Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Paul Skinner, on 21 February 2025, following his release from HMP Forest Bank

**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 Paul Skinner died from multiple drug toxicity on 21 February 2025 following his release from HMP Forest Bank the previous day. He was 51 years old. We offer our condolences to those who knew him.

5. Mr Skinner was a persistent offender and he had a significant history of alcohol and drug use in the community. As a result, he frequently returned to prison, which disrupted any progress he made during his release. His short stays in prison prevented him from benefiting fully from the available interventions.

6. We understand that short-term custodial sentences create challenges for staff working with prisoners, especially in terms of rehabilitation and release preparation. The Independent Sentencing Review, commissioned by the Justice Secretary, has identified this issue, and we support any changes aimed at addressing the problems linked to short custodial sentences.

7. Mr Skinner left prison without suitable accommodation in place. Staff made an error while processing his referral for CAS3 accommodation. However, even if they had processed the referral correctly, we cannot know whether a suitable placement would have been available.

8. We did not identify any significant learning and make no recommendations.

# The Investigation Process

9. HMPPS notified us of Mr Skinner's death on 21 February 2025.

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

11. We informed HM Coroner for Bolton of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

12. The Ombudsman's office contacted Mr Skinner's father to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

# Background Information

### HMP Forest Bank

14. HMP Forest Bank in Salford holds adult men both on remand and sentenced. The prison serves the courts of Greater Manchester. The prison is managed and run by Sodexo Limited.

### Probation Service

15. 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.

### HM Inspectorate of Prisons

16. The most recent inspection of HMP Forest Bank was in December 2024. At the time, inspectors reported that the support and treatment for prisoners with addictions was good for both clinical care and psychosocial interventions. Inspectors concluded that the prison's discharge planning was effective.

17. They said that staff contacted community mental health teams and GPs to support the transfer of care, although most patient stays were short due to a rapid turnover of prisoners coming in and out of Forest Bank.

# Key Events

## Background

18. Mr Paul Skinner was a prolific offender and had a significant custodial history. His offences, which included theft and being threatening and abusive, were predominantly linked to his alcohol addiction.

19. Mr Skinner had a history of poor mental health, alcoholism and taking drugs, including heroin and cocaine.

20. On 7 May 2024, Mr Skinner was sentenced to six months in prison for theft, threats and assault and he was sent to HMP Preston. During his initial health screen, Mr Skinner said that he had been taking alcohol and drugs but denied having any mental health concerns.

21. On 22 May, Mr Skinner was transferred to HMP Lancaster Farms.

22. On 14 June, Mr Skinner told healthcare staff that he had anxiety, depression and trauma. Following a mental health review, Mr Skinner was referred to talking therapies (where the patient works with a health practitioner to understand and overcome problems). Because there was a waiting list, Mr Skinner was not seen before he was released.

23. On 3 July, Mr Skinner was released on licence. He attended his initial probation appointment but he later missed his meeting with the housing provider and his community offender manager, was unable to reach him by phone. This breach of licence led probation to recall him to prison.

24. On 8 July, Mr Skinner was sent to HMP Berwyn.

25. On 9 July, a resettlement officer saw Mr Skinner and recorded that he was due to be released on 18 July and that accommodation had been arranged for him. He said Mr Skinner had told him that he was keen to address his alcohol and mental health issues.

26. Later that day, a mental health nurse reviewed Mr Skinner. It was recorded that Mr Skinner had said that he had post-traumatic stress disorder (PTSD) and he had taken part in a one-to-one and group substance misuse session earlier.

27. On 16 July, a substance misuse worker met Mr Skinner. They discussed harm minimisation and she told Mr Skinner that referrals to community services had been made. Mr Skinner told her that he was fed up being recalled for short periods as all it did was create more community issues. Mr Skinner was given naloxone (a medication to reverse the effects of opiate overdose) to take with him ahead of his release.

28. On 18 July, Mr Skinner was released from prison on licence.

29. On 21 October, Mr Skinner was arrested and charged with robbery and theft. His licence was revoked and he was sent to HMP Preston.

30. During his initial health screen, it was noted that Mr Skinner needed to see the mental health team because he was taking antipsychotic medication. Mr Skinner said that he did not want to be referred to the alcohol treatment service.

31. On 22 October, a mental health nurse met Mr Skinner. An entry was made in his medical record that there was no record of Mr Skinner being prescribed antipsychotic medication in his Summary Care Record (the national database that holds patient information, including current medications).

32. On 23 October, one of the nurses contacted the community mental health team who told them that Mr Skinner had been discharged from their service (the previous day) due to a lack of engagement. She said that Mr Skinner had significant issues with substance misuse and he had not been prescribed any medications for his mental health.

33. On 28 October, Mr Skinner saw a psychosocial practitioner. He agreed to engage with the substance misuse service.

34. On 1 and 7 November, the psychosocial practitioner saw Mr Skinner. She told him that she was referring him to be considered for abstinence supported housing.

35. On 21 November, the psychosocial practitioner saw Mr Skinner. He told her that he had been offered a bed space by an abstinence housing provider which would be available for him on release.

36. On 2 January 2025, Mr Skinner was released from prison, and he moved to Redwood House (a supported abstinence housing scheme).

37. On 4 February, a community offender manager (COM) was notified that Mr Skinner had been taken to hospital after being found by the side of a canal, heavily intoxicated and having had a seizure. Because Mr Skinner had started to drink again, he was evicted from Redwood House.

38. On 5 February, Mr Skinner left hospital. However, he returned to hospital later that day, having been found unresponsive in a public area. The COM made repeated attempts to contact him by phone, but he did not respond. She also spoke to paramedics to share her concerns about the potential impact of detoxification.

39. On 6 February, Mr Skinner left hospital. The COM sent a message to Mr Skinner to ask him to come to the probation office, but he did not respond. The decision was made to issue him with a 14-day fixed term recall to prison.

40. On 7 February, the police told the COM that Mr Skinner had been arrested the day before for a breach of the peace and that it had been related to alcohol.

41. On 11 February, Mr Skinner was sent to HMP Forest Bank. A GP operating at the prison, reviewed Mr Skinner as part of his initial health screen. He recorded that Mr Skinner needed methadone stabilisation and to undergo an alcohol detoxification. Mr Skinner declined sertraline (an antidepressant) and they agreed that he would request a GP appointment to consider an alternative once he had stabilised.

42. On 12 February, a substance misuse support worker saw Mr Skinner and a substance misuse management plan was agreed. The SMS team saw Mr Skinner each day up to the day before he was released.

43. That day, the COM emailed the Northwest Homeless Prevention Team (NWHPT) asking for guidance on referring Mr Skinner for CAS3 accommodation as he was due to be released in eight days. The NWHPT responded the next day and told the COM to proceed with a referral which would be treated as an emergency. (CAS3 accommodation is a government scheme which provides housing for people who are leaving prison homeless). The COM told the investigator that she should have referred Mr Skinner to the local council for accommodation at the same time under the statutory duty to refer those at risk of homelessness but she did not.

44. On 13 February, an officer from the resettlement team saw Mr Skinner. She recorded that Mr Skinner had no fixed abode and wanted to live in Preston. She emailed the COM a summary of what they discussed and explained that she was not able to link him with the housing team at Forest Bank as he wanted to move outside of the area that they covered.

45. On 14 February, the COM submitted the CAS3 referral using the digital portal. She stated that his release date was 20 February.

46. Later that day, the COM emailed the NWHPT and the Offender Management Unit (OMU) to advise that Mr Skinner's release date of 20 February was incorrect, she referenced that he had been returned to custody on 11th February on a fixed term recall. She advised the OMU that his release date should be 25 February and, in the email, informed NWHPT to be aware of this. The OMU replied to the email (including to the NWHPT) the same day and confirmed that Mr Skinner's release date was 20 February. A Senior Operational Support Manager (SOSM) for NWHPT, told the investigator that they had received the email from the OMU but the administrative team had missed it and therefore not passed it on to the person dealing with the referral.

47. The SOSM told the investigator that the person managing the inbox at that time was not fully aware of the protocols in place and since then, they have strengthened their processes to reduce the likelihood of such an error occurring again.

48. On 17 February, the application for CAS3 was allocated to a probation services officer, to process. At the time, the officer was not aware of the revised release date of 20th February and therefore proceeded with planning for a release date of 25 February 2025.

49. On 18 February, Mr Skinner told a prison officer that probation staff were trying to arrange for him to be placed in CAS3 accommodation.

**20 February 2025**

50. A substance misuse worker met Mr Skinner before his release. They recorded that Mr Skinner was anxious as all he could think about was alcohol. They wrote that they had an in-depth discussion about harm minimisation, and they gave him naloxone. Before leaving, Mr Skinner spoke to his community sponsor and an appointment was made for him to see the community services team later that day.

51. The COM told the investigator that she spent the morning trying to find out where Mr Skinner was and she completed a housing referral to Preston Council under the duty to refer those at risk of homelessness. She said that she had completed a referral the previous year but it had been rejected on the basis that the supported housing which Mr Skinner had previously lived in was not considered to be settled housing.

52. At 12.30pm, Mr Skinner was due to attend the probation office. He did not turn up for this appointment. She told the investigator that she made a number of attempts to call Mr Skinner but his phone was switched off.

53. At 1.37pm, the probation services officer emailed the COM to say that she noticed that Mr Skinner had been released but that they had been processing a referral based on a release date of 25 February. Emails had also been also received by NWHPT to this effect. In line with CAS3 Operational Guidance version 4.2 dated December 2023 the referral was closed by NWHPT at 1:39pm.

54. The SOSM told the investigator that a CAS3 referral could not be processed on the day of release as the NWHPT had to give their suppliers 12 hours' notice of a booking to ensure everything was ready to receive the person and that they had identified a resident welfare officer.

55. At 3.16pm, a worker from Red Rose Recovery (a charity that supports people with alcohol and substance misuse issues) called the COM. He told her that Mr Skinner had been to see them and he had described being at the end of his tether and did not know what to do. He said that he told Mr Skinner to go to probation.

56. A community worker at Inspire (a community drug and alcohol service) had also contacted the COM to tell her that Mr Skinner had visited them, heavily intoxicated. They told her that he declined to have a meeting and did not want any support. However, they booked an appointment for him to see them the next day.

57. At 4.43pm, the COM received a response from Preston Council. The council said that they would not provide housing assistance to Mr Skinner and he should make an application to the council where he had previously lived in settled accommodation.

58. The COM spoke to her manager about her concerns for Mr Skinner. They decided that if Mr Skinner did not attend the probation office by lunchtime the next day, they would arrange for him to be recalled.

### Circumstances of Mr Skinner's death

59. On 21 February, two homeless outreach workers found Mr Skinner on a public bench, unresponsive and not breathing. They called the emergency services and the police and paramedics attended. The paramedic pronounced life extinct at 9.44am.

### Post-mortem report/Cause of death

60. The post-mortem report concluded that Mr Skinner died from multiple drug toxicity. The toxicology report identified evidence of potentially fatal alcohol poisoning, and that Mr Skinner had also used methadone and cocaine.

### Inquest into Mr Skinners death

61. The inquest into Mr Skinner's death was held on 15 December 2025 and a verdict of alcohol and drugs was recorded. The coroner concluded that Mr Skinner's death was due to multiple drug and alcohol toxicity. Alcoholic liver disease was listed as a contributory factor.

### Support for staff

62. The COM told the investigator that she had been well supported by her manager and colleagues following Mr Skinner's death and she was appropriately signposted to the nominated support provider.

# Findings

63. Mr Skinner had a history of alcohol and drug misuse which was directly linked to his criminal behaviour. He also had episodes of poor mental health.

64. When he arrived in prison, Mr Skinner's mental health was assessed and he was encouraged to engage in psychosocial interventions and talking therapies. However, this was not always possible due to the brief duration of his sentence.

65. While in prison, Mr Skinner underwent detoxification and he was supported by the prison's substance misuse services. When leaving prison, appropriate arrangements were made with community services to support him with his abstinence. This included referrals to abstinence supported housing and linking him with community support groups. Sadly, Mr Skinner was not able to maintain his sobriety which resulted in him becoming homeless.

66. It is evident that his community offender manager liaised with several different agencies to ensure that his needs were met. She told the investigator that this became increasingly difficult because his behaviour meant that some of the supported housing providers were not willing to offer him another place.

67. During his last spell in prison, the pre-release team saw Mr Skinner and identified his needs. While there was a delay in referring him to the local authority under the statutory duty to refer those at risk of homelessness, we note that his request for assistance was refused so this delay did not change the outcome for him.

68. Mr Skinner's community offender manager referred him to CAS3 as soon as she was aware that he had been sent to prison. However, the subsequent emails about his release date resulted in confusion about when he was due to be released and the email confirming his release date was then missed by the NWHPT. Given that the availability of CAS3 accommodation is dynamic, there is no guarantee that a place would have been available for Mr Skinner if there had not been a mix up with his release date. We note the actions taken by the NWHPT to reduce the likelihood for error and we therefore make no recommendation.

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

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