Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Patrick Horner, on 21 December 2024, following his release from HMP Leeds

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO

WHAT WE VALUE

Summary

1. 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.

2. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.

3. 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.

4. Mr Patrick Horner died from a pulmonary embolism (when a blood vessel in the lungs is blocked by a blood clot). This was caused by sepsis which was in turn caused by cellulitis (a bacterial infection in the deep layers of the skin). He died on 21 December 2024 following his release from HMP Leeds on 17 December. He was 76 years old. We offer our condolences to those who knew him.

5. The clinical reviewer concluded that the care Mr Horner received at Leeds was of a good standard and was equivalent to that which he could have expected to receive in the community. She did not make any recommendations.

6. We did not identify any significant learning relating to the pre-release planning for or post-release supervision of Mr Horner.

The Investigation Process

7. HMPPS notified us of Mr Horner's death on 23 December 2024.

8. The PPO investigator obtained copies of relevant extracts from Mr Horner's prison and probation records.

9. NHS England commissioned an independent clinical reviewer to review Mr Horner's clinical care at the prison.

10. We informed HM Coroner for West Yorkshire of the investigation. She told us that Mr Horner's death had not been referred to them and there would not be an inquest as he had died of natural causes in the community.

11. The Ombudsman's office contacted Mr Horner's next of kin, his daughter, to explain the investigation and to ask if she had any matters she wanted us to consider. She had the following concerns and questions:

    - She asked about an incident which took place on 31 October 2024, where she said Mr Horner was subjected to an invasive rectal examination and was forced to have a 'buzz cut'.
    - Did Mr Horner have access to a walking stick/mobility aid at HMP Leeds?
    - Was Mr Horner appropriately located while at HMP Leeds?
    - Should Mr Horner have been moved to H Wing sooner?
    - Why did he have a neurological scan and an MRI scan?
    - Did Mr Horner attend any classes or activities where his memory could be observed?
    - Why was supported accommodation not arranged before his release?
    - Why was Mr Horner released to accommodation that was not suited to his needs? For example, it was not a secure room, it had a heavy door, the TV did not work, the sofa was too low for him to sit on, there was no shower and it was on the first floor with steep stairs.
    - Why did social services only visit him three times a day for half an hour?
    - What did the carers observe when they visited Mr Horner?
    - Why was his release not delayed until a safe place was available for him?

    Her concerns have been addressed in the clinical review, in this report and by separate correspondence.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

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

Background Information

HMP Leeds

13. HMP Leeds is a category B reception and resettlement prison in Leeds, Yorkshire. Practice Plus Group provides healthcare services, including mental health services and substance misuse services.

Probation Service

14. The Probation Service works with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, prepare reports to advise the Parole Board and have links with local partnerships to which they refer people for resettlement services, where appropriate. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Key Events

Background

15. On 18 June 2024, Mr Patrick Horner was convicted of sex offences and was sentenced to 12 months in prison. He was sent to HMP Leeds.

16. Mr Horner had a history of asthma, chronic obstructive pulmonary disease (COPD), high blood pressure and heart disease. While in prison, he was diagnosed with prostate cancer.

Pre-release planning

17. On 21 June, an officer from the prison's resettlement team saw Mr Horner who told him he lived alone in private rented accommodation. The officer completed a referral to the Commissioned Rehabilitative Services (CRS, a probation service which aims to help break the cycle of reoffending by providing guidance, support and practical help to tackle the barriers to rehabilitation) to arrange for the tenancy to be maintained while Mr Horner was in custody. The referral was sent to St Giles Trust. Mr Horner told the officer that he had multiple health conditions, and that he was registered with a GP in the community.

18. On 11 July, Mr Horner attended an appointment with St Giles Trust. Mr Horner's Community Offender Manager (COM) told us that the referral was closed following this meeting at Mr Horner's request as there were plans for his daughter to manage the property while he was in prison.

19. On 17 July, a GP operating at Leeds, saw Mr Horner. She noted that he had oedema (swelling) in both legs, which Mr Horner reported was longstanding.

20. On 16 October, a Nurse saw Mr Horner. She noted that he had some foot and ankle oedema. She advised him to elevate his legs. Mr Horner told her that he would see a GP on release for follow-up care.

21. On 29 October, Mr Horner's Prison Offender Manager (POM), saw Mr Horner for a planned supervision session. Mr Horner signed a medical consent form which stated that he was happy for the COM and herself to receive relevant information from healthcare staff to help plan for his release.

22. On 5 November, an officer from the prison's resettlement team saw Mr Horner to discuss his accommodation plans for release. A COM told us that Mr Horner's daughter said that when she attended Mr Horner's previous address, it was a complete mess. As Mr Horner had not been looking after it, she was asked to take his belongings and he was not allowed back there.

23. On 6 November, a nurse saw Mr Horner. It is noted that he was struggling with daily tasks so was relocated within the prison to receive social care support (local authority provided carers to help with daily living tasks).

24. On 7 November, a COM completed another CRS referral to St Giles Trust to arrange accommodation for Mr Horner's release.

25. On 15 November, a COM referred Mr Horner to both York Council and Leeds Council for accommodation under the statutory duty to refer those at risk of homelessness. Both councils later responded that they could only offer a rough sleeper hostel accommodation and that there was a two to three year waiting list for permanent accommodation.

26. On 19 November, a COM referred Mr Horner to be considered for an approved premises (AP). This was later rejected as Mr Horner was deemed unsuitable for an AP due to his health and social care needs.

27. On 20 November, a nurse and COM exchanged emails about finding suitable accommodation for Mr Horner. A nurse completed an adult social care referral to Leeds City Council. A COM completed a referral to HMPPS' Community Accommodation Service Tier 3 (CAS3, a service open to adult prison leavers at risk of homelessness on release from prison. The service provides access to up to 84 days of accommodation). This was completed as an emergency option due to there being no success with the local councils or other housing services.

28. On 22 November, a nurse emailed Leeds Adult Social Care. They informed her that they would be able to arrange a package of care if Mr Horner had an address to which he would be released. It is recorded that both the nurse and COM had explored all options but were unable to secure a fixed address for Mr Horner.

29. On 25 November, a COM referred Mr Horner to NHS Reconnect (a care after custody service which aims to improve the continuity of healthcare after release from prison). The referral was accepted.

30. That day, a GP operating at Leeds saw Mr Horner and they discussed his leg oedema. Mr Horner told him that he was not concerned about his legs, and the GP found no evidence of deterioration.

31. On 27 November, a nurse phoned York Council about a home placement in York for Mr Horner, and they asked her to complete a duty to refer form. She also sent Mr Horner's social care assessment to York Council. She recorded that Mr Horner was happy to explore options to live in York. She also completed a six-item cognitive impairment test (6CIT) with Mr Horner after his daughter raised concerns about him having dementia. The results did not indicate memory impairment.

32. On 28 November, Reconnect assessed Mr Horner. A Healthcare Assistant (HCA) also saw Mr Horner and it was noted that his legs were very swollen and red. The HCA took observations and Mr Horner's National Early Warning Score (NEWS2) score was 0 which indicated that he was not at risk of clinical deterioration.

33. On 29 November, a GP saw Mr Horner due to ongoing concerns about leg swelling. Mr Horner told him that it had not got worse recently. The GP recorded in the medical records that Mr Horner had warm legs but there were no obvious signs of cellulitis. He told Mr Horner to keep his legs elevated and to seek help if he had any new or worsening symptoms. He prescribed a course of antibiotics.

34. On 5 December, a nurse had a phone call with York Council and Mr Horner. The council said that there was a large waiting list for a permanent property in York, and they could only offer Mr Horner a space at a homeless hostel or a crash bed

(described as a mattress on the floor in a place of warmth and safety) in the meantime. She explained that a crash bed would be highly inappropriate for Mr Horner due to his age and health.

35. On 10 December, a CAS3 property was arranged for Mr Horner in Leeds. A COM informed the accommodation provider of Mr Horner's needs, and it was confirmed that social services could visit him daily.

36. On 11 December, a COM emailed a nurse and gave her the CAS3 address for Mr Horner's release. The nurse completed a referral to Leeds Council to arrange a social care package. Healthcare staff sent Mr Horner a letter and a form to help him register with a GP on release.

37. On 12 December, Mr Horner's medication was arranged for his release. A POM saw Mr Horner to discuss his CAS3 accommodation. He confirmed that he had already been notified that he was being released to temporary accommodation in Leeds and that he understood the reasons for this, despite requesting accommodation in York. He was given and signed a copy of the CAS3 compact.

38. On 13 December, a nurse phoned Leeds Council and gave them the details of the care he had received in prison so that a mirrored package of care could be set up.

Release from HMP Leeds

39. On 17 December, a nurse saw Mr Horner in reception before release and he was given his medication to take with him. He was given details about how to access further medication. He declined help to register with a GP practice. Reception staff gave him a clothing parcel, toiletries and arranged for a taxi to take him to the probation office.

40. Mr Horner attended his probation induction with a COM. As Mr Horner said that he was hungry, the COM went to a food bank and got some meals for him to eat that evening. Further meals were to be provided as part of his social care package. The COM explained Mr Horner's licence conditions to him and arranged to call him as he would not easily be able to attend the probation office in his condition. CAS3 staff picked Mr Horner up from the office and took him to the CAS3 accommodation.

41. Later that day, the CAS3 Resident Welfare Officer emailed a COM and raised concerns about the property as it was on the first floor, and they were concerned about whether Mr Horner could manage the stairs. The COM passed this information to her Senior Probation Officer (SPO).

42. On 18 December, a COM had an email exchange with the Resident Welfare Officer about Mr Horner's CAS3 property. She recorded that she was going to look for alternative accommodation on the ground floor and contacted charities to see if they could offer Mr Horner support.

43. On 20 December, the CAS3 Resident Welfare Officer emailed a COM and told her that Mr Horner had been admitted to hospital with cellulitis of his legs.

44. The COM continued to explore alternative accommodation for Mr Horner. She recorded that there were no CAS3 properties available in Leeds or in the areas near

Leeds. Due to the social care package arranged, she did not want to widen the search further.

Circumstances of Mr Horner death

45. On 21 December, the police notified the Probation Service that Mr Horner had died in hospital.

Cause of death

46. A post-mortem examination was not carried out as the Coroner accepted the cause of death provided by a hospital doctor. The doctor gave the cause of death as a pulmonary embolism caused by sepsis, which was in turn caused by cellulitis.

Findings

Clinical care

47. The clinical reviewer concluded that the care Mr Horner received during his time at Leeds and before his release into the community was of a good standard and was equivalent to that which he could have expected to receive in the wider community.

48. She found that Mr Horner's care was in line with guidance, and he had the appropriate care plans in place. She also concluded that his ongoing health concerns were addressed, and the healthcare team responded promptly and proactively to his needs.

49. The clinical reviewer found that the healthcare team planned for Mr Horner's release well in advance by liaising with the appropriate agencies and sharing information about his risks and needs. She made no recommendations.

Accommodation

50. The provision of suitable accommodation for people leaving prison is an issue that extends beyond the remit of Leeds or local probation services. A COM suitably prepared for Mr Horner's release by promptly completing accommodation referrals to the local authorities. However, it is unfortunate that the local authorities were unable to provide suitable accommodation.

51. The Regional Homelessness Prevention Team Coordinator told us that given the limited options, the CAS3 accommodation was the most suitable arrangement that could have been made for Mr Horner. He said that he felt the Homeless Prevention Team and Probation Service did everything within their capacity to support Mr Horner in the CAS3 property.

52. We appreciate that the CAS3 accommodation arranged for Mr Horner did not meet all his needs. However, we are satisfied that the COM and nurse did everything they could to arrange suitable accommodation for his release and it was unfortunate that the CAS3 temporary accommodation was the only feasible option available to him at the time.

Good Practice

53. Although Mr Horner's housing situation on release was not ideal, we consider that the nurse and COM took extensive steps to identify suitable accommodation for Mr Horner. They were proactive and responsive to his needs. We consider their actions to be examples of good practice.

Adrian Usher
Prisons and Probation Ombudsman **August 2025**

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