Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lawrence Hodge, a prisoner at HMP Holme House, on 4 February 2023

A report by the Prisons and Probation Ombudsman

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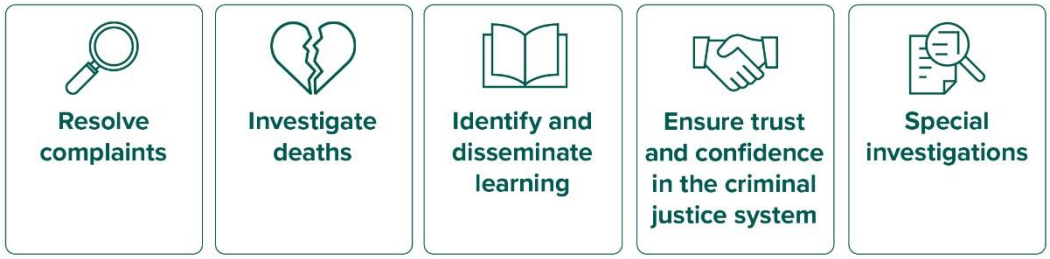
OUR VISION

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

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.

If my office is to best assist His Majesty's 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.

Mr Lawrence Hodge died in hospital from heart disease on 4 February 2023, while a prisoner at HMP Holme House. He was 74 years old. I offer my condolences to Mr Hodge's family and friends.

The clinical reviewer concluded that the overall care Mr Hodge received at Holme House was equivalent to the care he could have expected to receive in the community. However, she also considered that a nurse should have requested an emergency ambulance when he was sent to hospital on 30 January.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **February 2024**

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Summary

Events

1. On 17 September 2021, Mr Lawrence Hodge was convicted of a number of historical child sex offences and was later sentenced to 15 years in prison. He was initially sent to HMP Durham and was then transferred to HMP Holme House on 7 April 2022.

2. In the late evening of 30 January 2023, Mr Hodge complained that he felt breathless. An ambulance was called and while he was being taken to the ambulance, he had a heart attack. The paramedics and a prison nurse resuscitated him, and he was taken to hospital.

3. At hospital, Mr Hodge had a further heart attack on 4 February, but efforts to resuscitate him were unsuccessful.

Findings

4. The clinical reviewer concluded that the overall care that Mr Hodge received at Holme House was of a reasonable standard.

5. The clinical reviewer identified some areas of learning, including the need for nurses to call for an emergency ambulance, where appropriate.

Recommendations

- The Head of Healthcare should ensure that clinical staff are aware of emergency codes and the need to call them when clinically indicated.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and asking anyone with relevant information to contact him.

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

8. The investigator interviewed six members of staff from Holme House between 25 March and 15 May. All of the interviews were conducted by telephone or video link.

9. NHS England commissioned a clinical reviewer to review Mr Hodge's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with the clinical staff.

10. We informed HM Coroner for Teesside of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

11. The Ombudsman's family liaison officer contacted Mr Hodge's wife to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Hodge's wife said that her husband had developed a severe cough in the weeks leading up to his death. She said that he had asked to see a prison doctor but had still not been seen before his heart attack on 31 January. She said that at hospital, he was diagnosed with a severe chest infection, and he then spent two days in intensive care as the hospital needed to stabilise his breathing. She considered that the prison's failure to deal with her husband's chest infection contributed to his death.

12. We have addressed Mr Hodge's wife's concern in this report and the clinical review and also answered another of her concerns in separate correspondence.

13. The initial report was shared with Mr Hodge's family and with HM Prison and Probation Service (HMPPS). Neither party identified any factual inaccuracies.

Background Information

HMP Holme House

14. HMP Holme House is a category C training and resettlement prison holding up to around 1159 prisoners. Spectrum provides healthcare services at the prison.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Holme House was in March 2023. Inspectors noted that relationships between staff and prisoners was a strength at Holme House and was a standing agenda item on the monthly wing consultation meetings where prisoners could speak openly about their experience with staff. Inspectors reported that in their survey, 74% of responders said that most staff treated them with respect and 73% said there were staff they could turn to if they had a problem. Inspectors found that keywork meetings between designated officers and prisoners were well developed, and the frequency of meetings and quality of support were much better than usually seen during inspections.

16. Inspectors noted that the several teams and organisations delivering healthcare, worked together effectively to provide a seamless patient-centred service. Inspectors found that excellent leadership was supported by a skilled and conscientious staff group who were delivering a good standard of care. Inspectors noted that external hospital referrals were monitored efficiently with records made to explain when and why appointments needed to be rescheduled.

Independent Monitoring Board

17. 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 December 2022, the IMB noted that the general atmosphere in the prison was bright and pleasant, with prisoners treated well and with respect. The IMB found that services provided by healthcare were good and that treatment was timely and effective.

Previous deaths at HMP Holme House

18. Mr Hodge was the twenty-first prisoner to die at Holme House since February 2020. Of the previous deaths, 16 were from natural causes, three were self-inflicted and one was drug-related. In our investigation into a death in April 2020, we found that there had been a delay in setting up a care plan for a long-term health condition.

Key Events

19. On 17 September 2021, Mr Lawrence Hodge was convicted of a number of historical child sex offences and sent to HMP Durham. It was his first time in prison. He was later sentenced to 15 years in prison.

20. On 7 April 2022, Mr Hodge moved to HMP Holme House. Mr Hodge was clinically obese and had kidney failure for which he received dialysis in hospital three times a week.

21. On 27 April, an officer found Mr Hodge collapsed on his cell floor. The officer radioed a medical emergency code blue (indicating a prisoner is unconscious or has breathing difficulties). Nurses responded and Mr Hodge was taken to hospital by ambulance, where he was found to have had a heart attack. Tests showed that no surgical intervention was needed, and his condition was to be managed by medication alone. He returned to Holme House on 3 May.

22. On the morning of 27 November, a prisoner reported to staff that Mr Hodge had collapsed in his cell. Staff responded, including the response nurse. Mr Hodge told the nurse that he had collapsed to the floor when he stood up to go to the toilet. She examined him and noted no abnormalities. Mr Hodge said that he had no chest pain and was feeling “okay”. Mr Hodge was taken to hospital for tests and was diagnosed with vasovagal syncope (a fainting episode).

23. Mr Hodge returned to Holme House on 28 November. A doctor saw him two days later for a follow-up appointment. Mr Hodge reported that he felt dizzy at times and the doctor referred him to the community elderly medicine department.

Events from 23 January to 29 January 2023

24. The investigator spoke to nurses and pharmacy technicians who dispensed medication to Mr Hodge during his final days at Holme House. They all said that Mr Hodge did not complain of any symptoms and none of them noticed any symptoms that needed intervention. There was no entry in his medical record about a cough during this period.

25. The investigator also spoke to Mr Hodge’s keyworker. Her last keyworker meeting with him was on 24 January. She said that Mr Hodge told her that he was not feeling very well that day because he had had dialysis the day before and never felt well immediately afterwards.

26. On 25 January, Mr Hodge declined to go to hospital for dialysis as he had ‘flu’ and was not feeling very well.

Events of 30 January 2023

27. At around 10.00pm on 30 January, Mr Hodge rang his cell bell. An officer responded and Mr Hodge said that he was struggling to breath. The officer told the investigator that Mr Hodge was sitting on his bed and had no trouble speaking. He was also leaning forward and shuffling some of his belongings. The officer did not

consider that he needed to call a medical emergency code blue but instead he called a nurse and the senior officer on duty to unlock the cell.

28. A nurse went to see Mr Hodge. Mr Hodge said that he had had difficulty breathing for the last five or six days. He said that his condition had deteriorated with pain across his chest and down both arms. He also said that he felt dizzy at times. The nurse telephoned the out-of-hours doctor who advised that Mr Hodge needed to go to hospital for assessment. The doctor and nurse agreed that he needed an urgent transfer to hospital rather than an emergency transfer.

29. Ambulance paramedics arrived at just before 11.00pm and treated Mr Hodge for around 20 minutes. As Mr Hodge was being taken by wheelchair to the ambulance, he had a heart attack. The paramedics started chest compressions and he was given two electric shocks with a defibrillator. After around four minutes, Mr Hodge regained a pulse and began to breath. He was then taken to hospital, where he stabilised after he was given intravenous antibiotics.

30. On 1 February, Mr Hodge was given dialysis.

31. In the early evening of 4 February, Mr Hodge had another heart attack while receiving further dialysis. Hospital staff tried to resuscitate him, but without success. He died at 7.40pm.

Contact with Mr Hodge's family

32. One of Holme House's family liaison officers (FLOs) contacted Mr Hodge's wife on the morning of 31 January to tell her that her husband was in hospital. She visited him a number of times over the following days.

33. The FLO was contacted on the evening of 4 January and told that Mr Hodge had died. The FLO and a colleague visited Mr Hodge's wife at around 8.20pm and broke the news to Mr Hodge's wife and one of their sons.

34. Mr Hodge had a pre-paid funeral plan, so the family did not require a contribution to his funeral costs.

Support for prisoners and staff

35. After Mr Hodge's death, Holme House's Head of Security and Intelligence debriefed the bedwatch officers who were with Mr Hodge when he died to ensure they had the opportunity to discuss any issues arising, and to offer support. He also debriefed the family liaison officers. The staff care team also offered support.

36. The prison posted notices informing other prisoners of Mr Hodge'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 Hodge's death.

Post-mortem report

37. Mr Hodge's post-mortem report gave his cause of death as ischaemic and hypertensive heart disease caused by coronary artery atherosclerosis and hypertension. Mr Hodge also had end-stage renal disease and diabetes.

Findings

Clinical care

General

38. The clinical reviewer concluded that the overall care Mr Hodge received at Holme House was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She noted that he received appropriate care for his long-term conditions and was transferred to hospital whenever this was clinically indicated.

39. However, the clinical reviewer noted that there was no evidence that a care plan was made for Mr Hodge's kidney disease and renal dialysis. The clinical reviewer made a recommendation about this. She also made recommendations about two other matters, including the need for information to be shared across the healthcare team when a patient reports feeling unwell, which the Head of Healthcare will want to address.

Emergency response on 30 January

40. When the officer responded to Mr Hodge's cell bell on the evening of 30 January, Mr Hodge complained about difficulty breathing but he had been able to speak properly and to explain his symptoms. The officer did not consider that Mr Hodge's condition warranted a code blue emergency call at that stage, but when the nurse checked on Mr Hodge, he also complained about pain across his chest and down both arms. The nurse then telephoned the out-of-hours doctor for advice before arranging Mr Hodge's transfer to hospital as an urgent transfer. The clinical reviewer considered that by the time the nurse saw Mr Hodge, his symptoms warranted a code blue for his emergency transfer to hospital. The clinical reviewer has made a recommendation which we repeat:

    The Head of Healthcare should ensure that clinical staff are aware of emergency codes and the need to call them when clinically indicated.

Inquest

41. An inquest into Mr Hodge's death concluded that his cause of death was ischaemic and hypertensive heart disease due to coronary artery atherosclerosis and hypertension.

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