Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Arron Hamer, a prisoner at HMP Buckley Hall, on 21 June 2025

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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 Arron Hamer died in hospital on 21 June 2025, after being found hanging in his cell at HMP Buckley Hall on 18 June. He was 32 years old. I offer my condolences to Mr Hamer's family and friends.

Mr Hamer was the second prisoner to take his life at Buckley Hall since June 2022.

Mr Hamer had some risk factors for suicide and self-harm, including that he was serving Imprisonment for Public Protection (IPP). While he had seemingly settled at Buckley Hall, in the lead up to his death he did not attend work and later evidence indicated that he had been assaulted. Despite the outcome, we consider that staff's decision not to start suicide and self-harm prevention procedures (known as ACCT) was reasonable at the time, based on the information they had. However, wing staff might have demonstrated more professional curiosity to better understand the underlying reasons for Mr Hamer's changing behaviour.

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 **February 2026**

Contents

Summary

Events

1. On 3 October 2009, Mr Arron Hamer was sentenced to Imprisonment for Public Protection (IPP) for attempted robbery, with a tariff of just over two and a half years. In 2022, Mr Hamer was released from prison on licence but was recalled a year later.

2. Mr Hamer had a history of suicide attempts as a young child in the community. He had no history of attempted suicide or self-harm in prison and had never been monitored under suicide and self-harm procedures (known as ACCT). Mr Hamer had an extensive history of substance use.

3. On 30 April 2025, Mr Hamer transferred to HMP Buckley Hall. After seeming to settle into the prison well, in the days before he died Mr Hamer stopped attending work and told staff that he was ill. After he died, several pieces of intelligence indicated that Mr Hamer had been assaulted due to a drugs debt and had sold or given away some of his possessions.

4. At around 2.09pm on 18 June, staff found Mr Hamer hanging in his cell. Healthcare staff arrived around three minutes later and started CPR. Paramedics took Mr Hamer to the Royal Oldham Hospital, where he died at 4.15pm on 21 June.

Findings

5. Mr Hamer had some risk factors and apparent triggers for suicide and self-harm. While it was reasonable that staff did not start suicide and self-harm procedures (known as ACCT) based on what they knew at the time, it is important that staff identify and properly explore behaviour changes, such as a refusal to attend work, to help determine whether there are any underlying issues.

6. When officers found Mr Hamer, they did not start CPR until healthcare arrived, around three minutes later. Officers did not provide an adequate handover to healthcare staff when they arrived at the cell and they did not initially realise that that Mr Hamer had been found hanging.

The Investigation Process

7. HMPPS notified us of Mr Hamer's death on 21 June 2025.

8. The investigator issued notices to staff and prisoners at HMP Buckley Hall informing them of the investigation and asking anyone with relevant information to contact her. A prisoner's solicitor contacted the investigator to provide information on behalf of the prisoner, who wished to remain anonymous and subsequently declined to be interviewed.

9. The investigator visited Buckley Hall on 4 July. She obtained copies of relevant extracts from Mr Hamer's prison and medical records. She also obtained CCTV and body worn video camera footage of the emergency response, the HMPPS Early Learning Review and North West Ambulance Service records.

10. NHS England commissioned an independent clinical to review Mr Hamer's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed five members of prison and healthcare staff in August 2025.

11. The investigator additionally interviewed eight members of staff and four prisoners.

12. We informed HM Coroner for Greater Manchester North of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

13. The Ombudsman's office contacted Mr Hamer's mother and partner to explain the investigation and ask if they had any matters they wanted us to consider. Mr Hamer's partner said that when she saw him in hospital, Mr Hamer had injuries on his face that were clearly days old. She also said that he had cancelled his visit with her on 14 June as he said he had a stomach bug. She wanted to know when he was last checked. Mr Hamer's mother told us that she had been contacted by a prisoner, via their solicitor, who indicated that the CCTV from a couple of days before his death was relevant.

14. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies which we have amended.

15. We also shared the initial report with Mr Hamer's mother and partner. They did not make any comments.

Background Information

HMP Buckley Hall

16. HMP Buckley Hall is a category C training prison. Spectrum Healthcare provides physical healthcare services and Greater Manchester Mental Health (GMMH) provide mental health services. Change Grow Live (CGL) provides drug and alcohol services.

17. The Aspire unit (actively supporting progression in a rehabilitative environment) is a unit for those serving indeterminate sentences. The unit aims to provide opportunities for prisoners to demonstrate progression. Prisoners have access to cooking facilities which enables them to live more independently. The unit has a local incentive scheme called enhanced behaviour monitoring (EBM) which includes three stages in which prisoners can earn more privileges.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Buckley Hall was in February 2024. Inspectors reported that Buckley Hall remained a generally safe prison but that a lack of grip on the safety strategy in recent years was reflected in an increase in drug use, violence and self-harm. They noted that leaders in some functions, including safety, had not always used data effectively to inform plans to drive and monitor improvement. However, they found that, at the time of the inspection, there were early signs of improvement.

19. Inspectors found that rates of self-harm were lower than similar prisoners but were much higher than at the last inspection. They found that there had been recent improvements in investigations of serious self-harm incidents but some weaknesses persisted, particularly in a failure to thoroughly explore the underlying reasons behind prisoners' self-harm. Inspectors noted that violent incidents were investigated to a reasonable standard, although subsequent support plans for those involved were not always effective. They also found that staff did not always set and reinforce high standards of prisoner behaviour and low-level rule breaking sometimes went unchallenged.

20. Inspectors reported that 48% of prisoners said it was easy to get illicit drugs and, over the six months prior to the inspection, 27% of random drug tests were positive. They found that there was a good drug strategy and a dedicated senior leader focused on this area, overseeing some excellent joint working between prison staff and substance use services. However, they found that only 58% of requested cell searches had been completed in the past three months and the monthly drug strategy meeting had been cancelled for two consecutive months due to staff unavailability.

21. The inspection found that much of the prison's success was predicated upon excellent staff and prisoner relationships, both informally but also through a targeted application of the key work scheme aimed at prioritising high risk or more vulnerable prisoners. They noted that key work was among the best they had seen.

Independent Monitoring Board

22. 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 July 2024, the IMB reported that incidents of self-harm and the number of open ACCTs increased at the start of 2024 and had remained at a concerning level.

23. The board found that there were 22 incidents of violence between April and June 2024. They noted that incidents of prisoners being found under the influence had increased substantially.

24. The IMB noted that improvements had been made on the Aspire Unit, but they felt that much more needed to be done if it was to successfully prepare prisoners for release. They found at, as of July 2024, there were 45 prisoners serving IPP sentences at Buckley Hall.

Previous deaths at HMP Buckley Hall

25. Mr Hamer was the fourth prisoner to die at Buckley Hall since June 2022. One of these deaths was self-inflicted. There were no significant similarities between our findings in the previous self-inflicted death and those in this investigation. To the end of November 2025, there have not been any more deaths at Buckley Hall.

Assessment, Care in Custody and Teamwork (ACCT)

26. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

27. Part of the ACCT process involves assessing immediate needs and drawing up support actions to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all support actions are completed. Guidance on ACCT procedures is set out in the Prison Safety Policy Framework (from January 2025, and prior to that Prison Service Instruction (PSI) 64/2011 on safer custody).

Imprisonment for Public Protection (IPP) sentences

28. Imprisonment for Public Protection (IPP) sentences were introduced in 2005 and abolished in 2012. They were intended to protect the public against offenders whose crimes were not serious enough to merit a normal life sentence, but who could only be released once they had served their minimum tariff and had demonstrated to the satisfaction of the Parole Board that they had sufficiently reduced their risk. As of March 2025, there were 2,544 IPP prisoners, of which 1,012 had never been released and 1,532 had been recalled to custody.

29. In April 2023, the government published a refreshed IPP action plan to ensure HMPPS systems and processes effectively supported those serving an IPP

sentence. As part of this, each area has an IPP Delivery Plan which was rolled out in June 2024.

30. In December 2024, HMPPS developed and issued an IPP Safety Toolkit which includes a focus on raising awareness of the risks of suicide and self-harm for those serving an IPP sentence. The Safety Policy Framework highlights IPP prisoners as a high-risk cohort.

Key Events

31. On 3 October 2009, Mr Arron Hamer was remanded to HMP Hindley. On 9 April 2010, Mr Hamer was sentenced to Imprisonment for Public Protection (IPP) for attempted robbery. He was given a tariff of just over two and a half years.

32. Mr Hamer had a history of suicide attempts between the ages of seven and ten. He had no history of attempted suicide or self-harm in prison and was never managed under suicide and self-harm (ACCT) procedures.

33. Mr Hamer had a history of anxiety. He also had a history of illicit substance use both in the community and in prison. During his time in prison, he engaged at various points with substance use teams. In 2024, Mr Hamer told a member of the probation service that his use of cocaine was to mask suicidal thoughts.

34. On 4 April 2022, Mr Hamer was released from prison on licence.

35. On 18 April 2023, Mr Hamer was recalled for failing several drug tests and was sent to HMP Preston. Prior to his recall, Mr Hamer told a member of probation staff that he had experienced suicidal thoughts.

36. On 2 May, Mr Hamer transferred to HMP Wymott.

37. On 1 July, staff referred Mr Hamer to the OUT Spoken therapy service. (OUT Spoken is part of We are Survivors charity and is designed to help individuals understand the impact of unresolved trauma, maladaptive coping mechanisms and explore how past experiences may be connected to offending.) Mr Hamer remained on the waiting list while he was at Wymott. Mr Hamer was not prescribed any mental health medication following his recall to prison.

38. During his time at Wymott, Mr Hamer tested positive in mandatory drug tests for non-prescribed medication on three occasions. (Mr Hamer said that he had used other prisoners' prescribed medication for his own pain relief).

39. On 11 December 2024, Mr Hamer attended a Parole Board hearing. The Parole Board did not recommend Mr Hamer for release. They noted that Mr Hamer needed to develop a better understanding of the risks of substance use. In January 2025, Mr Hamer moved onto the therapeutic community at Wymott as part of his sentence plan. (The therapeutic community provides a structured, therapeutic environment for prisoners with substance dependency issues.)

40. In March, Mr Hamer's prisoner offender manager (POM) made a referral to the Aspire unit at HMP Buckley Hall on Mr Hamer's behalf. On 9 April, she informed Mr Hamer that he had been accepted onto the unit. She recorded that Mr Hamer was happy with this.

41. On 8 April, Mr Hamer told his drug recovery practitioner that he felt good and that he was drug free. He said that he experienced anxiety and woke up in the morning thinking that something bad was going to happen that day. He also explained he would like to sleep better. The drug recovery practitioner recorded that she discussed counselling support offered by We are Survivors. She noted that she had

made a referral on Mr Hamer's behalf which he was happy with. (Mr Hamer had already been referred and was on the waiting list.)

HMP Buckley Hall

42. On 30 April, Mr Hamer transferred to Buckley Hall. In his first night interview, Mr Hamer said that he was happy to be at Buckley Hall and did not have any thoughts of suicide or self-harm. During his initial health screening, healthcare staff incorrectly recorded that Mr Hamer said he had not previously used drugs. Mr Hamer again said he had no thoughts of self-harm. At the time of his transfer, Mr Hamer was not prescribed any medication for mental ill health.

43. On 2 May, the substance use orderly (a prisoner employed to assist the substance use service) completed an induction meeting with Mr Hamer. Mr Hamer confirmed that he wanted support from the substance use service.

44. On 7 May, a nurse saw Mr Hamer for a mental health induction screening. (This screening is conducted for all new prisoners.) Mr Hamer declined a referral to the mental health team. He explained that he had received support for his trauma (related to historical events) and that he was engaging with the substance use team. (Mr Hamer had only engaged with the substance use orderly at this point.)

45. Mr Hamer did not disclose any thoughts of suicide or self-harm. The nurse told Mr Hamer that he would be discharged from the mental health team but told him how to put in an application if he required support.

46. On 9 May, Mr Hamer met his new POM. They discussed Mr Hamer completing the Building Choices programme (which aims to address both offence-specific and wider offending behaviour risks).

47. On 13 May, the substance use orderly saw Mr Hamer and completed an initial substance use assessment. Mr Hamer said that he was motivated to better himself. He told the orderly that he started using illicit substances at an early age but was not currently using drugs. He said that he wanted to participate in groups on cocaine awareness and triggers. Staff allocated Mr Hamer with a recovery worker.

48. On 15 May, Mr Hamer met his key worker. She introduced herself and told him that she would aim to see him three times a month. They spoke about his sentence, the reasons for his recall, his parole and where he would like to work while at Buckley Hall.

49. Mr Hamer told his key worker that he had settled in okay, that his mental health was fine and he had no issues to raise. He explained he would have family support while he was at Buckley Hall. (Mr Hamer had regular phone calls with his partner, mother and friends, speaking on the phone almost every day.)

50. The key worker asked Mr Hamer about drug use and he explained he had issues in the community where he used cocaine daily but not so much while in prison. He said he was going to engage with the substance use service.

51. On 19 May, Mr Hamer started working in the fabric workshop (Workshop 2).

52. On 23 May, Mr Hamer had an introductory counselling session with a therapist from the OUT Spoken therapy service. (Mr Hamer met the therapist for a further three sessions, with the last session taking place on 13 June.)

53. On 21 May and 29 May, Mr Hamer tested negative for drugs. (On the Aspire unit, prisoners are supposed to have voluntary drug tests every fortnight. Mr Hamer did not receive any further drug testing. A Custodial Manager (CM) told us that this was due to staffing shortages.)

54. On 28 May, Mr Hamer met his recovery worker. He said that he had not used cannabis and cocaine for years and that he was not currently using any substances. The recovery worker told Mr Hamer that she would see him every four weeks. Mr Hamer told the recovery worker that he was not keen on the Aspire unit because of the number of prisoners serving life sentences but knew it was a progressive move and that he wanted to keep his head down.

55. On 2 June and 10 June, Mr Hamer attended group sessions run by the substance use team on cocaine awareness and triggers and risks awareness. Staff did not raise any concerns about him.

56. In June, due to staff shortages, Mr Hamer only worked half days in Workshop 2.

57. On 9 June, Mr Hamer met his key worker. He said that he was doing okay. The key worker noted that he presented as settled and positive. Mr Hamer told the key worker that he was engaging with the substance use team and had recently met a psychologist who had considered him suitable for the Building Choices programme. Mr Hamer told her that he did not have any current issues with his mental health and did not require any additional support at that time.

58. On 9 June, Mr Hamer called a friend. He told him that a prisoner was getting out and was going to meet his friend with some “green” (a term often used for cannabis), £100 and a phone. (All prisoners’ telephone calls are recorded. Prison staff listen to some at random and others are listened to if security staff have intelligence that information about the safety of individuals or the prison might have been discussed. No one listened to Mr Hamer’s calls until after his death.)

59. On 11 June, Mr Hamer met his POM and his new community offender manager (COM). Mr Hamer told them that he was engaging with trauma support with We are Survivors. Mr Hamer explained he found this okay because it was more of a catch-up conversation than therapy and much less intensive than what he had done in the past. They spoke about him completing the Building Choices programme, which was likely to start in July, and his engagement with the substance use service.

60. After the meeting, the POM spoke to Mr Hamer for around an hour as they waited to go back to the unit. Mr Hamer spoke about his IPP sentence and the injustices of this. Mr Hamer spoke about his future plans, including that he wanted to go to America when he had finished his IPP sentence.

61. On 12 June, Mr Hamer called his partner and spoke to her for 18 minutes. (This was his last recorded phone call.) Mr Hamer and his partner spoke about several topics and Mr Hamer did not raise any concerns. They spoke about Mr Hamer’s

new COM and that he was happy he had a new one, but Mr Hamer also said that he was unhappy that he had had four different COMs in the last two years.

62. That day, a staff member submitted an intelligence report that Mr Hamer was in possession of a mobile phone which he used after he was locked up and on the weekends.

63. Security staff added Mr Hamer to the cell search list and rated this as an "amber" cell search. (The time frame for staff to conduct an "amber search" is within a month.) Staff did not search Mr Hamer's cell before he died. (Police informed us that the post-mortem examination found a mobile phone concealed in Mr Hamer's rectum.)

64. On 13 June, the therapist met Mr Hamer. At interview, she told the investigator that Mr Hamer seemed in good spirits and was laughing and joking. Mr Hamer told her that he was looking forward to his visit that weekend. Mr Hamer spoke with the therapist about his progression, parole and plans for the future. She did not have any concerns and said she did not note any change in his behaviour.

65. On 14 June, Mr Hamer was due to have a visit from his partner. This did not go ahead. (At the hospital, Mr Hamer's partner told the prison's family liaison officer that Mr Hamer had cancelled this visit and told her he had sickness and diarrhoea.) There is nothing in Mr Hamer's prison record about the reasons for the cancelled visit and no record he was ill on this day.

66. Mr Hamer's partner told the prison's family liaison officer that she spoke to Mr Hamer on 15 June. (This was not recorded on the prison system which suggests this was made using a mobile phone.) Mr Hamer's partner said that this conversation did not raise concerns.

67. A prisoner, via their solicitor, told the investigator that two prisoners on the wing were supplying Mr Hamer with drugs. (This prisoner declined to be interviewed for this investigation. We believe this is the same prisoner who advised Mr Hamer's family of the relevance of CCTV in the time before Mr Hamer's death.) He said that around two to three days before Mr Hamer was found hanged, a prisoner entered Mr Hamer's cell with three other prisoners and assaulted him. The prisoner said that these prisoners bullied Mr Hamer for payment for drugs. (There is no evidence that Mr Hamer reported this alleged assault or bullying to staff.)

68. A prisoner who lived next door to Mr Hamer told the investigator that Mr Hamer seemed a bit different in the days before he was found hanged and that he told the prisoner that he was "stressed out". The prisoner told the investigator that he noticed bruising on Mr Hamer's eye and a scratch on his face around a week before. He said that Mr Hamer tried to get rid of his CDs and asked prisoners if they wanted to buy them.

69. Another prisoner said that he did not notice any change in Mr Hamer in the lead up to him going to hospital. He told the investigator that Mr Hamer continued to spend time in his cell during the association period but that this was normal for him.

70. On 16 June, an officer recorded in Mr Hamer's prison record that he had refused to attend work and had reported as sick. No record was made in the wing observation

book to alert other staff. The officer told the investigator that Mr Hamer said he did not feel well. She told us that she thought she added Mr Hamer to the triage list for healthcare to see the following day. There is no evidence that Mr Hamer was seen by healthcare staff.

71. A workshop instructor said that wing staff told her that Mr Hamer had reported as "rest in cell" as he was not well. (Rest in cell is a term that usually means a prisoner is not attending work or education because they are ill.)

72. That afternoon, a treatment manager spoke to Mr Hamer to check that he intended to complete the Building Choices programme. The treatment manager recalled that he went to Mr Hamer's cell at around 3.15pm and spoke to Mr Hamer through his door. He noticed that Mr Hamer's cell was dark, but he did not have any concerns about Mr Hamer.

73. On 17 June, an officer spoke to Mr Hamer at his cell door. She told the investigator that Mr Hamer was lying in bed with his curtains drawn. He told her that he did not feel good and did not want to go to work. The officer told the investigator that she told Mr Hamer that he would either need to get a sick note or go to work the next day. Mr Hamer said he did not know how to get a sick note and the officer told him how to contact healthcare.

74. That day, an officer gave Mr Hamer a negative behaviour warning for failing to attend work without a medical certificate. (The officer was absent from work so we were unable to interview him. His manager told us that he was completing admin tasks that day, did not interact with Mr Hamer and put the entry on behalf of the wing officers. We do not know who requested this warning, and if Mr Hamer was told about this.)

75. That day, Mr Hamer checked his balance on his phone. (Mr Hamer did not have any credit on his prison phone account. He had £22.00 in his prison account, but the last time he purchased phone credit was 30 April.)

Events of 18 June

76. The following account has been drawn from staff statements, interviews, body worn video camera (BWVC) footage, CCTV footage and ambulance service records.

77. At around 8.30am, an officer unlocked Mr Hamer's cell. She looked through the observation panel and moved on. (The officer was not based on the Aspire Unit and had not met Mr Hamer before).

78. At around 9.00am, Mr Hamer left his cell for around a minute. That morning, several prisoners went in and out of Mr Hamer's cell.

79. A prisoner told the investigator that he spoke to Mr Hamer that morning. Mr Hamer told him that he had not been feeling too well but that he might go to work that afternoon. The prisoner said that Mr Hamer seemed like himself and he did not notice anything different about him. Another prisoner told the investigator that he spoke to Mr Hamer that morning and said that he did not notice anything different about him or have any concerns. He explained that Mr Hamer's cell was pretty much empty but that he did not come to prison with many things.

80. At around 9.55am, an officer went to Mr Hamer's cell as part of a routine check. He returned around 40 minutes later and opened Mr Hamer's flap. (The officer told the investigator that he thought this was part of the accommodation fabric check.) The officer said that he did not work on the Aspire unit, did not know Mr Hamer and did not recall anything about this interaction.

81. At around 11.05am, an officer unlocked Mr Hamer's cell. Mr Hamer left his cell for a few seconds. At 11.40am, a prisoner went into Mr Hamer's cell and left around nine minutes later. From CCTV it is possible to see this prisoner moving around the cell and raising his arms, possibly in frustration. (This prisoner declined an interview with the PPO.)

82. At 11.47am, another prisoner joined them in the cell and left around two minutes later. The CCTV does not provide a clear picture but it appears that this prisoner walked around the cell and at certain points gestured with his arms.

83. At 11.52am, Mr Hamer shut his cell door. At 12.03pm, an officer opened Mr Hamer's observation panel and looked into the cell. Around four minutes later she opened the panel again and looked in to conduct a routine check. At interview, she could not recall what she saw but assumed she had seen Mr Hamer and did not have any concerns.

84. At around 1.43pm, an officer started unlocking prisoners who were going out for work. She walked past Mr Hamer's cell. (The officer told the investigator that she had seen on the board in the wing office that Mr Hamer was "rest in cell".)

85. At 2.09pm, two officers conducted the afternoon routine check. One officer opened Mr Hamer's observation panel (which appears from CCTV to be blocked), unlocked the door and told the other officer to call a medical emergency code blue, indicating a life-threatening situation. The second officer immediately radioed a code blue and switched on her body worn video camera. (The first officer did not switch on her body worn video camera until a few minutes later.)

86. The officers entered the cell and saw Mr Hamer sitting under the desk with a ligature (made from fabric) tied from the window frame. The first officer cut the ligature and Mr Hamer fell backwards under his desk and banged his head. The officers started to move him from under the desk. The first officer told the investigator that Mr Hamer was very warm to touch and said on body worn video that she could not find a pulse.

87. At 2.10pm, another officer arrived and told the other officers to put Mr Hamer in the recovery position and shouted for a defibrillator. She then escorted one of the officers, who was visibly distressed, away from the scene.

88. At 2.12pm, additional officers arrived and cut the ligature from around Mr Hamer's neck. A CM instructed officers to look for a pulse. Around 30 seconds later, healthcare staff arrived and, at 2.13pm, a nurse started CPR.

89. Around 30 seconds later, a nurse asked if Mr Hamer had been found hanging. Someone responded that he had. (The Head of Safety confirmed that this was an officer.)

90. At 2.22pm, the nurse asked what had happened and the CM told the nurse that Mr Hamer was found hanging. The nurse asked whether he was suspended. The CM explained that he had sent off the officers who were first on scene so had not had a debrief with them yet.

91. At 2.25pm, paramedics arrived at the cell and continued CPR. At around 2.27pm, they managed to restore Mr Hamer's circulation, although he remained unconscious throughout.

92. At 3.05pm, paramedics took Mr Hamer to Royal Oldham Hospital. He died at 4.15pm on 21 June.

93. At the hospital, nurses handed Mr Hamer's family a note which said, "I'm forgiven (I hope)." Mr Hamer's family could not confirm that this was Mr Hamer's handwriting and we do not know when or who wrote this. (The note was originally used by healthcare staff to record observations during the emergency response. We do not know where they obtained it.)

94. After Mr Hamer went to hospital, staff and prisoners submitted a number of intelligence reports and other information concerning Mr Hamer including the following

- Mr Hamer had sold a lot of his property and was believed to be in debt.
- Prisoners had noticed marks to his face earlier in the week.
- Mr Hamer was assaulted in his cell on the weekend of 14 June, over a drug debt.
- Mr Hamer was in debt for psychoactive substances (PS) and something had happened between him and another prisoner on the Aspire unit.
- Mr Hamer had not been to work for two weeks and said he had the flu, that he was sick of his IPP sentence and that he had got rid of some of his things. (When the investigator visited Mr Hamer's cell, a number of CDs had been posted through the door, which might indicate that prisoners had returned them following his death.)
- Mr Hamer was hit in his cell and took his life due to being in debt for £50.
- Mr Hamer had been slapped in the workshop.
- A prisoner had been putting pressure on Mr Hamer for information about an event in the community and had mentioned £10,000.
- At the hospital, Mr Hamer's family and the Head of Safety identified that he had a black eye and yellow bruising on his face.

95. The police seized a grey sweatshirt from Mr Hamer's cell with blood stains on the right chest and on the left sleeve. They also noted blood stains on a pillowcase under the bed, on one of the pillows and on a sheet under the table in the corner of the cell. At the time of writing, the police were still making enquiries in relation to an alleged assault.

Contact with Mr Hamer's family

96. The prison appointed an officer as family liaison officer and the Head of Safety as the deputy. At 3.52pm on 18 June, the deputy family liaison officer phoned Mr Hamer's partner, explained what had happened and advised her to attend the hospital. She asked Mr Hamer's partner to inform Mr Hamer's mother. (The phone number that the prison had for Mr Hamer's mother did not connect.)

97. At 5.20pm, the family liaison officer and the deputy family liaison officers met Mr Hamer's mother and partner at the hospital. They stayed in contact with them over the following days while Mr Hamer remained in hospital.

98. The prison contributed toward the cost of Mr Hamer's funeral in line with national policy.

Support for prisoners and staff

99. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted 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.

100. After Mr Hamer went to hospital, the duty senior manager debriefed the operational and healthcare 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.

101. The prison posted notices informing other prisoners of Hamer'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 Hamer's death. The prison deployed Listeners onto the wing the day after Mr Hamer's death. (The prison informed us that there were issues with a contingency plan being completed when Mr Hamer died which caused delays to deploying the Listeners. The Head of Safety told the investigator that information has now been shared with all senior managers relating to contingency plans and a grab pack has been developed for duty managers to use following a death in custody.)

Post-mortem report

102. The report of the post-mortem examination concluded that Mr Hamer died from complications from hanging.

103. The toxicology report identified a low level of mirtazapine (an antidepressant). Mr Hamer was not prescribed mirtazapine and we do not know how he obtained this.

104. The post-mortem report identified other injuries, including yellow bruising and scratches on the right side of Mr Hamer's face. The pathologist noted that these bruises typically take 18 hours to develop and indicated that the bruise was caused

before Mr Hamer was found hanging. They also noted that Mr Hamer's nose was broken but were unable to identify the time frame for this.

Findings

Identifying the risk of suicide and self-harm

105. The Prison Safety Policy framework requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm and to manage prisoners identified as at risk under ACCT procedures.

106. The guidance note accompanying the Prison Safety Policy Framework identifies several factors that could be indicators that prisoners are being victimised. These include becoming withdrawn or reluctant to leave their cell, their cell being empty of personal possessions, or refusing to attend work or education.

107. Mr Hamer had some risk factors for suicide and self-harm: he had a history of attempted suicide at a young age in the community, a history of substance use and he was an IPP prisoner. In the days before his hanging, Mr Hamer stopped attending work, and told officers that he was ill. Mr Hamer had not missed work before while at Buckley Hall and this therefore indicated a change in behaviour.

108. It is not unusual for prisoners to decline to attend work for what they say are health reasons, but staff should recognise that this can potentially disguise other issues. Intelligence reports after Mr Hamer's death suggested that it is likely he was assaulted in the lead up to his death, that he may have been in debt and that he had sold or given away some of his possessions. While there is no evidence that prison staff were aware of this until after Mr Hamer went to hospital, there is also no evidence that anyone considered that Mr Hamer's withdrawal might be indicative of a wider issue or noticed that he had seemingly sustained bruising to his face.

109. The CM told the investigator that around the time of Mr Hamer's death there were staffing challenges meaning that there were a lot of guest staff who did not know the prisoners on the Aspire unit. The CM said that the guest staff on the unit would not then notice if a prisoner had fewer possessions in their cell than normal. (There was also a presence of permanent Aspire unit staff at the time, none of whom identified that Mr Hamer had fewer possessions.)

110. At Buckley Hall, the expectation is that IPP prisoners are seen for key work sessions three times a month. Mr Hamer had two key work sessions during his time at Buckley Hall. We found that, while Buckley Hall has a dedicated cohort of key workers, they are often redeployed to other duties due to staff shortages. (In August 2025, Buckley Hall had around 30% of staff unable to complete normal duties, for various reasons including maternity leave or those on restricted duties. Their priority therefore was to deploy staff to allow them to run the regime.) Key work sessions are particularly important to staff/prisoner relationships and fewer key work sessions give staff less chance of identifying whether a prisoner has any new or underlying issues that might affect their risk of suicide and self-harm.

111. In the absence of regular key work, staff need to be even more vigilant about changes in behaviour. The Head of Safety told us that in June and August, the prison delivered upskilling training aimed at covering risks, triggers and protective

factors. She also informed us that the prison are currently reviewing their rest in cell procedures to ensure that officers properly record and share information.

112. While we do not think it was unreasonable for staff not to start ACCT procedures, based on the information they knew at the time, the Governor will want to ensure that staff explore changes in behaviour in further detail to ensure that there is appropriate support in place.

Clinical care

113. The clinical reviewer concluded that the clinical care Mr Hamer received at Buckley Hall was equivalent to that which he could have expected to receive in the community.

114. A mental health nurse saw Mr Hamer within one week of his arrival at Buckley Hall, as is standard for all prisoners arriving at the prison. Mr Hamer declined any support from the mental health team but was provided with information on how to access mental health services. When he entered Buckley Hall, Mr Hamer was seen promptly for trauma therapy.

115. Mr Hamer was allocated a drug recovery worker and referred for a number of group work interventions. The clinical reviewer found that there was comprehensive and person-centred support by the substance use service.

Illicit drug use

116. The toxicology report found that Mr Hamer had mirtazapine, which was not prescribed to him, in his system. (Prisoners sometimes use mirtazapine illicitly due to the sedating effects of the medication.) We do not know how Mr Hamer obtained this medication. There are also intelligence reports, submitted after Mr Hamer died, which suggest that he may have been in debt for drugs.

117. From July 2024 to June 2025, the average positive mandatory testing rate for illicit substances was 37%. This is very high and suggests that prisoners find it easy to access substances in the prison. The prison is currently reviewing and updating the drug strategy. The Governor will want to ensure that this includes measures in place to prevent the diversion of medications. Once the strategy is finalised, he will want to ensure that this is properly communicated to staff and is reviewed regularly to ensure that the positive testing rate decreases.

Emergency response

CPR and ligature

118. The Prison Safety Policy Framework notes that staff must attempt resuscitation unless there is a reason not to do (such as a do not attempt CPR order). It also notes that all staff who have contact with prisoners must be familiar with how to use a ligature tool. The first three officers on scene had all been trained in first aid in the last three years.

119. When staff found Mr Hamer hanging in his cell, an officer immediately cut the ligature from the window. However, it took around two and a half minutes before staff cut it from around Mr Hamer's neck. One officer said she was following the other officer and she did not realise that the ligature was still around Mr Hamer's neck. (We were not able to interview the other officer as she was on an extended absence from work.)

120. No one started CPR until healthcare staff attended Mr Hamer's cell, around three and a half minutes after staff called the emergency code. (We acknowledge that some of this time was spent trying to move Mr Hamer.) The CM, the duty manager, said that he did not know whether the staff were first aid trained and did not start CPR himself as he had other responsibilities, including ensuring that information was handed over to the paramedics.

121. We cannot say whether these delays made a difference to the outcome for Mr Hamer but in cases of hanging the swiftest possible response is necessary.

122. The Head of Safety informed us that a training video, covering cutting a ligature and starting CPR, has been sent to all line managers for them to go through individually with all staff members. The Governor will wish to consider what more can be done to support dynamic decision making (including starting CPR where necessary) in high stress situations.

Informing the ambulance

123. Prison Service Instruction (PSI) 03/2013 (Medical Emergency Response Codes) notes that local protocols must explain that the member of staff using the medical emergency code must also provide relevant information about the condition of the prisoner to control room staff, so that they can pass it on to the ambulance service for use in the triage process. This is particularly important in a life-threatening situation, to ensure that the ambulance service can give the emergency the appropriate priority.

124. On 17 October 2024, Buckley Hall issued a notice to staff covering medical emergency codes for emergency responses. This set out the information, including whether the prisoner was breathing, which should be given to the prison control room as soon as possible after calling the emergency code.

125. After an officer called the emergency code, the control room called an ambulance. However, control room staff were not initially able to confirm the condition or whether Mr Hamer was breathing. They asked three times for staff on the scene to give an update for the ambulance service, and it took a minute and a half to get information to pass on. This meant that there was a delay before ambulance service controllers were able to set the emergency as the highest priority.

126. While on this occasion there was not a considerable delay, the Governor will want to ensure that staff understand the importance of swiftly providing additional information after they call an emergency code.

Inquest

127. The inquest into Mr Hamer's death concluded on 11 June 2026, and recorded a verdict of suicide.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100