Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Horner, a prisoner at HMP Leeds, on 22 September 2018

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*

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

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

Mr Darren Horner died on 22 September 2018 of methadone toxicity with aspiration (inhalation of vomit) at HMP Leeds. He was 44 years old. I offer my condolences to Mr Horner's family and friends.

Mr Horner had a long history of substance misuse and the clinical reviewer found that he received a good standard of clinical and substance misuse care at Leeds, equivalent to that which he could have expected to receive in the community.

An internal prison investigation into the actions of the prison officers responsible for completing the roll checks and welfare checks prior to Mr Horner's death found that they did not carry out these checks as they should have done. These failures resulted in disciplinary action and the subsequent dismissal of four prison officers. I am satisfied that the prison has introduced training to ensure prison staff are aware of the vital importance of completing unlock and welfare checks. We cannot say whether the outcome would have been any different for Mr Horner if the checks had taken place.

My investigation also found that some prison staff were not carrying a radio on the day of Mr Horner's death, which caused some delays in the emergency response (although this did not affect the outcome for Mr Horner). Since Mr Horner's death, the prison has ensured that all staff in prisoner-facing roles carry a radio.

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 **December 2021**

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Summary

Events

1. Mr Anthony Horner was serving a 10-week prison sentence at HMP Leeds for failing to surrender at court.

2. Mr Horner was an intravenous heroin user, and also suffered from anxiety and sciatica. When he arrived at Leeds on 6 September 2018, he was referred to the substance misuse team and a substance misuse nurse created a care plan for him. A prison GP prescribed Mr Horner methadone (heroin replacement medication) and an anti-inflammatory medication for his sciatica.

3. The substance misuse team monitored Mr Horner daily. Prison staff noted that Mr Horner only left his cell to collect his medication and other prisoners often brought his meals to his cell for him.

4. On 21 September, Mr Horner saw his substance misuse keyworker and asked for an increase in his methadone dose to keep him stable. He denied using any illicit non-prescribed medication.

5. At approximately 4.40pm, a prison officer unlocked Mr Horner's cell so he could collect his evening meal. Mr Horner did not leave his cell and he was locked up shortly afterwards. This was the last time Mr Horner was seen alive.

6. Prison staff did not complete roll checks correctly for the remainder of 21 September, and the roll check at 7.00am on 22 September was not completed.

7. At approximately 9.50am, a prison officer unlocked Mr Horner's cell but did not check his wellbeing. A prisoner went into Mr Horner's cell and found him unresponsive on the cell floor. He called for assistance and the prison officer returned to Mr Horner's cell. Another prison officer radioed a medical emergency code at approximately 9.53am. Two prison nurses attended but did not attempt cardiopulmonary resuscitation (CPR) because Mr Horner did not display any signs of life. Paramedics arrived at approximately 10.03am and pronounced Mr Horner dead at 10.14am.

8. The post-mortem concluded that Mr Horner had died from methadone toxicity with aspiration.

Findings

9. The clinical reviewer concluded that overall, Mr Horner received a good standard of substance misuse and clinical care that was equivalent to that which he could have expected to receive in the community.

10. The substance misuse team monitored him regularly and his methadone dose was adjusted appropriately in accordance with his withdrawal symptoms.

11. The clinical reviewer agreed with the decision of the prison nurses not to attempt CPR to protect Mr Horner's dignity because he did not display any signs of life.

12. The internal prison investigation into the actions of prison staff who failed to conduct roll and welfare checks on 21 and 22 September resulted in disciplinary action against five officers, four of whom no longer work for the Prison Service.

13. We are satisfied that since Mr Horner's death, Leeds provides specific training to prison staff to emphasise the vital importance of completing roll checks and welfare checks in accordance with their local security strategy.

14. The officer who found Mr Horner unresponsive in his cell did not call a medical emergency code immediately because he was not carrying a radio. Since Mr Horner's death, all residential wing staff are now required to carry a radio.

Recommendations

15. We have made no recommendations.

The Investigation Process

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

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

18. NHS England commissioned a clinical reviewer to review Mr Horner's clinical care at the prison.

19. We informed HM Coroner for West Yorkshire of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. Our investigation was delayed while we waited for the outcome of the police investigation.

21. We contacted Mr Horner's family to explain the investigation. Their solicitor asked about Mr Horner's medication and the actions of prison officers when Mr Horner was found unresponsive in his cell on 22 September 2018. We have addressed these questions in our report.

22. Mr Horner's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

23. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Leeds

24. HMP Leeds is a local prison holding up to 1,218 prisoners who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including clinical substance misuse and mental health services. The prison has 24-hour primary healthcare cover.

HM Inspectorate of Prisons (HMIP)

25. Prior to Mr Horner's death, HMIP carried out an inspection at Leeds in October/November 2017. They found that the prison's drug supply reduction strategy was reasonable, and some positive action had been taken to reduce supply. However, 63% of prisoners they surveyed said it was easy to get illegal drugs and about a third of prisoners tested positive for drugs during random mandatory drug tests.

26. The most recent full inspection of Leeds was in November/December 2019. Inspectors found that, since the previous inspection, there had been substantial work to reduce the availability of illicit substances, including the installation of a body scanner, an itemiser to detect drugs on prisoners' mail, and netting over all exercise yards to stop packages from being thrown over. The mandatory drug testing positive rate was low. Target searching and suspicion testing were almost always carried out when requested and there had been some substantial drugs finds. Inspectors noted that Care UK provided clinical substance misuse treatment and Inclusion, a drug and alcohol recovery service, provided psychosocial support. Co-location with the mental health team and electronic record sharing aided integrated working. Regular prisoner consultation informed service delivery and prisoners were positive about the help they received.

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. The IMB report for the year ending December 2018 found that prisoners were treated with humanity and respect, given staff constraints.

Previous deaths at HMP Leeds

28. Mr Horner's was the 15th death at Leeds since September 2016. Of the previous deaths six were self-inflicted deaths, six prisoners died from natural causes and there was one drug-related death and also one homicide.

29. Since Mr Horner's death, there have been seven more self-inflicted deaths at Leeds, nine deaths from natural causes, three drugs-related deaths and one where the cause of death is currently unknown.

Key Events

30. On 6 September 2018, Mr Darren Horner was sentenced to 10 weeks in prison for failing to surrender to court and was sent to HMP Leeds.

31. A nurse completed Mr Horner's initial health screen when he arrived and noted that he had a history of anxiety and suffered from back pain caused by sciatica. She also noted that he had used heroin since 2004 and had overdosed in October 2012. Mr Horner tested positive for opiates and the nurse referred him to the substance misuse service (SMS).

32. A substance misuse nurse saw Mr Horner the same day and created an integrated drug treatment service (IDTS) care plan. The nurse assessed Mr Horner using the clinical opiate withdrawal score (COWS - used to indicate the common signs and symptoms of opiate withdrawal). Mr Horner's score was 11, which indicated he had mild drug withdrawal. The SMS team monitored Mr Horner overnight and did not record any concerns.

33. The following day, Mr Horner told a prison nurse that he spent approximately £25 a day on illicit substances in the community and had last injected drugs two days ago. A prison GP prescribed Mr Horner 15mls of methadone (opiate substitute medication) and naproxen (an anti-inflammatory) for sciatica. The SMS and IDTS team continued to monitor and review Mr Horner daily.

34. On 11 September, a substance misuse nurse saw Mr Horner. Mr Horner said he was not interested in counselling. He was prescribed 30mls of methadone and his COWS score was recorded as 0 (no withdrawal symptoms).

35. The same day, Mr Horner saw his allocated substance misuse keyworker. Mr Horner told her he had been using three bags of heroin intravenously a day, plus amphetamines, in the community. Mr Horner refused a referral to the mental health team. He said he still suffered from sciatica but did not want to see healthcare staff.

36. Mr Horner continued to receive his methadone prescription daily and was monitored by the SMS and IDTS teams. Prison staff noted that he only left his cell to collect his medication and other prisoners often brought his meals to his cell.

Events of 21 and 22 September

37. At approximately 11.22am on 21 September, Mr Horner collected his methadone but refused his naproxen.

38. At approximately 11.46am, Mr Horner saw his substance misuse keyworker and asked for his methadone dose to be increased. Mr Horner denied using non-prescribed substances and said he needed an increase in methadone to keep him stable. She said she would speak to the IDTS team about increasing his methadone dose and a plan was made for him to be assessed before his release on 10 October.

39. Mr Horner did not collect his naproxen at 3.00pm and there is no evidence that prison staff spoke to him about this.

40. CCTV shows that at approximately 4.40pm, Officer A unlocked Mr Horner's cell so he could collect his evening meal. Mr Horner declined his evening meal and did not leave his cell. In her statement, she said she was aware that Mr Horner had a back problem which meant he sometimes struggled to walk. She said she advised Mr Horner to use his cell bell if he needed assistance. She did not complete a roll check at 5.30pm after the prisoners had returned to their cells as she should have done.

41. At approximately 8.45pm, Officer B checked the cell doors and closed the observation panels. CCTV shows that he did not appear to be counting as he went from cell to cell and that the 9.00pm roll check was not completed. Before she went off duty at 9.30pm, another officer signed the wing security book to say she had completed the 9.00pm roll check.

42. At 7.00am on 22 September, the early start officer, was tasked with completing the early morning roll check with Officer B. CCTV shows that this was not completed. Officer B signed the morning roll check sheet and wing observation book to confirm that it had been.

43. CCTV footage shows Officer C unlocked Mr Horner's cell at approximately 9.50am. In his statement, he said when he unlocked Mr Horner's cell, he looked through the observation panel and saw Mr Horner lying on his back on the cell floor. He said he asked Mr Horner if he was alright but did not receive a response. He continued unlocking the other cells.

44. Shortly afterwards, a prisoner looked through the observation panel and entered Mr Horner's cell and almost immediately called out that Mr Horner was cold and unresponsive. Officer C said that he entered Mr Horner's cell and was unable to find a pulse and Mr Horner was cold to touch. Because he did not have a radio, he pressed the emergency alarm and shouted for assistance. Very shortly after, Officer A arrived at Mr Horner's cell. At approximately 9.53am she radioed an emergency code blue (which indicates a prisoner is unconscious or not breathing) and the control room immediately called an ambulance.

45. Two nurses went to Mr Horner's cell with Officer A. One nurse said that Mr Horner was showing no signs of life: his eyes were fixed open, he was blue around the fingers and mouth, and he was rigid. The nurse and his colleague agreed not to start cardiopulmonary resuscitation (CPR). Paramedics arrived at approximately 10.03am and assessed Mr Horner. At 10.14am, the paramedics confirmed that Mr Horner had died.

Contact with Mr Horner's family

46. After Mr Horner's death, staff identified that his sister was his next of kin. The prison appointed an officer as the prison's family liaison officer. At 12.20pm, he visited Mr Horner's sister and broke the news of Mr Horner's death. The prison provided ongoing support and contributed towards the costs of Mr Horner's funeral in line with national instructions.

Support for prisoners and staff

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

48. 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

49. The post-mortem concluded that Mr Horner died from methadone toxicity with aspiration, meaning that he had inhaled his stomach contents (vomit).

50. The toxicology tests revealed the presence of Mr Horner's prescribed medication (methadone and naproxen). The pathologist commented that although the concentration of methadone was within the therapeutic range, it was also within the range associated with fatalities, especially in individuals who have a low tolerance to methadone. The pathologist said that the naproxen was unlikely to have contributed to Mr Horner's death.

Findings

Substance misuse and clinical care

51. The clinical reviewer concluded that the general clinical care that Mr Horner received was at least equivalent to that which he could have expected to receive in the community.

52. She considered that Mr Horner's substance misuse care was of a good standard. He was regularly monitored and appropriately assessed using the clinical opiate withdrawal score (COWS). Mr Horner's methadone dose was adjusted in accordance with his withdrawal symptoms.

53. The clinical reviewer did however raise some concerns about the failure to use the National Early Warning Score (NEWS) tool when Mr Horner arrived at Leeds and about the fact that he did not receive a secondary health screen within seven days of his arrival. Neither issue had any bearing on Mr Horner's death, but the clinical reviewer has made a recommendation in her report about the use of the NEWS tool which the Head of Healthcare will need to address.

54. The Deputy Head of Healthcare told us that since Mr Horner's death, healthcare staff now receive training on the importance of completing the secondary health screen and all reception staff are required to confirm that they are familiar with the integrated first night pathway at Leeds. Outstanding secondary health screens are monitored daily to ensure prisoners are assessed within the required timescale. We are satisfied that the healthcare team have taken steps to ensure prisoners receive a secondary health screen and we do not make a recommendation about this.

55. We agree with the clinical reviewer's conclusion that the decision made by prison nurses not to resuscitate Mr Horner was appropriate as resuscitation would have proven futile and would have been undignified for Mr Horner and distressing for staff.

Roll checks and welfare checks

56. Our investigation found that prison staff did not complete roll checks and welfare checks as they should have done.

57. The primary purpose of a roll check is to confirm that all prisoners are present and correctly accounted for. Not completing a roll check is, therefore, a serious breach of security. However, roll checks are also an opportunity to check on prisoners' well-being and to identify any obvious signs that a prisoner may be ill or dead. When Mr Horner was discovered dead in his cell, he was lying on his back on the cell floor. If he had been seen in this position during a roll check, we would have expected officers to be concerned for his well-being and to try to get a response from him and to raise the alarm if they could not.

58. Mr Horner was described as being 'rigid' when he was found, which suggests that rigor mortis was present. As this normally sets in within two to six hours after death, it is possible that Mr Horner was already dead at 7.00am when the early morning roll check should have taken place, and he may even have been

dead at 9.00pm when the previous roll check should have taken place. We cannot say whether the outcome might have been different for Mr Horner if these roll checks had been completed but, at the very least, Mr Horner might have been found earlier.

59. With regard to welfare/well-being checks, Prison Service Instruction (PSI) 75/2011, *Residential Services,* says:

> "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight, apparently from natural causes, but staff unlocking them have not noticed that the prisoner has died. This is not acceptable.
>
> "The appropriate arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock. For example, if a prisoner is expected to leave their cell for an activity shortly after being unlocked, then it will be sufficient for there to be a check on any prisoner who does not do so. Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

60. Officer C unlocked Mr Horner's cell at approximately 9.50am. He said he could see Mr Horner lying on his back on the cell floor and asked him if he was alright, but he did not receive a response. Shortly afterwards, another prisoner entered the cell and found Mr Horner dead. We are concerned that the officer did not carry out an effective well-being check when he unlocked Mr Horner's cell (although we are satisfied that this did not affect the outcome for Mr Horner as it is It is clear that he was already dead).

61. The prison took disciplinary action against Officer A, Officer B and two other officers for failing to complete roll checks on 21 and 22 September. Action was also taken against Officer C for allowing a prisoner to enter Mr Horner's cell before he had completed a welfare check and again after he found Mr Horner unresponsive on his cell floor. As a result of the disciplinary action, four officers were dismissed from the Prison Service. Officer A appealed against her dismissal and was reinstated in her role but resigned shortly afterwards. Officer C received formal guidance and support regarding his responsibilities when unlocking cells and the importance of preserving a potential crime scene.

62. The prison's internal investigation also recommended that all prison staff should be reminded of the need to adhere to the local security strategy when conducting roll checks and welfare checks. The prison told us that prison officers now receive specific training on this issue, and that the local security strategy has also been amended to allow staff enough time to complete roll checks and welfare checks and for staff to complete a formal handover before they go off duty.

63. While we are concerned that the actions of prison officers meant that Mr Horner was not checked for several hours, we cannot say if his death could have been prevented. We are satisfied that the prison has since taken appropriate steps to ensure staff are fully aware of their role and responsibilities and we do not make a recommendation about this issue.

Emergency response

64. Although staff responded quickly when Mr Horner was found unresponsive, Officer C, who was first on scene, was unable to call an emergency medical code because he did not have a radio. He pressed the emergency alarm to alert staff that there was an emergency. However, staff told us that when the emergency alarm is pressed this disables the radio network so no transmissions over the radio can take place. The failure to call an emergency code would also have caused a slight delay in calling an ambulance. These delays made no difference to the outcome in Mr Horner's case but could make a critical difference in other medical emergencies.

65. The safer custody manager told us that at the time of Mr Horner's death only certain members of wing staff were required to carry a radio: the wing manager, the movements officer and the cleaning officer. Other staff might have had access to a radio, but these three roles were the only required radio carriers. (Officer A, who called the emergency code, had a radio because she was the movements officer for that day.)

66. The safer custody manager told us that 10 radios are now available for staff on all residential units: two radios for the wing managers and the remaining eight for prison officers. In addition, all other staff in prisoner-facing roles such as gym officers, reception staff and keyworkers, now have the opportunity to draw a radio. We welcome the changes the prison has put in place to ensure that all staff on residential units carry a radio, and we do not, therefore, make a recommendation.

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