Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gary Watson a prisoner at HMP Hull on 30 July 2018

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*

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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.

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

Mr Gary Watson died of bilateral pneumonia (an infection of both lungs) as a result of pancreatic cancer on 30 July 2018 while a prisoner at HMP Hull. He was 57 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the care Mr Watson received at HMP Hull was of a good standard and equivalent to that which he could have expected to receive in the community. Prison healthcare staff responded appropriately to Mr Watson's deteriorating health. However, a prison GP should have referred Mr Watson for a specialist assessment under the urgent suspected cancer pathway. Although this did not affect the outcome for Mr Watson, it may affect other prisoners if urgent referrals are not made in future.

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

Sue McAllister CB
Prisons and Probation Ombudsman **February 2019**

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Summary

Events

1. On 17 December 2015, Mr Gary Watson was remanded to HMP Hull. The next day, he was sentenced to nine years in prison for sexual offences and returned to Hull.

2. In March 2017, Mr Watson saw a prison GP, as he had back pain and constipation. The GP referred him for a non-urgent appointment with a gastrointestinal specialist (a specialist in diseases of the digestive system). In April, Mr Watson saw another prison GP, who referred him urgently to the specialist.

3. Mr Watson had a number of tests and was found to have small growths in his colon. They were tested and, in September, he was told they were not cancerous. The specialist thought that his bowel problems were related to his diabetes medication, which was changed.

4. Mr Watson continued to have symptoms and, in late September, a prison GP made another non-urgent referral to the gastrointestinal team. Just over a week later, he was examined again by a prison nurse, and an urgent referral was made to the gastrointestinal team.

5. Mr Watson had more tests and, in December, he was told that he had advanced pancreatic cancer. In February 2018, a scan showed the cancer had got worse, and he started chemotherapy treatment in March. However, the treatment was stopped in April due to the side effects.

6. Mr Watson's health continued to deteriorate. He was admitted to hospital on 1 June, where he died on 30 July. Mr Watson's cause of death was established as bilateral pneumonia as a result of pancreatic cancer.

Findings

Clinical care

7. The clinical reviewer concluded that the care Mr Watson received at HMP Hull was of a good standard and equivalent to that which he could have expected to receive in the community. There is evidence that appropriate monitoring and assessment processes were in place to monitor and manage Mr Watson's pre-existing conditions. As a result, Mr Watson had access to services that met his individual health needs within the prison setting.

8. The clinical reviewer considered that on the whole, prison healthcare staff appropriately responded to Mr Watson's deteriorating health and sought advice and support from specialist services. Every effort was made to ensure that Mr Watson was appropriately accommodated during his illness and that his needs were considered.

9. When a prison GP examined Mr Watson on 18 September 2017, he did not refer him urgently for a specialist assessment using the NHS suspected cancer

pathway as he should have done. Although this did not affect the outcome for Mr Watson, it may affect other prisoners if the process is not followed in future.

Recommendations

- **The Head of Healthcare should ensure that prisoners identified with suspected cancer are appropriately referred for specialist assessment in line with guidance from the National Institute of Clinical Excellence (NICE).**

The Investigation Process

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

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

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

13. We informed HM Coroner for Hull of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. The investigator wrote to Mr Watson's son to explain the investigation and to ask if he had any matters he wanted us to consider. He responded to our letter and asked us to consider the timeliness of the prison referring Mr Watson to hospital for further investigation. Mr Watson's son received a copy of the draft report. He did not make any comments.

15. We have 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 compassionate release was considered.

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

Background Information

HMP Hull

17. HMP Hull is a local prison, which holds up to 1,056 prisoners in ten wings. City Healthcare Partnership provides health services at the prison. Hull closed its healthcare inpatient unit in October 2014, and it became the Wellbeing Unit to support prisoners with complex healthcare needs which are difficult to meet in a standard prison environment.

18. In August 2018, HMP Hull was selected to be part of the “10 Prisons Project”, which seeks to improve safety, security and decency in the prisons involved. The project is focusing on improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Hull was in April 2018. Inspectors found that healthcare provision was reasonable and governance was mostly effective, but some health services had deteriorated since the last inspection. They noted that the team offered an appropriate range of primary care clinics, within an acceptable timeframe. They found that social care assessments were timely and the provision was reasonably good.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year 2015, the IMB noted that Hull was managed effectively, provided a safe environment and benefited from strong leadership.

21. The IMB noted that prisoners had a full health screen at reception which identified immediate risks, and outpatient clinics to manage long-term medical conditions. However, the IMB had received many complaints from prisoners, mostly about medication and prescribing issues.

Previous deaths at HMP Hull

22. Mr Watson was the fifteenth prisoner to die at HMP Hull since July 2015, and the eleventh from natural causes. There are no similarities between Mr Watson’s death and the previous deaths from natural causes.

Findings

23. On 17 December 2015, Mr Watson was remanded to HMP Hull, charged with sexual offences. When he arrived, a nurse completed an initial health screen for Mr Watson and noted his medical history, which included Type 2 diabetes, a hiatus hernia (when part of the stomach squeezes into the chest through an opening in the diaphragm) and three previous strokes, which had left him with weakness on his right side. He also had depression, heartburn, eczema, high cholesterol and high blood pressure. The prison healthcare team managed these conditions.

24. On 18 December, Mr Watson was sentenced to nine years in prison. He returned to Hull.

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

25. On 8 March 2017, a prison physiotherapist examined Mr Watson as he had lower back pain. He told her that his bowel habits had changed and that he had a bloated, painful stomach which got worse after he had eaten. She found that his symptoms were not consistent with low back pain and referred him to a prison GP.

26. The following day, Mr Watson was examined by a prison GP. Mr Watson told him that he had a pain in his back which went from front to back and that he had wind and gas and had been constipated for the past two to three months. He said there was no blood in his stools. The GP did a rectal examination but found nothing of concern. He thought that Mr Watson may have indigestion but referred him for a non-urgent appointment with a gastrointestinal specialist (a specialist in diseases of the digestive system) because of the change in his bowel habits.

27. On 21 April, a nurse saw Mr Watson, who told her that the pain had got worse and that he was worried it was cancer. Another nurse asked a prison GP to examine him.

28. A prison GP did so later that day. Mr Watson told him that he had worsening pain in his back and groin, which radiated to his upper thighs. He said he also sometimes had blood in his stools. The GP referred him urgently to the gastrointestinal specialists at hospital under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

29. On 3 May, Mr Watson had a rigid sigmoidoscopy (a procedure to look at the rectum and lower large bowel) at the hospital. As the examination did not indicate any issues, Mr Watson was referred for a colonoscopy (a procedure to look at the entire large bowel).

30. On 5 June, Mr Watson had a colonoscopy. The examination identified a polyp (a small growth, usually benign, on a surface inside the body). Hospital staff could not take a biopsy (when a tissue sample is examined under a microscope) of it as Mr Watson was on blood-thinning medication which increased his risk of bleeding. They planned a further colonoscopy and advised Mr Watson to stop taking his blood-thinning medication a week before the procedure.

31. On 20 July, Mr Watson had another colonoscopy which identified small colonic polyps, which were removed for examination.

32. On 31 July, a consultant colorectal surgeon examined Mr Watson, and told him that the polyps showed no issues, but that the biopsy results were outstanding. The consultant thought that Mr Watson's bowel problems were related to his diabetes medication and arranged for Mr Watson's medication to be changed. Mr Watson was told that he would receive written confirmation of his biopsy results.

33. On 1 September, a prison GP told Mr Watson that the polyps that were removed were not cancerous and that the consultant colorectal surgeon did not need to see him again.

34. On 18 September, a prison GP examined Mr Watson again, as he still had abdominal pain and bleeding from his rectum despite the change of medication. He had also lost a significant amount of weight (10.3kg) since June. The GP made a non-urgent referral to the hospital's colorectal team (bowel specialists).

35. On 26 September, a nurse examined Mr Watson's abdomen and noted that he had lost a lot of weight, had ongoing abdominal pain and rectal bleeding. He referred him urgently to the gastrointestinal team at the hospital under the 2-week suspected cancer NHS pathway.

36. On 16 October, Mr Watson had a procedure to examine the rectum and lower colon. There was only evidence of haemorrhoids. The consultant colorectal surgeon then referred Mr Watson for a CT scan (a scan that uses x-rays and a computer to create a detailed image of the inside of the body) of his chest, abdomen and pelvis, which he had on 29 November.

37. On 12 December, the consultant colorectal surgeon told Mr Watson that he had advanced pancreatic cancer. He said that the tumour had gone through a major artery in the abdomen and was inoperable. He was told that a biopsy would be taken to confirm this and that he would be referred to the oncology team (specialists who treat people with cancer) to discuss palliative options. A biopsy was performed on 29 December.

38. On 15 January 2018, a member of the pancreatic surgical team told Mr Watson that the biopsy confirmed that he had pancreatic cancer, that his prognosis was very poor and could be a matter of months. He was told again that the oncology team would review his case and discuss palliative care.

Mr Watson's clinical care

39. On 19 February, a consultant oncologist told Mr Watson that another CT scan had shown that the cancer had progressed and that the most suitable treatment was palliative chemotherapy.

40. Mr Watson started chemotherapy in March 2018, but was admitted to hospital on 3 April 2018 as he had diarrhoea, lower abdominal pain and was being sick. Mr Watson was found to have low levels of white blood cells which help the body fight infection and are a common side effect of chemotherapy. His chemotherapy was stopped due to the side effects and he returned to Hull on 27 April.

41. Between March and May, Mr Watson lost 44kg in weight. On 24 May, the prison received a letter from a consultant oncologist, who confirmed that this was caused by malnutrition and Mr Watson not having enough calories. Prison healthcare staff tried to improve his nutritional intake by following a care plan which the hospital had recommended.

42. Hospital and prison healthcare staff put an end of life care plan in place for Mr Watson. On 27 April, prison healthcare staff referred Mr Watson for specialist palliative care support, which he received.

43. Mr Watson's health got worse and he was admitted to hospital on 1 June, where his health continued to deteriorate and he died on 30 July. Mr Watson's cause of death was established as bilateral pneumonia as a result of pancreatic cancer.

44. The clinical reviewer found that Hull had appropriate monitoring and assessment processes in place to manage Mr Watson's pre-existing medical conditions, and that he had access to services that met his health needs. She considered that overall, prison healthcare staff appropriately responded to Mr Watson's deteriorating health and sought advice and support from specialist services. This ensured that Mr Watson received appropriate care from specialist services. The clinical reviewer also found that every effort was made to ensure that Mr Watson was appropriately accommodated during his illness and to ensure that his emotional, psychological, social, cultural and spiritual needs were considered.

45. The clinical reviewer made other recommendations in her report, which the Head of Healthcare will need to address.

46. Mr Watson's health began to deteriorate in March 2017, but it was not until December 2017 that he received a formal diagnosis. The clinical reviewer said that pancreatic cancer can be difficult to diagnose as symptoms can be vague and there are not many specific symptoms in the early stages.

47. Guidance from the National Institute of Clinical Excellence (NICE) on recognising and referring cases of suspected cancer says that people who present with unexplained weight loss, should be urgently investigated or referred under the suspected cancer pathway for an appointment within 2 weeks. NICE guidelines suggest that adults should be referred using a suspected cancer pathway (for an appointment within 2 weeks) for colorectal cancer if they are over 40 years old, with unexplained weight loss and abdominal pain.

48. On 18 September 2018, Mr Watson presented with ongoing rectal bleeding, abdominal pain and weight loss. A prison GP's decision to refer Mr Watson for a non-urgent appointment with a specialist on 18 September was not therefore in line with NICE guidelines.

49. The clinical reviewer concluded that it would not have changed the outcome for Mr Watson (as he was appropriately referred on 26 September), but noted the risk of harm to other prisoners if the process was not followed.

50. Given Mr Watson's symptoms and the national guidelines, we consider that he should have been urgently referred using the suspected cancer pathway and recommend that:

The Head of Healthcare should ensure that prisoners identified with suspected cancer are appropriately referred for specialist assessment in line with guidance from the National Institute of Clinical Excellence (NICE).

Mr Watson's location

51. When Mr Watson arrived at Hull, a nurse noted during his initial health screen that he was able to care for himself independently and assessed him as suitable to be located on a standard wing.

52. Mr Watson had supportive friends on his wing and wanted to live there for as long as possible. However, after he started chemotherapy, he agreed to move to the Wellbeing Unit on 6 March 2018 so that healthcare staff could care for him in an appropriate environment.

53. On 18 May, Mr Watson told a Macmillan Nurse that if he was not released early from prison on compassionate grounds, he wanted to die in a hospice. We are satisfied that prison healthcare staff took account of his views. They referred him to a hospice after his application for early compassionate release was turned down, but there were no beds available and a long waiting list. They asked Mr Watson to consider a different hospice, but it was too far for his family to travel. Therefore, Mr Watson continued to receive palliative care in hospital.

Restraints, security and escorts

54. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's health and mobility.

55. When Mr Watson was transferred to hospital on 1 June, no restraints were used and he was escorted by two officers. The Escort Risk Assessment documented that he had been to hospital for treatment on many occasions, with no need to use restraints. It also noted medical objections to the use of restraints as Mr Watson had been diagnosed with terminal cancer, was receiving palliative care and was very frail. We are satisfied that prison and healthcare staff took Mr Watson's health and mobility into consideration appropriately.

Liaison with Mr Watson's family

56. Mr Watson had regular contact with his son, who was his next of kin, and other members of his family.

57. On 13 December 2017 (the day after Mr Watson was told that he had pancreatic cancer), the prison appointed a family liaison officer (FLO).

58. On 15 December, the FLO introduced herself to Mr Watson and contacted his son to explain her role and offer support. She developed a good relationship with Mr Watson and his family. She visited him frequently throughout his illness and was in regular contact with his family. She kept the family informed about his

health and location, facilitated visits and their attendance at meetings with the healthcare team.

59. After learning that Mr Watson had died, the FLO visited the hospital, where she offered her condolences and support to Mr Watson's son. On 31 July, she and a prison manager visited Mr Watson's son.

60. Mr Watson's funeral took place on 16 August and Hull contributed to the costs in line with national instructions.

61. Hull held a memorial service for Mr Watson in the chapel on 4 September, which Mr Watson's family attended.

62. We consider that Hull provided Mr Watson and his family with a high level of support throughout his illness.

Early compassionate release

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

64. Between December 2017 and May 2018, staff at Hull held seven meetings to discuss the suitability of early compassionate release for Mr Watson, but did not make the application as they did not have a clear clinical prognosis. On 21 May, the prison applied to the Public Protection Casework Section (PPCS) at HM Prisons and Probation Service, but Mr Watson's application was refused as he was deemed not to meet the criteria.

65. We are satisfied that Hull appropriately considered Mr Watson's suitability for early compassionate release, and submitted the application to the PPCS in a timely manner.

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