Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ross Hodgkinson, a prisoner at HMP Birmingham, on 16 January 2021

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*

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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 Ross Hodgkinson died of a brain haemorrhage as a result of a brain tumour on 16 January 2021 while a prisoner at HMP Birmingham. He was 42 years old. I offer my condolences to his family and friends.

The clinical reviewer found that, overall, the care that Mr Hodgkinson received at Birmingham was of a good standard and equivalent to that which he could have expected to receive in the community.

The clinical reviewer did, however, have some concerns: Mr Hodgkinson did not have a secondary health screen in line with NICE guidelines; he was assumed, without supporting evidence, to be under the influence of drugs when he was unsteady on his feet in November 2020; and it was not until 4 December that healthcare staff read Mr Hodgkinson's previous medical records and realised he had been diagnosed with epilepsy in January 2020. The clinical reviewer was unable to say what effect, if any, these issues may have had.

There was also a delay of five days after Mr Hodgkinson returned to Birmingham from hospital before a GP completed an order to say that he did not want to be resuscitated if his heart or breathing stopped. This delay could have led to him being resuscitated inappropriately.

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 **November 2021**

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Summary

Events

1. On 18 November 2020, Mr Ross Hodgkinson was sentenced to 20 weeks in prison for theft and was sent to HMP Birmingham.

2. At his initial health screen, he tested positive for opiates and was prescribed methadone (opiate replacement medication).

3. On 28 November, prison staff found Mr Hodgkinson on the floor of his cell. A nurse saw that he was responsive but ‘bleary eyed’.

4. On 29 November, prison staff told healthcare staff that they felt that Mr Hodgkinson’s mental health was worsening. A nurse noted that he was ‘vacant’. A mental health nurse noted that he was drowsy, unsteady on his legs, unable to stand up, spoke little, mumbled and made minimal eye contact. He noted that Mr Hodgkinson had a history of substance misuse.

5. On 2 December, officers told healthcare staff that they were concerned about Mr Hodgkinson’s condition. A nurse saw him and considered he had a ‘neurological deficit’ and may have had a head injury. A prison GP advised the nurse to send him to hospital.

6. Mr Hodgkinson went to hospital, where a brain scan showed that he had a large brain tumour. On 4 December, Mr Hodgkinson had an operation to remove as much of the tumour as possible.

7. On 4 December, a prison GP reviewed Mr Hodgkinson’s Summary Care Record (a summary of community GP medical records) and noted that he had been admitted to hospital several times in early 2020 with seizures and had a CT scan which showed no abnormalities.

8. On 24 December, Mr Hodgkinson returned to Birmingham, where he lived in the inpatient unit for palliative/end of life care. His health gradually deteriorated.

9. At 3.50pm on 15 January 2021, an officer told a nurse that Mr Hodgkinson looked unwell. The nurse saw that he was unresponsive, and his pupils were fixed and dilated. The officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing and triggers the control room to call an ambulance immediately). The nurse gave Mr Hodgkinson oxygen and inserted an airway. At 4.10pm, ambulance paramedics arrived and took him to hospital.

10. On 18 January, Mr Hodgkinson died. A hospital consultant established that he died of a brain haemorrhage as a result of a brain tumour.

Findings

11. The clinical reviewer said that, overall, the care that Mr Hodgkinson received at Birmingham was equivalent to that which he could have expected to receive in the community.

12. However, the clinical reviewer did have some concerns.

13. Mr Hodgkinson did not have a secondary health screen in line with NICE guidelines on the physical health of prisoners. It was not until 4 December, after Mr Hodgkinson had been diagnosed with a brain tumour, that a prison GP reviewed his Summary Care Record and saw that he had had a number of seizures in early 2020.

14. When Mr Hodgkinson displayed signs of neurological deficit on 29 November, it was assumed this was the result of substance misuse and no drug tests or neurological observations were carried out. As a result, Mr Hodgkinson was not taken to hospital for assessment for another four days.

15. The clinical reviewer could not say if this would have affected the outcome for Mr Hodgkinson.

16. When Mr Hodgkinson returned to Birmingham from hospital, there was a delay of five days before a prison GP completed an order to say that he did not want to be resuscitated if his heart or breathing stopped. This delay could have led to an inappropriate resuscitation attempt during that five-day period.

17. The clinical reviewer also made two recommendations which were not directly related to Mr Hodgkinson's death but which the Head of Healthcare will need to address.

Recommendations

- The Head of Healthcare should ensure that reception screening staff make all reasonable attempts to obtain past healthcare records, including the Summary Care Record, and that these are used to obtain information about the prisoner's previous medical history.
- The Head of Healthcare should ensure that a secondary health screen is offered to all newly arrived prisoners.
- The Head of Healthcare should ensure that requests by prisoners not to be resuscitated are discussed and implemented without delay.

The Investigation Process

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

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

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

21. We informed HM Coroner for Birmingham and Solihull of the investigation. She gave us the cause of death. We have sent the Coroner a copy of this report.

22. The Ombudsman's family liaison officer wrote to Mr Hodgkinson's sister to explain our investigation. She had no specific questions.

23. We shared the initial report with the prison service. There were no factual inaccuracies.

24. We shared the initial report with Mr Hodgkinson's sister. She did not respond.

Background Information

HMP Birmingham

25. HMP Birmingham is a local prison which holds up to 1,054 prisoners. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour healthcare services at the prison and sub-contracts Birmingham Community Healthcare NHS Trust to provide primary care services, including a 15-bed healthcare unit.

HM Inspectorate of Prisons

26. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Birmingham in July 2018. They noted a dramatic deterioration in the prison's overall performance since the previous inspection. They judged outcomes for prisoners to be 'poor' against all four of their healthy prison tests – safety, respect, purposeful activity, rehabilitation and release planning. They issued an Urgent Notification to the Secretary of State for Justice, seeking immediate improvements.

27. Notwithstanding their overall judgement of the prison, inspectors noted that health services at the prison had improved and the working relationship between health providers and the prison was good. They also noted that the retention of healthcare staff had improved and that staffing levels were adequate. They found that record keeping by healthcare staff was of a good standard. However, they noted that while the environment in the healthcare centre was generally good, many of the wing-based clinical rooms were dirty and failed to meet infection control standards.

28. At their subsequent Independent Review of Progress in May 2019, HMIP reported that prison leaders at Birmingham had made progress against many of their recommendations, with significant work done to restore order to the prison.

29. HMIP also carried out a scrutiny visit of HMP Birmingham (a shortened inspection during the pandemic) in November 2020 and January 2021. Inspectors reported that COVID-19 had created significant challenges for leaders at the prison and that the prison had experienced three outbreaks of the virus. Inspectors reported that there was effective communication between staff and prisoners throughout the period of COVID-19 restrictions and frontline staff were visible when prisoners were unlocked. Healthcare was good but prisoners waited too long to see a GP.

Independent Monitoring Board

30. 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 June 2020, the IMB reported that the prison was safer than before and that CCTV, installed in February 2020, had helped to identify perpetrators and provide evidence in disciplinary hearings.

31. The IMB reported that the management of COVID-19 by the senior leadership team resulted in only three prisoners testing positive for COVID-19 in the

reporting period. The IMB reported that healthcare provision was generally good, with inpatient wards being particularly well-run and prison staff working well together.

Previous deaths at HMP Birmingham

32. In the two years before Mr Hodgkinson's death, there were seven deaths from natural causes, including one from COVID-19. There has been one death from natural causes and one self-inflicted death at Birmingham since Mr Hodgkinson's death. There are no significant similarities to the findings in our investigation of these deaths.

Key Events

33. On 18 November 2020, Mr Ross Hodgkinson was sentenced to 20 weeks in prison for theft and was sent to HMP Birmingham.

34. That day, a nurse carried out Mr Hodgkinson's initial health screen and noted that he was homeless and a heroin and crack cocaine user who appeared to have drug withdrawal symptoms. His urine tested positive for opiates. He was placed under observation and a GP prescribed detoxification medication. The nurse referred him to the substance misuse service.

35. On 19 November, Mr Hodgkinson was prescribed methadone. It was planned that he would have daily observations for five days and attend ongoing appointments for psychosocial interventions with a healthcare worker.

36. On the same day, a pharmacy technician reviewed Mr Hodgkinson's Summary Care Record and recorded there was no recent relevant information in it.

37. There is no evidence that healthcare staff carried out a secondary health screen.

38. On 28 November, prison staff found Mr Hodgkinson on the floor of his cell. A nurse saw that Mr Hodgkinson was responsive but 'bleary eyed'. She thought that he might have taken an illicit substance. Prison staff searched his cell but found nothing. Mr Hodgkinson was unable to provide a sample of urine for drug testing.

39. On 29 November, prison staff told healthcare staff that they felt that Mr Hodgkinson's mental health was getting worse. A nurse saw him and noted that he became 'vacant and communicated minimally'. Later that day, a mental health nurse saw Mr Hodgkinson and noted that he was drowsy, unsteady on his legs and unable to stand up. He spoke little, mumbled and made minimal eye contact. He noted that Mr Hodgkinson was under the care of the substance misuse team and was prescribed methadone. He also noted that there were two inhalers in Mr Hodgkinson's cell that did not belong to him. These were confiscated by prison officers. He planned to reassess Mr Hodgkinson on 2 December.

40. On 30 November, when Mr Hodgkinson went to the medication hatch, a nurse noted that he was 'highly confused'.

41. On 2 December, officers told healthcare staff that Mr Hodgkinson was unsteady on his feet, that he had short-term memory problems, and was unsure of basic tasks such as collecting meals or taking a shower. A nurse saw him and noted that he did not appear to be under the influence of drugs but was unable to obey commands or follow instructions, did not know the time, month and place and believed that he was in hospital. Mr Hodgkinson told the nurse that he had been diagnosed with epilepsy. She noted that there was no evidence of this. She also noted that she thought that he had been incontinent of urine as there was a strong smell of it.

42. The nurse felt there was an obvious 'neurological deficit' and was unsure if Mr Hodgkinson had had a head injury. Mr Hodgkinson told her that he had not

taken any illicit substances. She spoke to a prison GP, who advised her to send him to hospital.

43. Mr Hodgkinson was taken to hospital, where a brain scan showed that he had a large brain tumour. On 4 December, he had an operation to remove as much of the tumour as possible.

44. That day, the prison GP reviewed Mr Hodgkinson's Summary Care Record and noted that he had been admitted to hospital several times in early 2020 with seizures but had had a CT scan which showed no abnormalities.

45. Healthcare staff remained in daily contact with hospital staff who said that Mr Hodgkinson needed palliative/end of life care. Hospital staff spoke to staff at St Mary's Hospice, Birmingham, who said that he was too well to go to the hospice at that time.

46. On 24 December, Mr Hodgkinson returned to Birmingham and was located in the prison's inpatient unit. A nurse noted that Mr Hodgkinson walked into the prison. She recorded that his clinical observations were stable and that he was alert and coherent. She noted that there was no record in Mr Hodgkinson's discharge information that he had signed an order to say that he did not want to be resuscitated if his heart or breathing stopped or a ReSPECT form (a national patient-held document, completed during the advanced care planning process), despite hospital staff having told healthcare staff that this had been completed.

47. On 29 December, a prison GP completed an order to say that Mr Hodgkinson did not want to be resuscitated if his heart or breathing stopped.

48. At 3.50pm on 15 January 2021, an officer told a nurse that Mr Hodgkinson was lying across his bed and looked unwell. The nurse saw that Mr Hodgkinson was unresponsive and his pupils were fixed and dilated. At 3.51pm, the officer radioed a medical emergency code blue. The nurse gave Mr Hodgkinson oxygen and inserted an airway. At 4.10pm, ambulance paramedics were at his side and took Mr Hodgkinson to hospital.

49. At 7.00pm, a prison governor authorised Mr Hodgkinson's release on temporary licence.

50. On 18 January, Mr Hodgkinson died in hospital. A hospital consultant established that he had died of a brain haemorrhage as a result of a brain tumour.

Contact with Mr Hodgkinson's family

51. On 15 January, the Head of Safety appointed the Head of Reducing Reoffending as the family liaison officer. At 5.05pm, she telephoned Mr Hodgkinson's sister and told her that Mr Hodgkinson was seriously ill in hospital.

52. Mr Hodgkinson's sister said that the family would visit him in hospital, and when Mr Hodgkinson died, his family were at his side. His funeral took place on 11 February. The prison contributed to its cost in line with national policy.

Support for prisoners and staff

53. After Mr Hodgkinson's death, the Head of Safety debriefed the staff who were at the hospital when Mr Hodgkinson died to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

54. The prison posted notices informing other prisoners of Mr Hodgkinson'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 Hodgkinson's death.

Cause of death

55. There was no post-mortem examination. A hospital consultant stated that Mr Hodgkinson died of a catastrophic inter-cranial event (a brain haemorrhage) as a result of a grade four glioblastoma (a brain tumour).

Findings

Clinical issues

56. The clinical reviewer concluded that, overall, the care that Mr Hodgkinson received at Birmingham was equivalent to that which he could have expected to receive in the community.

57. When Mr Hodgkinson arrived at Birmingham on 18 November, his urine tested positive for opiates. In response, methadone treatment was commenced straight away, and he was monitored and assessed regularly for the first six days in line with best practice. He was appropriately referred to the substance misuse team and healthcare staff created a plan for ongoing psychological support while he had methadone treatment.

58. On 2 December, when Mr Hodgkinson presented as very unwell, a nurse carried out an appropriate neurological assessment. And, after she discussed his condition with a prison GP, Mr Hodgkinson was appropriately sent to hospital.

59. On 24 December, before Mr Hodgkinson went back to Birmingham, a nurse spoke to hospital staff about his care needs and created a care plan for adults at the end-of-life. Mr Hodgkinson had a social care assessment and a care package which began the week before he died.

60. The clinical reviewer did, however, have some concerns.

61. Mr Hodgkinson did not have a secondary health screen in line with NICE guidelines on the physical health of prisoners. A secondary health screen would have provided an opportunity for him to disclose that he had a diagnosis of epilepsy (which he did not do until 2 December).

62. The clinical reviewer also noted that when Mr Hodgkinson was exhibiting obvious signs of neurological deficit on 29 November, these symptoms were considered to be illicit substance misuse or mental health issues, and the presence of unprescribed inhalers in his cell was cited as evidence of substance misuse. The clinical reviewer was concerned that there is no evidence that urine or blood tests were taken to support these assumptions and that no neurological observations were taken. It was, therefore, four days before Mr Hodgkinson was admitted to hospital for further assessment.

63. The clinical reviewer also noted that a pharmacy technician reviewed Mr Hodgkinson's Summary Care Record on 19 November and said that there was no up to date information of relevance in it. However, a prison GP reviewed the same record on 4 December following Mr Hodgkinson's diagnosis of a brain tumour and found that the SCR held information about an admission to hospital in February 2020, where he had a brain CT scan following epileptic seizures. The CT scan results were negative for any brain abnormality at that time, but knowledge of this admission may have provided healthcare staff with information to inform the assessment of apparent neurological deficits on 28 and 29 November. However, the clinical reviewer could not say if earlier knowledge would have had any bearing on Mr Hodgkinson's eventual diagnosis.

64. We make the following recommendations:

The Head of Healthcare should ensure that reception screening staff make all reasonable attempts to obtain past healthcare records, including the Summary Care Record, and that these are used to obtain information about the previous medical history.

The Head of Healthcare should ensure that a secondary health screen is offered to all newly arrived prisoners.

65. The clinical reviewer was also concerned that there was a delay of five days after Mr Hodgkinson returned from hospital before a prison GP completed an order to say that he did not want to be resuscitated if his heart or breathing stopped, even though this appeared to have been completed in hospital. The clinical reviewer considered that the delay was unacceptable because if Mr Hodgkinson had stopped breathing during this five-day period, it might have resulted in an inappropriate resuscitation attempt taking place. We make the following recommendation:

The Head of Healthcare should ensure that requests by prisoners not to be resuscitated are discussed and implemented without delay.

Non-clinical issues

66. We are satisfied that when an officer found Mr Hodgkinson slumped across his bed in his cell, she appropriately called to a nurse who was nearby in the inpatient unit and radioed a medical emergency code blue within a minute.

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