Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Philip Walton, a prisoner at HMP Stafford, on 19 May 2022

## 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 Philip Walton, who was 62 years old, died from throat cancer on 19 May 2022 at HMP Stafford. We offer our condolences to Mr Walton's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Walton received at HMP Stafford was equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.

5. We found no non-clinical issues of concern.

# The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Walton's clinical care at HMP Stafford.

7. The PPO investigator investigated the non-clinical issues relating to Mr Walton's care, including his 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 Walton's next of kin, his son, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

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

## Previous deaths at HMP Stafford

10. Mr Walton was the fourteenth prisoner to die at Stafford since May 2020. Of the previous deaths, 13 were from natural causes. There are no similarities between our findings in the investigation into Mr Walton's death and our investigation findings for the previous deaths.

# Key Events

11. On 28 September 2018, Mr Philip Walton was remanded to HMP Hewell, charged with sexual offences. On 29 October, he was sentenced to 14 years in prison. On 23 November, he was transferred to HMP Stafford.

12. Mr Walton had a medical history of rheumatoid arthritis, chronic obstructive pulmonary disease (COPD), bilateral hip replacements, elbow replacement and osteoporosis. Prison healthcare staff saw him regularly to monitor his conditions and administer his medications.

13. On 3 November 2020, Mr Walton told a nurse that he had a sore throat and had had dizzy spells. She checked his observations and noted that these were all within the normal range. Mr Walton took a COVID-19 test and the result was negative. The nurse arranged for healthcare staff to monitor him.

14. On 30 November, Mr Walton told a prison GP that he was having hearing problems with his left ear. The prison GP referred him to hospital Ear Nose and Throat (ENT) specialists to investigate further. Mr Walton attended hospital for some tests and the results indicated that he had hearing loss in both ears. Further tests were arranged.

15. On 30 December, ENT specialists completed an examination of Mr Walton's head and neck region and arranged for specialists from the head and neck cancer multi-disciplinary team to review him.

16. On 28 March 2022, a consultant told Mr Walton that a lump in his neck had caused his earache and he had widespread cancer. The consultant offered him palliative chemotherapy to improve his symptoms and survival because a cure was not possible. Mr Walton decided that he did not want to receive treatment. Hospital specialists confirmed his decision and recommended to prison healthcare staff that they provide supportive care.

17. On 1 April, Mr Walton said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

18. Prison healthcare staff coordinated discussions with Mr Walton and palliative community nurse specialists for his end of life care, and he moved to the prison's palliative care suite. Prison managers agreed that Mr Walton's cell door could remain open for healthcare staff to visit him and ensure responsive access. Prison staff enabled visits with close family members in the weeks before he died.

19. On 19 May, a prison nurse and healthcare assistant entered Mr Walton's cell and noted that his breathing was shallow and slow. Nursing staff remained with Mr Walton until he died at 9.16am. Ambulance staff attended the prison and verified his death at 9:38am.

## Cause of death

20. The coroner confirmed that no post-mortem examination was carried out. The coroner gave Mr Walton's cause of death as grade 4 nasopharyngeal carcinoma (throat cancer). Rheumatoid arthritis and chronic obstructive pulmonary disease (COPD) were also listed as contributory factors.

**Lisa Burrell**
**Assistant Prisons and Probation Ombudsman** **March 2023**

## Inquest

At the inquest, held from 6 to 8 May 2026, the jury concluded that Mr Walton died from natural causes.

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