Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robin Matthews, a prisoner at HMP Isle of Wight, on 1 April 2023

A report by the Prisons and Probation Ombudsman

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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

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, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Robin Matthews died of heart failure on 1 April 2023, at HMP Isle of Wight. He was 68 years old. We offer our condolences to Mr Matthews' family and friends.

4. The clinical reviewer concluded that the clinical care Mr Matthews received at Isle of Wight was partially equivalent to that which he could have expected to receive in the community. She found that Mr Matthews' end of life care was compassionate and reactive to his needs, but she made several recommendations about his wider clinical care which the Head of Healthcare will need to address.

5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Matthews' death on 1 April 2023.

7. NHS England commissioned an independent clinical reviewer to review Mr Matthews' clinical care at Isle of Wight.

8. The PPO investigator investigated the non-clinical issues relating to Mr Matthews' care.

9. The PPO family liaison officer wrote to Mr Matthews' son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not have any questions but asked for a copy of our report.

10. The initial report was shared with Mr Matthews' son. He did not make any comments.

11. The initial report was shared with HMPPS. There were no factual inaccuracies.

Previous deaths at HMP Isle of Wight

12. Mr Matthews was the twenty-seventh prisoner to die at Isle of Wight since March 2020. Of the previous deaths, 20 were from natural causes, five were self-inflicted and one was from unknown causes.

Key Events

13. On 7 September 2017, Mr Robin Matthews was sentenced to 18 years imprisonment for sexual offences. On 31 May 2018, he was moved to HMP Isle of Wight.

14. Mr Matthews had diabetes, high blood pressure, high cholesterol and he had previously had a heart attack. He also had a learning disability.

15. When he arrived at Isle of Wight, the healthcare team found Mr Matthews was struggling with his memory and his mobility. He was seen daily by carers who helped him with all aspects of his self-care.

16. On 25 March 2022, Mr Matthews' carers found that he was unwell. They radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts staff to attend and the control room to call an ambulance). A nurse took his clinical observations. She found that his oxygen levels were low and that he tested positive for COVID-19. He was taken to hospital by ambulance and admitted.

17. On 4 April, Mr Matthews was discharged from hospital to the inpatient healthcare unit (IHU) at Isle of Wight. The healthcare team continued to monitor Mr Matthews' clinical observations as his breathing rate and oxygen levels were fluctuating. Later in the evening, a nurse found Mr Matthews lying on the floor and he told her he had hit his head. His breathing rate continued to deteriorate, and he was taken to hospital. While in hospital he was diagnosed with COVID-19 pneumonia. He was discharged back to the IHU at Isle of Wight the next day.

18. On 6 April, healthcare staff again found Mr Matthews on the floor of his cell. He again told them that he had hit his head. The healthcare team found no sign of an injury but continued to monitor him.

19. On 3 May, a GP at Isle of Wight saw Mr Matthews. He told Mr Matthews that he had been diagnosed with cerebral atrophy (loss of brain cells) and was to be moved to the IHU for treatment.

20. Mr Matthews' condition continued to fluctuate. He was frequently admitted to the IHU for periods of rehabilitation, and then moved back to his standard prison cell when he was well enough.

21. On 11 August, Mr Matthews was short of breath and coughing. Healthcare staff took his clinical observations, which were abnormal, and phoned for an ambulance. He was taken to hospital for a chest X-ray and was subsequently admitted. Hospital doctors diagnosed Mr Matthews with aspiration pneumonia (inflammation of the lungs caused by something such as water or food getting into the lung).

22. On 13 August, Mr Matthews agreed with hospital doctors to put a Do Not Attempt Resuscitation (DNAR) order in place. This meant he would not be resuscitated if his heart or breathing stopped.

23. On 17 August, Mr Matthews was discharged from hospital back to the IHU. His mobility continued to deteriorate and over the following months he had several falls.

24. On 28 February 2023, a nurse saw Mr Matthews. She found he was in pain when she moved his legs, and he told her he had fallen the day before (he had not told staff of this at the time). She took his clinical observations, which were normal, and arranged for him to see the GP the next day. Mr Matthews told the GP that he had pain in the left-hand side of his chest. The GP found no sign of injury but increased his pain relief.

25. On 4 March, Mr Matthews' carers found him in his cell feeling unwell and confused. The healthcare team took his clinical observations and found that he had low oxygen levels and blood pressure. They gave him oxygen and transferred him to hospital.

26. While in hospital, Mr Matthews was treated for a chest infection. He was given intravenous antibiotics and oxygen. A nurse on the ward told the healthcare team at Isle of Wight that his health had deteriorated, and he would be started on palliative care.

27. On 13 March, the prison started an application for Mr Matthew's early release on compassionate grounds. This was not progressed before Mr Matthews died.

28. On 18 March, a nurse at Isle of Wight spoke to a nurse on the hospital ward who told her that Mr Matthews was diagnosed with an acute kidney injury (AKI – where the kidneys stop working properly) and pneumonia. While in hospital, Mr Matthews also tested positive for COVID-19.

29. On 24 March, Mr Matthews was discharged from hospital. He was moved to the IHU for palliative care. The hospital doctors and healthcare team at Isle of Wight agreed that Mr Matthews would only be admitted to hospital again if he suffered an injury, not if his health deteriorated.

30. On 31 March, Mr Matthews' breathing slowed. At approximately 10.43pm, two nurses found him unresponsive and not breathing. As there was no one available who could verify Mr Matthews' death, the prison staff called for an ambulance. At 2.31am on 1 April, a paramedic confirmed that Mr Matthews had died.

Post-mortem report

31. The post-mortem report concluded that Mr Matthews died of severe congestive cardiac failure caused by ischemic heart disease and high blood pressure. Chronic obstructive pulmonary disease (COPD - a group of lung conditions that cause breathing difficulties) and idiopathic pulmonary fibrosis (where the lungs become scarred and breathing becomes increasingly difficult) were also listed as contributory factors.

Findings

Governor to note

32. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release are set out in the Early Release on Compassionate Grounds (ERCG) Policy Framework. Among the criteria is that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of HMPPS.

33. The prison started an ERCG application for Mr Matthews on 13 March, when his condition was deteriorating in hospital. However, we could find no evidence that any action was taken beyond completing basic details on the application form.

34. The prison told the PPO investigator that the ERCG application was started by a staff member at the direction of the senior management team. They were unable to say why it was not progressed any further.

35. We accept that Mr Matthews died just over two weeks after the ERCG application was started and so it is unlikely that a decision could have been made in that time. However, we would expect that once an ERCG application is started, that staff are clear on who is responsible for coordinating the completion of the application form so that it is progressed and submitted promptly to PPCS.

Adrian Usher
Prisons and Probation Ombudsman **November 2023**

Inquest

At the inquest, held on 14 October 2025, the Coroner concluded that Mr Matthews died from natural causes.

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