Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Damien Horner a prisoner at HMP Lindholme on 6 March 2019

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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 Damien Horner was found hanged in his cell in the segregation unit at HMP Lindholme on 6 March 2019. He was 24 years old. I offer my condolences to Mr Horner's family and friends.

While Mr Horner had some risk factors for suicide and self-harm, I am satisfied that there was little to indicate that he was at heightened risk in the period before his death. Despite this, I am concerned that there was little investigation into the underlying reasons behind the behaviour that led to Mr Horner's segregation. Segregation unit staff also appear to have had little quality interaction with Mr Horner, contrary to national instructions for segregated prisoners, and I am concerned that this would have limited their ability to support him.

I am also concerned that there were deficiencies on the night of Mr Horner's death, including a delay of several minutes before anyone opened his cell.

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 **September 2019**

Contents

Summary

Events

1. On 7 September 2017, Mr Damien Horner was remanded in custody to HMP Hull. He was later sentenced to five years and four months in prison. Mr Horner was diagnosed with depression and prescribed medication to treat this throughout his time in custody. In March 2018, he was transferred to HMP Lindholme.

2. At Lindholme, prison staff opened suicide and self-harm prevention procedures, known as ACCT, three times. The most recent ACCT was opened in September 2018, when Mr Horner broke furniture in his cell and cut his wrist in the process.

3. From 22 to 24 January 2019, Mr Horner engaged in disruptive behaviour, including damaging prison property and threatening to assault staff and other prisoners. He was subsequently segregated. Mr Horner's disruptive behaviour continued in his first weeks in the segregation unit and, on 15 February, he threw faeces over four prison officers, an assault which was reported to the police to investigate. Because of his disruptive behaviour, prison staff arranged for Mr Horner's future transfer to HMP The Mount, which would be further from where his family lived.

4. At around 5.30am on 6 March, the night patrol officer found Mr Horner's observation panel partially blocked. From what he could see in the cell, the night patrol officer thought that Mr Horner might be hanging. He called for assistance, and when colleagues arrived, they opened the cell and found that Mr Horner had died. Mr Horner had left notes in his cell to his family, in which he indicated that he had made a clear decision to end his life.

Findings

Identifying the risk of suicide and self-harm

5. Although Mr Horner had some risk factors for suicide and self-harm, we found there was little to indicate to prison staff that he was at heightened or imminent risk in the period before his death. We consider that it would have been difficult for staff at Lindholme to have foreseen or prevented his actions.

Mr Horner's segregation

6. Decisions to segregate Mr Horner were reasonable and appropriate given the disruptive and violent nature of his behaviour. However, the underlying reasons for this behaviour, and the suggestion that it was related to debt and the corresponding fear of violence, were not properly investigated. We also found that segregation unit staff did not hold good quality conversations with Mr Horner at the frequency required by national instructions.

Emergency response

7. Staff took too long to go into Mr Horner's cell and call for emergency medical assistance when they found him hanging.

Sharing our report with staff

8. We consider that it is important for staff who were involved in Mr Horner's care to see the findings of and learn lessons from our investigation.

Recommendations

- The Governor should ensure that all information indicating violence, bullying, debt and intimidation is fully coordinated and investigated and that apparent victims are effectively protected and supported.
- The Governor should ensure that segregation unit staff carry out good quality conversations with all prisoners, in line with the requirements of PSO 1700.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
  - night staff enter cells as quickly as possible in a life-threatening situation; and
  - night staff use the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.
- The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

The Investigation Process

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

10. The investigator obtained copies of relevant extracts from Mr Horner's prison and medical records.

11. The investigator interviewed nine members of staff at Lindholme in April 2019. He interviewed one further member of staff by telephone in May.

12. NHS England commissioned a clinical reviewer to review Mr Horner's clinical care at the prison. The clinical reviewer joined the investigator for interviews with clinical staff

13. We informed HM Coroner for South Yorkshire (Eastern District) of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Horner's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Horner's mother asked what medication he was prescribed for his mental ill health. (We have addressed this in the 'Key Events' section of this report.)

15. Mr Horner's mother received a copy of the initial report. She did not make any comments.

16. We also shared the initial report with HM Prison and Probation Service (HMPPS). They did not find any factual inaccuracies.

Background Information

HMP Lindholme

17. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1,000 men. Care UK provides healthcare services and healthcare staff are on duty between 7.30am and 7.30pm every day.

18. In August 2018, Lindholme was selected to be part of the "10 Prisons Project", which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering prisons and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Lindholme was in October 2017. Inspectors reported that staff in the segregation unit managed challenging behaviour well. They reported that all prisoners had a formal reintegration plan and efforts were made to reintegrate prisoners safely to standard residential units. Inspectors also reported that some prisoners, particularly those with mental health problems, stayed too long in the segregation unit and they were concerned by the impact that this had on the wellbeing of these prisoners.

20. Inspectors reported that prisoners at Lindholme harmed themselves more frequently than those at comparable prisons. They also reported that mental health provision did not meet the high levels of need, which they found was a result of staffing shortages and a lack of consistent clinical leadership.

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 January 2018, the IMB reported that incidents of self-harm had increased during the year. They also reported concerns about the length of time some prisoners spent in the segregation unit, and noted that it was not unusual for there to be several prisoners at any one time who had been segregated for over six weeks.

Previous deaths at HMP Lindholme

22. Mr Horner was the eleventh prisoner to die at Lindholme since March 2017, and the fourth in this period to take his own life. Our investigation into the death of a prisoner in November 2017 found that staff did not enter the cell as quickly as they should have done when they found the prisoner hanged, and they did not use the appropriate radio code to summon emergency medical assistance.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of

supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Segregation units

24. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air.

Key Events

25. Mr Damien Horner was convicted of a number of offences from 2009 onwards, and served several short sentences in Young Offender Institutions and prisons. As a child, he was diagnosed with attention deficit hyperactivity disorder (ADHD) for which he was prescribed medication for several years. Mr Horner also reportedly misused alcohol and cannabis from childhood. Other than punching a wall in 2010, he had no recorded history of self-harm.

HMP Hull

26. On 7 September 2017, Mr Horner was remanded in custody to HMP Hull. He told prison healthcare staff that he had depression, and was prescribed citalopram (an antidepressant medication). This was later changed to mirtazapine as Mr Horner said that he found citalopram ineffective.

27. On 13 September, prison staff began ACCT procedures when Mr Horner spoke about his low mood and said that he had thought about harming himself. They stopped ACCT monitoring two weeks later.

28. On 5 February 2018, Mr Horner cut his arm. He told staff that he did this because he had not received his medication and because he was frustrated about being on the basic level of the Incentives and Earned Privileges (IEP) scheme (which aims to encourage and reward responsible behaviour in prisons). Prison staff began ACCT procedures, which they ended after three days.

HMP Leeds

29. On 21 February, Mr Horner was sentenced to five years and four months in prison for burglary and theft. He was transferred to HMP Leeds after court. On arrival at Leeds, Mr Horner told healthcare staff that he had been using illicit heroin and tramadol in prison. A prison doctor prescribed methadone (an opiate substitute medication). Mr Horner's mirtazapine prescription was stopped, although the reasons why are not recorded.

30. On 29 March, Mr Horner was transferred to HMP Lindholme. Before leaving Leeds, he cut his arm and told prison staff that he did not want to transfer. They began ACCT procedures.

HMP Lindholme

31. A nurse assessed Mr Horner when he arrived at Lindholme. He noted Mr Horner's depression and substance misuse issues, and completed a referral to the mental health team.

32. On 1 April, a Supervising Officer (SO) stopped the ACCT procedures. He noted that Mr Horner would have an appointment with the mental health team to consider restarting the antidepressant.

33. On 16 April, a mental health nurse, assessed Mr Horner. She noted Mr Horner's history and that he regretted stopping his medication. The nurse referred Mr Horner to the prison psychiatrist for further assessment.

34. On 1 May, a psychiatrist assessed Mr Horner. He recorded that Mr Horner experienced low mood but there was no evidence of psychosis. The psychiatrist prescribed mirtazapine.

35. On 30 July, Mr Horner set fire to his cell. Prison staff began ACCT procedures. At an ACCT case review the next day, Mr Horner said that his medication was not working, and that he heard voices as though people were talking about him. Mr Horner also said that he had frequent thoughts of suicide. Prison staff stopped the ACCT procedures on 8 August.

36. At around the same time, Mr Horner stopped taking methadone. He later told a substance misuse practitioner that he had had enough of having to collect it every morning.

37. On 14 August, the psychiatrist assessed Mr Horner. He recorded that Mr Horner said that he had no thoughts of suicide and spoke of protective factors. The psychiatrist concluded that Mr Horner had moderate depression, which had deteriorated since their last assessment, but there were no symptoms of psychosis. He increased Mr Horner's mirtazapine dose.

38. On 4 September, the psychiatrist reviewed Mr Horner. He recorded that there had been no change since their last appointment and that Mr Horner's mood remained low. He changed his antidepressant to venlafaxine.

39. On 29 September, Mr Horner smashed the furniture in his cell. Prison staff segregated him for a week. They also began ACCT procedures because Mr Horner cut himself on a piece of broken furniture.

40. On 22 October, Mr Horner told a substance misuse practitioner that he felt well since stopping methadone. Mr Horner said that he was drug-free and was not inclined to use drugs. He said that he felt he had done all he could, and signed a form to confirm that his treatment was complete.

41. On 6 November, an SO stopped the ACCT procedures. He recorded that Mr Horner engaged well, had no thoughts of harming himself and was well settled on J Wing, a standard residential wing.

42. On 11 December, the psychiatrist reviewed Mr Horner. Mr Horner said that his mood was still low and he had not always taken his antidepressant medication recently because it gave him headaches. The psychiatrist changed the medication to sertraline.

43. On 22 January 2019, Mr Horner smashed items in his cell and then made a barricade to prevent wing staff from entering. After removing the barricade, Mr Horner said that he did not know why he had acted in this way. He moved to a cell on G Wing, a standard residential wing.

44. The next day, Mr Horner threatened to assault wing staff and other prisoners if his cell was unlocked. An officer recorded that Mr Horner made other threats to try to force a move to the segregation unit, and would not elaborate on why he wanted to move. The officer wrote that Mr Horner's actions "appear to be safer custody related".

45. On 24 January, Mr Horner smashed the observation panel of his cell. He then poured water and threw faeces onto the landing and threatened to assault wing staff. Prison staff charged Mr Horner with an offence of endangering the health and safety of others, and segregated him under Prison Rule 45, which allows prisoners to be segregated for the good order of the establishment or in the prisoner's own interests.

Segregation

46. A nurse assessed whether there were healthcare reasons not to segregate Mr Horner. She concluded that there was no evidence to indicate that Mr Horner's mental health would deteriorate significantly were he to be segregated, or that he would not be able to "cope" with segregation. The nurse recorded that Mr Horner had said that his actions were to instigate a transfer to another prison. She concluded that there were no healthcare reasons not to segregate Mr Horner.

47. On 25 January, a healthcare assistant visited Mr Horner to determine why he had missed an appointment with the psychiatrist three days earlier. Mr Horner told her that he had not intended to miss the appointment as he thought his mental health was deteriorating. He said that he could hear a voice with whom he had had conversations. Mr Horner said that he had no thoughts of suicide or self-harm. The healthcare assistant sent a memo to the psychiatrist to review Mr Horner.

48. On 26 January, the Head of Segregation chaired Mr Horner's disciplinary hearing. Mr Horner pleaded guilty to the charge. A nurse again assessed that there were no healthcare reasons not to segregate Mr Horner. The Head of Segregation punished him with three weeks' cellular confinement in the segregation unit.

49. On 1 February, a prison education worker spoke to Mr Horner about the interventions programme, a course offered to all segregated prisoners and tailored to the individual circumstances of their segregation, with the aim of helping them reintegrate to a standard residential unit. Mr Horner declined to participate. She visited the segregation unit twice a week, and told us that Mr Horner was always very clear that he did not wish to engage with the programme.

50. On 2 February, Mr Horner smashed the observation panel in his cell. He told an officer that he did so because he had not been the first person to read the newspaper.

51. On 4 February, Mr Horner told an officer that he did not want to be at Lindholme and would assault staff in order to get a transfer. The next day, he smashed his cell door observation panel. He did not give a reason for his actions.

52. On 8 February, the psychiatrist reviewed Mr Horner. He recorded that Mr Horner's mood had reportedly improved since he started on sertraline although he had occasional passive suicidal thoughts. Mr Horner said that he did not intend to act on these thoughts and that his relationship with his family was a strong protective factor. The psychiatrist told us that his use of the word "passive" meant someone who did not want to deal with their current problems but did not have any active intent to take their life.

53. On 12 February, Mr Horner spoke to his community offender manager about his sentence plan. An offender supervisor at Lindholme, recorded that Mr Horner did not engage very well as he said he felt "stressed and depressed" as he wanted to transfer to another prison closer to his family.

54. On both 13 February and 14 February, Mr Horner broke the observation panel in his cell. On the second occasion, he also threw faeces over the wall and landing. Mr Horner gave no reason for his actions. Segregation unit staff charged him with an offence against prison discipline. (This disciplinary hearing did not take place before Mr Horner's death.)

55. On 15 February, Mr Horner smashed the contents of his cell and threw a bowl of faeces over four officers. Prison staff reported this to South Yorkshire police to investigate. Their investigation was ongoing when Mr Horner died.

56. On 17 February, Mr Horner was one of five prisoners who simultaneously smashed their observation panels. Mr Horner repeated this on 18 February. This was the last occasion on which segregation staff recorded that he had broken prison rules or behaved inappropriately. The Head of Segregation told us that Mr Horner was influenced for a while by a group of four or five disruptive prisoners, after which he settled down and was pleasant to her and unit staff. An officer also said that Mr Horner was pleasant and caused no further issues.

57. On 18 February, when his cellular confinement ended, the Head of Residence authorised his continuing segregation under Prison Rule 45, because of Mr Horner's ongoing violent behaviour. A nurse concluded that there were no healthcare reasons not to segregate Mr Horner.

58. On 20 February, an operational manager chaired a segregation review board, which are to be held within 72 hours of first segregation under Prison Rule 45 and then at least at 14-day intervals afterwards, with the aim of returning the prisoner to standard prison accommodation. He noted Mr Horner's poor behaviour in the previous week and that he had an appointment with the psychiatrist booked for 20 March. A nurse assessed Mr Horner and found no healthcare reasons not to segregate him. The operational manager authorised Mr Horner's continuing segregation until 28 February.

59. On 28 February, the Head of Residence chaired a segregation review board. He recorded that Mr Horner's behaviour had improved since the last review and that his target should be to maintain this. He told us that he was concerned about whether Mr Horner would be able to safely return to a standard residential unit because they had not been able to identify what had caused the poor behaviour that led to his segregation. He recorded that Mr Horner was to be transferred to another prison. He told us that prison staff had arranged for Mr Horner to transfer to HMP The Mount, and he explained this to Mr Horner at the review. He recalled that Mr Horner asked where this was and remarked that it was a long way from his home. He told us that he had no concerns that Mr Horner was at increased risk of suicide or self-harm. A nurse assessed that there were no healthcare reasons not to segregate Mr Horner, and recorded that he was coping well with segregation. The Head of Residence authorised Mr Horner's continuing segregation until 14 March.

60. When a prisoner is to be segregated for longer than 42 days, an area manager is required to review and authorise the continuing segregation. A SO, who was a segregation unit manager, completed the review form and sent it to the Regional Operations Manager to consider. The SO detailed the reasons for Mr Horner's initial segregation and the challenging behaviour that he had since presented, including that which was subject to police investigation. He recorded that Mr Horner had been accepted by The Mount and was awaiting transportation arrangements to complete the transfer. The Regional Operations Manager told us that he spoke to the SO and established that Mr Horner had committed these actions because he did not want to return to a standard wing at Lindholme due to debts he had accumulated. He concluded that Mr Horner should remain in segregation until his transfer, and authorised Mr Horner's continuing segregation.

5 to 6 March 2019

61. On the afternoon of 5 March, an officer spoke to Mr Horner and recorded that he had no concerns. He told us that Mr Horner remained in his cell rather than having exercise or making a telephone call but that this was not unusual for him. In the evening, an officer recorded that there was "nothing to report" about Mr Horner.

62. An operational support grade (OSG), was the night patrol on the segregation unit. He started work at around 8.00pm on 5 March.

63. Mr Horner pressed his cell call bell four times during the night: at 8.37pm, 8.51pm, 9.17pm, and 10.11pm. Each time, the OSG answered the bell promptly. He told us that the light in Mr Horner's cell did not work that night, and when he pressed the call bell, it was to ask for the night light (which is operated from outside the cell) to be switched on or off. He said that Mr Horner was polite each time and seemed "absolutely fine".

64. At around 5.30am on 6 March, the OSG began a count of prisoners. When he arrived at Mr Horner's cell, he said that he found the observation panel partially blocked. CCTV footage shows that he spent one minute and thirty seconds looking into the cell. He told us that the observation panel was covered by Mr Horner's jumper and he could see what appeared to be Mr Horner's shoulder. He said that he could also see the side of Mr Horner's face, which looked "a funny colour". He said that he was not sure if Mr Horner was hanging. He radioed for other prison staff to attend the segregation unit, stating that he "thought a prisoner had ligatured".

65. The OSG then continued the count of prisoners. After 35 seconds, he returned to Mr Horner's cell and remained outside.

66. After one minute and forty seconds, two other officers arrived. They looked into the cell and remained outside with the OSG. A minute later, the night manager arrived, followed by other officers. The night manager unlocked the cell and found Mr Horner hanged from a ligature. He removed the ligature and identified that Mr Horner had no pulse and that rigor mortis had begun to establish. The night manager concluded that resuscitation was not appropriate. He telephoned the control room and asked them to telephone for an ambulance with this

information. Paramedics arrived at around 6.05am, and confirmed that Mr Horner had died.

67. Mr Horner left notes in his cell for his mother and sister, in which he indicated that he had made a clear decision to end his life.

Contact with Mr Horner's family

68. On the morning of 6 March, the Governor and a prison family liaison officer (FLO), visited Mr Horner's mother and told her of his death. Lindholme contributed to the costs of the funeral in line with national instructions.

Support for prisoners and staff

69. After Mr Horner's death, an operational manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

70. The prison posted notices informing other prisoners of Mr Horner'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 Horner's death.

Post-mortem report

71. A post-mortem examination identified the cause of Mr Horner's death as hanging. Toxicology tests identified no illicit drugs or medication.

Findings

Identifying the risk of suicide and self-harm

72. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at HMP Lindholme should have recognised Mr Horner as at risk and started ACCT procedures.

73. During his time in prison, Mr Horner was subject to ACCT monitoring five times, sometimes after he had cut himself. The most recent ACCT procedures were stopped in November 2018. As well as this history, Mr Horner had other risk factors for suicide and self-harm. He was being treated for depression. He was segregated, and it was thought (but not substantiated) that the actions that led to his segregation might have related to debt. He had also been told that he was going to transfer further from home. Mr Horner left notes for his family which indicated that he had made a clear decision to take his life.

74. While Mr Horner had some risk factors and was, therefore, always at long-term risk of suicide, ACCT procedures are designed to support and manage prisoners during short periods of crisis. No one who met Mr Horner in the weeks before his death considered that he was at increased risk. We are satisfied, despite his underlying risk factors, that there was little reason for staff to consider starting ACCT procedures in the weeks before his death.

75. It is very difficult to prevent someone determined on suicide from carrying out that plan without making living conditions extremely restrictive. Had prison staff managed Mr Horner under ACCT procedures at the time of his death, it is unlikely that monitoring levels would have been sufficiently frequent to prevent his suicide, if he had planned it. We consider it would have been difficult for staff at Lindholme to have predicted or prevented his actions.

Mr Horner's segregation

76. Mr Horner was segregated on 24 January 2019, following several days of poor behaviour including damaging prison property, threatening staff and prisoners with assault and throwing faeces on the landing. In his first weeks in the segregation unit, Mr Horner continued to display similar behaviour, including an assault on staff that was reported to the police. We think that the decisions to segregate Mr Horner were reasonable and appropriate. While his conduct improved as segregation continued, the serious nature of the staff assault meant that it was not unreasonable to arrange a transfer.

77. However, we are concerned that prison staff did not give themselves the opportunity to identify the underlying reasons behind Mr Horner's actions. Before he was segregated, an officer recorded that Mr Horner's actions "appear to be safer custody related" (indicating that he might be in debt, in fear of violence, or the victim of bullying). During his time in segregation, staff recorded that his actions might have been to instigate a transfer. The then Regional Operations

Manager said that he had been told that Mr Horner did not want to return to a standard residential unit at Lindholme because he was in debt.

78. Lindholme has a local violence reduction policy, dated September 2017, which states that all suspected incidents of violence, threats of violence and/or anti-social behaviour must be reported to the safer custody team, who will then investigate. If proven, the safer custody team should implement measures to support the victim and to challenge and manage the perpetrator. While the policy does not explicitly state it, we would expect allegations of prisoner debt (and the resulting potential of violence) to be reported and investigated. There is no evidence that anyone reported the allegations that Mr Horner was in debt, or questioned him about it.

79. Prison Service Order (PSO) 1700, which governs segregation procedures, states that a designated officer must be allocated to each prisoner in segregation each day. The designated officer should engage in purposeful dialogue and record at least three quality entries every day. There is no evidence that segregation unit staff held good quality conversations at the required frequency, and most of their interaction with Mr Horner was brief. While more meaningful contact would not necessarily have identified Mr Horner's concerns or plans, this was a missed opportunity to identify any underlying issues he might have had. We make the following recommendations:

The Governor should ensure that all information indicating violence, bullying, debt and intimidation is fully coordinated and investigated and that apparent victims are effectively protected and supported.

The Governor should ensure that segregation unit staff carry out good quality conversations with all prisoners, in line with the requirements of PSO 1700.

Emergency response

80. At night, officers have a key in a sealed pouch for use in an emergency. Prison Service Instruction 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

81. The OSG said that Mr Horner looked a "funny colour" and he made a radio call in which he said he "thought [Mr Horner] had ligatured". He did not open the cell as he said he had been told that he had to call the night manager and wait for them to arrive before entering a cell. However, when there is a potentially life-threatening situation, it is essential to act quickly. Instead, nearly five minutes passed from when the OSG arrived at Mr Horner's cell until it was opened. He thought that Mr Horner might be hanging and, in these circumstances, we would

normally expect prison staff to go into a cell as soon as possible, in case there is a chance of saving someone's life, in line with national instructions.

82. PSI 03/2013 on medical emergency response codes sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors and directors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure there are no delays in calling an ambulance and it should not be a requirement for a member of the healthcare team or a manager to attend the scene before calling an ambulance.

83. Lindholme's local instruction on emergency response codes (Notice to Staff 75/2017) instructs the use of the emergency codes 'red' and 'blue' to comply with PSI 03/2013. Examples of the circumstances in which staff should use code blue are when the prisoner has difficulty breathing or is unconscious.

84. The OSG did not radio a code blue medical emergency. He acknowledged that he should have done so but added that he was unsure about what had happened.

85. Given that rigor mortis had begun to establish when the cell was opened (which is likely to indicate that Mr Horner had been dead for at least two to three hours), it is unlikely that these delays affected the outcome for Mr Horner. Nevertheless, it is important that prison staff understand their roles in a medical emergency as early intervention when someone is found hanging might save their life. We make the following recommendation:

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

- **night staff enter cells as quickly as possible in a life-threatening situation; and**
- **night staff use the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.**

Sharing our report with staff

86. We consider that it is important for staff who were involved in Mr Horner's care to see the findings of and learn lessons from our investigation. We make the following recommendation:

The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

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Independent Investigations

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