Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevan Mulligan, a prisoner at HMP Forest Bank, on 29 January 2024

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

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.

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.

Mr Kevan Mulligan died from lobar pneumonia on 29 January 2024 while a prisoner at HMP Forest Bank. He also had hepatic steatosis (fatty liver disease) and multiple drug toxicity from a combination of prescribed medication and illicit drugs which contributed to but did not cause his death. He was 34 years old. I offer my condolences to Mr Mulligan's family and friends.

Prison staff acted quickly and appropriately when they found Mr Mulligan unresponsive in his cell.

However, there was a delay in an ambulance being called and confusion whether one was needed. Although the delay would not have changed the outcome for Mr Mulligan, and there is no evidence this is a systemic issue, this could be crucial in other emergencies.

The clinical review into Mr Mulligan's death concluded that the care he received at Forest Bank was equivalent to that which he might have expected to receive in the community. The substance misuse team provided opportunities for meaningful engagement and healthcare staff appropriately supported his physical and mental health needs.

I make no recommendations.

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

Adrian Usher
Prisons and Probation Ombudsman **October 2024**

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Summary

1. On 18 April 2023, Mr Kevan Mulligan was remanded into custody at Forest Bank, charged with violent and racially aggravated offences.

2. He had a history of illicit drug use and mental health concerns for which he was prescribed antipsychotic medication and methadone (an opiate substitute). He was under the care of the substance misuse team from his arrival at the prison.

3. Mr Mulligan asked to live on the drug recovery wing and had one-to-one sessions with his substance misuse worker. He moved to the drug recovery wing on 3 May 2023 and remained there until his death.

4. In the two days before his death, Mr Mulligan spent more time in his cell than usual and told other prisoners he felt unwell. He said he had pains in his head and chest.

5. At around 7.21am on 29 January 2024, a Prison Custody Officer (PCO) unlocked Mr Mulligan's cell to begin the morning regime. They checked on him five minutes later as he had not come out of his cell for breakfast and found him unresponsive in bed. Prison staff tried to resuscitate him. When a nurse arrived, she told them to stop as she saw signs of rigor mortis. Paramedics attended and, at 8.04am, pronounced that Mr Mulligan had died.

Findings

Clinical care

6. The clinical reviewer found that the healthcare Mr Mulligan received was equivalent to that which he could have expected to receive in the community.

7. Two prisoners who knew Mr Mulligan told the investigator that they had noticed a rapid decline in his physical health in the two days before his death. They said he complained of head and chest pains and spent most of 28 January, the day before he died, in bed. They believed prison staff were aware and should have noticed but had differing views about whether Mr Mulligan would have told them.

8. The PCO who was on duty on 28 January and was the last person to see Mr Mulligan alive, has now left the Prison Service. The PPO investigator asked to interview her, but she did not respond. We have therefore been unable to ascertain whether Mr Mulligan told her he felt unwell or asked for medical help the day before he died. We found no evidence that staff had been told of Mr Mulligan's poor health and no evidence that they had in turn failed to act on such information.

Substance misuse

9. The substance misuse team appropriately prescribed Mr Mulligan methadone and a named substance misuse worker saw him regularly. At Mr Mulligan's request, he moved to the drug recovery wing, where he was offered additional support. He was offered harm reduction advice following positive mandatory drug test results and encouraged to engage with interventions. Mr Mulligan always denied illicit drug use and declined support, other than his methadone prescription.

10. Mr Mulligan was checked appropriately throughout the night and early morning of 28 and 29 January. After she unlocked Mr Mulligan to begin the morning regime, a PCO correctly returned to his cell when she noticed he had not come out for breakfast. She immediately raised a code blue when he failed to respond and shouted for help.

Director to note

11. Taking into account discrepancies between prison and ambulance records, there was an unacceptable delay of between twelve and eighteen minutes for control room staff to call an ambulance. They only did so when a nurse confirmed one was needed. Although the delay would not have changed the outcome for Mr Mulligan as he was found with rigor mortis (a clear sign of death), an ambulance must be called as soon as a code blue is radioed.

12. A previous PPO investigation in 2021 identified failures in the control room not calling an ambulance automatically when a code blue is called. This issue has not featured in subsequent investigations and there is no evidence it represents a systemic problem. While we therefore do not make a recommendation on this occasion, we bring it to the Director's attention.

The Investigation Process

13. HMPPS notified us of Mr Mulligan's death on 29 January 2024. 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. Two prisoners responded.

14. The investigator visited HMP Forest Bank on 7 February 2024. She obtained copies of relevant extracts from Mr Mulligan's prison and medical records. In addition, the investigator watched CCTV footage from 28 and 29 January 2024 and obtained information from the Northwest Ambulance Service.

15. The investigator interviewed seven members of staff and two prisoners at HMP Forest Bank on 8 April 2024. Two staff interviews were conducted remotely on 22 April 2024.

16. NHS England commissioned a clinical reviewer to review Mr Mulligan's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

17. We informed HM Coroner for Greater Manchester of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's office contacted Mr Mulligan's family to explain the investigation and to ask if they had any matters they wanted us to consider. They told us they believed Mr Mulligan had collapsed on the stairs on 28 January, the night before he died, and another prisoner helped him. They wanted to know whether this had been reported to staff, whether there was CCTV footage of this incident and what action staff had taken.

19. The initial report was shared with HMPPS. They did not find any factual inaccuracies.

20. Mr Mulligan's family received a copy of the final draft report. They did not find any factual inaccuracies.

Background Information

HMP Forest Bank

21. HMP Forest Bank is a privately managed category B reception prison in Salford near Manchester. Healthcare services, including mental health services, are provided by Spectrum (Greater Manchester Mental Health NHS Foundation Trust). Change, Grow, Live (CGL) provides substance misuse services.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Forest Bank was in January 2023. Inspectors reported the threat posed by the ingress of drugs remained and the mandatory drug testing failure rate was among the highest for this type of prison. However, they noted a substantial reduction in the availability of drugs, weapons and mobile phones since the previous inspection and measures to disrupt and repel the large number of items thrown over the prison walls had been mostly effective.

Independent Monitoring Board

23. 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 2022 (updated March 2023), the IMB reported that the prison continued to take a proactive stance against contraband, focusing on the supply of drugs and illicit items, organised crime and staff corruption. Various measures had been introduced to improve the overall security and good order of the prison. IMB observed the drug and alcohol rehabilitation team continued to be a well-led team of skilled and motivated staff who work closely with other prison departments to inform and improve practices.

Previous deaths at HMP Forest Bank

24. Mr Mulligan was the fifteenth prisoner to die at HMP Forest Bank since January 2021. Of the previous deaths, two were self-inflicted, two were drug-related and eleven were due to natural causes. Two prisoners have died since Mr Mulligan’s death. Both were due to natural causes. A previous investigation in 2021 identified failures in control room staff not automatically calling for an ambulance after an emergency code blue (used when a prisoner is unconscious and/or not breathing) was raised.

Key Events

25. On 18 April 2023, Mr Mulligan was remanded into custody to HMP Forest Bank, charged with violent and racially aggravated offences.

26. He was automatically assigned to the substance misuse service (Change Grow Live) from his arrival. He was prescribed methadone and allocated to a caseworker.

27. The following day, the caseworker completed an initial assessment for Mr Mulligan, who told him he wanted to complete one-to-one work. He declined psychosocial intervention. During subsequent sessions, Mr Mulligan denied illicit drug use. He said that he wanted to stabilise his methadone dose and was expecting a long sentence so had time to address underlying issues.

28. On 3 May and at his request, Mr Mulligan moved to G1 wing, a drug recovery wing.

29. During June and July, the caseworker met Mr Mulligan regularly to review his progress. Mr Mulligan's methadone dosage had been increased and he said he was hopeful this would help him feel more stable before starting psychosocial interventions. He said he struggled in groups and did not want to engage with them.

30. On 1 August, Mr Mulligan was subject to a random mandatory drug test. He tested positive for synthetic cannabinoids and methadone (which was prescribed). He was placed on report pending a disciplinary hearing on 15 August. He refused to attend, and the charge was proven in his absence.

31. On 16 August, Mr Mulligan was placed on report again pending a further disciplinary hearing after an improvised weapon was found in his cell. Intelligence also suggested Mr Mulligan was selling psychoactive substances on the wing and had assaulted another prisoner.

32. The caseworker gave Mr Mulligan harm reduction advice during sessions in August and September. Mr Mulligan asked for his methadone dose to be increased again and was advised this was unlikely as the dose had only recently been increased. Mr Mulligan said he would see how things went and tell the caseworker if anything changed. He continued to decline psychosocial and group interventions.

January 2024

33. On 8 January**,** Mr Mulligan was placed on report pending a disciplinary hearing following a mandatory drug test on 28 December which returned a positive result for cannabis and synthetic cannabinoids. Mr Mulligan refused to attend the disciplinary hearing and the charge was proven in his absence.

34. On 12 January, the caseworker met Mr Mulligan, who denied using illicit drugs, said he was happy with his methadone prescription and did not want to engage with any interventions.

35. On 25 January, Mr Mulligan had an electrocardiogram (ECG, a test that records the electrical activity of the heart) and blood tests. These were routinely requested to monitor him due to his prescribed medications. A prison doctor reviewed the ECG but did not identify any concerns and advised that no further action was needed.

The doctor also reviewed Mr Mulligan's blood test results and recommended repeating two of them as he noticed some abnormalities.

36. During his health check, a nurse recorded Mr Mulligan's respiratory rate was slightly low. On 26 January, she returned to check Mr Mulligan's physical observations. She told the investigator that Mr Mulligan appeared well, and he had told her that he was fine. He declined to be checked.

Events of 28 and 29 January

37. At around 11.43am on 28 January, Mr Mulligan sat on the stairs between the bottom and first floor landings, waiting for his lunch. He collected his meal, but as he walked back up the stairs, he caught the end of his shoe on the edge of the metal stair and tripped over, dropping his food. He immediately stood up and returned to the lunch hatch to collect a replacement meal before walking back to his cell at around 11.47am.

38. At around 2.05pm, Mr Mulligan left his cell and walked downstairs, returning to his cell at around 2.17pm. He stayed there for the rest of the afternoon and did not collect his evening meal. A prisoner who lived in the cell next to Mr Mulligan, told the investigator that Mr Mulligan stayed in his cell for most of that day as he said he felt ill. He said he complained about his stomach and chest (but did not go into any further detail) and had not used psychoactive substances for two days as he had felt too unwell.

39. At approximately 5.05pm, PCO A spoke to Mr Mulligan at his cell door before locking his cell for the night. Her statement does not expand on the details of their conversation but records that he replied to her. It is unknown if staff noticed or asked Mr Mulligan why he did not collect his evening meal.

40. At around 10.00pm, during routine checks, an officer looked through Mr Mulligan's cell door observation panel to check he was in his cell (which he was). The officer conducted a further check at 4.50am the following morning.

41. At around 7.15am on 29 January, PCO B was unlocking prisoners on the wing to begin the morning regime. CCTV footage shows that she unlocked Mr Mulligan's cell at around 7.21am. She told the investigator that she said good morning to him and asked if he was going to come downstairs for breakfast. When he failed to respond, she thought he may still be asleep so decided to return a few minutes later to check on him.

42. Five minutes later, PCO B returned to Mr Mulligan's cell. She noticed he looked pale and touched his forehead which she said felt cold. She checked for a pulse and radioed an emergency code blue when she could not find one. She left the cell, locked it, and shouted for colleagues to assist. PCO C arrived and began cardiopulmonary resuscitation (CPR).

43. At the same time, a nurse was dispensing medication nearby and heard the code blue on her radio. She went into Mr Mulligan's cell and saw PCO C giving chest compressions. She took over and told him to stop CPR as rigor mortis was present and Mr Mulligan had died.

44. A Senior Prison Custody Officer (SPCO) answered a radio request to go to G1 wing. At an unrecorded time, she went into Mr Mulligan's cell and saw PCO C and the nurse. Her statement noted that she received a call from the control room asking whether an ambulance was needed. She said she did not think so as Mr Mulligan appeared to have died but she would ask a nurse to call them back. The nurse recalled hearing the SPCO asking if an ambulance was needed. She told her it was, as she could not formally pronounce Mr Mulligan's death.

45. The prison control room log recorded an ambulance was called at 7.38am, while Northwest Ambulance Service recorded the call at 7.44am. At 7.51am, rapid response paramedics arrived at Forest Bank and went into Mr Mulligan's cell at 7.56am. An ambulance arrived at the prison at 7.56am and a second one arrived two minutes later. Paramedics assessed Mr Mulligan and pronounced his death at 8.04am.

Contact with Mr Mulligan's family

46. At 8.28am, the prison appointed a PCO as the prison's family liaison officer (FLO). A prison chaplain and an Operational Support Officer (OSO) were appointed as deputies. At 10.15am, the FLO and OSO visited Mr Mulligan's family at their home address and informed them of his death. On 31 January, the FLO and prison chaplain supported Mr Mulligan's parents and two sons during a visit to the mortuary. The prison contributed to the cost of Mr Mulligan's funeral in line with national policy.

Support for prisoners and staff

47. After Mr Mulligan's death, the Heads of Residence 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 Mulligan'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 Mulligan's death.

Post-mortem report

49. The pathologist gave Mr Mulligan's cause of death as lobar pneumonia. Mr Mulligan also had hepatic steatosis (fatty liver disease) and multiple drug toxicity, including synthetic cannabinoids and methadone, which contributed to but did not cause Mr Mulligan's death.

50. The post-mortem and toxicology reports identified the presence of synthetic cannabinoids in Mr Mulligan's system. However, it was not possible to determine when he had last used the drug or if he had consumed a potentially toxic amount. No other illicit substances were detected. All other medications detected were prescribed and indicated therapeutic levels of use.

Inquest

51. At an inquest held between 3 and 7 March 2025, the Coroner concluded that Mr Mulligan died as a consequence of a combination of sudden onset pneumonia and drug use.

Findings

Assessment of risk - physical healthcare

52. Four days before his death, Mr Mulligan underwent routine ECG and blood tests. A nurse appropriately returned to see him the following day (26 January) because his respiratory rate had fallen below the normal range, but he declined to have his observations taken. Mr Mulligan had missed some other appointments with the prison doctor and hospital outpatients (for ailments unrelated to his cause of death) so this was not out of character for him.

53. The investigator reviewed CCTV footage of the day before Mr Mulligan's death. This showed him tripping up the stairs at around 11.43am after he had collected his lunch. He appeared to catch his shoe on the edge of the stair and although he fell, he immediately stood up, collected more food and walked back to his cell. There is no evidence he spoke to staff. The investigation was unable to identify evidence of another incident in which he collapsed or fell.

54. Two prisoners on Mr Mulligan's wing told the investigator that they noticed a rapid decline in Mr Mulligan's physical presentation in the two days before he died. They both said Mr Mulligan complained of chest, stomach and head pain and spent most of the day on 28 January in bed. They had differing views about whether Mr Mulligan would have told staff he felt unwell.

55. Two PCOs saw Mr Mulligan in the week before his death and did not notice anything of concern. One PCO felt that Mr Mulligan would have told staff he was feeling unwell and asked to see a nurse. PCO A no longer works at Forest Bank and has not responded to our invitation to be interviewed as part of the PPO investigation. We have therefore been unable to ascertain whether she was aware Mr Mulligan was unwell or details of their last conversation. We found no evidence that staff were aware.

Clinical review

56. The clinical reviewer found that the healthcare Mr Mulligan received was equivalent to that which he could have expected to receive in the community, except for a delay in being referred for a mental health assessment and the lack of clinical review after receipt of the hospital discharge letter, neither of which related to his death. The clinical reviewer made five recommendations which did not relate to Mr Mulligan's death but which the Head of Healthcare at Forest Bank will need to address.

57. The clinical reviewer identified good practice in the care the substance misuse team provided: they saw Mr Mulligan on arrival, prescribed him medication without delay, reviewed his medication promptly and put in place a comprehensive support plan to review his withdrawal symptoms.

Substance misuse

58. Post-mortem and toxicology results indicated that Mr Mulligan had used psychoactive substances sometime before his death and therefore had access to them in prison.

59. The caseworker saw Mr Mulligan regularly and consistently. He provided harm reduction advice following Mr Mulligan's positive drug test in August 2023 and repeatedly offered him psychosocial and group interventions. Mr Mulligan always declined these and always denied taking illicit drugs.

60. The caseworker told the investigator that Mr Mulligan rarely wanted to engage in meaningful work. He never saw anything of concern during interactions with Mr Mulligan on the wing. PCO B and another PCO both told the investigator they had never seen Mr Mulligan using drugs or appearing to be under the influence.

61. We acknowledge the challenges in preventing drugs entering Forest Bank and positive steps the prison has taken to reduce supply and demand. Enhanced physical security in the form of new windows and vertical netting across wings had seen a significant reduction in over the wall conveyance and drone activity. Forest Bank has introduced enhanced measures to address the increasing problem of psychoactive substances. All prisoner social mail is photocopied, and since January 2024, all parcels are checked before they enter the prison. The prison has enhanced gate security so that all staff and visitors are searched on entry and there is a body scanner in reception to search prisoners on an intelligence-led basis. Forest Bank have three officers embedded in intelligence and liaison roles at the prison and liaise with the local neighbourhood policing team.

58. The most recent HMIP inspection (January 2023) and IMB annual report (updated March 2023) identified progress the prison had made to reduce the availability of and demand for drugs. The IMB noted that the drug and alcohol rehabilitation team (CGL) continued to be a well-led team of skilled and motivated staff who offered good care and support to prisoners.

Director to note

Emergency response

59. After receiving a medical emergency code blue, staff in the control room failed to contact the Ambulance Service automatically in line with PSI 03/2013 on medical emergency response codes. Entries in their log indicate that PCO B radioed a code blue at 7.26am and an ambulance was called at 7.38am, only after the nurse confirmed that one was needed. Northwest Ambulance Service recorded the time of the call as 7.44am. This indicates an unacceptable delay of between twelve and eighteen minutes. We do not make a recommendation as the delay would not have changed the outcome for Mr Mulligan and there is no evidence the failure is systemic, but we bring it to the Director's attention.

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