Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr George Holden, a prisoner at HMP Doncaster, on 7 November 2022

**A report by the Prisons and Probation Ombudsman**

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T l 020 7633 4100

## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO


## WHAT WE VALUE

# 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. If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr George Holden died in hospital on 7 November 2022 of pneumonia (an inflammation of the lungs) while a prisoner at HMP Doncaster. This was caused by a fractured neck of the femur (thigh bone). He also had ischaemic and valvular heart disease and dementia which did not cause but contributed to his death. He was 89 years old. We offer our condolences to Mr Holden's family and friends.

4. Mr Holden was admitted to hospital on 1 November following two falls, one of which had occurred during an altercation with his cellmate. The circumstances relating to this fall were investigated by South Yorkshire Police and they concluded that no criminal offence had occurred.

5. The clinical reviewer concluded that the clinical care Mr Holden received at Doncaster was partially equivalent to that which he could have expected to receive in the community. The clinical reviewer made four recommendations which were not directly related to Mr Holden's death, but which the Head of Healthcare will need to address.

# The Investigation Process

6. The PPO was notified of Mr Holden's death on 7 November 2022. NHS England commissioned an independent clinical reviewer, to review Mr Holden's clinical care at HMP Doncaster.

7. The PPO investigator investigated the non-clinical issues relating to Mr Holden's care.

8. During the course of the investigation, we spoke to South Yorkshire Police who had carried out an investigation into the circumstances that led to Mr Holden's admission to hospital.

9. The PPO family liaison officer wrote to Mr Holden's next of kin, his son, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

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

## Previous deaths at HMP Doncaster

11. Mr Holden was the twenty-fourth prisoner to die at Doncaster since November 2019. Of the previous deaths, thirteen were from natural causes, seven were self-inflicted and one was drug-related. There are no similarities between our findings in the investigation into Mr Holden's death and our investigation findings for the previous deaths.

# Key Events

12. On 5 November 2021, Mr George Holden was sentenced to 13 years in prison for sex offences and sent to HMP Doncaster. He first lived on a standard wing but was then moved to the healthcare annex on 22 November 2021, where he shared a cell with another prisoner.

13. Mr Holden had a number of medical conditions, including ischaemic heart disease (where the heart is starved of oxygen due to a lack of blood flow), atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate) and heart failure (the heart is unable to pump blood around the body properly).

14. On 29 November, Mr Holden saw a nurse who carried out a falls risk assessment and a malnutrition assessment. Mr Holden was identified as being at high risk of malnutrition so a fortified diet was ordered and he was referred for monthly weight monitoring.

15. On 12 January 2022, a physiotherapist assessed Mr Holden and concluded that he was able to walk safely and had not had any falls.

16. On 13 March, a nurse attended to Mr Holden after he had fallen. While Mr Holden had not sustained a significant injury, the nurse was concerned that Mr Holden appeared unwell and called an ambulance. Ambulance paramedics assessed Mr Holden and concluded that he did not need to go to hospital.

17. The nurse carried out a second falls risk assessment on 27 August. It is recorded in the medical notes that an order was raised for Mr Holden to be given a raised seat and frame for his toilet. He was given these on 8 September.

18. At 2:52pm on 1 November, a nurse saw Mr Holden in his cell after he had fallen. The nurse recorded that Mr Holden told him that he had tripped over and bumped his head. There was no record that he had lost consciousness and his Glasgow Coma Scale (a clinical scale to measure a person's level of consciousness) was 15 which indicated that Mr Holden was fully responsive and had no cognitive or memory problems. Although Mr Holden did not show signs of distress or significant injury, the nurse completed physical observations and calculated a National Early Warning Score (NEWS2, a tool to detect and respond to clinical deterioration) of 0. This score indicated that all of Mr Holden's physical observations were within normal limits.

19. At approximately 3.15pm, the nurse saw Mr Holden in his cell after an officer reported that Mr Holden had fallen off the toilet. The nurse examined Mr Holden and diagnosed a potential hip fracture. An ambulance was called at 3.28pm and arrived at 6.08pm. Mr Holden left the prison for hospital at 6.49pm and was admitted. (There is no information in the incident log or medical records to explain the reason for the ambulance delay.)

20. On 2 November, Mr Holden told an officer (who was on bed watch at the hospital) that his cellmate had pushed him over. A Custodial Manager (CM) submitted an incident report. She recorded that Mr Holden had reported that he had had a scuffle with his cellmate. She wrote that his cellmate had said that there had been a scuffle but this had not been the cause of Mr Holden's injury. His cellmate told the CM that,

following the scuffle, Mr Holden had got up and was walking around but then fell as he was getting off the toilet.

21. In a statement provided to the Forensic Pathologist, she said that Mr Holden's cellmate had told her, "he had my slippers on, I asked for them back, and he hasn't so I tried to take them off his foot, he then came at me with clenched fists, so I have pushed him, he fell over but back up he got up wandering about, went to toilet and fell and didn't get back up again".

22. At 12.28am on 7 November, officers at the hospital with Mr Holden told the control room that he had died.

## Post-mortem report

23. The post-mortem report concluded that Mr Holden died of pneumonia caused by a fractured neck of the femur. He also had ischaemic and valvular heart disease and dementia which did not cause but contributed to his death.

## Inquest into Mr Holden's death

24. The inquest into Mr Holden's death was held on 30 October 2023 and a verdict of natural causes was recorded. The coroner concluded that Mr Holden's death was due to pneumonia caused by a fractured neck of the femur. He also recorded that he had ischaemic and valvular heart disease with dementia.

# Clinical Findings

25. The clinical reviewer concluded that the clinical care Mr Holden received at HMP Doncaster was partially equivalent to that which he could have expected to receive in the community. The clinical reviewer made four recommendations, which did not relate to Mr Holden's death, but which the Head of Healthcare will need to address.

# Non-clinical findings

## Police investigation into incident between Mr Holden and his cellmate

26. On the day that Mr Holden fractured his femur, it was reported that there had been a scuffle between Mr Holden and his cellmate. We investigated this incident and reviewed the cell sharing risk assessments and intelligence reports for both Mr Holden and his cellmate. Our investigation found no evidence to indicate that the two prisoners should not have shared a cell and no intelligence to suggest that there had been any issues between Mr Holden and his cellmate before 1 November 2022.

27. The prison told us that the police had carried out an investigation into the events of 1 November. The police confirmed to us that they had looked into the incident, including interviewing and gathering statements from officers, healthcare staff and prisoners. They also interviewed Mr Holden's cellmate under caution. The police concluded that there was no suggestion of any third party involvement in the fall that resulted in Mr Holden's injury and their investigation had subsequently been closed, with no further action taken. They confirmed that they had shared all of the information about their investigation with the Coroner.

28. Based on our review of all the information we have seen during our investigation, there is no evidence that Mr Holden incurred significant injuries as a result of the scuffle with his cellmate.

**Adrian Usher** **June 2023**
**Prisons and Probation Ombudsman**

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100