

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edwin Wallis a prisoner at HMP Whatton on 9 December 2019

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*



© 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.

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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Edwin Wallis died in Nottingham City Hospital on 9 December 2019 of bronchopneumonia and metastatic lung cancer while a prisoner at HMP Whatton. Mr Wallis was 69 years old. I offer my condolences to Mr Wallis' family and friends.
4. The clinical reviewer concluded that the clinical care Mr Wallis received at HMP Whatton was equivalent to that he could have expected to receive in the community. She made one recommendation.
5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Wallis' clinical care at HMP Whatton.
7. The PPO investigator has investigated non-clinical issues, including Mr Wallis' location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Wallis' next of kin, his ex-wife and son, to explain the investigation. They did not respond to our letter.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Whatton

10. Mr Wallis was the 12th prisoner to die at Whatton since December 2017, all from natural causes. Two of these deaths were caused by pneumonia. There are no similarities between our findings in the investigation into Mr Wallis' death and our investigation findings for the previous deaths.

Key Events

11. On 2 December 1988, Mr Edwin Wallis was sentenced to life imprisonment for sexual offences and taken to HMP Albany. He transferred to HMP Whatton on 31 August 2006.
12. Mr Wallis had heart disease, and in 2007 had a surgical procedure to restore normal blood flow to an obstructed coronary artery. He also had chronic obstructive pulmonary disease (COPD, a lung condition), type 2 (diet controlled) diabetes, high blood pressure and arthritis. These conditions were managed appropriately with regular healthcare reviews.
13. In 2008, Mr Wallis was diagnosed with bladder cancer. This was successfully treated with immunotherapy. He had two further episodes of bladder cancer in 2010 and 2015. On 17 March 2015, Mr Wallis was told that his cancer had spread to his lymph nodes. On 5 June, he received palliative chemotherapy. This treatment was successful and in September 2015 his oncologist confirmed that his bladder cancer appeared to be in remission. In February 2017, examination of his bladder and urethra showed no obvious abnormalities.
14. In October 2018, Mr Wallis was recommended for release by the Parole Board. This was put on hold when he was admitted to hospital after having a stroke. As a hospital inpatient he was unable to fulfil the Parole Board's licence conditions for release. It was explained that he needed appropriate healthcare support in place before release could be reconsidered.
15. On 15 July 2019, Mr Wallis attended City Hospital, Nottingham, for a ureteroscopy, (a procedure to examine his bladder, ureter and kidneys). Mr Wallis was not restrained during the escort to hospital. They could not carry out the procedure as his bladder was scarred from previous chemotherapy treatment. Doctors told Mr Wallis that, because they could not confirm that his cancer had spread, they would monitor him closely. A CT scan (a scan that produces detailed images of inside the body) of his chest abdomen and pelvis was booked for February 2020.
16. Mr Wallis was taken to City Hospital by ambulance on 12 November, after a suspected stroke. He was not restrained during the escort to hospital. On 18 November, while still an inpatient Mr Wallis had a chest CT scan. Scan results later confirmed that Mr Wallis had lung cancer.
17. Mr Wallis was discussed at the hospital's multi-disciplinary team meeting on 20 November, to decide on a plan of care. Mr Wallis said that he did not wish anyone to resuscitate him if his heart or breathing stopped and on 26 November signed an order to that effect. He needed a nebulizer to help him breathe.
18. On 6 December, a hospital doctor confirmed that there was no further treatment and asked the prison if they would accept Mr Wallis back for palliative care. The hospital said Mr Wallis' life expectancy was 'weeks'.
19. Mr Wallis was due to be discharged back to Whatton on 9 December. A discharge plan was agreed and specialised medical equipment was in place to meet his care needs. The duty governor visited Mr Wallis in hospital on 8

December. She spoke to Mr Wallis' named nurse who confirmed that in his current condition he would no longer be fit enough for discharge. Mr Wallis died on the morning of 9 December at 2.55am.

20. Mr Wallis died from pneumonia. There is no evidence that Mr Wallis was suffering with a chest infection or breathing problems before his transfer to hospital on 12 November. The clinical reviewer wrote that Mr Wallis probably caught pneumonia while in hospital.
21. An application for early release on compassionate grounds was not made before Mr Wallis' death. After he was discharged from hospital in December 2018 (following his first stroke), extensive work was done with healthcare, and social care services to find appropriate supported accommodation suitable for release. Mr Wallis was given a life expectancy of weeks on 6 December 2019, three days before he died. He was due to be discharged back to the prison and the speed of his deterioration was unexpected.
22. The prison's family liaison officer (FLO) contacted Mr Wallis' ex-wife, his next of kin on 20 November, after his cancer diagnosis. She asked to be kept informed of his condition and contacted by telephone only. The FLO telephoned Mr Wallis' ex-wife on 9 December when he died. The prison arranged Mr Wallis funeral at his ex-wife's request.

Post-mortem report

23. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Wallis' cause of death as bronchopneumonia caused by metastatic lung cancer. He also suffered an acute ischaemic stroke, had bladder cancer and ischaemic heart disease, which did not cause but contributed to his death.

Karen Johnson
Prisons and Probation Assistant Ombudsman

June 2020

**Prisons &
Probation**

Ombudsman
Independent Investigations