

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Hogarth, a prisoner at HMP Risley, on 14 August 2016

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 | 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



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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Richard Hogarth was found hanged in his cell at HMP Risley on 14 August 2016. He was 50 years old. I offer my condolences to Mr Hogarth's family and friends.

Mr Hogarth had never been to prison before. He feared for his safety and was upset that he had no contact with his children. On several occasions, he mentioned that he had suicidal thoughts.

I am, therefore, troubled by the series of opportunities missed by staff at both Altcourse and Risley to identify Mr Hogarth's risk of suicide and self-harm, share important information about him and give him the support he needed. Had these opportunities been taken, the outcome might have been different.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

July 2018

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Summary

Events

1. On 29 March 2016, Mr Richard Hogarth was remanded to HMP Altcourse, charged with sex offences against a child who was a relative. It was his first time in prison. Due to his offence, staff monitored his post, visitors and telephone calls. Mr Hogarth said he had depression and took antidepressants in the community. This was not correct, but it took prison healthcare staff several weeks to contact his community GP to check.
2. On 1 April, Mr Hogarth told his friend by telephone that he had put a belt around his neck to kill himself, but his cellmate had found him. Staff were not aware of the call at the time, but listened to it on 21 May. No action was taken as a result – staff did not talk to Mr Hogarth, note the information in his person escort record before his transfer to Risley or consider starting suicide and self-harm prevention (ACCT) procedures.
3. On 13 May, at Mr Hogarth's second health screen and mental health assessment, a nurse noted in Mr Hogarth's clinical record that he had arrived at Altcourse with a suicide and self-harm warning form. (This form was not in Mr Hogarth's prison records and no-one else recorded that they had seen it.) The nurse concluded that Mr Hogarth had no current risk of suicide or self-harm.
4. On 27 May, Mr Hogarth was sentenced to 2 years 8 months in prison and was transferred to HMP Risley. At reception, he said he had no thoughts of suicide and self-harm.
5. On 21 June, a social worker told Mr Hogarth that he could not have contact with his children. Prisoners said that he was upset about this. He told the social worker that he had thought about taking his life but did not want to hurt his wife and children. Intelligence reports in July also recorded that Mr Hogarth had wanted to tell other prisoners about his offence so that he could "get a beating". He was concerned about his immediate family's safety as he believed that his victim's parents had threatened them.
6. Mr Hogarth also feared for his safety in prison. On 18 July, he told a friend by telephone that a prisoner had threatened to kill him and he was frightened of what might happen to him. On 12 August, his friend visited and said he told a visits officer and the safer custody team that he was concerned about Mr Hogarth's wellbeing. The prison said that they had no record of this.
7. On 14 August, around 4.30pm, an officer went to Mr Hogarth's cell after he did not collect his meal and found him hanged. The officer radioed a code blue emergency and staff started resuscitation. Paramedics arrived and took over but pronounced Mr Hogarth dead at 5.16pm.

Findings

8. We do not know whether Mr Hogarth arrived at Altcourse with a suicide and self-harm warning form or whether reception staff were aware of it, despite it being referenced in his clinical record.
9. No one at Altcourse spoke to Mr Hogarth about his risk of suicide and self-harm or considered starting ACCT monitoring after listening to a telephone call, in which he said he had tried to take his life. Altcourse did not satisfactorily pass on this information or the information about Mr Hogarth's risk and mental health when he was transferred to Risley on 27 May.
10. Although there was no specific information in Mr Hogarth's person escort record relating to his risk, staff at Risley should have considered the broad risk factors present given his offence and personal circumstances along with the specific risk factors included in his prison records. They failed to do so, and missed an opportunity to support Mr Hogarth.
11. Staff failed to share or act on the information about Mr Hogarth's risk throughout his time at Risley. There was intelligence that Mr Hogarth feared for his safety but he was not supported through violence reduction or ACCT procedures.

Recommendations

- The Director and Head of Healthcare at Altcourse should ensure that staff:
 - Have a clear understanding of their responsibilities and the need to share all relevant information about risk.
 - Start ACCT procedures when a prisoner has recently self-harmed or expressed suicidal intent.
 - Complete person escort records fully and accurately with details of a prisoner's risk and mental health needs to ensure good continuity of care for prisoners transferring to another prison and to alert the receiving prison of any concerns.
- The Governor and Head of Healthcare at Risley should ensure that reception staff have a clear understanding of their responsibilities and the need to share all relevant information about risk, and that they consider and record all the known risk factors of a newly arrived prisoner when determining risk of suicide and self-harm.
- The Governor and Head of Healthcare at Risley should ensure that, where staff have information about a prisoner's risk, they should share it appropriately, respond proactively to the identified risk, fully record actions taken and where necessary, start ACCT procedures without delay.
- The Governor of Risley should ensure that:
 - All information about bullying and intimidation is fully recorded, co-ordinated and investigated.
 - Those suspected of involvement are appropriately challenged and monitored.
Staff consider whether victims are at increased risk of suicide or self-harm.

- Apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Risley informing them of the investigation and asking anyone with relevant information to contact her.
13. The investigator visited HMP Risley on 16 August 2016. She obtained copies of relevant extracts from Mr Hogarth's prison and medical records. She met the Governor, a member of the safer custody team and a member of the IMB. She visited Mr Hogarth's cell, spoke to officers and interviewed two prisoners.
14. NHS England commissioned a clinical reviewer to review Mr Hogarth's clinical care at the prison.
15. The investigator interviewed staff at Risley in August 2016. The clinical reviewer joined her for the interviews.
16. We informed HM Coroner for Cheshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Hogarth's mother to explain the investigation. She had no specific questions for us to consider.
18. We sent a copy of the report to Mr Hogarth's mother. She did not identify any inaccuracies or omissions.

Background Information

HMP Altcourse and HMP Risley

19. Altcourse is a privately run Category B local prison for adults and young adults in Liverpool. Risley is a Category C training and resettlement prison near Warrington, holding 1,115 adult men mainly from the north-west.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Altcourse was in June 2014. Inspectors reported that levels of self-harm were higher than at similar prisons. They found that ACCT entries were excellent and prisoners in crisis spoke positively about the care they had received. However, inspectors found that prison staff had not addressed all of the learning points from recent self-inflicted deaths.
21. The most recent inspection of Risley was in June 2016. Inspectors said that a fifth of prisoners did not feel safe, including those deemed to be vulnerable due to the nature of their offence. They said that they observed many wing staff who did not engage with prisoners positively and said they spent too much time in the wing offices. Prisoners said that they were unable to turn to officers for support. They said that integrated offender management processes were not always effective and prisoners' risks and needs were not systematically assessed on arrival. They found that staff in the Offender Management Unit staff were routinely redeployed and the unit could not fulfil its role in managing sentences. Inspectors said that there were not enough discipline staff who had basic life support skills.

Independent Monitoring Board

22. 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.
23. In its latest annual report for the year to June 2016, the Altcourse IMB reported that there had been a rise in the number of incidents of self-harm, and a subsequent rise in the number of ACCT documents opened. They found that the safer custody team made continuing efforts to ensure Altcourse was a safe prison, although staff shortages had had a significant impact throughout the prison.
24. In its latest annual report on the year ending March 2016, the Risley IMB said that the security department made great efforts to ensure the safety of the prisoners. They said there had been a number of changes to the way the department was managed.

Previous deaths at HMP Altcourse and HMP Risley

25. This is the second self-inflicted death at Altcourse since the beginning of 2016. We found similar issues relating to person escort records in the other investigation.

26. Mr Hogarth was the third prisoner to take his life at Risley since 2014. Our investigation of Mr Hogarth's death repeats our previous criticisms about Risley underestimating prisoners' risk and about deficiencies in the way staff operated suicide and self-harm prevention procedures.

Assessment, Care in Custody and Teamwork

27. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

HMP Altcourse

28. On 29 March 2016, Mr Richard Hogarth was remanded to HMP Altcourse, charged with sexual offences against a child who was a relative. It was his first time in prison. Due to the nature of his alleged offence, staff monitored his post, telephone calls and visitors.
29. A nurse at Mr Hogarth's initial reception health screen noted that he said he had depression and took citalopram, an antidepressant. She noted that Mr Hogarth firmly denied thoughts of suicide or self-harm and his mood appeared settled. She noted that he should see a doctor for his medication and referred him to the mental health team. On 6 April, he started work in a workshop.
30. On 9 April, Mr Hogarth did not attend his second health screen. On 28 April, a nurse visited him, but he was at work. On 5 May, staff requested Mr Hogarth's community clinical records and received them on 9 May. The community records showed that Mr Hogarth was not prescribed citalopram and there was no evidence in them that he had been diagnosed with depression or any other mental illness.
31. On 13 May, a mental health nurse saw Mr Hogarth for his second health screen and a mental health assessment. He noted in his medical record that Mr Hogarth had arrived with a suicide and self-harm warning form and that his risk had been monitored in police custody. Neither Risley nor Altcourse had a copy of the warning form and we were unable to establish whether it had been available in reception when Mr Hogarth arrived.
32. The mental health nurse assessed Mr Hogarth's mental health. He concluded that Mr Hogarth was settled and had engaged well. Mr Hogarth described feeling "okay" and strongly denied ever having depression or thoughts of suicide or self-harm. Mr Hogarth said that he socialised on the wing and that he got on well with other prisoners. He declined further help from the mental health team but said that he would contact them if he felt that he needed support. The nurse noted that there was no evidence that Mr Hogarth was fearful or anxious.
33. On 21 May, an officer monitored Mr Hogarth's telephone calls and heard in a telephone conversation on 1 April that Mr Hogarth had told his friend that he had put a belt around his neck in his cell. He said that his cellmate had found him and supported him. The officer completed an intelligence report but there is no evidence that anyone acted on this information, and no one made an entry in Mr Hogarth's electronic case notes. Mr Hogarth was not monitored under ACCT suicide and self-harm prevention procedures.

HMP Risley

34. On 27 May, Mr Hogarth was sentenced to two years and eight months in prison, and was transferred to HMP Risley. Staff at Altcourse completed a person escort record, but did not include any information about Mr Hogarth's recent self-harm. He attended a reception health screen with a nurse from the primary care team. Mr Hogarth told the nurse that he felt well and denied thoughts of suicide and self-harm

but had felt low when he had been arrested. She also said it was not routine for reception healthcare staff to receive a person escort record and she did not receive one for Mr Hogarth. She received no information from Altcourse that Mr Hogarth had told his friend that he had put a belt around his neck the previous month or that he had arrived at Altcourse with a suicide and self-harm warning form.

35. The nurse said that she did not see the mental health nurse's note of 13 May reflecting Mr Hogarth's risk of suicide and self-harm. She said this was because she was unable to see his full clinical history on the computer until she had completed the assessment. She said that she was guided by what prisoners told her about their risk and offences. Mr Hogarth told her that he had no history or thoughts of suicide or self-harm but had felt very low in mood when he was sentenced.
36. On 2 June, Mr Hogarth's offender supervisor completed a public protection assessment for Mr Hogarth. She told him that he could not contact his children until the Public Protection Unit directed what level of contact he was allowed. She explained that he had been put on the sex offender register and reminded him that his post, telephone calls and visits were being monitored.
37. On 21 June, the social worker for Mr Hogarth's children visited Mr Hogarth and told him that he was not allowed contact with his children. Mr Hogarth told her that he had thought about hanging himself but decided not to because it would hurt his wife and children. As a result, the social worker contacted the safer custody team to express concern. A member from the safer custody team noted her concerns in Mr Hogarth's prison record and said she had passed the information to a custodial manager. The custodial manager could not remember speaking to Mr Hogarth about the social worker's concerns and said he knew nothing about Mr Hogarth. There is no evidence that anyone spoke to Mr Hogarth about how he felt or considered monitoring him under suicide and self-harm prevention procedures.
38. On 11 July, a member from the National Careers Team visited Mr Hogarth to discuss his employment plans on release. Mr Hogarth told her his victim's family was threatening his mother, his wife and his children. She said she suggested reporting it to the police, but Mr Hogarth disregarded her suggestions. She asked a band 3 assistant officer to complete an intelligence report about this, but said she had no concerns about Mr Hogarth's risk of suicide or self-harm. There is no evidence that anyone spoke to Mr Hogarth after her conversation with him but there was a note of their conversation in Mr Hogarth's prison record.
39. Mr Hogarth's offender supervisor at Risley said that she first met Mr Hogarth on 11 July. She told him that his sentence planning board had been postponed and he was not allowed contact with his children. She said that Mr Hogarth did not seem unduly stressed and she was not concerned about him.
40. On 14 July, an intelligence report noted that Mr Hogarth told an (unidentified) officer in the workshop that he was as well as he could be but was waiting for the inevitable to happen. He said that he had committed the worst kind of offence and had not been honest with other prisoners. Mr Hogarth believed that, when they found out about his offence, they would beat him up. The officer noted that (s)he telephoned an officer on Mr Hogarth's wing, who said that he would keep an eye on Mr Hogarth. Although we tried to contact the officer, we did not receive a response.

There is no evidence that anyone spoke to Mr Hogarth, started violence reduction measures or considered the need for ACCT procedures.

41. That day, Mr Hogarth telephoned his friend. When staff listened to Mr Hogarth's calls on 18 July, they noted that Mr Hogarth told his friend that he was expecting trouble for his offence and someone had made a death threat against him. There is no evidence that staff investigated the matter or that Mr Hogarth told staff about his concerns.
42. On 15 July, Mr Hogarth's offender manager participated in a video conference with Mr Hogarth and his offender supervisor at Risley for a sentence planning review. The offender manager told the investigator that she was surprised at Mr Hogarth's deterioration since she had completed his pre-sentence report. She said that he sounded extremely anxious, and said that awful things were going to happen to him such as prisoners "disembowelling him" and putting a recording on YouTube. Mr Hogarth seemed to be terrified of punishment from other prisoners. The offender manager said that she had considered contacting Risley about her concerns but thought his offender supervisor, who was present, would support Mr Hogarth.
43. The offender supervisor said that in her opinion Mr Hogarth did not seem terrified. She said he did not ask her to contact his family and was on a wing which only housed sex offenders, and he worked in a workshop with only sex offenders. She said she therefore did not consider violence reduction measures or ACCT procedures were necessary.
44. On 19 July, according to an intelligence report, while Mr Hogarth was at work he told an officer that he would climb a ladder and tell everyone his offence. He said he believed that prisoners would find out about his offence and he wanted to get it "out in the open and take the beatings". The officer, whom we have not been able to identify, noted that (s)he told Mr Hogarth that he could not do this, that he needed to deal with his guilt and paranoia and should return to work or his wing. Mr Hogarth returned to work and staff took no further action.
45. On 22 July, Mr Hogarth telephoned his mother. He told her that he had ruined everyone's lives, he could not afford the mortgage and had let his children down. He said that these were very grave circumstances and he believed he was the "most evil person on the planet". This call was monitored on 1 August and noted in an intelligence report. No one spoke to Mr Hogarth about it or took any further action.
46. On 1 August, Mr Hogarth telephoned his mother and said that he felt guilty, that he had done the most awful things and that he was sorry. On 10 August, he called his mother and said he was not in a good place and did not want her to visit him. These calls were noted in Mr Hogarth's telephone monitoring record, but no further action was taken.
47. On 12 August, Mr Hogarth's friend visited him. His friend said that he told a visits officer that Mr Hogarth seemed extremely anxious and talked about suicide. He said he spoke to someone in the safer custody team by telephone but they told him that they could not give him any information. Risley said they could not identify whom he spoke to, and we have seen no evidence of this information being recorded or that anyone spoke to Mr Hogarth afterwards.

14 August 2016

48. At 4.29pm on 14 August, Officer A noticed that Mr Hogarth had not collected his meal or completed his canteen request. He went to Mr Hogarth's cell and noticed his observation panel was covered and that Mr Hogarth had locked his cell using a courtesy lock (which could be overridden by staff keys). He said that this concerned him but his first thought was that Mr Hogarth might be using the toilet. He unlocked the door and tried to push it open but something was blocking the door. He said he pushed harder and saw a locker on its side on the cell floor and realised by touch that Mr Hogarth's body was blocking the door.
49. Officer A said that Mr Hogarth was suspended by a ligature (made from a belt attached to bedding) from the light fitting. He said he held Mr Hogarth and tried to lift him to take the pressure off his neck. He said he tried to loosen the ligature but was unable to do so. He said he shouted for other prisoners to sound the general alarm bell, which they did and he radioed a code blue. (A code blue is an emergency code used when a prisoner is unconscious or not breathing.)
50. Officer A tried to reach his anti-ligature knife on his belt but could not do so while holding Mr Hogarth. Two prisoners who lived next door to Mr Hogarth's cell arrived. One prisoner retrieved Officer A's anti-ligature knife and handed it to him. The officer then cut the belt and lowered Mr Hogarth to the bed. Another officer and a Supervising Officer (SO) arrived to help. The officers put Mr Hogarth into the recovery position and checked for a pulse and signs of life.
51. Mr Hogarth was not breathing and his face was purple. They turned him onto his back and an officer started chest compressions. Another officer arrived at the cell, took over compressions and Officer A left the cell.
52. On hearing the code blue, two nurses took an emergency bag to Mr Hogarth's cell while the officers started cardiopulmonary resuscitation. One nurse noted that Mr Hogarth was blue and was not breathing. She could not find his pulse so she attached a defibrillator to him. (A defibrillator is an electric machine which can restart the heart in the right circumstances.) It advised not to shock but to continue cardiopulmonary resuscitation. Medical staff continued resuscitation efforts until paramedics arrived and took over at 4.43pm. They pronounced Mr Hogarth dead at 5.16pm.
53. The two prisoners told the investigator that Mr Hogarth generally kept to himself but had talked about how upset he was not to have contact with his children.

Contact with Mr Hogarth's family

54. At 5.30pm, the Head of Safer Custody was appointed as the family liaison officer. She contacted a prison close to where Mr Hogarth's mother lived, and asked them to visit her to tell her of his death. At 8.10pm, the family liaison officer at this prison, and a chaplain, informed Mr Hogarth's mother of his death.
55. On 15 August, the Head of Safer Custody and an officer visited Mr Hogarth's mother and offered support. Risley contributed to the cost of Mr Hogarth's funeral in line with prison instructions.

Support for prisoners and staff

56. The Head of Safer Custody said that he individually debriefed staff involved in the emergency response and offered support. He said that the staff care team also offered support. The Governor posted notices informing staff and other prisoners of Mr Hogarth's death and offering support. Staff reviewed all prisoners subject to suicide and self-harm monitoring in case they had been adversely affected by Mr Hogarth's death.

Post-mortem report

57. The post-mortem examination concluded that the cause of Mr Hogarth's death was hanging. The toxicology tests found no evidence of drugs in Mr Hogarth's bloodstream.

Findings

Assessment of Mr Hogarth's risk of suicide

Altcourse

58. Prison Service Instruction (PSI) 64/2011 on safer custody requires staff who have contact with prisoners to be aware of the risk factors and triggers for suicide and self-harm, and to take appropriate action. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. Mr Hogarth had a number of risk factors:
- It was his first time in prison.
 - He had committed a sexual offence against a member of his family.
 - He had depression and had been taking citalopram.
59. On 13 May, a nurse noted that Mr Hogarth had arrived at Altcourse with a suicide and self-harm warning form. We have seen no evidence that staff were aware of it at Mr Hogarth's reception health screen on 29 March and neither Altcourse nor Risley had a copy of the form. While we cannot conclude whether or not it was available in reception and therefore whether staff should have started ACCT monitoring when he arrived, it was reasonable that the nurse did not start monitoring Mr Hogarth on 13 May as by then, he appeared settled and strongly denied thoughts of suicide and self-harm.
60. On 21 May, staff at Altcourse were made aware that Mr Hogarth reported trying to kill himself the previous month. Staff should have spoken to Mr Hogarth and considered ACCT monitoring. We have seen no evidence that anyone spoke to Mr Hogarth, considered his risk or satisfactorily notified Risley when he transferred less than a week later. These were missed opportunities to identify Mr Hogarth's risk and support him appropriately. We recommend that:

The Director and Head of Healthcare at Altcourse should ensure that staff:

- **Have a clear understanding of their responsibilities and the need to share all relevant information about risk.**
- **Start ACCT procedures when a prisoner has recently self-harmed or expressed suicidal intent.**
- **Complete person escort records fully and accurately with details of a prisoner's risk and mental health needs to ensure good continuity of care for prisoners transferring to another prison and to alert the receiving prison of any concerns.**

Risley

61. PSI 07/2015 on early days in custody says that reception staff must examine the person escort record and any other available documents to identify a prisoner's

immediate needs or recorded risks. While we recognise that the person escort record did not note Mr Hogarth's attempt to take his life at Altcourse, this information was in his prison record and staff should also have been aware of his offence and that he had depression. There is no evidence that anyone noted or discussed these issues, all of which can be indicative of risk of suicide or self-harm, with Mr Hogarth at reception and he was never supported by ACCT procedures.

62. The reception nurse said health screen nurses did not routinely receive a prisoner's person escort record and she was unable to look at Mr Hogarth's history on his computerised medical record until she had completed his assessment. This should not have prevented staff from being aware of Mr Hogarth's risk factors from his prison record and intelligence file, and we consider that first night staff should therefore have considered ACCT monitoring for Mr Hogarth and whether he needed to see the mental health team about his depression. We make the following recommendation:

The Governor and Head of Healthcare at Risley should ensure that reception staff have a clear understanding of their responsibilities and the need to share all relevant information about risk, and that they consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm.

Using intelligence about identified risks

63. Prison Service Instruction 04/16 on intercepting communications in prisons and security measures says that the Offender Management Unit should oversee prisoners whose communications are being monitored. It says that the unit must work closely with the security and safer custody departments to ensure that they share information appropriately and properly assess prisoners' at risk.
64. Monitoring staff at Risley completed a number of intelligence reports, identifying that Mr Hogarth had been threatened with death, feared for his safety when prisoners found out about his offence, was worried about his family's safety and was unable to contact his children, all of which were significant risk factors for suicide and self-harm. A social worker, Mr Hogarth's friend and a member of the National Careers Team also raised concerns about him with the safer custody team. We would have expected Risley to build a picture of the issues affecting Mr Hogarth, and use it to support him appropriately. Staff failed to respond to these concerns, discuss them with Mr Hogarth or consider starting ACCT monitoring. Staff repeatedly missed opportunities to assess Mr Hogarth's risks and provide appropriate support. Had they done so, the outcome might have been different for him. We make the following recommendation.

The Governor and Head of Healthcare should ensure that where staff have information about a prisoner's risk, they should share it appropriately, respond proactively to identified risks, fully record actions taken and where necessary, start ACCT procedures without delay.

Bullying and intimidation

65. Risley's violence reduction policy says that they must take a proactive approach to dealing with perpetrators and supporting victims. The policy requires all prison staff to identify and support those prisoners who might be vulnerable. It lists a number of factors for staff to consider when assessing a prisoner's vulnerability, including those isolated from the wider community and those who seem upset.
66. Mr Hogarth told staff that he was expecting a beating when prisoners found out about his offence. He said he was frightened that someone would disembowel him and put a recording on social media. He said he had received a death threat. No one evaluated this information, spoke to Mr Hogarth or assessed his risk of suicide or self-harm. The security department, safer custody team and the Offender Management Unit failed to work together to support Mr Hogarth and reduce his risk.
67. Telephone monitoring staff recorded the content of Mr Hogarth's calls and the safer custody team was aware of concerns raised by a social worker, the careers officer and Mr Hogarth's friend, who said that he had also told an officer in the visits hall that he was concerned for Mr Hogarth's wellbeing. Although staff recorded these concerns in Mr Hogarth's intelligence file, it is troubling that they took no action to respond to the information and support Mr Hogarth.
68. In three previous investigation reports about deaths at Risley, we identified that Risley underestimated prisoners' risk of suicide and self-harm. We are concerned that we need to repeat those concerns in this report, and agree with HM Inspectorate of Prisons that communication between departments should be more effective. We make the following recommendation:

The Governor should ensure that:

- **All information about bullying and intimidation is fully recorded, co-ordinated and investigated.**
- **Those suspected of involvement are appropriately challenged and monitored.**
- **Staff consider whether victims are at increased risk of suicide or self-harm.**
- **Apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.**

Clinical care

69. The clinical reviewer concluded that while the emergency response was effective, Mr Hogarth did not receive care equivalent to that which he would have received in the community while at Altcourse or Risley. She said that there were opportunities when Mr Hogarth should have been monitored under ACCT procedures and reception staff at Altcourse should have monitored Mr Hogarth's depressive illness more closely. She makes a number of recommendations in her review, which the Head of Healthcare at Risley will need to address. She concluded that insufficient prison staff were trained in first aid, a concerns echoing HM Inspectorate of Prisons' comment after their inspection in November 2016.

Inquest

70. The inquest into Mr Hogarth's death concluded on 12 July 2024 and found that he died by suicide.

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

Email: mail@ppo.gov.uk
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T | 020 7633 4100