Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martyn Woods, a prisoner at HMP Wymott, on 29 September 2024

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, 2025

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 concern

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. In February 2018, Mr Martyn Woods was sentenced to 14 years in prison for sexual offences. He died in hospital of empyema of the left hemithorax (a collection of pus in the area between the lung and chest wall) on 29 September 2024, while a prisoner at HMP Wymott. He was 79 years old. We offer our condolences to Mr Woods' family and friends.

4. The Ombudsman's office wrote to Mr Woods' next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted us to consider. She asked for a copy of the report and wanted to know why Mr Woods was admitted to hospital. She also wanted reassurance that Mr Woods had received all the medical care he needed. Her concerns have been addressed in the clinical review.

5. NHS England commissioned an independent clinical reviewer to review Mr Woods' clinical care at HMP Wymott.

6. The clinical reviewer concluded that the clinical care Mr Woods received at Wymott was of a good standard and was equivalent to that which he could have expected to receive in the community. She found that Mr Woods had the appropriate care plans in place and his ongoing health concerns were addressed accordingly. The clinical reviewer made one recommendation, which was not related to Mr Woods' death but which the Head of Healthcare will want to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Woods care.

8. We did not identify any non-clinical learning and we make no recommendations.

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

10. Mr Woods' family received a copy of the draft report. They did not make any comments.

11. At an inquest held on 9 January 2026, the Coroner concluded that Mr Woods died of natural causes.

Adrian Usher **April 2025**
Prisons and Probation Ombudsman

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 I 020 7633 4100