Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Hodgson, a prisoner at HMP Holme House, on 12 August 2017

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*

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 Stephen Hodgson was found hanged in his cell on 12 August 2017 at HMP Holme House, five days before he was due to be released. Mr Hodgson was 38 years old. We offer our condolences to Mr Hodgson's family and friends.

Staff at Holme House were monitoring Mr Hodgson under Prison Service suicide and self-harm prevention procedures when he died. We are concerned that staff underestimated his risk of suicide evidenced by his frequent suicidal statements and his escalating pattern of self-harm. We are also concerned that Mr Hodgson's mental health assessments were not sufficiently robust and that intelligence systems did not operate effectively.

There was a delay in administering emergency life support to Mr Hodgson because healthcare staff awaited the arrival of prison officers before entering his cell. There was also a delay in calling an ambulance.

Finally, we are concerned that the prison did not make a full contribution towards the cost of Mr Hodgson's funeral.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **December 2020**

Contents

Summary

Events

1. Mr Stephen Hodgson was remanded to HMP Holme House on 27 June 2016 and was subsequently sentenced to 26 months imprisonment for burglary and driving offences. Mr Hodgson had a history of drug use, was suspected of being involved in bringing drugs into the prison and disclosed that his involvement in drug trafficking had placed him under threat.

2. On 20 July 2017, Mr Hodgson asked to see the mental health team. Later that month, Mr Hodgson's mother and one of his brothers raised concerns about his mental health. On 27 July and 9 August, three mental health clinicians saw Mr Hodgson, who said that unspecified prisoners had threatened him. On both occasions, the clinicians decided that Mr Hodgson did not present any signs of psychosis.

3. On 10 August, a nurse began Prison Service suicide and self-harm monitoring (known as ACCT) after Mr Hodgson said that he was going to take his own life and that he was not eating because the food had been poisoned. A prison manager made an urgent mental health referral and Mr Hodgson was moved to the healthcare unit. Later that day, two mental health nurses assessed Mr Hodgson and concluded that he was not having a psychotic episode.

4. In the early hours of 12 August, Mr Hodgson said that staff were going to "gas" him and he "would not be alive by tomorrow". He also cut his left hand and then refused to attend a video conference with a hospital to check his wound. At 11.15am, a mental health nurse saw Mr Hodgson, who said that staff were trying to kill him and that he would "leave here in a box".

5. At 4.15pm, a healthcare assistant went to Mr Hodgson's cell to check on him and saw him lying on the floor. She called for assistance and three nurses responded. One of the nurses saw Mr Hodgson had a towel tied around his neck and another called a code blue emergency (which indicates that a prisoner is unconscious or not breathing) at 4.17pm. Officers responded to the code blue, opened Mr Hodgson's cell door and removed the towel. The nurses and a prison manager started cardiopulmonary resuscitation (CPR) and gave Mr Hodgson oxygen. The control room called an ambulance at 4.20pm and paramedics reached Mr Hodgson at 4.37pm. They were unable to resuscitate him and a paramedic declared Mr Hodgson's death at 4.44pm.

Findings

Assessment of Mr Hodgson's risk of suicide and self-harm

6. While Holme House managed much of Mr Hodgson's ACCT well, we are concerned that staff underestimated his risk of suicide and self-harm by not placing sufficient weight on his frequent suicidal statements and his escalating pattern of self-harm. We are also concerned that staff did not update Mr Hodgson's caremap when his risk increased and that they did not consider involving his brothers, who were both in Holme House, in ACCT reviews.

7. We are concerned Mr Hodgson said that he had refused food on two occasions but that staff did not consider managing him under the Department of Health's 'Guidelines for the clinical management of people refusing food in immigration removal centres and prison'.

Mental health

8. The clinical reviewer considered that Mr Hodgson's mental health care was not to the standard he could have expected to receive in the community. He was concerned that the mental health assessments were not sufficiently robust and they should have explored whether Mr Hodgson's presentation was a drug-induced psychosis.

Substance misuse

9. Throughout his time at Holme House, prison and healthcare staff thought that Mr Hodgson was under the influence of illicit substances. Mr Hodgson's substance misuse worker continued to review him on a monthly basis but he refused to engage. We agree with the clinical reviewer that Mr Hodgson's substance misuse care was delivered well.

10. Holme House introduced a new Drug and Alcohol Strategy in October 2017 and have attempted to reduce the demand for and supply of illicit substances.

Bullying

11. Mr Hodgson regularly told staff that he was under threat as a result of trafficking drugs around the prison. Staff do not appear to have taken this seriously, to have taken any concrete steps to address these concerns or to have submitted intelligence reports about the allegations. As mental health staff concluded that Mr Hodgson was not experiencing psychosis, and given the existing intelligence about Mr Hodgson's involvement in drug trafficking, we consider that the prison should have taken these concerns much more seriously, treated his statements as genuine and supported him in line with its Violence Reduction policy.

Emergency response

12. We are concerned that none of the healthcare staff entered Mr Hodgson's cell when he was seen lying on the floor with a towel around his neck. We are also concerned that there was a three minute delay in calling an ambulance.

Funeral expenses

13. Although the prison paid £2,503 towards the cost of Mr Hodgson's funeral, we consider that they should have contributed the full £3,000, in line with prison instructions.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that:
  - Staff consider all risk factors, including frequent suicidal statements and escalations in self-harm, when assessing a prisoner's risk to themselves.

- Staff set new, specific and meaningful ACCT caremap actions that are aimed at reducing a prisoner's risks to themselves.
- Staff involve the prisoner's family when that would be appropriate.

- The Governor and Head of Healthcare should ensure that prisoners who refuse food are managed in accordance with the Department of Health 'Guidelines for the clinical management of people refusing food in immigration removal centres and prison'.

- The Head of Healthcare, in conjunction with the mental health lead, should ensure that mental health staff use more comprehensive assessment tools to identify prisoners at risk of drug-induced psychosis.

- The Governor should ensure that:
  - All information about bullying, intimidation, debt and the use of drugs is fully coordinated and investigated.
  - Staff submit intelligence reports about bullying, intimidation, debt and the use or trafficking of drugs in line with national guidelines.
  - Staff consider whether victims are at increased risk of suicide and self-harm.
  - Apparent victims are effectively supported and protected with meaningful, long-term solutions, which address their individual situations.

- The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency in order to help preserve the life of a prisoner and are able to do so.

- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and that the control room calls an ambulance immediately when an emergency code is used.

- The Governor should ensure that up to £3,000 is offered towards reasonable funeral expenses following a death in custody and in this particular case, should arrange for the balance to be paid to Mr Hodgson's family.

The Investigation Process

14. 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. No one responded.

15. The investigator visited Holme House on 22 August 2017. He obtained copies of relevant extracts from Mr Hodgson's prison and medical records.

16. NHS England commissioned a clinical reviewer to review Mr Hodgson's clinical care at the prison.

17. The investigator and clinical reviewer interviewed ten members of staff and Mr Hodgson's two brothers at Holme House on 26 and 27 September.

18. We informed HM Coroner for Teeside of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Hodgson's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She wanted to know:

    - What the prison did after family members raised concerns about Mr Hodgson's mental health and why they did not act sooner.
    - What the prison had done after Mr Hodgson stopped eating in the three weeks before his death.
    - What happened during Mr Hodgson's mental health assessments and what medication he had been prescribed.
    - What happened after Mr Hodgson cut his arms and how the prison monitored him.

20. Mr Hodgson's mother also raised some other matters that have been answered in separate correspondence.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. We are disappointed that it took HMPPS over two and a half years to produce their action plan.

22. The initial report was shared with NHS Commissioners. They pointed out a factual inaccuracy and this report has been amended accordingly.

23. Mr Hodgson's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Holme House

24. HMP Holme House is a category C training prison holding over 1,200 men. Until May 2017, it was a category B local prison, holding men on remand or who had been recently convicted by courts in the local area. G4S provides health services at the prison. There is a 24-hour healthcare unit with 16 beds and palliative care facilities.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Holme House was in July 2017. Inspectors reported that the quality of care reflected in ACCT documentation varied widely. They found that some were completed well but in most cases there was little continuity of case management, many case reviews were not multidisciplinary, observations were often perfunctory and some risk assessments were very poor. Inspectors found there was a wide range of integrated mental health services, but high demand and staff shortages affected their provision and waiting times.

26. Inspectors also reported that levels of recorded violence were much higher than at the previous inspection in August 2013 and that not all violent incidents were recorded or investigated. They found that there was little use of victim support planning. They were also concerned that the prison had a very serious problem with drugs, with concerning levels of positive mandatory drug test results for the use of synthetic cannabinoids or new psychoactive substances. Nearly 60% of prisoners thought it was easy to get drugs in the prison.

Independent Monitoring Board

27. 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 31 December 2016, the IMB reported that there had been an exponential rise in the number of prisoners on ACCTs but that this could be attributed to a group of troubled prisoners. The IMB found that mental health care had been efficient and effective throughout 2016 with staff having good working relationships with the prison and wider community. They also found that the availability of psychoactive substances impacted on the mental health service.

28. The IMB reported an increase in incidents of violence towards officers and among prisoners and a decrease in stability and safety for prisoners.

Previous deaths at HMP Holme House

29. Mr Hodgson was the second person to take his own life and sixth person overall to die at Holme House since January 2016. We have previously made a recommendation about the need to enter cells in order to preserve life.

Assessment, Care in Custody and Teamwork

30. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide and self-harm. The

purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

31. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

32. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction 64/2011, Management of prisoners at risk of harm, to self, to others and from others (Safer Custody).

New Psychoactive Substances (NPS)

33. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide and self-harm.

34. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

35. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled new psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

36. On 27 June 2016, Mr Stephen Hodgson was remanded to HMP Holme House on suspicion of burglary. On 12 December, Mr Hodgson was sentenced to 26 months imprisonment for burglary and driving offences.

37. During his initial health screen at Holme House, Mr Hodgson told a nurse that he had a history of drug use, including heroin, diazepam and cocaine, and that his community GP prescribed him methadone. He also told her he did not have any mental health issues. Prison GPs prescribed Mr Hodgson a daily dose of methadone and he initially agreed to engage with the prison's Drug and Alcohol Recovery Team (DART).

38. Between 30 June and 5 December, officers recorded that they suspected Mr Hodgson was not only taking illicit substances but was also involved in bringing drugs into the prison and holding them in his cell. They thought that he was in possession of a large package containing unknown substances, was regularly under the influence of an illicit substance, that he became popular with other prisoners after receiving a social visit and that he had swallowed medication belonging to another prisoner. On two occasions, prison staff searched Mr Hodgson's cell. On the second occasion, on 23 September, prison staff found and seized fermenting liquid, unidentified tablets and three improvised phone chargers, and they placed Mr Hodgson on report for possession of these items.

39. On 5 July, a DART keyworker saw Mr Hodgson to discuss his recovery plan but thought he was under the influence of an illicit substance. The DART keyworker spoke about the dangers of new psychoactive substances (NPS) but Mr Hodgson said he would not use NPS. Mr Hodgson did not participate in any other DART sessions with the DART keyworker or his replacement.

40. On 7 October, a healthcare assistant tested Mr Hodgson's urine for drugs, which was negative for all drugs except methadone. Mr Hodgson told him that he wanted to be sentenced before engaging with DART.

41. On 28 March 2017, prison staff tested Mr Hodgson's urine as part of a mandatory drug test. It tested positive for synthetic cannabinoids (NPS), benzodiazepines and cannabis. They placed Mr Hodgson on report for the failed drug test.

42. On 28 June, the healthcare assistant tested Mr Hodgson's urine for drugs, which was negative for all drugs except methadone.

43. On 20 July, Mr Hodgson told a nurse that his cellmate was smoking "Spice", which caused his head to feel "done in". Mr Hodgson asked to see the mental health team and to be sent to hospital. The nurse noted that he was tearful and anxious so made a mental health referral.

44. On 26 July, Mr Hodgson's mother contacted the prison and said she was concerned about her son. Later that day, staff moved Mr Hodgson to a cell next door to his brother for support. A Safer Custody officer also spoke with Mr Hodgson, who said that he felt okay, had no thoughts of self-harm and was aware of the support available to him.

45. The following day, a Safer Custody administrator received an email from Mr Hodgson's mother expressing concern. She forwarded the email to a prison manager. The prison manager told the investigator that he asked another member of staff to speak to Mr Hodgson, though there is no record that this happened.

46. On the same day, a mental health nurse saw Mr Hodgson after a member of staff noticed that he was staring and not engaging in conversation as normal. Mr Hodgson said that he felt more settled on the wing but that he had received threats from unspecified prisoners and so wanted to move to the segregation unit or the healthcare unit. He said that he was avoiding association and eating his meals, though he denied any thoughts of hurting himself or taking his own life. The nurse recorded that Mr Hodgson had no problems with his memory or concentration and that he was aware of where he was. She decided that Mr Hodgson did not present any signs or symptoms of psychosis so the mental health team discharged him.

47. On 28 July, Mr Hodgson's mother contacted the prison again and spoke to a Safer Custody officer. She said her son had told her he was going to be killed and that he had used NPS. She sent this information to the prison manager in charge of Mr Hodgson's wing.

48. On the same day, Mr Hodgson's brother told a nurse that he was concerned about his brother's mental health because he would not leave his cell. An officer also told the nurse that Mr Hodgson had become increasingly paranoid. The nurse spoke with Mr Hodgson, who said that he felt low in mood but that he would wait for his next mental health appointment. The nurse passed this information to the mental health team.

49. On 2 August, the mental health team told the nurse that they had discharged Mr Hodgson following an assessment. The nurse then saw Mr Hodgson, who said that he felt okay but that he was scared to leave his cell due to threats from other prisoners. He asked to be admitted to the healthcare unit, as he was frightened to go to another wing, but the nurse was not able to arrange this. The nurse offered to refer Mr Hodgson to the mental health team but he declined this. After seeing Mr Hodgson, the nurse spoke with a senior officer (SO), who was aware of the ongoing issues. There is no record of any further action to address this.

50. Later that day, a SO and a prison manager saw Mr Hodgson in relation to the information from his mother. Mr Hodgson said that he and his family were in danger because he was being blamed for "grassing" on other prisoners, and he reiterated that he wanted to move to the healthcare unit or segregation unit until his release on 17 August. The manager said that a move to either unit was not possible but Mr Hodgson could be moved to another wing. He declined this as he did not feel that he would be safe there. The manager gave Mr Hodgson a form to complete if he wanted to be moved to the segregation unit for his own safety but there is no record that he completed this form.

51. On 7 August, an offender manager saw Mr Hodgson to complete his release plan. Mr Hodgson told her that he planned to set up his own business when released.

52. At approximately 7.45am on 9 August, Mr Hodgson gave a letter to a member of staff, which said that another prisoner was going to throw battery acid into his brother's face. Mr Hodgson said that these threats were due to him being blamed for "grassing" on prison drug dealers. Officers spoke to Mr Hodgson's brother and asked him whether he wanted to be moved from the houseblock, but he declined the move.

53. At approximately 8.00am, Mr Hodgson broke the sink in his cell. A prison manager in the Security Department spoke to Mr Hodgson, who said that he was under threat and that he did not want to stay in this or any other houseblock. The manager told the investigator that Mr Hodgson believed other prisoners were blaming him after prison staff found significant quantities of NPS in July, though he was aware that this was not as the result of any intelligence from prisoners but due to systematic searches on Houseblock 2. Due to the damage, he moved Mr Hodgson to the segregation unit. At 9.45am, a nurse reviewed Mr Hodgson and decided that he was fit to remain in the segregation unit.

54. Later that afternoon, two mental health clinical leads saw Mr Hodgson for an urgent mental health review, after his mother wrote to the prison with her concerns. Mr Hodgson said that he had been trafficking drugs from the laundry to other areas of the prison. Shortly after he had stopped doing so, unspecified prisoners had threatened him because he believed that prison staff caught the other prisoners who had been involved. There is no record that the nurses passed this intelligence to the prison's Security Department.

55. Mr Hodgson denied any mental health problems and said his brother had given his mother inaccurate information. A nurse recorded that Mr Hodgson was amenable, responsive to questioning, capable of maintaining good eye contact and orientated to time, place and person. He also recorded that Mr Hodgson spoke at a normal rate and tone. The nurses decided that there was no evidence that Mr Hodgson was suffering from a psychotic disorder. The following day, a mental health clinical lead decided that Mr Hodgson did not require further mental health assessments.

56. At 11.25am on 10 August, a nurse began Prison Service suicide and self-harm monitoring (known as ACCT) after Mr Hodgson said that he was going to take his own life. Mr Hodgson also said that he had swallowed razor blades, that unidentified people were going to "get him" and that he would not eat the food provided because people had poisoned it.

57. Later that day, a senior prison manager completed an immediate action plan. He decided that staff should observe Mr Hodgson on an hourly basis, that he needed an urgent mental health referral and that his location should be reassessed once he had been seen by the mental health team. He added these actions to Mr Hodgson's caremap (designed to identify the main areas of concern and the actions required to reduce risk).

58. A senior prison manager then assessed Mr Hodgson as part of the ACCT procedures. Mr Hodgson said that he felt unsafe, paranoid and anxious in the segregation unit and wanted to be moved to the healthcare unit. He said that he had never self-harmed before and that he did not want to take his own life, though he did not know what else to do. She decided that there were no

exceptional reasons to hold Mr Hodgson in the segregation unit, so suggested that he be moved to the healthcare unit.

59. At 2.15pm, a SO held the first ACCT case review with Mr Hodgson and several staff. The SO recorded that Mr Hodgson said that he still felt terrified and that he would attempt to take his own life if he was not moved to the healthcare unit. As Mr Hodgson had a week to serve before his release, the attendees agreed to move him to the healthcare unit. He moved later that day. The SO considered that Mr Hodgson presented a low risk of suicide and self-harm (on a scale of low, raised and high) and decided that observations should continue on an hourly basis. The SO scheduled the next ACCT case review for 14 August.

60. At 5.35pm, two nurses saw Mr Hodgson for an urgent mental health review. Mr Hodgson reiterated that other prisoners had threatened him and that nurses would protect him on the healthcare unit. Mr Hodgson said that there were numerous ways to kill himself though he had not planned anything and said he did not have "the balls" to do it. He said that he was only eating his canteen purchases as he thought other prisoners could poison his meals. One of the nurses recorded that Mr Hodgson did not display any evidence of psychosis and that no further action was required by the mental health team.

61. That night, an officer recorded in Mr Hodgson's ACCT observation record that he felt people were out to get him. He tried to reassure Mr Hodgson that all prisoners were locked in their own cells for the night.

62. At 6.21am on 11 August, a nurse reviewed Mr Hodgson, who denied any mental health problems.

63. At 11.15am, a DART keyworker reviewed Mr Hodgson, who said that he felt at risk from other prisoners. She noted that he was withdrawn and shaky, though he said that he did not have any current thoughts of taking his own life.

64. That afternoon, various members of staff recorded in Mr Hodgson's observation record that he was seen watching television, though few talked to him directly. A nurse noted that Mr Hodgson had remained in his cell, as the healthcare unit had been locked down.

65. At 10.00pm, an officer recorded in Mr Hodgson's observation record that he still thought people were trying to stab him. The officer gave him an old newspaper to distract him.

12 August 2017

66. Between 2.00am and 4.00am on 12 August, an officer recorded in Mr Hodgson's observation record that he said that staff were going to "gas" him or kill him. Mr Hodgson also told the officer that he would pour boiling water over the next person who entered his cell. He also temporarily blocked his observation panel, though the officer noticed, at some time before 5.22am, that Mr Hodgson had removed the blockage.

67. At 6.37am, a nurse reviewed Mr Hodgson and found that he had wrapped a towel around his face, as he believed that members of staff were going to "gas" him. She also noted that he was aggressive and argumentative.

68. At approximately 9.35am, Mr Hodgson made three cuts to his left hand. A nurse saw this and called a code red emergency (which indicates that a prisoner has suffered a severe loss of blood). Mr Hodgson said that he had cut himself because staff were trying to kill him and that he wanted to go to hospital. A nurse and a prison GP responded to the code red and decided that he needed to go to hospital for his wounds to be sutured, though the GP acknowledged that his condition was not critical. Due to critical staffing levels (the prison had been in lockdown that day), a healthcare administrator arranged a video conference appointment with an NHS Foundation Trust at 2.00pm to allow a hospital doctor to assess Mr Hodgson's injury and confirm whether hospital admission was required.

69. At 10.40am, a prison chaplain recorded in Mr Hodgson's observation record that he said that he "would not be alive tomorrow". There is no record that this information was passed to anyone else in the prison.

70. At 11.15am, a mental health nurse saw Mr Hodgson for an urgent mental health review, as a nurse was concerned about his mental state. She noted that Mr Hodgson was dishevelled and had lost weight since their first meeting on 26 July. Mr Hodgson said that staff were trying to kill him, though he did not know why. He also said that he did not plan to end his life but that he would "leave here in a box" and that "I won't get out on Thursday". Mr Hodgson said that he felt sad and had nothing to concentrate on when locked in his cell, though he did say that he was eating normally. She decided Mr Hodgson needed to remain on the ACCT and that she would discuss his condition in the next mental health team meeting. The meeting was not held before Mr Hodgson's death.

71. At 11.30am, the mental health nurse held a second ACCT case review with Mr Hodgson, a nurse and an officer, due to him cutting himself. Mr Hodgson said that he had cut himself to get to hospital though he did not plan to end his life. He also said that unidentified staff were trying to kill him and he was convinced he would not get out of prison. The nurse recorded that there was evidence that Mr Hodgson had set fire to pieces of paper in his cell and that the furniture had been moved to enable him to barricade his cell. The attendees decided that Mr Hodgson now presented a raised risk of suicide and self-harm and decided that observations should be increased to twice an hour at different intervals. The attendees did not plan further caremap actions and scheduled the next ACCT case review for 14 August.

72. At approximately 2.00pm, a prison manager visited the healthcare unit to escort Mr Hodgson to his video conference appointment with the hospital. Initially, Mr Hodgson followed the manager but, before reaching the video conferencing room, he said that there was no point in attending. The manager asked him why but Mr Hodgson refused to elaborate. He then escorted Mr Hodgson back to his cell.

73. At 3.30pm, a healthcare assistant checked on Mr Hodgson, who said that he would not let anyone touch his hand. This was the last time that anyone saw Mr Hodgson alive.

74. At approximately 4.15pm, the healthcare assistant went to Mr Hodgson's cell to perform an ACCT check and saw him lying on the floor. She shouted for help

and three nurses quickly responded. They looked through the observation panel and saw that Mr Hodgson had tied a towel around his neck and attached it to a radiator pipe. One nurse used her radio and called a code blue emergency (which indicates that a prisoner is unconscious or not breathing). The control room log noted that the nurse called the code blue at 4.17pm. Despite seeing the ligature, none of the healthcare staff entered Mr Hodgson's cell as they had been specifically told not to enter a prisoner's cell without being accompanied by an officer.

75. Staff responded to the code blue and opened Mr Hodgson's cell door. An officer attempted to cut the ligature but it was too thick to cut. Another officer untied the towel and rolled Mr Hodgson onto his back. Staff started cardiopulmonary resuscitation (CPR), gave Mr Hodgson oxygen and attached a defibrillator but it did not detect a shockable heart rhythm and advised to continue CPR.

76. The control room log noted that they called for an ambulance at 4.22pm, though information from the North East Ambulance Service noted that an ambulance was requested at 4.20pm. Paramedics reached Mr Hodgson at 4.37pm. They took over the resuscitation attempt but they were unable to resuscitate him and a paramedic declared Mr Hodgson's death at 4.44pm.

Contact with Mr Hodgson's family

77. Following Mr Hodgson's death, the prison appointed an officer as the prison's family liaison officer. At 8.00pm, two officers visited the home address of Mr Hodgson's mother to break the news of his death and to offer their condolences and support. At 9.30pm, both officers returned to the prison and broke the news of his death to Mr Hodgson's two brothers. One of the officers arranged for Mr Hodgson's brothers to speak to their mother on the telephone and staff placed them both on ACCTs to ensure that they had ongoing support.

78. One officer continued to support Mr Hodgson's mother and other family members until his funeral. Mr Hodgson's funeral was held on 8 September 2017 and the prison made a financial contribution.

Support for prisoners and staff

79. After Mr Hodgson's death, a senior prisoner manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

80. 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 and self-harm in case they had been adversely affected by Mr Hodgson's death.

Post-mortem report

81. The post-mortem examination found that Mr Hodgson's death was caused by pressure to the neck, consistent with using a towel as a ligature as part of a low-suspension point hanging.

82. The toxicology examination found the presence of methadone in Mr Hodgson's blood, which was at a level consistent with his prescribed methadone

maintenance therapy. No other substances, including synthetic cannabinoids, were found in his blood so were discounted from being involved in Mr Hodgson's death.

Findings

Assessment of Mr Hodgson's risk of suicide and self-harm

83. Prison Service Instruction (PSI) 64/2011 'Safer Custody' sets out the processes that should be followed when an ACCT has been opened. This includes that the case review team should review the level of risk that a prisoner presents, that a caremap should be updated to reflect the decisions of the case review team and that consideration should be given to involving the prisoner's family in ACCT reviews. Guidance on these processes is also contained in the ACCT documentation and it states that a prisoner should be regarded as a high risk of suicide and self-harm when they present frequent suicidal ideas that are not easily dismissed, there is evidence of mental illness and there is an escalating pattern of self-harm.

84. For the most part, Holme House managed Mr Hodgson's ACCT well. However, during the second case review, we believe that the attendees underestimated Mr Hodgson's risk of taking his own life. On the morning of 12 August, Mr Hodgson made numerous comments to a prison chaplain, a mental health nurse and the attendees of the second case review that he would not be alive by the following day. The nurse had also recognised that Mr Hodgson required a further mental health review and a prison GP noted that he had cut himself sufficiently seriously to need his wounds to be sutured. When considering these statements and actions against the Suicide/ Self-Harm Risk Guidance in the ACCT document, we believe that they should have put Mr Hodgson's risk at high rather than raised. While we cannot be sure what impact this would have had, it is likely that it would have resulted in more regular observations and a more immediate mental health review.

85. During the second ACCT case review, the attendees increased Mr Hodgson's level of risk from low to raised. However, the attendees did not add any new caremap actions to address this increase in risk.

86. Additionally, Mr Hodgson's brothers had been at Holme House since 10 December 2015 and 11 August 2017 respectively. Despite their close proximity, there is no record that staff considered including them in the ACCT reviews.

87. Staff records of observations, particularly on 11 August, focused on what Mr Hodgson was doing at the time he was observed, rather than his behaviour and his state of mind. There was minimal evidence that staff had actively engaged with him and the record of observations lacked substance in terms of recording Mr Hodgson's state of wellbeing. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that:

- **Staff consider all risk factors, including frequent suicidal statements and escalations in self-harm, when assessing a prisoner's risk to themselves.**
- **Staff set new, specific and meaningful ACCT caremap actions that are aimed at reducing a prisoner's risks to themselves.**

- **Staff involve the prisoner's family when that would be appropriate.**

88. PSI 64/2011 provides guidance on how to manage prisoners who refuse food, including recommending starting a food refusal log. It provides a link to a Department of Health 'Guidelines for the clinical management of people refusing food in immigration removal centres and prisons'.

89. On 27 July and 10 August, Mr Hodgson told two nurses respectively that he was not eating. A mental health nurse noticed on 12 August that he had lost weight since their last meeting. One of Mr Hodgson's brothers told the investigator that he found large amounts of uneaten food when he cleaned his brother's cell and that he had noticed his brother was losing weight. When Mr Hodgson told staff that he was not eating, they did not discuss this with him to find out the underlying cause or consider starting a food refusal log. There is also no record that staff considered managing Mr Hodgson's food refusal in accordance with the Department of Health guidelines. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners who refuse food are managed in accordance with the Department of Health 'Guidelines for the clinical management of people refusing food in immigration removal centres and prison'.

Mental health

90. Mental health staff assessed Mr Hodgson's mental health on four occasions between 27 July and 12 August. In their examinations on 27 July, 9 August and 10 August, healthcare staff did not consider that Mr Hodgson displayed any signs of a psychotic disorder or other mental health issue. It was not until a mental health nurse's second examination, on 12 August, that she considered that Mr Hodgson's condition required further attention from the mental health team.

91. The clinical reviewer considered that Mr Hodgson's mental health care was not to the standard he would have received in the community. The clinical reviewer was concerned that the mental health assessments were not sufficiently robust because they should have explored whether Mr Hodgson's out of character presentation - including believing that his food was being poisoned and that staff were going to gas him - was a drug-induced psychosis. We appreciate that Mr Hodgson was reluctant to tell mental health staff about his paranoia but he had been open with other members of staff. A prison manger told the investigator and the clinical reviewer that Mr Hodgson's mental health assessments would have been based on his self-reported perception of his problems and on the practitioner's clinical judgment. We agree with the clinical reviewer that, given the concerns raised by staff and Mr Hodgson's family, a more comprehensive assessment in line with guidance from the National Institute for Health and Care Excellence (NICE) 'NG66 Mental health of adults in contact with the criminal justice system' may have obtained further information. We make the following recommendation:

The Head of Healthcare, in conjunction with the mental health lead, should ensure that mental health staff use more comprehensive assessment tools to identify prisoners at risk of drug-induced psychosis.

Substance misuse

92. On occasions throughout his time at Holme House, prison and healthcare staff thought that Mr Hodgson was under the influence of illicit substances and he was suspected of significant involvement in the drugs trade. Two weeks before his death, Mr Hodgson's mother said that he had used NPS. While these concerns did not result in specific referrals to DART, we note that a DART keyworker continued to review Mr Hodgson on a monthly basis and offered him access to recovery services. We agree with the clinical reviewer that Mr Hodgson's substance misuse care was delivered well.

93. We note that in October 2017, Holme House introduced a new Drug and Alcohol Strategy. The strategy introduced monthly, multidisciplinary Drug Strategy Meetings and other confidential measures to reduce the supply of illicit substances into the prison. The strategy also introduced a new Drug Recovery Programme, scheduled to run until 2020, which will develop, promote and monitor sustainable improvements in recovery from drug and alcohol addiction. We set out below our concerns about the need for the strategy to make effective use of intelligence.

Bullying

94. Holme House's local Violence Reduction policy sets out the processes that should be followed to limit instances of violence, including abuse, threats and assaults. This includes that staff should manage violence using a victim support plan, which should highlight the assistance that is available to a prisoner to help them cope in the prison without becoming a victim of violence.

95. From 27 July, Mr Hodgson began telling staff that he was under threat from unidentified prisoners and that he was being blamed for "grassing" on them. Mr Hodgson's mother also told the prison on a number of occasions that she was concerned about her son's safety as he said that he was going to be killed. Mr Hodgson was suspected of involvement in the drugs culture at the prison in 2016, though there was no intelligence to suggest that his involvement continued in 2017, and told staff that the threats he faced were linked to this.

96. There is no evidence that staff took Mr Hodgson's concerns seriously or took any steps to protect him. Prison staff believed that Mr Hodgson's claims were evidence of paranoia but we note that mental health staff did not consider that he was displaying any signs of any psychotic disorder or any other mental health concern until 12 August. Given that the clinical reviewer is critical of this decision by healthcare staff, and given that the broader intelligence picture was consistent with Mr Hodgson's disclosure, we consider that prison staff should have treated his statements that he was at risk as genuine and started a victim support plan. By starting a victim support plan, prison staff would have given Mr Hodgson appropriate support and may have lessened his concerns.

97. We are disappointed that there was no evidence that staff submitted intelligence reports about Mr Hodgson's statements that he had trafficked drugs around the prison. By failing to do so, staff limited the prison's understanding of the drug supply routes and missed opportunities to address the reasons why Mr Hodgson felt exposed.

98. A Prisons and Probation Ombudsman publication of June 2011 found there was evidence of bullying and intimidation in 20 per cent of self-inflicted deaths that we investigated. In our thematic report into self-inflicted deaths in 2013-14, we found that reports or suspicions that a prisoner is being threatened or bullied, needs to be recorded, investigated and robustly responded to. We make the following recommendation:

The Governor should ensure that:

- **All information about bullying, intimidation, debt and the use of drugs is fully coordinated and investigated.**
- **Staff submit intelligence reports about bullying, intimidation, debt and the use or trafficking of drugs in line with national guidelines.**
- **Staff consider whether victims are at increased risk of suicide and self-harm.**
- **Apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situations.**

Emergency response

99. PSI 64/2011 contains a mandatory instruction that the preservation of life is the first priority when managing at risk prisoners. Additionally, PSI 24/2011 'Management and Security of Nights', contains a mandatory instruction that staff have a duty of care for prisoners and that the preservation of life must take precedence over the requirement for officers to be present when cells are unlocked. We appreciate that the latter PSI applies to prisons at night but we consider that the same, minimum standard applies to prisons that are in lockdown during the day.

100. Holme House's Governor Order 21-2017 'Opening of Cells on Nights' says that staff can enter a cell without permission of the Orderly Officer where there is or appears to be an immediate danger to life, though they must balance the preservation of life against their own safety.

101. PSI 03/2013 'Medical Emergency Response Codes', contains a mandatory instruction that control room staff must call an ambulance immediately when a code blue or code red emergency is called.

102. When a healthcare assistant found Mr Hodgson unresponsive in his cell, three nurses quickly joined her and one nurse promptly called a code blue emergency. However, despite noticing that Mr Hodgson had tied a towel around his neck and that his life was at risk, none of the healthcare staff entered his cell.

103. We also note that despite the control room recording that the code blue was called at 4.17pm, they did not call an ambulance until at least 4.20pm according to the North East Ambulance Service.

104. The healthcare assistant and one nurse told the investigator that they did not have keys to healthcare cells. The nurse said that even if she had held a key, she had been told that under no circumstances should she enter a cell during the

patrol state. Another nurse told the investigator that he did have a key but that he had also been told that, even in an emergency, he could not enter a prisoner's cell without an officer being present.

105. Notwithstanding the clinical reviewer's conclusion that healthcare staff and officers delivered the emergency care well and that officers promptly allowed access to Mr Hodgson's cell, nurses did not prioritise the preservation of Mr Hodgson's life by immediately entering his cell. There was also a delay of at least three minutes in calling an ambulance despite a nurse having called an emergency code. We cannot say whether entering Mr Hodgson's cell without delay or immediately calling an ambulance would have changed the outcome for him, but it could be vital in the future. We make the following recommendations:

The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency in order to help preserve the life of a prisoner and are able to do so.

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that the control room calls an ambulance immediately when an emergency code is used.

Funeral expenses

106. PSI 64/2011 contains a mandatory action that a prison must offer to pay up to £3,000 towards reasonable funeral expenses. It states that reasonable expenses include funeral director's fees, a hearse, a simple coffin, burial fees and minister's fees but does not include transportation for mourners, a wake or an obituary notice.

107. Following Mr Hodgson's death, his family arranged a funeral with Crake and Mallon Funeral Service, which cost a total of £3,937. The funeral expenses consisted of a coffin, transportation of Mr Hodgson's body, a horse-drawn hearse, a limousine, funeral director's fees, minister's fees, burial fees and an obituary notice. After receipt of an invoice, the prison agreed to pay a contribution of £2,903 but were not prepared to pay the expenses for the horse-drawn hearse, the limousine and the obituary notice.

108. We agree with the prison that they were entitled, in line with PSI 64/2011, to refuse to pay the expenses for the limousine and the obituary notice. As far as the cost of the hearse is concerned, the PSI requires prisons to pay "reasonable" funeral expenses and specifies that the coffin is to be "simple". We agree that "reasonable" expenses would not include the cost of a horse-drawn hearse. However, the PSI clearly requires prisons to pay for a standard hearse and we, therefore, consider that Holme House should have contributed to the cost of the hearse, without paying the full amount. As the prison had already paid £2,503, we consider that they should pay Mr Hodgson's family the remaining balance of £497 to meet their obligation of paying up to £3,000 towards reasonable funeral expenses. We make the following recommendation:

The Governor should ensure that up to £3,000 is offered towards reasonable funeral expenses following a death in custody and in this

particular case, should arrange for the balance to be paid to Mr Hodgson's family.

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