

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Nathan Forrester, a prisoner at HMP Thameside, on 2 July 2019**

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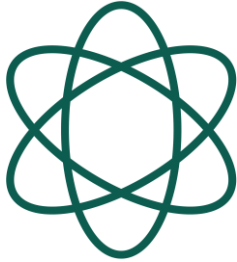
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## Our vision

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



## Our values

**We are:**

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**Respectful:** we are considerate and courteous

**Inclusive:** we value diversity

**Dedicated:** we are determined and focused

**Fair:** we are honest and act with integrity

**OGL**

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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Nathan Forrester died on 2 July 2019. His death was due to acute heroin, cocaine and methadone toxicity. Mr Forrester was 36 years old. I offer my condolences to his family and friends.

Mr Forrester died the day after arriving at Thameside. The investigation found that although his escort documents noted a history of concealing drugs, there was no record of the level and outcome of Mr Forrester's search in reception, and that staff seemed unaware of some of the mandatory actions in the national policy on searching. In addition, the Director should consider whether drug detection technology would be of value in the reception process, given the high turnover of prisoners.

I am concerned about the reported delay in responding to the shouts for help from Mr Forrester's cell mate and that the staff who arrived first did not attempt resuscitation. I am also concerned that both staff and prisoners are unclear about the policy on using cell call bells; and how prisoners are expected to communicate their needs to wing staff.

The clinical care Mr Forrester received before he was found unresponsive was timely, appropriate and equivalent to that he could have expected to receive in the community. However, I am not satisfied that the resuscitation attempt met this standard. I agree with the findings of the clinical review that healthcare staff need further training and development in the management and handling of resuscitation procedures.

After Mr Forrester's death, some of the key staff involved in the emergency response were not invited to a debrief and several days elapsed before their participation was recognised and support offered. I have previously raised with Thameside the issue of support for staff after such incidents.

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

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**October 2020**

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# Summary

## Events

1. Mr Nathan Forrester was recalled to prison and taken to HMP Thameside on 1 July 2019. He had a history of substance misuse and appeared to be drowsy and withdrawing from drugs when he arrived. The escort documents indicated that Mr Forrester had previously concealed illicit drugs, so the reception manager instructed staff to carry out a full search and pay close attention when searching him.
2. A nurse conducted an initial health screen. A prison GP then assessed Mr Forrester but decided not prescribe methadone that evening as his pulse rate was low. After the reception procedures, Mr Forrester was allocated to a shared cell on the drug stabilisation wing. Mr Forrester's cellmate said that he had brought drugs to the cell and used some that night.
3. The next day, Mr Forrester had several health assessments and his vital signs observations were taken. He received a dose of methadone just before 11.45am and was then locked in his cell. He and his cellmate both fell asleep during the lunch period. When his cellmate woke up, he noticed that Mr Forrester did not appear to be breathing and his arm was blue. He shouted and banged on his cell door to attract the attention of staff.
4. Wing officers attended and radioed a medical emergency code at 3.10pm. An ambulance was requested and healthcare staff attempted resuscitation until the paramedics arrived. Mr Forrester did not regain consciousness and the paramedics confirmed his death at 4.01pm.

## Findings

5. We agree with the clinical reviewers that Mr Forrester's clinical management before the emergency was appropriate and equivalent to that he could have expected to receive in the community.
6. Thameside has an up to date substance misuse strategy that is regularly reviewed. A referral had been completed for Mr Forrester to receive psychosocial support from the substance misuse interventions provider, but he died before this was processed.
7. Staff interviewed seemed to be unaware that all new prisoners should be subject to a full search, unless they have transferred from another prison, and that such searches should be documented, regardless of whether anything is found. There is no record of Mr Forrester's search, so it is unclear whether he had a full search, as directed by the reception manager.
8. Given the high turnover of prisoners in reception, and the propensity for some recalled prisoners to conceal drugs in preparation for returning to prison, Thameside might benefit from drug detection technology.
9. There was a delay in responding to the shouts for help when Mr Forrester's cellmate found him unresponsive, and the first three officers to arrive did not attempt to move him from the top bunk or begin resuscitation.

10. The paramedics expressed serious concerns about the management and handling of the resuscitation attempt. The clinical reviewers considered that there was a lack of leadership and that the staff involved did not have the confidence, or level of expertise to deliver effective life support. They concluded that this aspect of Mr Forrester's care was not equivalent to that expected in the community.
11. Mr Forrester's cellmate did not use the cell call bell to get the attention of staff. There appears to be confusion among staff and prisoners about the appropriate use of the cell call bell.
12. Some of the staff involved in the emergency were not invited to a debrief and there was a delay of several days before they were offered support.

## Recommendations

- The Director should ensure that, on reception, new prisoners who have not transferred from another prison are given a full search and that the details and outcome are documented, in line with national policy.
- The Director should assess the benefits of drug detection technology during the next review of the drug and alcohol strategy.
- The Director should initiate an investigation into PCO A's conduct on 2 July 2019 with a view to considering whether disciplinary action is warranted.
- The Director should ensure that prison staff respond appropriately and promptly when a prisoner summons help.
- The Director should ensure that all prison staff are briefed about the importance of starting cardiopulmonary resuscitation as quickly as possible when a prisoner is unresponsive until medical staff arrive.
- The Head of Healthcare should ensure that staff receive clear guidance and sufficient training to deal effectively with an emergency, including:
  - Management and leadership training for staff expected to lead in an emergency and a test of competence before they do so.
  - Establishing that all staff are aware of their roles and how to perform tasks assigned to them.
  - Training in the use of airways.
  - The information to be gathered for the ambulance service.
  - The role of the prison GP in the event of an emergency.
- The Director should ensure that:
  - staff and prisoners understand the policy on the use of cell bells; and
  - there is an effective system for prisoners to communicate any needs to staff when they are locked in their cells.
- The Director should ensure that the names of all staff involved in a critical incident are recorded and that, in line with national policy, staff are offered appropriate and timely support after a serious incident or a death in custody.

## The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Thameside informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. The investigator visited Thameside on 10 July 2019. She met the Director, interviewed Mr Forrester's cellmate and spoke to other prisoners on Mr Forrester's wing. She also obtained copies of relevant extracts from Mr Forrester's prison and medical records.
15. The investigator contacted the Metropolitan Police to discuss their evidence and emerging evidence and to obtain copies of the statements taken by the police.
16. NHS England commissioned associates to review Mr Forrester's clinical care at the prison. Two independent clinical reviewers carried out the clinical review on their behalf. The investigator and a clinical reviewer interviewed 18 members of staff and one prisoner at Thameside on 23, 24 September and 7 November.
17. We informed HM Coroner for Inner South London of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. One of the Ombudsman's family liaison officers explained the investigation to the solicitors acting on behalf of Mr Forrester's next of kin. The solicitors asked for the investigation to consider a number of questions and concerns, including the following:
  - Was Mr Forrester lawfully recalled to custody?
  - Was there a delay in responding to the calls for help from Mr Forrester's cellmate?
  - Was Mr Forrester's cellmate involved in his death?
  - Had Mr Forrester been assaulted in prison?
  - Were the reception and induction procedures conducted properly, given that Mr Forrester reportedly appeared unwell when he arrived at Thameside?
  - Did Mr Forrester take drugs in prison and, if so, how did he obtain them?
  - Were the emergency procedures handled appropriately?

We have addressed the issues that fall within our remit.

19. We shared aspects of this report with the prison, in line with our advance disclosure process.
20. The solicitors acting for Mr Forrester's next of kin received a copy of our initial report. They made no comments.
21. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendations.

## Background Information

### HMP Thameside

22. HMP Thameside is a local prison which holds up to 1,232 male prisoners who have either been convicted or are on remand. It is managed by Serco. Healthcare is provided by Oxleas NHS Trust. A dedicated healthcare unit has inpatient facilities for 20 prisoners.

### HM Inspectorate of Prisons

23. The most recent inspection of HMP Thameside was in May 2017. Inspectors found that, overall, HMP Thameside was a relatively good prison and they identified an unusually high number of examples of good practice.
24. Inspectors reported that a high number of prisoners were received into the prison and all new arrivals were strip searched. First night interviews were not private and were insufficiently focussed on risk and vulnerability. Reception processes were quick and prisoners needing stabilisation from substance misuse were promptly taken to the drug stabilisation unit. The unit was supportive and well-managed with the number of prisoners not requiring drug treatment kept to a minimum. Prisoner peer support workers assisted during the reception, first night and induction periods.
25. Inspectors considered that the number of prisoners receiving opiate maintenance was appropriate, given the high turnover. The medication queue was not always monitored by an officer, which increased the risks of medication diversion. Outcomes for those with drug and alcohol problems were good, but treatment services were not adequately integrated, partly due to poor attendance at drug strategy committee meetings and a consequent lack of strategic leadership across departments. Inspectors found that 27% of prisoners surveyed said it was easy to obtain drugs.

### Independent Monitoring Board

26. 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 June 2019, the IMB reported that while there were still areas of concern, healthcare provision had improved, and that healthcare staffing levels had risen. The Board also noted that Turning Point provided good quality, responsive support and intervention for prisoners with substance misuse problems.

### Previous deaths at HMP Thameside

27. Mr Forrester was the seventh prisoner to die at Thameside since July 2017. Of the previous deaths, two were from natural causes, one was self-inflicted, two were drug-related and one has yet to be determined. There have been two further deaths, one due to natural causes and the other apparently self-inflicted. We have made previous recommendations about wing staff performing resuscitation and support for staff following deaths of prisoners.

## Key Events

28. Mr Nathan Forrester was recalled to prison on 5 December 2017 and held on remand at HMP Thameside. He had a history of substance misuse in the community and had committed offences to fund his drug addiction. During this and previous periods in custody, he used illicit substances.
29. On 12 June 2018, Mr Forrester was sentenced to two years imprisonment for burglary and theft. He was released from prison, on licence, on 25 January 2019, but was recalled in April and May.
30. Mr Forrester was released from Thameside on 12 June 2019. However, he failed to attend appointments with his offender manager (probation officer) and committed a further offence. As a result, his licence was again revoked on 27 June and formal notification of his recall was issued to criminal justice agencies.

### Recall to Thameside on 1 July

31. On the morning of 1 July, Mr Forrester was stopped by the police and a check revealed that he had been recalled to prison. He was arrested and detained at Bethnal Green Police Station. In the afternoon, Mr Forrester was taken to Thameside, arriving at 3.25pm. Many of the operational and healthcare staff at Thameside knew Mr Forrester well, including the Custodial Operations Manager (COM) in charge of reception that day, and the Prison Custody Officer (PCO) who conducted his reception interview.
32. A Person Escort Record (PER) accompanies prisoners on all journeys between police stations, courts and prisons, to communicate risk factors. Mr Forrester's PER noted that he used illicit drugs and was known to conceal them in body orifices.
33. The COM and PCO both noticed that Mr Forrester was drowsy while in the holding area in reception. At interview, the COM said that Mr Forrester was not himself, he could barely stand and his presentation was very different to his normal demeanour. He had therefore instructed reception staff to conduct a thorough, full search to prevent anything illicit reaching the wings. (A full search includes a check of clothing and body orifices, in which men can be asked to squat, if necessary.) The COM also said he had asked healthcare staff to admit Mr Forrester to the inpatient unit, but was told that no healthcare beds were available, so he would have to go straight to the drug stabilisation unit.
34. A nurse conducted an initial health screen. Mr Forrester said he spent £150 a day on crack cocaine and heroin and he had last used drugs on 29 June. He had also been prescribed sertraline, an antidepressant. The nurse noted that she could not assess Mr Forrester properly as he was very sleepy and drowsy and unable to answer some of the questions. A urine test was positive for opiates, benzodiazepines, cocaine, cannabis and methadone. The nurse referred Mr Forrester to the prison GP, substance misuse service and the mental health team.
35. Mr Forrester was then reviewed by a prison GP. Although he was still sleepy and unable to answer most questions, he told the doctor that he had been receiving 40ml of methadone daily and was using heroin as well. The prison GP decided

against prescribing methadone as Mr Forrester's pulse rate was low, but he prescribed several drugs to relieve opiate withdrawal symptoms. These included ibuprofen and paracetamol (painkillers), mebeverine and metoclopramide (to help relieve cramping and nausea) and loperamide (for diarrhoea). The prison GP concluded that Mr Forrester was not acutely unwell and did not need to be admitted to the healthcare inpatient unit.

36. At around 7.00pm, after the reception procedures had been completed, Mr Forrester was taken to the drug stabilisation unit. He was allocated to cell A1-20, a double cell which he shared.
37. Mr Forrester's cellmate told the investigator that when Mr Forrester arrived in the cell, he appeared to be in a poor state and had brought illicit drugs with him - "three whites and one brown" (slang for cocaine and heroin) - and tin foil. He asked him for his milk carton (the metal in the cartons can be heated to use drugs). He said that Mr Forrester smoked a white substance and a brown substance.
38. Prisoners with opiate dependence are monitored closely for the first five days. Mr Forrester was observed twice during the night, at 12.55am and 5.47am. His cellmate said that Mr Forrester had slept all night.

## Events on the morning of 2 July

39. Mr Forrester's cellmate said that on the morning of 2 July, he saw a packet with a brown substance on the cell floor and handed it to the officer who delivered the breakfast pack. There is no record of this incident and staff interviewed said they had not been handed the packet. (The breakfast packs for the next day are usually issued at about 4.00pm, with the evening meal, but Mr Forrester had arrived on the wing at 7.00pm. It is therefore possible that his breakfast had been delivered that morning.) He added that when Mr Forrester woke up, he repeatedly said that he had lost his 'brown.' (There is an anomaly in this account as he also said that Mr Forrester had used the 'brown' the previous evening.)
40. Several staff saw Mr Forrester during the morning. At around 9.00am, he attended an induction with a peer mentor and said that he wanted to get clean. A support worker with Turning Point, the substance misuse interventions service, saw Mr Forrester in passing and he completed a referral form for him at lunchtime. He described him as subdued, tired and unkempt, but he did not appear to be under the influence of drugs.
41. Sometime between 8.00am and 10.00am, a healthcare substance misuse support worker, assessed Mr Forrester. As part of this process, she used the Clinical Opiate Withdrawal Scale (COWS), a tool to rate and monitor signs and symptoms of opiate withdrawal. Mr Forrester scored seven, which indicated mild withdrawal.
42. Shortly after 10.00am, a chaplain spoke to Mr Forrester during her routine welfare checks. He confirmed his religion, did not appear unwell and told her that he was all right. As a former nurse, she knew the signs of substance misuse and withdrawal and had no concerns about Mr Forrester.
43. A nurse tried to conduct a dual diagnosis assessment. (Dual diagnosis is when a person has severe mental health problems at the same time as problematic

substance misuse.) Mr Forrester was unwilling to engage and appeared restless, but alert and asked the nurse to come back another time.

44. A nurse conducted a secondary health screen and completed clinical observations. The nurse found Mr Forrester orientated, cooperative, cheerful and communicative.
45. At around 10.40am, a nurse prescriber assessed Mr Forrester for restarting methadone. She had planned to see him that afternoon, but he had gone to the medication room demanding medication and another nurse had asked for him to be given priority. They discussed harm reduction and how prison staff could support him. She noted that he was clearly withdrawing from opiates and it was not the best time to engage, but he acknowledged what she said. Mr Forrester felt that he could start on 30ml of methadone, the dose before his discharge in June. She prescribed a dose of 10ml of methadone, with a view to a gradual increase to 30ml.
46. Mr Forrester's cellmate said that during the morning, a few other prisoners had approached Mr Forrester asking if he had anything – meaning illicit drugs. CCTV footage shows Mr Forrester at the medication hatch at 11.44am, presumably receiving his methadone. At 11.45am, he went back to his cell and was locked up. At 11.46am, the footage shows an unidentified prisoner standing at the door of cell A1-20, apparently talking to someone inside. At one point, the man appears to reach into the cell through the hatch.
47. Mr Forrester's cellmate said that Mr Forrester went to sleep on the top bunk, but took a call on the cell telephone during this time. He then fell asleep, but heard Mr Forrester having a coughing fit. When asked if it was more like heavy snoring (which can be a sign of an overdose), he insisted it appeared to be coughing.

## Medical emergency

48. When his cellmate woke up, he noticed Mr Forrester's arm was blue and that he did not seem to be breathing. He shouted out to him, but there was no response. He said he then shouted for help through the door for what he described as 10 - 15 minutes, but did not press the cell call bell. He said a female officer arrived and told him that she had only attended as he did not normally call for staff. She opened the door and stood in the doorway at a distance, looked around and shouted Mr Forrester's name. According to him, she then shouted a code blue to colleagues, without using a radio.
49. A prisoner in a neighbouring cell, said he heard Mr Forrester's cellmate banging his cell door for at least 20 minutes, repeatedly shouting, "Gov, gov, gov." A prisoner, who lived in a cell opposite, said that he heard Mr Forrester's cellmate banging on the door and shouting for about 20 minutes.
50. PCO A said that around 3.00pm (3.07pm on CCTV footage) she heard a prisoner shouting, something along the lines of "Oh God, God." She looked down the wing and shouted back, asking who was shouting. Mr Forrester's cellmate identified himself and waved his arm through the observation panel. PCO A then asked why he was shouting and he replied that something was wrong with his cellmate and his arm was blue. PCO A walked down to the cell (which was at the furthest end of the landing) and looked in. She estimated that this was no more than four or five minutes after the cellmate first began to shout.

51. PCO A saw Mr Forrester on the top bunk, with his arm hanging over the bed. She shouted his name three times, but he did not respond. She then shouted to a colleague, another PCO, telling him it was a code blue. Although she tried to radio a code blue herself, there was no response so the other PCO radioed the code as well (timed at 3.10pm on the incident log). The other PCO touched Mr Forrester's arm and it felt cold.
52. The control room immediately telephoned the ambulance service. Staff were instructed not to search the ambulance when it arrived, to allow it through quickly.
53. A third PCO joined the two officers. CCTV footage shows that the three officers left the cell, with the cellmate. They closed the door and began locking other prisoners in their cells.
54. A nurse was nearby and the first clinician to arrive at the cell. There were no other staff at the door, or inside, so he stood on a chair to assess Mr Forrester quickly.
55. A PCO had been working upstairs on a different wing and joined the nurse a few seconds later. They lifted Mr Forrester from the top bunk onto the floor and the nurse began cardiopulmonary resuscitation (CPR). The officer offered to help, but the nurse asked him to get an emergency bag. By then, several other healthcare and operational staff had arrived and one of them went to fetch the bag. Another nurse took over the compressions from the nurse, who then applied a defibrillator. No shocks were advised. Several nurses continued the resuscitation efforts in rotation, including attempts to give oxygen.
56. London Ambulance Service records show that the first paramedic arrived at 3.20pm and reached the cell at 3.24pm. Another ambulance arrived around ten minutes later. The ambulance report noted that the CPR attempts were of "extremely poor quality". The paramedics gave advanced life support, but confirmed Mr Forrester's death at 4.01pm. The paramedics noted that when they arrived, Mr Forrester was very cold with a body temperature of 32.3°C and cyanosed (meaning his skin was a blue colour because of a lack of oxygen to the blood). From this they estimated that it was likely he had not been breathing for 1½ -2 hours.

### **Additional information provided after Mr Forrester's death**

57. A clinical psychologist wrote to the investigator a few days after Mr Forrester's death. She said she felt she had a duty of care to report information given by an anonymous patient during a counselling session. The prisoner had heard loud door-banging and shouts for help from Mr Forrester's cellmate, which he said had lasted around 45 minutes. He had also heard a female member of staff telling the person shouting to "fuck off" and that she "will open the door when [she is] ready".

### **Contact with Mr Forrester's family**

58. A COM was assigned as the prison's Family Liaison Officer (FLO). The FLO and an Assistant Director visited Mr Forrester's next of kin, to break the news of Mr Forrester's death. They offered condolences and explained the processes to follow. The FLO kept in touch and liaised with the coroner's office and the funeral director.

59. He went to see Mr Forrester's next of kin again on 15 July, and facilitated a visit to the prison. Mr Forrester's next of kin met the Director, healthcare manager and a prison chaplain.
60. In line with national policy, the prison made a contribution to the costs of Mr Forrester's funeral, which was held on 2 August. The FLO kept in touch with Mr Forrester's mother for several months after the funeral.

### **Support for prisoners and staff**

61. After Mr Forrester's death, a prison manager held a debrief. No learning points were identified at that time, but it was noted that the ambulance crew had raised concerns about the emergency response which they intended to raise with the healthcare provider.
62. The prison posted notices informing other prisoners and staff of Mr Forrester's death, and offering support.

### **Post-mortem report**

63. The report of the post-mortem examination concluded that Mr Forrester died from acute toxic effects of heroin, cocaine and methadone.
64. The pathologist could not determine when or how Mr Forrester had taken the illicit substances, or the quantities involved. He found that the concentration of methadone in Mr Forrester's blood sample was consistent with therapeutic levels.
65. Mr Forrester's family asked whether Mr Forrester might have been assaulted. The pathologist noted that fractures to Mr Forrester's ribs and sternum were consistent with injuries that can be sustained as a result of CPR attempts and there was no evidence of any recent physical assault, or that he had been forcefully given drugs.

## Findings

### Clinical care

66. Mr Forrester died just over 24 hours after arriving at Thameside. During his short time in custody he received initial and secondary health screens, opiate dependency assessments and several vital signs observations were recorded. Healthcare staff noted he was withdrawing from drugs and referred him for drug treatment.

### Clinical management of Mr Forrester's drug dependence

67. The clinical reviewers found that Mr Forrester's clinical management during the reception procedures and his methadone treatment the following day were "appropriate and logical" and in line with national guidelines. Notably, the prison GP decided not to prescribe methadone on the first night due to Mr Forrester's low pulse rate; and the next day, the non-medical prescriber acted with caution by prescribing a minimal dose of methadone and declining Mr Forrester's request for a higher dose.
68. The clinical reviewers concluded that Mr Forrester's clinical care before he was found unresponsive was equivalent to that he could have expected to receive in the community. However, they identified shortcomings in the management of the resuscitation attempt that are outlined below.

### Drug strategy and referral for psychosocial interventions

69. Thameside has a current Drug and Alcohol Strategy which sets out the policy and processes to manage substance misuse. It is reviewed annually, with the next review due in September 2020. The strategy is overseen at a monthly meeting, with representatives from departments across the prison as well as substance misuse service providers. The Director said that up to 80% of prisoners at Thameside stated they had substance misuse problems and that, over the past year, the prison had achieved a significant reduction in drug supply and demand.
70. The staff from Turning Point said that the referral forms for new prisoners are completed during induction on the day after their arrival and they are allocated a substance misuse key worker the following day. Mr Forrester died before his referral was processed.

### Reception security procedures

71. Paragraph 2.24 of Prison Service Instructions (PSI) 7/2016, Searching of the person, lists a mandatory requirement for prisoners to be given a full search on initial reception to prison, unless they have been transferred from another prison. The PSI also requires records to be kept of such searches, irrespective of whether any items are found.
72. Thameside receives and processes a high number of prisoners in reception and HM Chief Inspector of Prisons drew attention to this in the most recent inspection report.

The Director told the investigator that, as an example, there had been around 1700 movements through reception in May 2019. Anecdotally, an increasing number of recalled prisoners appear unwell when they arrive.

73. Mr Forrester went through the standard reception procedures. This is said to have included a full search of his body and clothing, to which staff had been asked to pay particular attention because of Mr Forrester's presentation and the concern that he might have concealed drugs.
74. An officer said that full searches are usually intelligence-led and conducted when there is reasonable suspicion that a prisoner is concealing drugs. He added that the PER should have triggered such a search, but the fact that a search had taken place would only be recorded if contraband had been found.
75. The investigation was unable to establish when Mr Forrester had taken the illicit drugs that led to his death. However, he had been recalled many times and would almost certainly have known that he would return to prison, having breached his licence conditions. With a previous history of concealing and taking drugs into prison, it is conceivable that he did so again, particularly as his cellmate suggested that Mr Forrester already had drugs when he joined him in the cell immediately after the reception process. Of course, it is also possible that he might have sourced drugs from others in reception and/or on the wing the following day.
76. We cannot be certain that Mr Forrester was given a full search, as directed, as no records were kept. Reception staff interviewed seem to be unaware that such a search is compulsory for new prisoners and that it must be recorded.
77. However, a full search will not necessarily find items that have been 'plugged' in a prisoner's rectum. Some prisons now use body scanners which can detect drugs hidden internally. Given the high turnover and the number of new arrivals going through reception at this prison, we consider that Thameside might benefit from a body scanner. We make the following recommendations:

**The Director should ensure that, on reception, new prisoners who have not transferred from another prison are given a full search and that the details and outcome are documented, in line with national policy.**

**The Director should assess the benefits of drug detection technology during the next review of the drug and alcohol strategy.**

## Emergency response

### Response to Mr Forrester's cellmate's calls for help

78. Mr Forrester's cellmate and two other prisoners told the investigator that there was a long delay before staff responded to his shouts for help when he saw that Mr Forrester was unresponsive. In addition, another prisoner told a prison psychologist that a female officer had been uncivil and had deliberately waited for a long time before going to the cell. As this prisoner did not raise it as a grievance, or ask for the information to be passed on, there appeared to be no ulterior motive and nothing to be gained by him mentioning it. This lends credibility to his account. The prisoners variously estimated the delay as between 10 to 45 minutes.

79. PCO A said that she went to the cell around four or five minutes after she first heard Mr Forrester's cellmate shouting. When pressed, she said that she could not immediately tell who was shouting and shouted back to find out. As she walked down the wing, she saw Mr Forrester's cellmate's hand waving through the observation hatch. She could not account for why it took her so long to go to the cell.
80. We understand that in traumatic situations, it is difficult to estimate the passage of time and that some accounts might have been exaggerated. We cannot say whether there was any malicious intent on the part of PCO A, and we cannot verify the allegations of incivility. However, the weight of evidence, not least from the officer's own account of events, suggests that she could have gone to the cell and responded to the cellmate's shouts for help sooner. We recommend:

**The Director should initiate an investigation into PCO A's conduct on 2 July 2019 with a view to considering whether disciplinary action is warranted.**

**The Director should ensure that prison staff respond appropriately and promptly when a prisoner summons help.**

81. At least two of the first three wing officers who went to the cell had been trained in basic life support, yet none of them attempted to move Mr Forrester from the top bunk and begin CPR. An officer who arrived from another wing on a different floor, was the first to assist a nurse, who was on his own in the cell. It is understandable that the officers wanted to lock up other prisoners, but we consider that, at the very least, a couple of them should have attempted to lay Mr Forrester on the floor and start CPR, or waited at the cell to assist healthcare staff in getting him down.
82. Following the investigation of a previous death at Thameside, we also found that the first two officers at the cell did not attempt resuscitation. It is unclear whether staff lack the confidence to do so, or do not see it as part of their role in an emergency. While there is no indication that the delay in starting CPR affected the outcome for Mr Forrester, failure to act quickly in a life-threatening situation could have serious consequences in future emergencies. We make the following recommendation:

**The Director should ensure that all prison staff are briefed about the importance of starting cardiopulmonary resuscitation as quickly as possible when a prisoner is unresponsive until medical staff arrive.**

### **Resuscitation attempt**

83. The clinical review report describes in detail the handling of the resuscitation procedures and the actions of the nurses, GP and paramedics involved.
84. The London Ambulance Service paramedics expressed concerns about the resuscitation attempts performed by the prison nurses, which they felt were "far from acceptable." They considered that the airway management was poor and the chest compressions were not deep enough. They, therefore, gave instructions on basic life support procedures, which the nurses had followed. They were also concerned about the leadership of the incident; treatment in a small cell with over six members of staff present; and that staff were unable to provide information, such as Mr Forrester's medical history and what had happened before they arrived.

The paramedics noted that before they left the prison, they had informed prison senior managers and healthcare directors of their “severe clinical concerns.”

85. Some of the nurses said they were unhappy with the manner of the ambulance crew. They had expected the paramedics to physically take charge when they first arrived, but around ten minutes had elapsed before they took over.
86. The clinical reviewers found that, in line with the policy of the healthcare provider, Oxleas, nurses had only received training in basic life support rather than the more usual immediate life support and they had acted within the scope of their training and competence at that time. Oxleas has since made changes, but some of the specifics are unclear.
87. A prison GP arrived at the cell just before the paramedics, but there is no record of any action or direction by him. At interview, he said that he had been trained in the use of airways. The clinical reviewers found that there is no policy setting out the expected role of a GP in an emergency in the prison.
88. The clinical reviewers concluded that, overall, the resuscitation attempt was not equivalent to that which Mr Forrester could have expected to receive in the community. They considered it lacked leadership and clear clinical direction and most of the staff involved did not have the level of training, or confidence, to deliver effective life support. They also suggested that the system for training and assessing the competence of the emergency response nurses might not be sufficiently robust.
89. However, the clinical reviewers were satisfied that the shortcomings identified did not adversely affect the outcome for Mr Forrester, as it was likely that he had stopped breathing up to two hours before he was found. We agree with their findings and make the following recommendations:

**The Head of Healthcare should ensure that staff receive clear guidance and sufficient training to deal effectively with an emergency, including:**

- **Management and leadership training for staff expected to lead in an emergency and a test of competence before they do so.**
- **Establishing that all staff are aware of their roles and how to perform tasks assigned to them.**
- **Training in the use of airways.**
- **The information to be gathered for the ambulance service.**
- **The role of the prison GP in the event of an emergency.**

90. The clinical reviewers made additional, wide-ranging recommendations, which we have not repeated here as they are not directly linked to Mr Forrester’s death. However, the Head of Healthcare will wish to consider them.

## **Prisoners’ use of cell call bells**

91. We are concerned that there is a lack of clarity about use of the cell call bell at Thameside. (The bell does not sound in the wing, it goes to staff in a central hub,

who then alert wing staff.) A prisoner said that the rules about use of the bell were not explained to prisoners:

“...in my opinion, the emergency cell bell is there as an emergency, but...if you can't raise attention of the staff by banging and shouting, how else are you meant to do it? ... in a sense they've been told, 'You carry on pressing that cell bell, you know, you're going to be on basic'...”

92. An officer said the cell bell was only for medical emergencies and an officer said:

“... they will press it if they want an extra break, which obviously we discourage as much as we can, but I'd say it's more emergencies or if let's say if they are behind the door or anything, they should be in court or something, that's also acceptable. But yeah generally, emergencies is what it's used for... a lot of the time they'll just, they will shout out the flaps.”

93. PSI 17/2012, Certified prisoner accommodation, says that “all prisoners must have the means to summon assistance when necessary” and that “each cell must provide prisoners with a cell call system or other effective means of communication with staff. It also says that “cell call systems must provide both a visual and an audible means of alert”.

94. In this instance, Mr Forrester's cellmate should clearly have used his cell bell, but he did not. (He was released a few days after Mr Forrester's death, so we were unable to clarify this and some other issues with him.) Both staff and prisoners emphasised that the bell is for emergencies only and a prisoner suggested that in his view prisoners were sometimes unfairly penalised if staff considered they had used it inappropriately or too frequently. No one could clearly explain how prisoners were expected to attract the attention of staff for routine requests if the cell bell is strictly to be used for emergencies, or what constitutes an emergency. We make the following recommendation:

**The Director should ensure that:**

- **staff and prisoners understand the policy on the use of cell bells; and**
- **there is an effective system for prisoners to communicate any needs to staff when they are locked in their cells.**

## **Support for staff**

95. PSI 64/2011 requires prisons to hold a 'hot debrief' after all deaths in custody. This should be led by a senior manager and all staff directly involved in the incident, including healthcare staff, should be invited. The instruction also sets out the expectation that prisoners should be offered support.

96. A debrief was held after the emergency with staff. However, most of the attendees appear not to have been directly involved in the incident. Of the seven who attended, three were assistant directors and one was a custodial operations manager. With the exception of an officer, the roles of the others were unclear as they were not mentioned in the incident log or any of the other documents submitted to the investigation. Healthcare staff held a separate debrief.

97. Neither the second officer to arrive at the cell, nor the officer who came down from upstairs and helped the nurse to lift Mr Forrester down from the top bunk, were invited to the debrief, nor offered support for several days. The officer who helped the nurse said a member of the chaplaincy called him around a week later, as no one had remembered that he was involved. The other officer said he received a call from the chaplaincy a few days after the incident, but he was still unsure how to access support if he needed it.
98. We have previously drawn attention to the importance of debriefs and access to structured support after deaths or serious incidents at Thameside. We make a further recommendation on this issue:

**The Director should ensure that the names of all staff involved in a critical incident are recorded and that, in line with national policy, staff are offered appropriate and timely support after a serious incident or a death in custody.**

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