Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Hodgson, a prisoner at HMP Full Sutton, on 3 February 2023

A report by the Prisons and Probation Ombudsman

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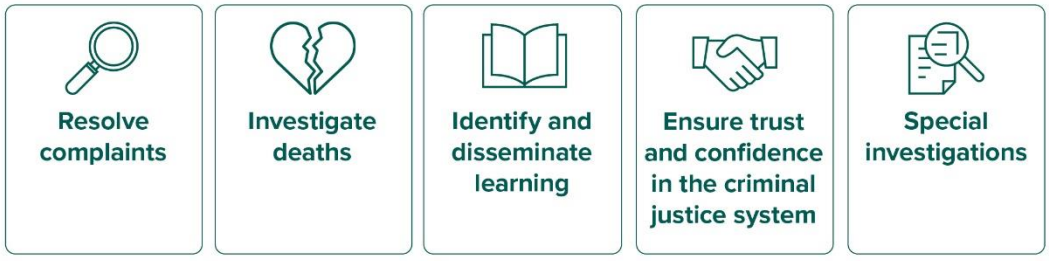
OUR VISION

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

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.

If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Stephen Hodgson was found hanged in his cell on 3 February 2023 at HMP Full Sutton. He was 26 years old. I offer my condolences to Mr Hodgson's family and friends.

Mr Hodgson was a challenging prisoner for staff to manage. He was located in the segregation unit during his time at Full Sutton. His behaviour was poor and despite the best efforts of staff, he refused to return to a standard wing. Mr Hodgson's frequent incidents of self-harm meant that staff monitored him under Prison Service suicide and self-harm prevention measures (known as ACCT) for the majority of his time at Full Sutton. My investigation found that staff provided good support to 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.

Adrian Usher
Prisons and Probation Ombudsman **March 2024**

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Summary

Events

1. In May 2020, Mr Stephen Hodgson was convicted of attempted rape and sentenced to eight years in prison. In August 2021, he was sentenced to life in prison for wounding another prisoner at HMP Wymott.

2. Mr Hodgson was difficult to manage in prison and he was moved from the segregation unit at HMP Wakefield to the segregation unit at HMP Full Sutton on 23 September 2022. He was managed under Prison Service suicide and self-harm prevention measures (known as ACCT) on 28 occasions before he arrived at Full Sutton.

3. Mr Hodgson had a history of poor mental health and personality disorders. Mental health nurses saw him daily in the segregation unit and a GP at the prison prescribed Mr Hodgson anti-psychotic and antidepressant medication.

4. Mr Hodgson refused to move to a standard wing for vulnerable prisoners and on 11 October, staff made a referral to the STEP unit (which aims to break the cycle of long-term segregation and prepare prisoners to re-enter mainstream location). Staff held fortnightly segregation review boards and created a care plan to support Mr Hodgson's progression out of the segregation unit.

5. Staff managed Mr Hodgson under ACCT procedures for most of his time at Full Sutton. Mr Hodgson said that he would continue to self-harm until he was moved to a prison outside of the long-term high security estate (LTHSE). Mr Hodgson used threatening and abusive language and behaviour towards staff regularly.

6. On 23 December, staff from the STEP unit decided that Mr Hodgson's poor behaviour meant that he was unsuitable for the unit and would need to demonstrate a period of stability.

7. Mr Hodgson's behaviour continued to decline and on 2 February 2023, he assaulted an officer. Staff decided that a minimum of four officers in personal protective equipment (PPE) should be present when staff unlocked Mr Hodgson's cell.

8. At 3.45pm on 3 February, a Supervising Officer (SO) went to Mr Hodgson's cell, but could not see him because he had covered his observation panel. The SO removed the inundation point (a fire safety measure to allow a hose into a cell) and saw Mr Hodgson hanging from a light fitting. He immediately radioed a medical emergency code and authorised staff to enter the cell without PPE in an attempt to preserve Mr Hodgson's life. Staff started cardio-pulmonary resuscitation (CPR). Paramedics arrived at 4.11pm, and at 4.51pm they confirmed that Mr Hodgson had died.

Findings

9. Mr Hodgson was considered to be at risk of self-harm but there were no particular indications that his risk of suicide had increased in the days before his death. The ACCT procedures provided good support to Mr Hodgson. Case reviews were multi-

disciplinary and care map actions reflected his concerns about his pathway out of the LTHSE, his medication and mental health needs.

10. Segregation is known to negatively impact a prisoner's mental state and can increase the risk of suicide or self-harm. Mr Hodgson was located in the segregation unit at Full Sutton because his poor custodial behaviour meant he was unsuitable for the STEP unit and he refused to move to a wing for vulnerable prisoners. His behaviour meant that he could not easily be transferred to another prison, and certainly not one outside the LTHSE.

11. The investigation found that Mr Hodgson being held in segregation did not appear to negatively impact on his mental state or level of risk. On the evidence available, we consider that it was appropriate to locate Mr Hodgson in the segregation unit.

12. The clinical reviewer concluded that Mr Hodgson's mental health care was equivalent to what he could have expected to receive in the community. Mental health nurses attended ACCT reviews and implemented a mental health care plan to support Mr Hodgson's move from the segregation unit.

The Investigation Process

13. On 3 February 2023, HMPPS informed us of Mr Hodgson's death. The investigator issued notices to staff and prisoners at HMP Full Sutton informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

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

15. NHS England commissioned a clinical reviewer to review Mr Hodgson's clinical care at the prison.

16. The investigator interviewed eleven members of staff at Full Sutton between April and June 2023. She and the clinical reviewer jointly interviewed healthcare staff.

17. We informed HM Coroner for Hull and the East Riding of Yorkshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. We wrote to Mr Hodgson's uncle to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Hodgson's uncle did not have any questions but asked for a copy of the report.

19. Mr Hodgson's uncle received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Full Sutton

21. HMP Full Sutton is a high security prison that holds up to 626 adult men. Spectrum Community Health CIC provides health services, and healthcare staff are on duty 24 hours a day.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Full Sutton was in February and March 2020. Inspectors reported that the number of self-harm incidents had increased over recent years, but was now declining. Prisoners subject to ACCT procedures for those at risk of suicide or self-harm received good support, including oversight from the weekly safety intervention meeting.

Independent Monitoring Board

23. 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 December 2022, the IMB reported that staff maintained safety in the prison and there was no increased risk of men self-harming during the year.

Previous deaths at HMP Full Sutton

Mr was the seventh prisoner to die at Full Sutton since February 2020. Of the previous deaths, five were from natural causes and one was self-inflicted. There are no significant similarities with our findings in the investigation into Mr Hodgson's death and the findings of the previous deaths at Full Sutton.

Assessment, Care in Custody and Teamwork

24. 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. 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.

The STEP unit

25. The STEP unit is a small unit at Full Sutton with a capacity of ten prisoners, opened in 2019, as part of the long-term and high security estate's (LTHSE) pathways to progression programme. It aims to break the cycle of long-term segregation and prepare prisoners to re-enter mainstream location through a high level of purposeful activity and other psychology-informed services. The STEP unit offers a mixed regime for both general and vulnerable prisoners.

Care Programme Approach

26. The Care Programme Approach (CPA) is an NHS system of delivering community mental health services to individuals diagnosed with a severe mental illness or other vulnerabilities such as a history of violence or self-harm. Someone who needs CPA support should have a formal written plan that outlines any risks and a CPA care coordinator to organise and review the plan.

Key Events

27. On 19 May 2020, Mr Stephen Hodgson was convicted of attempted rape and sentenced to eight years in prison. On 25 August 2021, he was sentenced to life in prison for wounding another prisoner at HMP Wymott. Mr Hodgson had been in prison before.

28. Mr Hodgson had a poor custodial history and assaulted both staff and prisoners. He spent a brief period in The Westgate Unit (for prisoners with complex psychological needs) at HMP Frankland but was removed after he had flooded his cell and threatened staff.

29. On 25 November 2021, Mr Hodgson transferred to HMP Wakefield. After an initial period on the reverse cohort unit (a process for the temporary separation of newly received prisoners for 14 days to confirm that there is no risk of COVID-19 infection) Mr Hodgson refused to move to a standard wing. Prison staff moved him to the segregation unit on 8 December after he had damaged his cell and threatened violence towards staff. Mr Hodgson's poor custodial behaviour meant that he was unsuitable for a move to the STEP unit at Wakefield. After he assaulted staff and concealed a weapon in his cell, prison managers authorised Mr Hodgson's transfer to the segregation unit at HMP Full Sutton.

30. Before he moved to Full Sutton, Mr Hodgson was managed under Prison Service suicide and self-harm prevention measures (known as ACCT) on 28 occasions after making cuts (sometimes recorded as superficial and sometimes requiring hospital treatment), expressing suicidal thoughts and reporting suicide attempts.

HMP Full Sutton

31. On 23 September, Mr Hodgson arrived at Full Sutton. Staff took him straight to the segregation unit and he did not go through the normal reception procedures. An officer completed Mr Hodgson's first night interview and noted his history of suicide attempts, self-harm and mental health issues. The officer assessed Mr Hodgson as a high risk to staff and other prisoners due to his custodial history. They also referred him to the Safety Intervention Meeting. (SIM - a weekly multi-disciplinary meeting to discuss prisoners who are at risk). Staff allocated Mr Hodgson a keyworker who saw him regularly in the segregation unit.

32. A nurse completed Mr Hodgson's initial health screen and noted that he was calm, in a good mood and communicated well with staff. He raised no medical concerns and denied any thoughts of suicide and self-harm. The nurse noted that Mr Hodgson had a dissocial personality disorder (a mental health condition where a person shows no regard for right and wrong and ignores the rights and feelings of others), an emotionally unstable personality disorder (a mental health condition that affects how a person thinks, feels and interacts with others) and depression. No diagnosis dates were recorded in Mr Hodgson's clinical record. His current medication was recorded as quetiapine, used to treat symptoms of a personality disorder and sertraline, an antidepressant.

33. The Head of Residence and Catering held an initial segregation review board and authorised Mr Hodgson's segregation under Prison Rule 45, in order to maintain

good order and discipline. A mental health nurse completed the segregation safety algorithm and indicated that there were no medical reasons why Mr Hodgson could not be segregated. (Segregation can increase the risk of suicide or self-harm because it isolates the prisoner and reduces their access to the normal regime and can have a negative impact on their mental health. As a result, a nurse must complete a safety algorithm to indicate if there are any medical reasons why an individual should not be segregated, a supervising manager will then countersign it.)

34. Prison staff notified the Independent Monitoring Board (IMB) that Mr Hodgson was being held in segregation and records show that an IMB member attended the segregation review boards.

35. On 27 September, the Head of Reducing Reoffending held a segregation review board. He told Mr Hodgson that he would remain segregated for a period of assessment to determine his suitability for the STEP unit. Mr Hodgson was compliant with the segregation regime and did not have any concerns. He told staff that he would refuse to be located on a standard wing. Staff gave Mr Hodgson a diary to help him express his feelings. The Head reviewed Mr Hodgson's custodial history and security information report and noted that he was suitable to move to a standard wing for vulnerable prisoners (due to the nature of his original offence). He set Mr Hodgson six segregation care plan targets to enable him to demonstrate a willingness and ability to change his behaviour and to support his progression from the segregation unit.

36. That day, the mental health team meeting referred Mr Hodgson to the psychiatrist and added him to a mental health nurse's caseload. The mental health team managed Mr Hodgson under the NHS Care Programme Approach (CPA - used to coordinate the care of patients with complex mental health disorders).

37. On 30 September, the Deputy Director of Custody (DDC) for the LTHSE reviewed Mr Hodgson's continuing segregation. The DDC recommended that the mental health team implement an appropriate care plan and prison staff identify a progressive pathway to support Mr Hodgson's move to an alternative location, and segregation review boards should continue to set Mr Hodgson behavioural targets. The DDC continued to authorise Mr Hodgson's segregation every 42 days at Full Sutton. Staff provided Mr Hodgson with a copy of his care plan and behavioural targets.

38. Staff completed a One Page Plan with Mr Hodgson to identify why he was in the segregation unit, his risks and problem behaviours and to support his progression. Staff provided Mr Hodgson with distraction material to help him occupy his time.

39. A mental health nurse assessed Mr Hodgson on 2 and 5 October. Mr Hodgson was compliant with his prescribed medication and had no thoughts of suicide and self-harm. He had no concerns with the segregation unit regime.

40. On 4 October, an officer from the STEP unit spoke to Mr Hodgson about a referral. He explained that the unit would provide him with the opportunity to progress in a supportive environment. Mr Hodgson said he was unsure if the unit was his best option, but he would not relocate to a standard wing. A further discussion took place on 10 October. Mr Hodgson said that he was easily triggered by a change in his

circumstances and he was worried about coping in the unit. Staff reassured Mr Hodgson that he would receive support.

41. On 7 October, a nurse saw Mr Hodgson. Mr Hodgson agreed to engage with the mental health team and said that he found keeping a mood diary helpful. He struggled to cope most in the evening and during the night. The pharmacist agreed to change the time of Mr Hodgson's medication to the evening.

42. The duty prison manager saw Mr Hodgson daily in the segregation unit. The Head of Segregation held a segregation review board on 11 October and noted that Mr Hodgson was now willing to give the STEP unit a chance, but he would not move to a standard wing. Staff made a referral to the STEP unit.

43. On 12 October, prison staff started ACCT monitoring after Mr Hodgson smashed his cell observation panel and made cuts to his right arm and bicep. Mr Hodgson told a multidisciplinary ACCT case review that he was frustrated about being in a prison that was part of the long-term high security estate (LTHSE). He was also having difficulty sleeping. He denied any further thoughts of suicide and self-harm. Prison staff added two actions to Mr Hodgson's caremap (designed to identify the main areas of concern and the actions required to reduce risk), which included that he should see the GP to discuss his medication and speak to his prison offender manager (POM) about his sentence plan targets. Prison staff assessed Mr Hodgson's risk of suicide and self-harm as low and decided he should be monitored once an hour. A prison manager completed the defensible decision document which said that Mr Hodgson should remain segregated during ACCT monitoring. Records show that this was completed again on each occasion Mr Hodgson was subject to ACCT monitoring in the segregation unit.

44. During an ACCT case review on 13 October, Mr Hodgson said that he wanted to make a fresh start at Full Sutton and had no thoughts of suicide and self-harm. A GP at the prison had amended his anti-psychotic medication to help him sleep, and staff had sent an email to his POM to arrange a meeting. Mr Hodgson declined the opportunity to attend a psychology drop-in session. Staff agreed to stop ACCT monitoring. Mr Hodgson's risk was assessed as low and the actions on his caremap were complete. The post-closure phase would end on 20 October.

45. On 15 October, prison staff started ACCT monitoring again after Mr Hodgson made superficial cuts to his arm with a plastic knife that he was issued with to eat his meals. Mr Hodgson said that he was frustrated about his lack of progression in the prison and felt that his anti-psychotic medication had impacted negatively on his sleep. Prison staff decided that Mr Hodgson should be monitored once every hour and added one additional action to his caremap which said that he should engage with the psychiatrist.

46. On 20 October, a community consultant forensic psychiatrist saw Mr Hodgson. Also present was a trainee psychiatrist and a nurse. Mr Hodgson said he coped with the rapid fluctuations in his thoughts through violence and deliberate self-harm. The psychiatrist noted that Mr Hodgson demonstrated a level of insight into his personality dysfunction and wanted to address his response to traumatic events. He amended Mr Hodgson's anti-psychotic medication to once a day in the early evening and said this should improve his sleep.

47. On 25 October, staff held a multi-disciplinary ACCT case review. Mr Hodgson said that his medication issues were resolved and that he felt better. As his behaviour had improved, staff agreed that he could meet with his POM in person. Staff agreed to stop ACCT monitoring and noted that the post-closure phase would end on 1 November. Later, staff held a segregation review board and approved Mr Hodgson's segregation for a further fourteen days.

48. Mr Hodgson met with his POM on 27 October. She noted that Mr Hodgson presented a very serious risk of harm to prisoners due to his violent offending. Prison records indicated that he would struggle to cope on a standard wing and his behaviour was often aggressive and disruptive. Mr Hodgson said he wanted a transfer to HMP Dovegate. Mr Hodgson's POM explained that he would need to demonstrate a reduction in his risk before he would be considered for a move outside of the LTHSE and she encouraged him to engage with prison staff on the STEP unit. His POM did not recommend a transfer to a prison out of the LTHSE and noted that Mr Hodgson's current location in the segregation unit meant he did not meet HMP Dovegate's eligibility criteria.

49. On 31 October, Mr Hodgson became verbally and physically abusive towards staff and self-harmed by making a superficial cut to his arm. Staff started ACCT monitoring again. During an ACCT case review, staff told Mr Hodgson that a place was available for him on a standard wing for vulnerable prisoners. Mr Hodgson refused to leave the segregation unit and said he would only move to Dovegate. Staff noted that Mr Hodgson's ACCT reviews would take place on the same day as the segregation review boards to ensure prison staff considered the impact of segregation on Mr Hodgson's risk of suicide and self-harm.

50. On 4 November, the Head of Healthcare saw Mr Hodgson to discuss his referral to the STEP unit. She explained that Mr Hodgson would need to demonstrate a reduction in his self-harm and an improvement in his behaviour before he could be eligible.

51. On 8 November, Mr Hodgson attended an ACCT case review before his segregation review board. Staff noted that Mr Hodgson's behaviour had improved. He told staff that he had changed his mind about going to the STEP unit and wanted a move to a prison outside of the LTHSE. As Mr Hodgson did not have any thoughts of suicide and self-harm, staff agreed to stop ACCT monitoring. At his segregation review board, Mr Hodgson said there was no reason for him to be at Full Sutton and he would continue to refuse to leave the segregation unit.

52. That day, Mr Hodgson met with his POM. She noted that Mr Hodgson used violent and reckless behaviour as an attempt to manipulate staff.

53. On 12 November during the post-closure review period, Mr Hodgson self-harmed again and staff restarted ACCT monitoring. He told staff that he would continue to self-harm unless they transferred him to another prison.

54. On 17 November, a Supervising Officer (SO) told Mr Hodgson that STEP unit staff would discuss his referral at a multi-disciplinary team meeting (MDT) and if successful, he would be allocated a place when one became available. That day, Mr Hodgson told the trainee psychiatrist that he had superficially self-harmed but

had no intention to attempt suicide. Mr Hodgson appeared settled and did not display any symptoms of psychosis.

55. During an ACCT case review on 28 November, staff agreed to stop ACCT monitoring. Mr Hodgson was settled and did not express any thoughts of suicide and self-harm. The post-closure period would end on 6 December. Records show that Mr Hodgson self-harmed during the post-closure period. Staff decided that due to his pattern of self-harm, they would monitor him under ACCT procedures for the remainder of his time at Full Sutton for extra support.

56. Mental health nurses saw Mr Hodgson every day and attended ACCT case reviews and segregation review boards. Staff noted that Mr Hodgson attempted to manipulate staff regularly by threatening to self-harm.

57. Staff reported incidents where Mr Hodgson's behaviour had been threatening and abusive towards staff. On 7 December, he had threatened to rape a female officer, damaged the smoke detector in his cell and attempted the throw pieces of toilet paper he had set on fire through his observation panel.

58. On 14 December, the STEP unit declined Mr Hodgson's referral due to concerns about his behaviour. An MDT decided that Mr Hodgson's behaviour could not be managed safely on the STEP unit and he would have a negative impact on the other prisoners and their progression. The MDT said that following a period of stability, a potential onward pathway for Mr Hodgson could include an assessment for a personality disorder service or an assessment for a therapeutic community. The MDT noted that Mr Hodgson had not completed any work to explore his offending behaviour.

59. On 21 December, a pharmacy technician noted that Mr Hodgson was concealing his anti-psychotic medication in his mouth. Mr Hodgson said that he did not want to take his medication and became verbally abusive toward staff. As a result, the psychiatrist discontinued Mr Hodgson's anti-psychotic medication for one week.

60. On 24 December, a SO told Mr Hodgson that his referral for the STEP unit was unsuccessful. He advised Mr Hodgson that the unit would accept another referral after a period of three months if his behaviour improved.

61. The psychiatrist saw Mr Hodgson on 29 December. He noted that Mr Hodgson's mood had deteriorated since he had stopped taking the anti-psychotic medication. Mr Hodgson agreed to restart his anti-psychotic medication and the psychiatrist prescribed a single daily dose to be given at 4.00pm, with a further review in six weeks.

62. Mr Hodgson's behaviour continued to decline and staff reported that he was uncooperative and had made threatening and sexually abusive comments. Mr Hodgson continued to refuse to move to a standard wing and told staff that he intended to remain in the segregation unit until staff transferred him to a prison outside of the LTHSE.

63. Staff continued with ACCT monitoring and held multidisciplinary ACCT case reviews and segregation review boards. Mental health staff saw Mr Hodgson every day and he saw a GP in the prison once a week.

64. On 18 January, Mr Hodgson asked to speak to a prison listener (prisoner volunteers trained by Samaritans to listen to prisoners who are in distress). Staff arranged for a listener to speak to Mr Hodgson in the segregation unit. The next day, Mr Hodgson told a SO that he wanted a move to C wing (a standard wing for vulnerable prisoners). Due to his long period of segregation, staff arranged for Mr Hodgson to spend a period of association on C wing to help him adjust to a new environment. Staff arranged for a peer mentor and a listener to meet Mr Hodgson on the wing. Mr Hodgson spent the evening association period on C wing and staff noted that he had interacted well with other prisoners and he did not have any concerns.

65. On 20 January, the Head of Segregation spoke to Mr Hodgson about his move to C wing. Mr Hodgson would spend association periods on the wing and would move there permanently on 23 January. Mr Hodgson told him that he would not move to C wing and intended to remain in the segregation unit.

66. Over the next few days, staff reported that Mr Hodgson was misusing his cell bell and was verbally abusive towards staff and other prisoners. During a keyworker session with an officer on 26 January, Mr Hodgson said that he was keen to focus on a pathway out of segregation but wanted to move to a prison out of the LTHSE. The officer encouraged Mr Hodson to move to a standard wing because it would help with a transfer application to a prison outside of the LTHSE.

Events of 2 and 3 February

67. At approximately 3.18pm on 2 February, an officer unlocked Mr Hodgson's cell for dinner and Mr Hodgson headbutted the officer in the face. Mr Hodgson was threatening and abusive towards staff. Staff removed him under restraint to a high control cell (a designated cell for prisoners who pose a high risk of harm to others). The Head of Segregation told segregation staff that they should only unlock Mr Hodgson when four officers in personal protective equipment (PPE) were present. A review would take place on 7 February.

68. At 5.15pm, the Head of Operations saw Mr Hodgson in the segregation unit. Mr Hodgson was confrontational and continued to make derogatory comments towards staff. The Head noted that segregation was the appropriate location for Mr Hodgson and completed the defensible decision document.

69. Staff observed Mr Hodgson every hour during the night and did not report any concerns.

70. At 8.15am, a SO went to Mr Hodgson's cell and saw that he had made superficial cuts to his arms. Mr Hodgson refused to be assessed by a mental health nurse and was shouting abuse.

71. At 9.35am, the SO and three officers went to Mr Hodgson's cell to complete a fabric check in his cell. As Mr Hodgson left his cell, he attempted to assault staff and was threatening and abusive. Staff completed their checks, and a nurse gave Mr Hodgson his medication through the observation panel.

72. At 10.05am on 3 February, a SO held an ACCT case review with another SO and a nurse. Mr Hodgson refused to contribute from his cell. The SO noted that Mr

Hodgson had made superficial cuts to his arms. She decided that staff should continue to observe him once every hour.

73. At 10.30am, the Head of Segregation spoke to Mr Hodgson. Mr Hodgson said that he did not know why he was violent the previous day and wanted a fresh start. He encouraged Mr Hodgson to think about his behaviour. Mr Hodgson accepted his lunch at 1.00pm. Staff observed him in his cell at 1.45pm, 2.18pm, 2.28pm and 3.22pm. Mr Hodgson did not raise any concerns.

74. At 3.45pm, a SO went to Mr Hodgson's cell to ask if he wanted his medication. Mr Hodgson had covered his observation panel and was unresponsive. He removed the inundation point in the cell door and saw Mr Hodgson sitting on the floor with his back to the cell door. He saw that Mr Hodgson had a ligature around his neck. He radioed an emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties). The control room staff called an ambulance immediately.

75. Staff arrived at the cell and agreed with the SO that they should enter Mr Hodgson's cell with caution but without PPE. An officer used her anti-ligature knife to remove the ligature from Mr Hodgson's neck and started CPR. Staff attached a defibrillator to Mr Hodgson and it did not detect a shockable rhythm.

76. A nurse arrived very shortly after and assisted with emergency lifesaving support. Paramedics arrived at 4.11pm. At 4.51pm, the paramedics confirmed that Mr Hodgson had died.

Contact with Mr Hodgson's family

77. The prison appointed the safer custody manager as family liaison officer. Due to the location of Mr Hodgson's mother's address, the prison asked family liaison officers (FLOs) from HMP Haverigg to break the news of his death.

78. At 11.00am, the FLOs from Haverigg visited the address recorded on Mr Hodgson's prison record and they were informed that Mr Hodgson's mother had moved. The police provided an alternative address and at 2.15pm, the FLOs told Mr Hodgson's mother that he had died.

79. The prison contributed towards the cost of Mr Hodgson's funeral in line with national policy.

Support for prisoners and staff

80. After Mr Hodgson's death, the Head of Offender Management 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.

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

82. The Samaritans attended the prison and met with the listeners who had provided support to Mr Hodgson. They also attended the segregation unit and spoke with both prisoners and staff.

Post-mortem report

83. The pathologist gave Mr Hodgson's cause of death as hanging. The toxicology report did not detect any illicit substances in Mr Hodgson's blood.

Findings

Assessment of Mr Hodgson's risk of suicide and self-harm

84. Mr Hodgson was a challenging prisoner who had assaulted both staff and prisoners. He used threatening and abusive language, particularly towards female officers regularly. Mr Hodgson was frequently managed under ACCT suicide and self-harm prevention procedures before he was transferred to Full Sutton, and his pattern of self-harm continued despite his new location.

85. Prison Service Instruction (PSI) 64/2011 on safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. Mr Hodgson had several of these risks including previous self-harm, poor mental health including the diagnosis of a serious mental illness and recent contact with psychiatric services.

86. When Mr Hodgson self-harmed on 3 February, the day of his death, staff continued to monitor him regularly. Mr Hodgson told a prison manager that he wanted a fresh start and there was no indication that his risk of suicide had increased or that he was in crisis.

87. We consider that the ACCT procedures provided good support to Mr Hodgson. Staff held regular and supportive multi-disciplinary case reviews which appropriately assessed his risk. They added actions to Mr Hodgson's caremap which reflected his concerns about his pathway out of the LTHSE, his medication and his mental health needs.

Location in the Segregation Unit

88. PSO 1700 Segregation, acknowledges the specific risks of holding vulnerable prisoners in segregation. It notes that rates of suicide among segregated prisoners are high, and that segregation should only be used as a last resort. Prisoners monitored under ACCT procedures can be segregated but only when they are such a risk to others that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate. We have considered whether, in the circumstances, it was appropriate to hold Mr Hodgson in the segregation unit when he was on an ACCT.

89. Mr Hodgson had spent time in the segregation unit at Wakefield before he transferred to the segregation unit at Full Sutton. Mr Hodgson remained in the segregation unit at Full Sutton for just over four months. His behaviour was clearly challenging for staff to manage and he assaulted an officer shortly before he died. His poor behaviour meant he was unsuitable for the STEP unit and despite the best efforts of staff, he refused to move to a standard wing for vulnerable prisoners. Staff held regular segregation review boards and sought support from the DDC who advised on the appropriate actions to assist with Mr Hodgson's progression. Staff reviewed the action plan at least every two weeks.

90. Mr Hodgson repeatedly told staff he should not be in a high security prison and that he intended to remain in the segregation unit until he was moved to another prison.

Staff regularly explained to Mr Hodgson that he would need to show an improvement in his behaviour before he could move to a lower security prison.

91. We consider that staff continuously reviewed whether it was appropriate to keep Mr Hodgson segregated, actively explored other reasonable options and persisted in encouraging Mr Hodgson to consider realistic pathways out of segregation. On the evidence available, it does not seem that being segregated, in itself, increased Mr Hodgson's risk of suicide. It is difficult to see how Full Sutton could have managed this differently.

Mental health

92. The clinical reviewer concluded that Mr Hodgson's mental healthcare was equivalent to what he could have expected to receive in the community.

93. Healthcare staff referred Mr Hodgson to the mental health team when he arrived at Full Sutton on 23 September and he received good mental health support from staff using the Care Plan Approach. Mental health nurses attended ACCT case reviews and a psychiatrist reviewed him regularly. Mental health nurses implemented an appropriate mental health care plan to support Mr Hodgson's move from the segregation unit.

Good Practice

94. When the SO found that Mr Hodgson had blocked his observation panel and was unresponsive, he quickly removed the inundation point to enable him to see inside Mr Hodgson's cell. He saw that Mr Hodgson had ligatured.

95. Mr Hodgson's violent behaviour towards staff meant that they would not unlock his cell without the presence of at least four staff who were wearing PPE. The SO made a rapid dynamic risk assessment and concluded that the preservation of Mr Hodgson's life should take precedence over normal unlock procedures.

96. We consider that the decision of the SO to authorise the emergency response officers to enter Mr Hodgson's cell with caution but without PPE, to be good practice. This ensured that staff were able to start CPR quickly.

Inquest

97. At the inquest, which took concluded on 10 February 2025, the Coroner concluded that Mr Hodgson died by suicide.

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