Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Forbister, a prisoner at HMP Lowdham Grange, on 18 December 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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.

I carry out investigations to understand what happened and identify how the organisations whose actions I oversee can improve their work in the future.

Mr David Forbister died on 18 December 2017 from the toxic effects of cocaine and MDMA (ecstasy) at HMP Lowdham Grange. He was 39 years old. I offer my condolences to Mr Forbister's family and friends.

Mr Forbister had a significant history of substance misuse and continued to take illegal and trafficked prescription drugs at Lowdham Grange. Although he had engaged with substance misuse services and the prison took action to limit his access to drugs, I am concerned that he was clearly able to obtain and use illicit drugs without difficulty. Before his death he had taken a large number of different drugs, had other drugs hidden in his body and drugs paraphernalia in his cell, apparently without staff on the wing being aware.

In a previous PPO investigation into another prisoner's death from drug toxicity at Lowdham Grange in February 2017, we found that despite the prison's comprehensive drug strategy, there appeared to be an accepted drug culture which the prison was failing to tackle effectively. I am concerned that this still appeared to be the case at the time of Mr Forbister's death nearly a year later.

I am also concerned that staff did not carry out appropriate safety and welfare checks on the morning of Mr Forbister's death, and that staff did not respond quickly enough when they found Mr Forbister unresponsive in his cell.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **September 2018**

Contents

Summary

Events

1. On 20 September 2013, Mr David Forbister was sentenced to ten years in prison. On 9 September 2014, he was transferred to HMP Lowdham Grange.

2. Mr Forbister had a long history of substance misuse in the community. Despite completing two methadone reduction programmes at Lowdham Grange and frequent contact with the substance abuse service, he continued to take a wide range of illicit and trafficked prescription drugs in prison. He was believed to be part of the prison's drug culture and to be bringing drugs in through visits. Staff submitted many intelligence reports and Mr Forbister was placed on extended periods of closed visits from 2016, punished at disciplinary hearings and issued with IEP warnings as a result of his drug use.

3. Two days before Mr Forbister died, an officer reported a suspicion that Mr Forbister's partner had passed him drugs during a visit. Staff searched him but found nothing. After Mr Forbister's death a prisoner said that Mr Forbister told him that he had received drugs at the visit.

4. On the morning of 18 December, staff conducted a roll check at about 6.45am and opened Mr Forbister's cell door to deliver milk at about 7.45am, but noticed nothing of concern.

5. At around 8.15am, two officers found Mr Forbister unresponsive in his cell. Although they radioed for healthcare assistance, they did not call a medical emergency code immediately or provide assistance to Mr Forbister. They said they thought Mr Forbister was sleeping off the effect of drugs, as he had done in the past. Once nurses arrived, they started cardiopulmonary resuscitation procedures. When paramedics arrived they instructed the nurses to stop resuscitation and, at 9.02am, they pronounced Mr Forbister dead.

6. The post-mortem examination concluded that the cause of Mr Forbister's death was cocaine and MDMA toxicity. (MDMA, usually known as 'ecstasy', is an illegal psychoactive drug used recreationally.) He had also taken a number of other drugs (including prescription drugs he had not been prescribed) before his death. Other drugs were found hidden in his rectum and drug paraphernalia, psychoactive substances (PS) and cocaine were found in his cell.

Findings

7. The clinical reviewer concluded that the clinical care that Mr Forbister received at Lowdham Grange, including addressing his substance misuses issues, undergoing methadone detoxification, mental health interventions and prescription of medication, was equivalent to that which he could have expected to receive in the community.

8. We found no intelligence or other evidence to suggest that Mr Forbister's death was anything other than accidental and a consequence of his conscious decision to take illicit drugs.

9. Mr Forbister's illicit drug use on the day of his death was not a one-off, and he was known to have been misusing a range of drugs at Lowdham Grange for a long time. Despite his two completed detoxification programmes, Mr Forbister was clearly determined to continue to abuse a range of drugs.

10. Although staff took action in line with local policy to tackle his drug use, we are concerned that this was evidently insufficient. Staff working on Mr Forbister's wing on 17 and 18 December 2017 did not identify signs of or appear to be aware of the scale of Mr Forbister's recent drug use and did not act accordingly.

11. We are particularly concerned that he was evidently able to access illicit drugs at Lowdham Grange so readily and that what appears to be a significant weakness in controlling the trafficking of prescribed medication has not been more effectively addressed.

12. On the morning of his death, staff missed two opportunities to check on Mr Forbister's welfare.

13. The emergency response on 18 December was compromised by poor staff judgement. As a result, Mr Forbister did not receive immediate healthcare assistance and there was a delay in calling an emergency code over the radio. Although these failings may not have affected the outcome in Mr Forbister's case, they might make a crucial difference in other cases.

14. The prison broke the news of Mr Forbister's death to his next of kin over the phone and did not try to approach other prisons to request the assistance from their family liaison officers.

Recommendations

- The Director should ensure that:

  - effective supply and demand reduction strategies are properly implemented to help reduce the availability and abuse of drugs, including the trafficking of prescription medications; and

  - staff are vigilant to signs of drug use and take appropriate action.

- The Director should ensure that all prison staff are made aware of and understand PSI 03/2013, *Medical Emergency Response* and their responsibilities during medical emergencies, in line with the local Medical Emergency Response Code protocol staff:

  a) are provided with guidance on identifying and correctly communicating the nature of a medical emergency; and

  b) ensure there are no delays in calling for healthcare assistance, directing or discharging ambulances.

- The Director should ensure that the local policy on roll checks is reviewed and updated and that staff properly check on a prisoner's wellbeing during relevant roll checks so that if they identify signs of a prisoner's not breathing they request urgent medical assistance accordingly.

- The Director should ensure that, when necessary, prison staff request the assistance of a family liaison officer from another prison to break the news of a prisoner's death.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Lowdham Grange informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

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

17. The investigator obtained copies of relevant extracts from Mr Forbister's prison and medical records. He interviewed five members of staff by telephone (due to severe weather conditions) on 27 February 2018, and four members of staff at Lowdham Grange on 28 March 2018 together with the clinical reviewer.

18. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Forbister's partner and mother to explain the investigation and to ask whether they had any matters within our scope that they wanted the investigation to consider. They wanted to know:

    - whether staff should have checked Mr Forbister between 2am and 8am on 18 December;
    - whether Mr Forbister received adequate healthcare; and
    - whether Mr Forbister had access to healthcare while at Lowdham Grange.

20. Mr Forbister's family received a copy of the initial report. They wrote to us with comments but they were not about specific factual inaccuracies.

21. The prison service also received a copy of the initial report. In their response to our recommendations they made minor accuracy comments. We have amended the report accordingly.

Background Information

HMP Lowdham Grange

22. HMP Lowdham Grange is a medium secure prison, managed by Serco, which holds around 920 men. There are five houseblocks, two of which hold approximately 250 men and the other three houseblocks typically hold up to 130 men. It holds long-term prisoners, many of whom are serving life sentences or indeterminate sentences. Nottinghamshire Healthcare NHS Foundation Trust provides general healthcare, which includes 24-hour nursing cover.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Lowdham Grange was conducted in June 2015. Inspectors reported that some security procedures were disproportionate to the risks posed and although the prison was sighted on its security issues, actions from its intelligence reports were not always prompt enough. Mandatory drug testing was below target but security finds and intelligence reports indicated a growing use of undetectable psychoactive substances. Inspectors noted that more prisoners than at the last inspection said it was easy to obtain illegal drugs and alcohol.

Independent Monitoring Board

24. 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 January 2017, the IMB commented that Lowdham Grange had made great efforts to prevent drugs entering the prison. The security department had regularly carried out successful intelligence-led cell searches.

Previous deaths at HMP Lowdham Grange

25. Mr Forbister was the sixth prisoner to die at Lowdham Grange since January 2015. The previous death (in February 2017) was also due to drug toxicity – in that case psychoactive substances. In that investigation we also found that the prison's drug strategy appeared to have been ineffective in preventing the prisoner obtaining drugs without difficulty.

Psychoactive Substances (PS)

26. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and 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 PS 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, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

27. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at the time NPS) and its dangers, including its close association with debt,

bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

28. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Incentives and Earned Privileges (IEP) Scheme

29. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

Key Events

30. On 20 September 2013, Mr David Forbister was sentenced to 10 years in prison for aggravated burglary. He was remanded to HMP Durham in 2013. This was not his first time in prison. Mr Forbister had a history of misusing drugs, including heroin, cocaine, 'crack' (a smokable form of cocaine) and Valium *(*diazepam), in the community.

31. On 9 September 2014, Mr Forbister was transferred to HMP Lowdham Grange. At his initial health screening, a nurse recorded that Mr Forbister was on a methadone detoxification plan which consisted of a gradual reduction from 15ml of prescribed methadone. The nurse continued this prescription and referred Mr Forbister to the substance misuse team. Mr Forbister concluded his detoxification programme in November. Mr Forbister was prescribed pregabalin (a medication used to treat epilepsy, anxiety and nerve pain) for pain in his right hand.

32. The same month, Mr Forbister self-referred to the mental health team because he said he was not sleeping well. The mental health team found that Mr Forbister was not suffering from any acute mental health issues. He did not have any previous history of mental ill health.

33. From January to March 2015, Mr Forbister had one-to-one sessions on drug awareness and prevention. On 18 March, he self-referred to the substance misuse team and said that he was taking illicit subutex (a synthetic opiate drug used as a heroin substitute) for pain.

34. In October 2015, Mr Forbister told a member of the substance misuse team that he had been misusing prescription drugs (medication not prescribed to him). Mr Forbister said that in August he had taken illicit dihydrocodeine (an opioid drug for pain relief), subutex, tramadol (another opioid for pain relief) and benzodiazepines (tranquilisers).

35. Mr Forbister received illicit items during visits from his girlfriend in October 2015. He was placed on closed visits for three months and given a punishment of cellular confinement, following a disciplinary hearing. (When prisoners are placed in closed visits the prisoner and his visitor are in two adjacent rooms, separated by a glass screen.)

36. The substance misuse team discussed treatment options with Mr Forbister and, on 12 December, started a further methadone reduction plan (again with 15ml of methadone) which he completed two months later.

2016

37. On 17 February, Mr Forbister tested positive for opiates during a random urine test. Mr Forbister told a nurse that he was using co-codamol (an opioid drug which contains codeine) for dental pain, although it had never been prescribed to him. The nurse told him that this finding was going to affect his substance misuse programme. The nurse recorded that Mr Forbister knew the potential consequences of using illicit drugs and he planned a follow up substance misuse assessment.

38. On 4 March 2016, a substance misuse practitioner reviewed Mr Forbister, who said that he had relapsed in his drug abuse by using illicit subutex. On 17 March he started Mr Forbister on a course of lofexidine (a drug used to reduce withdrawal symptoms during opioid detoxification). Records show that on 18 and 22 March healthcare staff also prescribed Mr Forbister zopiclone, a sleeping pill.

39. On 26 March, an officer started suicide and self-harm prevention procedures (known as ACCT) for Mr Forbister because he said that he was going to slash his wrists and pour boiling water on his head if he did not see a paramedic. He also said that he had taken an overdose of tablets. Mr Forbister had asked a nurse for a hospital appointment as he said that he had back pain and had had a fit, but the nurse refused to arrange it because Mr Forbister appeared well. The ACCT was closed the same day because Mr Forbister said that he did not have any thoughts of suicide and self-harm and had lied about having taken the tablets. Officers carried out Mr Forbister's ACCT post-closure review on 4 April and raised no concerns. This was the only occasion that Mr Forbister was managed under suicide and self-harm prevention measures.

40. The same day, an officer submitted an intelligence report which stated that Mr Forbister was constantly making attempts to get medication although healthcare staff found him well and not in need of medication. She noted that Mr Forbister was involved in the drug culture in the prison, and that he regularly appeared to be under the influence of drugs. She planned an intelligence-led cell search of Mr Forbister and informed the wing manager.

41. On 17 August, an officer noted that Mr Forbister appeared to be under the influence of drugs, possibly trafficked medication he was receiving from another prisoner suspected to be supplying drugs on the wing. She submitted an intelligence report and arranged a cell search. The next day, during the search, an officer found Mr Forbister in possession of a metal bar (but no drugs) and placed him on a disciplinary charge. Mr Forbister was found guilty and placed on closed visits initially for three months.

42. On 24 August, Mr Forbister told a member of the substance misuse team that he had been using benzodiazepines and wanted to start a further detoxification programme. She told Mr Forbister that prescribing medication to patients was not the first treatment option but he could have one-to-one sessions. Mr Forbister was not happy with this response and did not want any further help or support.

43. On 20 September, a mental health professional reviewed Mr Forbister on the wing after he self-referred to the service. Mr Forbister said that he was feeling anxious and asked for his pregabalin to be increased from 225mg to 300mg. He told Mr Forbister to speak to his GP and assessed that Mr Forbister did not present with any anxiety or acute mental health problems. Mr Forbister did not arrange a GP appointment.

44. On 3 October, after Mr Forbister was searched in reception, an officer found Mr Forbister with tablets and a wrap of a vegetable matter. A later test confirmed they were tablets of buprenorphine (subutex), mirtazapine (an antidepressant drug) and quetiapine (an antipsychotic drug) as well as PS. The officer placed Mr Forbister on a disciplinary charge. On 1 December, Mr Forbister was found

guilty of possession at a disciplinary hearing and was punished with 21 days cellular confinement.

45. Mr Forbister's closed visit restriction was reviewed on 9 November and remained in place.

2017

46. On 16 February, a member of the substance misuse team assessed Mr Forbister following another self-referral. Mr Forbister repeated that he was taking illicit subutex and wanted to start another detoxification programme and be prescribed opioid replacement drugs. The drugs worker explained to Mr Forbister that he needed to attend one-to-one and group psychosocial interventions before he could go into drug treatment. As Mr Forbister wanted to receive drug treatment immediately, he opted to withdraw his referral. The drugs worker provided advice to Mr Forbister on drug addiction and the risks associated with taking drugs.

47. On 22 May, Mr Forbister received a visit from his sister. They open-mouth kissed. Officers suspected that she was passing drugs and submitted an intelligence report. Mr Forbister was also searched but nothing was found. The same day two officers found a wrap of unknown substances in his cell following a search. They issued Mr Forbister with an IEP warning, which meant his IEP level was at risk of being lowered to basic level. Mr Forbister was also placed on a disciplinary charge, and placed on closed visits again (until 16 September).

48. Six days later, two officers found seven packets of tobacco in Mr Forbister's cell, which was on a non-smoking unit at the time. (A complete smoking ban now operates across the entire prison estate.) The officers placed Mr Forbister on a disciplinary charge and Mr Forbister subsequently received a punishment of received 14 days stoppage of earnings, 14 days of loss of canteen, facilities to purchase and use of private cash, and six months suspension of TV and gym use.

49. On 24 May Mr Forbister was subject to a mandatory drug test (MDT) which was positive for PS. An officer placed Mr Forbister on a disciplinary charge, but charges were later dismissed when Mr Forbister denied taking any drugs and requested a confirmation test.

50. On 29 September, Mr Forbister was subject to another drug test, which produced a negative result.

51. On 3 November, Mr Forbister requested an appointment with the mental health team. A nurse discussed his request at a multidisciplinary meeting and noted that Mr Forbister had not had recent contact with mental health services. She referred Mr Forbister for a mental health assessment on 21 November but he did not attend.

52. On 10 November 2017, staff suspected that Mr Forbister was possibly under the influence of drugs during a visit with his partner. They thought Mr Forbister's partner may have passed him drugs and they searched him but did not find anything.

53. On 4 December, Mr Forbister was subject to another mandatory drug test, which produced a negative result. Three days later a drugs worker recorded that an officer found Mr Forbister apparently under the influence of drugs (possibly PS) and referred him to the substance misuse team. He assessed Mr Forbister and explained the risks associated with the use of illicit drugs, including PS, to him. Mr Forbister said that he did not take any drugs and said that he did not need any support from the substance misuse team.

54. On 16 December, Mr Forbister had a visit from his partner. An officer who was monitoring the Closed-Circuit Television (CCTV) in the visits area suspected that saw that Mr Forbister's partner might have passed an item (possibly drugs) to him. She alerted staff over the radio and a Custodial Manager (CM) and an officer immediately went to Mr Forbister. He offered no resistance, was searched, but nothing was found. The CM then allowed Mr Forbister to continue with the visit.

55. A prisoner who was a friend of Mr Forbister and lived in the next cell said that they had had a conversation at around 5.30pm on 17 December, before the prisoners were locked in their cells for the evening. He said that Mr Forbister was slurring his words and was unsteady on his feet. He said that it was obvious that Mr Forbister had taken drugs.

56. Later, at 10.00pm, Officer A was conducting a roll check on the wing. He noted that Mr Forbister had left two applications for visits in front of his cell so went to collect them. He said that he noted nothing of concern.

18 December 2017

57. On 18 December, at 17 minutes past midnight, Mr Forbister pressed his alarm bell. Officer A answered 33 seconds later. He said that he opened Mr Forbister's observation panel and saw Mr Forbister standing in front of it. Mr Forbister asked the officer whether he had taken the application forms as he thought they might have fallen out. He said that Mr Forbister appeared to be fine and healthy so he had no concerns.

58. At 2.00am, Officer A carried out another roll check on the wing. When he arrived at Mr Forbister's cell he noted that the light was on. He saw that Mr Forbister was standing at the sink, rinsing a cup. He told the police that Mr Forbister said, "Alright, guv" and that he appeared to be fine. He said he had no concerns.

59. At about 4.00am, a prisoner said that he was woken up by noise coming from Mr Forbister's cell as if he was stumbling around trying to catch his feet. He said that the noise had gone on for about 25 minutes when the stumbling stopped with a sound like a wheezing noise. (He described the sound as being like when someone has something stuck in their throat.) He said that this was not the first time Mr Forbister had woken him up in this same way.

60. At 6.45am, Officer B, carried out a further roll check in the unit. He told the investigator that he opened Mr Forbister's observation panel but that he could not remember how Mr Forbister presented or what he was doing at the time. He said that he did not have any concerns about Mr Forbister. He did not enter the cell.

61. At around 7.45am, two officers did a 'milk round', placing bottles of milk into prisoners' cells, including Mr Forbister's. Officer C said that they unlocked the cell and opened the door narrowly, placed the milk into the sink then locked the door again. He said that he did not enter the cell and was unable to see the inside.

62. At around 7.50am, a nurse arrived at the medication hatch on the wing to dispense medication to prisoners. Officer C said that he unlocked all the prisoners who needed medication, including Mr Forbister. He told the investigator that when he unlocked the cell, he did not open the door and did not look inside the cell. He said that he shouted to Mr Forbister that it was "time for his meds". He said that Mr Forbister did not reply or come out of the cell. He said this was not uncommon for Mr Forbister, so he had no concerns.

63. At approximately 8.15am, as all prisoners, except Mr Forbister, had collected their medication, Officer C asked Officer D to bring him from his cell. Officer D opened Mr Forbister's cell and saw Mr Forbister sitting in his chair, in front of his desk, with his head in his arms facing the window. She shouted Mr Forbister's name, but he did not respond. She told the investigator that she thought that Mr Forbister was sleeping deeply, but she decided to call Officer C because she felt that something was not right as Mr Forbister would not wake up.

64. Officer C arrived at Mr Forbister's cell about a minute later. He placed his right hand on Mr Forbister's left shoulder and repeated that it was time for his medication. Mr Forbister did not respond. He told the investigator that Mr Forbister felt warm to the touch but he did not know whether he was breathing. He said that he thought Mr Forbister was under the influence of drugs but he did not see any evidence at that point that he had taken anything.

65. At around 8.21am, Officer C asked Officer D to use her radio to call for healthcare assistance, communicating that a prisoner was possibly under the influence of drugs, and she did so. A prisoner who had been unlocked for work, went to Mr Forbister's cell. He told the police that he saw Officer C checking Mr Forbister's pulse but obtaining no response. He said that he told the officer that he thought Mr Forbister was dead and needed assistance but the officer left to return to the medication hatch. The officer told the investigator that he did not think that he needed to apply any first aid procedures to Mr Forbister because he had found him asleep in similar positions in the past and was not concerned.

66. At around 8.33am, a nurse responded to the call for healthcare assistance. She said that as soon as she saw Mr Forbister she suspected that he was dead. She checked for a pulse but found none. She said that Mr Forbister was cold to the touch, had no colour and was stiff. She immediately asked Officer D to call a code blue emergency. (This indicates that a prisoner is unconscious or having difficulty breathing.) The officer did so and two nurses responded and arrived with the emergency bag. Notwithstanding Mr Forbister's presentation, the first nurse started cardiopulmonary resuscitation procedures (CPR) and a great deal of vomit emerged from Mr Forbister's mouth.

67. At 8.35am, the control room officer called an ambulance. At 8.50am the ambulance arrived at the prison gate and paramedics arrived at Mr Forbister's

cell four minutes later. Paramedics instructed the nurses to stop CPR procedures and, at 9:02am, they pronounced Mr Forbister dead.

68. After Mr Forbister's death, drugs, including PS and subutex tablets and powder, were found 'plugged' (hidden) in his rectum. Drug paraphernalia containing PS and cocaine and the remnants of tobacco were found on the desk and under his bed.

Contact with Mr Forbister's family

69. At 9.50am, the deputy Director broke the news of Mr Forbister's death to his mother by telephone and told her that he was coming to visit her in person. He visited Mr Forbister's mother personally at around 5.15pm with the assistant Director and offered support.

70. An officer was appointed as the family liaison officer and continued in contact with family thereafter. He called Mr Forbister's mother on 19 December at 11.35am and offered further support.

71. Mr Forbister's funeral took place on 15 January 2017. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

72. After Mr Forbister's death, the deputy Director 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.

73. The prison posted notices informing other prisoners of Mr Forbister'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 Forbister's death.

Post-mortem report

74. The post-mortem examination found that Mr Forbister died from cocaine and MDMA toxicity.

75. The pathologist said that, although cocaine and MDMA were not present at toxic levels, fatalities due to the use of cocaine and MDMA may not be directly related to their respective blood levels but may reflect cardiovascular and/or renal complications associated with regular stimulant use.

76. Toxicology analysis also showed the presence of zopiclone at potentially toxic levels and pregabalin, diazepam (a benzodiazepine), buprenorphine (subutex) and clonazepam (a benzodiazepine) at levels consistent with therapeutic use. (Only pregabalin was prescribed to Mr Forbister at the time.) The pathologist said that, when these drugs are taken together, their toxic effect on the central nervous system may be enhanced.

Findings

Clinical care and substance misuse services

77. Mr Forbister presented with no significant physical health issues at Lowdham Grange but made several requests to be assessed by the mental health team. The mental health team assessed him frequently and concluded that he did not have any significant mental health problems. Mr Forbister did not attend his last mental health appointment on 21 November.

78. Mr Forbister also received help with his significant substance misuse problems. In November 2014 and February 2016, he completed two methadone reduction programmes. He also frequently met members of the substance misuse team who offered him psychosocial interventions and explained the dangers of taking illicit drugs.

79. The clinical reviewer found that Mr Forbister's rate of methadone reduction during his second reduction programme was quicker than expected in NICE guidelines, which are 12 weeks for a community setting. But Mr Forbister agreed with the pace of the reduction plan, his withdrawal symptoms were adequately monitored and he was prescribed lofexidine to reduce them.

80. The clinical reviewer had no concerns about Mr Forbister's substance misuse, mental healthcare and medication monitoring, and concluded that the clinical care and healthcare access that Mr Forbister had at Lowdham Grange was equivalent to that which he could have expected to receive in the community.

Drug strategy

81. Lowdham Grange operates a 'zero-tolerance policy' on substance misuse and has a drug strategy to tackle drug supply and demand. The strategy sets out measures to target drug trafficking using prisoner and visitor searches, the IEP scheme, the adjudication process and closed visit sanctions.

82. One of the key objectives of the strategy is to reduce the availability of substances in the establishment. It acknowledges ongoing concerns about the inappropriate use of prescribed medication by prisoners and sets out a range of steps to tackle this, including:

- standardised procedures for management of medication not held in possession;
- audit systems of in-possession medication; and
- a monthly review of the MDT results cross-referenced with the distributed medication list to inform intelligence-led checks.

83. The drug strategy also recognises the significant risk that the emergence of PS has presented to the safety and security of the prison and sets out actions to combat this risk.

84. Mr Forbister was a long-standing abuser of illicit drugs during his time at Lowdham Grange. Intelligence linked him with the supply of drugs on the wing

and he was suspected of receiving drugs through visits. He took a range of illicit drugs, including PS and prescription medication that had not been prescribed to him, including subutex, tramadol and benzodiazepines. He also made attempts to have medication prescribed to him which was not clinically necessary. Despite this Mr Forbister engaged with and was offered support by substance misuse services.

85. The prison had a range of intelligence to assist them in understanding the nature of Mr Forbister's drug abuse and how he sourced his drugs. Staff responded by placing Mr Forbister on closed visits for extended periods, subjecting him to drug testing, managing him through the IEP scheme, placing him on disciplinary charges and punishing him with cellular confinement.

86. Two days before Mr Forbister died, an officer reported a suspicion that Mr Forbister's partner had passed him drugs during a visit. Another prisoner told the police that Mr Forbister later told him that he had received drugs at the visit. He also said that when he spoke to Mr Forbister for the last time before they were locked in their cells on 17 December, Mr Forbister was clearly under the influence of drugs. He told the police that Mr Forbister used to take a mixture of crack, subutex and sometimes heroin. We found that staff were largely unaware of this.

87. Mr Forbister had taken a cocktail of drugs before he died: cocaine, MDMA, pregabalin (which he had been prescribed) and various prescription medications that he had not been prescribed. He had also hidden drugs, including PS and subutex, in his rectum and drug paraphernalia containing PS and cocaine was found in his cell.

88. This all suggests that Mr Forbister was able to obtain and use drugs at Lowdham Grange without difficulty. Although we recognise that staff had taken actions in line with local policy to deal with Mr Forbister's drug misuse, these actions were clearly insufficient in the face of his determination to continue to take illicit drugs.

89. HM Inspectorate of Prisons found in its last inspection in June 2015 that illicit substances and diverted prescription medications were widely available at Lowdham Grange. In its latest report to January 2017, the IMB reported that mandatory drug testing figures continued to show that drugs were available in the prison, with PS usage continuing to be high.

90. In a previous PPO investigation into another prisoner's death from drug toxicity at Lowdham Grange in February 2017, we found that despite the prison's comprehensive drug strategy, there appeared to be an accepted drug culture which the prison's strategy was failing to tackle effectively.

91. In the light of Mr Forbister's death, we continue to be concerned about the apparent ease with which prisoners are able to obtain and use illicit drugs at Lowdham Grange, including Class A controlled drugs, PS and trafficked prescription medications. We repeat the following recommendation:

The Director should ensure that:

- **effective supply and demand reduction strategies are properly implemented to help reduce the availability and abuse of drugs, including the trafficking of prescription medications; and**

- **staff are vigilant to signs of drug use and take appropriate action.**

Emergency response

92. PSI 03/2013, *Medical Emergency Response Codes*, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring that staff take the relevant equipment to the incident and that there are no delays in providing medical assistance to prisoners or calling an ambulance.

93. We are concerned that some of the actions of staff on 18 December were ill-considered. Officers C and D acted with no sense of urgency when they found Mr Forbister unresponsive in his cell. Officer D told the investigator that she thought that Mr Forbister was sleeping deeply. Officer C said that he thought Mr Forbister was under the influence of drugs and had fallen asleep as this had happened in the past, but he appears not to have seen this as a cause for concern.

94. Officer D did not radio an emergency code until about 18 minutes after the officers first discovered Mr Forbister, and then only at the request of a nurse. The nurse said that as soon as she saw Mr Forbister in his cell, she suspected that he was dead. She said that based on Officer D's first radio call for healthcare assistance for a "prisoner under the influence", she expected Mr Forbister to be simply agitated so had not responded more urgently.

95. A nurse also said that after the initial radio message he replied that a nurse would be sent "as soon as possible" but asked to be informed if Mr Forbister deteriorated or started to vomit so that a nurse would be sent urgently. Nobody raised any further concerns, and as a result there was a delay before a nurse attended. Another nurse told the investigator that in her experience staff at Lowdham Grange radio emergency codes when prisoners present with issues that are not necessarily urgent and suggested officers do not use the code system appropriately.

96. Staff judgement is fundamental in these situations but officers must always act with caution as they are not medically trained. Officers C and D should have called a code blue emergency immediately on the discovery of Mr Forbister because he was not responding and appeared to be unconscious. Although the clinical reviewer said that calling the code blue earlier would not have made any difference as it appears that Mr Forbister had been dead for some time, in other cases calling a code earlier could be crucial. We make the following recommendation:

The Director should ensure that all prison staff are made aware of and understand PSI 03/2013, *Medical Emergency Response* and their responsibilities during medical emergencies and that, in line with the local Medical Emergency Response Code protocol, staff:

a) are provided with guidance on identifying and correctly communicating the nature of a medical emergency; and

b) ensure there are no delays in calling for healthcare assistance, directing or discharging ambulances.

97. Although the nurse suspected that Mr Forbister was dead when she attended (he was cold to the touch, had no colour and was stiff) she started cardiopulmonary resuscitation procedures (CPR). The clinical reviewer said that the CPR attempt was justified by the circumstances of the radio call and by staff confusion about the nature of the emergency which had suggested that Mr Forbister was alive when he was first discovered.

Roll checks

98. The Assistant Director told the investigator that according to local policy, officers are expected to conduct welfare checks:

- At 6.45am, when staff should do a physical check of the prisoner through the observation panel of the cell door, with a torch or the night light.
- At 7.30am when two officers carry out the 'milk round'. Officers unlock, open and enter cells to place the milk inside. Staff must engage with the prisoner and be satisfied about his welfare.

99. The Assistant Director's explanation of the 6.45am roll check differs from the prison's local security strategy on roll checks, last reviewed on 24 January 2018, which says that, there will be a full roll count of prisoners at 6.45am every day, carried out by two members of staff, who will "enter the cell" and check that prisoners are present.

100. When he carried out the 6.45 roll check on 18 December, Officer B did not enter the cell and did not identify anything of concern. Officers C and D did not conduct any welfare checks or observations while placing milk in Mr Forbister's cell. Both officers told the investigator that they were only expected to unlock the cell briefly to place the milk inside during the milk round, but not to do anything else.

101. We are concerned that staff missed two opportunities on the morning of 18 December to check on Mr Forbister's welfare before he was found unresponsive at 8.15 am.

102. We make the following recommendation:

The Director should ensure that the local policy on roll checks is reviewed and updated and that staff properly check on a prisoner's wellbeing during relevant roll checks so that if they identify signs of a prisoner's not breathing they request urgent medical assistance accordingly.

Contact with Mr Forbister's next of kin

103. Prison Rule 22 states that when a prisoner dies, the governor should inform next of kin "at once". Prison Service Instruction 64/2011 requires that where possible,

the family liaison officer and another member of staff should visit the next of kin in person and that this should be done quickly to ensure that the prisoner's family does not hear of the death by other means. PSI 64/2011 also says that where the prisoner had been located a long distance from their next of kin, consideration must be given to requesting the assistance of a family liaison officer from the prison nearest to the next of kin.

104. The deputy Director broke the news of Mr Forbister's death to his next of kin, his mother, over the phone on 18 December. He said he did so because she lived some distance away from the prison and he was concerned that she could have heard about the death by other means before he could visit her home in person.

105. The deputy Director said that he did not try to approach other prisons to request the assistance from their family liaison officers because he did not know that this was possible, as he thought it was the responsibility of the prison where the prisoner died to break the news. We make the following recommendation:

The Director should ensure that, when necessary, prison staff request the assistance of a family liaison officer from another prison to break the news of a prisoner's death.

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