Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stuart Hodgson, a prisoner at HMP Moorland, on 9 June 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

OGL

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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 Stuart Hodgson died in hospital of a stroke on 9 June 2021 while a prisoner at HMP Moorland. He was 75 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the care Mr Hodgson received at HMP Moorland was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

However, the clinical reviewer found that there were system failures in relation to Mr Hodgson's heart and blood pressure monitoring and follow up care.

I am concerned that when two officers went to see Mr Hodgson in his cell because he was feeling unwell, they did not have up to date first aid training.

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 2022**

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Summary

Events

1. On 26 October 2020, Mr Stuart Hodgson was sentenced to 11 years in prison for sexual offences. He was transferred to HMP Moorland on 19 January 2021.

2. Mr Hodgson had several longstanding medical problems (including a history of strokes from 2002 and 2003). Prison healthcare staff monitored his conditions and facilitated specialist care. Over time, Mr Hodgson's health deteriorated. Healthcare staff created care plans for his risk of falls, cellulitis, wound care, and social care.

3. On 7 June, Mr Hodgson appeared unwell and lost the feeling in his arm. Three officers went to his cell and thought that he might have had a stroke. Staff sent him to hospital, where hospital doctors confirmed that he had had a stroke.

4. Mr Hodgson's condition deteriorated in hospital and on 9 June, it was confirmed that Mr Hodgson had died.

Findings

5. The clinical reviewer concluded that the care Mr Hodgson received at Moorland was equivalent to that which he could have expected to receive in the community. We found that healthcare staff provided responsive care and support as his needs changed

6. The clinical reviewer did, however, identify some shortcomings in Mr Hodgson's care.

7. She found that the management of Mr Hodgson's high blood pressure and heart disease was poor. From February 2021, when he had fainting episodes, healthcare staff gave no consideration to the cause or considered if this was possibly a further stroke.

8. We are concerned that when two officers went to see Mr Hodgson in his cell because he was feeling unwell, they did not have up to date first aid training.

9. The prison was unable to provide the PPO with a copy of a fully completed escort risk assessment.

Recommendations

- The Head of Healthcare should ensure that healthcare staff adhere to Hypertension in adults: diagnosis and management NICE guideline [NG136] and ensure that plans of care are in place.

- The Governor and the Head of Healthcare should ensure that there is a stroke recognition tool such as FAST (Face Arm Speech Time) in place, in line with NICE guidance for stroke and transient ischaemic attack: diagnosis and initial management (NG128) and ensure that Mandatory First Aid training is up to date for prison and response staff.

- The Governor should ensure that all evidence relevant to a death in custody is completed and retained and that evidence is made available to the PPO, in line with PSI 58/2010.
- The Governor and the Head of Healthcare should share this report with all staff named in it so that they are aware of the Ombudsman's and clinical reviewer's findings

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Moorland 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. The investigator interviewed three members of staff over the telephone on 5 and 6 August 2021. The interviews were conducted by telephone because of the COVID-19 restrictions in place.

13. NHS England commissioned a clinical reviewer to review Mr Hodgson's clinical care at the prison. The investigator and clinical reviewer jointly interviewed prison and healthcare staff.

14. We informed HM Coroner for South Yorkshire East of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. We contacted Mr Hodgson's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Moorland

17. HMP Moorland is a category C resettlement prison which holds up to 1,000 men. The Practice Plus Group provides healthcare services at the prison, including primary care, mental health, and substance misuse services. Healthcare at Moorland is covered from 7.30am until 7.30pm. Outside of these hours, cover is available by telephone consultation with an emergency care practitioner or one of the local prisons' heads of healthcare on a rota system.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Moorland was in February 2019. Inspectors found that there had been many improvements since their previous visit in 2016. A strategic approach to health promotion had been developed and bespoke events took place throughout the year. Reception screening identified individuals who needed ongoing help and advice and healthcare referrals were made appropriately. An appropriate range of primary health services and secondary care services were available.

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 published in August 2021, the IMB reported that despite COVID-19 and the resulting impact on healthcare provision, they were satisfied that everything possible had been done to maintain essential services and to minimise the risk of infection.

Previous deaths at HMP Moorland

20. Mr Hodgson was the ninth prisoner to die at Moorland since June 2019. Of the previous deaths, seven were from natural causes (one death was related to COVID-19) and one was drug related. Since Mr Hodgson's death, there have been three natural causes deaths at Moorland.

21. There are no similarities between Mr Hodgson's death and the previous deaths.

22. In our previous investigation into the death of a prisoner who died at Moorland in March 2021, we made a recommendation about refresher training on cardiopulmonary resuscitation and said that training should be delivered at appropriate intervals. The prison accepted our recommendation and said that Immediate Life Support training was completed annually in line with mandatory training requirements. The prison also said that prison training would be developed for annual refresher training for staff on cardiopulmonary resuscitation.

23. Although not specific to resuscitation, first aid retraining was also an issue in this investigation, and we are disappointed to have to raise it as an issue again in this report.

24. This is the second investigation at Moorland where escort risk assessment documentation went missing and was not made available for the purpose of our investigation.

Key Events

25. On 26 October 2020, Mr Stuart Hodgson was sentenced to 11 years in prison for sexual offences. He was sent to HMP Leeds. On 19 January 2021, he transferred to HMP Moorland.

26. Mr Hodgson had a medical history of two strokes, heart disease, heart attack, severe vascular disease, cerebrovascular disease (blood flow problems to the brain), lower urinary tract problems, gout, arthritis, and high blood pressure. He had mobility issues after fracturing his ankle and used a walking stick.

27. Healthcare staff completed his reception screen and ensured he had received his medication to manage his conditions. They also arranged for him to receive a Zimmer frame to help with his mobility.

28. Mr Hodgson received COVID-19 vaccinations on 3 February and 21 April.

29. On 17 February, a nurse examined Mr Hodgson as he reported that he had fainted. She noted that he was having trouble making sense when speaking. She arranged for him to have an ECG (test tracing of the heart) and checked his blood pressure which was low. She scheduled further blood pressure reviews.

30. On 23 February, a social worker and occupational therapist completed a joint social care assessment and assessed that Mr Hodgson needed two hours of social care support per week. They created a health and well-being care plan to help him with washing.

31. On 24 and 26 March, nurses checked Mr Hodgson's blood pressure and the results were low. Healthcare staff sent him to Doncaster Royal Infirmary. He was diagnosed with sepsis, cellulitis in his right leg and kidney failure.

32. On 31 March, the hospital discharged Mr Hodgson back to Moorland. Healthcare staff arranged for him to have a multi-professional complex case conference to discuss the best way to manage his conditions. Blood tests were arranged, and a falls risk assessment was completed which identified that he was at high risk of falls. Healthcare staff advised him not to make sudden movements when standing or bending to minimise losing his balance and falling.

Events on 7 June 2021

33. Mr Hodgson was located in a shared cell. At approximately 6.05am, an Operational Support Grade (OSG) was completing the morning roll count. When she looked into Mr Hodgson's cell, she saw him on the floor. In her written statement, she said she could see that he was breathing, but he was unresponsive as she knocked on the door. His cellmate woke up and she asked him to check on Mr Hodgson. He asked Mr Hodgson if he was ok, and Mr Hodgson responded but she could not hear what he had said.

34. The OSG went to the centre office and telephoned the night orderly officer to ask for officers to attend the cell to help put Mr Hodgson back into bed. She returned to the cell and updated Mr Hodgson's cellmate.

35. At approximately 6.15am, staff arrived at the cell and went in. Body worn video camera (BWVC) footage shows three officers in the cell. The BWVC for each officer has been viewed. As the officers tried to ascertain what had happened, a male officer is heard to say, “Turn towards your padmate, you’re a grown fella”, “Why are you talking like that”, “I’m not here to baby you fella”, “he’s fucking covered in sweat.”

36. The OSG said an officer told her that Mr Hodgson had a suspected stroke and he called for an ambulance. The prison log noted that an ambulance was called at 6.25am. Paramedics arrived at 7.02am and left the prison with Mr Hodgson at 7.33am. Two officers escorted Mr Hodgson to hospital and the duty manager instructed that handcuffs should not be used. At interview, the prison custodial manager said that the duty manager had authorised the use of an escort chain. The Prisoner Escort Record (PER) signed by the prison custodial manager said, “no cuffing arrangements”.

37. In hospital Mr Hodgson’s condition deteriorated, and he died there on 9 June 2021.

Contact with Mr Hodgson’s family

38. On 7 June, the prison appointed a Family Liaison Officer (FLO). He telephoned Mr Hodgson’s nominated next of kin, to let her know that Mr Hodgson was in hospital following a suspected stroke. The duty manager arranged for her to visit him. Mr Hodgson’s next of kin was present when he died in hospital. The FLO remained in contact with her to offer support.

39. The prison offered a contribution to Mr Hodgson’s funeral, in line with national instructions.

Support for prisoners and staff

40. After Mr Hodgson’s death, the Head of Residence and Segregation debriefed the escorting staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

41. The prison posted notices informing other prisoners of Mr Hodgson’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 Hodgson’s death.

Post-mortem report

42. The post-mortem report gave Mr Hodgson’s cause of death as acute intracerebral haemorrhage (a bleed on the brain) and cerebral infarction (a stroke), caused by essential hypertension (high blood pressure) and atrial fibrillation (irregular heartbeat).

Findings

Clinical care

43. The clinical reviewer concluded that the care Mr Hodgson received at Moorland was of a reasonable standard and was equivalent to that which he could have expected to receive in the community.

44. The clinical reviewer noted that when Mr Hodgson's incontinence problems persisted, healthcare staff referred him to urology specialists in a timely manner.

45. She did, however, identify some shortcomings in Mr Hodgson's care.

Hypertension care and stroke recognition

46. Prison Service Order (PSO) 3050, *Continuity of Healthcare for Prisoners,* gives guidance on the clinical management of prisoners and emphasises the importance of continuity in the success of clinical interventions and treatment. There should have been a plan for Mr Hodgson's hypertension care with good, clear, holistic care plans, which should have been communicated within the healthcare team.

47. The clinical reviewer noted that on arrival at Moorland healthcare staff did not create a heart disease care plan. She said that one should have been created to monitor his heart disease.

48. Mr Hodgson had a history of strokes so when he had a fainting episode and low blood pressure in February 2021, healthcare staff should have completed assessments to explore if this was another stroke. The clinical reviewer said that in line with NICE guidelines, a validated identification tool should have been used.

49. In March 2021, healthcare staff recorded two low blood pressure readings. The clinical reviewer said these could have been indications of infection or the effects from some of his medication.

50. We are concerned that when officers attended Mr Hodgson's cell because he had become unwell, they did not have up to date first aid training. We make the following recommendations:

    The Head of Healthcare should ensure that healthcare staff adhere to Hypertension in adults: diagnosis and management NICE guideline [NG136] and ensure that plans of care are in place.

    The Governor and the Head of Healthcare should ensure that there is a stroke recognition tool such as FAST (Face Arm Speech Time) in place, in line with NICE guidance for stroke and transient ischaemic attack: diagnosis and initial management (NG128) and ensure that that Mandatory First Aid training is up to date for prison and response staff.

Incomplete paperwork

51. The investigator asked for the last escort risk assessment. The prison said that the duty manager had instructed staff not to use handcuffs. The duty manager said that

an escort risk assessment was completed by security staff and he instructed the dispatching manager that under no circumstances were any handcuffs to be used. He said that two officers were to provide the escort and to minimise delays, the paperwork could be given to the escorting staff when they were in the ambulance. He also said that Mr Hodgson was not of an age or condition where restraints may have been used. However, he never completed the escort risk assessment form and at her interview the custodial manager said that the duty manager had authorised the use of handcuffs.

52. We are concerned that this is the second recent investigation where the prison was unable to provide us with the completed escort risk assessment. From the copy that was provided, there were no details of the authorising manager's decision. These records can provide crucial evidence for investigations and we would expect the prison to ensure that evidence is completed and preserved following a death in custody to enable appropriate scrutiny and accountability. We are therefore unable to confirm whether Mr Hodgson was restrained when he was taken to hospital for the last time on 7 June 2021. We repeat the following recommendation:

The Governor should ensure that all evidence relevant to a death in custody is completed and retained and that evidence is made available to the PPO, in line with PSI 58/2010.

Learning lessons

53. When Mr Hodgson was found collapsed on the cell floor, the body-worn video camera (BWVC) footage shows that the three officers in the cell were trying to assess what had happened to him. All three officers were invited to attend for interview. Two attended and one officer failed to attend or provide an explanation for his non-attendance.

54. The BWVC footage showed that in the process of completing the assessment some of the comments made could be deemed as insensitive and inappropriate. The officer was invited to comment on his BWVC footage, but he did not respond to a request to review his footage and comment on it.

55. We consider it essential that staff learn the lessons from our reports. We therefore recommend that:

The Governor and Head of Healthcare should share this report with all staff named in it so that they are aware of the Ombudsman's and clinical reviewer's findings.

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