

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Hodge, a prisoner at HMP Bullingdon, on 27 September 2019

A report by the Prisons and Probation Ombudsman

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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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 Edward Hodge died on 27 September 2019 of necrotising otitis externa (a progressive ear infection that had spread to the bone and brain) while a prisoner at HMP Bullingdon. He was 78 years old. I offer my condolences to his family and friends.

Mr Hodge had diabetes which was poorly controlled. The clinical reviewer noted that necrotising otitis externa is a recognised complication of an ear infection in a diabetic patient.

The investigation found that the clinical care that Mr Hodge received at Bullingdon was not equivalent to that which he could have expected to receive in the community.

Mr Hodge did not have a second health screen which might have identified more promptly and effectively the need to manage his chronic health conditions, namely diabetes and hypertension (high blood pressure). Healthcare staff did not treat these conditions in a structured or coordinated way and did not follow up his raised blood pressure readings.

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

July 2020

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Summary

Events

1. On 8 February 2017, Mr Edward Hodge was sentenced to 19 years in prison for sex offences and was sent to HMP Bullingdon.
2. At his initial health screen, a nurse noted that Mr Hodge was paralysed from the waist down, used a wheelchair, and had Type 2 diabetes and hypertension. Mr Hodge was sent to the prison's healthcare inpatient unit. There is no record that he had a second health screen.
3. On 15 August 2018, another prisoner in the inpatient unit assaulted Mr Hodge by pulling him out of his wheelchair. A Custodial Manager (CM) noted that Mr Hodge was not injured. A nurse noted that the prisoner pushed Mr Hodge from his wheelchair onto the floor and punched him but he had no bruising or skin damage. On 19 August, Mr Hodge told a nurse that when he was assaulted, he was punched twice on the left-hand side of his neck.
4. On 16 October, a prison GP saw Mr Hodge who had swelling around the right side of his face and discharge from his right ear, and prescribed him antibiotic ear drops. Mr Hodge continued to have pain on the right side of his face. On 24 October, a prison GP, saw Mr Hodge and thought that he may have otitis externa (inflammation of the ear canal) and gave him more ear drops. Mr Hodge did not use the eardrops and a prison GP strongly advised him to take them.
5. On 26 November, a prison GP sent Mr Hodge to hospital when his health deteriorated. Hospital staff treated him for 'ear necrotising' (the infection spreading to other parts of the head). On 2 January 2019, Mr Hodge went back to Bullingdon.
6. On 25 June, when Mr Hodge's health continued to deteriorate, he had difficulty swallowing and the pain in his right ear was not easing. A nurse sent him to hospital. An ear, nose and throat (ENT) doctor said that Mr Hodge had extensive necrotising otitis externa (a severe inflammatory process affecting soft tissue and bone) which had spread to three areas of his skull.
7. On 22 August, prison staff moved Mr Hodge to a hospice and on 30 August, the Governor authorised his release on temporary licence.
8. On 27 September, Mr Hodge died. A hospice doctor confirmed that he had died of necrotising otitis externa.

Findings

Clinical care

9. The clinical reviewer said that the care that Mr Hodge received was not equivalent to that which he could have expected to receive in the community.
10. Mr Hodge did not have a second health screen. The clinical reviewer also found that healthcare staff did not have a structured or coordinated approach to treating Mr Hodge's chronic health conditions, including diabetes and high blood pressure.

He found that the lack of coordinated care of Mr Hodge's diabetes may have resulted in poor diabetic control. He noted that necrotising otitis externa was a recognised complication of otitis externa in a diabetic patient.

11. Although the clinical reviewer noted that a trauma to the ear could cause an ear infection, we do not have the evidence to say whether the assault of 15 August 2018 led to Mr Hodge developing an ear infection.
12. We are not satisfied that the need to restrain Mr Hodge in hospital for two months was fully justified.

Recommendations

- The Head of Healthcare should ensure that a second health screen is carried out for all prisoners.
- The Head of Healthcare should ensure that the procedures in place for managing chronic diseases, particularly diabetes and hypertension, are in line with National Institute for Health and Care Excellence (NICE) guidelines and that healthcare staff understand and apply them appropriately.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position 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

13. The investigator issued notices to staff and prisoners at HMP Bullingdon informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Hodge's prison and medical records.
15. NHS England commissioned an independent clinical reviewer to review Mr Hodge's clinical care at the prison.
16. We informed HM Coroner for Oxfordshire of the investigation. He gave us the cause of death. We have sent the Coroner a copy of this report.
17. Mr Hodge had no known next of kin.
18. We shared the initial report with the Prison Service. There were two factual inaccuracies, this report has been amended accordingly and their action plan has been appended to this report.

Background Information

HMP Bullingdon

19. HMP Bullingdon is a training and local prison, serving the courts of Oxfordshire and Berkshire. It holds approximately 1,100 prisoners. Care UK provides healthcare services and Cotswold Medicare Ltd provides general practitioner services. There is an inpatient healthcare unit, with 24-hour nursing care.

HM Inspectorate of Prisons

20. The most recent inspection of Bullingdon was conducted in May 2017. Inspectors found that the management of prisoners with long-term conditions had deteriorated since the previous inspection. They noted that nurse-led clinics were limited to a diabetic clinic, triage and discharge clinics, and that not all nurses were adequately trained in nurse triage. The assistant practitioner held a phlebotomy clinic and undertook regular observations for prisoners with long-term conditions.
21. Inspectors noted that there was good attendance at primary care clinics, and waiting lists were in line with those in the community. They found that GP provision was appropriate and waiting times for routine appointments were acceptable. They noted that allocated daily slots ensured that emergency appointments were available. Inspectors found that while a 24-hour nursing service was provided, the NHS 111 telephone line was accessed appropriately for medical support.

Independent Monitoring Board

22. 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 most recent annual report for the year to 30 June 2019, the IMB noted that levels of violence and drug misuse had significantly increased. Some older prisoners were treated unfairly because of a lack of accommodation suitable for social care elsewhere in the prison. Care UK had continuing difficulties in recruiting permanent staff and healthcare provision depended on a number of long-serving agency staff.

Previous deaths at HMP Bullingdon

23. Mr Hodge was the ninth prisoner to die at Bullingdon since September 2017. Three of the previous deaths were from natural causes and five were self-inflicted. There were no significant similarities between Mr Hodge's death and the circumstances of the previous deaths.

Key Events

24. On 8 February 2017, Mr Edward Hodge was sentenced to 19 years in prison for sex offences and was sent to HMP Bullingdon.
25. That day, a nurse carried out his initial health screen. She noted that Mr Hodge was paralysed from the waist down, used a wheel chair and had Type 2 diabetes and hypertension (high blood pressure). Mr Hodge went to the healthcare inpatient unit.
26. On 9 February, a prison GP and a nurse reviewed Mr Hodge. The nurse created a social care plan which included care for incontinence and paralysis and noted that healthcare and social care staff should review Mr Hodge daily.
27. There is no record that Mr Hodge had a second health screen.
28. On 2 March, a prison GP saw Mr Hodge because he had raised blood pressure. Blood tests showed that Mr Hodge had some kidney damage because of his diabetes. The prison GP prescribed ramipril for hypertension. Healthcare staff frequently measured Mr Hodge's blood pressure and frequently found it to be raised. On most of these occasions, there is no record to indicate that the nurses who measured his blood pressure took any action.
29. On 11 May, a specialist diabetes nurse reviewed Mr Hodge's diabetes. She noted that his control was excellent and planned to review him and repeat blood tests in six months. A specialist nurse did not see Mr Hodge again and no one followed up his diabetes and hypertension. There is no record that healthcare staff created a diabetes care plan, regularly reviewed blood tests or physically monitored Mr Hodge's diabetes.
30. On 16 June, a prison GP reviewed Mr Hodge because he said that he had chest pain. The prison GP took an electrocardiogram (ECG) which showed a normal heart rhythm. There is no record that the prison GP considered Mr Hodge's raised blood pressure.
31. On 23 September, a healthcare assistant saw Mr Hodge and noted that his diabetes and hypertension was controlled with metformin. The clinical reviewer said that there was no evidence of diabetic control and his blood pressure remained uncontrolled.
32. On 16 April 2018, a prison GP stopped Mr Hodge's ramipril medication for hypertension and gave him amlodipine instead.
33. On 15 August, a prisoner living in the inpatient unit, assaulted Mr Hodge. A Custodial Manager (CM) noted that the prisoner had bullied Mr Hodge and pulled him out of his wheelchair, but that Mr Hodge was not injured. An orderly officer's report noted that Mr Hodge was 'dragged from his wheelchair'.
34. A nurse noted that the prisoner had approached Mr Hodge and punched him so that he fell from his wheelchair onto the floor. Staff helped Mr Hodge back into

his chair. She noted that Mr Hodge's skin was not bruised, and that he was alert and orientated but upset. She gave him paracetamol. On 19 August, Mr Hodge told a nurse that when he was assaulted, he was punched twice on the left side of his neck.

35. On 15 October, a prison GP noted that Mr Hodge's diabetes had resolved itself.
36. On 16 October, a prison GP saw Mr Hodge who had swelling on the right side of his face and some discharge from his right ear. The prison GP prescribed antibiotic ear drops for an ear infection.
37. Mr Hodge continued to have pain on the right side of his face, which he thought was toothache. On 24 October, a prison GP saw Mr Hodge and thought that he may have otitis externa (inflammation of the ear canal) and gave him more antibiotics.
38. On 30 October, a prison GP saw Mr Hodge because he still had pain in his right ear and jaw which was painful when he swallowed. Mr Hodge said that the pain was caused by the assault. The prison GP saw signs that his right ear was still infected and prescribed him more antibiotics.
39. On 5 November, a prison GP saw Mr Hodge on his inpatient round and noticed that he had not used any of his eardrops. He strongly advised him to take them.
40. On 12 November, a prisoner told a nurse that Mr Hodge was in a lot of pain, had discharge from his ear and had not eaten for three days. She saw that there was a bloody fluid coming out of his right ear which she cleaned and gave him ear drops. She arranged for a GP to review him. The next day, a prison GP reviewed Mr Hodge and told him to continue using the ear drops and to take paracetamol for pain relief.
41. On 20 November, a nurse, a social worker, and the Practice Supervisor, saw Mr Hodge. They arranged for him to have another social care assessment because of the deterioration in his health. Mr Hodge said that he did not want the assessment. He told them that he was unable to eat properly. Mr Hodge agreed to have social care twice a day.
42. The Practice Supervisor and social worker expressed concerns about Mr Hodge's mental capacity with regard to his care needs provision. They noted a marked change to how he had been in the past when they had seen him and asked for him to be reviewed medically to see if an infection was the cause in the change. They advised the need for a best-interests decision to be made with regard to his delivery of care but, he declined.
43. That day a mental health nurse assessed Mr Hodge and noted that because of his current infection (which the mental health nurse noted was likely to have caused a mild cognitive impairment), he did not have the mental capacity to make decisions about his health and personal care.
44. On 26 November, a prison GP sent Mr Hodge to hospital because his health had deteriorated further. The next day, a nurse spoke to a nurse at the hospital who said that they were treating Mr Hodge for 'ear necrotising'.

45. On 2 January 2019, Mr Hodge went back to Bullingdon. His discharge summary said that he had diabetes and was prescribed metformin.
46. On 11 February, when a prison GP saw Mr Hodge on his inpatient round, he refused to go to the ENT department at hospital. He had previously told healthcare staff that he would not go to hospital restrained but now he refused to go regardless of whether or not he was restrained.
47. On 28 March, Mr Hodge told a nurse that he could no longer hear in his right ear. The next day, a prison GP reviewed Mr Hodge. The prison GP noted that he had refused to go to the ENT department in January and that he had a planned appointment with the maxillofacial (mouth, jaws, face and neck) surgeons. Mr Hodge went to the maxillofacial department in April but there is no hospital discharge record for the appointment.
48. On 25 May, a prison GP reviewed Mr Hodge and noted that he had 'borderline hypertension' and planned for him to have an ECG and blood tests. Mr Hodge refused to allow healthcare staff to carry out an ECG and a nurse tried to take bloods on 28 May, but was unsuccessful.
49. On 11 June, a prison GP reviewed Mr Hodge who complained that an ENT surgeon had cut his ear without consent. The prison GP saw that his ear was inflamed and prescribed him antibiotics.
50. Mr Hodge's health deteriorated and a nurse sent him to hospital on 25 June because he had difficulty swallowing and the pain in his right ear had not eased. Healthcare and prison staff completed an escort risk assessment. A nurse noted that Mr Hodge was bedbound but she did not object to the use of restraints. Prison staff said that he was a Category B prisoner and posed a medium risk to the public and to hospital staff because he had previously been abusive towards nurses. One of the Heads of Residence, said that two officers should escort Mr Hodge and that he should be restrained with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).
51. The following day, a nurse spoke to an ENT doctor who told him that Mr Hodge had extensive necrotising otitis externa which had spread to three areas of his skull.
52. While in hospital, prison staff noted daily that Mr Hodge was abusive and obnoxious towards hospital and prison staff, refused treatment and was aggressive and rude.
53. On 19 August, Mr Hodge assaulted a nurse who was trying to put a drip into his arm and also assaulted an officer, using the escort chain to pull her towards him and throwing the device used to call staff in an emergency at her. The Head of Residence reviewed the risk assessment and decided that Mr Hodge should be double cuffed. Officers removed the double cuff so that a nurse could treat Mr Hodge. Later that day, the Head of Residence again reviewed the level of restraint and said that the double cuff should be removed because it served no purpose in his current medical condition and with his poor prognosis.

54. On 22 August, Mr Hodge went to a hospice. One of the Heads of Residence authorised officers to remove Mr Hodge's restraint. He remained unrestrained.
55. On 30 August, the Governor authorised Mr Hodge's release on temporary licence.
56. Mr Hodge died in the hospice on 27 September.

Contact with Mr Hodge's family

57. Mr Hodge had no next of kin listed in the prison records. On 5 July 2019, a safer custody manager, wrote to Mr Hodge's friend to tell him that Mr Hodge's health had deteriorated. Mr Hodge's friend did not know of any next of kin and had not seen Mr Hodge for two years.
58. On 27 September, the Head of Business Assurance telephoned Mr Hodge's friend, told him that Mr Hodge had died and offered her condolences. She noted that his friend was elderly and disabled. On 8 October, Mr Hodge's friend declined to take on the role of next of kin.
59. On 9 October, the Head of Safety appointed an officer as the family liaison officer. She was unable to identify a next of kin for Mr Hodge. Bullingdon arranged and paid for Mr Hodge's funeral in line with national instructions.

Support for prisoners and staff

60. The prison posted notices informing other prisoners of Mr Hodge's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Hodge's death.

Cause of death

61. There was no post-mortem examination. A hospice doctor confirmed that Mr Hodge died of necrotising otitis externa (an ear infection that had spread to the bone and brain).

Findings

Clinical care

62. The clinical reviewer found that the care that Mr Hodge received at Bullingdon was not equivalent to that which he could have expected to receive in the community.
63. Mr Hodge did not have a second health screen as prescribed in NICE guidelines on the physical health of prisoners. This might have led to his chronic health needs being addressed more promptly and effectively. We make the following recommendation:

The Head of Healthcare should ensure that a second health screen is carried out for all prisoners.

64. Mr Hodge lived in the healthcare inpatient unit, where he was treated with compassion despite his challenging and, at times, abusive behaviour. On many occasions, he refused his diabetic and hypertension medication against the advice of healthcare staff. The clinical reviewer found that the lack of consistent treatment may have accounted for his raised blood pressure, but there were also infrequent referrals for Mr Hodge to see a prison GP to discuss the risks of not taking his medication.
65. Mr Hodge's blood pressure was identified as raised each month from February to May 2019, but healthcare staff took no action until a prison GP reviewed him on 25 May and noted that he had borderline hypertension.
66. The clinical reviewer noted that ramipril, which a prison GP prescribed in March 2017, was not the first-line anti-hypertension medication recommended by NICE for a person of Afro-Caribbean origin (as Mr Hodge was). The clinical reviewer also noted that another prison GP prescribed amlodipine in April 2018, although NICE guidelines recommend a different first-line treatment, namely an angiotensin receptor blocker.
67. The clinical reviewer said that the care of Mr Hodge's chronic health conditions was not delivered in a structured or coordinated way. The diabetes nurse accepted that when she saw Mr Hodge on 11 May 2017, she did not put a diabetes care plan in place. She noted that Mr Hodge would be reviewed every six months, but this never happened: the specialist nurse never saw him again and healthcare staff never followed up his diabetes and hypertension. The clinical reviewer noted there was no record that NICE guidelines on managing diabetes and its complications had been considered or followed: there were no care plans in place, regular blood tests were not taken or reviewed, Mr Hodge's diabetic medication was not reviewed and healthcare did not complete physical checks (such as monitoring Mr Hodge's feet for potential nerve damage).
68. The clinical reviewer also said that, although a prison GP noted in October 2018 that Mr Hodge's diabetes had resolved itself, there is no evidence in the medical records that this was correct.

The ear infection

69. Mr Hodge said that his ear problems were caused by the assault on him in August 2018. The clinical reviewer said that otitis externa could result from ear trauma. However, Mr Hodge's prison and medical records do not identify precisely how and where he was assaulted, and there is conflicting evidence about whether the assault affected the left or right side of his head. Contemporaneous evidence indicates that the injury was to the left side of his neck, although a few months later, Mr Hodge complained that the pain to the right side of his ear and jaw was caused by his assault. (The prisoner who assaulted Mr Hodge subsequently died at Bullingdon.) We are therefore unable to say whether the assault of 15 August contributed to his ear infection.
70. The clinical reviewer noted that the lack of coordinated care of Mr Hodge's diabetes may have resulted in poor diabetic control. He also noted that necrotising otitis externa is a recognised complication of otitis externa in a diabetic patient. We recommend that:

The Head of Healthcare should ensure that the procedures in place for managing chronic diseases, particularly diabetes and hypertension, are in line with NICE guidelines and that healthcare staff understand and apply them appropriately.

Use of restraints

71. When prisoners leave prison (for example, to go to hospital), staff complete a risk assessment to determine the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public which must 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.
72. 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.
73. On 25 June 2019, before Mr Hodge went to hospital, prison staff completed a risk assessment. The nurse who completed the medical section noted that Mr Hodge was bedbound. The officer who completed the risk assessment noted that Mr Hodge was a Category B prisoner who posed a medium risk to the public and a medium risk to hospital staff because he had previously been abusive towards nurses. A prison manager decided that Mr Hodge should be escorted by two officers and restrained with an escort chain. He remained restrained in hospital for two months.
74. Mr Hodge was 83 years old, bedridden, seriously ill and had a poor prognosis. He was accompanied at all times by two prison officers. We do not consider that the use of restraints was justifiable on the grounds that Mr Hodge had previously been 'abusive' to nurses, or on the grounds that he was 'abusive',

'obnoxious', 'rude' or refused treatment in hospital. None of these things can be prevented by the use of restraints.

75. Given that Mr Hodge's ability to escape was minimal, the only justifiable grounds for restraint would have if he had been considered to pose a risk of assault to others – that is, of being physically (not just verbally) aggressive. This may have been the case – and we note that he committed two minor assaults on 19 August – but if so, this should have been spelt out in the initial risk assessment and in subsequent reviews.
76. On 22 August, when Mr Hodge went to the hospice, a senior manager reviewed the level of restraint and authorised that the restraint should be removed. He remained unrestrained until his death five weeks later.
77. We recommend:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position 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.

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