

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Hugh Gallon a prisoner at HMP Northumberland on 28 November 2017

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

## 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 Hugh Gallon was found hanged in his cell at HMP Northumberland on 28 November 2017. He was 44 years old. I offer my condolences to Mr Gallon's family and friends.

Mr Gallon had been at Northumberland for nearly two years when he died and there had been no indication that he was at risk of suicide during that time, although there appears to have been some confusion in his interactions with mental health support.

The investigation identified a short delay in the emergency response due to the radio network being blocked but this did not affect the eventual outcome for Mr Gallon.

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

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

**August 2018**

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# Summary

## Events

1. Mr Hugh Gallon was sentenced to 60 months imprisonment on 2 June 2015 for robbery. He was transferred to HMP Northumberland on 17 December 2015. Staff in reception noted no concerns about Mr Gallon's physical health, mental health or risk of suicide and self-harm. However, a secondary health screening on 19 December identified a diagnosis of hepatitis C as well as a history of self-harm and substance misuse. Staff made a referral for a mental health assessment.
2. Mr Gallon attended a mental health assessment but declined any further support. He said that he had post-traumatic stress disorder (PTSD) from his time in the army but he was getting support from Veterans in Custody.
3. On 7 February 2017, during a routine blood test appointment, Mr Gallon told a nurse that he was worried about his PTSD and that he was feeling low. He also told the nurse that he was experiencing some physical symptoms due to his hepatitis C treatment. The nurse referred him to the GP for his physical symptoms and noted that he had support from his mother and from the mental health team (although he was not being seen by the mental health team at that time).
4. On 9 May, a nurse noted that Mr Gallon was on the mental health referral waiting list, although no referral had been received. The nurse noted that a triage decision was awaited but nothing further was recorded on Mr Gallon's notes.
5. On 28 November, at 7.40am, Mr Gallon was found hanging from his upended bed, having used a sheet as a ligature. An officer tried to use his radio to try to call for assistance, but was unable to do so as the network was blocked. The officer contacted the control room by phone from the staff office and asked them to call an ambulance. Staff attempted cardiopulmonary resuscitation until the paramedics arrived at 8.30am. Mr Gallon was pronounced dead by paramedics at 8.36am.

## Findings

6. There was no indication that Mr Gallon was at risk of suicide or self-harm and we are satisfied that staff could not have foreseen his actions. We consider that he made a determined effort to take his own life, and it is unlikely that his death could have been prevented.
7. There was a short delay in the emergency response because the officer who found Mr Gallon hanging in his cell was unable to call for help on his radio as the network was blocked. Although the delay did not impact on the eventual outcome for Mr Gallon, we consider that any such delay could be critical in future cases.
8. It was unclear why Mr Gallon had appeared on the mental health referral waiting list in May 2017 and his medical records gave no indication of what happened in response to the referral. We were told that he had been assessed as suitable for

a low-level mental health intervention but he was never offered an appointment. It is unlikely this had any direct impact on Mr Gallon's death but we consider it important that mental health referrals are actioned and records kept.

## **Recommendations**

- The Director should:
  - ensure that the radio network is fully operational at all times so that staff can use their radios to make emergency calls; and
  - provide written guidance to staff on alternative methods for raising the alarm in an emergency should radio communication fail.
  
- The Director and Head of Healthcare should ensure that all prisoner interactions, decisions and actions are appropriately documented, in particular that:
  - the outcomes of mental health triage considerations are properly recorded; and
  - onward referrals are followed up to ensure that appointments are offered to patients.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Gallon's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Gallon's clinical care at the prison.
12. The investigator and clinical reviewer jointly interviewed three members of staff at HMP Northumberland. The investigator interviewed one member of staff by telephone. The clinical reviewer interviewed one member of healthcare staff by telephone. The interviews took place between February and April 2018.
13. We informed HM Coroner for Northumberland of the investigation who sent the results of the post-mortem examination to us. We have given the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Gallon's mother to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Gallon's mother did not raise any issues.
15. Mr Gallon's family received a copy of the initial report. They did not raise any concerns regarding factual accuracy of this report.
16. We shared our initial report with the Prison Service. The Prison Service did not identify any factual inaccuracies and its action plan is annexed to this report.

# Background Information

## HMP Northumberland

17. HMP Northumberland is a training prison holding up to 1,348 men, predominately from the North East of England. Sodexo Justice Services manage the prison, G4S provide the primary healthcare services and Tees, Esk and Wear Valley NHS Foundation Trust provide mental health services.

## HM Inspectorate of Prisons

18. The most recent inspection of HMP Northumberland was in August 2017. Inspectors criticised many aspects of the prison but noted the Director's determination and leadership in making improvements. Inspectors were concerned that violence had more than doubled since their last inspection and that the number of prisoners who reported feeling unsafe was significantly higher than in similar prisons. Inspectors noted positive interactions between prisoners and staff and reported that 80% of prisoners felt staff treated them with respect. Inspectors said that mental health services within the prison were effective and noted that the majority of uniformed officers had received mental health awareness training.

## Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to 31 December 2016, the IMB noted that direct prisoner feedback about healthcare services was generally positive but that the mental health provision was over-stretched.

## Previous deaths at HMP Northumberland

20. Mr Gallon was the fourth prisoner to take his own life at Northumberland since January 2016. There were no significant similarities with our previous investigations.

## Key Events

21. On 2 June 2015, Mr Hugh Gallon was sentenced to 60 months imprisonment for robbery. He was transferred from HMP Holme House to HMP Northumberland on 17 December 2015.
22. The person escort record (PER – a document that accompanies prisoners on transfer from court and other establishments) stated that Mr Gallon had previously been subject to suicide and self-harm monitoring (ACCT procedures) while in prison in 2010. It also stated that he had a previous history of alcohol and drug misuse but there were no recent concerns noted about substance misuse or suicide and self-harm. Mr Gallon was assessed as suitable to share a cell and he was located on Houseblock 9.
23. On 19 December, a healthcare screening identified a history of self-harm eight years previously. Mr Gallon said he had a history of depression and agreed to be referred for an initial mental health assessment. The nurse also noted that Mr Gallon had a diagnosis of hepatitis C but had refused treatment for the last seven years due to a bad reaction to the medication.
24. On 15 January 2016, Mr Gallon attended an appointment with a community psychiatric nurse (CPN). The CPN made a note on Mr Gallon's medical records to say that he declined a mental health assessment as he said he was getting support for post-traumatic stress disorder (PTSD) from an organisation called Veterans in Custody. Mr Gallon was therefore discharged from the mental health team.
25. On 19 January, Mr Gallon was moved to Houseblock 8.
26. On 20 April, Mr Gallon lost his job in the prison kitchen because he had stolen some cheese. He had worked there since shortly after arriving at Northumberland and records state that he was disappointed in himself. He went on to work as a wing cleaner and received good reports from prison staff.
27. On 1 June, Mr Gallon told staff that he was being intimidated by other prisoners and was being pressured to keep a phone charger in his cell. Staff submitted an intelligence report and Mr Gallon was moved from Houseblock 8 to Houseblock 5. Despite the change of location, Mr Gallon began a period of self-isolation on Houseblock 5.
28. On 29 August, Mr Gallon was moved to the Vulnerable Prisoners' Unit on Houseblock 12. He stopped self-isolating and returned to working as a wing cleaner and on the servery. Staff reported good behaviour and compliance and Mr Gallon was considered a trusted prisoner on the unit.
29. Mr Gallon began complying with his hepatitis C medication on 9 December, but had stopped taking it again by 30 December. On 5 January 2017, he was sent to hospital after he began vomiting blood and became acutely unwell. On return to the prison on 9 January, he continued to refuse his medication.
30. On 7 February, Mr Gallon attended a blood test appointment with a nurse prescriber. Mr Gallon told her that he supported other prisoners with PTSD but

was worried about what would happen if his own PTSD got worse or he felt low. She noted that Mr Gallon had support from his mother and the mental health team. He was not in fact being supported by the mental health team at that time.

31. On 9 May, the CPN noted Mr Gallon's medical record to say that he was on the mental health waiting list but that no referral had been received. It is not clear when or why Mr Gallon's name had been added to the mental health team's waiting list as he had previously declined support from them. The mental health lead told the clinical reviewer that Mr Gallon's case had been assessed as suitable for a low level mental health intervention with an organisation called Rethink. It was not clear what, if anything, happened subsequently but Mr Gallon never received an appointment with Rethink. The mental health lead was unable to explain why.
32. On the morning of 28 November, an operational support officer carried out the morning roll check and saw Mr Gallon in his cell at approximately 6.00am. The operational support officer told the investigator that he was satisfied that Mr Gallon was alive at that time although he could not recall exactly what led to this judgement.
33. At approximately 7.40am, a prison officer began unlocking the prisoners and found Mr Gallon hanging from his upended bed, having used a sheet as a ligature. The officer tried to use his radio to call for assistance but the network was busy. He said there were no colleagues close by that he could shout to and other prisoners who had been unlocked were beginning to gather on the landing. He felt he had no option but to close and lock the cell door, leaving Mr Gallon suspended, in order to run to the wing office to contact the control room by telephone so that they could request an ambulance.
34. The officer returned to Mr Gallon's cell with a supervising officer and they were joined by another officer. The two officers lifted Mr Gallon while the supervising officer cut the ligature and placed Mr Gallon in the recovery position. Two nurses attended immediately and began cardiopulmonary resuscitation (CPR) with the assistance of one of the officers and the supervising officer. Paramedics arrived at approximately 8.30am and took over CPR before pronouncing Mr Gallon dead at 8.36am.

### **Contact with Mr Gallon's family**

35. Mr Gallon's mother was listed as his next of kin. Two supervising officers visited her at her house on 28 November at approximately 11.20am to inform her of her son's death. The prison contributed to the cost of Mr Gallon's funeral, in line with Prison Service instructions. Mr Gallon's mother said she had received an exceptional standard of care from the prison's family liaison officers.

### **Support for prisoners and staff**

36. Staff involved in the emergency response attended a debrief led by a senior manager and the prison's care team offered support.
37. The prison's Director posted a notice for prisoners informing them of Mr Gallon'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 Gallon's death.

### **Post-mortem report**

38. The pathologist concluded that death was caused by pressure on the neck due to hanging. Toxicology results found the presence of synthetic cannabinoids in Mr Gallon's blood, but it was not possible to determine if he was under the influence of this substance at the time of his death.

# Findings

## Mental health care

39. Mr Gallon had declined mental health support during his time at Northumberland. It is not clear from the records why or when his name was added to the mental health waiting list, but the CPN noted in his medical record on 9 May 2017 that there was an outstanding referral awaiting triage. The mental health lead told the clinical reviewer that Mr Gallon had been triaged and assessed as suitable for an intervention with Rethink, an organisation that provides talking therapies for those with anxiety, depression and low level mental health needs. It is not clear from Mr Gallon's medical record where this information was recorded or if the referral to Rethink was ever made. What is clear is that Mr Gallon was not offered an appointment and the mental health lead was unable to explain why this did not happen.
40. While we do not know if Mr Gallon would have engaged with Rethink, we are concerned that he was not offered the opportunity to do so. We also note that Mr Gallon had some concerns around PTSD and, although he was reportedly in touch with Veterans in Custody, the prison holds little information about this. Looked at in the round, we find the recording of Mr Gallon's interactions with mental health processes insufficiently clear. We consider that there may be potential for other mental health referrals to be missed and we therefore make the following recommendation:

**The Director and Head of Healthcare should ensure that all prisoner interactions, decisions and actions are appropriately documented, in particular that:**

- **the outcomes of mental health triage considerations are properly recorded; and**
- **onward referrals are followed up to ensure that appointments are offered to patients promptly.**

## Emergency response and communications network

41. Prison Service Instruction (PSI) 03/2013 sets out the framework for calling a medical emergency over the radio network in all public and contracted prisons. It states, "the intention is to ensure timely, appropriate and effective response to medical emergencies and thereby to maximise the likelihood of a positive outcome for the patient". Northumberland's Director's Order 01/2015 sets out the requirements for staff to use the appropriate medical response code when contacting the control room in an emergency to ensure that an ambulance is called.
42. The prison's Head of Security and Operations told the investigator that there have been ongoing problems with the network "locking" and staff being unable to get through to the control room. She said that this was being investigated by the service provider, Capita, who believed it might be caused by a software issue but were yet to find a solution. The Head of Security and Operations said that staff were advised to use the telephone or press the general alarm if they were unable to contact the control room via their radio. She was not aware of any specific

written protocol or guidance advising staff of these alternative methods, but she said all staff were made aware of this during their training.

43. When the officer found Mr Gallon hanging in his cell, he immediately tried to call for assistance on his radio but was unable to get through as the network was busy. The officer believed that it took him no longer than one minute to go to the wing office to use the telephone and it is therefore unlikely that this delay had any impact on the eventual outcome for Mr Gallon. However, any delay in future cases could be critical. In addition, we are concerned that staff do not have the assurance that they can always use their radios in an emergency situation. In the event that radio communication fails, staff should be aware of alternatives such as pressing the general alarm or using their personal alarms in order to bring immediate help in an emergency. The Head of Security and Operations said that new processes had been approved that would reduce radio traffic and ensure that emergency calls got through to the control room but these were not yet in place. We make the following recommendation:

**The Director should:**

- **ensure that the radio network is fully operational at all times so that staff can use their radios to make emergency calls; and**
- **provide written guidance to staff on alternative methods for raising the alarm in an emergency if radio communication fails.**

### **Physical health care**

44. We found that the physical healthcare provided to Mr Gallon was of a good standard. Mr Gallon made an informed decision to stop taking medication for hepatitis C, despite knowing the risks.

### **Violence reduction strategy**

45. Mr Gallon had previously reported to staff that he was being intimidated by other prisoners and, as a result, he self-isolated for a number of months. However, this took place in 2016 and there is no evidence to suggest it was a factor that led to Mr Gallon's death. We are satisfied that prison staff acted in accordance with their Violence Reduction Strategy to investigate the allegations and to support Mr Gallon, eventually moving him to the Vulnerable Prisoners' Unit.



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