Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Ogden, a prisoner at HMP/YOI Forest Bank, on 29 March 2022

A report by the Prisons and Probation Ombudsman

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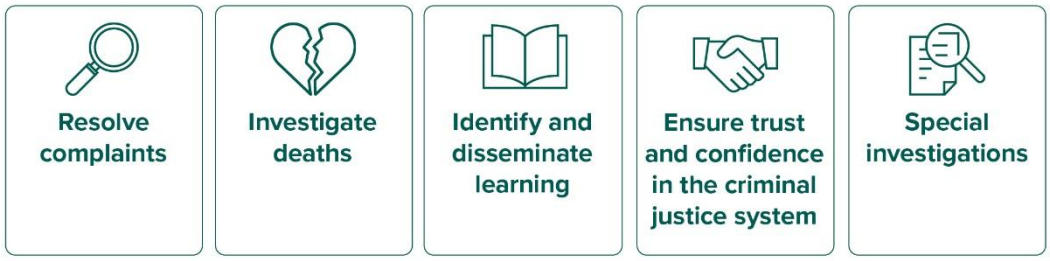
OUR VISION

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 HM 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 David Ogden died on 29 March 2022 from oxycodone toxicity at HMP Forest Bank. He was 44 years old. I offer my condolences to Mr Ogden's family and friends.

It was Mr Ogden's first time in prison having been convicted of sexual offences against a family member the day before his death. He was on oxycodone (strong pain relief) for arthritis and the toxicology results showed he had taken an overdose of his medication.

HM Chief Inspector of Prisons identified some areas of improvement at Forest Bank and considered newly received prisoners required better support. The Independent Monitoring Board's report said that reception numbers had significantly increased.

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 **February 2024**

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Summary

Events

1. On 28 March 2022, Mr David Ogden attended the last day of his trial at Manchester Crown Court. He was convicted of sexual offences against a family member and was remanded to prison awaiting sentence. He had not been in prison before.

2. While at court, the police witnessed Mr Ogden on CCTV carrying a bag of medication around and he was seen putting something in his mouth. Mr Ogden's mother said that following his conviction, Mr Ogden had left a note in the dock saying he could not cope or carry on. The note was never recovered, or the contents verified.

3. That afternoon, escort staff took Mr Ogden to HMP Forest Bank. They mistakenly left his medication at the court.

4. On arrival at Forest Bank, the reception nurse did not identify any risk factors associated with suicide and self-harm. The nurse identified Mr Ogden had mobility issues associated with his arthritis and recommended he be given a bottom bunk.

5. A Prison Custody Officer (PCO) took Mr Ogden to his cell which he would share with another prisoner. Mr Ogden and his cell mate did not interact much and went to bed.

6. At 7.09am on 29 March, a Healthcare Assistant (HCA) went to Mr Ogden's cell to talk to Mr Ogden and his cellmate about smoking cessation. Mr Ogden was unresponsive. The HCA went to get assistance as he did not have a radio. A PCO radioed a medical emergency code and nurses attended.

7. As rigor mortis had set in, staff did not attempt cardiopulmonary resuscitation (CPR). Paramedics attended and at 8.57am, they confirmed that Mr Ogden had died.

8. The post-mortem report concluded that Mr Ogden died from oxycodone toxicity.

Findings

9. The clinical reviewer concluded that not all the care Mr Ogden received at Forest Bank was equivalent to what he could have expected to receive in the community. Her concerns, however, relate to issues which were unlikely to have changed the outcome for Mr Ogden – ensuring prisoners receive their pain management medication and that reception screening is informed by the Person Escort Record.

The Investigation Process

10. HMPPS informed us of Mr Ogden's death on 29 March 2022.

11. 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.

12. The investigator obtained copies of relevant extracts from Mr Ogden's prison and medical records. GEOAmey shared with us their investigation report into the events of 29 March. She liaised with Greater Manchester Police.

13. NHS England commissioned a clinical reviewer to review Mr Ogden's clinical care at the prison.

14. The investigator interviewed six members of staff and a prisoner between July and August 2022. She and the clinical reviewer jointly interviewed staff.

15. We informed HM Coroner for Greater Manchester West District of the investigation. Our investigation was suspended while we waited for the cause of death. We have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officers contacted Mr Ogden's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Ogden's mother asked:

    - What was communicated from the court to prison staff about Mr Ogden's risk of suicide?
    - Why was Mr Ogden not on suicide watch?
    - Did Mr Ogden arrive at the prison with his medication?
    - How did Mr Ogden overdose?

    We have addressed these questions in this report.

17. Mr Ogden's family did not respond to the findings in the initial report.

18. HMPPS made no comment on our findings and no factual inaccuracies were noted.

Background Information

HMP Forest Bank

19. HMP/YOI Forest Bank holds up to 1,460 adult and young adult male prisoners both on remand and sentenced. The prison serves the courts of Greater Manchester.

20. The prison is managed and run by Sodexo Limited, who are also responsible for the provision of primary healthcare services, including primary mental services, inpatient facilities and substance misuse services within the prison.

HM Inspectorate of Prisons

21. The most recent inspection of HMP/YOI Forest Bank was in February 2022. Inspectors reported that since their last inspection in 2019, the decline in living standards had stalled and managers had identified sensible priorities. However, some areas still required improvement and plans were needed to ensure newly received prisoners were properly supported and inducted.

Independent Monitoring Board

22. 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, the IMB reported that a new Director had instigated a comprehensive programme of reform. The key priorities included: creating momentum as well as prison stability for a sustained period, focusing on good prisoner management, regime consistency with an emphasis on purposeful activity for prisoners and keeping prisoners safe and the prison secure. Reception numbers had increased, and vulnerable prisoners felt significantly less safe on their first night compared with the rest of the population. However, the early days in custody processes had been changed and early indications suggested that improvements had been made and that prisoners felt safer.

Previous deaths at HMP Forest Bank

23. Mr Ogden was the 12th prisoner to die at Forest Bank since March 2019. Of the previous deaths, five were from natural causes, three were drug related and three were self-inflicted.

24. In a report following the death of another prisoner at Forest Bank, which was issued after Mr Ogden's death, we recommended that (Health Care Assistant) HCA A should carry a radio. (He tends to be the first person to speak to new prisoners first thing in the morning as part of his smoking cessation advice role.) He was not carrying a radio on the morning of Mr Ogden's death either but assured us that ever since, he has been given a radio every day.

Assessment, Care in Custody and Teamwork

25. 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.

Key Events

26. On 28 March 2022, Mr David Ogden was remanded to HMP Forest Bank awaiting sentence after being convicted of sexual offences against a family member. He had previously been on bail, and this was his first time in prison custody.

27. Mr Ogden had several medical conditions which included psoriatic arthritis. His community GP prescribed him with medications to manage his conditions, including oxycodone (a strong, opioid pain relief medication) to manage the symptoms of his arthritis.

Manchester Crown Court

28. Mr Ogden attended Manchester Crown Court for the last day of a two-week re-trial. He had been on bail and so was only escorted when in the dock. Mr Ogden brought some medication with him in a white bag. A property form completed later that day described the contents of the bag as ‘numerous meds’. The exact contents of the bag were not recorded by anyone who had contact with Mr Ogden at court.

29. The police shared information with the investigator about sightings of Mr Ogden on CCTV with the bag. At 10.22am, Mr Ogden took the bag into court with him and at 11.11am, he left with it when the jury retired. At 11.12am, Mr Ogden handed the bag to a female (believed to be his mother) and went into the toilet. He came out at 11.16am. At 11.23am, Mr Ogden took something out of the bag and put it into his mouth.

30. At 11.44am, Mr Ogden went back into the court room and his mother was carrying the bag. The jury retired again at 11.55am and Mr Ogden left the court carrying the bag. At 12.11pm, Mr Ogden returned to the court with his mother who was carrying what was thought to be the bag scrunched up. At 12.12pm, the jury delivered its verdict and found Mr Ogden guilty of the charges.

31. The dock officer, a PCO (Prison Custody Officer) asked Mr Ogden if he had any property bags and Mr Ogden said that his mother had his medication. The PCO informed Mr Ogden’s counsel about the medication and they made arrangements to secure it in the court’s property area. Mr Ogden did not have access to it again.

32. The case worker working with Mr Ogden’s solicitor said in her police statement that after Mr Ogden’s conviction, his mother asked her if he had left her a note in the dock. She was aware that Mr Ogden had been scribbling on the cardboard back of his notepad that day and had left it folded in the dock. She asked a member of court staff to recover it, which they did. She said it just contained doodles and no discernible words. She asked Mr Ogden if he wanted it, and he told her to throw it away, so she did – in what she described as the custody staff’s bin.

33. Mr Ogden’s barrister also gave a statement to the police. He said that Mr Ogden seemed disappointed by his conviction but had resigned to it and he had no concerns about him. He said he also saw the dock note and described the contents as ’just random jottings’. He said that he later threw it in the custody staff’s bin.

34. The PCOs at the court searched Mr Ogden and he voluntarily handed in a wallet containing cash, a vape and vape liquid. He also had a phone in his pocket, which he gave to staff.

35. A PCO asked Mr Ogden if he was generally okay and, more specifically, if he had any thoughts of suicide or self-harm, which he denied. Mr Ogden asked how he would get his medication once he was in prison and the PCO told him that he would see medical staff at Forest Bank and could ask them about it. Mr Ogden declined a standard health check to measure his blood oxygen levels and blood pressure. The PCO recorded on the digital Person Escort Record (PER) that he had not completed a suicide and self-harm warning form (used to pass on concerns about the individual's risk of suicide or self-harm between court and prison staff) because Mr Ogden had said that he was feeling okay.

HMP Forest Bank

36. After staff gave him some refreshments, escort staff took Mr Ogden to Forest Bank at approximately 3.20pm. They left his medication at court by mistake (and did not take it to the prison until the next day).

37. The PER did not note any concerns about Mr Ogden and showed that standard observation levels were in place and did not highlight any health or substance misuse issues.

38. Reception staff conducted a full body scan (search) of Mr Ogden. They recorded that it was negative.

39. A nurse conducted Mr Ogden's first night screen. She did not access the digital PER because she had been provided with the wrong computer login details. She noted that Mr Ogden had no issues with drugs or alcohol and had not self-harmed or considered suicide (in the last 12 months). He had severe psoriatic arthritis, and his community prescription included a variety of medications and also pain relief in the form of oxycodone (with the brand name Reltebon).

40. At interview, the nurse said Mr Ogden had been a little unsteady on his feet and his heart rate was 122 beats per minute (normal resting rate is 50-100 beats), but she was not surprised at this because he had just been subject to a full search and walked up the corridor to her. His respiratory rate was 15 breaths per minute which was considered normal.

41. A GP at the prison noted in Mr Ogden's medical record that Mr Ogden was happy to receive dihydrocodeine instead of oxycodone, but staff did not give him any medication that night. He was due to receive it the next morning.

42. An officer completed Mr Ogden's induction checklist. Mr Ogden said that it was his first time in prison.

43. The nurse completed the healthcare section of the Cell Sharing Risk Assessment (CSRA). She considered Mr Ogden presented no increased risk and was suitable to share a cell, but that he should be located on a bottom bunk only because of his limited mobility.

44. A PCO completed the custodial section of the CSRA. He highlighted that Mr Ogden was significantly vulnerable to assault but did not comment why. He did specifically note that it was Mr Ogden's first time in prison, that he had checked his PNC record and that he had Vulnerable Prisoner (VP) status. VPs are at particular risk of bullying, suicide or self-harm which is often related to their offence.

45. A PCO noted on NOMIS that an induction officer and an Insider had welcomed Mr Ogden (a prisoner trained to provide information and support to other prisoners). They told him what would happen to him over the following 24 hours, and they told him about how to seek support if he needed it and how to use the emergency cell bell.

46. At approximately 6.30pm, a PCO escorted Mr Ogden and another new prisoner (Mr Ogden's cellmate) to cell 29 on E wing, the induction wing. Mr Ogden asked when unlock was and the officer told him it would be around 8.00am.

47. The cellmate said that he and Mr Ogden hardly spoke, but he chose the top bunk because of Mr Ogden's mobility issues. He also said that Mr Ogden seemed out of breath and in some pain.

48. The cellmate rang the cell bell because the television did not have an aerial, but a wing cleaner answered and made it clear they would not be getting one and called him a 'nonce' (a derogatory term for someone accused or convicted of sexual offences).

49. A PCO conducted a combination of routine and first night checks at 8.00pm, 10.00pm, 12.01am, 2.30am and 5.00am. She said that her view of Mr Ogden was slightly obstructed by the shadow cast by the top bunk steps, but she could still see the outline of his body and had no concerns. The checks did not require her to gain a response from either Mr Ogden or his cellmate.

50. The cellmate said that he got up in the night to use the toilet but had no idea what time that was. He heard Mr Ogden snoring at this point. He woke again in the night between 4.00am and 5.00am and everything was quiet. There is no evidence that either prisoner used the cell bell during the night.

Events of 29 March

51. At approximately 7.05am, HCA A, a smoking cessation support worker, went to see Mr Ogden and his cellmate about joining a smoking cessation course. He went to the cell and called both their names. The cellmate was in the top bunk and was sitting up and responded to his questions. Mr Ogden did not move or respond. He was lying in bed facing the wall with a blanket over his head and shoulders. The HCA went into the cell and tried to wake him by gently rocking his shoulders, but he still did not respond. He tried to turn him over, but he felt stiff, and his leg was very cold when he touched it.

52. HCA A did not have a radio and left the cell to ask PCO A to call a code blue (indicating a prisoner is unconscious or is having breathing difficulties), which she did straight away at 7.10am. He went back to the cell to see if he could rouse Mr Ogden. PCO A and a senior PCO attended the cell and he left.

53. The custodial staff also attempted to rouse Mr Ogden and found him rigid, cold to the touch and they were unable to roll him onto his back. PCO A said blood was coming out of his mouth. Staff escorted the cellmate out of the cell.

54. A nurse heard the code blue and arrived at the cell at 7.12am. She turned Mr Ogden on his back which she found quite difficult – she considered rigor mortis was present. Another nurse arrived shortly after the first nurse and agreed with her that attempts at resuscitation would be futile. Control room staff informed the emergency services.

55. Paramedics arrived at 8.46am and at 8.57am, they confirmed that Mr Ogden had died.

56. Escort officers brought the medication that had been left at court to Forest Bank the next day. It did not include any Reltebon.

Contact with Mr Ogden's family

57. On 29 March, the prison appointed a family liaison officer (FLO). The FLO and a PCO attended Mr Ogden's mother's address that morning and informed her that Mr Ogden had died. They remained in contact with the family to offer support and answer questions.

58. The prison contributed to Mr Ogden's funeral in line with national policy.

Support for prisoners and staff

59. After Mr Ogden'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.

60. The prison posted notices informing other prisoners of Mr Ogden'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 Ogden's death. The cellmate said that he had not been offered support after Mr Ogden's death. This might have been because he was initially considered a suspect in Mr Ogden's death.

Post-mortem report

61. The post-mortem report gave Mr Ogden's cause of death as oxycodone toxicity, a medication prescribed to Mr Ogden in the community. The toxicologist indicated that the levels found in Mr Ogden's blood were much higher than those normally attributable to therapeutic use and described it as an overdose but could not rule out that Mr Ogden had experienced a fatal build-up of oxycodone from his slow release medication. The coroner is considering whether to call an expert toxicologist/pharmacologist to inquest to explore this possibility.

Findings

62. Mr Ogden arrived at Forest Bank having just been convicted of crimes against a family member, and it was his first time in prison. These are both factors which can put an individual at a higher risk of suicide. However, there was nothing to indicate to staff that Mr Ogden was at increased risk of suicide or self-harm. The post-mortem report said he died from a medication overdose.

63. The PPO liaised with a Detective Inspector from Greater Manchester Police during this investigation. The police provided the court's CCTV timeline and took statements from Mr Ogden's legal team. The police did not recover Mr Ogden's dock note and concluded that the contents of it, as described by his mother, could not be verified.

64. Crucial aspects of this case remain unclear as none of the three investigations conducted (by the PPO, the police and GEO Amey) were able to conclude when, or indeed if, Mr Ogden took the overdose. He could have taken it before he arrived at court on 28 March, somewhere within the court building itself, in the prison van or later when arrived at Forest Bank. CCTV showed Mr Ogden putting something in his mouth at court, but we do not know for certain what that was. His medication did not officially travel with him to Forest Bank, but it is possible that despite the usual checks he secreted it somewhere in his body and took it once in prison.

65. Without knowing when Mr Ogden took the medication and, given he did not display any obvious physical signs of having taken an overdose, we conclude that no one responsible for Mr Ogden could reasonably have realised something was wrong and taken different action.

66. The note Mr Ogden's mother said he had written while he was in the dock saying he could not cope or carry on, was never recovered and other witnesses' descriptions of it do not concur with hers. His legal team said it contained nothing more than doodles or random jottings. As such, there was no reason for the PER to contain any suicide and self-harm warnings to prison staff, or for staff to have specific concerns about him.

67. Although it was Mr Ogden's first time in prison and he had offended against a family member, it is also unlikely that had suicide and self-harm monitoring procedures (ACCT) been opened, the outcome would have been any different. Staff would not have been due to carry out an ACCT case review until the following day (after Mr Ogden's death). Mr Ogden was subject to routine first night checks throughout the night, during which staff thought he was sleeping. We consider it unlikely that, had additional ACCT checks been in place during the night, staff would have registered any concerns.

Clinical care

68. The clinical reviewer concluded that not all Mr Ogden's care was equivalent to what he could have expected to receive in community. He did not receive his pain relief medication at Forest Bank, partly because he did not arrive with it but also because, once he had arrived, his medication was prescribed after the last medication round

that day. He would not have received it until the next morning although he did have the option of requesting other pain relief medication during the night via his cell bell.

69. The reception nurse did not open the PER because she did not have the right computer log in. The clinical reviewer made recommendations about both issues that the Head of Healthcare will wish to address.

Director and Head of Healthcare to note

70. Although the PER did not provide any additional information suggesting Mr Ogden was at risk, and we do not think the reception staff should have opened an ACCT, the first night screen nurse told the investigator that she did not consider he had any risk factors.

71. The nurse said she had received ACCT training 19 months before the PPO's interview in August 2022. The Head of Healthcare will wish to consider this.

72. Mr Ogden's cellmate told the investigator that a wing cleaner had answered their cell bell and was abusive. It is not appropriate for wing cleaners to be answering cell bells. The Director will wish to consider this.

Inquest

73. At the inquest, held on 12 November 2024, the jury concluded that Mr Ogden's death was caused by excess consumption of his prescribed medication with his intention undetermined.

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