Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wayne Hodgson, on 5 July 2024, following his release from HMYOI Wetherby

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, 2025

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. If my office is to best assist HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic process failures.

4. Mr Wayne Hodgson died of multiple traumatic injuries after a road traffic collision on 5 July 2024, following his release from HMP Wetherby on 3 July. He was 18 years old. We offer our condolences to his friends and family.

5. Toxicology tests identified that Mr Hodgson had taken excessive pregabalin (which he was not prescribed) in the time before his death, which may have impaired his judgement when driving. He had a history of pregabalin misuse and was appropriately referred to substance misuse services in prison. Although he attended an initial care planning meeting, Mr Hodgson often chose not to engage with the substance misuse service at Wetherby.

The Investigation Process

6. We were informed of Mr Hodgson's death on 8 July 2024.

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

8. We informed HM Coroner for Durham of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

9. The Ombudsman's office contacted Mr Hodgson's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

Background Information

HMYOI Wetherby

10. HMYOI Wetherby is a young offender institution (YOI) in Yorkshire, for children and young people aged 15-18.

Probation Service

11. The Probation Service work with all individuals over 18 years of age subject to custodial and community sentences. (Children under 18 are managed by the local Youth Offending Team.) 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.

Key Events

12. On 5 January 2024, Mr Wayne Hodgson was sentenced to a nine-month detention and training order (DTO) for theft. He arrived at HMYOI Wetherby that day. Mr Hodgson had previously spent time in Wetherby for various offences. He had a history of self-harm and was prescribed antipsychotic medication (quetiapine) as well as an antidepressant (sertraline). Mr Hodgson had diagnoses of ADHD, PTSD and schizophrenia. He had previously been assessed by local children and adolescent mental health services (CAMHS), but his referral was closed in June 2023.

13. On arrival at Wetherby, Mr Hodgson told staff that he frequently misused pregabalin (medication usually prescribed for epilepsy but which is commonly misused), which he was not prescribed. He said that he had not used the drug for two days and did not have any withdrawal symptoms.

14. On 11 January, Mr Hodgson completed a Young Persons Drug and Alcohol Support Services (YPDASS) induction and engaged well with his care plan in regard to substance misuse. During his time at Wetherby, Mr Hodgson's engagement with YPDASS was irregular and he chose to miss many sessions.

15. Mr Hodgson's first weeks at Wetherby were mixed and staff made several entries citing poor behaviour. By March, staff recorded that he was more settled and highlighted his progress and positive attitude. In April, his behaviour became more mixed and staff identified threatening or abusive behaviour.

16. In April 2024, Mr Hodgson experienced a deterioration in his mental health. He described hearing voices, which he said was a result of losing the distraction of his television. (Mr Hodgson lost access to in-cell television as a sanction following a fight with another young person.) During this period, he set a cell fire and cut his face, reportedly to distract himself from his distress. A GP at Wetherby increased the dose of quetiapine, which Mr Hodgson said he found very helpful in reducing intrusive thoughts and voices and in helping him settle at night.

17. On 21 June, Mr Hodgson and his mother attended a pre-release planning meeting with his community offender manager (COM) and representatives from Handcrafted (a local housing charity), social services and the Youth Offending Team. They confirmed that Handcrafted would provide supported housing for Mr Hodgson on release and that they would be able to help him with transport to meetings and appointments. Mr Hodgson said that he was happy with these arrangements.

18. On 29 June, staff started suicide and self-harm monitoring procedures (known as ACCT) due to Mr Hodgson setting his cell on fire. Mr Hodgson said that he did this due to frustration and boredom. On 1 July, staff closed the ACCT procedures. Staff noted that Mr Hodgson's behaviour was unpredictable and could change in seconds.

19. On 3 July, Mr Hodgson was released from prison. His quetiapine prescription was continued on release and he was referred to the community mental health team.

20. Following recent road traffic offences, Mr Hodgson's licence conditions included provision that he give his supervising officer the details of any vehicle that he owned, hired or had regular use of.

Post Release

21. On 3 July, Mr Hodgson attended his post-release appointment with his COM. He completed a probation contract agreement. Mr Hodgson highlighted a problem he had had collecting his prescription from a local pharmacy, and she contacted the community mental health team to make alternative arrangements.

Circumstances of Mr Hodgson's death

22. On 5 July, Mr Hodgson was travelling on a motor scooter when he was involved in a collision with a car, having swerved into the path of oncoming traffic.

Post-mortem report

23. The post-mortem examination concluded that Mr Hodgson died as a result of multiple traumatic injuries. The pathologist noted that his injuries were consistent with involvement in a road traffic accident involving his motor scooter and a car.

24. Toxicology showed that Mr Hodgson had taken pregabalin, cocaine and quetiapine in the time before his death. The concentration of pregabalin detected was higher than recreational or therapeutic use and the toxicologist commented that this suggested it was taken in excess. They commented that the effects of excessive pregabalin can include sedation, dizziness, nausea and impaired decision-making skills, all of which can impair driving ability. The concentration of cocaine was consistent with low recreational or non-recent use of the drug.

25. The toxicologist found that the concentration of quetiapine was consistent with therapeutic use and was unlikely to have caused significant intoxication at the level detected.

Findings

26. Mr Hodgson died as a result of a road traffic accident. Although he had previously been monitored under ACCT procedures in prison, and had a history of mental ill-health, there is nothing to indicate that his actions were deliberate.

27. Toxicology tests identified that Mr Hodgson had used excessive pregabalin, which he was not prescribed, in the time before he died. This may have impaired his judgement at the time of his death. When he arrived at Wetherby, Mr Hodgson spoke about a history of pregabalin misuse and was appropriately referred to the local substance misuse support service. He attended an induction and care planning session, but only intermittently engaged afterwards.

28. Mr Hodgson's mother was able to attend a pre-release planning meeting at Wetherby, which is an example of good practice.

29. The inquest into Mr Hodgson's death concluded on 25 October 2024 and returned a verdict of misadventure.

Adrian Usher
Prisons and Probation Ombudsman **July 2025**

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