

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Connor Hoult, a prisoner at HMP Wakefield, on 10 June 2019

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 Connor Hoult died on 10 June 2019 at HMP Wakefield from hanging. He was 24 years old. I offer my condolences to Mr Hoult's family and friends.

Mr Hoult had a number of mental health issues including anxiety, depression, personality disorder and bi-polar disorder. He also had a significant history of attempted suicide and self-harm and he struggled with suicidal thoughts. Mr Hoult took every opportunity to work, attend education and attend mental health courses in prison. Sadly, despite his efforts to understand and cope with his mental health, he left a note to his family indicating that he could no longer carry on.

Mr Hoult had a high number of risk factors for suicide and self-harm which meant that his risk fluctuated according to context but was never entirely absent. With the benefit of hindsight and given the number and nature of Mr Hoult's risk factors, he might have benefitted from a medication review at Wakefield. However, we did not find any evidence that staff could have foreseen that Mr Hoult was at imminent risk of suicide before he died.

Four separate members of staff made checks on Mr Hoult between about 5.30am and 8.55am but did not realise he had died because he appeared to be sitting on the heating pipes watching television. We make a recommendation about engaging with prisoners who appear awake at unusual times.

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

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 5

Findings 9

Summary

Events

1. Mr Connor Hoult had a history of self-harm, attempted suicide and mental illness including bi-polar disorder, borderline personality disorder, depression, anxiety and post-traumatic stress disorder.
2. On 4 October 2018, he was remanded to HMP Leeds charged with the rape and sexual assault. It was his first time in custody. Staff began Prison Service suicide and self-harm monitoring procedures, known as ACCT, after he said that he wanted to kill himself.
3. ACCT procedures were stopped in mid-November and Mr Hoult attended courses about mental health as well as education classes, the gym and workshops. He was managed by the mental health team and a psychiatrist prescribed a low dose of anti-psychotic medication. His dose was increased after Mr Hoult reported visual hallucinations and this appeared to work.
4. On 18 April 2019, Mr Hoult was transferred to Wakefield. He was assessed by the mental health team and was put on the waiting list for the psychiatrist to review his medication. He did not get an appointment before he died.
5. Mr Hoult attended education, the gym and workshops during his time at Wakefield. He had regular contact with his keyworker and frequent contact with his family.
6. On 10 June, Mr Hoult was found hanged by a sheet attached to his cell window. He left a note addressed to his family explaining why he had taken his own life.

Findings

7. Mr Hoult had a high number of factors that indicated he was at risk of suicide and self-harm and his mental health meant that this risk fluctuated according to context but was never absent. Mr Hoult appeared to be trying to make the best of his situation and took every opportunity to complete courses and attend education, work and the gym. Despite his risk factors, we did not see any evidence that staff could have been expected to identify that Mr Hoult was at heightened or imminent risk of harming himself in the period leading to his death.
8. Mr Hoult was last seen alive in his cell at about 7.30pm on 9 June. Four different members of staff looked through Mr Hoult's observation panel on the morning of 10 June at about 5.30am, 6.30am, 8.00am and 8.55am. Three of the officers remembered he was sitting on his pipes apparently looking at the door. On the balance of evidence, we consider that Mr Hoult was most likely dead before the 5.30am roll check. It is unlikely that earlier intervention would have changed the outcome for him.
9. We consider that it is reasonable and appropriate that staff do not wake prisoners who appear to be lying asleep in their beds in the early morning. We would however expect staff to take action if they had immediate concerns or if a prisoner was behaving unusually, such as being up and awake and apparently

watching television at 5.00am or 6.30am. If a prisoner is awake and up, then there is no reason why the officer checking them should not ask if they are alright.

10. Mr Hoult was managed by the mental health team in Leeds and in Wakefield. He was still waiting for a planned medication review when he died. The clinical reviewer concluded that, given Mr Hoult's numerous mental health issues and his suicidal ideation, he would have benefitted from an earlier medication review at Wakefield.
11. The officer who found Mr Hoult hanged on the morning of 10 June did not call a code blue emergency as he should have done, but there was no significant delay and it did not affect the outcome for Mr Hoult.
12. Mr Hoult showed clear signs of rigor mortis when he was found on the morning of 10 June and staff made an appropriate decision not to try to resuscitate him in line with European Resuscitation Council Guidelines.

Recommendations

- The Governor should ensure that staff completing roll counts obtain a verbal or physical response from all prisoners who are awake at early morning roll count.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Wakefield informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Hoult's prison and medical records. He asked for CCTV and other recorded evidence but this had already been taken by the police. A second investigator took over the investigation. She spoke to three staff on the telephone in August 2019. She also obtained a number of detailed statements taken by the police after Mr Hoult died.
15. NHS England commissioned an independent clinical reviewer to review Mr Hoult's clinical care at the prison. The clinical reviewer did not speak to any healthcare staff.
16. We informed HM Coroner for West Yorkshire Eastern District of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. The second investigator spoke to Mr Hoult's mother's solicitor to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Hoult's mother asked:
 - If Mr Hoult was checked four times between 6.20am and 9.50am and was noted to be sitting on the pipes on each occasion, why didn't that raise alarm bells with the officers?
 - Is it not usual practice to engage with a prisoner when the officers are carrying out checks and entering cells?
 - Why did the officer go into the cell for the boots at that specific time?
18. We have answered these questions in this report.

Background Information

HMP Wakefield

19. HMP Wakefield is a high security prison and holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (a small unit aiming to provide a supportive, safe, structured and consistent environment for some of the most challenging offenders). Care UK provides healthcare at Wakefield.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Wakefield was carried out in June 2018. Inspectors reported that the prison was calm, and the inspection was a positive one. The quality of ACCT documents was generally good and quality assurance processes were sound. Staff-prisoner relationships were generally good and enhanced by the keyworker scheme. Overall living conditions and health services were good.

Independent Monitoring Board

21. 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 April 2018, the IMB reported that the prison continued to provide a regime that was just, consistent and inclusive despite the pressures on HMPPS. The IMB reported that levels of violence were relatively low and investigated properly. ACCT documentation was generally good, as were health services.

Previous deaths at HMP Wakefield

22. Since 2016, there have been 20 deaths due to natural causes at Wakefield. Mr Hoults' death was the second self-inflicted death during that time. Our investigation into the other self-inflicted death, in November 2018, found that there was delay entering the cell when the prisoner was found unresponsive and that mental health care was not equivalent to that which he could have expected to receive in the community.

Key Events

23. Mr Connor Hoult had a history of self-harm, attempted suicide and mental illness including bi-polar disorder, borderline personality disorder, depression, anxiety and post-traumatic stress disorder.
24. On 4 October 2018, Mr Hoult was remanded to HMP Leeds charged with the rape and sexual assault of two girls aged 15 years. It was his first time in custody. Staff began Prison Service suicide and self-harm monitoring procedures, known as ACCT, after he said that he wanted to kill himself. Mr Hoult said that he had tried to kill himself several times before.

HMP Leeds

25. Mr Hoult told a nurse at an initial health assessment that he had self-harmed or attempted suicide in the previous 12 months and had thought about how to kill himself. She referred him for an urgent mental health assessment and advised officers he should share a cell. A nurse assessed Mr Hoult's mental health immediately afterwards and he was placed on constant observation. The next day he told the nurse that his level of suicidal intent was "6/10", which he said was normal for him.
26. Mr Hoult remained on constant observation on the First Night Centre until 9 October, when he was moved to the vulnerable prisoner unit. He remained on the mental health team caseload and nurses assessed him regularly. A consultant forensic psychiatrist saw Mr Hoult on 29 October. Mr Hoult said he was anxious and depressed and had a long history of attempted suicide and self-harm. The psychiatrist prescribed him a low dose of quetiapine (an anti-psychotic) to help stabilise Mr Hoult's mood and to help him sleep.
27. On 2 November, Mr Hoult's ACCT was closed, however it was reopened on 5 November after he made superficial cuts to his arm. Mr Hoult said that he could not get to sleep and had cut himself in frustration.
28. On 13 and 20 November, Mr Hoult attended the Managing Emotions and Wellbeing Group. He also started work in a prison workshop and attended education classes and the gym. On 23 November, he reported at an ACCT review that he was feeling more settled in prison and was enjoying being occupied, and ACCT procedures were stopped.
29. On 30 November, Mr Hoult was sentenced to 12 years, 10 months in prison. The prison resumed ACCT procedures as a precaution in the light of his long history of suicidal thoughts. ACCT procedures were stopped the next day after Mr Hoult said that he was focussing on appealing his sentence and had a supportive family and cellmate.
30. Mr Hoult continued to complain of poor sleep due to back pain and asthma. On 7 December, a prison GP prescribed him a short course of sleeping tablets. On 13 December, Mr Hoult told a consultant forensic psychiatrist that the quetiapine was effective but wore off at night. The psychiatrist increased his dose by 25mg at night and asked to review Mr Hoult after three months.

31. On 15 January 2019, Mr Hoult began a Managing Stress course. He told the course facilitator that he had more than one personality disorder and that this affected his ability to put “theory into practice” despite attending a number of courses. He completed this course and also began treatment with a physiotherapist for his back pain.
32. On 11 April, Mr Hoult told a consultant forensic psychiatrist that he experienced visual hallucinations. The psychiatrist increased Mr Hoult’s dose of quetiapine as a trial and asked to review him in eight to ten weeks.

HMP Wakefield

33. On 18 April, Mr Hoult was transferred to HMP Wakefield, a standard progression from a local prison to a training prison for a long sentence prisoner. A nurse completed a mental health assessment with him the next day. Mr Hoult appeared calm but said he thought that his previous drug use in the community had had a detrimental effect on his mental health. At a follow-up assessment on 21 April, Mr Hoult told a nurse that he was happy to be at Wakefield and agreed to be referred to the psychiatrist for a medication review.
34. A nurse saw Mr Hoult again on 25 April. Mr Hoult said he was anxious that he had not been given his last two doses of quetiapine. The nurse reassured him that this had been re-prescribed and he would now receive it on time. Mr Hoult declined further engagement with the mental health team but said he wanted to remain on the waiting list to see the psychiatrist for a medication review. He said he had not experienced any more visual hallucinations and was happy with his dose of quetiapine. He denied any thoughts of suicide or self-harm.
35. On 29 April, a mental health team multi-disciplinary meeting approved the plan for Mr Hoult to see the psychiatrist for a medication review. Mr Hoult did not see either a member of the mental health team or a psychiatrist again before he died.
36. Mr Hoult attended regular sessions with his keyworker. His keyworker said Mr Hoult was polite and friendly and always chatted at their meetings. His main issue was an ongoing application to see his younger sister. (Mr Hoult was placed on the Sex Offenders’ Register as a result of his conviction and was unable to see his sister who was under 18.) Mr Hoult’s keyworker spoke to Mr Hoult’s Offender Supervisor to chase this up, but no progress had been made before he died. Mr Hoult had good family ties and his mother and girlfriend were very supportive.
37. Mr Hoult’s keyworker said Mr Hoult did not tell her he was struggling with suicidal thoughts. The last time she spoke to him was on 8 June and he told her everything was fine. Mr Hoult asked her about her contact with his Offender Supervisor and went off to exercise. Mr Hoult’s mother said she spoke to Mr Hoult on the telephone on 8 June and he appeared to be his usual self, although he had previously said he did not like being at Wakefield. She also said that he had never told her that he had suicidal thoughts or wanted to harm himself.

9- 10 June 2019

38. Mr Hoult’s girlfriend said that she spoke to him on 9 June at about 4.30pm. He told her about his day and said he would call her again the next day.

39. The officer on evening duty on A wing completed a roll count of all the prisoners on the wing. He said he remembered Mr Hoult was lying on his bed when he checked him at about 7.30pm and that Mr Hoult had nodded to him to acknowledge his check.
40. Another officer was the night patrol officer on A wing. He did not go to Mr Hoult's cell during the night because Mr Hoult was not on any special checks. The cell bell record shows that Mr Hoult did not press his cell bell during the night.
41. At 5.00am, the night patrol officer completed the early morning roll count. He told police that he did not remember what Mr Hoult was doing when he checked him but said that he would have responded if there had been anything out of the ordinary.
42. Officer A started duty on A wing at about 6.20am. He received a hand over from the night patrol officer and began a count of every prisoner to confirm it tallied with the night patrol officer's count. Officer A said he is required to check that every prisoner is alive and well in their cell. He estimated that he checked Mr Hoult at about 6.30am. He said that Mr Hoult was sitting on the pipes at the back of his cell looking directly at the observation panel. He said he thought Mr Hoult had just looked up in response to him opening the observation flap and moved on to the next cell. He said a lot of prisoners sat on their pipes and he did not think it was unusual.
43. Officer A was not on A wing for the 8.00am unlock which was completed by Officer B. Officer B said he looked through the observation flap and saw Mr Hoult sitting on the pipes at the back of his cell. His light and the television were both on. Officer B said he often unlocked Mr Hoult's landing and he was usually sitting on his pipes at unlock so he did not think anything was wrong.
44. At about 8.55am, Officer B and Officer C counted the prisoners again to record who had gone to work and who was still in their cell. Officer C said that he looked into the cells and Officer B ticked off the names on a board. Officer C saw Mr Hoult sitting on the pipes at the back of his cell. He said prisoners often sat on their pipes because they are at a convenient height and position to watch the television. He did not notice anything unusual about Mr Hoult.
45. At about 9.50am, Officer B went to collect a pair of Mr Hoult's boots that he had been given in reception but was not allowed in possession. (Officer B was the dedicated search officer on A wing that morning and also worked in the prison's reception.) He said that he looked through the observation flap and noticed Mr Hoult was in the same position he had seen him in earlier. He went into the cell and started speaking to Mr Hoult while looking at the floor to find the boots. Mr Hoult did not reply so he looked up and noticed that Mr Hoult's face and lips were blue and he had a sheet tied around his neck and attached to the window.
46. Officer B shouted for staff to attend and tried to lift Mr Hoult to release the pressure on his neck. He noticed that Mr Hoult was not actually sitting on the pipes as had appeared from the door and he was suspended in a kneeling position. He used his cut down tool to cut the sheet from the window. Mr Hoult was very cold and stiff and remained in the same position after he had cut the

sheet. He did not attempt to resuscitate Mr Hoult because he had apparently been dead for some time.

47. Two officers were nearby on A wing and responded first. One officer said she radioed a code blue emergency as soon as she saw Mr Hoult. The control room log shows that an ambulance was called immediately. She said Mr Hoult was in rigor mortis and the emergency response nurse arrived very soon after her.
48. A nurse said he arrived at Mr Hoult's cell with the emergency equipment together with a healthcare support worker. Mr Hoult was in a kneeling position at the back of his cell. Several signs of rigor mortis were present including pooling of the blood (hypostasis) in his arms and feet. The nurse did not attempt cardio-pulmonary resuscitation in line with National Resuscitation Council guidelines. Paramedics arrived at 10.10am and recorded that Mr Hoult had died.
49. Staff found a handwritten letter to his family on Mr Hoult's desk telling them that he had taken his own life. The letter indicated he had written it at 9.30pm the previous evening. Mr Hoult said it had been difficult being away from his family and girlfriend.
50. After Mr Hoult died, the prison received intelligence from another prisoner that Mr Hoult had used psychoactive substances and was in debt, and that this had contributed to his death. Mr Hoult's prison canteen account had plenty of money in it and toxicology tests showed that he had not taken drugs before he died.

Contact with Mr Hoult's family

51. At 11.00am on 10 June, an operational manager and an officer drove to Mr Hoult's partner's house, but no one was home. They went immediately to Mr Hoult's mother's house and broke the news of his death.
52. The prison contributed to the cost of the funeral in line with national guidance.

Support for prisoners and staff

53. After Mr Hoult's death, prison managers 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.
54. The prison posted notices informing other prisoners of Mr Hoult's death, and to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Hoult's death.

Post-mortem report

55. The pathologist concluded Mr Hoult died from hanging. Toxicology showed that Mr Hoult was not under the influence of any substance when he died.

Findings

Assessment of risk

56. Mr Hoult had a high number of factors that indicated he was at risk of suicide and self-harm and his mental health meant that this risk fluctuated according to context but was never absent. Mr Hoult appeared to be trying to make the best of his situation. He appealed his sentence, applied to have contact with his sister and had good family support. He took every opportunity to complete courses and attend groups to better understand and cope with his mental health and attended education, work and the gym. He regularly spoke to his keyworker and was in frequent contact with his mother and his girlfriend. Neither his family nor his keyworker thought Mr Hoult was at risk of harming himself. Despite his risk factors we have not seen any evidence that staff had any reason to consider that Mr Hoult was at heightened or imminent risk of harming himself in the period leading to his death.

Checks on 10 June 2019

57. Mr Hoult was last seen alive at about 7.30pm on 9 June by the officer on evening duty. He was in rigor mortis when Officer B discovered him hanged at about 9.50am, which indicates he had been dead for at least four hours. Four different members of staff looked through Mr Hoult's observation panel at about 5.30am, 6.30am, 8.00am and 8.55am. The 8.00am check was when his cell was unlocked and the other three were roll counts. The first officer who checked Mr Hoult could not remember him but the officers who completed the following three checks all said he was sitting on his pipes. The cell light and television were on and Mr Hoult left a note that indicated he took the decision to take his own life at 9.30pm the previous evening. On the balance of evidence, we consider that Mr Hoult was most likely already dead at the first check.
58. Prison Service Instruction (PSI) 75/2011 on residential services expects staff to check on the welfare of prisoners at morning unlock by, for example, obtaining a verbal response. There is no national instruction on what should happen at roll counts.
59. At interview, staff told the investigator that they understood they were required to check that the prisoner was alive and well in their cell, although they would not wake prisoners who appear to be lying asleep in their beds in the early morning. We consider that this is reasonable and appropriate. We would however expect staff to take action if they had immediate concerns or if a prisoner was behaving unusually, such as being up and awake and apparently watching television at 5.30am or 6.30am. If a prisoner is awake and up, then there is no reason why the officer checking them should not ask if they are alright.
60. It was clearly not obvious that anything was wrong with Mr Hoult as four different officers were not concerned by what they saw. We are satisfied that earlier intervention would not have changed the outcome for Mr Hoult. Nevertheless, in cases of hanging prompt assistance is crucial and might make a difference in other cases. We therefore recommend that:

The Governor should ensure that staff completing roll counts obtain a verbal or physical response from all prisoners who are awake at early morning roll count.

Mental health

61. Mr Hoult had a significant history of mental illness and was assessed by the mental health team at Leeds and Wakefield. On 11 April, a psychiatrist in Leeds increased his dose of quetiapine as a trial after Mr Hoult reported visual hallucinations. This increase was due for review in June, but Mr Hoult was still on the psychiatrist's waiting list at Wakefield when he died. The clinical reviewer concluded that, given Mr Hoult's numerous mental health issues and his suicidal ideation he would have benefitted from an earlier medication review at Wakefield. The clinical review contains some recommendations that the Head of Healthcare will wish to consider.

Emergency response and resuscitation

62. When Officer B found Mr Hoult hanged in his cell on the morning of 10 June, he did not call a code blue emergency. He prioritised cutting Mr Hoult down and shouted for assistance. Staff were nearby and arrived within seconds and an officer called a code blue immediately. Although Officer B did not call a code blue as he should have done, we are satisfied that there was no significant delay and it did not affect the outcome for Mr Hoult. We make no recommendation.
63. European Resuscitation Council Guidelines for Resuscitation 2015 which were shared with prison managers in September 2016 say that "resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines define examples of futility as including the presence of rigor mortis. The British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 on making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of an individual's situation. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased.
64. Mr Hoult showed clear signs of rigor mortis when he was found by Officer B and we consider the decision not to attempt to resuscitate him was correct. We therefore make no recommendation.

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