Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul David Horrocks, a prisoner at HMP Thorn Cross, on 30 June 2019

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 l 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

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Paul David Horrocks died on 30 June 2019 at HMP Thorn Cross after being found unresponsive in his cell. The cause of his death is unknown. He was 43 years old. I offer my condolences to Mr Horrocks' family and friends.

Mr Horrocks had a long history of drug misuse in the community and he had regular contact with the prison's substance misuse and mental health teams. The clinical reviewer concluded that, overall, Mr Horrocks' care at Thorn Cross was of a good standard and equivalent to that which he could have expected to receive in the community.

However, the clinical reviewer found that healthcare staff did not follow up on his high blood pressure reading when he arrived at Thorn Cross in April 2019 or arrange a secondary health screen.

I am concerned that when Mr Horrocks was found unresponsive in his cell on 30 June, prison staff did not immediately use a medical emergency code, meaning that healthcare staff were not aware of the nature of the medical emergency and an emergency ambulance was not called immediately. I am also concerned that there were no first aid trained prison staff who attended Mr Horrocks' cell on that day. I am satisfied, however, that this did not affect the outcome for Mr Horrocks.

Communication between the control room and the emergency services was unclear, and as a result the emergency services advised staff to continue with CPR despite a nurse already concluding that any attempts at resuscitation would be futile.

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

Sue McAllister CB
Prisons and Probation Ombudsman **March 2021**

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Summary

Events

1. On 5 September 2018, Mr Paul David Horrocks was sentenced to two years and eight months in prison for burglary. He was initially sent to HMP Forest Bank and transferred to HMP Thorn Cross in April 2019.

2. Mr Horrocks had a long history of substance misuse in the community and was prescribed methadone (a synthetic opiate used to treat heroin addiction) during his time in prison. When he arrived at Thorn Cross, Mr Horrocks continued with a methadone detoxification programme he had already started at his previous prison. He engaged with the prison's substance misuse team and prison's mental health team. He was prescribed antipsychotic and antidepressant medications.

3. On the evening of 29 June, prisoners described Mr Horrocks as being under the influence of illicit drugs. They did not inform prison staff.

4. At around 7.30am, on 30 June, Mr Horrocks did not attend the healthcare unit for his methadone medication. An officer went to his room and found him unresponsive on his bed. The officer called for healthcare assistance. A nurse attended and considered that Mr Horrocks had clearly been dead for some time and that any attempts at resuscitation would be futile, so she did not attempt cardiopulmonary resuscitation (CPR). Paramedics arrived and, at 8.15am, they confirmed that Mr Horrocks had died.

5. The post-mortem was unable to determine the cause of Mr Horrocks' death.

Findings

Management of Mr Horrocks' substance misuse and mental health

6. The clinical reviewer concluded that the substance misuse and mental health care Mr Horrocks received was of a good standard and equivalent to that which he could have expected to receive in the community. He had regular support from the prison's drug and mental health teams and had daily contact with healthcare staff.

Clinical care

7. The clinical reviewer concluded that the care Mr Horrocks received at Thorn Cross was good and equivalent to that which he could have expected to receive in the community.

8. However, the clinical reviewer was concerned that during his initial health screen, Mr Horrocks had high blood pressure. Healthcare staff did not complete further tests or arrange any follow up action. She was also concerned that healthcare staff did not arrange a secondary health screen for Mr Horrocks to ensure continuity of care.

Emergency response

9. Prison staff did not use a medical emergency code, as they should have done when Mr Horrocks was found unresponsive in his cell on 30 June. This meant that healthcare staff were not aware of the nature of the medical emergency, and there was a delay in calling an ambulance. However, this did not affect the outcome for Mr Horrocks.

10. Prison staff who responded to the emergency response on 30 June, did not have basic first aid training. Also, prison staff did not update control room staff about the nature of the medical emergency, meaning they were unable to relay accurate information to the ambulance emergency services. We are satisfied however, that this did not affect the outcome for Mr Horrocks.

Recommendations

- The Head of Healthcare should ensure that any prisoners with elevated blood pressure readings are monitored in accordance with NICE guidelines.
- The Head of Healthcare should ensure that all new prisoners receive secondary health screens within seven days, in line with NICE guidelines and PSO 3050, Continuity of Healthcare for Prisoners.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies including that staff:
    - use an emergency code immediately where there are serious concerns about the health of a prisoner to alert control room staff to call an ambulance automatically; and
    - efficiently communicate the nature of a medical emergency so that there is no delay in directing or discharging ambulances.
- The Governor should ensure there are a sufficient number of radios available to officers on each Unit.
- The Governor should ensure that this report is shared with Officer A and that a senior manager discusses the Ombudsman's findings with him.
- The Governor and the Head of Healthcare should liaise with the local Ambulance Service to ensure that an effective protocol is in place so that the Ambulance Service understands the nature of medical emergencies in a prison context and that staff who request ambulances might not be able to provide detailed information about a prisoner's medical condition immediately.
- The Governor should ensure there are sufficient numbers of first aid trained staff on duty at all times, in line with PSI 29/2015.

The Investigation Process

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

12. The investigator obtained copies of relevant extracts from Mr Horrocks' prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Horrocks' clinical care at the prison.

14. The investigator and clinical reviewer jointly interviewed five staff and two prisoners at Thorn Cross on 20 August 2019.

15. We informed HM Coroner for Cheshire of the investigation. We suspended our investigation from 22 August 2019 until 27 April 2020, while we waited for the post-mortem report. The coroner gave us the results of the post-mortem examination. We have sent him a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Horrocks' next of kin, his sister and niece, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not have any specific questions for the investigation to consider, but they requested a copy of our report.

17. Mr Horrocks' family received a copy of the initial report. The solicitor representing Mr Horrocks' family wrote to us pointing out a factual inaccuracy. The report has been amended accordingly.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

Background Information

HMP & YOI Thorn Cross

19. HMP & YOI Thorn Cross is an open prison holding up to 400 Category D adult male prisoners and young male offenders. Bridgewater Community Healthcare Foundation Trust provide healthcare services. Greater Manchester West Mental Health Care Foundation Trust provide mental health services. The integrated clinical and psychosocial substance misuse services are delivered by Change, Grow, Live (CGL). The healthcare centre is open from 7.30am to 5.30pm on Monday to Friday and from 7.30am to 12.15pm on weekends and bank holidays.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Thorn Cross was in August 2016. Inspectors reported that Thorn Cross was a good prison. They found that it was a well-led and confident prison that delivered very good outcomes for prisoners. Inspectors noted that good support was provided for new arrivals and there were few violent incidents. Integrated drug services were excellent. Inspectors assessed Thorn Cross as a respectful prison and the environment and accommodation were good. Health outcomes for prisoners were very good and appreciated by prisoners.

Independent Monitoring Board

21. 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 April 2019, the IMB reported that prisoners at Thorn Cross were treated fairly and the governors and staff provided a fair and reasonable environment for the prisoners. The Board noted that although there was an increasing availability of psychoactive substances (PS) in the community, this had not been mirrored at Thorn Cross. However, a worrying trend was the counterfeiting of tablets and capsules. The Board found that prisoners were led to believe that the substances were genuine and were bought in that belief. However, the drugs were rarely genuine and often contained harmful and addictive active substances and the risks to prisoners were apparent.

Previous deaths at HMP Thorn Cross

22. Mr Horrocks is only the second prisoner ever to die at Thorn Cross. The other death was a homicide which occurred while the prisoner was out of the prison on day release in October 2018. There are no similarities between our findings in the investigation into Mr Horrocks' death and our investigation findings for the previous death.

Psychoactive Substances (PS)

23. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a fundamental problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate,

raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

24. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

Key Events

25. On 5 September 2018, Mr Paul David Horrocks was sentenced to two years and eight months in prison for burglary. He was sent to HMP Forest Bank. He transferred to Thorn Cross on 2 April 2019.

26. On his arrival at Thorn Cross, prison staff submitted an intelligence report which recorded that Mr Horrocks was overheard asking other prisoners how to obtain drugs in the prison.

27. A nurse carried out Mr Horrocks' reception health screen. She checked his blood pressure and it was high. She noted his history of schizophrenia, depression, anxiety and substance misuse (cocaine, opiates, amphetamines and cannabis) and noted no significant physical concerns. Mr Horrocks was already on a methadone detoxification programme when he arrived at Thorn Cross. The reception nurse referred him to the prison's substance misuse team, DART (Drug and Alcohol Recovery Team), and the prison's mental health team. He continued with his methadone therapy and healthcare staff reviewed him regularly. They also completed a prescription for his mental health medication.

28. On 5 April, a mental health counsellor saw Mr Horrocks. She referred him for one to one counselling because he had talked about his past anxiety. He would either fail to attend these sessions or walk out of them. On 23 April, he attended his appointment with a psychological wellbeing practitioner and continued to attend the sessions frequently to help him address his anxiety.

29. On 1 May, a prison GP saw Mr Horrocks. It was agreed that Mr Horrocks could start methadone reduction therapy.

Events of 29 June 2019

30. Mr Horrocks had a single room on the second floor of Unit 1 at Thorn Cross. His neighbours on either side of him were Prisoner A and Prisoner B. Prisoners have their own room keys and can move around the unit at any time. A roll check (a count of all prisoners) is completed by the evening staff around 8.00pm, and the next roll check is completed by the night staff at around 6.00am.

31. On the evening of 29 June, Prisoner A said that he saw Mr Horrocks outside his room at about 8.10pm, while the other prisoners waited for the roll check to be completed. He said that he saw Mr Horrocks again at 8.45pm. He told the investigator that Mr Horrocks was not "in control of himself, walking funny" and wearing one flip flop and one sock. He said that Mr Horrocks dropped his crockery and he appeared to be under the influence of something.

32. Prisoner A said that at approximately 10.30pm, he heard a commotion from Mr Horrocks' room. He looked out into the corridor and saw Prisoner B also looking to see what had happened. Prisoner B said that he went outside Mr Horrocks' door and shouted to ask if he was ok, but there was no response. Both prisoners returned to their rooms. CCTV footage showed no one leaving or entering Mr Horrocks' room during that time.

Event of 30 June 2019

33. At 5.10am, an Operational Support Grade (OSG) started the morning roll check on Unit 1. When he reached Mr Horrocks' room, he opened the observation panel and saw Mr Horrocks sleeping. He told the investigator that he did not notice anything unusual and continued with his duties until the end of his shift.

34. Officer A arrived on Unit 1 and began his duties in the office. He said that at approximately 7.30am, a nurse telephoned him asking for Mr Horrocks to attend the healthcare unit for his methadone medication.

35. Officer A went to Mr Horrocks' room and opened the observation panel. He saw Mr Horrocks lying on his front on the bed, apparently asleep. He called Mr Horrocks' name but got no response. Prisoner B asked the officer if he needed help. The officer asked him to hold the door open as he walked over to the bed. He touched Mr Horrocks and said that he was cold and stiff. He ran to the unit office to get a radio to summon help.

36. Officer A radioed for the duty nurse, duty manager and orderly officer to attend Unit 1 and ran back to the room. He removed the quilt from Mr Horrocks' body and noticed that there was a small amount of blood on his pillow.

37. A nurse heard a radio call for the duty nurse to come to Unit 1. She did not bring any emergency equipment as the radio message had not indicated the nature of the call. She went to Mr Horrocks' room and an officer told her that he thought that Mr Horrocks was dead. She entered the room and told the officer she needed help to roll Mr Horrocks over on his back. She said that when they rolled him over his eyes were fixed and he felt warm. She checked for a pulse and noted that Mr Horrocks' body was stiff, so she did not attempt CPR.

38. The nurse said that a prison senior manager had told them that they needed to telephone an ambulance so that they could confirm Mr Horrocks' death. In his written statement, a Senior Officer (SO) said that the nurse had told him that an ambulance was needed to confirm Mr Horrocks' death so he asked the gate staff to call an ambulance.

39. The nurse told the investigator that a prison manager said that she could return to the healthcare unit to lock up. When she got there, she heard a radio message instructing staff to start CPR. She locked up the healthcare unit and returned to Mr Horrocks' room. She waited outside the room because paramedics had just arrived.

40. At 8.15am, paramedics confirmed that Mr Horrocks had died. The nurse said that she asked a paramedic if her actions in not attempting CPR had been correct and the paramedic told her that they were correct.

Information received after Mr Horrocks' death

41. After Mr Horrocks' death, staff submitted intelligence reports suggesting that two prisoners on another unit had supplied Mr Horrocks with pregabalin tablets the night before he died. (Pregabalin is prescribed medication for epilepsy, anxiety and nerve pain and is traded illicitly and abused in prisons for its euphoric effects.) Intelligence reports recorded that Mr Horrocks had told other prisoners that he was high because he had taken five pregabalin tablets, medication he had not been prescribed. The

intelligence reports were assessed, and an analyst concluded that the claims were unsubstantiated.

42. Police retrieved vials of liquids and a mobile telephone from Mr Horrocks' room and sent them for testing. The police said that the vials tested negative for drugs and were consistent with fragrance oils. The mobile telephone had four text messages, but they were not related to drugs or threats.

Contact with Mr Horrocks' family

43. On 30 June, the prison appointed a family liaison officer (FLO). Later that day, the FLO and a prison manager visited Mr Horrocks' next of kin, his sister, at her address and told her that her brother had died. They maintained contact with Mr Horrocks' family, offering support and information.

44. Mr Horrocks' funeral was held on 19 July. The prison contributed to the costs of Mr Horrocks' funeral in line with national policy.

Support for prisoners and staff

45. After Mr Horrocks' death, a duty manager 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.

46. The prison posted notices informing other prisoners of Mr Horrocks' 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 Horrocks' death.

Post-mortem report

47. The post-mortem was unable to establish the cause of Mr Horrocks' death.

48. There was no evidence of drug or alcohol misuse, although the pathologist said that the use of PS could not be completely ruled out as there are so many different types. Toxicology results showed the presence of Mr Horrocks' prescribed medication at therapeutic levels which did not contribute to his death.

49. There was no evidence of any natural disease or injury that would have been the cause of Mr Horrocks' death. The pathologist found that Mr Horrocks had an enlarged heart (possibly caused by high blood pressure or cocaine use) and dilated mitral valve, but neither were severe, and it could not be certain that these were factors in the cause of his death.

Findings

Management of Mr Horrocks' substance misuse and mental health

50. The clinical reviewer found that healthcare staff offered Mr Horrocks opportunities to engage with support services to address his substance misuse and mental health, and that this support was offered in a timely manner. DART staff and healthcare staff who had regular contact with Mr Horrocks had no suspicion that he was under the influence of drugs or using illicit substances in addition to his methadone.

51. The clinical reviewer concluded that the care Mr Horrocks received for his substance misuse and mental health was of a good standard and equivalent to that which he could have expected to receive in the community.

Clinical care

52. The clinical reviewer concluded that, overall, the care Mr Horrocks received at Thorn Cross was equivalent to that which he could have expected to receive in the community.

53. The clinical reviewer did, however, identify some concerns.

Follow up care and secondary reception screen

54. Prison Service Order (PSO) 3050, Continuity of Healthcare, emphasises the importance of continuity in clinical interventions and treatment. It says that:

    "In the week following first reception, every prisoner must be offered a general health assessment. This assessment is equivalent to a primary care assessment when registering with a new practice in the community…"

55. The secondary screen is an opportunity for care planning and a more in-depth assessment and investigation of healthcare issues. During his initial health screen on 2 April 2019, a nurse noted that Mr Horrocks' blood pressure was high. The clinical reviewer found that the nurse had not made any arrangements for follow up checks and had not arranged a secondary health screen. We make the following recommendations:

    The Head of Healthcare should ensure that any prisoners with elevated blood pressure readings are monitored in accordance with NICE guidelines.

    The Head of Healthcare should ensure that all new prisoners receive secondary health screens within seven days, in line with NICE guidelines and PSO 3050, Continuity of Healthcare for Prisoners.

Emergency response

56. Prison Service Instruction (PSI) 03/2013, requires prisons to have a medical emergency response code protocol, which ensures an ambulance is called automatically in a life-threatening emergency. It says that all prison staff must be made aware of and understand the protocol and their responsibilities during medical

emergencies. The PSI makes it clear that there should be no delay in admitting and discharging an ambulance.

57. Thorn Cross has local guidance for medical emergencies which is in line with national instructions. The local guidance says that in the event of a life-threatening situation the first member of staff on scene is responsible for requesting an ambulance prior to the attendance of any healthcare staff or prison managers.

58. When Officer A found Mr Horrocks unresponsive in his cell on 30 June, he did not have his radio with him to summon help. He ran to the unit office to use a radio. He told the investigator that although there were two officers working on Unit 1, only one radio was allocated to the Unit. He used the radio to ask a nurse and duty managers to attend Mr Horrocks' room. He should have immediately called an emergency medical code blue to indicate that Mr Horrocks was unresponsive. Because an emergency medical code blue was not called, the nurse did not bring an emergency medical bag and there was a delay between him first seeing Mr Horrocks lying unresponsive on his bed and the ambulance being called.

59. Although this did not affect the outcome for Mr Horrocks, who had clearly been dead for some time when he was found, it could make a significant difference in other medical emergencies. We make the following recommendations:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies including that staff:

- **use an emergency code immediately where there are serious concerns about the health of a prisoner to alert control room staff to call an ambulance automatically; and**
- **efficiently communicate the nature of a medical emergency so that there is no delay in directing or discharging ambulances.**

The Governor should ensure there are a sufficient number of radios available to officers on each Unit.

The Governor should ensure that this report is shared with Officer A and that a senior manager discusses the Ombudsman's findings with him.

60. PSI 3/2013 also requires prisons to agree written emergency response protocols with the local Ambulance Trust so that they understand medical emergencies within a prison context and to help eliminate any confusion.

61. When control room staff called an ambulance, the emergency services told them to start CPR. There were then repeated radio calls for staff to continue with CPR. A nurse had already attended Mr Horrocks' room and, after checking for signs of life, she considered that he had clearly been dead for some time and so she did not attempt CPR. This information was not communicated to the Ambulance Service and caused confusion. The clinical reviewer noted that this was very upsetting for the nurse, as she had made the correct decision not to attempt resuscitation. We make the following recommendation:

The Governor and the Head of Healthcare should liaise with the local ambulance service to ensure that an effective protocol is in place so that the ambulance service understands the nature and context of medical emergencies in prison and that staff who request ambulances might not be

able to provide detailed information about a prisoner's medical condition immediately.

First Aid Training

62. PSI 29/2015, First Aid, requires there to be suitably trained first aiders available to treat anyone who becomes ill in the prison. The PSI says that 'first aid provision must be adequate and appropriate in the circumstances'. This means that sufficient first aid equipment, facilities and personnel need to be available at all times.

63. HMP Thorn Cross does not have 24-hour healthcare cover. The investigation found that there was no list of trained first aid staff at Thorn Cross.

64. None of the custodial staff on duty who attended were first aid trained when they found Mr Horrocks unresponsive in his room on 30 June. It was fortunate on this particular occasion that a nurse was on duty that day to provide medical assistance. Although this did not affect the outcome for Mr Horrocks, we consider that there should be at least one first aid or basic life support trained member of staff on every shift, able to attend to any medical emergency and that it is imperative that Thorn Cross complies with national guidance and ensures there is first aid cover at all times. We make the following recommendation:

    The Governor should ensure there are sufficient first aid trained staff, at all times, in line with PSI 29/2015.

Inquest

65. At the inquest, held on 28 to 30 October 2024, the Coroner concluded that on the evidence available, it was not possible to ascertain how Mr Horrocks came by his death.

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