

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Andrew Bodkin a prisoner at HMP Leeds on 7 November 2017

**A report by the Prisons and Probation Ombudsman**

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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*

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**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.

On 7 November 2017, prison staff discovered Mr Andrew Bodkin hanging in his cell at HMP Leeds. Nursing staff and paramedics attended and attempted to resuscitate him but a prison GP pronounced Mr Bodkin dead. He was 46 years old. I offer my condolences to Mr Bodkin's family and friends.

Mr Bodkin had been recalled to custody from licence for a second time in November 2016. He was awaiting a deferred parole hearing which was likely to be heard in 2018. It is clear that the parole process and his IPP status was a cause of frustration for Mr Bodkin. During this period of custody, prison staff occasionally managed him using suicide and self-harm prevention procedures, and the management of these procedures was of a satisfactory standard.

There was little to indicate that Mr Bodkin was at high or imminent risk of suicide on 7 November. I am satisfied that staff could not have anticipated his death.

We do, though, have concerns about the quality of mental health support Mr Bodkin received.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**July 2018**

## **Contents**

Summary .....	1
The Investigation Process .....	3
Background Information .....	4
Key Events .....	6
Findings.....	15

# Summary

## Events

1. Mr Bodkin was remanded into custody on 14 March 2006 and was taken to HMP Hewell. On 10 November he was found guilty of sexual assault and actual bodily harm (ABH). The judge passed an Imprisonment for Public Protection (IPP) sentence on Mr Bodkin, with a tariff of 3 years 124 days.
2. Mr Bodkin was twice released on the directions of the Parole Board, first in September 2015 and again in November 2016. On both occasions, he breached the conditions of his licence soon after leaving prison and was recalled to custody.
3. Mr Bodkin was placed on suicide and self harm prevention measures (known as ACCT) on 23 March when he told staff at Doncaster that he was going to self-harm. He was transferred to HMP Leeds on 6 April 2017. The ACCT was closed a few days after his transfer.
4. Mr Bodkin had suffered an injury in the community that meant that he was unable to work and spent most of his time on the wing. In general, his behaviour was good, although he could be argumentative and demanding if things were not going his way.
5. A parole review held on 13 June decided that the hearing should be deferred for a psychiatric risk evaluation to be completed. Board members asked Mr Bodkin what he would do if his parole was not granted and he replied: "probably take my own life". Because of his comments, staff opened an ACCT document.
6. The ACCT remained open until 19 June, following reviews which were attended by staff from the mental health team. Despite his denial that he had any thoughts or intent to self-harm, staff considered the comments made by Mr Bodkin at the parole hearing a potential trigger, and monitored any future dates for his rescheduled hearing. Mr Bodkin did not mention self-harm after this, and was not subject to any further ACCT monitoring.
7. On 7 November, Mr Bodkin had spent the morning unlocked from his cell, interacting with other prisoners on the wing. During the morning he used the telephone and raised no concerns with staff. During the afternoon he was locked in his cell, apart from being briefly unlocked to use the telephone again. He became agitated during the afternoon, was verbally aggressive and suggested to staff that he might use a weapon when he was unlocked.
8. At approximately 4.30pm, an officer who went to check on Mr Bodkin banged on the door and shouted but got no response. He entered the cell and saw a ligature around Mr Bodkin's neck.
9. A medical emergency was called via the radio and prison staff and healthcare staff attended. An ambulance was called. A prison GP also attended to assist with resuscitation. Mr Bodkin did not respond to treatment, and the GP pronounced Mr Bodkin dead at 4.56pm.

## Findings

10. We reviewed the clinical care provided to Mr Bodkin while in custody at Leeds. Mr Bodkin was involved with mental health services over the 11 years he had been in prison. He had complained of depression and anxiety in the past and been prescribed medication. The clinical reviewer considers that the care provided was of a mixed standard. The physical healthcare provided was at least equivalent to that which Mr Bodkin could expect in the wider community. However, the mental health care provided was not equivalent to that which Mr Bodkin could expect to have received in the community.
11. It is clear that Mr Bodkin found the parole process a source of frustration. As someone under the provisions of an IPP sentence this frustration was compounded by the lack of progress. We are, though, satisfied that the prison appropriately considered the implications of the IPP process for Mr Bodkin's risk and we agree that the ACCT process was used appropriately.
12. There was, in the circumstances, little to indicate that Mr Bodkin was at high or imminent risk of suicide on 7 November, and we are satisfied that staff could not have predicted or prevented his death.

## Recommendations

- The Head of Healthcare should review the use of clinical assessment tools used within mental health services and ensure that all relevant staff are trained in the use and interpretation of the tools to ensure that prisoners are offered appropriate treatment from a suitably qualified member of staff.

## The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact him. No responses were received.
14. HMP Leeds provided copies of relevant extracts from Mr Bodkin's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr Bodkin's clinical care at the prison.
16. The investigator and clinical reviewer interviewed members of prison and healthcare staff at Leeds.
17. We informed HM Coroner for Wakefield of the investigation. The Coroner provided the post-mortem results, which give the cause of death as hanging. Toxicology indicated that no illicit substances were present in Mr Bodkin's system.
18. One of our family liaison officers contacted Mr Bodkin's mother and father to explain the investigation. Mr Bodkin's parents had no significant questions but asked what stage their son had reached in his parole process. The family received a copy of the draft report, but have not responded to our findings.

## Background Information

### HMP Leeds

19. HMP Leeds is a local prison holding up to 1,120 men. In April 2016, Care UK took over primary and mental health care.

### HM Inspectorate of Prisons

20. The most recent published inspection of HMP Leeds was conducted in November 2017. In that report, inspectors commented that there had been 367 incidents of self-harm in the previous six months which was higher than at similar establishments. There had also been an increase to 61 incidents a month, compared to 41 at the last inspection. There had been four self-inflicted deaths since the previous inspection and a fifth occurred during the inspection.

### Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent report, for the year to December 2016, published in June 2017, the IMB had concerns about mental health services being unable to cope with demand. It commented on the safer custody of prisoners, and that the use of drugs was unacceptably high and associated with sustained levels of violence and self-harm.

### Previous deaths at HMP Leeds

22. Mr Bodkin's death was the first apparently self-inflicted death at Leeds since June 2016, and another prisoner has apparently taken his own life at the prison since then. In previous investigations published in 2014, 2015 and 2016, we have raised concerns about staff at Leeds properly assessing risk, and the management of ACCT procedures.

### Assessment, Care in Custody and Teamwork (ACCT)

23. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system 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 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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions on the caremap have been completed.
24. 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, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

## **Imprisonment for Public Protection (IPP)**

25. The IPP sentence was introduced in 2005 and abolished in 2012 but those sentenced under it prior to that date continue to be managed under its original terms. The IPP was intended to provide protection for the public from those whose offences were not deemed serious enough to merit a normal life sentence, but were considered too dangerous to be released when their original sentence had expired.
26. The sentence comprises a punitive tariff intended to be proportionate to the crime committed and an indeterminate period, which commences after the tariff has been reached. This part of the sentence will last until such time as the Parole Board judges that a prisoner no longer poses a risk to the public. There is no time limit on how long a prisoner can be detained under an IPP, and some prisoners may never be released. Those that are released will be subject to a life licence and can be returned to custody at any time, if their risk to the public is considered to have increased.

## Key Events

### Initial custody and licence recalls

27. Mr Bodkin was remanded into custody on 14 March 2006 and was taken to HMP Hewell. He appeared at Crown Court on 10 November, where he was found guilty of sexual assault and actual bodily harm (ABH). The judge passed an Imprisonment for Public Protection (IPP) sentence on Mr Bodkin, with a tariff of 3 years 124 days.
28. Mr Bodkin remained in custody, undertaking various offending behaviour courses, until he was released on the direction of the Parole Board on 1 September 2015. On his release, Mr Bodkin lived at approved premises, where it was reported that he initially complied well with the conditions of his licence. However, on 13 November 2015, the Probation Service recalled Mr Bodkin to custody after it was claimed he had threatened staff. Mr Bodkin denied that he had made threats, and blamed his offender manager and staff at the premises.
29. He was returned to custody, where he remained until 7 November 2016. Following a review by the Parole Board, his release was directed for a second time. Prior to this release, prison staff had raised concerns that Mr Bodkin might be involved in illicit drug use, although he always denied this and always tested negative when providing urine samples. Staff at the prison shared these concerns with staff at the approved premises and, when Mr Bodkin arrived there, staff told him that he would be frequently drug tested and monitored for drug use. After completing the induction process, Mr Bodkin went into the local town where he later said he had met up with some people he had met while in custody. Mr Bodkin bought some 'Spice' (synthetic cannabinoid) and went back to the approved premises and smoked it in his room. Records indicate that Mr Bodkin had a seizure caused by the 'Spice' and was discovered by premises staff and transferred to hospital by ambulance.
30. He was discharged after treatment in the early hours of 8 November. He did not return directly to the approved premises and instead went into town to get breakfast. He returned to the approved premises later that afternoon, where staff informed him that he was in breach of his curfew. This, along with the use of 'Spice', meant that he would be recalled to custody. Mr Bodkin arrived back into custody at HMP Birmingham on 9 November 2016. When asked about his actions later, Mr Bodkin said that he knew he would be recalled, so thought that he might as well do something to be recalled.
31. Mr Bodkin remained at Birmingham until December 2016, when he was transferred to HMP Doncaster. Staff at Doncaster placed Mr Bodkin under suicide and self-harm (ACCT) procedures on 23 March after he told them that he was fed up with the rules and the prison and was going to self-harm.
32. A transfer to Leeds was planned for 5 April but Mr Bodkin told escort staff that he had taken an overdose of paracetamol and co-codamol. Leeds refused to accept Mr Bodkin. He was returned to Doncaster via a hospital, although he did not require any treatment.

## HMP Leeds

33. Mr Bodkin was transferred to HMP Leeds on 6 April 2017. A multi-disciplinary ACCT review was completed at Doncaster prior to his transfer. During the review, Mr Bodkin is recorded as speaking about his alleged overdose and said that he had been angry the previous day but was happy to transfer and had no thoughts or intentions to self-harm.
34. On arrival at Leeds, a nurse saw Mr Bodkin and completed a health assessment. The nurse noted that Mr Bodkin had fallen from scaffolding in 1999. He self-catheterised and had replacement catheters in possession. He was also in receipt of anti-depressant medication. The nurse recorded no other physical health concerns about Mr Bodkin and referred him for review of his medication by the GP. He also made a referral to the mental health team, due to the open ACCT.
35. On 7 April, an ACCT review was carried out with Mr Bodkin, chaired by a Custodial Manager (CM) and attended by a mental health nurse. Mr Bodkin said that he had been unhappy at his transfer as he wished to be moved further south and would still like this opportunity. The CM recorded that Mr Bodkin said that he accepted that he could be difficult if he did not get his own way, but that he had plans for the future and had a positive outlook.
36. The mental health nurse recorded that Mr Bodkin presented as hopeless, which she reflected back to him, and also that his notes suggested that he could become agitated quickly. However, Mr Bodkin denied any thoughts of further self-harm and stated that this was the first time he had ever been subject to ACCT procedures. The CM recorded on the ACCT review that the document was rather chaotic and the documentation was not up to date from Doncaster. She updated it as far as she could. She recorded that, as Mr Bodkin was unknown to staff at Leeds, the ACCT would be kept open, even though he expressed no intentions of self-harm. She recorded that this would give staff a chance to assess him and get to know his behaviour better over the weekend. A further review was scheduled for 12 April.
37. The ACCT review on 12 April was chaired by a CM and attended by a mental health nurse. During the review, Mr Bodkin said that he was happy to have left Doncaster but would have preferred to be closer to home. He said that he was awaiting a review by the Parole Board and wanted to keep himself busy. He denied any thoughts or intent to self-harm.
38. The mental health nurse recorded that Mr Bodkin spoke about his frustrations while at Doncaster as he felt that he was being lied to by staff, had not been given a job on the residential unit and had been 'fed up' with being locked in his cell 22 hours each day. She recorded that Mr Bodkin described feeling fed up in general with prison life and said that the anti-depressants he had been prescribed previously were not working. However, after discussion, she recorded that Mr Bodkin recognised things might improve now he had moved from Doncaster.

39. Mr Bodkin denied any current thoughts or intent to self-harm and said that he would speak with staff should his mood deteriorate. Mr Bodkin spoke about his parole review, which was scheduled to take place in June and his restricted activity due to physical health issues. The decision to close the ACCT document was made jointly between the CM and the mental health nurse.
40. When Mr Bodkin transferred to Leeds, he received a new Offender Supervisor (OS.) Her role was to assist Mr Bodkin in preparing for his parole review, collating reports, release plans and liaison between Mr Bodkin and the Parole Board.
41. The parole review took place on 13 June. The panel consisted of two Parole Board members. Also, present were Mr Bodkin's legal team, his Offender Manager, an independent psychologist (who had been commissioned to complete a psychological risk assessment at Doncaster) and his OS.
42. The panel heard lengthy verbal evidence from Mr Bodkin. They were concerned that the psychological assessment did not include an assessment of Mr Bodkin's personality, and how this related to his offending and considered it essential that a panel considering his release should include a psychologist. Mr Bodkin's hearing was deferred to a new panel. A psychological assessment of Mr Bodkin's personality and how it linked to his violence and future risk was also requested. The Parole Board indicated that the new hearing should not be re-listed before October 2017.
43. During the hearing, the panel asked Mr Bodkin what he would do if he were not granted parole. Mr Bodkin replied: "probably take my own life". Because of this, an ACCT document was opened. On 14 June, the morning after the parole hearing, Mr Bodkin approached his OS while she was on the residential wing. He told her that he was bored of his life and would kill himself at some point, and that in his opinion the ACCT was "pointless and not necessary". She explained to him that the document had been opened because of the comments he had made to the Parole Board about taking his life.
44. The OS said that Mr Bodkin said that he no longer wished to engage in the parole process and would not attend the deferred hearing. Mr Bodkin said that he found the panel members patronising, that they had their facts wrong, and he was not willing to discuss his offence any further. Mr Bodkin told her that he did not trust his Offender Manager, so release was pointless and he was not bothered about staying in prison.
45. On 14 June, a CM completed an ACCT review with Mr Bodkin. The review meeting included a mental health nurse and Mr Bodkin. The CM recorded that Mr Bodkin said that he would eventually take his own life as he was bored, but his parents were his protective factor. During the review, Mr Bodkin asked for the ACCT to be closed. When asked about his parents being a protective factor, Mr Bodkin said that it might be worth hurting them once, rather than hurting them continuously. The CM said that when discussing his feelings, Mr Bodkin was very matter-of-fact.

46. The mental health nurse recorded that Mr Bodkin had no history of mental health issues in the community, but he presented as flat in mood. He recorded that throughout the review, Mr Bodkin was very matter-of-fact in relation to his thoughts of self-harm. He also recorded that he felt that Mr Bodkin's risk was likely to increase if anything happened to his parents.
47. During the review, the CM and mental health nurse told Mr Bodkin about the various avenues of support such as Samaritans and the Chaplaincy, but recorded that Mr Bodkin was reluctant to engage. The mental health nurse recorded that the mental health team would continue to offer support using the ACCT process. The CM and mental health nurse decided that, in view of Mr Bodkin's presentation and responses, the ACCT should remain open. Observations were set at hourly during the day and throughout the night.
48. The ACCT remained open until 19 June when a further case review was chaired by a CM and attended by a mental health nurse and Mr Bodkin. During the review, it was recorded that Mr Bodkin was not visibly low in mood and denied any thoughts or intent to self-harm. Mr Bodkin said that he spoke with his family most days, was keeping himself busy by reading and had no issues on the wing. The review recorded that his presentation was positive, and all agreed that the ACCT could be closed. Mr Bodkin's original statement that he would take his own life if his parole were unsuccessful was still seen as a trigger, and the Safer Custody Team at Leeds therefore monitored any progress on a date for the deferred hearing.
49. Mr Bodkin had been involved with mental health services over the 11 years he had been in prison. A prison GP saw Mr Bodkin on 12 July about his physical health issues. He said that he believed from his consultation with Mr Bodkin that there was no evidence of any psychomotor symptoms of depression (where there is a low mood, along with an inability to carry out day-to-day functions). He felt that a more psychological approach would be appropriate, and made a referral for the Primary Care Mental Health Team (PCMHT) to assess Mr Bodkin. He said that the medication already prescribed for Mr Bodkin, duloxetine for depression, and buspirone for anxiety, was appropriate and required no change.
50. On 24 July, the OS spoke to Mr Bodkin on the wing and passed him a letter from the Parole Board. She told Mr Bodkin that he needed to decide whether he wanted the Parole Board to consider his case as a paper review or if he wished to request an oral hearing. She recorded that when she spoke with Mr Bodkin he was clearly frustrated at still being at Leeds as he was an IPP prisoner and wanted to be at a resettlement prison, rather than a local prison. She said that Mr Bodkin was still subject to a parole hold, so any move was unlikely to happen until this process was completed.
51. On 3 August, a mental health nurse, who is part of the PCMHT, assessed Mr Bodkin following his referral. At interview, she said that Mr Bodkin did not complain of feeling significantly depressed, his major concern was that he was sleeping a lot, up to twenty hours a day. As part of her assessment, she completed a 7-item Generalized Anxiety Disorder scale (GAD 7) a screening tool to diagnose, monitor and measure the severity of anxiety, and a 9-item Patient Health Questionnaire (PHQ 9), a screening tool to diagnose, monitor and

measure the severity of depression. Both the GAD 7 and PHQ 9 are standard assessment tools used in PCMH to support clinical opinion.

52. Mr Bodkin scored seven on the GAD 7, indicating mild anxiety and 24 on PHQ 9, indicating severe depression. At interview, the mental health nurse said that while the PHQ 9 score indicated a severe depression, she did not feel that this was reflected in Mr Bodkin's presentation during her assessment. She also said that she did not explore Mr Bodkin's responses to her questions on the PHQ 9 further during the twenty-minute consultation. She said that following the assessment, she asked a Health Support Worker (HSW) to provide follow up. However no further intervention with a mental health professional was scheduled and no care plan was completed.
53. The OS saw Mr Bodkin on 4 September. He had spoken to her previously about transferring to HMP Hull. He said that he wished to transfer to the prison's PIPE unit (a Psychologically Informed Planned Environment where prisoners, particularly those with personality disorders, are able to develop positive behaviours in a meaningful but controlled environment). Mr Bodkin asked her about the referral and she told him that Hull was assessing whether he was suitable, and as soon as she had any update she would let him know.
54. A forensic psychologist was tasked with completing the psychological risk assessment requested by the Parole Board. She said that she met Mr Bodkin to complete the assessment six times between 6 September and 3 October, for a total of 14.5 hours.
55. The forensic psychologist told the investigator that while her assessment did not reveal a diagnosis of personality disorder, she identified some traits that gave cause for concern. She said that these might have affected his level of risk and may have influenced the behaviour that led to previous recalls to custody. She was not intending to recommend Mr Bodkin's release, saying that he would benefit from further work around these issues.
56. The forensic psychologist said that she discussed her findings and decision not to recommend his release with Mr Bodkin. These were set out in a report, which was disclosed to Mr Bodkin, and which he signed to confirm that he had read it. She said that Mr Bodkin told her he intended to commission an independent report and challenge her through his solicitor. Mr Bodkin did not see her report as independent and felt that perhaps the Prison Service or Parole Board were telling her what to say.
57. The OS said that she had accompanied the forensic psychologist to see Mr Bodkin on 18 October, and she asked him how he felt after reading the report. She recorded that Mr Bodkin said that he was fine, but that if he were unsuccessful with parole, then he would end things under his own terms. She said that she asked him about any immediate thoughts of self-harm, which Mr Bodkin denied. She said that she discussed these comments with a CM, who was on duty on the wing. She told the investigator that it was decided that an ACCT was not required at that time.
58. Explaining this decision, the OS said that Mr Bodkin was still talking positively about his parole hearing and he was intending to prove that the psychology

report was wrong for not recommending his release. She said that Mr Bodkin was adamant that he intended to attend his hearing and she felt that any risk would be associated with him being refused parole, rather than there being an immediate risk. No date for a parole hearing had yet been set.

59. Between 6-16 November, Her Majesty's Inspectorate of Prisons carried out an unannounced inspection at Leeds. Staff said that Mr Bodkin was seen speaking a few times with members of the inspection team, but what Mr Bodkin spoke about is unknown and nothing of concern was recorded by the inspection team or mentioned by them to wing staff.
60. Mr Bodkin kept in contact with his parents and telephoned them frequently. The investigator has listened to the last few telephone calls Mr Bodkin made. On 1 November, Mr Bodkin telephoned his parents twice. Both calls were very short, and Mr Bodkin wished his parents a happy anniversary and told them he hoped that they had a good holiday. There was nothing to indicate that he was upset or distressed. He contacted them again on 6 November. The call lasted around two minutes; again, Mr Bodkin sounded upbeat, and there was no indication that he was upset. Mr Bodkin ended the call by telling his parents that he would speak with them soon.
61. A CM was the duty manager on F wing on both 6 and 7 November. He told the investigator that he had facilitated a telephone call from the wing office for Mr Bodkin on both days. He said that a governor had granted Mr Bodkin permission to use the office telephone to try to contact the Parole Board (the PIN telephone normally used by prisoners was not compatible with the automated system used by the Parole Board).
62. The CM said that on the morning of 6 November, he sat in the office while Mr Bodkin attempted to contact the Parole Board but, after trying for some time, he was unsuccessful. As he had other duties to complete, he told Mr Bodkin that they would try again the next day.

### **Events of 7 November**

63. On 7 November, the OS received a telephone call from the wing. Staff said that Mr Bodkin wanted to see her because he wanted to know about his parole. She told the officer that Mr Bodkin knew that they were still awaiting a date and this was not likely to be until January.
64. The same day, Officer A, was on duty on the fifth-floor landing on F wing, where Mr Bodkin had his cell. He told the investigator that he considered that he had a good rapport with Mr Bodkin, and that he was always polite and respectful. He said that Mr Bodkin was unlocked along with other prisoners on the wing. He spent the morning socialising with other prisoners and gave no cause for concern. The CM said that he had facilitated another telephone call from the wing office for Mr Bodkin to the Parole Board but, again, he was unsuccessful in speaking to anyone. Officer A said that after Mr Bodkin had collected his lunch he was locked back in his cell.
65. At around 1.45pm, staff began unlocking prisoners to attend work and education. Mr Bodkin did not attend either so remained locked in his cell. Officer A said that

after he finished unlocking those prisoners required for work, Mr Bodkin pressed his cell call light and asked to be let out to use the telephone. He said that he would not normally unlock anyone to use the telephone but, as he got on well with Mr Bodkin, he did so. He told the investigator that he did not witness Mr Bodkin using the prisoner telephone. Mr Bodkin was unlocked for around 20 minutes before he was locked back in his cell.

66. Officer A said that a short while after he had locked Mr Bodkin back in his cell, Mr Bodkin pressed his cell call bell repeatedly, asking to use the telephone. He said that he told Mr Bodkin that he had been unlocked all morning, he had given him the opportunity to use the telephone, and he could not do so again. He said that initially Mr Bodkin accepted what he was told, but then continued to press his cell call bell and when he told him again that he could not be unlocked, Mr Bodkin became quite aggressive and made threats towards staff.
67. Officer A told the investigator that when he had attended to the second cell call bell, Mr Bodkin showed him a small razor blade in his hand that he had taken out of a disposable razor. He stated: "just watch when I am unlocked, someone is going to get hurt". He said that he did not feel that Mr Bodkin was threatening him directly, and tried to calm him down but he said that Mr Bodkin was demanding to speak with a CM. He said that he explained to Mr Bodkin that he would have to deal with him, as the CM was busy. He told him that they should reach an understanding and try to help one another but Mr Bodkin just ignored him. He said that he left Mr Bodkin's door, informed the duty CM of the situation and made an entry in the wing observation book.
68. Officer A said that Mr Bodkin pressed his cell call bell several more times during the afternoon. He said he had asked other staff passing through the wing to answer some of these, as he felt that he was antagonising Mr Bodkin by going to his cell. He said that Mr Bodkin continued to ask to see a Governor or a CM, or to make another telephone call to the Parole Board. He explained that while this was going on he was also dealing with other things on the wing and Mr Bodkin was told that he could not be unlocked. He said that although Mr Bodkin seemed angry and frustrated he did not appear to be distressed.
69. Officer A said that he did not seem to be getting anywhere in reasoning with Mr Bodkin and asked a colleague if he would try to speak to Mr Bodkin. The two officers went to the cell and can be seen on CCTV looking through the observation panel and the sides of the door. Officer A said that when they first looked into the cell, they could not see Mr Bodkin, but then saw him seated on the floor below the door with his legs stretched out in front. He said that Mr Bodkin was moving but refused to speak with them.
70. CCTV covering the afternoon of 7 November shows Officer A going to Mr Bodkin's cell to answer the cell call bells, but also shows him checking on Mr Bodkin a final time at approximately 3.45pm. Now, Mr Bodkin's cell call light was not on and the investigator asked the officer what had prompted him to check again on Mr Bodkin. He said that he could not recall why but that he stood at the door for around fifteen seconds, during which time Mr Bodkin was standing in the middle of his cell with his back to him, and refused to acknowledge him. He said that Mr Bodkin did not appear upset or visibly distressed.

71. A prisoner on F wing had been brought back onto the wing from exercise at around 4.15pm and can be seen on CCTV going to Mr Bodkin's cell. He told the investigator that as he was on the basic regime, he decided to take the opportunity to "have a wander" around the wing. He said that he opened the observation panel and called to Mr Bodkin. Mr Bodkin was at the back of the cell with a curtain covering his back and did not respond to his calls.
72. Officer A had gone down to the fourth-floor landing, where Officer B was working. She said that Officer A asked her whether she would check on Mr Bodkin. She thought this a strange request. She said that he told her that Mr Bodkin had been upset during the afternoon and he did not want to look in on him again and antagonise him further. She said that she agreed to look in on Mr Bodkin and followed him up the stairs to the fifth-floor landing.
73. As the two staff came on the landing, Officer A shouted to the prisoner who was still at Mr Bodkin's door, and told him to return to his own landing and his cell. He said that the prisoner said that Mr Bodkin was ignoring him.
74. Officer B said that as she came onto the landing she saw a fellow officer, Officer C, walking along the landing and stopped to speak with him. She asked him if he would look in on Mr Bodkin's cell as he passed. He said that he did not know Mr Bodkin.
75. Officer C said that when he reached the cell he looked in through the observation panel. He said that he could see Mr Bodkin straight ahead and he appeared to be looking out of his window. He said that he was kneeling on hot water pipes running along the back of the cell, and his forearms were resting on the windowsill. He said that there was a curtain covering the back of Mr Bodkin's head, and he could only see him from the shoulders down.
76. Officer C said that he banged on the door and shouted but got no response. He shouted across to Officer A, who was on the other side of the landing, to alert him that he wanted to enter the cell and check on Mr Bodkin. He said that he entered the cell, approached slowly and asked Mr Bodkin if he was ignoring him. He said that as he got closer he felt that something was wrong, as Mr Bodkin was not moving and making no sound. He lifted the curtain and immediately saw the ligature around Mr Bodkin's neck.
77. Officer C said that he was not carrying a radio, but shouted "ligature" and "staff" to alert his colleagues. Officer C and Officer A lifted Mr Bodkin and cut the ligature from around his neck, before laying him on the floor. Officer C said that he then proceeded to deliver cardiopulmonary resuscitation (CPR) until healthcare staff arrived. He said that Mr Bodkin was cold to the touch.
78. Staff heard the calls from the officers. An officer made a code blue emergency radio call at 4.30pm, notifying the control room that Mr Bodkin was unconscious and not breathing. The control room immediately requested an ambulance at 4.33pm.
79. A nurse and a HCA were in the E/F wing triage room when they heard the emergency call over the radio. The nurse said that she and the HCA grabbed the emergency bag and made their way to F wing, which took around three

minutes. She said that on her arrival she assessed Mr Bodkin, and it was clear to her that he had not been breathing for some time. She said that, given how Mr Bodkin presented to her, if CPR had not already been started, then she would have questioned whether it was viable to start. The HCA took over CPR from Officer C. Other nursing staff arrived and resuscitation attempts continued.

80. A prison GP was finishing an afternoon clinic when he received a telephone call asking him to attend an emergency on F wing. He said that by the time he arrived, resuscitation had been continuous. Paramedics from Yorkshire Ambulance Service arrived a short while later at 4.40pm and efforts to resuscitate Mr Bodkin continued with adrenaline and oxygen being given. He did not respond. The GP discussed with the paramedics and agreed that there was no pulse and no respiratory output. He pronounced Mr Bodkin dead at 4.56pm. While trying to resuscitate Mr Bodkin, staff identified minor self-inflicted scratches on his torso, but these had been hidden by clothing and he had not reported them to staff.

### **Contact with Mr Bodkin's family**

81. Due to the location of Mr Bodkin's next of kin, HMP Leeds asked a family liaison officer from HMP Hewell in the West Midlands to visit and inform the family of the death. Mr Bodkin's mother and father, who were the nominated next of kin, were out of the country and the initial notification was given to Mr Bodkin's cousin.
82. A Supervising Officer (SO) was appointed as the family liaison officer at Leeds. He contacted Mr Bodkin's cousin and later spoke with his parents on their return from holiday on 9 November. He later visited the family to return Mr Bodkin's personal possessions. He informed the family of the processes that would follow and answered any immediate questions. The prison contributed to the funeral costs, in line with national policy.

### **Support for prisoners and staff**

83. After Mr Bodkin's death, the duty Governor de-briefed the staff involved. Members of the staff care and welfare team made themselves available to those staff that required their support.
84. The prison posted notices informing other prisoners and staff of Mr Bodkin's death, and offering support. Staff reviewed all other prisoners considered to be at risk of suicide and self-harm.

### **Post-mortem report**

85. The Coroner has confirmed that the initial post mortem concluded that the cause of death was hanging. Results from toxicology indicate that Mr Bodkin had not taken any illicit substances prior to his death.

# Findings

## Clinical care

86. Mr Bodkin was involved with mental health services over the 11 years he had been in prison, having complained of depression and anxiety previously and been prescribed medication. The clinical reviewer considers that the care provided was of a mixed standard. The physical healthcare provided was at least equivalent to that which Mr Bodkin could expect in the wider community. However, the mental health care was not equivalent to that which Mr Bodkin could have expected to receive in the community.
87. Mr Bodkin scored highly for anxiety and depression on tools that support clinical opinion. A score over 14 would indicate that treatment for depression was required, with either medication or psychotherapy, but no further intervention was planned.
88. Mr Bodkin was only seen once by a mental health professional and was not offered any psychological or mental health interventions. The clinical reviewer would have expected appropriate interventions with a suitably qualified mental health practitioner to have been offered immediately.
89. We make the following recommendation:
  - **The Head of Healthcare should review the use of clinical assessment tools used within mental health services and ensure that all relevant staff are trained in the use and interpretation of the tools to ensure that prisoners are offered appropriate treatment from a suitably qualified member of staff.**

## Self-harm

90. Mr Bodkin was clearly frustrated with the parole process and the constraints placed on him because of his IPP sentence. During the investigation the investigator was told by his Offender Supervisor that despite his frustrations, Mr Bodkin was still focused on gaining a positive outcome at his parole hearing.
91. He had been subject to ACCT monitoring in the past. On each occasion the document had been opened following Mr Bodkin becoming frustrated about a situation and making explicit threats of self-harm.
92. On 7 November, Mr Bodkin had been in the wing office attempting to telephone the parole board. He became frustrated during the afternoon, when Officer A told him that he was unable to allow him to leave his cell, and this resulted in further frustration with Mr Bodkin making veiled threats toward staff, although he later apologised. Despite this frustration, he did not indicate that he would harm himself, and the officer said that he did not have any such concerns during the afternoon.
93. Mr Bodkin was managed appropriately on the ACCT document and his risks and triggers around parole hearings were correctly recorded, with plans for follow up

demonstrated by the safer custody team at Leeds. We do not consider that staff had any grounds to consider it appropriate to open an ACCT on 7 November.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations