Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stuart Hodgkin a prisoner at HMP Exeter on 2 April 2017

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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 Stuart Hodgkin died on 2 April, of bowel cancer which had spread to other parts of his body, while a prisoner at HMP Exeter. He was 42 years old. I offer my condolences to Mr Hodgkin's family and friends.

I am satisfied that Mr Hodgkin received a high standard of care, at least equivalent to that which he could have expected in the community. Healthcare and prison staff at Exeter were caring and compassionate in challenging circumstances. They consistently considered Mr Hodgkin's best interests in their decision-making and provided good support and information to his family.

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 **October 2017**

Contents

Summary

Events

1. Mr Stuart Hodgkin was remanded to HMP Exeter on 17 April 2015. Around a month later, he told a prison GP that he had problems with constipation, pain and bleeding and the doctor prescribed laxatives. A planned review of Mr Hodgkin's symptoms did not take place due to his release a few days later. Mr Hodgkin returned to Exeter for a brief period between May and June, but he did not report any further symptoms at that time.

2. On 21 October, Mr Hodgkin returned to Exeter, charged with murder. He told a nurse that his community GP had referred him to a specialist and he was waiting for a hospital appointment. Mr Hodgkin's symptoms persisted. On 10 November, a GP asked healthcare staff to continue the referral. As this was not possible, the GP re-referred him to a colorectal specialist and requested blood tests. On 2 December, he reviewed the results, which revealed abnormalities. The GP immediately made an urgent referral for suspected lower gastrointestinal cancer.

3. Hospital specialists diagnosed incurable bowel cancer, which had spread to Mr Hodgkin's lungs. A course of radiotherapy had limited effect, so the hospital discharged Mr Hodgkin in July 2016 and the prison managed his palliative care, in consultation with a local hospice service.

4. Mr Hodgkin was a very difficult and challenging prisoner, who persistently threatened and abused medical and prison staff. He often failed to cooperate with his treatment and diverted medication to other prisoners.

5. The prison held multidisciplinary meetings to manage Mr Hodgkin's care and the prison's lead GP personally oversaw his treatment. Healthcare staff reviewed him daily to adjust his medication if necessary and consulted specialists for advice on managing his pain and other symptoms of his illness. When his condition deteriorated, staff moved him to the palliative care room. On 2 April, Mr Hodgkin died, with his family around him.

Findings

6. We agree with the clinical reviewer that healthcare staff referred Mr Hodgkin to a specialist promptly and that he subsequently received comprehensive and appropriate palliative care, at least the equivalent of that expected in the community. Doctors and prison staff also liaised effectively with his family, providing detailed information on his condition.

The Investigation Process

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

8. The investigator obtained copies of relevant extracts from Mr Hodgkin's prison and medical records.

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

10. We informed HM Coroner for Exeter and Greater Devon of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Hodgkin's sister, his next of kin, to explain the investigation. Mr Hodgkin's sister asked for the following matters to be considered:

    - Was there a delay in investigating Mr Hodgkin's symptoms and diagnosing his cancer?
    - Did Mr Hodgkin receive the right healthcare in prison? He had complained about constant pain after his operation and that staff had left him without medical aids such as adult pads, resulting in embarrassing leaks.
    - What medication had Mr Hodgkin received in addition to the morphine in his syringe driver?
    - Was it appropriate to use restraints when Mr Hodgkin was so ill?

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

13. Mr Hodgkin's sister received a copy of the draft report. She did not make any comments relating to factual inaccuracies.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out two factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Exeter

15. HMP Exeter is a local prison holding a maximum of 560 men either on remand, convicted or sentenced. The prison serves the courts of the South West. Dorset NHS University Foundation Trust provides health services, including mental health services. The prison has 24 hours healthcare cover. The prison also has a palliative care room in the social care unit, for terminally ill prisoners.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Exeter was in August 2016. Inspectors found positive working relationships between prison and healthcare staff. However, there was a shortage of healthcare staff, which had reduced the range of clinical services. Inspectors also reported that, owing to a lack of staff, the palliative care service was inconsistent and prisoners did not always receive timely care and medication.

Independent Monitoring Board

17. 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 December 2016, the IMB reported that Exeter was well run. They commended the exceptional care and professionalism of staff on F Wing (the social care unit), although staffing on the unit was sometimes inadequate. The Board also commented that the prison had quickly implemented the Ombudsman's recommendations after the investigation of deaths, including improved procedures for considering compassionate release.

Previous deaths at HMP Exeter

18. Mr Hodgkin was the 12th prisoner at Exeter to die from natural causes since January 2016. There has been one further death from natural causes. There are no significant similarities with the circumstances of the previous deaths.

Findings

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

19. Mr Stuart Hodgkin was remanded to HMP Exeter, on 17 April 2015, charged with possession of cannabis. It was not his first time in prison. At his initial health screen, he had no health concerns, but required stitches for cuts sustained in reception during a fight with another prisoner. He failed to attend a secondary health screen.

20. On 13 May, Mr Hodgkin told a prison GP that he had experienced constipation, pain and rectal bleeding for around a year, but had not previously sought help. The GP examined his abdomen but Mr Hodgkin refused a rectal examination. He prescribed a laxative and planned to see Mr Hodgkin again if there was no improvement. On 19 May, Mr Hodgkin told a nurse that he was still constipated. She placed him on the list to see the GP, but he was released from prison on 22 May, before his appointment.

21. Mr Hodgkin returned to Exeter on 25 May. When he arrived, he told healthcare staff that he had no medical problems and he was released again on 15 June.

22. On 21 October, Mr Hodgkin was remanded to Exeter on suspicion of murder. (He was later convicted and sentenced to life imprisonment.) At his reception health screen, Mr Hodgkin said that he was under investigation for ongoing rectal bleeding and constipation and was waiting to see a specialist at the hospital. The reception nurse requested his medical records from his community GP and noted that a prison GP should see him when they arrived.

23. Reception healthcare staff noted in Mr Hodgkin's medical record that staff should not see him alone, as he was volatile and aggressive. (Throughout his time at Exeter, Mr Hodgkin was persistently challenging, hostile, physically and verbally abusive to medical and wing staff and other prisoners. GPs found it difficult to take his history, or discuss his symptoms, as he was continually angry and threatening. In his last few months, healthcare staff generally only entered his cell with a prison officer present.)

24. At the beginning of November, Mr Hodgkin told nurses that he still had bowel problems. They gave him laxatives and painkillers and, on 3 November, listed him to see a GP. They also recorded that notes from his community GP mentioned a possible routine referral to a specialist in August 2015, but this had not happened. On 8 November, Mr Hodgkin told a nurse that he had contacted his solicitor to intervene, as he felt that healthcare staff did not take him seriously and his GP appointment should have been sooner.

25. On 10 November, a prison GP examined Mr Hodgkin and found a haemorrhoid, but he was unable to perform a rectal examination as Mr Hodgkin complained that it was painful. He asked healthcare staff to continue the routine referral made by Mr Hodgkin's community GP and, if this was not possible, to obtain a copy of the referral so that he could re-refer him. On 18 November, the GP sent a routine referral to the colorectal surgery service and requested urgent blood tests.

26. On 2 December, the prison GP received and reviewed the results, which showed iron deficiency anaemia. He immediately referred Mr Hodgkin to the endoscopy department at hospital for suspected lower gastrointestinal cancer, under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

27. Mr Hodgkin received an appointment for 23 December to undergo a gastroscopy and colonoscopy (internal examinations with a camera). This was subsequently rearranged for 5 January 2016, but the reason for the postponement is unknown. As Mr Hodgkin had not taken the medication required to cleanse his bowel, in preparation for his colonoscopy, and also found it difficult to tolerate the procedure, the hospital had to repeat the colonoscopy under general anaesthetic on 2 February. Doctors found a malignant tumour, possibly indicating advanced cancer and arranged CT and MRI scans. On Mr Hodgkin's return to the prison, a nurse spoke to him about the diagnosis and offered support at any time.

28. On 12 February, a prison GP recorded a provisional diagnosis of adenocarcinoma of the rectum (bowel/rectal cancer). On 16 February, a consultant colorectal surgeon confirmed this. He stated that the cancer had spread to Mr Hodgkin's lungs and was inoperable, but suggested palliative chemotherapy and palliative radiotherapy. (A few days later, hospital doctors estimated his life expectancy as around 18 months.)

29. We are satisfied that healthcare staff took appropriate and timely steps to seek a diagnosis. Although Mr Hodgkin first reported his symptoms to a prison GP in May 2015, he was released before the GP was able to follow this up substantively. The prison referred him to a specialist promptly when he returned to prison later in the year and restated his problems.

Mr Hodgkin's clinical care

30. On 17 February, a prison GP and Mr Hodgkin discussed the diagnosis. As a precaution, because of Mr Hodgkin's anger and upset, the GP began the Assessment, Care in Custody and Teamwork (ACCT) suicide and self-harm prevention procedures (which remained in place until 8 March). On 23 February, the GP spoke to a nurse specialist at the hospital to discuss treatment options. The nurse said Mr Hodgkin's pain was not well controlled, so the GP increased his dosage of painkillers and referred him to the hospice team at Hospiscare for advice on pain relief. At that point, Mr Hodgkin's life expectancy was a year, without systemic treatment and two years with such treatment.

31. On several occasions between February and July, nurses and prison officers saw Mr Hodgkin 'palm' (conceal) his medication and give it to other prisoners. When challenged, he denied it and argued. As he persistently diverted medication, healthcare staff took preventative action and warned him that doctors could change his dosage if he continued.

32. On 2 March, the community nurse specialist at Hospiscare visited Mr Hodgkin and recommended medications for pain relief, constipation and to help him sleep. Hospiscare staff frequently reviewed Mr Hodgkin and gave staff advice on pain control.

33. A consultant clinical oncologist at the hospital managed Mr Hodgkin's oncology care. On 3 March, Mr Hodgkin went into hospital for surgery to form a stoma (an opening on the abdomen to divert the flow of faeces) in preparation for chemotherapy and radiotherapy. Healthcare staff sought advice from the specialist stoma nurse and hospital staff when Mr Hodgkin experienced problems. Mr Hodgkin completed a course of radiotherapy in April.

34. Mr Hodgkin often reported increased pain. Each time, prison GPs reviewed and adjusted his dosage of painkillers. Although healthcare staff explained to him that his morphine should be dispensed as needed, he disputed this and insisted that because of his terminal diagnosis, he was entitled to it every four hours even if he was not in pain. Mr Hodgkin remained dissatisfied, so a GP reviewed and adjusted his dose of morphine tablets, adding liquid morphine when needed for breakthrough pain. He continued to ask for morphine more frequently than the prescribed four-hour intervals and a GP increased his dosage of amitriptyline (an antidepressant sometimes used for chronic pain).

35. Staff created pain management and medication care plans, but Mr Hodgkin continued to complain about insufficient pain medication. Prison GPs and nurses often saw Mr Hodgkin at short notice when he complained of increasing pain, but he did not always cooperate with attempts to assess his pain. A prison GP noted that it was difficult to assess his pain levels accurately and objectively, especially as he had a history of diverting medication. Hospiscare staff recommended prescribing an antidepressant and possibly sleeping pills, but at a prison healthcare meeting there was consensus that it was not safe to prescribe the latter while Mr Hodgkin was on B wing. Prison doctors and nurses often saw Mr Hodgkin at short notice when he complained of increasing pain, but he did not always cooperate with attempts to assess his pain.

36. In July, the hospital discharged Mr Hodgkin with a life expectancy of less than a year, as there had been little response to his treatment.

37. Mr Hodgkin also complained of rectal leakage, so staff gave him pads, as well as medication to reduce the discharge. These were not always effective and Hospiscare suggested a different type, recognising the need to be discreet because of his age and the sensitivity of the matter. Staff later supplied padded incontinence pants. In early September, a prison GP wrote to Mr Hodgkin's oncologist, suggesting the possibility of further treatment to reduce the leakage. She was willing to arrange an appointment, but Mr Hodgkin declined. On 18 October, a prison GP reminded staff to ensure there were sufficient supplies of medical aids. Nurses then arranged repeat prescriptions with the pharmacy and agreed with Mr Hodgkin the level of supplies he should receive daily.

38. On 2 November, a prison GP decided that she would personally review Mr Hodgkin every two weeks, to provide continuity in managing his care and to ensure that prison specific issues were addressed. In between reviews, doctors would see Mr Hodgkin immediately if his pain was uncontrolled. There were occasional delays when other prisoners had to take priority, but staff always recorded the reasons for this.

39. On 7 November, the prison GP had a 50-minute consultation with Mr Hodgkin in which they discussed a range of issues and she explained to him the changes he

might expect as he approached the end of his life. She also warned him against diverting his medication. Mr Hodgkin was very open about his fears – pain, breathlessness and dying - as well as his physical, emotional and psychological pain. She noted that all staff should be aware that his anger might reflect fear and be a cry for help; and that he had not come to terms with his diagnosis. She also wanted to meet his family so that they could work together to provide support. The prison held formal multi-agency team meetings to discuss all aspects of Mr Hodgkin's care.

40. With Mr Hodgkin's agreement, the prison GP re-referred him to the hospital oncology team. (He received an appointment for 28 November, but refused to attend as he felt there was no point.) On 19 November, she confirmed that Mr Hodgkin did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

41. On 30 December, the prison GP referred Mr Hodgkin to the mental health team for advice on improving his wellbeing, as his anger and aggression was preventing healthcare staff from fully supporting him. A mental health nurse assessed Mr Hodgkin the same day and agreed to see him informally between family visits. As there was no evidence of severe or enduring mental illness, the mental health team did not take him on as a patient, but she continued to have supportive talks with him.

42. Mr Hodgkin was due to attend an oncology appointment on 9 January 2017 and the prison GP planned to meet him at the hospital to act as an advocate. On the day it was due to take place, Mr Hodgkin said he felt too unwell to attend.

43. On 5 February, a nurse created an end of life care plan. Mr Hodgkin became frail, but he continued to care for himself and refused social care. Healthcare staff checked him hourly overnight through the glass panel of his cell, as he did not want to be disturbed during the night. On 20 March, healthcare staff inserted a syringe driver (a small pump to allow continuous pain relief under the skin). In addition, they gave Mr Hodgkin paracetamol, diazepam (an anti-anxiety medication) and zopiclone (a sleeping pill).

44. At 8.25pm on 2 April, Mr Hodgkin's family told staff that he had stopped breathing. A GP certified his death at 10.07pm. The report of the post-mortem examination gave Mr Hodgkin's cause of death as metastatic rectal carcinoma (bowel cancer which had spread to other parts of his body).

45. We are satisfied that Mr Hodgkin received wide ranging, appropriate and compassionate care at Exeter, at least equivalent to that he could have expected in the community.

Mr Hodgkin's location

46. In September 2016, prison staff and the hospice team had several discussions with Mr Hodgkin about moving to the palliative care room in the social care unit. Although he acknowledged that he might be better supported there, he said he wanted to wait a few more weeks.

47. On 7 November, a prison GP explained the benefits of F wing, for example, it was quieter and had ensuite facilities and a garden. Mr Hodgkin said he

regretted not moving before, so she asked prison managers to arrange the move urgently. He moved to the unit on 9 November.

48. Due to abusive comments and violent threats to other prisoners and staff, prison managers considered withdrawing Mr Hodgkin's place in the unit. The prison GP intervened, explaining her concerns and that it was the best place to provide treatment for him. Managers therefore put in place strict boundaries about his behaviour and limited his contact with other prisoners.

49. We are satisfied that, while respecting Mr Hodgkin's wishes to remain on his residential wing for as long as possible, staff encouraged him to transfer to the social care unit and moved him at an appropriate point. They also demonstrated compassion by allowing him to remain in the unit in spite of his poor conduct.

Restraints, security and escorts

50. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

51. Mr Hodgkin had a well-documented history of aggressive behaviour to staff and other prisoners. Security risk assessments for his hospital visits concluded that his risk of escape was low, but he was a medium risk to the public and hospital staff, given his explicit threats and aggression. Two prison officers escorted him, using double handcuffs (when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs). For a planned hospital visit on 9 January 2017, a prison manager noted that Mr Hodgkin was fully mobile and concerns about his anger and behaviour towards others remained unchanged. In spite of this, he felt that the risk could be managed using an escort chain. (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.) Mr Hodgkin later decided not to attend the appointment.

52. We are satisfied that prison managers appropriately reviewed the need for restraints.

Liaison with Mr Hodgkin's family

53. During the course of Mr Hodgkin's illness, two prison GPs proactively updated his family about his health in telephone discussions and meetings. His family also telephoned healthcare staff when they wanted to discuss concerns. The GPs explained his condition, prognosis, treatment, medication and end of life care planning. They also mentioned the difficulties with Mr Hodgkin's diversion of medication and the challenge of assessing his true level of pain. When a GP asked if his family could encourage him to improve his behaviour, his sister said that his aggression had been a longstanding issue before his illness.

54. An officer introduced herself to Mr Hodgkin's family on 21 January 2017 as the family liaison officer. She allowed his family visit him in the day room, or his cell and arranged for him to use the office mobile phone daily to call them. In the last

few weeks of Mr Hodgkin's life, the prison agreed that his family could visit at any time. His family asked to be informed immediately when he was near the end of his life, so that they could be with him when he died.

55. At around 9.20pm on 1 April, the family liaison officer telephoned Mr Hodgkin's family and advised them to go to the prison. They arrived in the early hours and stayed with him until he died. She was on duty to support them.

56. In line with national policy, the prison contributed to the costs of Mr Hodgkin's funeral, held on 25 April.

57. Prison Service policy requires prisons to ensure that a member of staff engages with the next of kin of prisoners who are either terminally or seriously ill. Although it is usual for a prison to appoint a dedicated family liaison officer as soon as a terminal illness is diagnosed, we acknowledge that there was effective liaison and communication throughout Mr Hodgkin's illness. Over many months, prison GPs spoke to his family directly to update them on his condition and treatment. A team of family liaison officers were available and a dedicated officer was appointed once his condition worsened. Mr Hodgkin's sister told the investigator that the family liaison officer went "above and beyond" her role to assist Mr Hodgkin and he relied on her help daily. She also appreciated a prison GP's updates. We are satisfied that the prison provided a high standard of support to Mr Hodgkin's family.

Compassionate release

58. 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.

59. Mr Hodgkin said that did not want to die in hospital and would prefer compassionate release, or to go to a hospice near his home. In November 2016, the prison began an application for early release. Mr Hodgkin's offender supervisor assessed him as a high risk of reoffending if released, owing to his recent conviction for murder, outstanding charges for violent sexual offences and his lack of offending behaviour work in prison. The Governor considered that in view of Mr Hodgkin's mobility and recent poor behaviour, he was unsuitable for early release and he did not support the application.

60. On 10 March 2017, the prison started the process to reconsider early release to a hospice and the Governor asked those involved to deal with it urgently. The Probation Service did not support the application and the nominated hospice had concerns about whether Mr Hodgkin was suitable, as they did not take long-term patients. The prison kept the papers on file in the event that his circumstances changed, but Mr Hodgkin died before the application could be given further consideration. We are satisfied that the prison actively considered the possibility of early release.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141