Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Kelly Hampson on 20 December 2021, following her release from HMP Eastwood Park

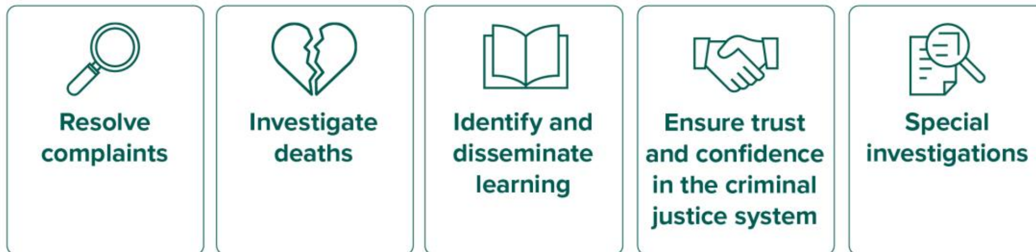
A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

© Crown copyright, 2023

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

Summary

1. 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.

2. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.

3. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

4. Ms Kelly Hampson was found hanged on 20 December 2021, following her release from HMP Eastwood Park on 6 December. She was 39 years old. I offer my condolences to those who knew her.

5. Ms Hampson was monitored using suicide and self-harm procedures (known as ACCT) during the five weeks she was at Eastwood Park. We found that ACCT documentation was not shared with community probation staff as it should have been. However, we are satisfied that Ms Hampson's community offender manager was aware of Ms Hampson's risks and put appropriate measures in place to try to support her.

6. The clinical reviewer concluded that the clinical care Ms Hampson received at Eastwood Park was of a good standard and was at least equivalent to that which she could have expected to receive in the community.

Recommendation

- The Governor at Eastwood Park should ensure, in line with the Annex to PSI 64/2011, that when a prisoner has been subject to ACCT monitoring within 12 months of release, staff share relevant risk information with probation colleagues, including the community offender manager, prior to release.

The Investigation Process

7. The PPO investigator obtained copies of relevant extracts from Ms Hampson's prison and probation records.

8. NHS England commissioned a clinical reviewer to review Ms Hampson's clinical care at the prison.

9. We informed HM Coroner for Avon of the investigation. They gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

10. The Ombudsman's family liaison officer contacted Ms Hampson's next of kin, her grandmother, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Eastwood Park

12. HMP Eastwood Park is a closed prison which holds up to 442 female prisoners who have either been convicted or are on remand. Practice Plus Group (PPG) provides physical health care services. Avon and Wiltshire Mental Health Partnership Trust provides mental health and substance misuse services.

Probation Service

13. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervise people throughout their licence period and post-sentence supervision.

Assessment, Care in Custody and Teamwork (ACCT)

14. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

Key Events

15. On 2 November 2021, Ms Kelly Hampson was convicted of assault of an emergency worker. She was sentenced to ten weeks in prison and sent to HMP Eastwood Park.

Pre-release

Mental health services

16. When Ms Hampson arrived at Eastwood Park, she told the reception nurse that she had borderline personality disorder and had an allocated community care worker from the North Somerset Recovery Team (adult mental health services). Ms Hampson told the nurse that she had attempted suicide in the past, but currently had no thoughts of suicide or self-harm.

17. On 4 November, a nurse saw Ms Hampson for a mental health assessment. Ms Hampson told the nurse that she had experienced suicidal thoughts for many years and had attempted suicide twice. She told the nurse that she had been thinking about which points in her cell she could attach a ligature to. The nurse started suicide and self-harm monitoring (known as ACCT) and opened a mental health crisis plan.

18. The next day, the nurse rang Ms Hampson’s community care worker. The care worker said that Ms Hampson was on a waiting list to have psychological therapy in the community. She confirmed that she would continue to work with Ms Hampson after she was released from prison.

19. Over the next few weeks, staff continued to support Ms Hampson using ACCT. She was seen regularly by her ACCT manager, wing staff and the mental health team.

20. On 3 December, a mental health nurse saw Ms Hampson for a pre-release appointment. Miss Hampson said that in general her mental health was better. She said that her suicidal thoughts had become more manageable, that she was taking her correct medication, and that since being in prison she had not attempted suicide or self-harmed. The nurse told Ms Hampson that she would ensure that the care worker was aware of her release on Monday 6 December.

Accommodation

21. As Ms Hampson was due to be released from prison homeless, on 4 November 2021, a member of the prison resettlement team submitted a ‘duty to refer’ application (where certain public authorities must notify local authorities that a person who has engaged with them might be homeless or at risk of homelessness) to Weston-Super-Mare Council.

22. On 24 November, Ms Hampson’s community offender manager (COM), met with Ms Hampson by video call. Ms Hampson said that she was worried about her mental health and about having nowhere to live on her release from prison. Later that day, the COM submitted a referral to the women’s commissioned rehabilitative

services (CRS). In her referral, she asked that they support Ms Hampson with her emotional wellbeing issues and help her to find accommodation on release. She then referred Ms Hampson to the Nelson Trust, a local charity that offer supported housing.

Release from HMP Eastwood Park

23. On 6 December, Ms Hampson was released from Eastwood Park with a one-week supply of her medication. The mental health team transferred her case to the community mental health services, and a prison nurse rang the community care worker to confirm Ms Hampson's release from prison.

24. On the day of her release, Ms Hampson attended her induction appointment with the COM. Ms Hampson told her that she was very anxious and that her mental health was suffering significantly. The COM told Ms Hampson that she would contact her mental health community care worker. Later that day, the COM emailed the mental health community care worker and asked if she could ring Ms Hampson and offer her some additional support.

25. Later that afternoon, the homeless team rang Ms Hampson and told her that they could offer her temporary emergency housing. The homeless team told Ms Hampson that this housing was only temporary, and that they had made a referral to CURO, a supported accommodation service for those with mental health issues. (CURO completed an assessment with Ms Hampson a few days later and she was due to move into one of their properties on 20 December.)

26. On 7 December, the mental health community care worker, rang the COM and they agreed for her to attend Ms Hampson's next probation appointment.

27. On 13 December, Ms Hampson attended her second probation appointment with the COM and the mental health community care worker. Ms Hampson said she felt unsafe, was having suicidal thoughts, and needed extra support. The mental health community care worker, agreed to see Ms Hampson in a few days' time. She considered that as there was no indication that Ms Hampson was going to end her life imminently and that she had appropriate support in place, she did not need to call the emergency services or the crisis team (a specialist mental health team who treat those who need urgent mental health care).

Circumstances of Ms Hampson's death

28. On 20 December, local builders found Ms Hampson hanged in the bedroom of her temporary accommodation. The builders had entered the property as they thought it was empty, as Ms Hampson had been due to move out that day. The builders called for an ambulance and paramedics confirmed Ms Hampson's death at 12.39pm.

Post-mortem report

29. The post-mortem report concluded that Ms Hampson died of hanging.

Findings

Pre-release planning

30. We are satisfied that the mental health team at Eastwood Park liaised with Ms Hampson's community mental health worker ahead of Ms Hampson's release from prison and ensured that she had mental health support in place for when she was released into the community.

31. We found that Ms Hampson's COM planned appropriately for her release. She submitted a referral to the women's CRS service, made multiple applications to housing agencies and ensured support was in place to manage her mental health issues. The COM kept in regular contact with both Ms Hampson and her community mental health worker to monitor and manage the ongoing risk of harm Ms Hampson posed to herself.

Sharing of information about Ms Hampson's risk of suicide and self-harm

32. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), says that when a prisoner has been supported by ACCT within 12 months of release, relevant information about their risk from their most recent ACCT should be shared with community probation staff. It specifies the ACCT documentation that should be shared.

33. We found that ACCT documentation was not shared with Ms Hampson's COM. We acknowledge that the COM was aware of Ms Hampson's risk of suicide and self-harm and had the information she needed to manage it. Nevertheless, the policy guidance was not followed in this case as specified ACCT documents were not shared. We recommend:

    The Governor at Eastwood Park should ensure, in line with the Annex to PSI 64/2011, that when a prisoner has been subject to ACCT monitoring within 12 months of release, staff share relevant risk information with probation colleagues, including the community offender manager, prior to release.

Clinical care

34. The clinical reviewer concluded that the clinical care Ms Hampson received at Eastwood Park was of a good standard and was at least equivalent to that which she could have expected to receive in the community. He found that the prison's mental health services had meaningful and impactful engagement with Ms Hampson and gave them credit for keeping Ms Hampson safe while she was in the custody of Eastwood Park, given the lack of self-harm attempts while she was there.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **June 2023**

Inquest

At the inquest held on 10 November 2023, the coroner concluded that Ms Hampson died after placing a ligature around her neck. Her intention is unknown.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100