

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Watson a prisoner at HMP Isle of Wight on 26 December 2018

A report by the Prisons and Probation Ombudsman

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 Edward Watson died on 26 December of heart failure and cancer of the oesophagus while a prisoner at HMP Isle of Wight. He was 71 years old. I offer my condolences to Mr Watson's family and friends.

I am satisfied that the care Mr Watson received at Isle of Wight was equivalent to that he could have expected to receive in the community. I commend the clinical staff at Isle of Wight for the compassionate end of life care Mr Watson received.

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

August 2019

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Summary

Events

1. Mr Edward Watson was serving a sentence of 15 years imprisonment for sexual offences. He arrived at HMP Isle of Wight on 13 October 2015. He was diagnosed with hypertension (high blood pressure) and pain in his knees. On arrival, he told a prison doctor that he had difficulty swallowing and had been vomiting. He was referred urgently to the gastroenterology service.
2. On 12 November 2015, Mr Watson was diagnosed with cancer of the oesophagus. In January 2016, he had an operation to remove the tumour and recovered well. On 14 September 2017, he told a doctor that he was again having trouble swallowing and in October, was informed that the cancer had returned. Mr Watson decided not to have chemotherapy but receive palliative care instead.
3. Mr Watson was cared for in the inpatient healthcare unit at Isle of Wight. He was given regular checks by clinical staff and any problems were addressed promptly. When required, his cell was unlocked permanently to allow nursing staff free access to care for him.
4. A compassionate release application was submitted promptly for Mr Watson but it was not approved by the Secretary of State. Prison staff stayed in regular contact with Mr Watson's family and provided updates on his condition.
5. Mr Watson's condition deteriorated in December 2018. He developed a cough and became short of breath. On 26 December, at 8.54am, Mr Watson was found to be not breathing. At 11.09am, a doctor confirmed that he had died.

Findings

6. The clinical reviewer concluded that the care that Mr Watson received was equivalent to that he could have expected to receive in the community. We agree with the clinical reviewer's finding and commend the prison for providing compassionate end of life care.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Isle of Wight 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 Watson's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Watson's clinical care at the prison.
10. We informed HM Coroner for Isle of Wight of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. The investigator wrote to Mr Watson's partner and brother to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They did not respond to our letters.
12. 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 compassionate release was considered.
13. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

Background Information

HM Prison Isle of Wight

14. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany, and holds approximately 1,100 men, mostly convicted of sex offences. Care UK provides healthcare services at the prison. There is a healthcare inpatient unit at the Albany site, providing 24-hour care for prisoners with a wide range of health needs. The inpatient unit includes special facilities for end of life care.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Isle of Wight was conducted in June 2015. Inspectors reported that health services were good and that the inpatient unit provided compassionate care to men with complex needs. Prisoners with palliative and end of life needs received excellent care.

Independent Monitoring Board

16. 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 to December 2017, the IMB said that overall healthcare provided at the prison was at least as good as that provided to the wider population. There was an ongoing shortage of nurses, however, with bank and agency staff covering the shortfall.

Previous deaths at HMP Isle of Wight

17. There have been 18 deaths from natural causes and three self-inflicted deaths at Isle of Wight in the last three years. There are no parallels to be drawn with these cases.

Findings

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

18. Mr Edward Watson was serving a 15-year sentence of imprisonment for sexual offences. He arrived at HMP Isle of Wight on 13 October 2015. He was diagnosed with hypertension (high blood pressure) and pain in his knees. This was noted on his reception assessment.
19. Mr Watson was seen by a prison GP the same day. Mr Watson told him that he had problems swallowing and had been vomiting. The GP made an urgent referral to the gastroenterology service under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. Mr Watson had an endoscopy (a procedure to look inside the body) and a report was sent to the prison on 26 October. This showed that Mr Watson had a tumour restricting his oesophagus (the tube connecting the mouth to the stomach). On 12 November, the GP received Mr Watson's pathology results and told him he had cancer of the oesophagus.
20. On 25 January 2016, Mr Watson had an operation to remove the tumour. His recovery went well and, in May, Mr Watson was discharged from the inpatient healthcare unit back to a residential wing.
21. In September 2016, Mr Watson was referred to an orthopaedic clinic due to the pain in his knees. He was listed for a left total knee replacement which took place in July 2017. After his surgery he had a period of recovery in the inpatient unit at Isle of Wight. Mr Watson told a prison GP in November 2016 that he was concerned that a tremor in his hands was the onset of Parkinson's disease. The GP referred him for a neurological assessment where Mr Watson was told in May 2017 that his symptoms were benign.
22. On 14 September 2017, Mr Watson told a prison GP that he had difficulty swallowing and the GP referred him for tests under the two-week rule. On 26 October 2017, the GP told Mr Watson that a CT scan showed that his cancer had recurred and had spread to his vocal chords and possibly his lungs.
23. On 20 December 2017, Mr Watson saw an oncologist and decided not to have chemotherapy but palliative care instead.
24. We are satisfied that Mr Watson's illness was diagnosed appropriately and without delay.

Mr Watson's clinical care

25. On 28 December 2017, Mr Watson transferred into the inpatient healthcare unit for better pain management. On 2 January 2018, Mr Watson said he did not want to be resuscitated if his heart or breathing stopped. He signed an order to that effect.
26. In early February 2018, a prison GP arranged an assessment of Mr Watson's condition by a local hospice. They found that he was not ill enough for a transfer to a hospice at that time.

27. Mr Watson remained in the prison's inpatient unit and was reviewed frequently by clinical staff. Any new complaints were addressed quickly. In May 2018, Mr Watson's pain was increasing and his medication was changed to a stronger opioid medication. He could look after himself independently, on the whole, and was able to eat his meals in the dining room on the unit with the use of a wheelchair.
28. Mr Watson's condition began to deteriorate in December 2018. He developed a cough and became short of breath. On 20 December, anticipatory palliative care pain relief medication was prescribed. On 22 December, Mr Watson was confused and had a fall without significant injury. His palliative care pain relief medication was started later that day. On 25 December, clinical staff noted that Mr Watson had increasingly laboured breathing and was not responding to questions. He was checked frequently by staff.
29. On 26 December, at 8.54am Mr Watson was found to be not breathing. His death was confirmed by a prison GP at 11.09am.
30. The post-mortem report found the cause of Mr Watson's death to be: 1a) cardiac failure, and 1b) carcinoma of the oesophagus.
31. The clinical reviewer found the care that Mr Watson received was equivalent to that he could have expected to receive in the community. The clinical reviewer stated that Mr Watson received good compassionate care at Isle of Wight and we commend the healthcare staff for the end of life care they provided.

Mr Watson's location

32. On 3 February 2016, Mr Watson returned to the inpatient healthcare unit at Isle of Wight after the operation to remove the tumour in his oesophagus. Due to a positive prognosis and good recovery from his surgery, Mr Watson moved back to a general residential wing on 19 May. Mr Watson had a further stay in healthcare following knee replacement surgery in July 2017 and finally moved back to healthcare on 28 December 2017 for better pain management and palliative care.
33. Mr Watson was cared for in the palliative care suite and, on 11 January 2018, his cell was unlocked 24 hours a day to allow nursing staff to freely access his cell, because he was very unwell. This decision was revoked after Mr Watson was found accessing the association room at 5.00am one morning. The decision to keep Mr Watson's cell unlocked was reviewed regularly, his cell was left unlocked on 17 February but locked again on 25 May when his condition improved. His cell was permanently unlocked for the final time on 20 December.
34. We are satisfied that Mr Watson was located appropriately during his illness.

Restraints, security and escorts

35. 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.

36. On 7 September 2018, Mr Watson attended hospital for an appointment. No restraints were applied during the transfer due to Mr Watson's ill health. We agree with the prison's decision not to restrain Mr Watson on this occasion.

Liaison with Mr Watson's family

37. On 2 November 2017, two prison officers were appointed as family liaison officers and introduced themselves to Mr Watson. They visited Mr Watson regularly during his illness. The family liaison officers made early contact with Mr Watson's partner and kept in touch with her about his condition, providing updates when available.
38. Mr Watson's partner, who was unwell and unable to travel from Leeds to the Isle of Wight, told the family liaison officers that she wanted to be kept updated about his condition and informed of his death when it occurred. One of the family liaison officers called Mr Watson's partner on the day he died to inform her of his death. While it is generally preferable for a prison to provide information of a prisoner's death to a next of kin in person, in this instance, Mr Watson's family had a good relationship with the prison family liaison officer and had asked to be updated by telephone. We make no criticism.
39. The family liaison officers kept in touch with Mr Watson's family and helped with the funeral arrangements. The prison contributed to the cost of the funeral in line with national policy.

Compassionate release

40. 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. On 8 February 2018, Mr Watson received notification that release on compassionate grounds had not been approved by the Secretary of State for Justice as he did not meet the criteria on his risk of reoffending.
41. Prison staff discussed a possible transfer for Mr Watson to a prison closer to his home, but a place could not be secured. Following this outcome, Mr Watson said that he wanted to die at HMP Isle of Wight. We are satisfied that the prison acted appropriately with regard to compassionate release.

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