Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Connor Milton, a prisoner at HMP Moorland, on 18 July 2025

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



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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.

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 Connor Milton died from the toxic effects of synthetic cannabinoids (a type of psychoactive substance (PS)) on 18 July 2025 at HMP Moorland. He was 20 years old. I offer my condolences to Mr Milton's family and friends.

Mr Milton had a long history of drug use and was suspected of taking PS several times at Moorland. The investigation found that Mr Milton received very good multidisciplinary support at Moorland and that the prison has appropriate measures in place to tackle drug supply and demand.

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 2026**

Contents

Summary 1

The Investigation Process.....3

Background Information.....4

Key Events.....6

Findings 12

Summary

Events

1. On 3 February 2025, Mr Connor Milton was recalled to prison. On 12 March, he was moved to HMP Moorland.

2. When he arrived at Moorland, Mr Milton told a nurse that he had no mental health problems or thoughts of suicide or self-harm. He declined a referral to the Substance Misuse Service (SMS), despite having a long history of drug use.

3. On 20 March, Mr Milton made superficial cuts to his forearms after his partner told him that his mother had said she wanted nothing more to do with him. Staff started suicide and self-harm procedures (known as ACCT). The next day, another prisoner punched Mr Milton several times in the face. Mr Milton then threatened the prisoner with a knife. Mr Milton told staff that he had £80 of drug debt from his previous time at Moorland but was no longer using drugs. Staff created a Challenge, Support and Intervention Plan (CSIP, a case management system used to manage prisoners at risk of perpetrating violence which is sometimes also used to support victims). The next day, Mr Milton tied a ligature around his neck and staff intervened. Later that month, healthcare staff prescribed antidepressants.

4. In April, Mr Milton engaged regularly with psychology services and SMS. Staff stopped ACCT monitoring. However, staff suspected that Mr Milton was under the influence of illicit substances on two occasions. Mr Milton told staff this was to cope with the reported death of his mother. He self-harmed again and staff opened a further ACCT. Chaplaincy staff later confirmed that his mother was alive. Staff closed the ACCT later that month. Between May and July, staff suspected that Mr Milton was under the influence on one occasion and that another prisoner had assaulted him. He continued to engage with SMS.

5. On 14 July, staff noted that Mr Milton appeared withdrawn. He told them that he was reluctant to leave prison and said he had “nobody and nothing” and that life outside was “shit”.

6. At 8.10am on 18 July, an officer unlocked Mr Milton’s cell. CCTV shows that he opened the door slightly and moved on, without looking in. In his statement, he said he called out “Good morning” but got no response.

7. Eight minutes later, the officer returned with another officer to tell Mr Milton that the workshop he was allocated to was closed. The second officer approached Mr Milton, who was lying on his bed, and noticed he appeared blue. The officer radioed a medical emergency code and started CPR, which was continued by healthcare staff and then ambulance paramedics. Resuscitation attempts were unsuccessful and at 8.50am, paramedics pronounced life extinct.

Findings

8. We found that Mr Milton received very good, multidisciplinary support at Moorland. His drug recovery worker provided personalised one-to-one support which included harm reduction, overdose risks and safer use. We are satisfied that Mr Milton was warned of the dangers of PS use and given support to help him stop using drugs.

9. In their last inspection of Moorland, HM Inspectorate of Prisons found that Moorland did not have a significant drug problem compared to the wider prison estate. We are satisfied that the prison has appropriate measures in place to tackle drug supply and demand.

10. The officer who unlocked Mr Milton on the morning of 17 July did not carry out a welfare check as he should have done. Had he done so, Mr Milton would have received emergency care sooner. The Head of Safety spoke to the officer concerned and reminded other staff about expectations when unlocking cells.

11. The clinical reviewer found that his care was equivalent to that which he could have expected to receive in the community.

12. We make no recommendations.

The Investigation Process

13. HMPPS notified us of Mr Milton's death on 18 July 2025

14. The investigator issued notices to staff and prisoners at HMP Moorland informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded and were interviewed.

15. The investigator visited Moorland on 28 July. He obtained copies of relevant extracts from Mr Milton's prison and medical records. He also obtained CCTV and body worn video camera (BWVC) footage and the HMPPS Early Learning Review.

16. NHS England commissioned an independent clinical reviewer to review Mr Milton's clinical care at the prison. The investigator and clinical reviewer jointly interviewed two healthcare staff over video call in October.

17. We informed HM Senior Coroner for County Durham and Darlington of the investigation. The Coroner gave us a copy of the post-mortem and toxicology reports. We have sent the Coroner a copy of this report.

18. The Ombudsman's office contacted Mr Milton's mother to explain the investigation and to ask whether she had any matters she wanted us to consider. Mr Milton's mother asked what happened in the lead up to her son's death and what caused it. She also asked why he was not monitored more closely and why she was not told right away when her son died. We have addressed these concerns in this report.

19. We shared the initial report with HMPPS who pointed out some factual inaccuracies and we have amended this report accordingly.

20. We also shared the initial report with Mr Milton's family. They did not make any comments.

Background Information

HMP Moorland

21. HMP/YOI Moorland is a category C training and resettlement prison. Practice Plus Group provides healthcare services at the prison, including primary care, mental health and substance misuse services. Healthcare services operate between 7.30am and 7.30pm, Monday to Friday.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Moorland was in March 2023. Inspectors found that violence at Moorland had reduced since the previous inspection, with 114 incidents recorded in the previous year, and levels remained below comparable prisons, although there were signs of a slight increase. Violence reduction work was supported by improved data and analysis. The safer custody team used this to identify causes and develop action plans. Challenge, Support and Intervention Plans (CSIP) were well embedded and generally of good quality. Referrals were proactive, involved different staff groups and focused on both perpetrators and victims. However, inspectors found that some plans were closed too early, and some prisoners were later involved in further incidents. This suggested variable impact in sustaining behaviour change.

23. Inspectors found that security arrangements were generally proportionate, with strong intelligence-led work and effective joint working between security, safety and drug supply teams. Measures to disrupt supply included photocopying mail, laundering incoming clothing and intelligence-led searches. Prisoners said drugs were less available than before. However, supply remained a risk. Trading of prescribed medication was the main concern, and mandatory drug testing had not been delivered consistently because of staffing pressures. Drug-free environments, such as the incentivised substance-free living unit, were effective. However, wider supply reduction depended on sustained operational activity. Inspectors also found some weaknesses in practice, including disproportionate strip-searching and limited supervision on exercise yards. This suggested that security measures were not always well balanced or consistently applied.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid appointees from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 28 February 2025, the IMB noted that the availability and use of illicit drugs remained a persistent challenge at Moorland. Synthetic cannabinoids were a particular concern, with prisoners presenting as under the influence on residential units and in workshops. Although overall levels were lower than in some nearby prisons, drug use fluctuated, including a spike in January 2025 which led the prison to put communication and security measures in place.

25. The Board identified several supply routes, including mail, visits and internally secreted items. This required ongoing disruption activity. Substance misuse

services were in place, but engagement was inconsistent. The Board also noted a link between drugs and violence, with debt-related violence increasing when drug availability reduced.

26. The Board found that, despite a range of security measures, preventing the entry and circulation of illicit items remained a significant challenge. Measures included body scanners, intelligence-led searches, photocopying of mail and the use of drug dogs, alongside segregation under the secreted items policy. Despite these controls, prisoner-on-prisoner violence increased. There were 132 incidents, mainly driven by retaliation, with drug debt a contributing factor. The use of CSIP increased significantly, with over 2,800 referrals. The Board said this process was embedded and central to managing violence. However, it noted ongoing operational limits, including restrictions on body-worn video cameras (BWVC). It concluded that drug supply and related violence continued to pose risks to safety and stability.

Previous deaths at HMP Moorland

27. Mr Milton was the thirteenth prisoner to die at Moorland since July 2022. Of the previous deaths, ten were from natural causes, one was self-inflicted and one was drug related. Up to the end of June 2026, there have been five further deaths at Moorland, all from natural causes.

Assessment, Care in Custody and Teamwork (ACCT)

28. 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.

Psychoactive substances (PS)

29. The term psychoactive substances (PS) is a broad term that refers to a drug or other substance that affects mental process. Synthetic cannabinoids and synthetic opioids (including nitazenes) are substances that mimic the effects of traditional controlled drugs such as cannabis, cocaine, heroin and amphetamines. Synthetic cannabinoids and synthetic opioids can be difficult to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.

30. PS can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of these substances can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

Key Events

31. On 3 February 2025, Mr Connor Milton was recalled to prison. On 12 March, he was moved to HMP Moorland. (He had been released from there on 31 January.)

32. When he arrived at Moorland, Mr Milton told a nurse he had no mental health problems, no thoughts of suicide or self-harm, and he declined a referral to the Substance Misuse Service (SMS), despite having a history of drug use in prison.

33. Mr Milton was moved to House Block (HB) 5A, a unit that houses both young adults completing or waiting to complete the Creating Future Opportunities (CFO) programme along with some general population prisoners. (CFO is a voluntary programme that helps people in prison to overcome barriers and prepare for a successful life in the community.)

34. On 20 March, Mr Milton made superficial cuts to his forearms after his partner told him about messages she had received from his mother which said she was better off without Mr Milton and she wanted nothing to do with him. Staff started suicide and self-harm monitoring (known as ACCT).

35. On 21 March, another prisoner punched Mr Milton several times in the face. Later that day, staff found him with a ligature around his neck. He was upset about the assault. At an ACCT review later that day, Mr Milton told staff he had an £80 debt for psychoactive substances (PS). He also admitted to having a knife and threatening the prisoner who had assaulted him.

36. Staff made a referral for a Challenge, Support and Intervention Plan (CSIP, a case management approach to managing prisoners who are at risk of perpetrating violence, also sometimes used to support victims of violence and bullying). The CSIP investigation found that Mr Milton had an old drug debt from his previous time at Moorland. He said he was not currently using drugs. The CSIP investigator noted he was vulnerable and recommended support through an intervention plan.

37. Later that afternoon, staff found Mr Milton making a ligature. Staff placed Mr Milton in anti-ligature clothing (which cannot be torn into strips to make ligatures), increased ACCT checks to four an hour, and moved him to a supervision cell. Staff noted that Mr Milton said his main issue was being on HB5 after the incident earlier in the day and that he wanted to move to HB2 where he would be with his cousin and would feel safer. Staff noted they would refer Mr Milton to SMS.

38. On 22 March, staff held another ACCT review. Staff noted Mr Milton was more positive and said he did not have any thoughts of suicide or self-harm. Mr Milton told staff that his partner had received messages from three different mobile numbers demanding payment of £100 into a bank account and had subsequently received multiple messages containing bank details. Mr Milton said the messages said that if the money was not paid, he would be assaulted again. Although Mr Milton did not admit to being in debt, staff encouraged him to talk about it. Mr Milton said he did not wish to remain on HB5. He agreed to a psychology referral.

39. On 23 March, staff moved Mr Milton to HB1, a normal residential unit that housed most of the prisoners prescribed methadone.

40. On 25 March, a consultant psychiatrist reviewed Mr Milton's notes and prescribed trazodone (an antidepressant).

41. On 27 March, staff conducted a CSIP review. As part of the CSIP plan, Mr Milton was asked to complete the Clear Minds programme because of links to violence and carrying a weapon. He was given a debt and violence booklet and asked to progress through the Incentives scheme (which rewards good behaviour with additional privileges). Staff noted Mr Milton was happy to engage with the plan. That day, staff noted they had referred him to SMS.

April

42. In early April, Mr Milton engaged well. Staff planned one-to-one sessions with psychology and added him to the Assistant Psychologist's caseload. Staff stopped ACCT procedures on 3 April. Mr Milton attended a one-to-one session with the Senior Recovery Worker, who completed naloxone (a medication that can temporarily reverse the effects of an opioid overdose) education and an SMS risk assessment, and gave him recovery workbooks. He also had a one-to-one neurodiversity dog therapy session. (Mr Milton believed he had ADHD, but did not have a formal diagnosis.) Staff noted that he enjoyed the sessions and had good relationships with staff on HB1.

43. On 11 April, staff noted that they found Mr Milton distressed after receiving news from his mother that her chemotherapy was not working and that she had six to 12 months to live. (Mr Milton had sporadic contact with his mother while in prison.) They supported him, encouraged rest and use of distraction materials, and offered further support. He appeared calmer before they left.

44. The next day, Mr Milton was told over the telephone that his mother had passed away (later confirmed not to be true). Staff noted he was offered support and did not have any thoughts of suicide or self-harm.

45. On the morning of 13 April, Mr Milton made superficial cuts to both forearms. Staff reopened his ACCT.

46. That afternoon, staff radioed a Code Blue (used to alert staff to a medical emergency where there are no obvious signs of blood) because they suspected Mr Milton was under the influence of illicit substances in the exercise yard. Healthcare staff attended and no treatment was needed.

47. On the morning of 14 April, Mr Milton's key worker and a chaplain visited him and offered him support. He told staff he had used PS to cope with the grief of losing his mother.

48. Later, staff held an ACCT review. Mr Milton told staff he had found out over the weekend that his mother had died. Staff warned him about the risks of PS. Mr Milton said he wanted to continue one-to-one psychology sessions.

49. On 15 April, chaplaincy staff phoned Mr Milton's mother and confirmed that she was alive. Staff noted that the news his mother had died appeared to be a cruel hoax by a "friend" he had called. (Mr Milton later said it was his sister who had told him that his mother had died.) That day staff held a CISP review. Staff noted there were

concerns about Mr Milton's recent behaviour. Mr Milton told staff that he felt he had made some positive progress. The CSIP plan was to remain open. Later that day, Mr Milton had a mandatory drug test (MDT) result come back positive for illicit substances. That evening, staff noted that Mr Milton was again under the influence and vomiting, a modified vape pen was removed from his cell.

50. Between 17 and 29 April, staff noted that Mr Milton said he was no longer using PS. He had two ACCT reviews and staff decided to close his ACCT on 22 April. Healthcare staff increased his antidepressant dose, and he had another one-to-one session with the Senior Recovery Worker. Mr Milton had another one-to-one neurodiversity dog therapy session. Mr Milton had a negative result from an MDT. Staff held a CSIP review and his CSIP plan remined open. Staff noted an injury to Mr Milton's eyebrow, but he repeatedly said that he received it by accident.

May

51. In early May, Mr Milton continued to engage with recovery and psychological interventions, although progress was mixed. He attended a one-to-one session with the Senior Recovery Worker, and a neurodiversity dog therapy session. Mr Milton was provided with art materials.

52. On 16 May, an officer saw Mr Milton for a key worker session. The officer noted that a lack of purposeful activity in the past had led to a decline in his behaviour. Mr Milton told the officer that he struggled with distraction and impulsivity. He also said his sister had incorrectly told him that his mother had died. The officer noted Mr Milton would continue attending neurodiversity sessions, which would look for suitable work to help him stay engaged. Staff would give him self-help workbooks to address distraction and impulsivity and review his progress in future sessions.

53. On 19 May, Mr Milton received treatment for a minor finger injury. Staff noted that he progressed through the Incentives scheme, moving from Basic (the lowest) to Standard level. Staff held a CSIP review. Staff noted that they had identified a further intervention for him to attend the CFO course. Mr Milton told staff that he wanted to progress to back to HB5. That day he was also given a new job.

54. On 20 May, Mr Milton was moved back to HB5.

55. On 21 May, staff noted Mr Milton had smashed his in-cell TV.

56. On 24 May, staff radioed a Code Blue as Mr Milton was suspected to be under the influence of illicit substances. He declined all healthcare interventions.

June

57. Between 1 and 15 June, Mr Milton engaged with psychological and recovery support. He had a one-to-one session with the neurodiversity therapy dog as part of neurodiversity support, although he had refused some earlier sessions. Staff noted that he had not been honest about recent drug use. He showed some poor behaviour, including not collecting medication, running away from staff, and arguing with another prisoner. Staff noted that Mr Milton started the argument. Staff noted that Mr Milton was warned that his Incentives level might be reduced if his behaviour did not improve.

58. On 16 June, an officer saw Mr Milton for a key worker session. They set targets to improve his behaviour, including staying stable, engaging positively with staff in workshops, and continuing his one-to-one neurodiversity sessions with the therapy dog.

59. Towards the end of June, staff noted that Mr Milton's behaviour improved and he took part positively in a CFO workshop.

60. On 30 June, at a CSIP review, staff noted Mr Milton said he felt positive about his release and was determined not to return to prison. (Mr Milton was due for release in October 2025.) Staff noted Mr Milton's positive behaviour and his action plan was complete and closed the CSIP.

July

61. On 1 July, staff noted that Mr Milton had injuries to his face and eye and made a CSIP referral. Healthcare staff noted that he had been assaulted, named another prisoner, and said this was linked to a comment about footage of a sexual assault on a woman.

62. Staff completed an investigation. They noted that CCTV footage showed Mr Milton and another prisoner entering a cell, but staff could not see what happened inside, so no formal reports were issued. Staff noted that they considered that the other prisoner likely assaulted Mr Milton and removed the prisoner from the wing. Staff noted a recommendation for a non-association marker between the two men, but there is no evidence that this was put in place. Staff noted that Mr Milton would be supported outside CSIP and discussed at the safety intervention meeting (SIM, a multidisciplinary meeting where staff from different departments discuss prisoners of concern and agree actions to manage any identified risks).

63. On 2 July, a nurse saw Mr Milton to review his injuries. The nurse noted that Mr Milton said he had a headache and a "dull head" but did not feel dizzy or nauseous. He had bruising, swelling and a haematoma (bruise), and the nurse referred him for external hospital care. Later that day, he attended Doncaster Royal Infirmary and was discharged with eye ointment. On 3 July, healthcare staff saw him for a follow-up review and noted that he had no further issues.

64. On 4 July, staff discussed the alleged assault at the SIM. Staff discussed what action to take against the alleged perpetrator but decided that due to lack of evidence they would not be able to take any disciplinary action. Throughout the month Mr Milton continued to engage with SMS.

65. On 14 July, staff noted that Mr Milton appeared withdrawn. He told them that there was a possibility he might be released on 2 September, but he was reluctant to leave prison as he had "nobody and nothing" and that life outside was "shit".

66. CCTV shows that on the afternoon of 17 July, Mr Milton was mixing with several prisoners, going in and out of other prisoners' cells. At 7.31pm, Mr Milton went into his cell and closed the door.

67. At around 7.45pm, an officer carried out a routine check of all prisoners. No issues were reported.

Events of 18 July

68. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to staff radio communications from 18 July. He also obtained staff statements.

69. At 5.11am on 18 July, during a routine check of all prisoners, an operational support grade (OSG) arrived at Mr Milton's cell. She looked in for around 90 seconds. In her statement she said that the cell was in semi-darkness and Mr Milton appeared half sitting up with a vape in his hand and a phone cable leading to the bed. She said she shone her torch into the cell and gave the door a gentle kick. She said that, because of his position and the light, it was difficult to see if he was breathing but stood until she stood until she "saw a shallow breath and then moved on".

70. At 8.10am, Officer A went to Mr Milton's cell and unlocked the door. CCTV shows the flap was open, but he did not look through it. He opened the door slightly and then carried on walking down the landing. In his statement he said he saw Mr Milton sitting up in bed and that he appeared to be on the telephone. He said he greeted Mr Milton with "Good morning" but received no response.

71. At 8.18am, Officer A returned with Officer B to tell Mr Milton the workshop was closed. In his statement, Officer B said he approached Mr Milton, who was on his bed, and saw that he was blue. He immediately radioed a Code Blue.

72. Officer A was distressed. Officer B took charge and ordered Officer A to assist him in moving Mr Milton from the bed to the floor. More prison staff and a healthcare staff member arrived. Staff secured the wing, locking prisoners behind their doors.

73. At 8.19am, the control room called an ambulance.

74. At 8.21am, staff attached a defibrillator to Mr Milton.

75. At 8.32am, at healthcare staff's request, Mr Milton was moved to the landing for more space.

76. At 8.38am, paramedics arrived. However, resuscitation attempts were unsuccessful and at 8.50am, paramedics pronounced life extinct.

77. Staff found ten vape capsules in Mr Milton's cell, one of which appeared to have been tampered with. Five other prisoners were found under the influence of drugs and staff carried out welfare checks on all prisoners on HB5.

Contact with Mr Milton's family

78. On the morning of 18 July 2025, following Mr Milton's death, the prison appointed a family liaison officer (FLO) and a deputy.

79. Ahead of staff visiting the next of kin's address a Police Intelligence Officer was tasked with completing a risk assessment in relation to the property and individuals living there. At the same time, there was conflicting information about the status of Mr Milton's next of kin, his mother, as prison records incorrectly indicated that she had died in April 2025 (following the malicious or hoax call from a family member,

which had not been updated on the system). This created uncertainty about both who should be notified and how, and alternative contacts were explored.

80. By 11.10am, the risk assessment had not been returned, and the prison decided to request that South Yorkshire Police undertake the death notification. Later that day, the police informed Mr Milton's mother. However, she reported that she had seen social media posts about Mr Milton's death at around 12.30pm, prior to being formally notified by police at around 1.52pm.

81. The delay in notification was attributable to both the outstanding risk assessment and the confusion arising from inaccurate next of kin information.

82. Following Mr Milton's death, the FLO remained in regular contact with Mr Milton's family. They assisted with advice, returning Mr Milton's property and funeral arrangements,

83. In line with national policy, the prison contributed to the cost of Mr Milton's funeral.

Support for prisoners and staff

84. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

85. After Mr Milton's death, prison managers held a hot debrief with the staff involved in the emergency response. This gave staff the chance to discuss any issues and receive support. The care team was also available to provide further support.

86. The prison put up notices to tell other prisoners about Mr Milton's death and to offer support. Staff carried out welfare checks on all prisoners on HB 5. Listeners visited prisoners who knew Mr Milton to offer support.

Post-mortem report

87. The post-mortem report concluded that Mr Milton died from a MDMB-4en-PINACA (synthetic cannabinoid - PS) induced seizure. The pathologist noted that MDMB-4en-PINACA is significantly more potent than cannabis and has been linked to serious harm and deaths. Reported effects include cardiovascular problems, seizures, psychosis, respiratory depression and sudden death. MDMB-4en-PINACA is a Class B drug in the UK.

Findings

Mr Milton's drug use

88. Mr Milton's death was caused by PS. He had a history of drug use and had been suspected of being under the influence of PS several times at Moorland.

89. Mr Milton's recovery worker told us Mr Milton received personalised drug education through regular one-to-one sessions. She gave him booklets on PS and cannabis, and told him about harm reduction, overdose risks, and safer use. Together, they developed a relapse prevention plan, discussed triggers and coping strategies, and reinforced the dangers of substances like PS.

90. We are satisfied that Mr Milton received appropriate support with his drug issues.

Tackling drug supply and demand

91. At their last inspection of Moorland in March 2023, HMIP inspectors found that the prison did not have significant problems with illicit drug use. This contrasted with the wider prison estate, where drugs remain a serious concern.

92. The Head of Security told us that intelligence showed three peaks in drug-related incidents since January 2025, each followed by about two months of decline. Mandatory Drug Testing (MDT) showed the same pattern. Random MDT rates remained about 8%, placing Moorland among the lowest in its comparator group. He said that PS, including synthetic cannabinoids, were the most common drugs. Even small amounts could have a significant impact. When supply reduced, demand often shifted to prescription medication.

93. The Head of Security said reception was the main risk point for trafficking. Visits, mail and gate entry also posed risks, with pressure shifting between routes. He said visits procedures were robust and under regular review, and staff had refresher training on their powers of arrest. Evidence suggested the drugs that caused Mr Milton's death entered the prison during another prisoner's visit on 17 July.

94. The Head of Security said detection measures, including the body scanner and passive drug dogs, had reduced supply. Since April, staff carried out 1,475 scans, with 54 positive results. Since January, staff found 82 instances of unauthorised medication and recorded 335 occasions when prisoners appeared under the influence, likely from PS. Only one such case had occurred in the previous 50 days. He said testing remained difficult because current methods did not detect new substances. There were no plans to change infrastructure, but staff reviewed security measures regularly.

95. Moorland's drug strategy focuses on prevention, monitoring and support. Staff provide ongoing education and identify substance misuse throughout custody through testing, reports and referrals. When staff identify concerns, they refer prisoners to the Inclusion team. Staff also review increases in drug use and share information across the prison and with healthcare staff.

96. We are satisfied that Moorland's approach to managing drugs is robust and effective. The prison combines education, monitoring and enforcement, and compares favourably with other prisons. While Mr Milton's death highlights the ongoing risks from illicit substances, staff respond promptly to changes in supply and demand and show a clear commitment to reducing harm.

Morning welfare check

97. Prison Service Instruction (PSI) 75/2011, Residential Services, sets an expectation that staff will check on the welfare of prisoners at morning unlock, for example, obtaining a verbal response from them. Prisons are required to have clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after morning unlock. The PSI also deems it unacceptable for staff completing morning unlock not to notice a prisoner has died overnight. This implies that a visual check of the prisoner should always happen at unlock. This is said more directly in the Prison Officer Entry Level Training (POELT) manual, which instructs staff to physically check that prisoners are in their cells before they unlock the door.

98. More recent guidance to staff on the HMPPS intranet sets an expectation that a welfare check is undertaken at unlock to check that the prisoner is present and in good health. The welfare check should include a physical check that the prisoner is present and a gesture of acknowledgement from the prisoner that they are alive and well. Should they fail to get a response, staff should open the door to check. All prisons are required to ensure their staff are aware of the requirements and that every prison's Local Security Strategy (LSS) reflects this.

99. Moorland's LSS requires any staff member carrying out a roll check or opening a cell door after a patrol period during the core day to fully satisfy themselves that the occupants are responsive. This may be by detecting clear bodily movement, such as a limb moving, a verbal response, or obvious breathing.

100. CCTV footage showed that the check carried out on Mr Milton at morning unlock at 8.10am on 18 July did not meet these standards. Officer A did not look through the observation panel before unlocking the cell. He opened the door slightly and then moved on without looking inside. CCTV showed the same approach at other cells. In his statement, Officer A said he called "Good morning" to Mr Milton but received no response. We are not satisfied this interaction met the requirements of the LSS, PSI 75/2011, the POELT manual, or what would be expected of an effective welfare check.

101. The Head of Safety told us she had spoken to Officer A. He accepted that he did not receive a verbal response and did not carry out the check in line with guidance, though he maintained that he had seen Mr Milton during unlock. He told the Head of Safety that he now obtained a verbal or physical response from every prisoner.

102. The Head of Safety told us that staff were reminded of expectations for unlocking in a Notice to Staff issued in March 2026 and published on Moorland's Safety Hub. She said this guidance was reinforced at a staff training day attended by 68 operational staff and would continue to be delivered at future training events. Given the prison has taken steps to address the issue, we make no recommendation.

Clinical care

103. The clinical reviewer found that the healthcare Mr Milton received at Moorland was equivalent to that which he could have expected to receive in the community. The reviewer made one recommendation on an issue not related to Mr Milton's death, which the Head of Healthcare will wish to consider.

Good practice

104. We found that staff provided coordinated, consistent and well-planned support for Mr Milton. Staff used ACCT, CSIP, psychology, SMS, chaplaincy, key work and neurodiversity sessions with a therapy dog, to respond to his needs. Mr Milton's prison record showed detailed, timely and thoughtful entries. These showed repeated, responsive, determined and conscientious efforts across disciplines to manage risks and provide support. In our view, this was a strong example of structured and proactive care, and among the best coordinated support we have seen.

105. During the emergency response, a custodial manager (CM) asked a member of staff to check all other cells on the unit. The staff member checked whether any other prisoners were unconscious or unresponsive. This showed that the CM recognised the risk that other prisoners might have taken the same substance as Mr Milton. The action was proactive and focused on keeping prisoners safe. It showed good judgement under pressure.

106. The Head of Safety, the security department, and prison and healthcare staff worked together to protect prisoners. They reviewed the available evidence and traced Mr Milton's interactions on 17 July. They identified visits as the most likely source of the substances. They then identified prisoners who might have had the substances and removed them from the general population to reduce the risk of further distribution.

107. Staff arranged forums on the wings to speak with prisoners and gather intelligence. They completed welfare checks for all prisoners on HB5 straight away. Staff also strengthened search procedures. They searched prisoners when leaving the unit to check for tampered vapes and other items. The dog team and search team supported this work. As a result, staff moved more prisoners to the segregation unit based on intelligence. These actions showed a clear focus on keeping prisoners safe and reducing the risk of harm.

Inquest

108. At the inquest, held from 12 to 15 October 2026, the jury concluded that Mr Milton's death was drug related.

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