

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Hughes, a prisoner at HMP Holme House, on 5 April 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 David Hughes, who was 82 years old, died of a stroke on 5 April 2020 at HMP Holme House. We offer our condolences to Mr Hughes' family and friends.
4. The clinical reviewer concluded that the clinical care Mr Hughes received was good and equivalent to that which he could have expected to receive in the community. She made two recommendations linked to his death.
5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare at HMP Holme House should ensure that there is a robust process for scheduling blood tests.
- The Head of Healthcare at HMP Holme House should ensure that nursing care plans and risk assessments are initiated promptly upon admission to the prison's inpatient unit.

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Hughes' clinical care at HMP Holme House.
7. The PPO has investigated the non-clinical issues in Mr Hughes' care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. Mr Hughes' family received a copy of the initial report. They did not raise any issues, or comment on any factual accuracies of the report.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at Holme House

10. Mr Hughes was the 14th prisoner to die at Holme House since May 2018. Of the previous deaths, eight were from natural causes, two were self-inflicted and three were drug-related. There are no similarities between our findings in the investigation into Mr Hughes' death and the other deaths.

Key Events

11. On 15 February 2019, Mr David Hughes was sentenced to 20 years imprisonment. He was moved to HMP Holme House on 1 March 2019.
12. Mr Hughes had several chronic health conditions, including epilepsy, small bowel restriction, chronic kidney disease, pulmonary fibrosis, diabetes, COPD, high blood pressure, and heart disease. He required support with all aspects of daily living and used crutches or a wheelchair to mobilise. He was cared for in the inpatient unit at Holme House until his death.
13. During the months before his death, Mr Hughes went to a hospital, in North Tees, many times for treatment.
14. On 8 October, Mr Hughes agreed that a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) should be put in place as his health continued to decline.
15. Mr Hughes last went to hospital on 6 March 2020 and it was decided that he should return to Holme House for end of life care.
16. An application for Early Release on Compassionate Grounds was made on 17 March. However, due to the nature of his offence, the accommodation that Mr Hughes had identified for release was not suitable. Consequently, Mr Hughes decided that he wanted to stay at Holme House.
17. The prison maintained good communication with Mr Hughes' family and arranged regular prison visits as Mr Hughes' health declined.
18. Mr Hughes died at Holme House on 5 April at 11:59pm, when he was seen by a nurse. However, his time of death was certified by a doctor at 3.02am on 6 April 2020.
19. There was no post-mortem examination as the coroner accepted the cause of death provided by the doctor. The doctor gave the cause of death as a stroke.

Karen Johnson
Assistant Ombudsman

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