Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Bailey, a prisoner at HMP Lindholme, on 23 February 2025

A report by the Prisons and Probation Ombudsman

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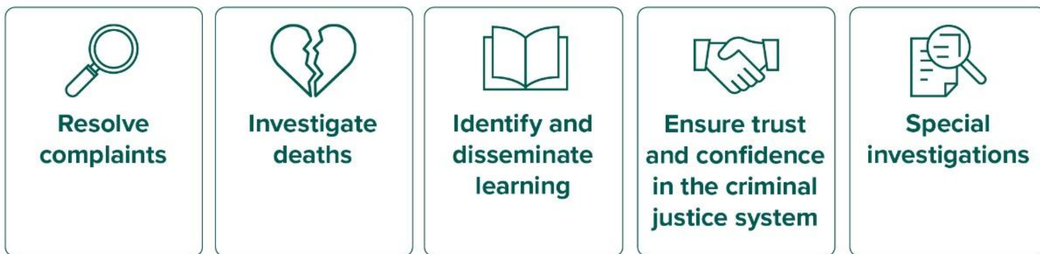
OUR VISION

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

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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.

If my office is to best assist His Majesty's 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 Daniel Bailey died of drug toxicity on 23 February at HMP Lindholme. He was 30 years old. I offer my condolences to Mr Bailey's family and friends.

Mr Bailey was the second prisoner to die from drugs at Lindholme in the previous three years. Senior leaders acknowledge the illicit drug economy problems at the prison, and are working closely with regional drug strategy teams and the police to tackle this. The investigation found that more needs to be done to tackle prescription medication being traded and diverted.

An inadequate routine roll check by a staff member on the morning of 23 February, meant that a prisoner discovered Mr Bailey deceased. I am concerned that this is the second investigation at Lindholme in a seven month period where routine roll checks have been an issue.

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 **November 2025**

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Summary

Events

1. On 5 June 2024, Mr Daniel Bailey appeared in court and was remanded to HMP Hull charged with wounding with intent. Mr Bailey told staff that he was dependent on cannabis, ketamine and alcohol and requested to work with the Drug and Alcohol Recovery Team (DART). He was assessed by them on 17 June and engaged in sessions with a DART worker on 10 July, 9 August, and 19 September.

2. Mr Bailey disclosed to healthcare staff that he had undergone a splenectomy in December 2023 and was prescribed long term medication as a result.

3. Staff referred Mr Bailey to Rethink (a programme supporting individuals with anxiety, managing emotions and self-esteem). He was supported by a Rethink wellbeing worker between June and October.

4. Mr Bailey was sentenced to four and a half years' imprisonment on 27 September. He transferred to HMP Lindholme on 22 October.

5. On arrival, Mr Bailey told healthcare staff he had a history of cannabis and amphetamine use and requested to work with the substance misuse team. Mr Bailey was assessed and approved to hold seven days' worth of medication in his possession.

6. Mr Bailey was triaged by a substance misuse worker on 25 October and requested support with alcohol use. He did not attend two further appointments with his substance misuse worker and requested to be discharged on 18 December. He stated he did not have a drug issue and did not require help from the service.

7. On 20 February, Mr Bailey was assessed by the healthcare team following concerns of an ongoing rash. Prison staff followed the suspected bed bugs protocol and moved him to another wing. He was placed in a shared cell.

8. Mr Bailey's cell mate told the investigator that Mr Bailey was smoking psychoactive substances before midnight on 22 February. At 5.31am, staff conducted a routine roll check on Mr Bailey's spur. They looked into his cell for approximately four seconds before moving on.

9. At approximately 9.00am, Mr Bailey's cellmate woke up and found Mr Bailey sat in the same position as he had been the previous evening. He attempted to get a response from Mr Bailey, but when he touched him felt that he was cold and stiff. He spoke with another prisoner and, at 9.08am, the other prisoner went to inform staff that Mr Bailey was dead. Prison staff entered Mr Bailey's cell at 9.09am and radioed an emergency code. Prison staff and healthcare staff agreed not to start CPR as there were clear signs Mr Bailey was dead and it would have been futile. Paramedics arrived and pronounced life extinct at 9.32am.

10. Following Mr Bailey's death, a significant amount of medication was found in his cell. There was a significant excess of his prescribed medication, as well as mirtazapine (an antidepressant) that was not prescribed to him.

11. The pathologist concluded that Mr Bailey had died of drug toxicity having consumed synthetic cannabinoids, pregabalin (that was not prescribed to him) and mirtazapine in the hours before he died.

Findings

12. Mr Bailey had a history of substance misuse. However, there was little evidence of him using drugs at Hull or Lindholme. We found that he was offered appropriate substance misuse support. Lindholme are taking appropriate steps to try to tackle illicit drugs coming into the prison. Whilst healthcare staff at Lindholme are aware of the issues around medication trading and diversion, more robust action needs to be taken.

13. Although Mr Bailey only received two key worker sessions, we are satisfied that this was sufficient, and a significant improvement compared to a previous investigation.

14. Staff failed to sufficiently check Mr Bailey during the routine roll count on the 23 February.

Recommendations

- The Governor and Head of Healthcare should introduce a robust and auditable process for monitoring the dispensing of medication across the prison.

- The Governor should satisfy himself that there is a robust quality assurance process to ensure that roll checks are being undertaken in line with national and local policy.

The Investigation Process

15. HMPPS notified us of Mr Bailey's death on 23 February 2025.

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

17. The investigator visited Lindholme on 27 February. She obtained copies of relevant extracts from Mr Bailey's prison and medical records.

18. The investigator interviewed eight members of staff and two prisoners at Lindholme in May 2025. She interviewed one member of staff via MS Teams in July.

19. NHS England commissioned a clinical reviewer to review Mr Bailey's clinical care at the prison. The clinical reviewer attended all interviews with the investigator.

20. We informed HM Coroner for South 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.

21. The Ombudsman's office contacted Mr Bailey's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of the report.

22. Mr Bailey's family received a copy of the draft report. They did not make any comments.

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

Background Information

HMP Lindholme

24. HMP Lindholme is a medium security prison near Doncaster. Practice Plus Group provides healthcare services, with healthcare staff on duty between 7.30am and 7.30pm every day.

HM Inspectorate of Prisons

25. The most recent inspection of Lindholme was in July 2023. Inspectors noted that during the previous three years, the frequency of deaths had reduced. A consolidated action plan addressed PPO recommendations and key messages on emergency response were reinforced to all staff twice a year. The key working scheme was not well established. Only about a third of scheduled appointments were delivered and records showed that they rarely focused on progression goals.

26. Inspectors concluded that illicit drugs were far too easily available in the prison, with cannabis and psychoactive substances identified as the drugs most commonly detected. Inspectors noted that Lindholme's site consisted of buildings spread over a large area with a very long fence line which was vulnerable to drones. Inspectors found that the increasing sophistication of drone technology was outstripping the prison's vigorous attempts to stop them.

Independent Monitoring Board

27. 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 January 2024, the IMB reported that illegal drugs were problematic within the prison.

Previous deaths at HMP Lindholme

28. Mr Bailey was the fourth prisoner to die at Lindholme since October 2022. Of the previous deaths, two were from natural causes and one was drug related.

29. In the previous drug related death, we were concerned that staff failed to undertake sufficient checks when unlocking the prisoner leading to a delay in finding him deceased.

30. Up to the end of July 2025, there has been one further death at Lindholme which was self-inflicted.

Psychoactive substances (PS)

31. The term psychoactive substances is a broad term that refers to a drug or other substance that affects mental process. Synthetic cannabinoids and synthetic opioids (including nitazenes) are substances that mimic the effects of traditional controlled drugs such as cannabis, cocaine, heroin and amphetamines. Synthetic

cannabinoids and synthetic opioids can be difficult to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.

32. PS 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 these substances 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, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

The key worker scheme

33. The key worker scheme was introduced in the men's prison estate in 2018. It provides prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address. Improving safety is a key aim of the scheme. All adult male prisoners should have around 45 minutes of key work each week, including a meaningful conversation with their allocated officer.

34. Due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Lindholme Spurs

35. At Lindholme, some prisoner accommodation is in the form of 'spurs' where eight prisoners live in either shared or single cells. Each prisoner has a key to their own cell, allowing them to lock and unlock it themselves. Prison officers do not lock prisoners into their cells. At both ends of the spur, there are locked gates that can only be unlocked by prison staff.

36. During the night, staff do not enter the spur unless there is a medical emergency. If prisoners need assistance during the night, they can press the spur alarm or their cell bell, which allows them to speak with staff through the gates.

Key Events

37. Between June 2017 and February 2019, while serving previous sentences of imprisonment, Mr Daniel Bailey was frequently found under the influence of PS. There was also some intelligence related to Mr Bailey being involved in the supply of drugs, particularly PS.

38. On 5 June 2024, Mr Bailey appeared at court, charged with wounding with intent. He was remanded to prison and taken to HMP Hull.

HMP Hull, 5 June – 22 October 2024

39. Mr Bailey arrived at Hull and told staff that he was dependent on drugs (cannabis and ketamine) and alcohol and would like to work with the Drug and Alcohol Recovery Team (DART). He told a nurse that he had undergone a splenectomy (an operation to remove the spleen) in December 2023 and was receiving long term medication for the condition (cholecalciferol, cyanocobalamin, and erythromycin). Staff appropriately completed a medication reconciliation (to check what he had been prescribed in the community) on 6 June and continued this medication.

40. Also on 6 June, an officer conducted Mr Bailey's first key working session. Mr Bailey disclosed regular use of cannabis and ketamine in the community. Mr Bailey had three further key working sessions with the safer custody team during his time at Hull.

41. Later on 6 June, the DART triaged Mr Bailey's referral. A DART worker, completed Mr Bailey's DART assessment on 17 June. She was allocated as Mr Bailey's DART practitioner. They discussed Mr Bailey's use of alcohol and ketamine and agreed a plan for future work. Mr Bailey engaged in further sessions with the DART worker on 10 July and 9 August. He also attended a DART awareness event on 19 September.

42. On 8 June, healthcare staff completed a mental health triage for Mr Bailey. They noted that Mr Bailey struggled with low mood, anxiety, and had difficulty managing his emotions. Staff added Mr Bailey to the Rethink programme (support for those struggling with anxiety, managing emotions and self-esteem).

43. On 11 June, an officer started Prison Service suicide and self-harm monitoring procedures, known as ACCT, for Mr Bailey. Mr Bailey had told the officer that he would kill himself if he was unable to speak to his son. Staff closed the ACCT the next day after Mr Bailey explained that he had said this out of frustration after he was told he could not have contact with his son.

44. Mental Health Nurse A assessed Mr Bailey's mental health on 12 June as part of the ACCT assessment. A Rethink wellbeing worker, supported Mr Bailey in one-to-one Rethink sessions following this. Mental Health Nurse B last saw Mr Bailey on 17 October. He agreed that Mr Bailey would receive a mental health check-in appointment in two weeks' time and could then be discharged, as he did not require any further input from the mental health team. Mental Health Nurse B provided a brief email handover to HMP Lindholme on 23 October.

45. On 27 September, Mr Bailey was sentenced to four and a half years' imprisonment via video link. Prison staff spoke with Mr Bailey following this who said he was fine. He declined to see a nurse.

46. On 9 October, Mr Bailey produced a negative random mandatory drug test (MDT).

47. On 21 October, Officer A completed Mr Bailey's final key worker session at Hull. Mr Bailey told Officer A that he was waiting to be transferred to Lindholme. He said he was taking his medication daily and was having regular visits from family and friends. He said he had no drug use or mental health issues at that time. A nurse confirmed that Mr Bailey was fit for medical transfer.

48. While at Hull, there was limited intelligence suggesting Mr Bailey may have been involved in PS supply and debt collecting.

HMP Lindholme, 22 October 2024 – 23 February 2025

49. Mr Bailey transferred to Lindholme on 22 October. Reception staff noted that he arrived with his prescribed medication (cholecalciferol, cyanocobalamin, erythromycin, ferrous sulphate, and paracetamol). He was offered a first night call in reception, but declined this stating his next of kin knew where he was, and he would contact them using his in-cell phone. Mr Bailey's in-cell phone was not working so an officer allowed him to use the office to call his next of kin that evening.

50. Nurse A completed Mr Bailey's healthcare reception screen. Mr Bailey disclosed a history of cannabis and amphetamines use and requested to work with the substance misuse team at Lindholme. Nurse A referred Mr Bailey to substance misuse services. She also completed a medication in possession risk assessment (MIPRA) and concluded that Mr Bailey could be permitted to hold seven days' worth of his medication in his possession.

51. On 23 October, Mr Bailey told staff that he had not received his medication since arriving at Lindholme. The pharmacy staff advised the prison that Mr Bailey had not arrived with any medication and all they could do was order it for him once it had been prescribed. A GP then prescribed Mr Bailey's medication. (We were not able to establish whether Mr Bailey did arrive with his medication, as noted in his reception records, or not, or why there was a discrepancy between records at Lindholme.)

52. On 25 October, Mr Bailey should have attended the Recovery Hub for his substance misuse services (SMS) triage. He did not attend so SMS Worker A, attended B wing to speak with Mr Bailey. He said he wanted to work with SMS to explore previous alcohol use in the community, but stated he did not have any cravings for alcohol and was not using alcohol illicitly. They did not discuss his alcohol or drug use further. SMS Worker A completed Mr Bailey's alcohol care plan and was allocated as his SMS worker on 11 November.

53. On 31 October, Mr Bailey attended court via video link and was sentenced to eight weeks' imprisonment for an assault committed in the community. Healthcare staff completed his secondary screening. They noted no concerns and Mr Bailey did not raise concerns about his additional sentence.

54. On 5 November, Mr Bailey was allocated full-time work in the kitchens. (Over the following months, his attendance at his employment was sporadic, and on 2 January 2025, staff removed him from this position.)

55. On 22 November and 3 December, Mr Bailey did not attend his SMS appointments with SMS Worker A. On 18 December, he went to the Recovery Hub and asked to be discharged from the SMS team. He told SMS Worker B, that he did not have a drug issue and did not require help from the service. SMS Worker B discussed reduced tolerance and overdose levels with Mr Bailey, and she was satisfied he understood this. She told Mr Bailey that he could self-refer into the service if he changed his mind in the future.

56. On 1 December and 9 January, Officer B conducted key worker sessions with Mr Bailey. During both of these sessions, Mr Bailey denied any issues with substances or debt and appeared settled on the spur.

57. On 9 January, Mr Bailey was given a disciplinary warning after staff found cannabis resin in his cell. The warning was later removed as staff accepted that the drugs belonged to Mr Bailey's cell mate.

58. On 4 February, Mr Bailey was allocated part-time work in a workshop, and this became a full-time position on 12 February. Mr Bailey reported sick on 18 and 19 February. A nurse reviewed Mr Bailey on 20 February after he complained of having an itchy rash. Mr Bailey was prescribed antihistamines and steroid cream.

59. Staff on B wing were advised by healthcare to follow their suspected bed bug protocol. Staff removed Mr Bailey's property to be cleaned and moved him to F wing. He was located in a cell on Spur 7 with another prisoner.

60. Staff did not raise any concerns about Mr Bailey in the two and a half days he was on F wing. On 22 February, Mr Bailey had a visit with his father and brother. Staff raised no concerns following this.

22 and 23 February

61. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to staff radio communications from 22 and 23 February. She also obtained information from the Yorkshire Ambulance Service. The following account has been taken from all sources.

62. At 6.50pm on 22 February, Officer C did the routine roll check of all prisoners on Spur 7 and spoke with Mr Bailey at the gate. Mr Bailey asked Officer C when he would get his property returned and Officer C said that it should be on Monday, 24 February. Officer C said that Mr Bailey was happy with this and was laughing and joking. Officer C knew Mr Bailey well and had no concerns about Mr Bailey's presentation during this interaction.

63. Between 6.50pm and 11.50pm, Mr Bailey was in and out of his cell. He returned to his cell at 11.51pm. This was the last time Mr Bailey was seen on CCTV.

64. Mr Bailey's cellmate told the investigator that Mr Bailey had been smoking PS in their cell sometime before midnight on 22 February. He said that Mr Bailey was sat on his bed talking to him at approximately 11.45pm.

65. At 5.31am on 23 February, Officer D entered Spur 7 to do the routine check of all prisoners. At 5.32am Officer D shone his torch into Mr Bailey's cell for four seconds. Officer D told the investigator that the roll check was completely unremarkable, and he could not recall anything specific about Mr Bailey's cell. Officer D told the investigator that the purpose of the roll count was to make sure that all prisoners were accounted for and where they should be.

66. A prisoner woke up at around 9.00am and saw Mr Bailey sat in the same place on his bed as the previous evening when they were talking. He touched Mr Bailey and shouted at him but Mr Bailey was cold and stiff. The prisoner left the cell and spoke with another prisoner. Both prisoners then re-entered Mr Bailey's cell at 9.02am. At 9.04am, both left the cell and the other prisoner told Officer F that Mr Bailey was dead in his cell. The prisoner told the investigator that he had taken a vape cap and paper with PS on it from near Mr Bailey and had put these in the kitchen bin before staff went into the cell.

67. At 9.05am, Officer E, Officer F, and Officer G entered Mr Bailey's cell. Officer E immediately radioed a code blue (an emergency medical code which means a prisoner has either stopped or is having difficulty breathing) and requested urgent assistance. Control room staff immediately called an ambulance. In his statement, Officer F noted that Mr Bailey was cold to the touch and had no pulse.

68. Nursing associate A arrived at the cell at 9.07am. She noted that Mr Bailey appeared deceased with mottling to his skin, rigid arms and fingers, and was cold to touch. Nurse B was also on her way to the cell. Nursing associate A radioed her and said she was not starting CPR as it would be futile. Nurse B arrived two minutes after Nurse B. On arrival, she agreed with Nursing associate A's assessment that CPR was not appropriate.

69. Paramedics arrived at the cell at 9.21am and pronounced Mr Bailey's life extinct at 9.32am.

70. Officers searched Mr Bailey's cell following his death. They found approximately 100 tablets of Mr Bailey's prescribed medication in the cell, which he should not have had, and 87 tablets of unprescribed mirtazapine (antidepressant). Some of the boxes of mirtazapine had printed pharmacy labels with the names of other prisoners on them. One of the named prisoners on the labels, told the investigator that he did not know how Mr Bailey had his medication but they had previously shared a cell.

Contact with Mr Bailey's family

71. The prison appointed Custodial Manager (CM) A as the family liaison officer. At 12.35pm, CM A and the Deputy Governor visited Mr Bailey's grandmother and broke the news of Mr Bailey's death and offered their condolences. Lindholme contributed to Mr Bailey's funeral costs in line with national instructions.

Support for prisoners and staff

72. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

73. After Mr Bailey's death, the Head of Residence, debriefed 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.

74. The prison posted notices informing other prisoners of Mr Bailey'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 Bailey's death. Listeners were made available across the establishment.

Post-mortem report

75. The pathologist concluded that the cause of Mr Bailey's death was drug toxicity. The toxicology analysis stated that there was evidence Mr Bailey had used synthetic cannabinoids in the hours before he died. Mirtazapine and pregabalin (a painkiller, not prescribed to Mr Bailey) were also found in Mr Bailey's system at a therapeutic level and had been taken in the hours before he died.

Inquest

76. The Coroner's inquest held in 24 March 2026 determined the medical cause of death to be drug toxicity.

Findings

Drug Use

77. Mr Bailey disclosed a history of substance misuse, primarily ketamine and cannabis, during his reception screens at Hull and Lindholme and requested to work with the substance misuse teams. During previous prison sentences, between June 2017 and February 2019, Mr Bailey had been found under the influence, primarily of PS.

78. There is little evidence to suggest that Mr Bailey was using drugs at either Hull or Lindholme. Mr Bailey was subject to a random mandatory drug test in Hull on 9 October which was negative. Officer C had known Mr Bailey when he was residing on B wing, just before his death. He told the investigator that he had not known Mr Bailey to be under the influence of drugs. He said other prisoners had also been shocked by his death as they had not known Mr Bailey to use drugs. The two prisoners who had shared cells with Mr Bailey did not report that he was a regular drug user.

79. There was some limited evidence that he may have been involved in drug supply and debt collection at Hull, however this was not evidenced at Lindholme.

80. We cannot say whether Mr Bailey's use of illicit drugs was regular, but it is clear that he used drugs the night before his death. We are satisfied that Mr Bailey was offered appropriate access to substance misuse services. We are also satisfied that prison staff have a reasonable understanding of what action to take if they consider someone to be under the influence.

81. In July 2023, HMIP noted that drugs were far too easily available in Lindholme, with cannabis and PS identified as the drugs most detected. Lindholme is particularly vulnerable to drones given there are multiple buildings spread out across approximately 128 acres of land, with a long perimeter fence line.

82. Lindholme has a Drug Strategy dated January 2024, which sets out the actions that the prison has taken and plans to take to eliminate the supply of drugs, reduce demand and promote user recovery. The Head of Drug Strategy said that Lindholme have introduced several important measures to try to address the issue of drones and the illicit drug economy problem, including working closely with the police and regional drug strategy teams, introducing a new drone protocol, and introducing amnesties for prisoners (allowing prisoners to voluntarily handover illicit drugs). Although they do not have enhanced gate security, The Head of Drug Strategy was satisfied that searching of staff and visitors had increased since the HMIP report.

83. This was the second drug death at Lindholme since October 2022. During that investigation, we found that the prison was taking proactive measures to try to stop drugs supply. Once again, we are assured that this is the case and make no recommendation.

Medication

84. Mr Bailey was prescribed medication for his long-term health condition which he routinely collected. However, following his death, approximately 100 tablets of Mr Bailey's prescribed medication were found in his cell, along with boxes of mirtazapine which had not been prescribed to him.

85. Mr Bailey's toxicology showed evidence of mirtazapine use and pregabalin use in the hours before his death. Mr Bailey was prescribed neither of these medications. Pregabalin is not given in possession to prisoners, meaning that they have to collect their prescribed pregabalin from the medication hatch and take it in front of healthcare staff. Mirtazapine can be prescribed to prisoners in their possession.

86. Mr Bailey's death suggests that trading and diversion of medication is occurring with apparent ease at Lindholme. Mr Holland told the investigator that prisoners often trade prescribed medication to get their preferred drug. However, there was no evidence, at the time, to indicate that Mr Bailey was trading medication and/or receiving medication from other prisoners.

87. In relation to medication diversion, the Head of Healthcare confirmed that the ability for prison and healthcare staff to minimise the risk of diversion of medication is a known concern. Nursing associate B explained that dispensing medication on the spurs is more manageable than on the standard wings. On the spurs, prisoners attend the Recovery Hub and are allowed to collect their medication one at a time. However, on the standard wings there are two medication hatches and often no prison staff are present to monitor the queue, which can result in multiple prisoners crowding at the medication hatch.

88. The Head of Healthcare explained that random spot checks are undertaken on those with in possession medication to check compliance. Healthcare staff will also undertake intelligence-led spot checks if intelligence is shared with them. Mr Bailey had not been subject to a spot check at Lindholme. Spot checks were directed to be completed on the prisoners named on the medication found in Mr Bailey's cell following his death.

89. We consider that the processes for spot checking in possession medication and monitoring the dispensing of medication need to be more robust and we make the following recommendation:

    The Governor and Head of Healthcare should introduce a robust and auditable process for monitoring the dispensing of medication across the prison.

Key working

90. Under the Offender Management in Custody (OMiC) model, every prisoner should have a dedicated key worker with whom they have weekly contact. Due to exceptional staffing and capacity pressures in parts of the estate, some prisons have been delivering adapted versions of the key work scheme while they worked towards full implementation. In a previous death at Lindholme, we raised concerns that the deceased had only received one key work session 10 weeks before his death. We were satisfied that their aim to provide a key work session to every

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prisoner every 28 days had led to an incremental improvement in the delivery of key work sessions.

91. At the time of Mr Bailey's death, Lindholme still aimed to deliver a key worker session to each prisoner once every 28 days, with additional sessions for priority cohorts. In April 2025, Lindholme completed 384 key worker sessions. However, in May and June, 810 and 778 were completed respectively. CM B leads on key working. He said that that any prisoners who do not receive a session in a 28-day period would be prioritised the following month.

92. Mr Bailey received two key working sessions whilst at Lindholme, on the 1 December and 9 January. While these did not occur within the 28-day periods, we are satisfied that Mr Bailey received sufficient sessions during his time at Lindholme. Given there was little to indicate that Mr Bailey was using illicit substances or trading medication, we do not consider that additional key worker sessions could have prevented Mr Bailey's death.

Routine Roll Checks

93. Routine roll checks are primarily a visual security check to count prisoners to ensure that they are present in their cells, but they are also an opportunity for any concerns about a prisoner's safety to be identified and managed. HMPPS' *Management of Internal Security Procedures Framework* expects welfare checks to take place at roll checks including that staff can see the prisoner's face and satisfy themselves that they are alive and well.

94. It seems likely that Mr Bailey was already deceased at the 5.30am roll check, given his cellmate said that he had not moved position from the night before when he found he was unresponsive and that signs of rigor mortis were present. Officer D carried out the early morning roll check and said that it was unremarkable. He could not remember anything specific about Mr Bailey's cell. Given that Mr Bailey was sitting upright, professional curiosity might have prompted the officer to check he was all right. Not doing so meant Mr Bailey's cellmate discovered Mr Bailey deceased, and also allowed him to remove a vape cap and paper with PS on from the cell before staff arrived (to our knowledge, although the police seized the contents of the kitchen bin, they did not find either item).

95. The Governor sent a notice to staff on 7 August 2024, directing that visual checks of prisoners should ensure that the prisoner is fine and there are no concerns around safety.

96. During their interviews in May 2025, Officer D and Officer C told the investigator that during a roll count staff were expected to check the prisoner was in the cell and it was not a welfare check. This indicates that the Governor's notice to staff has not been effective. The Head of Safety confirmed that he had re-sent the notice to staff reminding them of the requirement to ensure a prisoner is alive and well.

97. In a previous investigation, we found similar issues relating to insufficient routine roll checks. Experience tells us that notices to staff are not an effective means to change staff behaviour or make a genuine cultural shift. We therefore make the following recommendation:

The Governor should satisfy himself that there is a robust quality assurance process to ensure that roll checks are being undertaken in line with national and local policy.

Clinical Care

98. The clinical reviewer concluded that the clinical care Mr Bailey received was of a reasonable standard and was equivalent to that which he would have received in the wider community. She made no recommendations related to Mr Bailey's cause of death.

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