

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Michael Addison, a prisoner at HMP Isle of Wight, on 2 March 2021**

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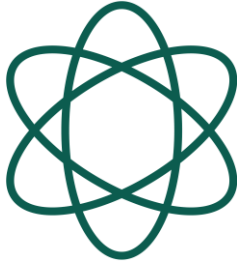
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## Our vision

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

**OGL**

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## 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 Michael Addison died of cardio-respiratory failure (insufficient oxygen in the blood) as a result of bladder cancer on 2 March 2021 at HMP Isle of Wight. He also had severe chronic obstructive pulmonary disease (COPD) and pulmonary fibrosis (both lung diseases), as well as chronic kidney disease, which contributed to but did not cause his death. He was 65 years old. We offer our condolences to his family and friends.
4. The clinical reviewer found that the clinical care that Mr Addison received at Isle of Wight was of a good standard and equivalent to that which he could have expected to receive in the community. She found many examples of good practice, and noted that his clinical care was person-centred, holistic and aimed to promote his comfort and dignity. She made a recommendation which did not directly relate to Mr Addison's death but which the Head of Healthcare will need to address.
5. We did not identify any non-clinical issues of concern and we make no recommendations.

## The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Addison's clinical care at HMP Isle of Wight.
7. The PPO investigator has investigated the non-clinical issues in Mr Addison's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The Ombudsman's family liaison officer wrote to Mr Addison's wife to explain our investigation. She did not respond.
9. We shared the initial report with the Prison Service. There were no factual inaccuracies.

## Previous deaths at Isle of Wight

10. Six prisoners died from natural causes at HMP Isle of Wight in the two years before Mr Addison's death, one of the deaths was related to COVID-19. Nine prisoners have died from natural causes at Isle of Wight since Mr Addison's death, two of those deaths were related to COVID-19. There are no significant similarities between our findings in this investigation and those of the other deaths.

## Key Events

11. In December 2017, Mr Michael Addison was sentenced to 14 years in prison for sex offences. On 2 May 2019, he was transferred to HMP Isle of Wight. He had diverticulitis (a digestive condition), asthma, depression and COPD.
12. On 6 November 2019, Mr Addison told a prison GP that he was passing urine more frequently at night. The GP arranged for blood tests. On 11 December, the GP told Mr Addison that he had an enlarged prostate.
13. On 13 December, Mr Addison told prison staff that he had blood in his urine. On 2 January 2020, a prison GP referred Mr Addison to the hospital urology department under the two-week suspected cancer pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. On 11 January, Mr Addison was diagnosed with bladder cancer.
14. On 2 March, Mr Addison's bladder tumour was removed at hospital. On 20 March, a prison nurse spoke to a hospital urology cancer specialist nurse who told her that Mr Addison's cancer had spread to the bladder wall and that he would need to have his bladder removed.
15. On 27 April, Mr Addison went to hospital for a pre-operation assessment. A CT scan showed that the tumour had grown. On 1 May, Mr Addison returned to hospital and had his bladder removed and a stoma bag put in place to divert urine. On 7 May, Mr Addison went back to Isle of Wight.
16. On 28 August, after a CT scan, a nurse noted that Mr Addison's cancer had returned and that he would need chemotherapy.
17. On 29 October, Mr Addison declined chemotherapy.
18. On 2 March 2021, Mr Addison died. A post-mortem examination found that he died from cardio-respiratory failure as a result of bladder cancer. He also had severe COPD, pulmonary fibrosis and chronic kidney disease which contributed to but did not cause his death.

**Caroline Mills**  
**Assistant Ombudsman**

**March 2022**

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