Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David James Woodhouse, a prisoner at HMP Full Sutton, on 18 October 2021

A report by the Prisons and Probation Ombudsman

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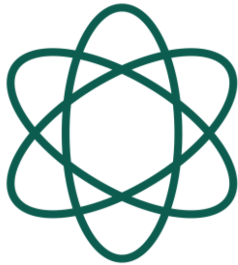
Our vision

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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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 David James Woodhouse died on 18 October 2021 of heart failure at HMP Full Sutton. He was 70 years old. I offer my condolences to Mr Woodhouse's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Woodhouse received at Full Sutton was equivalent to that which he could have expected to receive in the community. She made two recommendations about improving the management of the risk of falls and replacing faulty equipment.

5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Woodhouse's clinical care at Full Sutton.

7. The PPO investigator has investigated non-clinical issues, including Mr Woodhouse's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. The PPO family liaison officer wrote to Mr Woodhouse's next of kin, his wife, to explain the investigation. She had concerns about his end of life care. The clinical reviewer has addressed her concerns in the clinical review report.

9. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

10. We sent a copy of our initial report to Mr Woodhouse's wife. She did not notify us of any factual inaccuracies.

Previous deaths at HMP Full Sutton

11. Mr Woodhouse was the seventh prisoner to die at Full Sutton since October 2019. Of the previous deaths, five were from natural causes and one was self-inflicted.

12. There are no similarities between our findings in the investigation into Mr Woodhouse's death and our investigation findings for the previous deaths.

Key Events

13. On 8 July 2016, Mr Woodhouse was sentenced to 18 years imprisonment for sexual offences. On 4 August, he transferred to HMP Full Sutton.

14. Mr Woodhouse had several pre-existing medical conditions, including obesity (February 1999), hypertension (March 1999), ischaemic heart disease (December 2002) and type 2 diabetes mellitus (February 2003).

15. On 5 August, Mr Woodhouse had his reception health screening. Healthcare staff created detailed and appropriate care plans to manage his complex medical needs, which were regularly reviewed and updated.

16. In July 2018, Mr Woodhouse was diagnosed with rectal cancer. Initially, the disease responded well to radiotherapy.

2021

17. In June 2021, Mr Woodhouse's cancer returned and was assessed as terminal as the tumour could not be removed surgically.

18. On 3 September, after a series of falls, Mr Woodhouse was taken to York District hospital and admitted as an inpatient. He was diagnosed with urosepsis (a serious complication of a urinary tract infection). Examinations showed that the cancer in Mr Woodhouse's rectum had grown significantly and blocked the nerves at the bottom of his spine. A consultant at the hospital completed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order on Mr Woodhouse's behalf meaning that in the event his heart or breathing stopped he would not be resuscitated. A copy of the order was sent to the prison.

19. On 30 September, Mr Woodhouse returned to Full Sutton and his care was now palliative. Consideration was given to moving him to another prison with more resources to manage his declining health. Mr Woodhouse said that he did not want to leave Full Sutton. The prison created a care plan to allow him to remain there.

20. On 17 October, Mr Woodhouse said that he did want to be resuscitated if required until he could see his family. Healthcare staff arranged an emergency visit with Mr Woodhouse and has family the same day. A nurse explained the DNACPR order to Mr Woodhouse's family and why resuscitation was not in his best interests. Medical records indicate that, 'the relatives appeared to understand the decision about the DNACPR'.

21. At 9.48am on 18 October, it was confirmed that Mr Woodhouse had died.

Post-mortem report

22. The Coroner gave Mr Woodhouse's cause of death as congestive cardiac failure caused by hypertension, chronic kidney disease and obesity. He also had liver cirrhosis and diabetes mellitus, which did not cause but contributed to his death.

Lisa Burrell
Assistant Prisons and Probation Ombudsman **August 2022**

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