staff he was in a lot of pain. They called for healthcare support and a nurse came to assess Mr Graham. He found that his abdomen was very swollen and called for an emergency ambulance.
28. Mr Graham was taken to hospital where he had fluid drained from his abdomen. On 18 February, he was discharged from hospital and returned to Littlehey who put regular healthcare checks in place. A risk assessment was completed to keep his cell unlocked in the event that health and social care staff needed quick access.
29. On 17 February, a further application for compassionate release was submitted to PPCS.
30. On 28 February, Mr Graham told staff he was in a lot of pain and unable to get in or out of his bed. An officer asked a nurse for support. The nurse assessed Mr Graham and concluded that he had reached a stage at which he needed 24-hour healthcare, which could not be provided in the prison. Mr Graham was taken to hospital by ambulance and the consultant agreed that Mr Graham should remain there for end-of-life care.
31. On 2 March, Littlehey approved temporary licence (ROTL) for Mr Graham, to facilitate transfer to a hospice in the event that compassionate release was not granted. On 3 March, a case administrator notified Mr Graham that the second

application for compassionate release had been refused on the grounds of risk not being sufficiently reduced. PPCS considered that ROTL was the most appropriate arrangement for reducing the distress to Mr Graham and his family, while maintaining public protection.

32. Mr Graham's family were supported to visit him in hospital on 5 March.
33. Mr Graham died on 7 March at 7.00am in Hinchingsbrooke Hospital. An officer was with him when he died, and family were notified immediately.

Post-mortem report

34. The post-mortem concluded that Mr Graham died of coronary artery thrombosis (a blood clot inside the heart) caused by coronary artery atherosclerosis (a blockage inside the arteries that slows down the blood supply to the heart). Metastatic liver cancer (liver cancer that has spread to other parts of the body), type II diabetes, chronic kidney disease, hypertension (high blood pressure) were listed as contributory factors.

Tallulah Frankland
Assistant Ombudsman

October 2022

**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 | 020 7633 4100