Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Roland Hodgson a prisoner at HMP Wymott on 28 August 2018

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*

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 I oversee can improve their work in the future.

Mr Roland Hodgson died on 28 August 2018 while a prisoner at HMP Wymott. He died of heart failure following a heart attack. He was 75 years old. I offer my condolences to Mr Hodgson's family and friends.

I am satisfied that the healthcare Mr Hodgson received at HMP Wymott was equivalent to that he could have expected to receive in the community. When he became ill in August 2018, he was promptly sent to hospital, where he remained until his death.

However, I am concerned that the assessment of Mr Hodgson's risk did not reflect the deterioration in his health and that he was inappropriately placed in restraints when he was taken to hospital and that the restraints were not removed until four days before his death.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **April 2019**

Contents

Summary

Events

1. Mr Roland Hodgson received a life sentence in 1967. He was released on licence from 1984 to 2010, when he was recalled to prison. He had been at HMP Wymott since January 2013.

2. Mr Hodgson had a number of long-term medical conditions, including heart disease and chronic obstructive pulmonary disease (COPD, a group of lung conditions that cause breathing difficulties).

3. During his time at Wymott, Mr Hodgson was regularly admitted to hospital with breathing problems.

4. In May 2018, he was taken to hospital as an emergency and admitted for a week with shortness of breath, dizziness and leg pain. In June he was admitted to hospital for a further week after becoming aggressive and confused. As his condition gradually deteriorated he was only able to mobilise with a Zimmer frame and he received social care assistance with his daily living.

5. On the night of 21 August 2018, Mr Hodgson was seen by a nurse after becoming delirious. The nurse thought he might be suffering from acute dehydration. An ambulance was called and he was taken to hospital. The following day, Mr Hodgson's heart stopped for 15 minutes and he was transferred to a coronary care unit. On 28 August, Mr Hodgson died in hospital.

Findings

6. The clinical reviewer considered that the clinical care Mr Hodgson received at Wymott was of a good standard and equivalent to that which he could expect to receive in the community.

7. However, the clinical reviewer was concerned when Mr Hodgson was taken ill on 21 August, the nurse did not use the National Early Warning Score (NEWS) to monitor any deterioration in his condition while they waited for the ambulance to arrive, although this did not make any difference to the outcome.

8. The clinical reviewer was also concerned that there is no evidence that healthcare staff contacted hospital staff to get updates on Mr Hodson's condition. Although this did not affect the care Mr Hodgson received, good practice requires regular communication to ensure accurate care planning and continuity of care.

9. We are concerned that, despite Mr Hodgson's poor health and very limited mobility, restraints were used when he went to hospital on 21 August and were not removed until 24 August. We are not satisfied that the use of restraints was justified by a fully considered risk assessment.

Recommendation

The Governor should ensure that all staff undertaking risk assessments for prisoners in hospital understand the legal position on the use of restraints and

that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

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

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

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

13. We informed HM Coroner for Preston and West Lancashire of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

14. The investigator wrote to Mr Hodgson's son to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He did not respond to our letter.

15. 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.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies.

Background Information

HMP Wymott

17. Wymott is a medium secure prison which holds over 1,100 adult men. Bridgewater Community NHS Trust and Greater Manchester Mental Health Trust provide healthcare services and Geometric Results International provides locum GP services, including 24-hour nursing cover, and the out of hours GP is via the local provider. There are no inpatient beds.

HM Inspectorate of Prisons

18. The most recent inspection of Wymott was conducted in October 2016. Inspectors reported that Wymott remained a reasonably safe prison and relationships between staff and prisoners were generally respectful, but healthcare provision was weak and in some areas potentially unsafe. They found that the clinical care of prisoners with chronic conditions was not good enough.

Independent Monitoring Board

19. 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 May 2018, the IMB reported that the standard of healthcare provision continued to fall below that expected in the community. Although there had been some improvements in the second half of the reporting period, the service remained inadequate and unsatisfactory.

20. The Board noted that the lack of appropriate numbers of staff at all levels was an on-going problem. There had been an improvement in the provision of in-possession medication although there was a problem with continuity. Misuse of medication remained a matter for concern, largely due to lack of supervision of the queues at dispensing hatches. Communication on all levels was also a problem. The report highlighted two PPO reports which noted that not all care plans from hospitals were being followed by the prison. The report did note, however, that the Healthcare Forum continued to be a model of good practice.

Previous deaths at HMP Wymott

21. Mr Hodgson's is the ninth death from natural causes to occur at Wymott in the last two years. He is the fourth prisoner to die from heart disease.

Findings

Clinical Care

22. In 1967, Mr Roland Hodgson received a life sentence for sexual offences and assault. In 1984, he was released on license, but in 2010 he was recalled to prison. On 8 January 2013, Mr Hodgson was transferred to HMP Wymott.

23. Mr Hodgson had several long-term health conditions when he arrived at Wymott, including coronary pulmonary obstructive disease (COPD - a group of lung conditions which cause breathing difficulties) and heart disease. He had also suffered three heart attacks, the last in 2008. Mr Hodgson was prescribed numerous drugs for his health conditions.

24. In 2013 to 2017, he was admitted to hospital on several occasions with breathing difficulties.

25. In May 2018, he was taken to hospital as an emergency and admitted for a week with shortness of breath, dizziness and leg pain. In June he was admitted to hospital for a further week after becoming aggressive and confused. On his return to prison, it was noted that he was only able to mobilise with a Zimmer frame.

26. The clinical reviewer found that the healthcare Mr Hodgson received at Wymott was equivalent to that which he could have expected in the community. Healthcare staff managed Mr Hodgson's long-term conditions appropriately in line with national guidance, local care plans were created to support his long-term care needs, and when his needs escalated he was appropriately referred to a GP or to hospital.

27. The clinical reviewer was also satisfied that, as Mr Hodgson's health deteriorated, he was appropriately referred to the social care team to ensure that he had assistance with his day to day living.

21 August 2018

28. On the night of 21 August 2018, Mr Hodgson was seen by a nurse on the wing after staff had been alerted by prisoners that he appeared to be delirious. Mr Hodgson's vital signs were within normal limits, but the nurse thought that Mr Hodgson could be suffering from acute dehydration and at 10.38pm an ambulance was called.

29. The ambulance arrived at 11.45pm. After Mr Hodgson had been assessed by paramedics, it was decided that he should be transferred to hospital for further assessment. The ambulance left Wymott at 12.45am and took him to hospital, where he was admitted.

30. On 22 August, bedwatch staff noted that Mr Hodgson had had to be revived after his heart had stopped for approximately 15 minutes. After being resuscitated, Mr Hodgson was moved to the coronary care unit at another hospital.

31. The next entry in Mr Hodgson's medical records was made on 27 August by a staff nurse who recorded that a telephone call was received from one of the

officers on bedwatch who said that Mr Hodgson was very unwell and that a 'do not attempt cardio pulmonary resuscitation' (DNACPR) order had been put in place by hospital staff (meaning that no attempt would be made to resuscitate Mr Hodgson if his heart or breathing stopped). The nurse noted that she was unable to contact the hospital due to time restraints.

32. On 28 August, Mr Hodgson's breathing became shallow. At approximately 2.10am, an officer who was on bedwatch, called hospital staff after he noticed Mr Hodgson was not moving. At 3.00am, a doctor confirmed that Mr Hodgson had died.

33. The clinical reviewer was satisfied that Mr Hodgson was transferred to hospital appropriately and in a timely manner.

34. However, she was concerned that a nurse did not use the National Early Warning Score (NEWS – a scoring system of each vital sign which facilitates early detection of deterioration) to monitor any deterioration in Mr Hodgson's condition while they waited for the ambulance to arrive.

35. The clinical reviewer was also concerned that there is no evidence that healthcare staff contacted hospital staff to get updates on Mr Hodgson's condition. Although this did not affect the care Mr Hodgson received, good practice requires regular communication to ensure accurate care planning and continuity of care.

Post-mortem

36. The post-mortem found that Mr Hodgson died of heart failure following a heart attack.

Mr Hodgson's location

37. Mr Hodgson lived on B wing, a general residential wing at Wymott, before he was admitted to hospital. We are satisfied Mr Hodgson's medical needs could be met in this location.

Restraints, security and escorts

38. 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. The judgment indicated 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.

39. On 21 August when Mr Hodgson was transferred to hospital in an ambulance, he was restrained using an escort chain. (This is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) On

22 August, the chain was removed because nurses had to carry out cardiopulmonary resuscitation to revive Mr Hodgson after he stopped breathing. Later that afternoon the escort chain was reapplied, although it was clear that his health had deteriorated further. The escort chain was finally removed on 24 August, four days prior to Mr Hodgson's death.

40. Mr Hodgson was in very unwell and had very limited mobility when he was admitted to hospital for the final time on 21 August. The medical section of the escort risk assessment stated that he had asthma, chronic heart disease, COPD and high blood pressure. Additionally, notes from healthcare dating back to May stated that Mr Hodgson could only mobilise with assistance and using a Zimmer frame. The risk assessment appears to have been based primarily on Mr Hodgson's offence, with little consideration of his actual risk or how his health affected this risk, as the 2007 High Court judgment requires. We find it difficult to understand why it was thought that a frail 75-year-old category C prisoner required an escort chain in addition to two escort officers when he was taken to hospital.

41. We are not satisfied that the prison fully considered Mr Hodgson's risk. 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 assessments fully take into account the health of the prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Hodgson's family

42. Mr Hodgson had no recorded next of kin. After Mr Hodgson was admitted to hospital, a deacon from the chaplaincy visited him to ask for details about his son. Mr Hodgson did not have any information to share and did not mention any other family. He did not want anyone informed of his circumstances before his death.

On 28 August, HMP Wymott assigned a reverend as the prison's family liaison officer (FLO). He established from Mr Hodgson's file that he had seven children. However, it was believed that he had not had any contact with his children in recent years. Mr Hodgson's wife, from whom he was separated, did not want any contact either.

43. Later that day, the FLO made contact with one of Mr Hodgson's sons, who was happy to become involved and to act as next of kin. He explained the process and offered support.

44. On 31 August, the prison received a phone call from another of Mr Hodgson's sons who had found out about his father's death on social media and said that he was the next of kin. The FLO maintained regular contact with this son and, on 13 October, he and another of Mr Hodgson's sons visited the prison and collected Mr Hodgson's property.

45. Mr Hodgson's funeral took place on 18 September 2018 and was attended by the FLO. The prison provided a financial contribution in line with national policy.

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