Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Derek Watson a prisoner at HMP Oakwood on 25 November 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned

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 Watson died on 25 November 2017 of lung cancer while a prisoner at HMP Oakwood. He was 71 years old. I offer my condolences to his family and friends.

Mr Watson was in poor physical health when he arrived at HMP Oakwood, and suffered from a number of medical conditions, including diabetes and high blood pressure. He also had mobility problems.

The clinical reviewer concluded that the overall care Mr Watson received fell below the standard that he could have expected to receive in the community. A number of different prison GPs and hospital consultants were involved in his care, but prison healthcare staff failed to co-ordinate his care in the way that primary healthcare would be expected to do in the community. Had they done so, it is possible that his lung cancer might have been diagnosed a little earlier, although it is unlikely that this would have made any difference to the outcome.

We are also concerned that restraints were used on Mr Watson when he was admitted to hospital a month before his death and that a family liaison officer was not appointed earlier to support Mr Watson and his family.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **April 2018**

Contents

Summary 1
The Investigation Process 3
Background Information 4
Findings 5

Summary

Events

1. On 23 March 2017, Mr Derek Watson received a four-year sentence for sexual offences and was sent to HMP Leicester. He was transferred to HMP Oakwood on 2 May.

2. Mr Watson had numerous complex healthcare needs which were being managed at HMP Oakwood in conjunction with the local hospital.

3. On 22 October, Mr Watson was admitted to hospital due to fluid retention and shortness of breath. He also was complaining about a lump on his chest. While in hospital he was diagnosed with terminal lung cancer. He did not return to prison after his diagnosis and died in hospital on 25 November.

Findings

4. The clinical reviewer has raised concerns about Mr Watson's long-term disease management. The prison's primary care team should have acted as the main co-ordinator of Mr Watson's care, as would be the case with primary care in the community. However, they did not do so. The investigation found uncoordinated management of his complex health needs between primary and secondary care by the prison.

5. After his diagnosis, Oakwood made plans to move Mr Watson to a hospice with the facilities to manage his needs. The prison also started the process for Mr Watson's release on compassionate grounds. Due to the rapid deterioration of his health, these plans were not seen through.

6. We are concerned that, despite Mr Watson's poor health and limited mobility, restraints were used when he went to hospital on 22 October and were not removed until 23 October. We are not satisfied that the use of restraints was justified by a fully considered risk assessment.

7. The prison assigned a family liaison officer on the day that Mr Watson died in hospital. However, he was diagnosed with lung cancer a month prior to his death. A family liaison officer should, therefore, have been appointed earlier to provide support to Mr Watson and his family.

Recommendations

- The Head of Healthcare should ensure that where a prisoner has complex health needs, there are regular, minuted multidisciplinary briefings involving all relevant healthcare staff.
- The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for 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 Director should ensure that a family liaison officer is appointed when a prisoner is assessed as seriously ill and that appropriate and timely arrangements are made for early contact with families.

The Investigation Process

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

9. The investigator obtained copies of relevant extracts from Mr Watson's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Watson's clinical care at the prison.

11. We informed HM Coroner for Staffordshire South of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

12. The investigator wrote to Mr Watson's former partner, to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.

13. The investigation has assessed the main issues involved in Mr Watson's 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 his compassionate release was considered.

Background Information

HMP Oakwood

14. HMP Oakwood is managed by G4S and is one of the largest prisons in England and Wales, providing places for around 2,100 male prisoners. Care UK provides the healthcare services, which include a daily GP clinic, some specialist services and out-of-hours GPs.

HM Inspectorate of Prisons

15. The last inspection of HMP Oakwood was conducted in December 2014. Inspectors reported that health services had improved considerably since the last inspection and, overall, were reasonably good. The range of services was appropriate and the management of prisoners with lifelong or complex health needs was very good, although staff shortages had led to a backlog of nurse reviews. Inspectors found that the healthcare rooms were well equipped and staff created appropriate care plans. However, there were often delays in arranging external hospital appointments because of the high demand and insufficient escort staff.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board made up of unpaid volunteers from the local community who help to help ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2017, the IMB reported that the transition to Care UK from the previous healthcare provider went well without major problems. Care UK had introduced clinics led by nurses on some wings due to the uncertainty arising from the change of healthcare provider. (Worcester Health and Care Trust provided healthcare services prior to April 2016.) There were also a high number of professional vacancies and the use of agency staff had lowered continuity of care.

Previous deaths at HMP Oakwood

17. Mr Watson was the fourteenth prisoner to die from natural causes at Oakwood since January 2016. We have made a previous recommendation about the inappropriate use of restraints.

Findings

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

18. Mr Watson was serving a four-year sentence and had been at HMP Oakwood since 2 May 2017. He had a long history of complex health issues prior to entering custody. These included high blood pressure, type 2 diabetes, glaucoma and asthma. In 2016, he had had a stroke and triple bypass heart surgery. Mr Watson had 14 different medications to treat his health issues.

19. On 25 May, Mr Watson was breathless and had fluid retention in his legs. A nurse sent Mr Watson to hospital by ambulance. The hospital diagnosed and treated him for heart failure.

20. On 2 June, Mr Watson's conditions were discussed at a multi-disciplinary team (MDT) complex care caseload meeting. This meeting is held between prison staff, including healthcare, and specialist hospital staff. On occasions the prisoner will also attend. The meeting aims to discuss and manage the complexities of the prisoner's health needs.

21. On 5 June, blood tests showed that Mr Watson had poor control of his diabetes and also showed the presence of inflammation in his body (a possible early indicator of cancer). The next day, a prison GP gave Mr Watson dietary advice and increased his insulin. He instructed that his blood sugar should be checked regularly.

22. On 15 June, Mr Watson attended the Accident and Emergency unit at hospital with very high blood sugar levels. A diabetes specialist nurse at the hospital, informed prison healthcare that Mr Watson did not understand diabetes or its management despite having been on insulin for several years. She advised prison healthcare staff to educate, support and monitor Mr Watson closely.

23. On 27 June, a senior nurse noted that Mr Watson had been removed from the MDT caseload on the grounds that he had no major health concerns although Mr Watson's care needs were complex and needed to be managed pro-actively.

24. On 21 July, the prison GP reviewed Mr Watson. He remained short of breath with fluid retention in his legs. He documented that he did not prescribe spironolactone to treat the fluid retention but re-prescribed furosemide, which was contrary to the hospital's advice.

25. On 24 July, a hospital consultant in respiratory medicine told prison GPs that Mr Watson should have a repeat chest x-ray a month later to check if his chest was congested. If Mr Watson's lungs were still congested, then a computerised tomography (CT) scan (which produces detailed images of many structures inside the body) would be advised to exclude the possibility of cancer.

26. On 28 July, the prison GP referred Mr Watson to the heart failure clinic as blood tests showed that he required specialist intervention. He also prescribed spironolactone as his fluid retention had worsened.

27. On 1 August, a consultant in diabetes conducted a telemedicine consultation, advised changes to Mr Watson's diabetes medication and advised ramipril to reduce his fluid retention.

28. On 7 August, Mr Watson was admitted to hospital with worsening heart failure that was not responding to treatment. He was discharged on 12 August with recommended changes to his medication.

29. Mr Watson continued to be treated for his health concerns, but the advice from the hospital about changes to his medication was not always adhered to by prison healthcare.

30. On 29 August, a consultant of medicine and care of the elderly, reviewed Mr Watson in a clinic at hospital. The consultant stated that a previous x-ray had shown a worsening of pleural effusion (water on the lungs). The consultant highlighted again that a CT scan should be performed if the issue of fluid on his lungs continued. This was to exclude cancer as previously advised in July.

31. On 6 September, a letter from the cardiology consultant stated that he was unhappy that Mr Watson had been discharged from hospital on 12 August before his pleural effusion had been resolved. He suggested that he be re-admitted if he continued to have uncontrolled heart failure.

32. On 25 September, another chest x-ray was completed and it showed that Mr Watson's lungs appeared congested in a way which was consistent with mild heart failure. There is no evidence of the recommended chest CT scan taking place as advised on 24 July and 29 August.

33. On 3 October, a hospital consultant cardiologist reviewed Mr Watson. He noted that he was still breathless but had no signs of heart failure. He said he was concerned about Mr Watson's kidney function and suggested a change in his medication. He also noted there was a bony lump on Mr Watson's chest which, if there were any changes, would need to be referred for investigation.

34. On 11 October, a second telemedicine consultation took place and the consultant advised increasing insulin and, again, advised starting ramipril for Mr Watson's fluid retention. However, prison GPs did not start Mr Watson on ramipril prior to his last admittance to hospital on 22 October.

35. On 22 October, Mr Watson was again very short of breath, with increasing fluid retention. A healthcare assistant, noted that Mr Watson was complaining about a lump on his upper chest, which was tender to the touch and had been increasing in size. She asked a paramedic who was already on site to review Mr Watson. As a result, another ambulance crew attended and Mr Watson was taken to hospital. In hospital, on 27 October, Mr Watson was diagnosed with lung cancer that had spread to his bones.

36. The clinical reviewer raised concerns about Mr Watson's long-term disease management as he had multiple and complex long-term conditions that were challenging to manage. A variety of prison GPs and hospital consultants were involved in managing his condition but the prison's primary care team did not appear to act as the main co-ordinator of care in the way that a primary care function would be expected to do in the community.

37. The clinical reviewer noted that it was unfortunate that Mr Watson was removed from the prison multi-disciplinary complex care caseload.

38. One of the most concerning issues that the lack of management caused was that on two occasions (24 July and 29 August) hospital consultants advised that Mr Watson should have a chest CT scan if he continued to have fluid in his lungs, to rule out cancer. However, there is no evidence that this happened.

39. The clinical reviewer concluded that Mr Watson's lung cancer may have been masked by the persistence of his symptoms of heart failure. As a result, once diagnosed, the condition was too advanced for him to benefit from any treatment. However, the clinical reviewer considers that although there were opportunities for an earlier diagnosis of lung cancer and this could have been beneficial, it would be impossible to say by how much. We make the following recommendation:

The Head of Healthcare should ensure that where a prisoner has complex health needs, there are regular, minuted multidisciplinary briefings involving all relevant healthcare staff.

Mr Watson's clinical care

40. Mr Watson was diagnosed with lung cancer while he was at hospital on 27 October. Due to the rapid deterioration of his condition, Mr Watson never returned to HMP Oakwood.

41. When Mr Watson was in hospital, healthcare staff at Oakwood kept in regular contact with hospital staff to remain updated on his condition. Healthcare staff were arranging the necessary medical equipment, such as breathing apparatus, to be made available for his return to Oakwood. However, Mr Watson's condition deteriorated and he died in hospital on 25 November with his family present.

42. The clinical reviewer did not comment on the care that Mr Watson received after diagnosis as he was in hospital.

Mr Watson's location

43. Mr Watson was at HMP Oakwood for nearly six months and was placed on normal location. His cell mate, healthcare and wing staff assisted him in managing his needs.

44. After Mr Watson was diagnosed with lung cancer, healthcare staff considered whether Oakwood was a safe or appropriate location to discharge Mr Watson back to from hospital. A couple of days prior to his death, arrangements were being made for him to go to a hospice in Wolverhampton, where a bed was available. Mr Watson's health declined rapidly before the arrangements could be finalised.

45. We are satisfied Mr Watson was appropriately located over the course of his illness.

Restraints, security and escorts

46. 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.

47. 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.

48. Mr Watson went to hospital on at least six occasions during his time at Oakwood. His risk assessment stated that he posed a medium risk to the public, and a low risk to hospital staff, hostage taking, escape and likelihood of outside assistance. Although the prison reviewed his risk and healthcare provided input on Mr Watson's changing health and the impact this had on his risk, the level of restraint was not changed in light of his deteriorating condition. As Mr Watson's health worsened, he continued to suffer from shortness of breath and limited mobility which would have mitigated his risk further.

49. On 22 October, Mr Watson was escorted to hospital. Two officers escorted him and he was restrained using single cuffs for the journey. When he was admitted, this was changed to an escort chain. (This is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) The following day his risk was re-assessed and the handcuffs were removed and were never reapplied.

50. Mr Watson was in a very poor condition and had little mobility when he was admitted to hospital for the final time on 22 October. The medical section of the last risk assessment prior to Mr Watson's last admission stated that there was no medical reason why Mr Watson should not be restrained and that he had the physical ability to escape unaided, but did not comment on the impact of his physical condition on his risk, as required by the High Court judgement. The security section noted that he was a medium risk to the public. A prison manager concluded that two officers should escort Mr Watson and restrain him. It is difficult to see, however, how Mr Watson was a risk of escape or of re-offending when he was in such a weak condition and escorted by two officers.

51. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. We do not consider that staff appropriately assessed Mr Watson's risk, or took fully into account his condition at the time. We make the following recommendation:

    The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for 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 Watson's family

52. On 25 November, the prison appointed a prison manager in Safer Custody as the family liaison officer. She visited the hospital and introduced herself to Mr Watson's next of kin, who were at his bedside. She answered any questions that they had.

53. On the same day, the family liaison officer returned to the hospital after hearing that Mr Watson had died. The family were present at the time of his death and were offered support.

54. Mr Watson's funeral was held on 2 January. The prison contributed to the funeral in line with national instructions.

55. Mr Watson was diagnosed with lung cancer on 27 October and although he was in hospital at the time of his diagnosis, the prison should have appointed a family liaison officer to support Mr Watson and his family earlier in line with PSI 64/2011. Although, his health deteriorated quickly, the support from a family liaison officer would have been beneficial as a central point of contact for the family and Mr Watson. We make the following recommendation:

    The Director should ensure that a family liaison officer is appointed when a prisoner is assessed as seriously ill and that appropriate and timely arrangements are made for early contact with families.

Compassionate release

56. 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.

57. The application process for compassionate release was started on 21 November however this was not completed due to his rapid decline and in the absence of a definitive prognosis. We are satisfied that compassionate release was appropriately considered.

Prisons & Probation
Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141