Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Holloman, a prisoner at HMP Winchester, on 6 September 2022

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

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 Anthony Holloman died of heart failure at Royal Hampshire County Hospital Hospice on 6 September 2022, while a prisoner at HMP Winchester. He was 80 years old. We offer our condolences to Mr Holloman's family and friends.

4. Mr Holloman arrived at Winchester less than three months before he died. He had a range of pre-existing health conditions, including those which caused his death. The clinical reviewer concluded that the clinical care Mr Holloman received was equivalent to that which he could have expected to receive in the community. She makes one recommendation for the Head of Healthcare, to ensure that clinical observation scores are recorded when a patient's health shows rapid deterioration.

5. We found no non-clinical issues of concern.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Holloman's clinical care at HMP Winchester.

7. The PPO investigator investigated the non-clinical issues relating to Mr Holloman's care, including Mr Holloman'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 Holloman's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Holloman's wife responded with several concerns which have been addressed in the clinical review. Mr Holloman's family have asked for a copy of the report.

9. Mr Holloman's next of kin received a copy of the initial report. She raised further issues which have been addressed in a letter to her. She also commented on the factual accuracy of the clinical reviewer report, which have been addressed in the report.

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

Previous deaths at HMP Winchester

11. Mr Holloman was the second prisoner to die at HMP Winchester since May 2020. Both deaths were due to natural causes and there are no similarities in the findings across these investigations.

Key Events

12. On 10 June 2022, Mr Holloman was given a 16-year sentence for sex offences and transferred to HMP Winchester.

13. Mr Holloman's initial health screening identified several medical conditions, including heart failure and ischemic heart disease, prostate cancer and bone metastasis (where cancer has spread to other parts of the body). A Do Not Attempt Cardiopulmonary Resuscitation Order (DNACPR) was in place for Mr Holloman, based on his pre-existing health issues and the risks associated with CPR.

14. Later the same day, Mr Holloman's medications were reviewed by the prison healthcare team. It was agreed that they should be dispensed by staff, as opposed to being kept in possession, because of Mr Holloman's vascular dementia and the impact on his short-term memory. Mr Holloman's cell was on a flat location with no stairs, due to his limited mobility.

15. On the 13 June, Mr Holloman was moved into a cell closer to the medication hatch, so he could receive his medications more easily. The same day, a Healthcare Assistant (HCA) met with Mr Holloman to complete an initial social care assessment. He said he was worried about falling. She assessed that Mr Holloman required support with showering twice a week and made a referral for a full social care assessment.

16. On 16 June, Mr Holloman's care was discussed by the Multi-Disciplinary Team (MDT) in the Complex Care meeting. Staff noted that he had a long sentence and underlying health and social care needs. Healthcare made a referral to Palliative Care Services at Winchester Hospice, asking for further discussion on Mr Holloman's care planning. The prison GP and Mr Holloman reviewed his DNACPR, which they agreed should remain in place.

17. On 22 June, a representative from Hampshire County Council completed a full social care assessment for Mr Holloman. She agreed that he needed support with showering, twice a week. No further support was needed but healthcare could re-refer Mr Holloman if appropriate.

18. On 30 June, the healthcare team assessed Mr Holloman for a transfer to HMP Dartmoor, which could deliver risk reduction work related to his offending. They assessed that he was medically fit for the transfer. The next day, healthcare completed long-term conditions and social care reviews for Mr Holloman, and it was agreed that the transfer should not take place due to his deteriorating health.

19. On 1 July, a falls risk assessment was completed for Mr Holloman.

20. On the 3 July, Mr Holloman told staff that he had been woken by chest pains and was seen by a prison paramedic. He was anxious and upset and said he was missing his wife. At 12.45pm, Mr Holloman transferred to Royal Hampshire County Emergency Department for further observation. An electrocardiogram (ECG - a test which looks at the heart's rhythm and electrical activity) confirmed angina pains (attacks of chest pain caused by reduced blood flow to your heart). The hospital continued to monitor for cardiac changes and adjusted Mr Holloman's medications.

Mr Holloman was discharged on 7 July, with planned follow up from the Cardiology department at University Hospital Southampton. No follow up was completed because of the deterioration in Mr Holloman's health.

21. On 8 July, a representative from Hampshire County Council visited Mr Holloman to discuss an alarm system for requesting help in the event of a fall.

22. On 11 July, the prison GP and Mr Holloman completed another review of his DNACPR, which they kept in place.

23. On 13 July, Hampshire County Council fitted Mr Holloman's falls alarm.

24. On 4 August, prison officers told healthcare that Mr Holloman 'was not himself'. A nurse went to Mr Holloman's cell to see how he was feeling. She noted that his cell was warm, and the air was stale, so advised that the door should be opened to improve circulation. She also noted that Mr Holloman was a little dehydrated and advised him to rest and drink more fluids.

25. On 7 August, a nurse assessed Mr Holloman after a fall in the night. He had several small cuts to the right knee and the left wrist, which were cleaned and dressed.

26. On 22 August at 1.59pm, an officer was asked to complete a welfare check on Mr Holloman, following a call from his wife who said she was worried about him. She told us that she completed a check but did not record it.

27. On 5 September at 10.43pm, a nurse visited Mr Holloman in his cell to complete a routine review of his health. He was sitting on the floor and complaining of constipation. The nurse said he would be escalating Mr Holloman's concerns to the incoming shift lead. He documented that 'worsening symptoms advice was given' but did not record what was said or who the advice was given to.

Events of 6 September

28. On 6 September at 5.45am, officers found Mr Holloman on the floor of his cell. He had fallen out of bed and sustained a small cut at the side of his head. They alerted the healthcare team who requested an ambulance as a matter of urgency. A nominated family liaison officer left a message on Mr Holloman's wife's phone, to tell her that he had fallen out of bed and was seriously ill. Mr Holloman was helped back on to his bed and his basic observations were taken. His oxygen level was low, so oxygen was administered. He also had a high temperature and very low blood pressure. Healthcare completed observations every 15 minutes while awaiting the ambulance.

29. Paramedics arrived at Winchester at around 7.00am. They were concerned about the risk of cardiac arrest if Mr Holloman was transferred to hospital. Mr Holloman said that he did not want to go. The prison GP arrived a short while later and contacted Royal Hampshire County Hospital Hospice, who were able to allocate a bed. At 8.00am, the family liaison officer spoke with Mr Holloman's wife to update her on the situation. Healthcare staff then helped Mr Holloman to contact his wife via his in-cell telephone, to tell her about the move. Mr Holloman's condition continued to deteriorate and, at 8.44am it was agreed that his wife could visit him in

prison. A taxi was organised, but, in the meantime, Mr Holloman was transferred to the hospice.

30. On 6 September at 10.20am, Mr Holloman died at Royal Hampshire County Hospital Hospice. A short while later, Mr Holloman's wife arrived at Winchester. She was met by family liaison officers, who informed her that Mr Holloman had died. They accompanied her to the hospice.

Post-mortem report

31. A preliminary post-mortem examination found that Mr Holloman died of acute chronic heart failure caused by ischemic heart disease. Prostate cancer was listed as a contributory factor.

Inquest

32. The inquest into Mr Holloman's death concluded on the 21 June 2023. The coroner confirmed that Mr Holloman died of natural causes.

Tallulah Frankland
Assistant Ombudsman **September 2023**

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