Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Wood, a prisoner at HMP Hull, on 4 September 2023

A report by the Prisons and Probation Ombudsman

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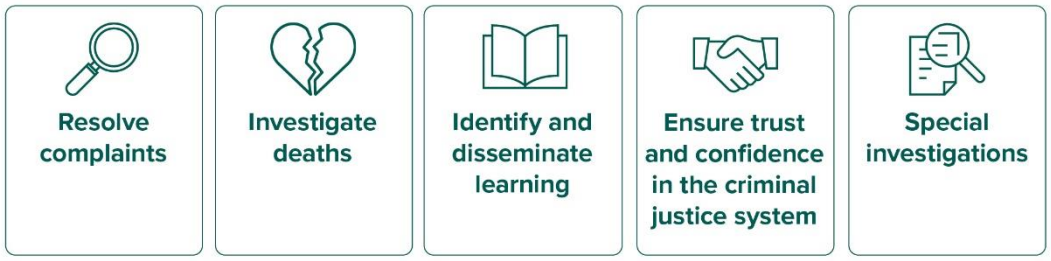
OUR VISION

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

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. On 15 February 1993, Mr James Wood was sentenced to life imprisonment for murder. He died in hospital of cancer on 4 September 2023, while a prisoner at HMP Hull. He was 52 years old. We offer our condolences to Mr Wood's family and friends.

4. The PPO family liaison officer wrote to Mr Wood's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond to our letter.

5. The PPO investigator investigated the non-clinical issues relating to Mr Wood's care. We did not find any non-clinical issues of concern.

6. NHS England commissioned an independent clinical reviewer to review Mr Wood's clinical care at Hull. The clinical reviewer concluded that the clinical care Mr Wood received at Hull was of a good standard and mostly equivalent to that which he could have expected to receive in the community. The clinical reviewer found that on one occasion the care Mr Wood received fell below expectations, when healthcare staff failed to refer Mr Wood for further tests when they first suspected he may have cancer.

7. We make the following recommendation related to the clinical care Mr Wood received:

   The Head of Healthcare should ensure that clinical staff receive training on when to make referrals under the two-week wait cancer pathway, in line with national guidance.

8. We shared our initial report with HMPPS and the healthcare provider at Hull. They found no factual inaccuracies. The healthcare provider provided an action plan which is annexed to this report.

Adrian Usher **March 2024**
Prisons and Probation Ombudsman

Inquest

The inquest, held on 18 October 2024, concluded that Mr Wood died from natural causes.

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