Prisons & Probation Ombudsman
Independent Investigations

Investigation into the death of Mr David Hodgson, a prisoner at HMP Wakefield on 21 April 2015

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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*

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.

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

Mr David Hodgson died of bronchopneumonia and cancer of the oesophagus in HMP Wakefield on 21 April 2015. He was 67 years old. I offer my condolences to Mr Hodgson's family and friends.

The investigation found that Mr Hodgson received professional treatment, with a timely referral to secondary care. There was positive involvement from medical agencies, including the prison's healthcare team, in the planning and delivery of Mr Hodgson's treatment and care.

I consider that, overall, prison and healthcare staff treated Mr Hodgson with compassion, dignity and respect during his illness. He received care equivalent to that he could have expected to receive in the community.

This version of my report, published on my website, has been amended to remove the names staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2015**

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SUMMARY

Events

1. In 2010, Mr David Hodgson was sentenced to 22 years in prison. He arrived at HMP Wakefield on 16 May 2011. He had a history of bowel problems, high cholesterol and an enlarged prostate. He smoked cigarettes and healthcare staff offered him help to stop. Mr Hodgson received medication for his ongoing health problems, but healthcare staff did not see him often.

2. In September 2014, a prison GP saw Mr Hodgson who complained of difficulty swallowing. She referred him to a specialist and he underwent tests and X-rays. On 24 October 2014, doctors diagnosed Mr Hodgson with cancer of the oesophagus. On 4 November, the hospital admitted him for further tests and, on 17 November, hospital staff told Mr Hodgson that the cancer had spread to his spine.

3. Mr Hodgson transferred from hospital to the inpatient unit in Wakefield's healthcare unit on 10 December. On the same day, he started a course of oral chemotherapy. However, Mr Hodgson's health deteriorated and, on 24 December, he moved to the palliative care suite at Wakefield.

4. Mr Hodgson refused to attend an outpatient appointment on 24 February 2015, and declined any further active treatment. Healthcare staff continued to care for him in the palliative care suite.

5. At 9.05am on 21 April, a nurse found Mr Hodgson unresponsive, an ambulance was called and a paramedic pronounced him dead at 9.20am.

Findings

6. We are satisfied that Mr Hodgson received a good standard of care for his terminal illness. Both healthcare and prison staff treated him with compassion, dignity and respect. He was appropriately referred and his diagnosis was timely. There were appropriate care plans in place and Mr Hodgson was involved in decisions about his care. The clinical reviewer found the care Mr Hodgson received at Wakefield was equivalent to that he could have expected to receive in the community.

7. However, we are not assured that health care staff made a sufficiently proactive contribution to the decision to use of restraints on the later occasions when Mr Hodgson went to hospital.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Wakefield informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

9. The investigator obtained copies of relevant extracts from Wakefield prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Hodgson's clinical care at the prison.

11. We informed HM Coroner for West Yorkshire (Eastern) of the investigation who provided the cause of death. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Hodgson's son, his next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not raise any issues.

13. The investigation has assessed the main issues involved in Mr Hodgson's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

14. The prison received a copy of the draft report, there were no factual inaccuracies noted.

BACKGROUND INFORMATION

HMP Wakefield

15. HMP Wakefield is one of eight high security prisons in England and Wales. It holds 750 men. There are four main residential wings, a healthcare centre, segregation unit and close supervision centre for exceptionally high-risk prisoners.

16. Spectrum CIC (Community Interest Company) provides primary healthcare services during normal working hours. Humber NHS Foundation Trust (intermediate care) employs the nurses in the inpatient unit, which provides overnight and weekend care for prisoners with physical health problems. There is a dedicated palliative care suite situated in the healthcare unit.

Her Majesty's Inspectorate of Prisons

17. The most recent inspection of HMP Wakefield was in July 2014. Inspectors found that health services were good overall but some parts of the healthcare environment, including the inpatient unit, were poor. Primary care services were very good and had an appropriate emphasis on the care of patients with long-term conditions.

Independent Monitoring Board

18. 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 their latest annual report, for the year to April 2014, the IMB reported that Wakefield had a significant number of older prisoners, and this brought its own problems and challenges for the provision of healthcare. There was a monthly healthcare forum, which included representatives from each wing who acted as a representative for any queries.

Previous deaths at HMP Wakefield

19. Mr Hodgson was the sixth prisoner to die from natural causes at Wakefield since the start of 2014. We have raised the issue of the insufficiently justified use of restraints a number of times.

FINDINGS

The diagnosis of Mr Hodgson's terminal illness and informing him of his condition

20. In 2010, Mr Hodgson was sentenced to an indeterminate sentence for public protection with a minimum of 22 years to serve. He arrived at HMP Wakefield on 16 May 2011.

21. Mr Hodgson had a history of bowel problems, high cholesterol and an enlarged prostate. Despite healthcare staff offering to help him stop smoking, Mr Hodgson did not stop until 12 months before his death. Doctors prescribed medication for his ongoing health problems.

22. There is nothing significant in the records until August 2014. A prison GP, Dr saw Mr Hodgson on 21 August 2014. He complained of pain in his ribs. The doctor referred Mr Hodgson for a chest X-ray and prescribed pain relief. The X-ray was normal.

23. On 19 September, he GP saw Mr Hodgson again, complaining of stomach pains. The doctor arranged a urine test, which indicated an infection, and prescribed antibiotics. Mr Hodgson also told the doctor he had swallowing difficulties when eating solid food and swallowing liquids.

24. The GP was concerned and made an urgent referral to a specialist at Pinderfields Hospital, Wakefield under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. Mr Hodgson attended an outpatient appointment at Pinderfields Hospital on 26 September for further tests and X-rays.

25. On 2 October, Mr Hodgson returned to Pinderfields Hospital for a gastroscopy (which looks into the stomach) and biopsies. Following the procedure, a hospital doctor told Mr Hodgson he had a possible tumour in his oesophagus and prescribed pain relief. Mr Hodgson returned to Wakefield later that day.

26. Two nurses saw Mr Hodgson the following morning. They offered their support and spoke to him about his suspected cancer. Mr Hodgson was reluctant to discuss his recent visit to the hospital.

27. A specialist nurse from Pinderfields Hospital visited Mr Hodgson at Wakefield on 24 October. She confirmed that the tumour in his oesophagus was cancerous and explained that further tests and scans would be arranged to see if the cancer had spread to any other parts of his body.

28. We agree with the clinical reviewer, that Mr Hodgson was appropriately referred to a specialist and there was no delay in his diagnosis. He was told by a hospital doctor and fully supported by healthcare staff at Wakefield.

Mr Hodgson's medical treatment

29. A doctor prescribed Mr Hodgson a liquid meal supplement and made arrangements for a soft diet to aid his swallowing.

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30. On 4 November, Pinderfields Hospital admitted Mr Hodgson, as an emergency with breathing difficulties. Hospital doctors fitted a stent into his throat to help him swallow and prescribed antibiotics for an infection. Mr Hodgson remained in hospital.

31. On 17 November, a further scan revealed that Mr Hodgson's tumour had spread to his spine. A nurse from Wakefield visited Mr Hodgson and discussed his treatment with him. The plan was to use oral chemotherapy to shrink the tumour and Macmillan nurses would be involved in Mr Hodgson's palliative care.

32. Hospital staff discussed Mr Hodgson's wishes regarding resuscitation if his heart or breathing stopped. He said he did not wish to be resuscitated and signed an order to that effect on 28 November.

33. On 5 December, the nurse attended a multi-disciplinary meeting at the hospital, which confirmed Mr Hodgson's treatment would be palliative and his life expectancy was six to 12 months.

34. On 10 December, Mr Hodgson returned to Wakefield as an inpatient, the same day he started a course of chemotherapy and continued the medication on a three weekly cycle at Wakefield. A palliative care nurse led Mr Hodgson's care. A Macmillan nurse also visited frequently to offer assistance and pain relief advice

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35. On 19 December, a multi-disciplinary meeting took place using the 'Gold Standard Framework of Care' with nursing staff and a chest specialist. (The gold standard framework of care is a structured yet flexible framework, aiming to build a step-by-step approach to improve the supportive and palliative care.) Mr Hodgson's condition had deteriorated and he now required full palliative care.

36. Mr Hodgson was often confused, and on 18 February 2015, a prison GP assessed his mental capacity. The doctor confirmed that Mr Hodgson was able to make informed choices about his care.

37. On 24 February, Mr Hodgson declined to attend a hospital appointment. He told the chest specialist that he was tired and did not want any further active treatments. The doctor discussed this with Mr Hodgson and the oncologist and all agreed that Mr Hodgson would stop chemotherapy.

38. Over the following months, healthcare staff nursed Mr Hodgson palliatively, with pain relief adjusted to meet his needs. He was unable to eat and lost weight.

39. On 21 April, nurses noted that Mr Hodgson had a settled night despite his laboured breathing. At 9.05am on 22 April, the palliative care nurse found Mr Hodgson unresponsive. An ambulance was called and a paramedic confirmed Mr Hodgson had died at 9.20am.

40. The coroner gave the cause of death as bronchopneumonia, metastic oesophageal cancer and ischaemic heart disease.

41. The clinical reviewer is satisfied that Mr Hodgson received a good level of care at Wakefield. There were appropriate care plans in place and regular multi-disciplinary meetings using the Gold Standard Framework for palliative care. Mr Hodgson was appropriately involved in decisions about his care.

Mr Hodgson's location

42. Mr Hodgson transferred to the inpatient unit at Wakefield on 10 December 2014, after his discharge from hospital. On 24 December, he moved to the palliative care suite of the prison, which provided a calm and peaceful environment for his end of life care.

43. We are satisfied that Mr Hodgson was appropriately located as his health deteriorated. The clinical reviewer noted that Mr Hodgson was appropriately cared for in the palliative care suite at the end of his life.

Restraints, security and escorts

44. When prisoners have to travel outside of the prison to a hospital or hospice, a risk assessment is conducted to determine the nature and level of any security arrangements. The Prison Service has a fundamental duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and also takes account of factors such as the prisoner's health and mobility.

45. Mr Hodgson was considered a high risk to the public and was restrained with an escort chain when attended hospital on 2 October. Healthcare input was through a series of ticked boxes and the word 'heart' noted. The level of restraint remained the same when he went to hospital on 4 November, this was after his cancer diagnosis (on 24 October) and this level continued when the risk assessment was reviewed on 12 November. On both occasions the healthcare input was limited to ticked boxes indicating no objections to restraints and that this condition did not impact on his risk of escape. There was no further information about his health condition at the time. We accept this was a number of months before Mr Hodgson died, and his risk may very well have remained high and therefore restraints may have been justified. However, we are concerned that healthcare input into the risk assessment and review in November was limited to a tick box exercise with no further information. It is important that there is meaningful healthcare input into

assessments, which clearly shows how the prisoner's health at the time impacted on their risk of escape.

46. Ultimately, it is the Governor's responsibility to ensure that the risk assessment process is managed properly. However, healthcare staff also need to have an appropriate and considered input into the risk assessment process. We do not make a recommendation but the Head of Healthcare should remind healthcare staff of the need for meaningful input into the risk assessment process.

Liaison with Mr Hodgson's family

47. Mr Hodgson did not have any visitors or contact with his family. On 22 December 2014, the palliative care nurse spoke to Mr Hodgson about telling his next of kin about his illness. Mr Hodgson told the nurse he did not want anyone told at the time.

48. The prison appointed a family liaison officer on 13 Jan 2015. She spoke to Mr Hodgson who told her his brother was his nominated next of kin, but he would like a visit from his former partner although he was not sure where she lived. The family liaison officer began enquiries to find Mr Hodgson's former partner.

49. The palliative care nurse and the family liaison officer frequently spoke to Mr Hodgson about contact with his family and prognosis. Initially he did not want anyone told about his condition, apart from his former partner. The family liaison officer eventually contacted Mr Hodgson's former partner, and arranged for her to visit him on 8 March.

50. On 19 April, with Mr Hodgson's permission, the family liaison officer spoke to his brother to inform him of Mr Hodgson's deteriorating condition. Mr Hodgson's brother told the officer he did not wish to be involved or act as next of kin. He suggested contact with Mr Hodgson's son.

51. Later that day, the officer spoke to Mr Hodgson's son. He told the family liaison officer that he did not wish to visit his father, but would like a telephone call when he died.

52. After Mr Hodgson died, the family liaison officer telephoned and informed his son and offered support. Mr Hodgson's son told the officer that he did not wish to be involved in arranging a funeral service, and asked that Wakefield arrange this as it was unlikely that any relatives would attend. Mr Hodgson's funeral was on 12 May at Wakefield. The family liaison officer and the prison chaplaincy arranged the service. The prison paid for the funeral in line with national guidance.

53. We are satisfied that there was appropriate liaison with Mr Hodgson's family in line with his and their wishes.

Compassionate release

54. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

55. The palliative care nurse discussed compassionate release with Mr Hodgson on several occasions. He said he did not wish compassionate release; he wanted to be cared for by the nursing staff at Wakefield. We are satisfied that the prison appropriately considered compassionate release, but did not make an application in line with Mr Hodgson's wishes.