Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Waterworth, a prisoner at HMP Leyhill, on 13 July 2022

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

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 Peter Waterworth, who was 73 years old, died of small bowel obstruction and cancer on 13 July 2022, while a prisoner at HMP Leyhill. We offer our condolences to Mr Waterworth's family and friends.

4. The clinical reviewer concluded that the care Mr Waterworth received at HMP Leyhill was of a good standard and equivalent to that which he could have expected to receive in the community. She was, however, concerned that Mr Waterworth's weight was not recorded during his first and secondary health screen, and that there is no evidence that screening related to the Bowel Screening Programme at the prison was recorded in line with National Prevention Compliance. We repeat her recommendations below.

5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that all prisoners at reception or secondary screening have their weight recorded as part of their initial assessments which will allow baseline recording and accurate reviews.

- The Head of Healthcare and the Primary Care Lead should ensure that screening related to the Bowel Screening Programme is recorded in line with National Prevention Compliance guidance.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Waterworth's clinical care at Leyhill.

7. The PPO investigator has investigated non-clinical issues, including Mr Waterworth's 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 telephoned Mr Waterworth's next of kin, his brother, to explain the investigation. He did not respond.

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

Previous deaths at HMP Leyhill

10. Mr Waterworth was the eighth prisoner to die at Leyhill since July 2020. All of the previous deaths were from natural causes. There are no similarities between our findings in the investigation into Mr Waterworth's death and our investigation findings for the previous deaths.

Key Events

10. On 13 December 2000, Mr Peter Waterworth was charged with murder and sentenced to life imprisonment. He was sent to HMP Gartree.

11. Mr Waterworth had several pre-existing medical conditions, including diabetes, ischaemic heart disease, osteoarthritis, which caused him mobility issues, high blood pressure (hypertension) and sciatica. He also had a history of alcohol misuse.

12. On 18 March 2018, Mr Waterworth was released from prison on licence and went to live in an Approved Premises (AP). In March 2019, he was recalled to prison for breaching the AP rules and was sent to HMP Exeter.

13. Healthcare care staff completed Mr Waterworth's initial and secondary health screens and noted his medical conditions. They created care plans and referred him to long-term clinics to manage his conditions. Mr Waterworth had little significant contact with healthcare over the years that followed.

14. On 26 January 2021, an entry in Mr Waterworth's medical records indicated that he was offered an NHS bowel screening kit (a test which looks for early indicators of bowel cancer). However, it is not clear from his medical records if Mr Waterworth took the test. Nor is it clear if he refused the test what actions healthcare staff took to encourage him to comply.

15. On 25 February, Mr Waterworth was transferred to HMP Leyhill.

16. A nurse carried out an initial health screen. She referred Mr Waterworth to the prison's substance misuse team and long-term clinics to ensure continuity of his care. She did not record his weight as she should have done. Healthcare staff reviewed and updated his care plans and prescribed medications. Healthcare staff conducted reviews regularly in the months that followed.

17. On 10 March 2022, a nurse saw Mr Waterworth after he reported severe abdominal pain. She recorded his observations, and they were within a normal range. She also noted that he was overweight, but that his stomach was soft and did not appear swollen. She referred him to a prison GP for further review.

18. Later that day, a prison GP saw Mr Waterworth. She carried out a faecal calprotectin test (a stool test) and the result was within a normal range. However, blood test results showed that there was a decline in his kidney function. She considered that in case of a further decline, he needed further blood tests and ongoing monitoring. She reviewed Mr Waterworth again on 15 March. She carried out a fecal occult blood test (a test carried out to check for signs of blood in the stools, which can be an early indicator of colon or bowel cancer). The result showed that there were traces of blood in his stools.

19. A few days later, a prison GP saw Mr Waterworth. He told her that he was still experiencing abdominal pain and that he could not get comfortable. He said that he felt like he had a blockage of some sort. She made a two week wait referral to the gastroenterology clinic at the hospital.

20. On 22 March, Mr Waterworth was taken to hospital for a CT (computerised tomography) scan. The result indicated that he had a swollen kidney due to the build-up of urine. The scan also showed evidence of possible colon and peritoneal cancer (peritoneal is the thin layer of tissue that lines the abdomen) and he needed to undergo further tests to confirm the diagnosis. Mr Waterworth returned to Leyhill later that day.

21. The next day, on 23 March, healthcare staff held a multidisciplinary team meeting to discuss the care Mr Waterworth may need as his condition deteriorated. The meeting referred him to the prison's Mental Health Inreach team to offer him support, and a care plan was devised to manage his care. Healthcare staff reviewed Mr Waterworth regularly, including checking his weight to help monitor his condition.

22. On 18 May, a prison GP saw Mr Waterworth after he complained of severe abdominal pain, nausea, and a raised temperature. The GP explained the importance of undergoing the colonoscopy and endoscopy, and Mr Waterworth agreed. The GP asked Mr Waterworth about his wishes should he have a cardiac arrest. He told the GP that he did not wish to be resuscitated and signed an order to that effect.

23. Later that day, Mr Waterworth's abdominal pain worsened, and he was taken to hospital by emergency ambulance. He was admitted to hospital as an inpatient and had an endoscopy and biopsy. The results showed that he had developed stage four cancer. Hospital staff considered that the only treatment option open to Mr Waterworth was palliative care. He was discharged from hospital and returned to Leyhill on 28 May.

24. On 30 May, a prison GP saw Mr Waterworth. She noted that he was experiencing bouts of confusion and as a result he was forgetting to take his pain relief medication as prescribed. She prescribed him pain relief in the form of patches. She also noted that his weight had dropped by sixteen kilos in three months. The following day, a nurse spoke with hospital staff, who informed her that the biopsy results confirmed that Mr Waterworth had developed stage four cancer. Hospital staff also informed her that he had a bowel obstruction and that he would need to undergo a surgical procedure to insert a stent.

25. On 15 June, a nurse telephoned hospital staff for an update on the results of his endoscopy. The results confirmed that Mr Waterworth had terminal cancer. They told her that he would be informed of his prognosis at his next appointment, but that the cancer had spread to his appendix, bowel, and peritoneal cavity (the space within the body that contains the intestines and the liver). She asked if she could discuss the spread of his cancer with him so it would not be a shock when he spoke with hospital staff. They agreed.

26. The following day on 16 June, Mr Waterworth's abdominal pain worsened. He was taken to hospital by emergency ambulance and was admitted to hospital as an inpatient. Hospital staff informed Mr Waterworth that he had a prognosis of less than three months to live.

27. On 4 July, the prison applied for release on compassionate grounds on Mr Waterworth's behalf. The application was refused because of the risk Mr Waterworth posed in relation to his history of alcohol misuse.

28. Mr Waterworth's condition continued to deteriorate in hospital.

29. At 12.20pm on 13 July, a hospital doctor confirmed that Mr Waterworth had died.

Cause of death

30. The coroner accepted the cause of death as provided by a hospital doctor and no post-mortem was carried out. The doctor gave Mr Waterworth's cause of death as small bowel obstruction and metastatic adenocarcinoma (cancer).

Inquest into Mr Waterworth's death

31. The inquest into Mr Waterworth's death was held on 27 June 2023 and a verdict of natural causes was recorded.

32. The coroner concluded Mr Waterworth's death was due to small bowel obstruction and metastatic adenocarcinoma.

Lisa Burrell **July 2023**
Assistant Ombudsman

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