

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Woodhouse a prisoner at HMP Channings Wood on 1 March 2017

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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.

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

Mr Anthony Woodhouse died on 1 March 2017 while a prisoner at HMP Channings Wood. He died of a haemorrhage in his stomach as a result of liver disease. He was 69 years old. I offer my condolences to Mr Woodhouse's family and friends.

The clinical reviewer found that the care Mr Woodhouse received after he was diagnosed with cirrhosis of the liver was equivalent to that he could expect to have received in the community. However, I am concerned that prison clinicians stopped and then amended a prescription without discussion with the specialist who prescribed it, and that there were nursing deficiencies when Mr Woodhouse became seriously ill.

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

September 2017

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Summary

Events

1. Mr Anthony Woodhouse was sentenced to 17 years in prison in December 2008. He spent time in a number of prisons before he was transferred to HMP Channings Wood in March 2013.
2. Between 2009 and 2011, blood tests indicated Mr Woodhouse had abnormal liver function. In May 2011, specialists diagnosed him with cirrhosis of the liver. Prison and hospital clinicians monitored Mr Woodhouse regularly.
3. In January 2013, hospital clinicians diagnosed and treated Mr Woodhouse for hepatic encephalopathy (a brain condition which is a complication of chronic liver disease). Over the next four years, Mr Woodhouse deteriorated slowly and had increasing episodes of confusion. He was diagnosed and treated for gastric varices (swollen veins in the stomach). Both prison and hospital clinicians saw him regularly and reviewed his medication.
4. In January 2016, a specialist prescribed a specific medication for Mr Woodhouse. Prison doctors stopped the prescription in March, without discussing it with the specialist who prescribed it. After the specialist raised concerns in April, the medication was started again. Prison doctors reduced the dose in August, again without discussion with the specialist.
5. Over the next year, both hospital and prison doctors saw Mr Woodhouse regularly and his condition deteriorated over time. Overnight on 20 February 2017, staff monitored Mr Woodhouse, who had started to vomit and pass blood.
6. On 21 February, a nurse took Mr Woodhouse's blood pressure but failed to note a significant drop from the day before. Later that day, a nurse manager noted Mr Woodhouse was still passing blood and his blood pressure had fallen further. Mr Woodhouse was taken to hospital by ambulance.
7. Hospital clinicians treated Mr Woodhouse for a significant gastric bleed. He remained critical but stable for several days, but on 1 March, he had a gastric haemorrhage and died that day.

Findings

Clinical care

8. The clinical reviewer found that the care Mr Woodhouse received after he was diagnosed with cirrhosis of the liver was equivalent to that he could expect to have received in the community.
9. We consider it inappropriate that doctors at Channings Wood stopped and then amended a prescription without discussion with the specialist who prescribed the medication. It is important that when a prison and hospital share a patient's care, there is effective liaison to ensure continuity of care.
10. The clinical reviewer noted that had the nurse who saw Mr Woodhouse on 21 February did not note the significant drop in blood pressure which, along with his

other symptoms and history, would have alerted her to the possibility of a gastric bleed, warranting a pulse measurement and further investigation. While this might have resulted in an earlier admission to hospital, the clinical reviewer said it would not have affected the outcome for Mr Woodhouse. The clinical reviewer raises some concerns and makes a number of recommendations for improvement to the Heads of Healthcare at HMP Isle of Wight, HMP Winchester and HMP Channings Wood, which the relevant Head of Healthcare will need to address.

Application for compassionate release

11. Although Mr Woodhouse was seriously ill, clinicians were unable to give a clear prognosis and we are satisfied that Channings Wood was not in a position to apply for release on compassionate grounds any earlier.

Family liaison

12. We are satisfied that Channing Woods' family liaison officer took reasonable steps to contact Mr Woodhouse's son to tell him he was critically ill in hospital and subsequently to break the news of his death.

Recommendations

- The Head of Healthcare at Channings Wood should ensure that prison clinicians discuss any amendment to medication with the specialist who prescribed it.
- The Head of Healthcare at Channings Wood should ensure that, when recording observations, nursing staff note previous readings and the prisoner's clinical history so that important diagnoses are not missed or delayed.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Channings Wood informing them of the investigation and asking anyone with relevant information to contact her. One prisoner contacted her.
14. The investigator obtained copies of relevant extracts from Mr Woodhouse's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr Woodhouse's clinical care at the prison.
16. We informed HM Coroner for Plymouth, Torbay and South West Devon of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
17. The investigator wrote to Mr Woodhouse's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.
18. Our investigation assessed the main issues in Mr Woodhouse's care, including his diagnosis and treatment, whether appropriate care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
19. The prison accepted our recommendations.

Background Information

HM Prison Channings Wood

20. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds over 700 men. Dorset NHS University Trust provides health services at the prison. There is one permanent GP, with locum GPs running additional clinics. Nurses are on duty every day and there is an out of hours GP service.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Channings Wood was in October 2016. Inspectors reported that the prison had deteriorated overall since their last inspection. The healthcare unit was clean and tidy and inspectors observed that staff were caring and professional. There were gaps in record keeping and a lack of care planning for prisoners with complex health needs. There were no nurse-led clinics for prisoners with long-term conditions and no effective recall system to maintain ongoing care. Such prisoners were managed through the GP, which affected GP waiting times, which were too long at six weeks.

Independent Monitoring Board

22. 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 August 2016, the IMB reported that healthcare at the prison continued to be a concern. The healthcare service was inconsistent, mainly due to a shortage of staff. Recent sick leave had increased the already long wait to see a GP and prisoners had to wait too long to access specialist services. Many prisoners had to wait too long to receive prescribed medication and hospital appointments were often missed. The IMB considered that the overall provision of healthcare at the prison fell short of that provided in the community but commended the conscientiousness of many staff.

Previous deaths at HMP Channings Wood

23. Mr Woodhouse was the fifth prisoner to die of natural causes since January 2015. There were no significant similarities with the circumstances of the previous deaths.

Findings

Diagnosing Mr Woodhouse's terminal illness

24. On 11 December 2008, Mr Anthony Woodhouse was sentenced to 17 years in prison for sexual offences. He spent time at a number of prisons.
25. Between 2009 and 2011, Mr Woodhouse had numerous blood tests which showed abnormal liver function. In May 2011, while Mr Woodhouse was held at HMP Isle of Wight, specialists diagnosed cirrhosis of the liver. However, the clinical reviewer was concerned that there was a delay in referring him to a liver specialist after his abnormal blood test results. The clinical reviewer was satisfied that Mr Woodhouse was well informed and supported after his diagnosis.
26. While this did not affect the outcome for Mr Woodhouse, the clinical reviewer said that the care Mr Woodhouse received before his diagnosis was not equivalent to that he could reasonably have expected in the community. He made a number of recommendations which the Head of Healthcare at HMP Isle of Wight will need to address.

Mr Woodhouse's clinical care

27. From May 2011, specialists monitored and treated Mr Woodhouse's cirrhosis of the liver. He was diagnosed and treated for gastric varices (swollen veins in the stomach, a complication of liver disease). He had periods of confusion which, clinicians noted, indicated his liver disease might have progressed. Prison and hospital clinicians treated him regularly and reviewed his medication.
28. In January 2013, Mr Woodhouse spent a few days in hospital after he became increasingly confused. Specialists diagnosed hepatic encephalopathy (a complication of liver failure caused by toxic substances building up in the bloodstream). Mr Woodhouse recovered after taking antibiotics and laxatives.
29. On 13 March 2013, Mr Woodhouse was moved to HMP Channings Wood, where a prison GP referred him to a consultant gastroenterologist at the hospital. His specialist noted that he was often incontinent and slept a lot. He noted Mr Woodhouse had a hepatic encephalopathic flap (a tremor of the hand due to inflammation in the brain).
30. On 12 May, Mr Woodhouse was admitted to hospital for assessment and treatment. He returned to prison on 29 May, and doctors implemented good care plans. The clinical reviewer noted that Mr Woodhouse received good care plan reviews for the rest of his life. Over the next four years, he deteriorated slowly and increasingly had episodes of confusion.
31. Clinicians saw Mr Woodhouse regularly and carried out regular blood tests. He remained fairly stable, with occasional mild confusion. An ultrasound scan in December 2013 showed his liver had shrunk, consistent with chronic liver disease. A prison GP discussed the scan results with Mr Woodhouse.
32. In 2014, prison and hospital clinicians monitored Mr Woodhouse as his condition deteriorated. He had constipation, for which doctors prescribed laxatives. Mr

Woodhouse often asked for the dose to be reduced, but this usually resulted in increased confusion, so doctors increased the dose again.

33. On 10 February 2015, hospital doctors reduced a shunt that had previously been inserted in Mr Woodhouse's liver to try to reduce his encephalopathy. He returned to prison the next day. On 16 April, a consultant and specialist nurse practitioner noted a slight improvement and that Mr Woodhouse slept better but remained unsteady occasionally.
34. In July, a gastroscopy revealed a large stomach varix. In December, a CT scan revealed a clot in the portal vein and large varices in the spleen.
35. In January 2016, the specialist prescribed rifaximin for Mr Woodhouse (an antibiotic used to treat hepatic encephalopathy). Prison clinicians appear to have stopped the medication in March without discussing it with the hospital consultant who prescribed it.
36. On 21 April, the consultant saw Mr Woodhouse and noted the importance of rifaximin and that prison GPs had discontinued it without his knowledge. Afterwards, Mr Woodhouse received rifaximin, prison GPs implemented a medication management plan, and the hospital agreed to prescribe and supply rifaximin every three months.
37. Over the next eight months, hospital and prison clinicians saw Mr Woodhouse regularly. He remained stable, but with periods of confusion. He had regular blood tests which showed his liver function deteriorating over time. In August, prison clinicians reduced his rifaximin dose from two tablets a day down to one tablet a day. The records do not explain why. In September, a CT scan showed the clot in his portal vein had gone. In November, the consultant increased the dose of rifaximin back to two tablets a day.
38. On 1 December 2016, Mr Woodhouse was admitted to hospital after falling and fracturing his wrist. Hospital doctors noted he was confused, off balance and had no sensation in his buttocks and thighs. Mr Woodhouse was moved to another hospital for tests. An MRI scan showed he had injured his spine. He was fitted with a back brace. Mr Woodhouse was moved to another hospital for rehabilitation on 12 December.
39. On 24 December, Mr Woodhouse returned to prison, and a GP appropriately assessed Mr Woodhouse the next day.
40. On 12 January 2017, a prison GP saw Mr Woodhouse and noted that he had pain in his wrist and back. He was confused, looked frail and had lost weight. She arranged urgent blood tests and an occupational therapy assessment. The blood tests were abnormal and his liver function tests were slightly worse, so on 18 January she sent him to hospital, with a referral letter. Hospital clinicians reviewed and amended Mr Woodhouse's medication and he returned to prison the next day.
41. On 2 February, the consultant and specialist nurse practitioner saw Mr Woodhouse again. They noted his progressive decline and weight loss, and that Mr Woodhouse's outlook was poor. Prison GPs continued to see him frequently. On the morning of 20 February, healthcare staff noted that Mr Woodhouse was

very jaundiced and arranged for a GP to review him. That afternoon, a prison GP saw Mr Woodhouse and noted he was “off his food” and not sleeping, his urine was darker than normal and he was jaundiced. Staff agreed to take blood and urine tests and review him in 24 hours. The clinical reviewer was satisfied this was an appropriate assessment.

42. During the night, the prison called the out of hours GP as Mr Woodhouse had diarrhoea and vomiting and had passed some blood. The GP advised overnight monitoring and for him to see the prison GP in the morning. The clinical reviewer was satisfied that this advice was appropriate.
43. On 21 February, Mr Woodhouse was still unwell and said he was passing blood. A nurse noted his blood pressure was normal (112/66), but did not record his pulse. The clinical reviewer said this was a significant omission. The nurse did not note that his pressure was a significant drop from the day before (132/82). The clinical reviewer said given his history, the drop should have alerted the nurse that the rectal bleeding described by Mr Woodhouse warranted further examination, including a pulse measurement.
44. Later that day, a nurse manager saw Mr Woodhouse who was still unwell. He told the nurse manager that he had rectal bleeding for several days. The nurse manager noted his blood pressure had fallen to 100/40 and his pulse was raised. He helped Mr Woodhouse back to bed and noted his blood pressure was now 98/45 and pulse had fallen. He arranged for Mr Woodhouse to go to hospital by ambulance.
45. Hospital clinicians treated him for a bleeding gastric varix and he remained critical but stable in hospital. On 27 February, the hospital told the prison that Mr Woodhouse’s condition had improved and they were considering whether to transfer him to a community hospital. Mr Woodhouse’s health then deteriorated, and he had a gastric haemorrhage.
46. He died at 10.32am on 1 March 2017. The coroner confirmed the cause of death was an acute gastric variceal haemorrhage caused by liver cirrhosis.
47. The clinical reviewer made a number of recommendations, which the Heads of Healthcare for HMP Winchester and Channings Wood will need to address. The clinical reviewer was concerned that prison GPs stopped and then reduced Mr Woodhouse’s medication (rifaximin) without discussion with the specialist who prescribed it. It is important that prison and hospital clinicians liaise well with each other when a patient’s care is shared to ensure effective continuity of care. We make the following recommendation:

The Head of Healthcare at Channings Wood should ensure that prison clinicians discuss any amendment to medication with the specialist who prescribed it.

48. The clinical reviewer was concerned that the nurse did not note the significant drop in Mr Woodhouse’s blood pressure on 21 February and did not take his pulse. The clinical reviewer considered this would have alerted the nurse that the rectal bleeding Mr Woodhouse described warranted investigation. He noted

this might have resulted in Mr Woodhouse going to hospital sooner, but would not have affected the outcome. We make the following recommendation:

The Head of Healthcare at Channings Wood should ensure that when recording observations, nursing staff note previous readings and the prisoner's clinical history so that important diagnoses are not missed or delayed.

Despite these concerns, we agree with the clinical reviewer that the care Mr Woodhouse received in prison after his diagnosis was equivalent to that which he could have expected to receive in the community. Prison clinicians regularly and carefully assessed him and staff showed a high level of caring and concern

Mr Woodhouse's location

49. We are satisfied that Mr Woodhouse was appropriately located during his illness and received the care he required. He remained in a standard residential cell for the majority of time. Clinicians occasionally admitted him to the prison's inpatient unit and appropriately sent him to hospital when his condition worsened.

Restraints and security

50. When prisoners travel outside of prison, a risk assessment determines the nature and level of security arrangements, including restraints. Restraints should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's health and mobility. We were pleased to note that Mr Woodhouse was not restrained in hospital.

Liaison with Mr Woodhouse's family

51. The Prison Service expects that the next of kin of a deceased prisoner is informed in person by a member of prison staff. Mr Woodhouse's son, his next of kin, lived in Portugal. A Supervising Officer (SO) was appointed as the prison's family liaison officer on 23 February 2017. He tried to contact Mr Woodhouse's son, trying several telephone numbers from his phone records and a number Mr Woodhouse's probation officer had given him. No one responded, so the SO left a voicemail for Mr Woodhouse's son to contact the prison.
52. After Mr Woodhouse died on 1 March, the SO tried again to call, and this time Mr Woodhouse's son answered. He said he knew his father was very ill and possibly near death. The SO broke the news of his father's death and offered his support. Channings Wood contributed to the cost of Mr Woodhouse's funeral in line with national policy. We are satisfied that the SO took reasonable steps to contact Mr Woodhouse's son to inform him he was critically ill in hospital and subsequently to inform him of his death.

Compassionate release

53. Prisoners can be released from custody before their sentence has expired on compassionate grounds. This is usually for medical reasons such as when they have a terminal illness and a life expectancy of less than three months. On 24 February, staff started an application to release Mr Woodhouse on compassionate grounds but he died before it was completed. Although Mr

Woodhouse was seriously ill, clinicians were unable to give a clear prognosis and we are satisfied that Channings Wood was not in a position to apply for release on compassionate grounds any earlier.

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