Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Hodgson, a prisoner at HMP Garth, on 30 November 2019

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*

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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.

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 Alan Hodgson was found dead in his cell at HMP Garth on 30 November 2019. His cause of death is unknown, but toxicology tests showed that Mr Hodgson had used psychoactive substances (PS) before he died. He was 39 years old. I offer my condolences to his family and friends.

Despite receiving support from substance misuse services in prison, Mr Hodgson continued to use drugs, particularly PS. When he arrived at Garth on 28 November, he told a nurse that he had used PS that day. He died less than 48 hours later, after using PS again.

Both HM Inspectorate of Prisons and the Independent Monitoring Board have expressed concern at the availability of drugs at Garth. Since Mr Hodgson's death, the prison has updated its drugs strategy with the aim of reducing supply and demand. The prison needs to ensure this is implemented fully, to reduce the serious harm caused by drug use.

The investigation found a short delay in the emergency response when Mr Hodgson was found unresponsive in his cell, although I am satisfied it did not affect the outcome for Mr Hodgson.

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

Sue McAllister CB
Prisons and Probation Ombudsman **June 2020**

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Summary

Events

1. Mr Alan Hodgson was sentenced to an indeterminate sentence for public protection (IPP) in July 2007, with a tariff of three and a half years.

2. During his time in custody, prison staff often suspected that Mr Hodgson had misused drugs, usually psychoactive substances (PS). They referred him to substance misuse services, but Mr Hodgson engaged only intermittently and continued to use PS.

3. From December 2018, Mr Hodgson was at HMP Woodhill. He was in the segregation unit from 7 October after assaulting a prison officer and was found under the influence of drugs on three occasions while he was in the unit.

4. Mr Hodgson moved to HMP Garth on 28 November 2019, after spending the night of 27/28 November at HMP Manchester.

5. When he arrived at Garth, he told a nurse he had used PS that day. Mr Hodgson had no clinical signs of being under the influence and he was located on a standard residential unit. He spent much of the next day, 29 November, unlocked and associating with other prisoners.

6. On 30 November at 5.20am, while completing the early morning roll check, the night patrol officer saw Mr Hodgson kneeling in his cell in an unusual position, but thought he was asleep. He returned several times to check on him and became concerned when he could not detect any movement or get a response. He contacted the interventions team for assistance and at 5.46am, staff opened the cell and found Mr Hodgson unresponsive.

7. Prison and healthcare staff did not attempt cardiopulmonary resuscitation (CPR) as it was clear Mr Hodgson was dead. Paramedics confirmed Mr Hodgson's death at 6.18am.

Findings

8. We are concerned that Mr Hodgson was apparently able to access PS without difficulty at Woodhill, including in the segregation unit.

9. Mr Hodgson told staff he had taken PS when he arrived at Garth on 28 November 2019. It, therefore, seems likely that he had obtained the drug at either Woodhill or Manchester (where he had stayed overnight).

10. Mr Hodgson clearly used PS again on 29/30 November before his death. We cannot say whether he obtained the drug at Garth on this occasion (although that is certainly a possibility), or whether he had brought it with him from Woodhill or Manchester.

11. Both HM Inspectorate of Prisons and the Independent Monitoring Board have expressed concern at the easy availability of drugs at Garth. Since Mr Hodgson's death, Garth has updated its drugs strategy with the aim of reducing the supply and demand for PS.

12. The clinical reviewer found the standard of care Mr Hodgson received for his substance misuse issues in prison was equivalent to that he could have expected to receive in the community. There is, however, no evidence that Mr Hodgson was motivated to stop using PS.

13. When the intervention team arrived at Mr Hodgson's cell on 30 November, there was an unnecessary delay of four minutes before they entered the cell. Although this did not affect the outcome for Mr Hodgson, such a delay could make a significant difference in other medical emergencies.

14. When staff entered the cell and found Mr Hodgson unresponsive, they initially called for urgent assistance, rather than calling a medical emergency code straightaway. Although this made no difference in this case as Mr Hodgson was dead when he was found, it is important that the correct medical emergency procedures are followed as it could make a difference in other cases.

Recommendations

- The Governor of Woodhill should evaluate the effectiveness of the prison's local drug strategy and identify areas of need and intervention.

- The Governor of Garth should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff:

    - enter a cell immediately when necessary to preserve life, subject to conducting a dynamic risk assessment; and

    - promptly use an emergency code to effectively communicate the nature of the emergency.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Garth informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

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

17. NHS England commissioned a clinical reviewer to review Mr Hodgson's clinical care at the prison. The investigator interviewed six members of staff at Garth with the clinical reviewer on 8 January 2020.

18. We informed HM Coroner for Preston and West Lancashire of the investigation. We have sent the Coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Hodgson's brother to explain the investigation and to ask if he had any matters that he wanted us to consider. Mr Hodgson's brother asked:

    - Was Garth made aware that code blues had been called at Mr Hodgson's previous prison and what care was put in place due to this history and associated risks?
    - Was Garth aware that there was a "bad batch" of PS in the prison at the time?
    - Why was Mr Hodgson moved to a prison with such a rampant PS problem, when he was known to use the drug excessively?
    - What is Garth doing to keep drug users safe?

    We have addressed these questions in this report.

20. Mr Hodgson's brother received a copy of the initial report. He did not identify any factual inaccuracies.

21. The prison also received a copy of the report and confirmed the name of the officer who radioed a medical emergency. The name has been amended.

Background Information

HMP Garth

22. HMP Garth holds up to 846 prisoners serving sentences of four years or longer or indeterminate sentences. Primary care services are provided by Bridgewater NHS Foundation Trust, mental health and clinical substance misuse services by Greater Manchester Mental Health NHS Foundation Trust and psychosocial substance misuse services are provided by Phoenix Futures.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Garth was in December 2018 and January 2019. Inspectors reported that the prison had a well-thought out approach to reducing the supply of drugs, but prisoners still found it far too easy to obtain illicit drugs. A survey conducted by inspectors found that 60 per cent of prisoners found it easy to obtain drugs, and over a quarter of prisoners said they had developed a drug problem at the prison.

24. Inspectors reported that interactions between prisoners and staff were respectful and courteous overall. However, some staff did not consistently enforce basic rules in residential units. The key worker system had been introduced between October 2018 and January 2019, and, although it was new, it was functioning well. Prisoners were allocated a key worker, who they met fortnightly to focus on their progression, set targets and discuss any concerns.

Independent Monitoring Board

25. 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 November 2018, the IMB reported that while Garth had previously been identified as one of the ten most violent prisons in the country, violence remained high but was not increasing. The Board noted this was due to an improved drugs strategy, better support for victims of violence and a new collaborative multidisciplinary working group. However, the Board found that even though there was a good drugs strategy in place, drug use remained a major problem.

Previous deaths at HMP Garth

26. Mr Hodgson was the 11th prisoner to die at Garth since November 2017. Of the previous deaths, four were from natural causes, three were self-inflicted, two were drug-related and one awaits classification.

27. In our investigation into the death of a man who took his own life at Garth in October 2018, we found evidence of widespread drug use in the prison. We recommended that the Governor should ensure that there were effective supply and demand reduction strategies, and that staff were vigilant for signs of drug use and knew how to respond when a prisoner appeared under the influence of such substances. Garth accepted our recommendations, and identified measures that they had taken, including the formation of a designated search team, increased interception of mail and increased searching of staff.

HMP Woodhill

28. HMP Woodhill in Milton Keynes is a complex institution known as a 'core local' prison. It combines a local prison function for just over 600 men with a high security responsibility, holding a small number of category A prisoners, and also operating a close supervision centre (a specialist facility for some of the country's most disruptive prisoners).

HM Inspectorate of Prisons

29. The most recent inspection of HMP Woodhill was in February 2018. Inspectors reported that over half of prisoners who responded to their survey said that illicit drugs were easily available at the prison. The random mandatory drug testing positive rate was lower than at other local prisons and mostly concerned tradable medications and PS, but the prison's supply reduction strategy and action plan were weak and out of date.

Independent Monitoring Board

30. In its latest annual report for the year to November 2018, the IMB reported that there had been a deeply concerning rise in the availability of non-prescription drugs during the year, and that the number of incidents involving PS had increased steadily. They also reported that the provider of substance misuse services had raised concern that prison staff were not following standard operating procedures and that the reporting of drug-related incidents was inaccurate.

Incentives and Earned Privileges Scheme (IEP)

31. Each prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are three levels: basic, standard and enhanced.

Psychoactive substances (PS)

32. Psychoactive substances (PS - formerly known as 'new psychoactive substances' (NPS) or 'legal highs') are a serious 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 PS 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 PS to precipitate or exacerbate the deterioration of mental health, and they are linked to suicide or self-harm.

33. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time, 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 PS, the need for more effective drug

supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

34. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

Key Events

35. On 20 September 2006, Mr Alan Hodgson was remanded in custody, charged with possession of an offensive weapon with intent to commit robbery. On 13 July 2007, he was given an indeterminate sentence for public protection (IPP), with a tariff of three years and six months.

36. Mr Hodgson spent time at several different prisons. He was frequently found under the influence of illicit substances, usually psychoactive substances (PS), and he often brewed illicit alcohol. There were over 40 recorded incidents of substance misuse between June 2010 and his death in November 2019. Throughout his time in prison, Mr Hodgson frequently breached prison rules: he made weapons, assaulted staff, held dirty protests and was often segregated for many months because of his poor behaviour.

37. Prison staff started violence reduction measures on numerous occasions at different prisons. Prison staff and staff from substance misuse services gave Mr Hodgson advice on drugs harm minimisation and support on avoiding debt, although he was often identified as the perpetrator of violence and so moved wings frequently.

38. On 9 September 2018, Mr Hodgson self-harmed by cutting his arm, because he said he was bored and did not have any vapes. Staff started suicide and self-harm prevention measures, but stopped them after four days when they assessed that Mr Hodgson's risk had reduced. This was his only recorded incident of self-harm.

HMP Woodhill

39. Mr Hodgson was moved from the segregation unit at HMP Whitemoor to HMP Woodhill on 12 December 2018. On 24 December, staff called a medical emergency code blue (indicating a potentially life-threatening incident) when Mr Hodgson was found vomiting and fitting in his cell after using PS. Paramedics treated Mr Hodgson and prison healthcare staff observed him until his clinical observations returned to within normal ranges.

40. Over the next few months, there were numerous further incidents when Mr Hodgson was found to be under the influence of illicit substances, usually PS, and he was found making illicit alcohol on at least three occasions. Mr Hodgson spent much of his time on the basic IEP regime. Mr Hodgson's key worker met with him regularly to provide support and encouragement to reduce his drug use and progress on the IEP scheme. (Key workers should get to know the prisoners they are responsible for, act as a first point of contact for any problems, help with resettlement issues and make regular entries in prisoners' records about their progress.)

41. In June 2019, the Parole Board concluded that Mr Hodgson was unsuitable for release, and scheduled his next review for 2021.

42. On 7 October, Mr Hodgson was told by wing staff that he could not leave his cell as he had made threats to assault staff. Mr Hodgson then seriously assaulted

one of the officers and he was taken to the segregation unit. He remained there during the rest of his time at Woodhill.

43. On 18 October, an officer found Mr Hodgson under the influence of an unknown substance: he was struggling to breathe, vomiting and hanging over the end of his bed. He radioed a code blue medical emergency and staff entered his cell. He noted that the substance Mr Hodgson was smoking was still alight and was in his lap. He placed him in the recovery position, until healthcare staff arrived. They administered oxygen and Mr Hodgson slowly recovered. Two days later, Mr Hodgson was again found under the influence.

44. On 22 October, the key worker visited Mr Hodgson in the segregation unit, but Mr Hodgson was unable to communicate as he was under the influence. On 6 November, the key worker met with Mr Hodgson and informed him that he would be getting a new key worker. Mr Hodgson told him that he would not leave the segregation unit as long as he remained at Woodhill and that he wanted to be moved to another prison.

45. The decision was taken to move Mr Hodgson to Garth to give him a fresh start in a new prison where he could be supported to address his violence and substance misuse issues and would be closer to his family in the North East. Mr Hodgson indicated that he would be willing to return to normal location at Garth.

46. On 20 November at 11.25am, an officer introduced himself to Mr Hodgson as his new key worker. Mr Hodgson told him that he felt mentally better as he had not smoked PS for a while and was looking forward to being transferred to HMP Garth.

47. On 25 November at 3.26pm, the key worker met with Mr Hodgson and wished him good luck with his transfer and encouraged him to remain drug free.

48. On 27 November, Mr Hodgson stayed overnight at HMP Manchester. He arrived in reception at 5.07pm, and an officer noted that he was happy and jovial and expressed a desire to share a cell. Mr Hodgson declined a telephone call and told staff he had no issues. A health care assistant completed Mr Hodgson's initial healthscreen where no significant issues were identified.

HMP Garth

49. On 28 November, Mr Hodgson arrived at Garth. At 1.50pm, an officer made an entry in Mr Hodgson's prison record that he had transferred in from Manchester. There are no other details recorded. Another officer completed the First Night Care and Integration document and noted Mr Hodgson had no concerns. He noted that Mr Hodgson should be observed four times overnight, which is standard for new arrivals.

50. At 2.39pm, a nurse completed the initial and secondary healthscreen in reception. She recorded Mr Hodgson had no significant physical or mental health needs and said he had no thoughts of suicide or self-harm.

51. Mr Hodgson told the nurse he had used PS that day. (It is not clear whether he meant he had taken it before he left Manchester or while in the transfer vehicle.) She took his physical observations which were all within normal limits, although

his pulse was at the upper level of normal at 100 beats per minute (normal pulse rate is 60 – 100 bpm). There were no other signs that he was under the influence and clinical intervention was not necessary. Mr Hodgson was located on A Wing, a standard residential unit.

52. Mr Hodgson was referred for a routine review by a GP when he arrived at Garth. A prison GP reviewed his medical records and prescribed E45 cream for eczema.

53. The only other entry in Mr Hodgson's prison record was made on 29 November at 11.38am by a prison chaplain. The chaplain noted that he had provided Mr Hodgson with the chaplaincy leaflet, confirmed he was a Mormon and advised him on how to make an application to attend services. He noted that there were no concerns.

54. On 29 November, prisoners on A Wing spent much of the day able to mix freely with each other. Closed Circuit Television (CCTV) shows that an officer locked Mr Hodgson in his cell for the night at 5.13pm – the time stamp was around 46 minutes fast but we have used real time. Officer A was the night patrol on A Wing and completed a count of prisoners around 8.00pm. He reported nothing unusual.

30 November

55. Officer A began a count of prisoners at around 5.15am the next morning, and arrived at Mr Hodgson's cell at around 5.20am. CCTV shows that he spent a short time looking into Mr Hodgson's cell and then went back to look through the observation panel again at 5.22am, before he left the wing. He returned to Mr Hodgson's cell at 5.26am, 5.34am and 5.37am, and each time looked through the observation panel, using his torch.

56. Officer A said in his statement he could see Mr Hodgson kneeling on the floor with his back towards the door. His head was on a chair and his right arm was raised, holding onto the bedframe. He thought his position was unusual but considered he could be asleep. He did not know anything about Mr Hodgson so he went to the wing office to check if Mr Hodgson was disabled or deaf, and then returned to the cell. He could not see any movement so he tried to get a response by knocking on the glass panel of the door but without success. He was concerned so he contacted the control room and asked for intervention staff to attend.

57. At 5.42am, three officers joined Officer A and went to Mr Hodgson's cell. They remained there for just under two minutes, before leaving the wing. Officer B contacted the Custodial Manager (CM), the night operational manager, and obtained permission to enter Mr Hodgson's cell.

58. They returned at 5.46am (Officer B stayed behind a locked gate and had possession of the rest of the intervention team's keys) and Officer A broke the seal on his key pouch, activated his body-worn video camera (BWVC) and entered the cell. He found Mr Hodgson unresponsive and cold to the touch. An officer radioed for urgent medical assistance. Officers laid Mr Hodgson on his back. His eyes were closed and his tongue was black and protruding from his

mouth. The CM arrived and radioed a medical emergency code blue (used to indicate a prisoner who is unconscious or having breathing difficulties).

59. A short time later, a nurse arrived at the cell in response to the urgent assistance request. She described Mr Hodgson's legs as purple and said that he had blood pooling around his abdomen, all indications that he had been dead for some time. Officer A said he and the interventions team, in discussion with the nurse, made a collective decision not to start cardiopulmonary resuscitation (CPR).

60. The investigator viewed the BWVC footage which showed staff entering Mr Hodgson's cell. The footage shows Mr Hodgson kneeling on the floor. His back was exposed and there were no obvious signs of discolouration of his skin.

61. North West Ambulance Service records show they received an emergency call from Garth at 5.47pm. Paramedics arrived at Garth at 6.08am and, at 6.18am, confirmed that Mr Hodgson had died.

62. Mr Hodgson did not make any telephone calls while at Garth.

Contact with Mr Hodgson's family

63. Garth appointed acting a Supervising Officer (SO) as the family liaison officer and the prison chaplain manager as her deputy. As Mr Hodgson's next of kin, his brother, lived in the north, they contacted HMP Frankland to ask for assistance in informing him of Mr Hodgson's death. A manager from Frankland travelled to the address the prison held for Mr Hodgson's brother, but he had moved. The SO tried to find contact details using information held on Mr Hodgson's PIN phone and mail, but was unable to do so.

64. The SO contacted Durham Police and asked for their assistance in locating Mr Hodgson's brother and breaking the news to him as a matter of urgency. On 1 December at 2.15pm, Mr Hodgson's brother contacted the SO, after being notified of his brother's death by Durham Police. She offered her condolences and ongoing support. In line with Prison Service instructions, the prison contributed towards the costs of Mr Hodgson's funeral, which was held on 23 December.

Support for prisoners and staff

65. After Mr Hodgson's death, the deputy governor debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any immediate issues and to offer support. The staff care team attended and offered their support.

66. The prison posted notices informing prisoners of Mr Hodgson's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Hodgson's death.

67. In addition, they issued a notice warning prisoners of the risks associated with using highly unpredictable illicit substances and offered advice on what to do if they observed another prisoner under the influence.

Post-mortem report

68. The post-mortem examination, which was carried out by scan rather than an invasive procedure, found no cause of death. Toxicology tests showed that Mr Hodgson had used PS before he died. The Coroner has not provided Mr Hodgson's cause of death and this will be determined at the inquest.

Findings

Substance misuse

69. Mr Hodgson was at Woodhill until four days before his death. On 28 November, the day after he left Woodhill, he told staff at Garth that he had taken PS before his arrival there. This means that he had had obtained the drug at either Woodhill or Manchester (where he had spent the night in a shared cell).

70. We note that Mr Hodgson had been found under the influence of PS in the segregation unit at Woodhill on three occasions in October 2019. Although we do not know where he obtained the PS he used on 28 November, we are concerned that Mr Hodgson was apparently able to access PS without difficulty at Woodhill, even in the segregation unit. We recommend:

    The Governor of Woodhill should evaluate the effectiveness of the prison's local drug strategy and identify areas where there is a need for further action.

71. It is clear that Mr Hodgson also took PS on 29/30 November before he died and it seems likely that this contributed to his death. It is possible that he had obtained the PS at Garth, where he associated with other prisoners during the day of 29 November. However, it is also possible that he had obtained it at Woodhill or Manchester and brought it with him.

72. During their inspection of HMP Garth in December 2018/January 2019, HM Inspectorate of Prisons found nearly half of prisoners said that it was easy to obtain drugs at Garth.

73. In response to a national instruction from HMPPS in April 2019 that all prisons should review their drug strategy, Garth issued their Integrated Substance Misuse Strategy in January 2020. This aims to address supply reduction, demand reduction, and the mitigation of risk, and says that monthly substance misuse management meetings will be held, attended by all relevant functional heads, including healthcare providers, to:

    - Co-ordinate all aspects of substance misuse and drug strategy
    - Monitor and identify emerging trends
    - Ensure staff, men and visitors are aware of the strategy through implementing an effective communication plan
    - Devise and implement an effective Debt Management Tool.
    - To review: MDT, Supply Reduction, Demand Reduction, Recovery/Through-care and impact on Safety and Violence
    - Monitor and evaluate the effectiveness of HMP Garth's Drug Strategy and identify areas of need and intervention
    - Ensure the implementation of evidence-based policies and procedures in line with national drugs strategy and partner agency and stakeholder requirements

74. After Mr Hodgson died, the prison received intelligence reports from prisoners suggesting that there had been a recent influx of drugs on Mr Hodgson's wing.

This information was supported by the fact that a number of prisoners were found under the influence the next day. In response the prison carried out targeted cell searches and found what they described as “quite significant amounts of PS”. They also informed Lancashire Police and one prisoner was transferred to another prison, while others were moved within Garth to disrupt the supply of drugs. Incidents of prisoners being found under the influence reduced in the following days.

75. Given the revised drug strategy and the swift response to obtain and act on intelligence about the supply of drugs, we make no recommendation.

Mr Hodgson’s substance misuse

76. Mr Hodgson had a long history of substance misuse, including the use of opiates, cannabis, PS and alcohol in the community and in prison. He received opiate substitute therapy (methadone), when he was initially imprisoned, but this was stopped in July 2012.

77. Mr Hodgson was offered support for his drug problems throughout his time in custody and he engaged intermittently with substance misuse services. However, he continued to be found under the influence of PS on many occasions and this impacted on his progression through his sentence and his ability to achieve parole and release from prison. His ongoing PS use was recognised as a significant problem, but there is no evidence that Mr Hodgson was motivated to stop using PS.

78. When he arrived at Garth on 28 November, Mr Hodgson told the reception nurse that he had used PS that day. His clinical observations were normal and the clinical reviewer is satisfied that no clinical intervention was required.

79. Phoenix Futures, who provide support to prisoners with substance misuse issues at Garth, assess all new arrivals to Garth within 48 hours. However, Mr Hodgson died before he had the opportunity to meet them.

80. The clinical reviewer found that the standard of care Mr Hodgson received for his substance misuse issues throughout his time in prison was good and equivalent to that he could have expected to receive in the community.

First Night Care

81. When Mr Hodgson arrived at Garth, an officer recorded that Mr Hodgson should be observed four times during the first night, which was standard for all new arrivals. However, there is no evidence this happened. On Mr Hodgson’s First Night Observations document, somebody has written 20.00, 01.00, 04.00 and 08.00, but only the first line has an entry ‘settled night, no issues’. This entry is not signed.

82. It appears, therefore, that night staff did not comply with the prison’s policy for ensuring the safety of all new arrivals. Although this did not affect the outcome for Mr Hodgson, it could make a crucial difference in other cases.

83. In response, the Head of Operations issued a Staff Information Notice - 20/006 - in January 2020, setting out the expectations of first night observations, and a revised document for staff to complete, including space to sign their name.

84. As the prison has already taken action to address this issue, we make no recommendation.

Emergency response

Entering the cell

85. At night, officers have a key in a sealed pouch for use in an emergency. Prison Service Instruction (PSI) 24/2011, *Management and Security at Night,* says that staff have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

86. Local Instruction 2.77, issued in April 2014, incorporates this into local guidance at Garth.

87. When conducting the early morning roll check, Officer A saw Mr Hodgson in an odd position but thought he may be asleep. He went back to check on him several times over 17 minutes and became concerned when he could not detect movement or get a response when he knocked on the glass panel in the cell door. He decided to contact intervention staff so that they could open the cell.

88. We do not criticise Officer A for not calling for help earlier. The investigator viewed the BWVC footage and from the view from the door, there were no obvious signs that Mr Hodgson was dead, although he was in an unusual position. We are satisfied the situation was unclear.

89. Nor do we do criticise Officer A for not entering the cell on his own to check on Mr Hodgson. Mr Hodgson was a category B prisoner who had only just arrived at Garth and was an unknown quantity.

90. However, when the intervention team arrived, Mr Hodgson had been in the same unusual position for 22 minutes and there were now four staff present. We consider that staff should have entered the cell at this point. Instead there was a delay of four minutes while they sought the night orderly officer's permission to enter the cell. This was not required under PSI 24/2011.

91. The delay made no difference in Mr Hodgson's case as he had been dead for some time when he was found. However, this was not obvious to staff before they entered the cell and a delay of even a few minutes may make a critical difference in a medical emergency.

Delay in calling medical emergency code

92. PSI 03/2013, *Medical Emergency Response Codes*, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for Governors to have a protocol on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It says that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure that there are no delays in calling an ambulance and it should not be a requirement for a member of the healthcare team or a manager to attend the scene before an ambulance is called.

93. Garth's Staff Information Notice 18/152, issued in August 2018, tells staff to use the emergency codes 'red' and 'blue' to comply with PSI 03/2013. Examples of the circumstances in which staff should use code blue are when the prisoner has difficulty breathing or is unconscious. Officer A said he had no immediate concerns for Mr Hodgson's welfare, but was concerned enough to return to the cell on several occasions before asking for the interventions team. We accept that it was not clear at that stage that Mr Hodgson was unconscious.

94. When staff first entered the cell and discovered that Mr Hodgson was unresponsive, Officer A radioed for urgent assistance. When the CM arrived, he radioed a code blue. There was less than a minute delay between these messages and a nurse taking the correct equipment in response to Officer A's call, as she could hear the urgency in his voice.

95. Mr Hodgson had clearly been dead for some time when he was discovered and therefore the short delay in calling a medical emergency code in this case made no difference to the outcome. However, it is important that staff follow the correct medical emergency procedures. We know that in an emergency situation, a delay of a few minutes may be critical. We therefore make the following recommendation:

The Governor should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff:

- **enter a cell immediately when necessary to preserve life subject to conducting a dynamic risk assessment; and**
- **promptly use an emergency code to effectively communicate the nature of the emergency.**

Escorting the ambulance to A Wing

96. When the ambulance arrived at Garth, it took around seven minutes to reach A Wing. Garth is a medium security prison and passing through the main gate can take up to two minutes, then staff must unlock and secure at least four interim gates to access A Wing.

97. We have previously criticised Garth for the length of time it has taken to escort an ambulance to a medical emergency. In this instance, the ambulance was escorted five minutes quicker than in a previous death, so improvements in the procedure have been made. The safer custody manager said Garth's local security strategy does not allow one person to go and open all the gates in advance, leave them and then go back to the ambulance, it must be one gate at a time.

98. The safer custody manager said that she has arranged to undertake an exercise with North West Ambulance Service to try to improve the timeliness of access and to obtain definitive times of how long escorting a vehicle to each area of the prison should take. We welcome this initiative and make no recommendation.

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