Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Harding, a prisoner at HMP Stafford, on 3 August 2024

A report by the Prisons and Probation Ombudsman

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

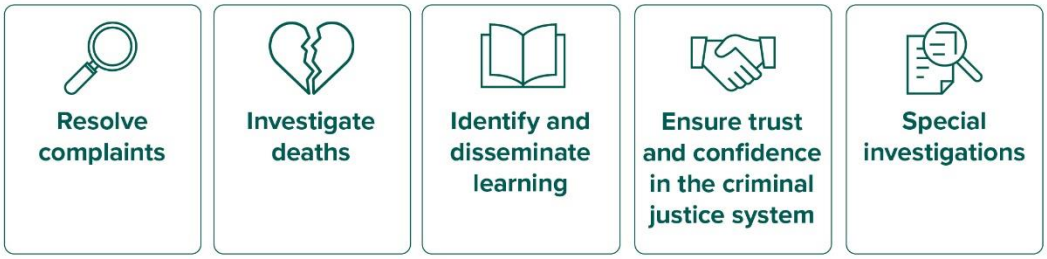
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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 13 January 2022, Mr Colin Harding was sentenced to 21 years in prison for sexual offences.

4. Mr Harding died of squamous carcinoma of the skin (type of skin cancer), with atrial fibrillation (irregular and often abnormally fast heart rate), ischaemic heart disease (heart problems caused by narrowed heart arteries), and carcinoma of prostate (prostrate cancer) contributory factors, on 3 August 2024 at HMP Stafford. He was 74 years old. We offer our condolences to Mr Harding's family and friends.

5. The Ombudsman's office wrote to Mr Harding's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of our report.

6. We also shared the initial report with Mr Harding's family. They indicated that they were satisfied with the findings.

7. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

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

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

10. NHS England commissioned an independent clinical reviewer to review Mr Harding's clinical care at HMP Stafford.

11. The clinical reviewer concluded that the clinical care Mr Harding received at Stafford was of a good standard and equivalent to that which he could have expected to receive in the community. However, she identified some issues, notably around communication and follow-up with the hospital treating Mr Harding:

    - On 28 February 2023, Mr Harding underwent surgery. Histology results taken following this, which identified the extent of his cancer, were not received at Stafford until 25 April and not reviewed by the GP at Stafford until 11 May. This meant that the results were not discussed with Mr Harding until 18 May, nearly three months after the tests, which the clinical reviewer found was an unacceptable delay.

    - On 13 June 2023, healthcare staff received an appointment for follow-up with plastic surgeons on 22 January 2024. GPs wrote to the hospital three times to

ask for the appointment to be expedited, as Mr Harding's wound condition was deteriorating. The clinical reviewer found that the mechanism for communicating urgent discussion about patient care decisions was inadequate and potentially delayed palliative care delivery to Mr Harding.

- There was a gap of 24 weeks from referral to the pain management clinic to receipt of advice from the clinic.

12. We make the following recommendations:

- **The Head of Healthcare should work in conjunction with Royal Stoke University Hospital to ensure there is a robust and efficient system for receipt of histology and other laboratory results, and ensure that this information is promptly relayed to patients.**

- **The Head of Healthcare should review and improve communication methods for liaising with hospital consultants and clinics, and evidence changes in system management to NHS England commissioners.**

Inquest

13. The inquest into Mr Harding's death concluded on the 4 December 2024. The coroner confirmed that Mr Harding died of natural causes.

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

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