Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen McDermott, a prisoner at HMP Isle of Wight, on 25 October 2022

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 I 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

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 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.

3. Mr Stephen McDermott died of pneumonia caused by pancreatic cancer which had spread to other parts of his body on 25 October 2022 while a prisoner at HMP Isle of Wight. He was 76 years old. We offer our condolences to Mr McDermott's family and friends.

4. The clinical reviewer concluded that the clinical care provided to Mr McDermott prior to his terminal diagnosis was not equivalent to that which he could have expected to receive in the community. The clinical reviewer makes a recommendation for the Head of Healthcare to lead a multidisciplinary review of Mr McDermott's care with a view to identifying learning and implementing changes to improve practice.

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

The Investigation Process

6. We were notified of Mr McDermott's death on 25 October 2022.

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

8. The PPO investigator investigated the non-clinical issues relating to Mr McDermott's care.

9. The PPO family liaison officer wrote to Mr McDermott's next of kin, to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond to our letter.

Previous deaths at HMP Isle of Wight

10. Mr McDermott was the 35th prisoner to die at Isle of Wight since October 2019. Of the previous deaths, 18 were from natural causes, seven were self-inflicted and the cause of one is currently unknown. There are no similarities between our findings in the investigation into Mr McDermott's death and our investigation findings for the previous deaths.

Key Events

11. On 4 February 2022, Mr Stephen McDermott was given a 16 year prison sentence for sexual offences and sent to HMP Lewes.

12. On 12 April, Mr McDermott transferred to HMP Isle of Wight. At his initial health screening, he told staff he had back and abdominal pain and concerns about his bowel movements. Healthcare made a referral to the GP.

13. Between April – August, the GP treated Mr McDermott for sciatica (pain that travels along the nerve from the lower back to the leg), abdominal pain and constipation with appropriate pain relief and laxatives.

14. In July, Mr McDermott was found on the floor of his cell. He had lost control of his bowels. Healthcare staff suggested Mr McDermott move onto the prison's inpatient healthcare unit (IHU), but he declined and signed a disclaimer to that effect.

15. On 16 August, Mr McDermott collapsed in his cell again. Healthcare assessed him and found he had low blood pressure. They changed his hypertension medication.

16. On 26 August, a prison paramedic reviewed Mr McDermott and recorded that he was sluggish, in pain around his hip and pelvis, struggling to walk and constipated. He was also dizzy and eating very little. The paramedic recorded that Mr McDermott's blood pressure was low and made an urgent referral to the GP for an urgent review. Prison records also show that wing officers had raised concerns that Mr McDermott appeared 'very unwell'. The GP met with Mr McDermott later the same day and transferred him to the IHU where pain relief and laxatives were continued. The GP recorded that they were "unconvinced Mr McDermott had a serious underlying disease".

17. On 30 August, the GP reviewed Mr McDermott and recorded that the laxatives were working and that he could return to the general wing. The GP recorded again that there were no signs of something seriously wrong. The GP also reviewed blood test results for Mr McDermott and recorded that they were 'borderline' with no further action required.

18. Mr McDermott transferred to the general wing on 1 September, but returned to IHU two days later because he was grey, struggling to sit up, eat and complete his personal care routine.

19. On 6 September, a GP reviewed Mr McDermott and recorded that he was struggling with motivation rather than a medical underlying issue.

20. On 10 September, healthcare staff recorded that Mr McDermott had lost between five to ten percent of his body weight in a period of three to six months, had not eaten for more than five days and was at high risk of malnutrition. Nursing staff recorded concerns about his overall condition.

21. On 13 September, a different GP reviewed Mr McDermott. The GP recorded that Mr McDermott was struggling with his back and sciatica pain, and food was getting stuck in his throat. The GP also recorded that he smelled of ketones. (Ketones are an acid made by the liver. If a person smells of ketones, it could mean that they

have a high level of ketones in their blood, making their blood too acidic.) The GP referred Mr McDermott for a spine X-ray and an urgent referral for an endoscopy (a procedure to look inside the body using a small camera).

22. On 14 September, a healthcare assistant found that Mr McDermott had vomited blood and seemed generally unwell. The healthcare assistant spoke to a GP, who recommended that he be taken to hospital. Hospital staff organised a blood transfusion and a CT scan, which showed that he had a possible lymphoma (a type of cancer) and a gastrointestinal bleed. The prison appointed a family liaison officer who informed Mr McDermott's next of kin.

23. On 15 September, after discussion with the hospital staff, Mr McDermott said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

24. On 23 September, Mr McDermott had a liver biopsy (an operation where a sample of body tissue is removed and tested for cancer). On 11 October, he received the results, which confirmed that cancer had spread to his liver. On 14 September, hospital staff agreed that Mr McDermott was not suitable for treatment and started end of life care.

25. On 19 October, Mr McDermott returned to Isle of Wight with a catheter (a tube connected to the bladder which allows the patient to pass urine without getting up) and a syringe driver (a machine which automatically gives regular doses of medication). He was located in a palliative care cell on the IHU. Isle of Wight started an application for early release on compassionate grounds.

26. On 23 October, Mr McDermott started showing signs that he was close to dying. A healthcare assistant stayed in the room with him.

27. At 2.53pm on 25 October, Mr McDermott died.

Post-mortem report

28. The post-mortem report concluded that Mr McDermott died of pneumonia (caused by metastatic carcinoma of the pancreas (cancer of the pancreas that has spread to other parts of the body).

Clinical Findings

29. The clinical reviewer concluded that the care Mr McDermott received before his terminal cancer diagnosis was not equivalent to the care he could have expected to receive in the community. Mr McDermott showed symptoms of possible significant disease including struggling to eat, abdominal pain and bowel issues in the months leading up to his death. Nursing and wing staff raised concerns about his condition. The GP who was supporting Mr McDermott at the time did not organise further investigation into his symptoms.

30. The clinical reviewer highlights that further investigation of Mr McDermott's symptoms would not have extended his life, but were likely to have led to earlier diagnosis and increased disease-specific support.

31. The clinical reviewer made a recommendation for the Head of Healthcare at the Isle of Wight to conduct a multidisciplinary investigation into the possible delay of Mr McDermott's cancer diagnosis and implement changes if learning is identified.

32. The clinical reviewer highlighted the exemplary care provided to Mr McDermott when he returned to Isle of Wight after his terminal diagnosis.

Adrian Usher
Prisons and Probation Ombudsman **September 2023**

Inquest

At the inquest, held on 18 September 2025, the Coroner concluded that Mr McDermott died from 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 I 020 7633 4100