Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Williams, a prisoner at HMP Isle of Wight, on 29 May 2023

A report by the Prisons and Probation Ombudsman

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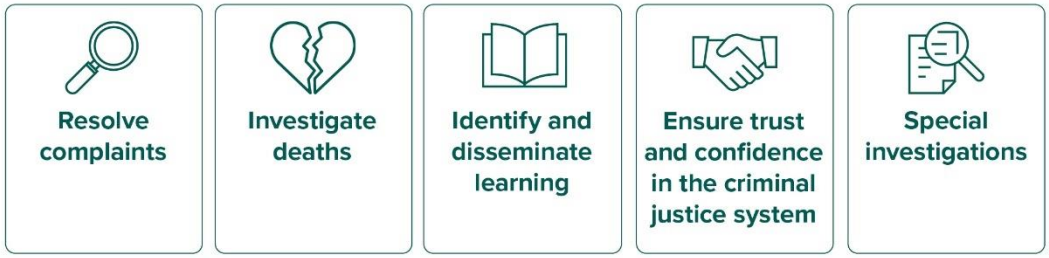
OUR VISION

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

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 HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic process failures.

3. Mr John Williams died of heart failure and kidney disease on 29 May 2023, while a prisoner at HMP Isle of Wight. He was 65 years old. We offer our condolences to Mr Williams' family and friends.

4. The clinical reviewer concluded that the clinical care Mr Williams received at Isle of Wight was of a good standard and was equivalent to that which he could have expected to receive in the wider community. The clinical reviewer made one recommendation in her report on communication between the prison healthcare team and external palliative care team when a referral has been made to them. We do not repeat the recommendation in this report, but the Head of Healthcare will wish to address it.

5. Mr Williams was inappropriately handcuffed when he was a hospital inpatient.

The Investigation Process

6. We were notified of Mr Williams' death on 29 May 2023.

7. NHS England commissioned an independent clinical reviewer to review Mr Williams' clinical care at HMP Isle of Wight.

8. The PPO investigator investigated the non-clinical issues relating to Mr Williams' care at HMP Isle of Wight.

9. Mr Williams did not have a next of kin.

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

Previous deaths at HMP Isle of Wight

11. Mr Williams was the 26th prisoner to die at HMP Isle of Wight since May 2020. Of the previous deaths, 21 were from natural causes, and four were self-inflicted. There have since been seven further deaths at the prison, all from natural causes. In three of our previous investigations, we found that restraints were inappropriately applied on frail or terminally ill prisoners.

Key Events

12. On 9 August 2016, Mr John Williams was convicted of sexual offences and sentenced to 20 years in prison. He was transferred to HMP Forest Bank. It was his first time in prison. Mr Williams had a medical history of diabetes type 2 and high blood pressure, for which he received prescribed medication. He was also diagnosed with depression. Mr Williams had neuropathic pain in his legs, hands and hip as the result of a motorbike accident in the 1980s, and experienced mobility problems as a result.

13. Between March 2018 and October 2021, Mr Williams was transferred to several prisons. He spent time as an inpatient in healthcare units and was supported by staff.

14. In November 2021, Mr Williams was diagnosed with chronic kidney disease stage four.

15. On 11 November, Mr Williams was transferred to HMP Isle of Wight. He was allocated a ground floor cell in the healthcare inpatient unit. Healthcare staff wrote a care plan and booked a social care assessment. Mr Williams settled well and there were no reported issues in his first weeks at the prison.

16. On 11 January 2022, Mr Williams was admitted to St Mary's Hospital, Newport, for treatment and monitoring after concerns by clinical staff for his health.

17. On 16 January, a bedwatch officer recorded that Mr Williams was mobile in hospital and using his Zimmer frame. The officer recorded that Mr Williams remained handcuffed to staff. Restraints were used throughout Mr Williams' hospital stay.

18. On 1 February, Mr Williams stated that he no longer wished to stay in hospital. A doctor explained to Mr Williams the high possibility of his health deteriorating if he left hospital. Mr Williams said he was "not bothered" and that he just wanted to leave. Mr Williams stated that whilst he was in hospital, he would refuse any more treatment and would not take any more medication. He said that he felt he had not got any better in the time that he had spent in the hospital so "why bother staying out any longer".

19. On 2 February, Mr Williams returned to the healthcare unit in Isle of Wight. A GP assessed him on his return and recorded a diagnosis of end stage renal failure. He continued to receive social care visits. Prison records stated it was clear he was quite unwell and spent much of his time asleep or sat in his chair watching television. Mr Williams had assistance to collect his meals and with other daily activities.

20. On 25 February, a specialist nurse created a palliative care plan for Mr Williams.

21. On 3 March, a healthcare multidisciplinary team meeting discussed Mr Williams. They recorded that he refused all active treatment or hospital admission, including for dialysis, although he accepted pain relief medication. Healthcare staff reviewed Mr Williams' wishes and mental capacity over the following year.

22. On 22 July, Mr Williams was admitted to hospital following abnormal blood test results. He returned to Isle of Wight the following morning.

23. On 28 July, Mr Williams said that he did not want to go to hospital again and signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form.

24. On 6 September, Mr Williams moved from the healthcare unit to a cell in another prison wing. The healthcare records do not say why this took place, but he was visited by social care workers to help with daily activities. Prisoner buddies also helped Mr Williams by delivering his meals and cleaning his cell.

25. On 15 October, a nurse checked Mr Williams' blood pressure, which was extremely high. The nurse reminded Mr Williams that it was imperative that he took his medication to help get his blood pressure reading closer to normal. Over the following months, Mr Williams continued to decline medication.

26. On 11 November, a hospital doctor called the prison with concerns about a blood test result for Mr Williams. The doctor wanted Mr Williams to be offered a visit to the hospital to discuss the results. Mr Williams declined to go to the hospital and signed a disclaimer.

27. On 5 December, Mr Williams moved back to the healthcare inpatient unit at the request of healthcare staff. Healthcare staff created a new palliative care plan, including a social care package.

28. In January 2023, Mr Williams was diagnosed with chronic kidney disease stage 5. This means that the kidneys are getting very close to failure or have already failed.

29. At 2.00am on 29 May, a nurse identified that Mr Williams had stopped breathing. Paramedics attended and, at 5.21am certified Mr Williams' death.

Post-Mortem Report

30. The post-mortem report concluded that Mr Williams died of decompensated cardiac failure (heart can no longer continue to compensate for its defects) caused by left ventricular hypertrophy (thickening of the wall in the pumping chamber), due to hypertension (high blood pressure), with severe chronic kidney disease due to diabetes mellitus (inappropriately elevated blood glucose levels) a secondary contributory factor.

Findings

31. The clinical reviewer made one recommendation that the Governor and Head of Healthcare should work together to address.

Governor to Note

32. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

33. Prison staff applied restraints throughout Mr Williams' hospital inpatient stay in January 2022. Mr Williams was an older prisoner in poor health and who required a walking aid to mobilise. The decision to restrain him was not proportionate to his risk.

34. We have previously reported on the inappropriate use of restraints at HMP Isle of Wight. These reports were all issued in 2021 or earlier. Since January 2022, our investigations have not made any findings of restraints being used inappropriately on hospital escorts. We bring this matter to the Governor's attention.

Inquest

35. The inquest into Mr Williams' death concluded on 3 November 2025. The coroner confirmed that Mr Williams died of natural causes.

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

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