Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Adrian Watts a prisoner at HMP Bristol on 17 March 2017

A report by the Prisons and Probation Ombudsman
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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*

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Adrian Watts died in hospital, on 17 March 2017, of widespread cancer, while a prisoner at HMP Bristol. He was 43 years old. I offer my condolences to Mr Watts' family and friends.

Hospital specialists were unable to establish the primary site of Mr Watts' cancer and he died within days of them discovering that his condition was terminal.

We agree with the clinical reviewer that there were a number of deficiencies in Mr Watts' care and that it was not the equivalent of that which he could have expected to receive in the community. Healthcare staff at Bristol should have referred him to a specialist sooner when he reported his symptoms and his pain management was not always effective. While this did not affect the outcome for Mr Watts, it is important that symptoms are investigated promptly. The investigation also found that Mr Watts' diet did not meet his needs and there was no evidence that he received responses to complaints about his treatment and care.

I am also concerned that the risk assessment considering the use of restraints for Mr Watts' last admission to hospital did not take proper account of his failing health.

This version of our report, published on our website, has been amended to remove the names of prisoners and staff involved in our investigation.

Richard Pickering
Deputy Prisons and Probation Ombudsman **June 2018**

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Summary

Events

1. Mr Adrian Watts was recalled to prison on 1 June 2016 and was later convicted of unlawful wounding. An initial health screen identified no serious health conditions, but he began drug and alcohol detoxification.

2. In late November, Mr Watts told a prison paramedic that he had constant pain near his ribs and had passed blood. On 2 December, a prison GP assessed him and requested blood tests, with a view to an ultrasound scan if the results were abnormal. In the following weeks, several prison GPs examined Mr Watts and he reported further symptoms of severe and persistent pain, constipation, a feeling of needing to open his bowels and weight loss.

3. An ultrasound scan on 5 January revealed a mass in Mr Watts' liver. On the same day, a prison GP referred Mr Watts urgently to a specialist, for suspected gastrointestinal cancer. On 13 January, the specialist assessed him and requested further tests to establish the nature of the mass. Prison healthcare staff checked Mr Watts frequently and tried to manage his pain. On 1 March, a prison GP diagnosed sepsis and immediately sent Mr Watts to hospital. On 10 March, hospital doctors diagnosed incurable cancer, with a life expectancy of a few weeks, but they were unable to determine the origin. Mr Watts remained in hospital, where he died on 17 March.

Findings

4. When Mr Watts presented with concerning symptoms in early December, this should have prompted an urgent referral under the NHS pathway for suspected cancer. A prison GP referred him just over a month later. While waiting for the outcome of tests to diagnose Mr Watts' condition, healthcare staff found some difficulty in managing his pain, particularly overnight when he sometimes did not receive sufficient morphine. We also found that catering staff did not always comply with requests for him to receive an alternative diet.

5. We agree with the clinical reviewer that in light of the above, Mr Watts' care at Bristol was not equivalent to that which he could have expected to receive in the community.

6. We are not satisfied that the risk assessment completed for Mr Watts' final admission to hospital prison took sufficient account of his poor condition at that time and the impact on his risk.

Recommendations

- The Head of Healthcare should ensure that clinicians follow National Institute for Health and Clinical Excellence (NICE) guidelines and refer prisoners to a specialist urgently if they present with unexplained and persistent symptoms of suspected cancer.
- The Head of Healthcare should ensure that prisoners with serious illnesses receive immediate and effective pain relief when required, including overnight. An appropriate policy should be developed to manage those also undergoing treatment for opiate addiction.
- The Head of Healthcare should ensure that complaints about healthcare are registered, dealt with quickly and the outcome recorded.
- The Governor and Head of Healthcare should ensure that prisoners with serious illnesses receive an appropriate diet to meet their needs, without delay.
- The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments justifying the use of restraints on prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

8. The investigator obtained copies of relevant extracts from Mr Watts' prison and medical records. She also obtained from Avon and Somerset Police four journals written by Mr Watts.

9. NHS England commissioned a clinical reviewer to review Mr Watts' clinical care at the prison.

10. We informed HM Coroner for Avon of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers spoke to Mr Watts' daughter, his next of kin, to explain the investigation. Mr Watts' daughter asked for the following matters to be considered:

    - Mr Watts was too unwell to make a complaint about his care.
    - Mr Watts kept detailed journals about his treatment and care from 2 December 2016 to 28 February 2017, which had been passed to the police.
    - The prison failed to contact her when her father was admitted to hospital and she had been told by another prisoner.

12. The investigation has assessed the main issues involved in Mr Watts' care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

13. Mr Watts' daughter received a copy of the initial report. She had concerns about the scope of the investigation and medical issues unrelated to the cause of Mr Watts' death. We have responded to her directly about these matters.

14. We shared the initial report with HM Prison and Probation Service and they found no factual inaccuracies. The action plan in response to our recommendations has been annexed to this report.

Background Information

HMP Bristol

15. HMP Bristol is a local prison, which can hold up to 614 sentenced and remanded men. Bristol Community Health and Hanham Health provide primary healthcare services. Avon and Wiltshire NHS Partnership NHS Trust provides mental health and substance misuse services. All wings have a treatment room staffed by a nurse and healthcare assistants during the day. There is a nurse and a healthcare assistant on duty at night.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Bristol was in March 2017. Inspectors reported that the prison had been understaffed and standards had declined. There was strong clinical leadership, but staff shortages had restricted improvements in the management of chronic diseases. Inspectors also found that support for those with complex or significant health needs was inadequate and, due to a lack of escort officers, 41% of healthcare appointments were missed.

Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its latest annual report for Bristol, for the year to July 2016, the IMB reported that priority and routine healthcare and medication was mostly provided on the wings. They considered that healthcare and wing staff needed to develop greater cooperation.

Previous deaths at HMP Bristol

18. Mr Watts was the fourth prisoner to die from natural causes at Bristol since January 2015. We have previously raised with Bristol the issue of compliance with the guidelines on referrals for suspected cancer, pain management for seriously ill prisoners and poor risk assessments in the support of the use of restraints.

Findings

The diagnosis of Mr Watts' terminal illness and informing him of his condition

19. Mr Adrian Watts was released on licence from HMP Bristol on 30 March 2016. On 1 June 2016, he was recalled to prison and returned to Bristol. (He was later convicted of unlawful wounding and sentenced to 30 months in prison.) At an initial health screen, a nurse noted Mr Watts' history of drug and alcohol misuse and referred him to the substance misuse service for detoxification. He was otherwise fit and well. Over the next few months, most of the entries in his medical record related to substance misuse treatment.

20. On 26 November, Mr Watts told a prison paramedic that he had a constant pain near his ribs and had passed blood during a bowel movement. He was concerned that he might have cancer. The paramedic made an appointment for Mr Watts to see the prison GP.

21. Between 2 December 2016 and 28 February 2017, Mr Watts documented in four journals his symptoms and dissatisfaction with his care and treatment at Bristol. He also told his offender supervisor about his concerns.

22. During December, Mr Watts saw several prison GPs and other healthcare staff. On 2 December, a prison GP examined him and found some tenderness in his abdomen, but little else of note. Mr Watts refused a rectal examination. The GP diagnosed haemorrhoids and prescribed a laxative, as Mr Watts had complained of recent constipation, pain on opening his bowels and tenesmus (a feeling of needing to open his bowels). The GP requested blood tests and planned an ultrasound scan if they were abnormal. The blood tests indicated inflammation, so they were repeated.

23. Several times during the next few weeks, Mr Watts reported increasing and persistent abdominal pain constipation, diarrhoea, and anxiety. On 12 December, he told a prison GP that he could feel a mass to the right side of his abdomen and that he had lost around 12kg in weight over a few months. On examination, the GP thought he could feel faeces in the right abdomen. He planned to chase the results of the blood tests.

24. On 16 December, a prison GP noted Mr Watts had lost 7kg in weight in six weeks. The GP requested an ultrasound of his gall bladder. On 23 December, another GP noted Mr Watts' continuing concern that he might have cancer and that he would need further investigation if the ultrasound found no cause for his persistent symptoms. On 30 December, another GP thought Mr Watts' symptoms were suggestive of irritable bowel syndrome.

25. On 3 January 2017, Mr Watts submitted a 'Listening to you' complaint form to healthcare staff. He said that he was waiting for a diagnosis, he was in great pain and discomfort and he had to sleep upright. He felt that healthcare staff had let him down and were unsupportive. He requested either a high back chair, or a special bed to help him sleep better. On 5 January, a healthcare manager, spoke to Mr Watts, who agreed to discuss his difficulty sleeping with the GP the next day. Mr Watts said he did not need to be seen sooner. Although an

acknowledgment was sent, there was no substantive response to Mr Watts' complaint.

26. During the afternoon of 5 January, Mr Watts had an ultrasound scan at the prison. This revealed a four to five centimetre mass in his liver. Within an hour, a prison GP referred Mr Watts urgently to the North Bristol NHS Trust, for suspected upper gastrointestinal cancer, under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. The next day, the GP told Mr Watts about the tumour and the hospital referral. She also prescribed an energy drink and paracetamol.

27. On 13 January, a specialist in upper gastrointestinal surgery at Cossham Hospital told Mr Watts that he had a tumour. The hospital specialist requested blood tests and urgent CT scans of the chest, abdomen and pelvis (under the two week pathway for suspected cancer). Prison healthcare staff later chased the hospital, as Mr Watts did not receive a timely appointment for the scans.

28. Mr Watts continued to report that he was in considerable pain, felt unwell and was unable to eat or drink fluids other than water. He slept in a chair, as it was too painful to lie down. Doctors frequently reviewed and adjusted his pain relief, but the options were limited, as Mr Watts was on an opiate blocking dose of buprenorphine (a drug which treats opiate addiction by preventing the body from responding to opioids, sold under the brand name subutex). Prison nurses checked him twice daily and made at least two welfare checks during the night. They also requested a low fat diet and ordered a beanbag so he could sleep in a more comfortable position.

29. In January and February, healthcare staff noted several requests to the kitchen for an appropriate diet. There was no evidence as to whether kitchen staff implemented this and Mr Watts noted in his journal many examples of unsuitable meals, such as burgers, chips, chicken cooked in cream and tuna mayonnaise. His prison record shows that a prison manager and the prison chaplain also spoke to catering staff, who said they were aware of Mr Watts' needs. On 10 February, the chaplain recorded his concern that Mr Watts was not receiving food specifically sent to the wing for him.

30. On 30 January, Mr Watts handed healthcare staff another complaint form. He did not receive a reply. The same day, he reported acute abdominal pain. A prison GP found it difficult to examine Mr Watts because of the severity of the pain, so she sent him to Southmead Hospital as an emergency. (He returned the same day.) She also tasked a nurse to seek his agreement to stopping his buprenorphine to allow stronger pain relief.

31. Mr Watts was anxious about the results of a scan taken on 3 February and said he did not want to stop taking buprenorphine until he knew the outcome. On 9 February, a prison GP told Mr Watts that the scan results showed possible cancer, but the hospital needed to perform further tests to confirm this and the nature of the cancer. The GP contacted hospital specialists for advice about increasing Mr Watts' pain relief and the plans for further tests. (With Mr Watts' agreement, she later stopped the buprenorphine to allow an increase in morphine.) On 10 February, the hospital specialist wrote to inform the prison that

the CT scan suggested possible lymphoma (blood cancer), but he had also arranged an urgent colonoscopy to examine a thickening of the colon.

32. Mr Watts remained in considerable pain, so prison GPs reviewed his pain management daily. In February, he twice threatened to end his life as he found the pain unbearable. On both occasions, staff gave him additional support, for a short period, under the Assessment, Care in Custody, Teamwork (ACCT) suicide and self-harm prevention procedures.

33. On 15 February, a prison GP noted the need to exclude another cause for Mr Watts' pain, such as sepsis. The next day, she informed a haematology registrar at Southmead Hospital that Mr Watts might need to be admitted soon, as his weight was falling rapidly.

34. On 18 February, a prison GP noted that Mr Watts struggled to eat, or stand, because of his pain and there was blood in his urine. She concluded that they were not managing his symptoms adequately and arranged an admission to hospital, where doctors improved his pain control. The hospital discharged Mr Watts on 20 February and requested urgent referrals for a cytoscopy (to examine his bladder) and a CT urography (for suspicion of cancer in the urinary tract).

35. On 27 February, a prison GP noted that Mr Watts was in unbearable pain and might need to go to hospital for pain management. However, she did not want him to miss an outpatient biopsy appointment due that day.

36. On 1 March, Mr Watts was doubled up in pain and shivering. A prison GP suspected symptoms of sepsis (a life-threatening complication of an infection) and sent Mr Watts to hospital as an emergency. Hospital doctors treated him with intravenous antibiotics and a significant level of painkillers. Healthcare staff telephoned daily and visited Mr Watts. During a visit on 3 March, hospital staff told a prison paramedic that Mr Watts' prognosis was uncertain, but they had performed various tests and scans and planned to conduct a biopsy of his bone marrow.

37. On 10 March, a hospital nurse told a prison GP that Mr Watts had only weeks to live and that he was not fit for intervention, or chemotherapy. She added that they would continue active treatment, as the diagnosis was inconclusive and resuscitate Mr Watts if his heart or breathing failed.

38. The National Institute for Health and Care Excellence (NICE) Guidance (revised in 2015) - *Suspected cancer: recognition and referral* advises that doctors should refer adults over 40 years old with symptoms of unexplained weight loss and abdominal pain under the suspected cancer pathway referral for colorectal cancer. They should also consider such a referral for those under 50, with rectal bleeding and any of the following unexplained symptoms or findings: abdominal pain; change in bowel habit; weight loss; or iron-deficiency anaemia.

39. The clinical reviewer had concerns about the steps taken to diagnose Mr Watts' illness. Mr Watts had reported stomach pain, weight loss, rectal bleeding, a mass and tenesmus for several weeks before he was referred to a specialist. Prison healthcare staff should have treated the mass in Mr Watts' abdomen as a potential malignancy, referred him sooner to a specialist under the provisions for

suspected cancer and requested relevant blood tests while waiting for the appointment. While the clinical reviewer acknowledged that the presentation of Mr Watts' symptoms was complex, he considered that the handling of this aspect was not an equivalent standard to that which he could have expected to receive in the community.

40. Although earlier intervention is unlikely to have made a difference to the outcome for Mr Watts, as his cancer was well advanced by the time he reported his symptoms, it is important that staff respond promptly to symptoms which might indicate cancer. We make the following recommendation:

The Head of Healthcare should ensure that clinicians follow National Institute for Health and Clinical Excellence (NICE) guidelines and refer prisoners to a specialist urgently if they present with unexplained and persistent symptoms of suspected cancer.

Mr Watts' clinical care

41. The terminal nature of Mr Watts' illness was diagnosed during his final admission to hospital, where he remained as an inpatient until his death. Prison and healthcare staff visited him and frequently telephoned for updates on his treatment and condition. Mr Watts died in hospital at 4.32am, on 17 March.

42. The clinical reviewer found that Mr Watts' general care while awaiting the outcome of specialist investigations was appropriate and that healthcare staff communicated well with hospital clinicians. However, his pain management was sometimes inadequate due to the complication of managing his opiate addiction and there were occasions when he did not receive sufficient morphine overnight to control his pain. The clinical reviewer considered that this aspect of Mr Watts' care was not equivalent to that expected in the community. We make the following recommendation:

The Head of Healthcare should ensure that prisoners with serious illnesses receive immediate and effective pain relief when required, including overnight. An appropriate policy should be developed to manage those also undergoing treatment for opiate addiction.

43. Entries in Mr Watts' medical records showed that he made formal complaints about his care on 3 and 30 January, but there was no evidence that he received responses. In addition, Mr Watts noted in his journals that he had received no response to previous complaints. We make the following recommendation:

The Head of Healthcare should ensure that complaints about healthcare are registered, dealt with quickly and the outcome recorded.

44. As Mr Watts found it difficult to eat and certain foods exacerbated his symptoms, staff made several requests for him to receive a low fat diet. In his journal, Mr Watts describes receiving unsuitable food. There is no audit trail to determine whether the kitchen complied with the requests, although it was mentioned that food meant for Mr Watts possibly went astray. The number of requests made suggest that his needs were not adequately met. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners with serious illnesses receive an appropriate diet to meet their needs, without delay.

45. The clinical reviewer has made additional recommendations, with which we concur and which the Head of Healthcare will wish to address, but we have not repeated them in this report.

46. The report of the post-mortem examination concluded that the cause of Mr Watts' death was metastatic adenocarcinoma (widespread cancer which begins in glandular cells of certain organs) of unknown primary (the initial site of the cancer is unknown).

Mr Watts' location

47. On 24 January, after a discussion with a prison GP and nurse, Mr Watts agreed that a move to the Brunel Unit would be beneficial to allow staff to monitor him more closely and provide comfortable furniture, such as a hospital bed. (The Brunel Unit is a reintegration unit for prisoners with complex mental health and physical needs.) Staff told him that he would still be able to associate with his friends on B wing. However, when they offered him a place in the unit later that day, he had changed his mind and said he would prefer to stay on the wing. On 6 February, Mr Watts agreed to move from the third to the first floor, but declined several further offers to move to the Brunel Unit.

48. We are satisfied that Mr Watts was offered the opportunity to move to accommodation more suited to his needs and that staff took account of his wishes. Prison doctors sent him to hospital promptly when they could not adequately manage his symptoms and when he developed a life-threatening infection.

Restraints, security and escorts

49. 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.

50. Mr Watts was in considerable pain throughout his illness and, immediately before he went to hospital with suspected sepsis on 1 March, healthcare staff described him as doubled up in pain and continuously shaking all over. He was a category C prisoner and security risk assessments for his outpatient appointments and hospital admissions, before 1 March, indicated that his risk of escape and all other security risk factors were low. For his final journey to hospital, staff assessed him as a medium risk to the public, but noted no reasons for raising

this level. Healthcare staff recorded on the risk assessment that there were no medical objections to the use of restraints. Two prison officers escorted Mr Watts to hospital, using single handcuffs.

51. On 4 March, given Mr Watts' poor and deteriorating condition and the risk of infection to escort staff, a prison manager authorised the removal of the restraints and they were not reapplied. When the prison learned that his illness was terminal, they quickly reduced the level of escort to one officer.

52. We are pleased to note that the restraints were removed promptly when Mr Watts' condition worsened. However, we are concerned that the initial risk assessment did not, as required by the High Court judgement, properly consider the implications of Mr Watts' weakened condition, as indicated in his medical records, and, as a consequence, properly justify the use of handcuffs. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments justifying the use of restraints on prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Watts' family

53. On 2 February, Mr Watts' daughter telephoned a member of the safer custody team as she was concerned that her father was in constant pain. Shortly afterwards, the safer custody team member and the prison chaplain spoke to Mr Watts and took steps to address some of his concerns about his food and the need for aids to help his sleeping position. The safer custody team member then telephoned Mr Watts' daughter to reassure her. A few days later, a prison manager authorised staff to allow Mr Watts to use an office telephone to speak to his daughter, but he could not always get through when he tried to call.

54. On 6 February, Mr Watts signed a consent form to allow healthcare staff to discuss his care and treatment with his daughter. A prison GP was the clinical liaison with Mr Watts' daughter. She telephoned Mr Watts' daughter to inform her of what they knew so far, the plans for further tests and the changes to his medication. She also explained that they could not give a prognosis until the outcome of tissue tests. The GP gave further updates to Mr Watts' daughter.

55. The safer custody team member became Mr Watts' family liaison officer (FLO). When he went into hospital, at 10.15am on 1 March, she recorded that she had tried to contact Mr Watts' daughter several times to notify her of the hospital admission but, as his daughter was at work, she did not get through until around 11.30am. On 10 March, after doctors told Mr Watts about his short life expectancy, she offered Mr Watts' daughter the opportunity for friends to visit to pay their last respects and gave her contact details for any questions or concerns.

56. The FLO visited Mr Watts on 15 and 16 March and met his daughter to offer support. She gave him his property, asked how best to support him while he remained in hospital and clarified who should act as his next of kin. A few days after Mr Watts' death, the FLO and other prison managers met several members

of his family to discuss procedures and offer further support. She then kept in touch by telephone.

57. The prison paid the full costs of Mr Watts' funeral, which took place on 13 April. The prison chaplain led the funeral service. We are satisfied that the prison liaised appropriately with Mr Watts' family.

Compassionate release

58. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

59. Mr Watts had several tests which suggested the possibility of cancer and he died only a week after tests revealed his condition was terminal. While there is no formal record that the prison considered the possibility of compassionate release, the Head of Offender Management said that he and other prison managers had discussed this. They concluded that as a high risk MAPPA prisoner (Multi-Agency Public Protection Arrangements - for the management of violent and sexual offenders), early release was unlikely to be approved, even if they were able to complete the process before Mr Watts' death. They also felt that his rapid deterioration and poor physical condition did not suggest early release was in his best interests.

60. We acknowledge that Mr Watts' prognosis was uncertain for most of his illness and there was little time to apply for early release, as he died shortly after doctors found it was terminal. However, in similar cases in the future, the prison should record that they have considered, but discounted, the possibility of compassionate release and note the reasons why.

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