

**Prisons &
Probation**

Ombudsman
Independent Investigations

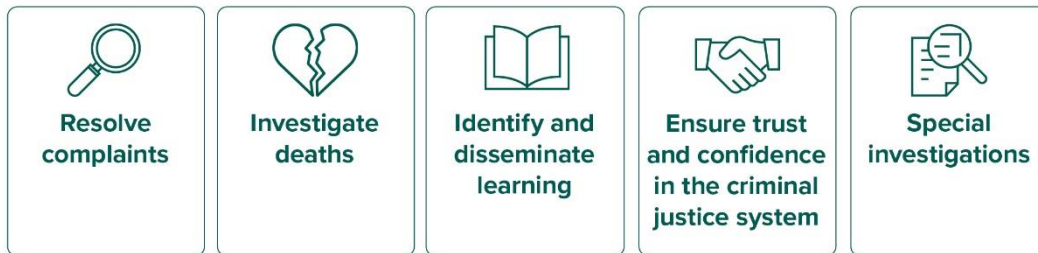
Independent investigation into the death of Mr Keith Wathen, a prisoner at HMP The Verne, on 28 December 2022

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



© Crown copyright, 2024

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. Mr Keith Wathen died in hospital from lung cancer on 28 December 2022, while a prisoner at HMP The Verne. He was 67 years old. We offer our condolences to Mr Wathen's family and friends.
4. Mr Wathen died within one month of being diagnosed with lung cancer. He had shown no obvious symptoms and was only diagnosed because he went into hospital for a planned operation on his arm.
5. The clinical reviewer concluded that the clinical care Mr Wathen received at The Verne was good and equivalent to that which he could have expected to receive in the community. She made no recommendations.
6. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

7. HMPPS notified us of Mr Wathen's death on 28 December 2022.
8. NHS England commissioned an independent clinical reviewer to review Mr Wathen's clinical care at The Verne.
9. The PPO investigator investigated the non-clinical issues relating to Mr Wathen's care, including Mr Wathen's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
10. The PPO family liaison officer wrote to Mr Wathen's next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

Previous deaths at HMP The Verne

12. Mr Wathen was the 15th prisoner to die at The Verne since December 2019. Of the previous deaths, 13 were from natural causes and one is awaiting classification.

Key Events

13. On 23 September 2022, Mr Keith Wathen was sentenced to four years imprisonment for sexual offences and was sent to HMP Winchester. On 25 October 2022, he was transferred to HMP The Verne.
14. When Mr Wathen arrived at The Verne, he had been suffering from pain in one of his elbows for just over a year and was waiting for an operation to take the pressure off a nerve. He was prescribed pain killers for this and statins for high cholesterol but had no other diagnosed medical conditions. He had been a heavy smoker for many years.
15. On 26 November, Mr Wathen was unwell with chest pains and healthcare staff suspected he was having a heart attack and called an ambulance. However, no heart abnormalities were found and Mr Wathen returned to prison the same day.
16. On 29 November, Mr Wathen returned to hospital for the operation on his arm. At the hospital, Mr Wathen told a doctor about his visit to hospital a few days earlier with chest pains and said he had some pain that day. The doctor established that X-rays had been taken in hospital three days previously but had not been analysed. Further X-rays and scans were carried out which showed that Mr Wathen had a mass on his lung. Hospital staff cancelled Mr Wathen's operation and sent a task to his GP asking them to make an urgent suspected cancer referral to the respiratory team.
17. The next day, a GP at The Verne made the suspected cancer referral. Mr Wathen was seen by a respiratory consultant in hospital on 2 December. Mr Wathen was diagnosed with advanced lung cancer and he was immediately transferred to another hospital for radiotherapy.
18. On 6 December, Mr Wathen returned to The Verne, but was unwell the following day. Prison healthcare staff consulted the hospital that was treating Mr Wathen, and they advised that he return to hospital for checking.
19. Mr Wathen was admitted to hospital and due to the pressure of a tumour on his throat had great difficulty swallowing and had to be fed through a tube. On 22 December, the hospital said that Mr Wathen only had weeks left to live and the prison began an application for Mr Wathen's early release on compassionate grounds.
20. However, the next day following further deterioration in Mr Wathen's condition, his prognosis was revised by the hospital who said it could now be only a few days before he died.
21. On 27 December at around 11.10pm, Mr Wathen stopped breathing. His death was certified in the early hours of 28 December.

Post-mortem report

22. A post-mortem examination found that Mr Wathen died from bilateral bronchopneumonia (inflammation of both lungs leading to difficulty in breathing), which was caused by left sided advanced lung cancer. The pathologist noted Mr Wathen's history of heavy smoking.

Adrian Usher
Prisons and Probation Ombudsman

August 2023

Inquest

The inquest, held on 30 November 2023, concluded that Mr Wathen died from natural causes.

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100