

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Roy Woodward, a prisoner at HMP Altcourse, on 23 July 2022

A report by the Prisons and Probation Ombudsman



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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Summary

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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Roy Woodward died from metastatic lung cancer (lung cancer which had spread to other parts of his body) on 23 July 2022, while a prisoner at HMP Altcourse. He was 57 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Woodward received at Altcourse was not equivalent to that which he could have expected to receive in the community. In April 2022, Mr Woodward was unable to attend a hospital appointment under the NHS suspected cancer pathway, because prison staff were not available to take him.
5. On 14 June, when Mr Woodward was admitted to hospital, prison managers judged that he should be handcuffed. Mr Woodward continued to be restrained until the day after he moved to a hospice, over two weeks later, despite his deteriorating health. It is disappointing that we have again identified deficiencies with risk assessments for seriously ill prisoners at Altcourse. The Head of Custodial Contracts for HMPPS will need to address this issue urgently.

Recommendations

- The Director should ensure that prisoners are able to attend two-week-wait suspected cancer pathway hospital appointments.
- The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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 Head of Custodial Contracts for HMPPS should write to the Ombudsman to set out what action he has taken to satisfy himself that meaningful improvements have been made to the assessment of risk and use of restraints on terminally ill prisoners.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Woodward's clinical care at Altcourse.
7. The PPO investigator investigated the non-clinical issues relating to Mr Woodward's care, including Mr Woodward's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The Ombudsman's family liaison officer wrote to Mr Woodward's son to explain the investigation. He did not respond.
9. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Previous deaths at HMP Altcourse

10. In the two years before Mr Woodward's death, thirteen prisoners died from natural causes at Altcourse, two of which were as a result of COVID-19. There were also four self-inflicted deaths in the same period. Our reports into the deaths of prisoners in November 2020 and February 2022 made recommendations regarding the inappropriate use of restraints for prisoners being taken to hospital.

Key Events

11. In July 2017, Mr Roy Woodward was remanded in custody to HMP Altcourse. In January 2018, he was sentenced to nine years in prison for sex offences and was later transferred to HMP Stafford. On 27 January 2021, Mr Woodward was convicted of further sex offences. On 7 January 2022, he was transferred back to Altcourse.
12. On 25 March, Mr Woodward was reviewed by a prison GP after he said that he had chest pain when breathing. The GP noted that Mr Woodward had had COVID-19 in January. He now had a two-to-three-day history of a cough and reduced air entry to his right lung. The GP prescribed antibiotics and asked for a chest X-ray.
13. On 31 March, Mr Woodward did not attend a mobile X-ray appointment. We do not know why he did not attend the appointment. That same day, a prison GP reviewed Mr Woodward and noted that he had a “resolving chest infection”, costochondritis (inflammation where the ribs join to the bone in the middle of the chest) and pleurisy (inflammation of the tissue between the lungs and ribcage). The GP changed Mr Woodward’s antibiotic and prescribed him pain relief. He noted that Mr Woodward still required a chest X-ray.
14. On 4 April, Mr Woodward had a chest X-ray.
15. On the same day Mr Woodward was sentenced to 21 years in prison.
16. On 7 April, a prison GP reviewed the chest X-ray and saw a lung mass. He referred Mr Woodward to the Respiratory Medicine Unit under the NHS suspected cancer pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks.
17. On 20 April, Mr Woodward was due to go to hospital under the two-week suspected cancer pathway referral. A healthcare information officer noted that Mr Woodward did not attend the hospital appointment because of prison staffing issues. She noted that prison staff had been dealing with a medical emergency. She noted that she telephoned the Duty Director to tell him that Mr Woodward’s appointment was for a two-week-wait cancer referral and that he must attend. She noted that the Duty Operations Manager told her that Mr Woodward would go to hospital but that he would be late.
18. The healthcare information officer recorded that she told hospital staff that Mr Woodward would be an hour late, but that they were unable to hold the appointment for him. She noted that the appointment was rearranged for 25 April.
19. On 25 April, Mr Woodward went to hospital and had a CT scan, which showed that he had a six-centimetre mass to the right upper part of his lung.
20. On 25 May, Mr Woodward had a PET CT scan (a scan which produces a detailed three-dimensional image of the inside of the body). The scan showed that Mr Woodward had lung cancer which was spreading to other parts of his body, including his bones and his liver.

21. On 14 June, Mr Woodward went to hospital for a review. Before he went to hospital, prison staff completed an escort risk assessment. A nurse completed the medical section and did not object to the use of restraints. She noted that the appointment was for chemotherapy/other lifesaving treatment. A first-line manager (FLM) completed the security assessment and noted that Mr Woodward was a high risk to the public, a high risk to the victim and a high risk of violence (all linked to his offence). He noted that Mr Woodward was a low risk of escape. The Head of Security authorised that Mr Woodward be double cuffed (double cuffing is when the prisoner's hands are handcuffed in front of them, and one wrist is attached to a prison officer by an additional set of handcuffs). When he went to hospital, Mr Woodward was escorted by two officers and restrained by a double cuff.
22. Mr Woodward was assessed by a respiratory medicine consultant who noted that his observations were grossly abnormal and arranged for him to be admitted to hospital. The following day, when Mr Woodward moved to a hospital ward, the Head of Security reviewed the level of restraint and authorised that it be reduced to an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).
23. Mr Woodward remained in hospital. His health deteriorated and officers at the hospital noted that healthcare staff attached a drip, that he was in pain and receiving pain relief. On 17 June, when Mr Woodward had a magnetic resonance imaging (MRI) scan a senior manager authorised that he be restrained with plastic cuffs for the scan. That same day, an officer noted that Mr Woodward was advised by hospital staff to remain flat on his back with his legs straight and still because the cancer in his spine could cause paralysis.
24. On 19 June, Mr Woodward was taken to another hospital for cancer treatment. When he received radiotherapy, a senior prison manager authorised that the restraints could be removed. They were reapplied after the treatment. Mr Woodward was transferred to this hospital every second day for cancer treatment.
25. On 21 June, prison staff reviewed Mr Woodward's restraints. The Head of Security authorised that the level of restraint should remain as an escort chain.
26. On 29 June, Mr Woodward was transferred to the Woodlands Hospice. The following day, the Head of Security reviewed the level of restraint and authorised that the restraints should be removed. He instructed that restraints should be reapplied were Mr Woodward to leave his room for treatment.
27. On 23 July, Mr Woodward died at the hospice.

Post-mortem report

28. There was no post-mortem examination. A palliative medicine doctor gave the cause of death as metastatic lung cancer (lung cancer which had spread to other parts of his body).

Non-Clinical Findings

Missed hospital appointment

29. On 20 April 2022, Mr Woodward was unable to attend a hospital appointment under the NHS suspected cancer pathway because prison staff were busy dealing with a medical emergency in the prison. The clinical reviewer found that, as a result, Mr Woodward was not seen in line with National Institute for Health and Care Excellence (NICE) guidelines for suspected cancer.
30. We accept that prison staff were dealing with a medical emergency when Mr Woodward needed to go to his hospital appointment. However, two-week-wait cancer referrals are important and prison managers should make every effort to ensure that prisoners attend these hospital appointments. We make the following recommendation:

The Director should ensure that prisoners are able to attend two-week-wait suspected cancer pathway hospital appointments.

Restraints, security and escorts

31. 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.
32. 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. It said 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.
33. On 14 June, when Mr Woodward was admitted to hospital, prison staff completed an escort risk assessment. The nurse completing the medical section did not object to the use of restraints. A prison manager authorised that Mr Woodward be restrained with a double cuff which after he was admitted to hospital was reviewed and Mr Woodward was restrained for an escort chain.
34. Mr Woodward's health deteriorated in hospital and, soon after he was admitted, hospital staff put him on a drip for pain relief. Tests showed that the cancer had spread to his bones and liver. Mr Woodward was told to lie on his back to prevent paralysis. Despite this, Mr Woodward was restrained throughout his stay and the only time the restraints were removed was when he received radiotherapy. Some scans took place in handcuffs. It was not until a day after he had been moved to a hospice that a prison manager authorised that the restraints be removed. Even then, the manager told officers to restrain Mr Woodward if he had to leave his room for further treatment.

35. We do not think that it was appropriate that Mr Woodward was restrained in hospital when he was very ill and receiving potentially life-saving treatment. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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.

36. We have previously made recommendations to address Altcourse's use of restraints on prisoners who are terminally ill. It is disappointing that this practice has continued, and particularly shocking in these circumstances when Mr Woodward was restrained for over two weeks in hospital and after his transfer to a hospice to receive end of life care. We consider that urgent action is now required. We make the following recommendation:

The Head of Custodial Contracts for HMPPS should write to the Ombudsman to set out what action he has taken to satisfy himself that meaningful improvements have been made to the assessment of risk and use of restraints on terminally ill prisoners.

**Mark Judd
Acting Assistant Prisons and Probation Ombudsman
March 2023**

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Ombudsman
Independent Investigations

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

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

T | 020 7633 4100