Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Henderson, a prisoner at HMP Isle of Wight, on 27 March 2021

A report by the Prisons and Probation Ombudsman

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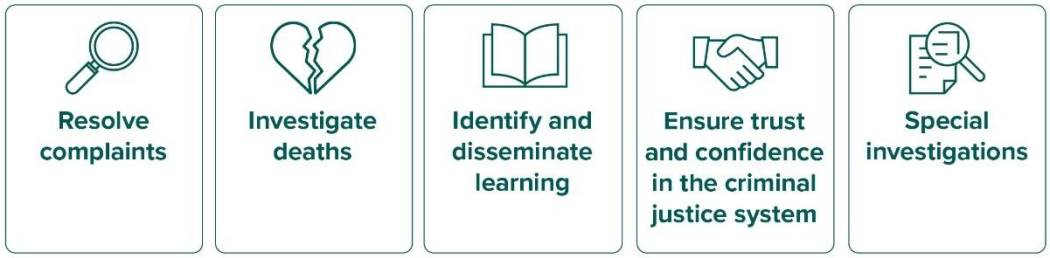
OUR VISION

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. 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 Ian Henderson died of multiple organ failure on 27 March 2021, while a prisoner at HMP Isle of Wight. He was 56 years old. I offer my condolences to Mr Henderson's family and friends.

4. The clinical reviewer concluded that the care Mr Henderson received at HMP Isle of Wight was equivalent to that which he could have expected to receive in the community. He made no recommendations.

5. We did not find any non-clinical issues of concern. We make no recommendations.

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Henderson's clinical care at HMP Isle of Wight.

7. The PPO investigator has investigated non-clinical issues, including Mr Henderson's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. Mr Henderson's next of kin, his partner, received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Isle of Wight

10. Mr Henderson was the sixteenth prisoner to die at Isle of Wight since March 2019. Of the previous deaths, ten were from natural causes and five were self-inflicted. There have been five further deaths since Mr Henderson's death, all from natural causes.

11. There are no similarities between our findings in the investigation of Mr Henderson's death and the previous deaths.

Key Events

12. On 11 June 2020, Mr Ian Henderson was sentenced to nine years in prison for historic sexual offences. He was sent to HMP Bristol.

12. Mr Henderson had been previously diagnosed with a hernia and sciatica. He also had a history of alcohol misuse, particularly in the six months prior to his trial. He was referred to the prison's alcohol misuse clinic.

13. On 17 September, Mr Henderson transferred to HMP Isle of Wight.

14. At his initial health screen, a nurse noted Mr Henderson's pre-existing conditions and his history of alcohol misuse. She referred him to the prison's substance misuse team for continuity of his alcohol misuse treatment.

15. On 19 January 2021, a nurse saw Mr Henderson after he complained of being short of breath and having had a persistent cough for the previous two weeks. He told her that he had also coughed up blood speckled sputum. She took his observations and they were all within a normal range. Mr Henderson had follow up reviews on 23 January and 1 February. His observations were normal, his sputum was clear, and he had no new symptoms.

16. On 8 February, Mr Henderson was the subject of a Code Blue emergency after telling prison staff that he was suffering from a shortness of breath, chest pain and an increased heart rate. A prison GP saw Mr Henderson and noted that his oxygen saturation level fluctuated between 75% and 90% (a normal oxygen saturation level is 95% to 100%) and that his heart rate was erratic. He was taken to St Mary's Hospital, Newport, by emergency ambulance.

17. In hospital, Mr Henderson was diagnosed with pneumonia with effusion (a build-up of fluid between the lung and chest wall) affecting his right lung. He was also diagnosed with a pulmonary embolism (a blockage in an artery of the lung). Tests were carried out and a chest drain was inserted to drain the fluid from his chest. He was admitted as an inpatient and discharged back to Isle of Wight on 13 February. Mr Henderson was prescribed medication to prevent further episodes of pulmonary embolisms and care plans were created to manage his condition. Prison healthcare staff reviewed him daily.

18. A GP carried out a follow up review on 16 February. He noted Mr Henderson continued to suffer from a shortness of breath and a persistent cough. Mr Henderson also told the GP that he had seen evidence of blood in his urine. The GP considered he was suffering from a frank haematuria (less than one millilitre of blood evident in urine). He made a two week wait referral to the urology department at St Mary's hospital.

19. The GP carried out a further review on 23 February. Mr Henderson told him that he had been suffering from upper abdominal and lower chest pain. The GP requested blood tests and the results showed that Mr Henderson had developed jaundice.

20. On 25 February, Mr Henderson attended St Mary's Hospital for his two week wait referral. The GP reviewed the results the following day. Mr Henderson was diagnosed with thickening and inflammation of the gallbladder and a blockage caused by small cysts. He had an urgent ultrasound scan which revealed nothing of note. Mr Henderson was referred for an Oesophagus-Gastro-Duodenoscopy (OGD - a thin flexible camera inserted into the throat).

21. The GP saw Mr Henderson on 1 March. He noted he appeared more jaundiced than before and that there was evidence of a build-up of fluid in his lower right leg. He also noted that despite adjustments to his prescribed medications, there was still evidence of abdominal pain and swelling.

22. The OGD was carried out at St Mary's Hospital on 8 February. The results showed that Mr Henderson had developed multiple throat tumours each measuring approximately ten centimetres. In addition, a single eight-centimetre tumour was found in his small intestine. Biopsies were taken and Mr Henderson was admitted to hospital as an inpatient to await the results. The results showed that Mr Henderson had developed oesophageal (throat), bile duct and duodenal cancer (cancer in the small intestine) which had also spread to his lymph nodes. Hospital staff considered that palliative care was the only treatment option open to him.

23. On 23 March, Mr Henderson was transferred to Southampton General Hospital to undergo a surgical procedure to identify the extent of the damage in his gallbladder, bile ducts and pancreas. While in hospital, hospital staff signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order on Mr Henderson's behalf, which meant that in the event his heart or breathing stopped, he would not be resuscitated. Mr Henderson returned to St Mary's Hospital on 26 March.

24. Mr Henderson's condition continued to deteriorate in hospital and at 1.15pm on 27 March, Mr Henderson died. His death was confirmed by a hospital doctor at 1.27pm.

Post-mortem report

25. A post-mortem concluded that Mr Henderson died of multiple organ failure caused by carcinoma of the oesophagus. Mr Henderson also had severe liver failure which did not cause but contributed to his death.

Lisa Burrell **March 2022**
Assistant Ombudsman

Inquest

At the inquest, held on 19 August 2025, the Coroner concluded that Mr Henderson died from natural causes.

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