Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Howard Woodin, a prisoner at HMP Coldingley, on 14 September 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Howard Woodin died of a brain tumour in at a nursing home on 14 September 2015, while in the custody of HMP Coldingley. He was 56 years old. I offer my condolences to Mr Woodin's family and friends.

The investigation found that there was a delay of some weeks in diagnosing Mr Woodin's brain tumour, and an urgent referral to hospital should have been made. However, the advanced stage of the cancer meant that an earlier assessment would not have altered the outcome.   After the diagnosis, I am satisfied that Mr Woodin received a good standard of palliative care, but I am concerned that Mr Woodin was restrained in hospital, albeit for brief periods, without fully considered risk assessments to justify this.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2016**

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Summary

Events

1. In May 2004, Mr Howard Woodin received a life sentence for murder. In February 2015, he was transferred to HMP Coldingley. Mr Woodin had a number of health conditions, including heart disease and diabetes.

2. On 27 April, Mr Woodin said he felt dizzy and had a pain down the side of his head and arm. The next day, a GP diagnosed a mini-stroke and referred Mr Woodin to a hospital stroke clinic. In May and early June, Mr Woodin suffered headaches, vomiting, dizziness and confusion. He also lost weight. Healthcare staff believed his symptoms were caused by a stroke and waited for the outcome of his stroke clinic appointment in June.

3. On 18 June, a CT scan at the stroke clinic indicated a possible brain tumour. The next day, Mr Woodin went back to hospital after his condition deteriorated. Further tests confirmed his condition was terminal and doctors gave him a prognosis of six months.

4. In early July, the hospital discharged Mr Woodin and he was admitted to the healthcare inpatient unit at HMP High Down. Healthcare staff drew up a palliative care plan. Mr Woodin's condition deteriorated and he was admitted to hospital again on 13 July. Doctors considered his prognosis was now two weeks and he was admitted to a hospice.

5. Mr Woodin's health stabilised and, on 11 August, he was discharged from the hospice. At High Down his condition deteriorated and, in early September, he was admitted to a nursing home. Formal responsibility for Mr Woodin's custody transferred back to Coldingley. Mr Woodin died at the nursing home on 14 September.

Findings

6. We consider that Mr Woodin should have been referred for an urgent specialist assessment when he continued to experience worrying symptoms in May and early June at Coldingley. However, there is no indication that an earlier diagnosis would have affected the outcome for Mr Woodin, as the tumour was very advanced.

7. After Mr Woodin was diagnosed with a brain tumour, he was appropriately admitted to the inpatient unit at High Down and received a good standard of palliative care. We are satisfied that High Down arranged suitable end of life care for Mr Woodin in a nursing home near his family.

8. However, we are concerned that managers at Coldingley and High Down decided that Mr Woodin should be restrained for hospital visits without full information about Mr Woodin's health and mobility and how this affected his risk. The prison made a timely application for compassionate release, but sadly a decision had not been made before Mr Woodin died.

Recommendations

- The Head of Healthcare at HMP Coldingley should ensure that prison healthcare staff are familiar with National Institute for Health and Clinical Excellence (NICE) guidelines for suspected TIAs and on the early diagnosis of cancer and that doctors refer prisoners to a specialist urgently if they present with unexplained and persistent symptoms.

- The Governor and the Head of Healthcare at HMP Coldingley and HMP High Down should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Coldingley and HMP High Down informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

10. The investigator obtained copies of relevant extracts from Mr Woodin's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Woodin's clinical care at the prison.

12. We informed HM Coroner for Surrey of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Woodin's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She wanted to know whether the prison had noticed the deterioration in Mr Woodin's health, including weight loss, before his diagnosis and why she had not been informed sooner about Mr Woodin's condition.

14. The investigation has assessed the main issues involved in Mr Woodin's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

16. Mr Woodin's daughter received a copy of the initial report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Coldingley

17. HMP Coldingley is a medium security prison on the outskirts of Woking, Surrey. It holds up to 513 men. Virgin Care provides health services at the prison. Doctors from a local practice provide a daily GP service, and there is a team of primary care and mental health nurses. There are no inpatient facilities.

HM Inspectorate of Prisons

18. The most recent inspection of Coldingley was in April 2013. Inspectors reported that the prison was safe, but living accommodation was poor with antiquated sanitary arrangements. Inspectors found that prisoners had good access to high quality healthcare services and were satisfied with their care.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to July 2015, the IMB for Coldingley reported that there was a high demand for healthcare services. A lack of escort staff meant that some prisoners missed hospital appointments.

Previous deaths at HMP Coldingley

20. The last death at HMP Coldingley from natural causes was in July 2013. There were no similarities with the circumstances of the previous death.

HMP High Down

21. HMP High Down is a local prison near Sutton, in Surrey. It holds up to 1,100 men. Virgin Care provides health services at the prison. There is a healthcare inpatient unit, which provides 24-hour care.

HM Inspectorate of Prisons

22. The most recent inspection of High Down was in January 2015. Inspectors reported that health services were good overall, but staff shortages meant too many healthcare appointments were cancelled.

Independent Monitoring Board

23. In its latest annual report, for the year to December 2014, the IMB for High Down considered that health care provision at High Down compared well with other prisons.

Previous deaths at HMP High Down

24. Since the start of 2014, there have been five deaths at High Down due to natural causes. In three of these cases we were concerned that restraints were used for hospital appointments without appropriate justification.

Findings

The diagnosis of Mr Woodin's terminal illness and informing him of his condition

25. On 5 May 2004, Mr Woodin was sentenced to life imprisonment for murder. He moved to HMP Coldingley on 3 February 2015. At an initial health screen, a nurse noted that Mr Woodin suffered from post-traumatic stress disorder, diabetes and hypertension (high blood pressure). A doctor prescribed medication for these conditions.

26. On 27 April, Mr Woodin told a nurse that he felt dizzy and numb on the right side of his head and down his right arm. The nurse examined him for signs of a possible stroke and recorded that there was no sign that his face had drooped and he had a good grip in both hands. An echocardiogram (ECG) showed his heart rhythm was normal. The nurse gave Mr Woodin pain relief and arranged a GP appointment for the next day.

27. The next day, a GP examined Mr Woodin, diagnosed a suspected transient ischaemic attack (TIA – a mini-stroke) and prescribed aspirin. He told Mr Woodin to contact healthcare staff if his problems persisted. The GP referred Mr Woodin to a hospital stroke clinic.

28. On 18 May, Mr Woodin made a formal complaint about waiting over two weeks for the hospital stroke assessment and said he wanted his symptoms fully investigated. A prison GP saw Mr Woodin the next day and noted that she would chase his stroke clinic appointment to see if it could be made sooner. The outcome is not recorded.

29. Between 19 May and 8 June, doctors and nurses saw Mr Woodin at least seven times after he had complained of headaches, vomiting, dizziness and difficulty eating. They believed his symptoms were associated with his suspected stroke and recorded that he was waiting for an appointment at the stroke clinic. On 8 June, a nurse recorded that Mr Woodin weighed 85kg, a loss of 10kg in three months. The nurse recorded that she would discuss this with the GP, but there is no record of this.

30. On 10 June, the healthcare manager noted that Mr Woodin appeared confused and forgetful and referred him for a mental health assessment. Two days later, a psychiatrist assessed Mr Woodin but found that he did not require any mental health input. The psychiatrist recorded a diagnosis of a suspected stroke.

31. On 16 June, a GP saw Mr Woodin, who had not been eating properly and had refused his medication the day before. She noted that Mr Woodin had neurological symptoms of loss of interest, memory and problems with word finding. As Mr Woodin had a hospital appointment two days later, she arranged for him to have a CT scan at the hospital on the day of his appointment.

32. On 18 June, Mr Woodin had a CT scan of his brain at the stroke clinic hospital, which indicated a possible brain tumour. Doctors referred him for an MRI scan to confirm this and Mr Woodin returned to the prison later that day.

33. The next day, the healthcare manager and a prison GP recorded that Mr Woodin needed 24-hour healthcare. Mr Woodin's condition deteriorated and he was taken back to hospital that afternoon. In hospital, doctors carried out further tests and, on 22 June, an MRI scan confirmed that Mr Woodin had an inoperable brain tumour. His condition was terminal and no treatment was possible. A prison healthcare manager visited Mr Woodin to discuss his diagnosis and to offer support.

34. Although a GP correctly referred Mr Woodin for a CT scan on 16 June, the clinical reviewer considered that Mr Woodin's ongoing symptoms after 28 April, when a TIA was first suspected, should have triggered a more urgent hospital referral for specialist investigation. The clinical reviewer considered that doctors did not follow the National Institute for Health and Care Excellence (NICE) Guidance for TIAs or for referring patients urgently where there is a possibility of progressive, sub-acute loss of central neurological function. This should result in an MRI or CT scan of the brain within two weeks to assess for brain or central nervous system cancer.

35. The clinical reviewer considered that the care Mr Woodin received before his diagnosis was not equivalent to that he could have expected to receive in the community. Although healthcare staff chased the hospital for an earlier appointment, he was not seen by a specialist within two weeks, as should have happened if the prison had made an earlier referral. However, the clinical reviewer noted that an earlier referral would not have affected the outcome as the brain tumour was very advanced. We make the following recommendation:

The Head of Healthcare at HMP Coldingley should ensure that prison healthcare staff are familiar with National Institute for Health and Clinical Excellence (NICE) guidelines for suspected TIAs and on the early diagnosis of cancer and that doctors refer prisoners to a specialist urgently if they present with unexplained and persistent symptoms.

Mr Woodin's clinical care

36. On 26 June, healthcare staff from Coldingley met hospital staff to discuss Mr Woodin's condition and clinical care. They did not consider that Coldingley would be able to manage Woodin's clinical care and the healthcare manager arranged for Mr Woodin to be discharged from hospital to HMP High Down's inpatient unit, which could provide 24-hour care.

37. On 2 July, the hospital discharged Mr Woodin and a nurse created a palliative care plan to manage Mr Woodin's pain and symptoms at High Down. The care plan included frequent observations, pain relief and measures to ensure his comfort and safety. A prison GP recorded that Mr Woodin was no longer mentally competent to make decisions and healthcare staff consulted Mr Woodin's family about his care. After consultation, she decided that Mr Woodin should not be resuscitated if his heart or breathing stopped. Nurses saw Mr Woodin several times a day to look after him in line with the care plan. They reviewed the care plan as his condition deteriorated and consulted Macmillan nurses (palliative care specialists) for further advice about how to manage his symptoms.

38. On 13 July, Mr Woodin's condition deteriorated and he was admitted to hospital. On 14 July, a consultant oncologist considered that Mr Woodin's prognosis was around two weeks and he needed specialist palliative care. On 23 July, he was taken to a hospice to be closer to his family. As Mr Woodin's condition stabilised, the hospice discharged him on 11 August and he returned to High Down.

39. Mr Woodin's condition declined again and on 8 September, he was admitted to a nursing home. The next day, Coldingley accepted technical responsibility for Mr Woodin's custody again. Mr Woodin remained in the nursing home and died there on 14 September. The coroner gave the cause of death as a brain tumour.

40. The clinical reviewer considered that, after his diagnosis, Mr Woodin's care at High Down was good and equivalent to that he could have expected to receive in the community. Healthcare staff aimed to meet Mr Woodin's personal needs and respected the views of his family about his care. They created appropriate care plans and worked well with hospital staff and palliative care nurses to ensure Mr Woodin received good care. We are satisfied that Mr Woodin received appropriate care.

Mr Woodin's location

41. When Mr Woodin was discharged from hospital in July, the Head of Healthcare at Coldingley arranged for him to go to High Down, which has an inpatient unit providing 24-hour care. We consider there was good liaison and planning between Coldingley and High Down to organise this and to ensure continuity of care.

42. Mr Woodin returned to hospital on 13 July. Healthcare staff at High Down arranged for Mr Woodin to move to a hospice nearer to his family and he moved there on 23 July. Mr Woodin returned to High Down on 11 August, after his condition stabilised. When his health declined further, the prison arranged for him to move to a nursing home, near to his family, where he remained until his death. We are satisfied that Mr Woodin's was appropriately accommodated throughout his illness.

Restraints, security and escorts

43. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

44. On 19 June, when Mr Woodin was to hospital from Coldingley he was handcuffed. A risk assessment indicated that Mr Woodin was 'normal' risk to the public, to hospital staff and of escape. In the medical information section of the

risk assessment, the healthcare manager recorded that there were no medical objections to the use of restraints, but gave no details about Mr Woodin's condition. She had seen Mr Woodin earlier that afternoon in the reception area of the prison before he went to hospital. She recorded in Mr Woodin's medical records that he had vomited over himself, was very unsteady on his feet and needed help to walk.

45. On 13 July, Mr Woodin went from High Down to hospital after his condition deteriorated. In the medical information section of the risk assessment, a nurse noted that Mr Woodin was very weak and receiving palliative care. She recorded that there were medical objections to the use of restraints, but indicated that an escort chain could be used when Mr Woodin was receiving treatment. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) A prison manager noted that, "Healthcare staff report that Mr Woodin is in advanced stage cancer and unable to walk. Physically very frail. Single cuffs to be used in preference to standard cuffs due to physical frailty". Mr Woodin was handcuffed for the journey to the hospital and by an escort chain in hospital. The next day, a senior prison manager reviewed the arrangements and decided that the escort chain should be removed. After this, Mr Woodin was not restrained again.

46. We note that a manager quickly recognised that Mr Woodin did not need to be restrained in hospital and that restraints were used for only a short period during Mr Woodin's illness. However, we are not satisfied that healthcare and other staff at either prison understood the requirements of the 2007 judgment and fully considered Mr Woodin's condition at the time and how this affected his risk of escape. We make the following recommendation:

The Governor and the Head of Healthcare at HMP Coldingley and HMP High Down should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Woodin's family

47. On 19 June, a custodial manager telephoned Mr Woodin's daughter, who he had named as his next of kin. He got no reply and he left a message for her contact the prison. He also telephoned Mr Woodin's son and told him that his father was in hospital undergoing tests for a suspected brain tumour. After the tumour was formally diagnosed, a prison manager acted as the prison's family liaison officer. On 22 June, he took Mr Woodin's daughter to the hospital to see her father.

48. On 24 June, Mr Woodin's daughter wrote to the prison stating that she was concerned by her father's deterioration since she had last seen him in May. On 15 July, the Governor replied with further information and offered support. In the letter, he explained that Mr Woodin had been referred for a suspected stroke and the seriousness of his condition had not been known until he went to the hospital appointment in June.

49. After Mr Woodin transferred to High Down, the prison manager continued to act as the family liaison officer. He remained in contact with Mr Woodin's daughter,

as his next of kin, arranged visits and helped to organise a hospice place for Mr Woodin.

50. When Mr Woodin moved to the nursing home, the prison arranged that staff at the home should keep his family informed directly about his condition. On 14 September, a member of staff at the nursing home informed Mr Woodin's daughter that he had died.

51. After Mr Woodin died, the Governor of Coldingley wrote to Mr Woodin's daughter to offer his condolences. The prison manager remained in contact with Mr Woodin's family to offer support and organised the funeral on their behalf.

52. Mr Woodin's funeral was on 28 September 2015. The prison contributed to the costs, in line with national policy.

53. We are satisfied there was good liaison with Mr Woodin's family. They were informed promptly when there was an indication he was seriously ill and updated and supported when his health deteriorated.

Compassionate release

54. 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. Among the criteria is that the risk of re-offending 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 the National Offender Management Service (NOMS).

55. At a case review meeting on 26 June, Coldingley agreed to apply for compassionate release for Mr Woodin. The prison sent an application to the Public Protection Casework Section (PPCS) at the National Offender Management Service on 14 July, after doctors had given Mr Woodin a prognosis of around two weeks.

56. On 27 July, the PPCS wrote to HMP Coldingley, requesting a release plan, including an appropriate address. Mr Woodin's offender manager considered the address originally proposed was unsuitable, because of victim issues. The prison began enquiries to find a suitable release address and, on 20 August, a nurse told Mr Woodin's offender manager that a nursing home had been found that had agreed to admit Mr Woodin. On 7 September, Mr Woodin's offender manager agreed that the nursing home was a suitable address for release and sent a further report to PPCS with this information. Sadly Mr Woodin died before a decision about his release was made.

57. We consider that Coldingley acted quickly in submitting the original application for compassionate release. Further delays were outside the prison's control and due to the need to take appropriate account of victim sensitivities about an appropriate release address.

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