Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Woodland, a prisoner at HMP Frankland, on 5 September 2023

A report by the Prisons and Probation Ombudsman

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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

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. 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. Mr John Woodland died in hospital of bilateral pneumonia (an inflammation of both lungs usually caused by an infection) on 5 September 2023, while a prisoner at HMP Frankland. Mr Woodland also had small cell lung carcinoma (lung cancer), chronic obstructive pulmonary disease (COPD - a lung disease) and hypertension (high blood pressure) which contributed to but did not cause his death. He was 72 years old. We offer our condolences to Mr Woodland's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Woodland received at HMP Frankland was partially equivalent to that which he could have expected to receive in the community. While there was evidence of good practice, she made recommendations relating to delays with annual reviews and nursing care plans. The clinical reviewer also made a recommendation not related to Mr Woodland's cause of death. The Head of Healthcare will wish to address these recommendations.

5. We concluded that the decision to restrain Mr Woodland when he went to hospital on 22 August 2023 was not appropriate.

Recommendations

- The Head of Healthcare should ensure that all prisoners with long-term conditions are offered an annual review.

- The Head of Healthcare should ensure that nursing care plans are implemented in a timely manner to deliver consistent, high-quality care.

- The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments justifying the use of restraints on 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

6. HMPPS notified us of Mr Woodland's death on 6 September 2023.

7. NHS England commissioned an independent clinical reviewer to review Mr Woodland's clinical care at HMP Frankland. The clinical reviewer's report is attached as Annex 1.

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

9. Mr Woodland had no recorded next of kin.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). They provided additional information about an agreement between the prison manager and hospital doctor for Mr Woodland to remain restrained unless his condition deteriorated. This report has been amended accordingly. The action plan has been annexed to this report.

Previous deaths at HMP Prison

11. Mr Woodland was the seventeenth prisoner to die at HMP Frankland since 5 September 2020. Of the previous deaths, sixteen were from natural causes and one was self-inflicted. In several of these cases, we have raised concerns about the inappropriate use of restraints.

Key Events

12. In 2007, Mr John Woodland was sentenced to four years imprisonment for a violent offence. When his victim died, Mr Woodland was convicted of murder. In 2009, he was resentenced to life imprisonment with a minimum tariff of 11 years. He transferred to HMP Frankland on 18 December 2009.

13. Mr Woodland's past medical history included COPD and hypertension. Mr Woodland was referred to the long-term conditions pathway when he transferred to Frankland.

14. On 15 June 2022, Mr Woodland was assessed by healthcare staff after coughing up blood. Healthcare staff urgently referred him for tests due to concerns Mr Woodland had lung cancer.

15. On 12 July, Mr Woodland had a CT scan (a test that takes detailed pictures of the inside of your body) which identified a mass in Mr Woodland's right lung and doctors suspected it was cancer. Mr Woodland also had a bronchoscopy (a procedure that allows a doctor to see the inside of the airways and remove a small sample of cells). The procedure showed progression of the lung tumour.

16. On 22 August, the results of Mr Woodland's bronchoscopy confirmed squamous carcinoma (a type of cancer). Mr Woodland was added to the Palliative Care Register at Frankland (a register for people who could be approaching the end of their life to discuss their care and progress).

17. Mr Woodland received chemotherapy between 13 February and 24 March 2023. His tumour responded well to treatment.

18. On 18 July, Mr Woodland developed a chest infection. He attended hospital and had a chest X-ray which confirmed that he had pneumonia. The next day, he returned to the prison and continued to take antibiotics.

19. On 22 August, a healthcare assistant reviewed Mr Woodland who was breathless, had high blood pressure and low oxygen saturation (90%). They referred Mr Woodland to a GP at the prison. The GP noted that Mr Woodland appeared pale and, after a chest examination, noted that he had a "widespread wheeze". Mr Woodland also said that he had started to cough up blood. Due to the deterioration in his condition, the GP arranged for Mr Woodland to go to hospital for assessment.

20. A nurse completed a risk assessment and had no medical objections to restraints being used when Mr Woodland went to hospital. In the box entitled "*Special instruction and cuffing advice*", they wrote, "This prisoner has been referred for emergency treatment by the GP within HMP Frankland. John has breathing problems and has a history of lung cancer this may affect his mobility and he may need a wheelchair for transfer to the hospital. This gentleman is on the palliative care register. His condition may deteriorate while out at hospital."

21. Mr Woodland was restrained using an escort chain and two officers accompanied him. (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.)

22. Following transfer to hospital, Mr Woodland's health rapidly deteriorated. On 23 August, escort staff observed that Mr Woodland was struggling with his breathing when walking to and from the toilet.

23. On 26 August, escort staff noted that Mr Woodland was experiencing pain in his lungs. Mr Woodland rated his pain from a scale of one (lowest) to ten (highest) as a ten. Mr Woodland was out of breath and had an oxygen mask. Later that day, the nurse was concerned that his blood pressure was low.

24. On 30 August at 7.45am, Mr Woodland told escort officers that he was not feeling well. At 2.15pm, a hospital doctor told escort staff that Mr Woodland's condition was deteriorating. An escort officer noted that he was unable to walk without oxygen and was unsteady on his feet. The escort officer requested a new risk assessment from the prison manager for permission to remove the restraints. At 3.20pm, a prison manager went to the hospital and spoke to the hospital doctor about Mr Woodland's current condition. The doctor told the manager that Mr Woodland was very unwell, he needed permanent oxygen, could not get to the door of the room without it and could not escape. However, they agreed that for the safety of those in the hospital, the restraints would remain in place unless Mr Woodland's condition further deteriorated.

25. Early on 31 August, Mr Woodland woke up in a distressed state, unable to breathe. Nurses assessed him and stabilised him. A doctor attended and Mr Woodland had an X-ray. The doctor asked for Mr Woodland's restraints to be removed due to Mr Woodland's very low oxygen saturation levels. Around 4.00am, escort staff spoke to a prison manager who authorised the restraints were removed. Mr Woodland moved to a respiratory ward (a ward specifically for people with breathing issues for higher levels of monitoring and support.)

26. On 4 September, Mr Woodland was distressed and struggling to breathe. On 5 September, he received further medication to help manage his pain. Mr Woodland died later that evening.

Post-mortem report

27. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Woodland's cause of death as bilateral pneumonia. Lung carcinoma, COPD, and hypertension were also listed as contributory factors.

Non-Clinical Findings

Restraints, security and escorts

28. 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. 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.

29. The investigator reviewed the escort risk assessment completed on 22 August 2023. The assessment was completed thoroughly and there were no medical objections to restraints. Healthcare staff had also answered 'no' to the question whether Mr Woodland's medical condition restricted his ability to escape unaided. However, the risk assessment also noted contradictory information that Mr Woodland had breathing problems and lung cancer which may affect his mobility and he might need a wheelchair for transfer to hospital.

30. Mr Woodland had been assessed as posing a high risk of harm to the public due to his conviction for murder and further historic offences which were currently being investigated. He was also assessed as a medium risk of escape. Mr Woodland was restrained with an escort chain. However, given Mr Woodland's breathing problems and compromised mobility, we conclude that the nurse should have objected to the use of restraints and Mr Woodland should not have been restrained when he went to hospital on 22 August. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments justifying the use of restraints on 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.

Adrian Usher
Prisons and Probation Ombudsman **May 2024**

Inquest

At the inquest, held on 1 February 2024, the Coroner concluded that Mr Woodland died from natural causes.

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