Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Hudson, a prisoner at HMP High Down, on 5 April 2023

A report by the Prisons and Probation Ombudsman

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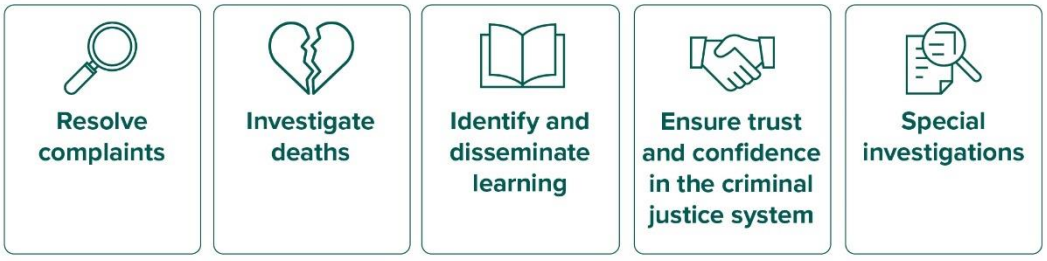
OUR VISION

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

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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. 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 Colin Hudson died in hospital of multiple organ failure with bilateral pneumonia caused by chronic obstructive pulmonary disease (COPD, a lung condition that causes breathing difficulties) with chronic myeloid leukaemia (a blood cancer), on 5 April 2023, while a prisoner at HMP High Down. He was 68 years old. We offer our condolences to Mr Hudson's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Hudson received at High Down was partially equivalent to that which he could have expected to receive in the community. She found that Mr Hudson should have had a cancer care plan in place from an earlier stage. The clinical reviewer made other recommendations about areas not directly related to Mr Hudson's death.

5. Restraints were disproportionately used in hospital, without due consideration for Mr Hudson's advanced age, frailty, and poor mobility.

Recommendations

- The Head of Healthcare should ensure that all patients with a cancer diagnosis have a formal and regularly reviewed care plan, in accordance with NICE guidelines.

- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.

The Investigation Process

6. We were notified of Mr Hudson's death on 5 April 2023.

7. NHS England commissioned an independent clinical reviewer to review Mr Hudson's clinical care at HMP High Down.

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

9. The PPO family liaison officer wrote to Mr Hudson's sister to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Hudson's sister asked some questions that were not directly related to his death and asked for a copy of our report.

10. An MP wrote to the Ombudsman on behalf of Mr Hudson's sister, his constituent, and asked the Ombudsman to investigate concerns she had raised with him. In her email to the MP, Mr Hudson's sister said that he was not released on compassionate grounds before his death. She said hospital staff made his family aware that he was very unwell three or four days before he died, but prison staff did not inform them of this. She also asked some questions that fall outside the remit of this investigation.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

12. Mr Hudson's family received a copy of the draft report. They did not make any comments.

Previous deaths at HMP High Down

13. Mr Hudson was the eighth prisoner to die at HMP High Down since April 2020. Of the previous deaths, four were from natural causes, two were self-inflicted and the cause of one is not yet known.

14. There are no significant similarities between the findings in our investigation into Mr Hudson's death and the findings from our investigations into the previous deaths.

Key Events

15. On 27 July 2018, Mr Hudson received an eight-year sentence for a sexual offence and was transferred to HMP High Down.

16. In 2021, Mr Hudson was diagnosed with atypical chronic myeloid leukaemia and, on 17 November, he started oral chemotherapy medication.

17. On 23 December, a Palliative Care Team assessed Mr Hudson and started advanced care planning. His condition remained stable for several months.

18. On 25 August 2022, the GP at High Down was notified that Mr Hudson's blood test results showed an increased white blood cell count. On 26 August, Mr Hudson was admitted to hospital, and on 28 August, he was discharged back to High Down with an increase in oral chemotherapy medication.

19. On 4 November, a Complex Case Multidisciplinary Team (MDT) discussed Mr Hudson's case. They noted that he was now receiving blood transfusions every other week and asked the Palliative Care Team to see him again.

20. On 7 November, Mr Hudson's Haematology Consultant emailed the healthcare team and said that he was transfusion dependent and the average life expectancy for someone with his condition was approximately two years.

21. On 15 November, a Complex Case MDT discussed Mr Hudson and noted that the Haematology Consultant had expressed concerns that the prison may not be able to facilitate his attendance at appointments in the future due to his predicted deteriorating condition. They concluded that staff would consider applying for Early Release on Compassionate Grounds so that he could transfer to a hospice when he needed to.

22. On 28 November, a Community Palliative Care Consultant met with Mr Hudson and informed him that he had a terminal haematological malignancy (blood cancer).

23. On 24 January 2023, a Haematology Consultant provided a letter to support the application for Early Release on Compassionate Grounds on Mr Hudson's behalf, which said that his life expectancy would be approximately one to two years.

24. On 3 March, a GP completed the healthcare section of the application for Early Release on Compassionate Grounds and said that it was difficult to predict Mr Hudson's prognosis but that it could be between months and a short number of years.

25. On 16 March, Mr Hudson attended hospital for an outpatient appointment. Prior to the appointment, staff completed an Escort Risk Assessment. On 13 March, a member of healthcare staff completed the section about healthcare information and indicated that he objected to the use of restraints because Mr Hudson was a cancer patient, elderly and frail and had reduced mobility. Wing staff reported that he complied with the regime. On 15 March, an operational manager authorised the use of single handcuffs and an escort chain. He did not record why restraints were necessary despite the healthcare objection.

26. On 23 March, the Primary Care Service Manager at High Down saw Mr Hudson for a Cancer Care Review. They created a Cancer Care Plan.

27. On 27 March, Mr Hudson was transferred to hospital following a National Early Warning Score (NEWS2) system result that indicated he presented a high clinical risk. A Haematology Consultant explained that the treatment he was receiving was no longer effective and he was reaching the end of his life. A Do Not Attempt Cardiopulmonary Resuscitation instruction (DNACPR) was reviewed, and it was concluded that Mr Hudson would not be resuscitated in the event of a cardiac arrest. He returned to High Down on 29 March. (We requested the escort risk assessment for this inpatient stay. It was not provided, and we do not therefore know what level of restraints was authorised and used.)

28. On 29 March, the Head of the Offender Management Unit (OMU) at High Down contacted the Specialist Casework Team and advised that they would shortly be submitting an application for Early Release on Compassionate Grounds (ERCG) for Mr Hudson. The Head of OMU said hospital staff had verbally advised that Mr Hudson's prognosis was 'only weeks'. On 30 March, staff from the Specialist Casework Team requested further information.

29. On 30 March, the Primary Care Service Manager at High Down contacted Mr Hudson's sister (with his consent) to discuss his diagnosis and prognosis. They planned to have a face-to-face visit.

30. On 30 March, staff completed an Escort Risk Assessment for Mr Hudson's hospital appointment the following day. An operational manager concluded that Mr Hudson should not be restrained, and staff did not therefore apply restraints on this visit. On 31 March, Mr Hudson attended a haematology appointment for a blood transfusion. He was transferred to the High Dependency Unit because tests showed he had low haemoglobin levels. He remained in hospital until he died.

31. On 3 April, a Haematology Consultant telephoned the prison healthcare team and explained that Mr Hudson's health had further deteriorated and hospital staff were stopping his treatment. They planned to refer him to a hospice.

32. On the evening of 3 April, an application for Mr Hudson's early release on compassionate grounds was submitted to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service (HMPPS), who sought further information over the following days. Consideration of the application was not completed before he died.

33. On 4 April, staff requested further information from the Haematology Consultant to progress the Early Release on Compassionate Grounds application. They were advised that Mr Hudson's life expectancy was approximately two weeks, and he was only receiving comfort enhancing and palliative care treatment.

34. On 4 April, staff granted Mr Hudson escorted Release on Temporary Licence (ROTL). This meant that he was accompanied by one officer for support, rather than the usual two-officer escort.

35. On 4 April, a hospital family liaison officer contacted Mr Hudson's family.

36. On an unknown date, a supervising officer (SO) was appointed as a prison family liaison officer. He did not start a family liaison log nor contact Mr Hudson's family.

37. On 5 April, the SO was not at work as he was unwell. Mr Hudson's family contacted the prison and asked to speak to the family liaison officer. An operational manager appointed an administrative officer as family liaison officer in the SO's absence. She opened a log, telephoned Mr Hudson's sister, and travelled to the hospital to meet with his sisters.

38. On 5 April, a Macmillan Lead Palliative Care Specialist Nurse emailed the Head of Healthcare and said Mr Hudson would be transferring to a hospice located closer to his family. Later that morning, a consultant at the hospital emailed the Head of Healthcare and said that Mr Hudson's health had further deteriorated, and he was too unwell to travel to the hospice.

39. Mr Hudson died on 5 April. His sisters were present with him.

40. The prison family liaison officer assisted Mr Hudson's family with his funeral arrangements.

Post-mortem report

41. The Coroner recorded Mr Hudson's cause of death as multiple organ failure with bilateral pneumonia caused by chronic obstructive pulmonary disease with chronic myeloid leukaemia.

42. At an inquest held on the 22 February 2024, the Coroner concluded that Mr Hudson died of natural causes.

Findings

Clinical findings

43. The clinical reviewer found that there was a delay before Mr Hudson's cancer care plan was created. She found that it should have been in place from an earlier stage and could have been created before any discussion about his estimated prognosis. The clinical reviewer identified that it would have been helpful to have had a care plan in place earlier to identify Mr Hudson's advanced wishes, and to identify what support services he would have felt he needed, in line with NICE guidelines.

    The Head of Healthcare should ensure that all patients with a cancer diagnosis have a formal and regularly reviewed care plan, in accordance with NICE guidelines.

Compassionate release

44. Early release on compassionate grounds is the means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release are set out in the Early Release on Compassionate Grounds Policy Framework. Among the criteria is that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service (HMPPS).

45. On 3 April, staff at High Down submitted an application for compassionate release on Mr Hudson's behalf when his short life expectancy was confirmed by hospital staff.

46. Obtaining a prognosis that might meet the criteria for early release is difficult and it is often the case that such a prognosis is only available close to death. Unfortunately, Mr Hudson died while this application was under consideration. We note that staff granted Mr Hudson escorted ROTL to attend hospital while the application for early release was being considered.

Restraints, security and escorts

47. 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.

48. Mr Hudson attended hospital numerous times while at High Down. While he was not restrained on his final visit to hospital, restraints were often used on earlier visits and admissions. In March, an operational manager authorised the use of handcuffs on a hospital escort despite healthcare staff reporting that he was elderly, frail, had reduced mobility and was a cancer patient.

49. We are not satisfied that staff complied with the High Court judgement or that they fully considered Mr Hudson's risk in light of his physical health. We make the following recommendation:

    The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.

Governor to Note

Liaison with Mr Hudson's family

50. Mr Hudson's family advised us that prison staff did not notify them that his condition had deteriorated. Prison Service Instruction (PSI) 64/2011, about safer custody, says that prisons must have arrangements in place for an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill and that it is good practice to keep a related log.

51. HMP High Down appointed a family liaison officer (FLO) for Mr Hudson's family. (The date on which they appointed the FLO was not recorded and we have not been able to establish this.) The FLO did not make contact with Mr Hudson's family or keep a log. While we note that Mr Hudson was in contact with his family and that they visited him in hospital, once appointed the FLO should have initiated contact with the family, built a relationship and acted as a point of contact should the family have had any questions or concerns, particularly those relating to prison that hospital staff would not be able to answer.

52. We note that High Down appointed a second family liaison officer on the day Mr Hudson later died. She attended the hospital to meet with his family, offered support and kept a log.

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

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