



Independent investigation into the death of Mr William Robinson, a prisoner at HMP/YOI Forest Bank, on 15 April 2020

A report by the Prisons and Probation Ombudsman

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



OGL

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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 William Robinson died from an upper airway obstruction and synthetic cannabinoid toxicity on 15 April 2020 at HMP Forest Bank. He was 55 years old. I offer my condolences to Mr Robinson's family and friends.

I am satisfied that Mr Robinson received appropriate care at Forest Bank. Prison and healthcare staff ensured that he was aware of the risks of using illicit substances and reminded him of the negative impact they could have. Mr Robinson refused support from the substance misuse service and his death appears to have been an accidental result of using drugs.

However, it is troubling that Mr Robinson was able to obtain psychoactive substances with apparent ease at Forest Bank, particularly during the COVID-19 restrictions.

We are concerned about the number of deaths we have investigated in which psychoactive substances have played a part and about the availability of psychoactive substances across the prison estate. The Governor at Forest Bank should continue to identify and address weaknesses in measures to prevent the supply of drugs into the prison and revise the substance misuse strategy in light of the findings.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman

October 2023

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Summary

Events

1. Mr William Robinson had been in prison since September 2018, serving a sentence of three years and eight months for burglary. He moved to HMP Forest Bank on 21 February 2020. Mr Robinson had a history of substance misuse, including synthetic cannabinoids also known as spice or psychoactive substances (PS). When he arrived at Forest Bank, Mr Robinson refused support from the substance misuse team.
2. On 28 March prison staff thought that Mr Robinson was under the influence of PS, but he denied that he had used any illicit substance and refused substance misuse support.
3. On 9 April, Mr Robinson moved to a wing for prisoners at a high risk of developing complications from COVID-19.
4. At around 7.25am on 15 April, a prison custody officer (PCO) unlocked Mr Robinson's cell door and saw him slumped over his desk. The PCO radioed a medical emergency code and staff responded quickly. A nurse examined Mr Robinson and found extensive rigor mortis, suggesting that he had been dead for some time. As there were clear signs of death, resuscitation was not attempted.
5. The post-mortem examination established that Mr Robinson died from pressure to the neck (caused by the position he collapsed in), upper airway obstruction and synthetic cannabinoid toxicity.

Findings

Drug strategy

6. Although Forest Bank has taken some steps to address its drug supply issues, Mr Robinson's death is a reminder that more needs to be done to reduce the availability and detection of drugs. The availability of illicit substances remains a problem across the whole prison estate and should remain a priority for Forest Bank.

Clinical care

7. The clinical reviewer concluded that Mr Robinson received a good standard of clinical care and substance misuse support, which was equivalent to that he could have expected to receive in the community. The decision not to attempt resuscitation was appropriate and preserved Mr Robinson's dignity.

Recommendations

- The Director should continue to identify and address weaknesses in measures to prevent the supply of drugs into Forest Bank and revise the substance misuse strategy in light of the findings.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Forest Bank informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Robinson's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Robinson's clinical care at the prison.
11. We informed HM Coroner for Greater Manchester West district of the investigation. They gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. We wrote to Mr Robinson's family to explain the investigation. We did not receive a response.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Forest Bank

14. HMP Forest Bank is a local prison in Salford, serving courts in north-west England. It holds 1,460 remanded and sentenced male prisoners. The prison is managed by Sodexo Justice Services, who also provide primary health care services, as well as clinical and psychosocial substance misuse care.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Forest Bank was in March 2022. Inspectors noted that a longstanding leadership team led services well and supported a team of skilled and motivated staff. Close working with other prison departments was evident, particularly in the delivery of the evolving drug strategy which was used to inform practice.

16. Inspectors found that steps had been taken to stem the flow of drugs and other illicit items and these measures were helping to reduce availability, but not all cell searches were carried out, which was a missed opportunity. Drugs had been easily available in the prison and had fuelled debt and associated violence. Inspectors recommended that the prison leaders should take robust and sustainable action to reduce the availability of illicit items, including acting on intelligence received.

Independent Monitoring Board

17. 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 October 2021, the IMB reported that over the past 12 months the integrated substance misuse service had delivered the key elements of the service for prisoners.

Previous deaths at HMP Forest Bank

18. Mr Robinson was the eighth prisoner to die at Forest Bank since April 2018. Of the previous deaths, four were due to natural causes, two were self-inflicted and one was drug-related. There have since been 13 deaths, eight from natural causes, two were self-inflicted, two were drug related and one is awaiting classification.

19. In our previous investigation into the death of a prisoner at Forest Bank in March 2021, we expressed concern and made a recommendation about prisoners being able to obtain illicit drugs. The prison accepted our recommendation and said that they had created a supply reduction action plan which identified actions to be taken to reduce the availability of illicit drugs coming into the prison. This was to be discussed at the security meeting and the substance misuse strategy meeting. That we are raising this issue again in this report indicates the particular difficulties prison leaders face in reducing the availability of drugs in prison.

Key Events

20. Mr William Robinson had a history of illicit drug use, including synthetic cannabinoid use (also known as Spice or PS) in prison. He was diagnosed with chronic obstructive pulmonary disease (a group of lung conditions that cause breathing difficulties) in 2014.
21. On 19 September 2018, Mr Robinson was sentenced to 3 years and 8 months for burglary. He spent time in several prisons before moving to HMP Forest Bank on 21 February 2020. This was not Mr Robinson's first time in prison. A nurse noted Mr Robinson's medical history and that he denied any thoughts of suicide and self-harm. Mr Robinson denied that he was using illicit substances and refused a referral to the prison's substance misuse service.
22. Mr Robinson had a key work session with a prison officer every week to check on his welfare and to address any problems. Mr Robinson did not raise any concerns.
23. On 23 March, a national lockdown was imposed due to the COVID-19 pandemic. Prison regimes were severely curtailed and face-to-face services were reduced or stopped. Key work was formally suspended across the prison estate on 24 March.
24. On 28 March, prison staff went to Mr Robinson's cell for a routine welfare check and found drug related paraphernalia. Staff suspected that he was under the influence of PS and asked for a prison nurse to see him. A nurse attended and noted that Mr Robinson's heart rate was elevated, and his oxygen saturation rate was low. The nurse did not record Mr Robinson's blood pressure or temperature and did not complete a NEWS2 score (a tool to assess the clinical condition of patients). The nurse noted that Mr Robinson was clearly under the influence of PS. Mr Robinson refused a referral to the substance misuse service and denied that he had used an illicit substance. Mr Robinson said he was aware of how and where to seek help and advice if he needed it. Prison staff submitted a security intelligence report.
25. On 31 March, healthcare staff wrote to Mr Robinson because he was at high risk of developing complications from COVID-19 and advised him to shield. Healthcare staff completed regular welfare checks to ensure Mr Robinson was feeling well and did not have any concerns.
26. On 9 April, Mr Robinson agreed to move to a wing for prisoners who were shielding. The Head of Healthcare told us that shielding prisoners were advised to socially distance but were allowed to leave their cells and associate with each other.
27. On 14 April, staff locked Mr Robinson in his cell at around 6.00pm. CCTV shows that an Operational Support Officer (OSO), a night duty officer, completed the night roll check on the shielding unit and checked that all cells were locked, and all prisoners were accounted for. In a statement, he said that he checked Mr Robinson's cell at 10.00pm and saw him sitting at his desk. Mr Robinson did not press his emergency cell bell during the night.

Events of 15 April

28. At 5.00am, the OSO completed the morning roll check. In a statement, he said that he could not recall if Mr Robinson was in bed when he checked. He signed the roll count to confirm that he was satisfied that all prisoners were alive. We were unable to interview him because he no longer works for Sodexo Justice Services.
29. At around 7.25am, a PCO (Prison Custodial Officer) unlocked Mr Robinson's cell and saw him slumped over his desk. He called Mr Robinson's name, but he did not respond. He went into Mr Robinson's cell and moved him to the bed, assisted by a prisoner. He radioed a medical emergency code blue, (indicating a prisoner is unconscious or is having breathing difficulties). The control room log recorded that this occurred at 7.30am, and an ambulance was called straightaway.
30. At 7.33am, a nurse arrived at Mr Robinson's cell. She did not start cardiopulmonary resuscitation (CPR) because it was evident that Mr Robinson was already dead. She noted that Mr Robinson was cold to touch, there was pooling of blood on his chest, arms and shins and rigor mortis was present, indicating that he had been dead for some time. Paramedics arrived at 8.05am and at 8.32am, confirmed that Mr Robinson had died.

Contact with Mr Robinson's family

31. At 8.50am, a prison family liaison officer telephoned Mr Robinson's mother and broke the news of his death.
32. The prison contributed towards the cost of his funeral in line with national policy.

Support for prisoners and staff

33. After Mr Robinson'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.
34. The prison posted notices informing other prisoners of Mr Robinson'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 Robinson's death.

Post-mortem report

35. The post-mortem report concluded that Mr Robinson died from pressure to the neck, upper airway obstruction and synthetic cannabinoid toxicity.
36. The toxicology reports revealed the presence of synthetic cannabinoids in Mr Robinson's blood.
37. The pathologist commented that although it is never entirely possible to rule out assault from a purely pathological perspective, the overall features were most in keeping with fatal pressure to the neck following a collapse onto the edge of the desk, caused by drug toxicity.

Findings

Assessment of Mr Robinson's risk and substance misuse

38. Mr Robinson had a history of using illicit substances in prison. Before he moved to Forest Bank in January 2020, Mr Robinson was suspected of being under the influence of PS on two occasions. When he arrived at Forest Bank, Mr Robinson denied using illicit substances and declined support from the substance misuse service.
39. Forest Bank's Integrated Substance Misuse Strategy states that to address substance misuse issues, staff must adopt three key principles in line with HM Prison and Probation Service's (HMPPS) national drug strategy 2019:
 - Support residents to reduce and avoid substance misuse
 - Provide treatment and support to maintain recovery
 - Prevent drugs being available.
40. When prison staff suspected that Mr Robinson was under the influence of PS, he was offered support from the substance misuse service but refused to engage. Mr Robinson told staff that he was aware of how to access support. Healthcare staff assessed Mr Robinson, who continued to deny that he was under the influence of PS. Prison staff removed drug paraphernalia from Mr Robinson's cell and submitted a security intelligence report. A few days later, Mr Robinson was advised to shield to reduce his risk of developing complications from COVID-19.
41. We found nothing to indicate that Mr Robinson was at high risk of suicide or self-harm at the time of his death. There is no evidence that Mr Robinson wanted to take his life or harm himself and we are satisfied that staff acted in accordance with the prison's substance misuse strategy.

Drug strategy at HMP Forest Bank

42. It is troubling that Mr Robinson was able to access PS, particularly during the COVID-19 lockdown when severe restrictions had been put in place on prisoner and visitor movements.
43. In April 2019, HMPPS issued a national instruction that all prisons should review their drug strategies. Forest Bank has since revised its drug strategy. The investigation found that the prison has a comprehensive Integrated Substance Misuse Strategy to help reduce the demand for and supply of illicit drugs. We note that in their last inspection, HMIP found that steps had been taken to stem the flow of drugs into the prison. These measures were helping to reduce availability, with 40% of prisoners saying that it was easy to obtain illicit drugs, in comparison to 61% at HMIP's last inspection in 2019.
44. The Head of Security told us that in June 2020, a notice to staff was issued which gave staff instructions on how to follow the Integrated Substance Misuse Service PS pathway for prisoners suspected of using PS. She said this would ensure prisoners who were suspected of using PS were appropriately assessed by

healthcare, the incident was recorded on the prisoner's record and a security intelligence report was submitted. The aim of these measures was to reduce the risk to prisoners and to help reduce the supply and demand for illicit substances.

45. We are satisfied that since Mr Robinson's death, the prison has taken steps to reduce the risk to prisoners who are suspected of using PS. Nevertheless, we are concerned by the ease with which Mr Robinson was able to obtain illicit drugs. We are also concerned that since Mr Robinson's death there has been another drug related death at Forest Bank, and it is apparent that the prison must continue their efforts towards reducing supply and demand.

The Director should continue to identify and address weaknesses in measures to prevent supply of drugs into Forest Bank and revise the substance misuse strategy in light of the findings.

Clinical care

46. The clinical reviewer concluded that the healthcare that Mr Robinson received at Forest Bank was of a good standard and equivalent to that which he could have expected to receive in the community.
47. When Mr Robinson was suspected of being under the influence of PS on 28 October, the nurse did not record his NEWS2 score. The clinical reviewer considered that although Mr Robinson's scores would not have indicated that further intervention was required, it is good practice to document a NEWS2 score when physical observations are taken. The clinical reviewer has made a recommendation to the Head of Healthcare about this which we do not repeat in this report but which the Head of Healthcare will need to address.
48. The clinical review that the decision not to start CPR was correct and in accordance with the European Resuscitation Council Guidelines.

Inquest

49. The inquest, heard on 20 March 2024, concluded that Mr Robinson's death was drug related.



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