Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr James Woodriff, a resident at Cardigan House Approved Premises, on 19 August 2019

**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 James Woodriff died of a pulmonary thromboembolism (a blocked blood vessel in the lungs) caused by deep vein thrombosis (a blood clot in his leg) on 19 August 2019 at Cardigan House Approved Premises. He was 37 years old. I offer my condolences to Mr Woodriff's family and friends.

I am satisfied that when staff became aware that Mr Woodriff was unwell, they responded immediately, appropriately tried to resuscitate him and promptly called an ambulance. I make no recommendations.

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

**Sue McAllister CB**
**Prisons and Probation Ombudsman** **March 2020**

## Contents

# Summary

## Events

1. On 25 February 2015, Mr James Woodriff was sentenced to 10 years in prison for firearms offences. On 1 August 2019, he was released on licence from HMP Lindholme to Cardigan House Approved Premises.

### Events of 19 August 2019

2. At 8.30am on 19 August, Mr Woodriff made a drink in the kitchen and went to the lounge. At 8.48am, Mr Woodriff saw a support worker and took his pain relief medication.

3. At 9.12am, CCTV footage shows that Mr Woodriff staggered, out of breath, up the stairs to the first floor. At 9.17am, CCTV shows that he went to the toilets, sweating heavily and with a pained expression on his face. At 9.19am, he went to his room and fell to the floor.

4. At 9.21am, the CCTV shows that Mr Woodriff left his room and went to the shower room. The administration and finance officer went to Mr Woodriff's room to tell him that a support worker had come to see him. She then went to the shower block and told him through the door, unaware that he was unwell.

5. A resident said that Mr Woodriff's friend was sitting in a car outside Cardigan House and told him that Mr Woodriff had told him by telephone that he was being sick in his room. The resident went to Mr Woodriff's room and saw him lying on the floor, outside his room, struggling to breathe. The resident went outside and told Mr Woodriff's friend to come back later. He returned to Mr Woodriff's room, but he was no longer there. The resident realised that Mr Woodriff was in the toilets and went to get help.

6. At 9.49am, the support worker went to the toilets, where he found Mr Woodriff sitting on the toilet, unresponsive, leaning back and to the side, with his eyes wide open. Mr Woodriff had no pulse and was not breathing.

7. The support worker and the resident lifted Mr Woodriff to the floor, and the support worker pressed the alarm. The administration and finance officer and a case manager responded. The support worker started cardiopulmonary resuscitation (CPR). At 09.51am, the case manager called for an ambulance. Staff continued resuscitation attempts until paramedics took over at 9.56am.

8. At 10.27am, they confirmed that Mr Woodriff had died. A post-mortem examination established that he had died from a blocked artery between his heart and lungs, caused by a blood clot in his leg.

## Findings

9. Staff at Cardigan House responded immediately and appropriately when they became aware that Mr Woodriff was unwell.

10. Staff promptly started resuscitation efforts and called an ambulance which arrived within five minutes. We make no recommendations.

## The Investigation Process

11. The investigator issued notices to staff and residents at Cardigan House Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Woodriff's approved premises records.

13. The investigator interviewed six members of staff and four residents at Cardigan House on 11 and 12 September.

14. We informed HM Coroner for West Yorkshire (Eastern) of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. The Ombudsman's family liaison officer wrote to Mr Woodriff's next of kin to explain the investigation and to ask if she had any matters for us to consider. She asked if Mr Woodriff's healthcare had continued when he was released from prison to Cardigan House. We have addressed this in this report. She also asked a number of questions which were outside our remit.

16. We shared the initial report with the National Probation Service. There were no factual inaccuracies.

17. Mr Woodriff's next of kin received a copy of the initial report. She raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

# Background Information

## Cardigan House Independent Approved Premises

18. Approved premises (formerly known as probation and bail hostels) mostly accommodate offenders released from prison on licence and those directed there by the courts as a condition of bail. Their purpose is to provide a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.

19. Cardigan House is one of four approved premises in the Leeds area, and one of two run by the charity Progress to Change, and works in close partnership with the Ministry of Justice, the National Probation Service and Community Rehabilitation Companies. It is contractually funded by the Ministry of Justice.

20. Cardigan House has 25 single rooms and one double room. A key worker is allocated to each resident to discuss their progress and wellbeing. The key worker also ensures that residents adhere to their individual licence conditions and the rules of the approved premises. Cardigan House is staffed 24 hours a day by employees of Progress to Change.

## Previous deaths at Cardigan House

21. There has been one previous death of a resident at Cardigan House since August 2017. There were no significant similarities between our findings in the two investigations.

# Key Events

22. On 25 February 2015, Mr James Woodriff was sentenced to 10 years in prison for firearms offences. On 1 August 2019, he was released on licence from HMP Lindholme to Cardigan House Approved Premises.

23. On 1 August, a probation officer explained the terms of Mr Woodriff's licence to him. A residential hostel worker completed his induction that day.

24. On 2 August, a case manager met Mr Woodriff and completed his community GP registration. Mr Woodriff told her that he was taking dihydrocodeine for pain relief because he had a bad back. She noted that he appeared unsteady on his feet.

25. On 7 August, Mr Woodriff met the probation officer and the case manager at Cardigan House. The probation officer said that Mr Woodriff engaged well, but looked tired and slurred his words. Mr Woodriff told them that this was caused by his strong prescribed medication. He said that he had not taken any illicit substances. The case manager said that Mr Woodriff often slurred his words and was unsteady on his feet, but never smelt of alcohol. She said that they had booked Mr Woodriff a GP appointment for 16 August. She said that Mr Woodriff had already seen the community GP, who had prescribed him pregabalin instead of dihydrocodeine for his bad back.

26. On 14 August, the case manager spoke to Mr Woodriff about his upcoming appointments because he could not remember them. She said that he had an appointment with the community psychiatric nurse, reminded him about his GP appointment for 16 August, and his appointment with a housing provider.

### Events of 19 August 2019

27. At 8.30am on 19 August, Mr Woodriff left his room and went to the kitchen, where he made a hot drink and went to the television lounge.

28. At 8.48am, Mr Woodriff saw a support worker for his medication. The support worker said that he looked fine. Mr Woodriff then returned to the television lounge.

29. A resident went outside with Mr Woodriff for a cigarette. Mr Woodriff told him that he was going to have a shower and returned inside.

30. At 9.12am, CCTV footage shows that Mr Woodriff staggered, out of breath, up the stairs to the first floor, where he walked along the landing. At 9.17am, Mr Woodriff went to the toilets, sweating heavily and with a pained expression on his face. At 9.19am, Mr Woodriff went to his room and fell to the floor.

31. At 9.21am, CCTV footage shows that Mr Woodriff left his room, wearing a pair of shorts and sweating heavily. He went to the shower block. The administration and finance officer went to Mr Woodriff's room to tell him that a support worker had come to see him. As he was not there, she went to the shower block and told him through the door, unaware that he was unwell.

32. At 9.31am, the CCTV shows that Mr Woodriff returned to his room. At 9.43am, he walked to the toilets and then went back to his room. As he opened the door, he collapsed.

33. A resident said that he spoke to Mr Woodriff's friend, who was in a car outside Cardigan House. He told the resident that Mr Woodriff had just telephoned him and said that he was being sick in his room. The resident went to Mr Woodriff's room and saw him lying on the floor, outside of his room. Mr Woodriff told him that he could not breathe. The resident went back outside and told Mr Woodriff's friend to come back later. He then returned to Mr Woodriff's room, but found him no longer there.

34. At 9.46am, CCTV footage shows that Mr Woodriff went to the toilets. The resident said that he found Mr Woodriff in the toilets and Mr Woodriff again told him that he could not breathe. He went downstairs to get a support worker.

35. At 9.49am, the support worker went to the toilets and found Mr Woodriff, unresponsive, sitting on the toilet, leaning back and to the right-hand side, with his eyes open. He said that Mr Woodriff's pupils were massive and his skin was pale and clammy. He said that Mr Woodriff had no pulse and was not breathing.

36. The support worker and the resident lifted Mr Woodriff to the floor. The support worker pressed his alarm and staff responded. The administration and finance officer helped the support worker to put Mr Woodriff on his back. She tilted his head back and the support worker started cardiopulmonary resuscitation (CPR).

37. At 09.51am, the case manager went to the office and called for an ambulance.

38. The administration and finance officer collected a defibrillator from the office and applied it to Mr Woodriff's chest. It advised not to shock Mr Woodriff but to continue CPR.

39. At 9.56am, paramedics arrived at Cardigan House, moved Mr Woodriff out of the toilet cubicle to give them more room, and continued CPR. At 10.27am, they confirmed that Mr Woodriff had died.

### Contact with Mr Woodriff's family

40. Soon after Mr Woodriff died, his next of kin telephoned Cardigan House because she was aware that he was unwell. (It is possible that Mr Woodriff's friend had told her.)

41. The case manager spoke to Mr Woodriff's mother but did not give her information about what had happened as she was aware that the police were on their way to her house to break the news to her, and "it was not [her] place to tell her that he had died". Mr Woodriff's next of kin also telephoned the National Probation Service (NPS) to speak to the probation officer, but they were unable to give her any information.

42. In line with the National Probation Service's instructions, the police later told Mr Woodriff's next of kin that he had died. On 21 August, the single point of contact (SPOC) telephoned Mr Woodriff's next of kin and offered her condolences.

43. Mr Woodriff's funeral took place on 20 September, and the National Probation Service offered to contribute to its cost in line with national instructions.

### Support for residents and staff

44. After Mr Woodriff's death, an approved premises manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

45. The approved premises manager and the approved premises area manager met the residents of Cardigan House to offer them support.

### Post-mortem report

46. A post-mortem examination established that Mr Woodriff had died from a pulmonary thromboembolism (a blocked blood vessel in the lungs), caused by deep vein thrombosis (a blood clot in his leg). No post-mortem toxicology tests were completed.

# Findings

### Events of 19 August 2019

47. Approved premises staff immediately responded when they became aware that Mr Woodriff was unwell. The support worker used his alarm to call for assistance and the two other members of staff on duty promptly responded.

48. Staff immediately started CPR, promptly collected and used a defibrillator, and called for an ambulance which arrived within five minutes.

### Contact with Mr Woodriff's family

49. National Probation Services instructions states that it is the responsibility of the police to inform the next of kin of a death at an approved premises and that it is the responsibility of the area manager or the approved premises manager to appoint a single point of contact (SPOC) to speak to the next of kin.

50. When Mr Woodriff's next of kin telephoned the approved premises, the case manager knew that police officers were on their way to see her to break the news of Mr Woodriff's death. She told her that she was sorry that she could not give her any information, and had the impression that she already knew that he had died. In these difficult circumstances, we consider that it was reasonable that the case manager did not disclose any further information by telephone.

51. When Mr Woodriff's next of kin telephoned the local probation office, the probation officer was not available to speak to her, staff were unaware what had happened to Mr Woodriff, and were therefore unable to give her any information.

52. The SPOC later spoke to Mr Woodriff's mother to offer her condolences.

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