

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Allan Hodson, a prisoner at HMP Isle of Wight, on 24 February 2020

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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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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Allan Hodson died on 24 February 2020, while a prisoner at HMP Isle of Wight. Post-mortem results are still outstanding, but at the time of his death he was receiving palliative care for renal cancer. Mr Hodson was 59 years old. I offer my condolences to Mr Hodson's family and friends.
4. The clinical reviewer reviewed the care Mr Hodson received at both HMP Brixton and at HMP Isle of Wight. She concluded that, while Mr Hodson had good quality of life up until his death, overall the care received while in prison was not equivalent to that which he could have expected to receive in the community. She made six recommendations, none of which directly relate to the circumstances of Mr Hodson's death, so we do not repeat them in this report.
5. We found no non-clinical issues of concern.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Hodson's clinical care at HMP Isle of Wight. The clinical reviewer's report is attached as Annex 1.
7. The PPO investigator has investigated non-clinical issues, including Mr Hodson's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Hodson's next of kin to explain the investigation. He did not respond to our letter.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.
10. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Previous deaths at HMP Isle of Wight

11. Mr Hodson was the 15th prisoner to die at HMP Isle of Wight since February 2018. Of these deaths, 13 were from natural causes (nine from cancer) and two were self-inflicted or drug-related. There has been one further death since. There are no similarities between our findings in the investigation into Mr Hodson's death and our investigation findings for previous deaths.

Key Events

12. On 15 April 2015, Mr Allan Hodson was remanded into custody for sexual offences and sent to HMP Thameside. He was sentenced to 12 years imprisonment on 16 June.
13. Mr Hodson smoked from a young age and was diagnosed with COPD (a lung condition) in October 2018. He first complained of lower back pain on 5 June 2019, and was given pain killers and anti-inflammatory medication. Mr Hodson transferred to HMP Brixton on 27 June.
14. On 2 September, Mr Hodson complained of severe pain in his legs when standing. He was admitted to the hospital emergency department where a MRI scan showed a fracture of the lumbar spine with severe compression of the spinal cord. Mr Hodson was offered surgery, but refused treatment and discharged himself against medical advice. After further investigation, Mr Hodson was diagnosed with renal cancer on 3 October.
15. On 14 October, the Family Liaison Officer (FLO) introduced himself to Mr Hodson, explaining his role. Mr Hodson spoke about his diagnosis but could not decide whether he wanted the prison to contact his family about his condition.
16. On 15 October, a social worker suggested Mr Hodson transfer to a prison with 24-hour care before his condition deteriorated further. The Head of Healthcare spoke to the Interim Head of Healthcare at HMP Highdown, but they did not have space for Mr Hodson.
17. On 25 October, Mr Hodson told the prison's family liaison officer, that he did not want his family to be told about his condition. During a hospital appointment on 31 October, a hospital registrar completed a Do Not Resuscitate Order (DNACPR).
18. Mr Hodson was discussed at a hospital multidisciplinary team meeting on 5 November. They agreed that his metastatic renal cancer was now terminal. They were reluctant to discuss life expectancy, but recorded that he had less than a year to live, possibly just weeks or months.
19. The prison started an application for compassionate release on 6 November. A GP noted in Mr Hodson's medical record on 11 November that this application had been declined.
20. On 16 November, Mr Hodson gave the FLO his son's address and asked the officer to contact him on his behalf. The FLO travelled to the address, but could not find Mr Hodson's next of kin or reach him on the telephone.
21. On 18 November, Mr Hodson transferred to HMP Isle of Wight. The FLO travelled with Mr Hodson and spoke to Mr Hodson's new family liaison officer. As soon as he got to HMP Isle of Wight, Mr Hodson was admitted to the Inpatient Healthcare Unit (IHU). The new FLO introduced himself to Mr Hodson. He said that he would continue to try to contact Mr Hodson's next of kin on his behalf. The FLO asked the prison's Police Liaison Officer to help to find Mr Hodson's next of kin.

22. A GP reviewed Mr Hodson on 20 November. Mr Hodson agreed to a palliative care referral to the local hospice, but declined any further investigations in hospital. He agreed a new DNACPR form.
23. On 11 December, Mr Hodson provided contact details for his cousin, suggesting he could help find his next of kin. The FLO got in touch the same day, but his cousin did not want any contact with Mr Hodson or the prison.
24. HMP Isle of Wight started another application for early release on compassionate grounds on 30 January 2020, but they needed a suitable release address. A nurse asked Mr Hodson the next day if he wanted the prison to pursue the application. He said that he was happy with his care in prison, but he wanted to vape again (which he could not do in the IHU), so he asked the prison to carry on with the application.
25. On 4 February, the FLO went to the address the previous FLO gave him for Mr Hodson's next of kin, but, as before, he was not there.
26. From 7 February, Mr Hodson had increasing difficulty breathing. On 20 February, a GP arranged for increased pain relief as Mr Hodson's condition deteriorated further. On 24 February, at 2.32pm, Mr Hodson stopped breathing. Resuscitation was not attempted, in line with Mr Hodson's wishes. The GP confirmed that Mr Hodson had died at 2.36pm. Mr Hodson's application for early release was not completed before his death.
27. On 25 February, after Mr Hodson died, the FLO contacted his cousin again. He apologised for calling, explaining that Mr Hodson had died and they were still trying to find his next of kin. Mr Hodson's next of kin contacted the prison the next day and spoke to the FLO who offered support.
28. A post-mortem examination was completed on 27 February 2020. At the time of writing this report Mr Hodson's cause of death is still unconfirmed. Mr Hodson's medical records show that he had metastatic renal cancer and a fractured spine when he died.

Sue McAllister, CB
Prisons and Probation Ombudsman

September 2020

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