Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Hough, a prisoner at HMP Hull, on 26 March 2020

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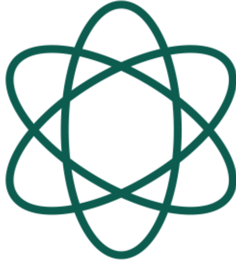
Our vision

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

OGL

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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 David Hough was found hanged in his cell on 26 March 2020 at HMP Hull. He was 56 years old. I offer my condolences to Mr Hough's family and friends.

Mr Hough was managed under suicide and self-harm procedures, known as ACCT, for seven months, from his arrival at Hull until three weeks before he hanged himself. There was good liaison between healthcare and residential wing staff, and he continued to receive comprehensive support from staff. We did not find any evidence that staff could have foreseen that Mr Hough was at imminent risk of suicide before he died.

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 **August 2021**

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Summary

Events

1. On 19 August 2019, Mr David Hough was remanded to HMP Hull, charged with sexual offences. Prison staff started suicide and self-harm prevention procedures (known as ACCT) as he was in low mood, he had been charged with serious offences and it was his first time in custody.

2. Mr Hough had a history of depression and social isolation and was in poor physical health but often refused to take his medication if he was annoyed with staff. He was assigned a 'care buddy' to help him with cleaning his cell and collecting his meals.

3. He remained under ACCT supervision for several months after two acts of self-harm and expressing thoughts of suicide. He had regular contact with his keyworker. On 14 January 2020, the ACCT was closed but re-opened on 17 January after he refused to take his insulin.

4. On 17 and 18 February, Mr Hough received discretionary life sentences for multiple sexual offences with a minimum period to serve of ten years.

5. On 4 March, Mr Hough's ACCT plan was closed after his mood continued to improve and avenues of support remained in place. On 11 March, he had an ACCT post closure interview. His ACCT case manager decided it did not need to be re-opened as he seemed stable and knew how to seek help if he needed to.

6. At 4.10pm, on 26 March, a supervising officer found Mr Hough kneeling on the floor of his cell with a ligature around his neck attached to a curtain rail. The officer radioed an emergency medical code for assistance. Staff began CPR, but paramedics were unable to resuscitate him, and at 5.12pm, it was confirmed that Mr Hough had died.

Findings

Clinical Care

7. The investigation found that the standard of physical and mental healthcare provided to Mr Hough at Hull were of an acceptable standard and equivalent to that which he could have expected to receive in the community.

Management of Mr Hough's risk of suicide and self-harm

8. Mr Hough had some significant risk factors for suicide and self-harm when he first entered prison and staff appropriately opened ACCT procedures.

9. Although we consider that the initial assessment of his risk as 'low' was not appropriate, we are satisfied that Mr Hough received a good level of support thereafter for the nearly seven months he remained subject to ACCT, and that his risk was raised when he self-harmed.

10. Mr Hough appeared to become more stable and settled and started to engage and interact with other prisoners and staff. We consider that it was reasonable for staff to have closed the ACCT when they did.

11. Despite his risk factors, we did not see any evidence that staff could have been expected to identify that Mr Hough was at heightened or imminent risk of harming himself in the three weeks before his death.

Emergency response

12. We are satisfied that officers arrived promptly when Mr Hough was found hanged and that they performed CPR competently. This enabled the healthcare staff who responded to assess his needs and prepare the appropriate equipment.

Post-incident debrief

13. We are concerned that the staff debrief was led by a member of staff who had taken part in the attempted resuscitation and who needed support himself.

Recommendation

- The Governor should ensure that the post-incident debrief is conducted by a member of staff who has not played a direct role in the incident.

The Investigation Process

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

15. Due to restrictions in response to the COVID-19 pandemic, the investigator was unable to visit Hull or view CCTV footage. She obtained copies of Mr Hough's prison and medical records by email.

16. NHS England commissioned a clinical reviewer to review Mr Hough's clinical records. The investigator and clinical reviewer conducted four joint interviews.

17. The investigator interviewed eight members of staff and one prisoner by telephone and online using Microsoft Teams between May and August 2020.

18. We informed HM Coroner for East Riding and Kingston upon Hull of our investigation. We have not yet received a copy of the post-mortem report. We have sent the Coroner a copy of this report.

19. We contacted Mr Hough's brother, his nominated next of kin, to explain the investigation. He did not raise any matters he wanted the investigation to consider.

20. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

Background Information

HMP Hull

21. HMP Hull is a local prison that holds up to 1,044 men in ten wings. I and J wings are for vulnerable prisoners. Healthcare services are provided by City Healthcare Community Partnerships.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Hull was in April 2018. Inspectors found a positive staff culture with a strong sense of community and openness to new ideas. Inspectors reviewed some personal case notes which showed staff provided prisoners with good support. The Safer Custody team had introduced a more robust quality assurance process to address weaknesses in the ACCT assessments and case reviews. Inspectors noted that most prisoners felt safe, respected and knew of someone they could turn to for help.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteer from the local community who help ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2020, the IMB reported that prisoners were safe, attempts at self-harm were frequently prevented and there was extensive provision to protect a significant proportion of prisoners who found it hard to cope. The IMB found that healthcare provision was generally good and key workers, staff and prisoners were helpful and supportive.

Previous deaths at HMP Hull

24. Mr Hough's death was the 13th at Hull since April 2018. Of the previous deaths, four were self-inflicted, seven were from natural causes and one is awaiting classification. There have been three deaths since Mr Hough's: two from natural causes and one apparently self-inflicted. There are no similarities between our findings in the investigation into Mr Hough's death and our investigation findings for the previous deaths.

Assessment, Care in Custody and Teamwork (ACCT)

25. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or 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.

26. 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 made at irregular intervals to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary 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.

27. 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 (PSI) 64/2011.

Key Events

28. On 19 August 2019, Mr David Hough was charged with multiple sexual offences against children. He was remanded into police custody. Mr Hough told a court custody officer that he would kill himself in prison and would not return to court for his trial. The officer, who was aware that Mr Hough had a history of self-harm, completed a suicide and self-harm (SASH) warning form and telephoned HMP Hull to alert them.

29. A reception officer started ACCT procedures on Mr Hough's arrival at Hull. Mr Hough told the officer that he would hurt himself because it was his first time in prison and he had mental health issues.

30. Mr Hough was assessed in reception by a nurse. He told her that he struggled with low mood and anxiety, had made several attempts to hang himself when he was a teenager and had taken an overdose 13 years ago. Mr Hough spoke about his poor physical health and said he had several long-term physical conditions (including hypertension and diabetes) which impacted on his mood. He said that he had suffered several heart attacks and had cancer (although his GP records did not confirm he had had treatment for those conditions). The nurse referred him for an initial mental health assessment. Mr Hough said that he did not drink alcohol or take illicit drugs and declined to be referred to the prison's substance misuse team.

31. On 20 August, Mr Hough told an ACCT assessor that he would attempt to take his life because he was 'a man of routine' and knew he would struggle in prison as he had anxiety and depression. He said that he wanted to die although he had not made plans to kill himself. A mental health nurse took part in Mr Hough's first case review which was held immediately after the assessment. The participants assessed Mr Hough's risk as 'low' and another ACCT case review was arranged for 27 August.

32. On 22 August, a nurse carried out an in-depth mental health assessment. Mr Hough told her about his difficulty in coming to terms with recent family bereavements, including his mother's death in 2018. He saw himself as having a poor physical prognosis as he believed he had cancer. The nurse thought that Mr Hough might have been suffering from Post-Traumatic Stress Disorder due to childhood experiences. She arranged for him to receive bereavement counselling and accepted him on to the mental health team caseload.

33. On 29 September, Mr Hough's cellmate discovered him under a blanket with a belt tied around his neck. Staff radioed an emergency code and the nurse who responded found that Mr Hough was breathing and that his airway was not obstructed. An ACCT review was held in response to his self-harm attempt and his level of risk was increased to 'raised'.

34. Mr Hough was found collapsed in his cell on three occasions (23 August, 22 September and 5 October) when he refused to collect or take his medication. Several staff told the investigator that he would sometimes decline his medication if he was annoyed or had been warned about his unkempt appearance or dirty cell. Staff described him as difficult and challenging at times and said he refused to speak to them. Each time he was found collapsed, he took his medication and recovered. Staff arranged for a 'care buddy' to assist Mr Hough with collecting his

meals and cleaning his shared cell as he said he was struggling with his mobility (he used a walking stick and a wheelchair) and that it was his cellmate's fault the cell was untidy.

35. Regular ACCT reviews took place at intervals between 7 and 14 days. Mr Hough's level of risk was increased to 'high' after he self-harmed by digging his nails into his arm following a police interview on 4 October. Mr Hough pushed a note under his cell door saying that he wanted to complete a Do Not Attempt Cardiopulmonary Resuscitation form. He told the nurse who checked on him that he had taken an overdose but was unable to specify which medications he had taken. The nurse recorded that his physical observations were within the normal range and that he was able to converse with her fully. On 23 October, Mr Hough was charged with nine further offences following the police interviews.

36. Staff continued to support Mr Hough through the ACCT process during difficult periods when he was feeling low in mood, such as the anniversary of his parents' death.

37. On 5 December, Mr Hough was convicted of further sexual offences and was aware that he faced a long sentence. He had regular contact with an officer who was his key worker, who updated his personal case notes.

38. Mr Hough's ACCT document was closed on 14 January 2020, because he appeared well, was complying with his diabetes medication and said he had no thoughts of self-harm. It was re-opened on 17 January, because he was refusing to take his medication, felt depressed and would not engage with staff.

39. On 3 February, staff noted that Mr Hough was mopping out his cell, smiling and had made efforts with his personal hygiene, which was unusual as he normally seemed socially isolated and introverted. His ACCT document was closed at an ACCT review that day, but it was re-opened on 7 February after a mental health appointment with a nurse-prescriber and a learning disabilities nurse. He told them that he was experiencing many negative thoughts, had nothing to look forward to and was due to attend court for sentencing.

40. On 18 February, Mr Hough was sentenced to life imprisonment with a minimum term of 10 years. An ACCT case review was held because his risk was considered to be raised. Mr Hough said that although he had known he was likely to receive a long period of imprisonment, he was surprised to receive a life sentence even though he had told staff previously that he would be happy with a ten-year tariff. Another ACCT case review was set for the next day. On 19 February, Mr Hough told a Supervising Officer (SO) and a Custodial Manager (CM) that he had fleeting suicidal thoughts but lacked the motivation to hang himself as he would panic if he could not breathe.

41. On 25 February, Mr Hough moved from J Wing to a single cell on I Wing. This was because he had been convicted of a same-sex rape and a Cell Sharing Risk Assessment assessed him as being at higher risk. Mr Hough was pleased to have his own cell and said he would sleep better now that he had been sentenced and had his own space.

42. On 4 March, an SO, CM and a mental health care assistant met with Mr Hough to discuss his risk to himself. He said that he felt more comfortable in his own room.

The SO said that she noticed he was interacting with others more and that he appeared to have made progress. All the staff and Mr Hough agreed that the ACCT document could be closed because he was aware of how to get support if he needed it. A post-closure interview was arranged for 11 March.

43. On 10 March, Mr Hough's key worker wrote in Mr Hough's prison record that his cell was clean and he seemed to be in better spirits. The key worker discussed him with the staff who were on duty (he worked on another wing) and they said that they had observed a significant improvement in how he seemed.

44. On 11 March, an SO spoke with Mr Hough as part of his post-closure interview. She noted that he appeared more stable. He said that he knew where to seek help and had occasional contact with one of his brothers.

Events of 26 March 2020

45. At 12.00 midday, an officer started the lunch time roll count. He said he saw Mr Hough lying on his bed asleep.

46. At 4.08pm, an SO unlocked Mr Hough's cell for his evening meal. She found him kneeling on the floor, suspended by a ligature around his neck which was tied to a curtain rail. She shouted for assistance from two officers who were across the landing and radioed a code blue, an emergency medical code indicating that a prisoner is unresponsive or having breathing difficulties. The SO cut the ligature from around Mr Hough's neck and laid him on the cell floor with the assistance of both officers. The SO began CPR, assisted by a CM. The CM told the investigator that three nursing staff arrived but left the cell and did not immediately take over CPR.

47. Two nurses arrived on I Wing with an emergency bag which contained a defibrillator. A healthcare assistant brought a larger emergency bag with oxygen and more equipment. They asked the officers to carry on with CPR while they assembled the oxygen and defibrillator outside the cell.

48. Paramedics arrived at 4.26pm and took over Mr Hough's care. He did not respond to resuscitation attempts and at 5.12pm, paramedics confirmed that Mr Hough had died.

Contact with Mr Hough's family

49. A prison Family Liaison Officer (FLO) and a senior manager contacted one of Mr Hough's brother's, who was named as his next of kin. His brother explained that Mr Hough was estranged from his family and that they did not wish to participate in his funeral arrangements.

50. The prison contributed to the cost of Mr Hough's funeral, in line with national policy.

Support for prisoners and staff

51. After Mr Hough's death, a CM who was a member of the staff care team, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and to offer support. He told the investigator that he felt

uncomfortable doing this, but no managers present had taken the lead, and that it had an emotional effect on him as he had been involved in the incident. The staff care team offered support to staff.

52. The prison posted notices informing other prisoners of Mr Hough'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 Hough's death.

Post-mortem report

53. The post-mortem report concluded that Mr Hough died from neck compression caused by hanging.

Findings

Management of Mr Hough's risk of suicide and self-harm

54. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* gives guidance to staff on how to identify, manage and support prisoners who are at risk of harm to themselves or others. It sets out the procedures (known as ACCT) that must be followed whenever staff assess that a prisoner is at risk of suicide or self-harm and requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action.

55. We are satisfied that ACCT procedures were appropriately opened when Mr Hough arrived at Hull in August 2019. He had a history of self-harm, he had told court staff he intended to kill himself, it was his first time in prison, his offences involved family members, and he was facing a substantial prison sentence - all known factors in heightening the risk of suicide in prisons. However, given the number of risk factors, we consider that his risk should have been assessed as higher than 'low' initially. However, his risk was appropriately raised when he self-harmed in September and October.

56. Staff closed the ACCT twice in January and February but re-opened it promptly when circumstances showed he was at greater risk. Staff were supportive and knowledgeable about him, even when he would not fully engage with them, they remained focused on his risk.

57. Overall, we are satisfied that the risk assessment and management was sound. We consider that it was reasonable for staff to have closed the ACCT on 4 March (two weeks after Mr Hough had been sentenced) and that there was no reason for staff to have foreseen that he would hang himself three weeks later.

Emergency response

58. We are satisfied that staff radioed the appropriate emergency code, officers arrived promptly and on finding Mr Hough performed CPR competently.

59. The CM who administered CPR told the investigator that the healthcare staff arrived but immediately left the cell before returning minutes later. We have established that the healthcare staff were present but were just outside the doorway, preparing equipment, rather than inside the cell. This enabled the healthcare staff who responded to assess Mr Hough's needs. Healthcare staff brought enough emergency equipment and we are satisfied that there were no undue delays in the care Mr Hough received.

Post-incident debrief

60. We are concerned that the CM felt he had to lead the post-incident debrief and that he found this distressing. We make the following recommendation:

The Governor should ensure that the debrief is conducted by a member of staff who has not played a direct role in the incident.

Clinical care

61. The investigation found that the physical and mental healthcare provided to Mr Hough were of an acceptable standard and equivalent to that which he could have expected to receive in the community.

62. We make no recommendation.

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