

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sean Horsley, a prisoner at HMP Gartree, on 16 April 2021

A report by the Prisons and Probation Ombudsman



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 Sean Horsley died on 16 April 2021 after he was found hanging in his cell at HMP Gartree. He was 52 years old. I offer my condolences to Mr Horsley's family and friends.

Mr Horsley was being monitored using suicide and self-harm procedures (known as ACCT) when he died and should have been checked every hour.

I am very concerned that staff had not checked on Mr Horsley for almost three hours when they found him hanging. It appears no one was given specific responsibility for carrying out the ACCT checks, so they were missed. This was unacceptable. The Governor must ensure that prisoners at risk of suicide are properly monitored.

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

June 2022

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Summary

Events

1. Mr Sean Horsley, who was serving a life sentence, was moved to HMP Gartree on 19 November 2015.
2. In March 2021, Mr Horsley told staff he was being threatened by other prisoners because they thought he was a sex offender. He remained in his cell and his meals were taken to him. He declined a move to another landing. Prison staff found no evidence that Mr Horsley was being threatened or bullied.
3. Mr Horsley continued to allege that prisoners were accusing him of being a 'nonce'. He said the jibes were constant and that people were shouting at him through his cell window at night. In early April, he told staff that he had heard prisoners planning to scald him when he was on his way to his drug treatment session, so he refused to go.
4. On 15 April, Mr Horsley told staff he had taken 70 paracetamol tablets to 'stop the voices'. He was taken to hospital but discharged the same day. Staff started suicide and self-harm procedures (known as ACCT) and set hourly observations.
5. The next day, a mental health nurse assessed Mr Horsley and concluded he should be discussed at the allocations meeting.
6. Staff checked on Mr Horsley hourly until 12.44pm. The next check was not until 3.34pm, when an officer found Mr Horsley hanging in his cell. The officer alerted a colleague and they cut Mr Horsley down. They called a medical emergency code and started CPR. Healthcare staff responded and an ambulance was called.
7. Paramedics arrived but were unable to resuscitate Mr Horsley. They pronounced his death at 4.00pm.

Findings

8. Despite being on hourly ACCT checks, Mr Horsley had not been checked for almost three hours when he was found hanging. Staff told us that no one had been given the specific task of carrying out the checks. As a result, two had been missed. This was unacceptable.
9. Staff did not call a medical emergency code straightaway when they found Mr Horsley hanging. While this caused only a minor delay, it is important that the correct medical emergency procedures are followed so that there is no delay in calling an ambulance.
10. The clinical reviewer found that the standard of care Mr Horsley received at Gartree was equivalent to that he could have expected to receive in the community.
11. While staff were offered support after Mr Horsley's death, some felt that support was lacking during the subsequent police investigation.

Recommendations

- The Governor should ensure that prisoners being managed using ACCT are monitored correctly, and in particular staff:
 - understand who is responsible for carrying out ACCT observations; and
 - carry out ACCT observations at the agreed frequency.
- The Governor should remind staff of their responsibilities during medical emergencies including that they should call the appropriate medical emergency code without delay.
- The Governor and Head of Healthcare should ensure that staff are offered appropriate support following a death in custody, including during any subsequent police investigation.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Gartree informing them of the investigation and asking anyone with relevant information to contact her.
13. The investigator obtained copies of relevant extracts from Mr Horsley's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Horsley's clinical care at the prison.
15. The investigator interviewed six members of staff at Gartree on 9 November 2021 and one by telephone in February 2022. The investigator jointly interviewed healthcare staff.
16. We informed HM Coroner for Leicester City and South Leicestershire of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Horsley's named next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not raise any concerns.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Gartree

19. HMP Gartree, which is near Market Harborough in Leicestershire, holds up to 700 men mainly sentenced to life imprisonment and other indeterminate sentences. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare. Nursing staff are available 24 hours a day.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Gartree was a scrutiny visit in September 2020. Inspectors reported that levels of self-harm had increased. Relations between staff and prisoners were good and most prisoners received key work sessions. Challenge, Support and Intervention Planning (CSIP) was widely used but most plans were too basic and support for victims was underdeveloped. Care for vulnerable prisoners was reasonably good.
21. The last full inspection was an unannounced visit in November 2017. Inspectors commented on the easy availability of drugs. They said that the prison's response to drug issues needed to be much better.

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 30 November 2020, the IMB had concerns about the support available for prisoners with complex mental health needs. They were concerned about the impacts of pandemic related lockdowns on prisoners' mental health.

Previous deaths at HMP Gartree

23. Mr Horsley was the eighth prisoner to die at HMP Gartree since April 2019. One of the previous deaths was self-inflicted and six were from natural causes. We have made a recommendation before about calling medical emergency codes promptly. We were told that a notice had been issued in June 2020 to remind staff of their responsibilities during medical emergencies.

Assessment, Care in Custody and Teamwork

24. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

25. As part of the process, a caremap (a 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, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

26. In January 2002, Mr Sean Horsley was sentenced to life imprisonment for robbery, with a minimum term to serve of four years and ten months. In July 2014, he absconded from an open prison but was recaptured the next day and sent back to closed conditions. While on the run, he committed a robbery and in February 2015, was sentenced to six years and nine months. He was moved to HMP Gartree on 19 November 2015.
27. Mr Horsley had a long history of substance misuse. He engaged with substance misuse services in prison but admitted using illicit substances.
28. Mr Horsley was on medication for anxiety and depression. He was also prescribed medication for ongoing back pain.

2021

29. On 8 March 2021, Mr Horsley told a Supervising Officer (SO) he was being threatened by prisoners because they had found out he had been at HMP Littlehey and assumed he was a sex offender. (Littlehey holds a high number of sex offenders but Mr Horsley had been there to complete a drug treatment programme.) He asked to go on 'Rule 45' (where vulnerable prisoners, such as sex offenders, are kept on a separate wing).
30. The SO noted that this was out of character for Mr Horsley. He spoke to the security department who advised that Mr Horsley had made a Rule 45 application almost exactly a year before. The SO contacted the safer custody department to see if there were any triggers for Mr Horsley around this date but got no response. He opened a Challenge, Support Intervention Plan (CSIP – used for prisoners who are either being bullied or bullying others, to support them and manage their behaviour).
31. Staff found no evidence to support Mr Horsley's claims and denied his Rule 45 request. However, the CSIP remained open.
32. The SO told the investigator that on 9 or 10 March, he offered Mr Horsley a move from the 'threes' landing (second floor) to the 'ones' (ground floor) where more of his friends were and away from where he had been having problems, but Mr Horsley refused the move. He remained in his cell and all meals were taken to him.
33. On 11 March, a SO met with Mr Horsley as part of the CSIP process. He concluded that Mr Horsley's behaviour was out of character and it would be beneficial for staff to monitor him, particularly in terms of any other prisoners paying Mr Horsley specific attention. Staff were to escort him to the showers.
34. Staff continued to monitor Mr Horsley under the CSIP and recorded interactions with him on NOMIS (electronic prison record) daily.
35. On 30 March, Mr Horsley told an officer that numerous people were shouting through his cell window at night that he was a sex offender. The officer noted that he reported the matter to security and safer custody.
36. On 4 April, Mr Horsley gave a note to a substance misuse worker at the medication hatch asking her to tell other healthcare staff that he was being bullied.

37. On 5 April, Mr Horsley told a SO that people were accusing him of being a 'nonce'. He said the jibes were constant from other cells throughout the wing, from a number of different people. The SO offered Mr Horsley a move to the 'ones' but Mr Horsley said the threats were constant no matter where he was and nowhere in the prison was safe for him. He said he no longer wanted to eat because he thought people were messing with his food and he was sleeping only one or two hours a night. The SO offered him the option to have sealed meals but Mr Horsley said this would make no difference. He encouraged Mr Horsley to change his routine and find some activities to distract him. The SO noted that he was concerned about Mr Horsley's mental state which appeared to be deteriorating rapidly, and that he had made a mental health referral (he actually did this the next day). He noted that he had spoken to healthcare staff about 'Sleep Watch' and was awaiting a call back. (He did not receive a call back.)
38. Another officer made an entry to say a prisoner friend of Mr Horsley's had taken him some tinned foods.
39. On 6 April, Mr Horsley gave the SO a note saying he thought prisoners were planning to scald him on his way to his drug treatment (IDTS) session as he had overheard prisoners planning it. He said it was now common knowledge that he had been to Littlehey and prisoners wrongly believed he was a paedophile. He wanted to be moved off the wing and preferably out of the prison, and to be put on Rule 45. The SO completed self-isolation paperwork. (This is different to Rule 45 which a governor must approve, whereas any prisoner can request self-isolation.)
40. The SO also completed an action plan with the following actions: open a self-isolation plan, continue liaison with other departments about a prison move, and make a mental health referral.
41. An officer emailed healthcare staff asking for a mental health assessment for Mr Horsley. It is not clear if she saw that the SO had already made a referral.
42. The same day, Mr Horsley told his substance misuse worker who visited him at his door, that he was not leaving his cell because he was being harassed and had missed his methadone. He said he would come down for it in the mornings (presumably when it was quieter). He did not want to continue his appointment with the substance misuse worker even over the telephone.
43. On 11 April, Mr Horsley told staff he had chest pain. He was taken to hospital but discharged later that day. He was subsequently diagnosed with high blood pressure.
44. On 13 April, an officer recorded that on the way back from escorting Mr Horsley to his drug treatment session, Mr Horsley had been convinced that prisoners were calling him a 'nonce' when in fact, prisoners had been shouting 'Hello' to her. She recorded that she made a mental health referral.
45. Mr Horsley was due to have a mental health assessment on 13 April, but he asked for it to be rescheduled to 15 April.
46. On 15 April, a nurse saw Mr Horsley in his cell for the mental health assessment. He said he was not paranoid and had no mental health issues so he saw no point in talking to her. He said his problem was that he needed to move prisons because he was under threat. The nurse recorded that she could not tell in the short time she

spoke to Mr Horsley whether his beliefs that prisoners thought he was a paedophile were based on evidence or whether he was paranoid. She noted that Mr Horsley should be discussed at an allocations meeting to see if further engagement was needed or if he should be discharged.

ACCT

47. On 15 April, Mr Horsley told staff he had taken 70 paracetamol tablets. He was taken to hospital but discharged the same day. He said he had taken the tablets to 'stop the voices'.
48. Staff started suicide and self-harm procedures (known as ACCT) and observed Mr Horsley hourly.
49. On 16 April at 8.50am, a SO carried out the ACCT assessment. Mr Horsley said he was under threat because other prisoners thought he was a sex offender. He also said that he was hearing voices. He said he had no intention of killing himself but was feeling really low.
50. Straight after, a SO chaired the first ACCT review. A nurse attended. Mr Horsley engaged well with them throughout the review but said he was not sleeping at night or eating servery food. He claimed to hear voices in his head and that other prisoners were accusing him of being 'a nonce'. He refused a cell move and agreed to work with the mental health team.
51. The SO kept observations at hourly with two meaningful conversations a day and scheduled the next ACCT review for 22 April.
52. The nurse carried out a mental health assessment. Mr Horsley told him that prisoners were calling him a 'nonce' and that there was an 11-page booklet of his offences circulating on the wing. The nurse noted that Mr Horsley was calm and 'matter of fact' when talking about this. He also noted that there was no prison security intelligence to back up any of these claims. Mr Horsley said that he had not slept for weeks but the nurse noted that he did not present as someone who was severely sleep-deprived.
53. Mr Horsley said he heard voices and the overdose was a cry for help. He denied any recent use of illicit substances and said he wanted to be prescribed gabapentin and diazepam as they were the only things that helped him. He said he would refuse to engage with the mental health team unless he got these medications. (Gabapentin is used to treat nerve pain and diazepam is used to treat anxiety, but both are widely abused and highly tradeable in prison.) The nurse noted that Mr Horsley had been prescribed gabapentin for a short time in 2018 but there was no record he had been prescribed diazepam. The nurse noted that Mr Horsley's mood appeared stable and that Mr Horsley said he had no current thoughts of suicide or self-harm. The nurse recorded that he would discuss Mr Horsley at the allocations meeting as he had asked for a fortnightly welfare check by phone.
54. At 11.19am, the substance misuse worker recorded he had seen Mr Horsley and discussed the overdose with him. Mr Horsley said he was struggling with things but had acted on the spur of the moment and had vomited most of the tablets up straight after taking them. He said it was not something he would repeat.

55. At 12.32pm, Mr Horsley called a friend for 35 minutes. He said he was concerned about the voices in his head and his fear that people wanted to harm him. He also discussed the overdose. He said he was anxious and wanted to be moved but officers were reluctant. They went on to discuss how staying in his cell might be detrimental to Mr Horsley's mental health and his friend asked him if he wanted him to speak to the Governor about a move, but Mr Horsley did not think that would help. The conversation ended with the friend telling Mr Horsley to call him if he ever felt like talking and to continue to ask officers to listen. Mr Horsley said that he had been told a psychiatrist would visit once a month.

16 April

56. From 8.00am to midday, an officer carried out the hourly ACCT checks on Mr Horsley. At 11.05am, he had the morning 'meaningful conversation' with Mr Horsley. He noted that Mr Horsley said he was concerned about his safety. The officer concluded that Mr Horsley seemed 'very paranoid' but 'okay'. At the midday check, the officer recorded that he had handed Mr Horsley his food, had no concerns and he seemed okay.
57. At 12.44pm, an officer carried out Mr Horsley's ACCT check (she made the entry about this at 1.05pm). She recorded that Mr Horsley was on the phone and that he gave her a thumbs up. Staff did not carry out the next ACCT check until almost three hours later.
58. At 3.34pm, an officer went to Mr Horsley's cell but he could not see him through the observation panel. He went into the cell and found Mr Horsley hanging from a ligature attached to the privacy curtain rail.
59. The officer shouted for a second officer to assist and he attended immediately. The second officer took Mr Horsley's weight and the first officer cut the ligature attached to the curtain rail and another one that was around Mr Horsley's neck. The second officer called a code blue over the radio – according to the control room log, it was still 3.34pm. The second officer then went to the office to use the landline to confirm further details as several prisoners were within hearing distance.
60. A nurse heard the code blue, grabbed the emergency bag and went to the cell with a colleague.
61. The officers laid Mr Horsley out flat on the floor. An officer realised he still had part of the ligature tied around his neck (he had only cut the part he was attached to the curtain rail by) and cut that too. The officer described the ligature as embedded in Mr Horsley's neck.
62. A SO arrived at the cell and started CPR with an officer. Nurses arrived as did a second SO who helped the first SO with CPR while the nurses got the equipment ready.
63. A nurse set up the defibrillator and oxygen. The defibrillator advised no shock and the nurse applied oxygen. Staff continued with CPR in between checking the defibrillator which at no point advised a shock.

64. At 3.44pm paramedics arrived at the cell. They moved Mr Horsley out of the cell onto the landing. Paramedics continued with resuscitation attempts before pronouncing Mr Horsley's death at 4.00pm.

Contact with Mr Horsley's family

65. On 16 April, the prison appointed an officer as the family liaison officer. She contacted Mr Horsley's named next of kin by telephone that day and broke the news of his death. The prison contributed to funeral costs in line with national policy.

Support for prisoners and staff

66. After Mr Horsley's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
67. The prison posted notices informing other prisoners of Mr Horsley'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 Horsley's death.

Post-mortem report

68. The post-mortem concluded that Mr Horsley died as a result of hanging. The toxicology report said methadone was present in a therapeutic to high therapeutic concentration, and mirtazapine at a sub therapeutic level. The paracetamol levels were low for someone who had allegedly recently taken 70 tablets, and the histology report reached the same conclusion.

Findings

Management of Mr Horsley's risk

69. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures (known as ACCT) that should be followed when a prisoner is identified as being at risk of suicide and self-harm.
70. Staff started ACCT monitoring for Mr Horsley on 15 April, after he told them he had taken 70 paracetamol tablets. He was being monitored when he died and was supposed to be checked every hour.
71. However, Mr Horsley was not checked between 12.44pm and when he was found hanging at 3.34pm, a period of two hours and 50 minutes.
72. When interviewed, the SO in charge of the wing that day said that he had not specifically allocated anyone to do the ACCT checks. He said practices had changed since Mr Horsley's death, but at the time, ACCT checks were a collective responsibility and he left officers to do them between them.
73. The investigator has been assured that a local policy change has been implemented and allocated staff are now assigned to ACCT checks, but, at the time of writing, has not seen any instruction to staff about this. We make the following recommendation:

The Governor should ensure that prisoners being managed using ACCT are monitored correctly, and in particular staff:

- **understand who is responsible for carrying out ACCT observations; and**
- **carry out ACCT observations at the agreed frequency.**

Emergency response

74. PSI 3/2013, *Medical Emergency Response Codes*, says that prisons must have a medical emergency response code protocol in place to ensure a timely, appropriate and effective response to medical emergencies. A code blue is called when a prisoner is unconscious or having breathing difficulties and a code red is called for serious blood loss or burns. We are content that Gartree's protocol satisfies the requirements of the PSI, but staff delayed calling the code blue.
75. The officer who found Mr Horsley told the investigator that although he did have a radio with him, he prioritised cutting him down. A second officer called the code blue once they had done this. Although the delay was minimal, it is important that staff call the relevant medical emergency code straightaway as this alerts healthcare staff and tells the control room to call an ambulance immediately.
76. The officer who found Mr Horsley hanging told the investigator he thought that once a code blue was called, communications staff would call those at the scene to confirm if an ambulance was required. This is incorrect as the calling of a medical

emergency code should trigger communications staff to call an ambulance immediately. We make the following recommendation:

The Governor should remind staff of their responsibilities during medical emergencies including that they should call the appropriate medical emergency code without delay.

Mr Horsley's allegations he was under threat

77. We are satisfied that staff responded appropriately when Mr Horsley told them he was under threat from other prisoners. Staff opened a CSIP, supported his request to remain in his cell and monitored him regularly. They also made mental health referrals when they became concerned that Mr Horsley's behaviour was out of character and concerning.
78. It would appear that Mr Horsley's allegations were unfounded. It is unclear what triggered them. There were suspicions that Mr Horsley may have taken psychoactive substances (PS, also known as 'Spice') which could have triggered drug-induced psychosis, but he denied any recent use of illicit drugs. No illicit drugs were found in Mr Horsley's system when he died.

Clinical care

79. Mr Horsley was under the care of mental health, substance misuse and primary care services and he was reviewed at multidisciplinary team (MDT) meetings. Healthcare staff attended ACCT reviews and information sharing between healthcare and prison services appeared to be appropriate. The clinical reviewer concluded that, overall, the clinical care Mr Horsley received was equivalent to that he could have expected to receive in the community.

Staff support

80. We note that the prison held a hot debrief after the incident and offered those who attended support. However, some staff said they received no support during the subsequent police investigation. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are offered appropriate support following a death in custody, including during any subsequent police investigation.

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