Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Rawlinson, a prisoner at HMP Forest Bank, on 29 January 2017

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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.

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 Darren Rawlinson was found dead in his cell at HMP Forest Bank on the morning of 29 January 2017. He had died of bronchopneumonia as a result of drug use. Mr Rawlinson was 38 years old. I offer my condolences to Mr Rawlinson's family and friends.

Mr Rawlinson was recalled to prison in April 2016. He had a history of drug misuse and mental health issues and in October he moved to the prison's drug recovery unit. He hoped to complete his recovery programme before his release in February 2017 but was struggling to do so and bought drugs from other prisoners. When prison officers unlocked his cell on the morning of 29 January, they were unable to elicit a response and called an emergency. Nursing staff attended but were unable to revive Mr Rawlinson.

It is of concern that Mr Rawlinson's mental health referral was not pursued and the investigation found a lack of effective communication between the drug recovery team and the security department. It is regrettable that when prison officers found Mr Rawlinson unresponsive, they placed him in the recovery position and did not begin attempts to revive him.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **October 2017**

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Summary

Events

1. Mr Rawlinson arrived at HMP Forest Bank on 27 April 2016 after his licence was revoked. He had a history of drug use and mental health concerns and began to work with the drug recovery team who referred him to the mental health team. The referral was not followed up. He was placed on a methadone treatment programme but found it difficult to reduce his intake. In October he applied to move to the prison's detoxification wing.

2. In December the Parole Board told Mr Rawlinson that he would be released to a Probation Service Approved Premises in February. At the end of the month, Mr Rawlinson told a prison doctor that he was due to be released soon and wanted to accelerate ending his methadone programme. The doctor changed his prescription.

3. Acting on intelligence that Mr Rawlinson was bringing drugs onto the wing, on 29 November, staff found some tablets in his cell. Intelligence continued to indicate that Mr Rawlinson was bringing drugs onto the wing. On 10 January he was taken off the drug treatment Reduction and Motivational Programme. He told staff that he was struggling with his detoxification programme and that he was using illicit drugs. On 16 January he failed a drug test. A doctor reintroduced methadone.

4. On 28 January, when Mr Rawlinson returned to the wing from work, he appeared drowsy. A nurse, who was asked to speak to him, reported that he looked tired, but Mr Rawlinson denied taking any illicit substances and said his tiredness was a side-effect of his medication. The nurse did not think he displayed signs of drug use and saw no reason to be concerned.

5. Staff locked prisoners into their cells from 5.00pm. A prison officer checked on Mr Rawlinson twice. On the first occasion, the officer reported that he was awake and well; on the second time that he was asleep although she noted movement. The night officer was informed that Mr Rawlinson had been suspected of taking something. She therefore checked on him during the night when passing his cell, pausing to note that he was breathing. CCTV footage shows her doing so on several occasions.

6. When prison officers began to unlock prisoners at 8.00am, they were unable to elicit a response from Mr Rawlinson. Officers called an emergency code and placed him in the recovery position. Nurses attended and provided first aid, until joined by ambulance paramedics. The paramedics were unable to revive him.

After Mr Rawlinson's death

7. When prison staff cleared Mr Rawlinson's cell, they found three wraps of a green substance. Tests showed these to be a synthetic cannabinoid, a New Psychoactive Substance (or NPS), sometimes known as 'spice'.

Post-mortem report

8. The post-mortem report showed that Mr Rawlinson died of bronchopneumonia, further to multiple drug toxicity. Toxicology reports showed the presence of a number of drugs in Mr Rawlinson's system, not all of which had been prescribed.

Findings

Risk assessments

9. Mr Rawlinson admitted to various people that he had been taking illicit drugs. He failed a drug test. Intelligence reports indicated that he was involved in the drug culture on the Eden Unit. After Mr Rawlinson died, drugs were found hidden in his cell. Healthcare, recovery and security staff were insufficiently inter-connected, with the result that the full picture of Mr Rawlinson's involvement with drugs in the prison was not clear.

Healthcare

10. Mr Rawlinson did not have any physical health concerns during his time in Forest Bank. The clinical reviewer noted that his substance misuse management was good. He was referred for a mental health assessment, but this was not followed up and does not appear to have taken place. Although Mr Rawlinson suffered from ongoing mental health concerns, while at Forest Bank only his addiction was addressed.

28-29 January

11. When Mr Rawlinson was suspected of being under the influence of an illicit substance on 28 January, he was assessed by a nurse. Prison officers checked on him throughout the evening and night. No record was kept of any concerns, however, and no contingency plans were put in place.

Emergency response

12. When prison officers found Mr Rawlinson, they immediately called the appropriate emergency code. Other staff, including healthcare, responded quickly and the logs show that an ambulance was called without delay. The logs have been altered, but from comparison with statements and Ambulance Service records, the corrected times seem to be accurate. The clinical reviewer noted that the emergency medical response was appropriate.

13. When the prison officers found Mr Rawlinson, he had no pulse, but nobody checked his breathing. Even so, staff put him into the recovery position, and attempts at resuscitation did not begin until a nurse arrived.

Recommendations

- The Director and Head of Healthcare should remind staff to submit intelligence reports for all concerns relating to the suspected misuse of prescribed and non-prescribed drugs so that appropriate action can be taken.

- The Director and Head of Healthcare should remind staff of the importance of making proper records of any concerns about prisoners.

- The Director should remind staff that documentary evidence should not be altered. Any errors should be clarified separately.

- The Director should ensure that staff who have contact with prisoners are aware that the recovery position is only appropriate for prisoners who are unconscious but breathing. Cardiopulmonary resuscitation should be delivered when a prisoner is unconscious and not breathing.

The Investigation Process

14. 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 him. One prisoner asked to see him.

15. The investigator visited Forest Bank on 8 February 2017. He obtained copies of relevant extracts from Mr Rawlinson's prison and medical records.

16. The investigator interviewed seven members of staff and three prisoners.

17. NHS England commissioned a clinical reviewer to review Mr Rawlinson's clinical care at the prison. The clinical reviewer joined the investigator for interviews of healthcare staff.

18. We informed HM Coroner for Greater Manchester West of the investigation. She sent us the results of the post-mortem examination and we have given the Coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Rawlinson's mother, to explain the investigation and to ask whether she had any matters they wanted the investigation to consider. Mr Rawlinson's mother asked whether access to healthcare had had any bearing on his death.

20. Mr Rawlinson's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Forest Bank

21. Forest Bank is a local prison in Salford, serving courts in the North West. It holds 1,460 remanded and sentenced men. The prison is managed by Sodexo Justice Services. Sodexo provides primary health care services. G1 wing, or the Eden Unit, is the prison's voluntary recovery unit for prisoners with substance misuse issues.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Forest Bank was in February 2016. Inspectors reported that the prison was well led with a focus on improvement. Drugs, however, were easily available. The substance misuse strategy was well managed and prisoners with substance misuse issues could access a wide range of recovery-focused interventions.

Independent Monitoring Board

23. 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 31 October 2016, the IMB reported that Forest Bank was a well-performing prison. Challenges arose from a growing number of incidents of violence, possibly linked to the increased usage of New Psychoactive Substances (or NPS, drugs formerly known as legal highs).

Previous deaths at HMP Forest Bank

24. Mr Rawlinson was the third prisoner to die at Forest Bank since the beginning of 2016. There are no significant similarities between his and the previous deaths.

New Psychoactive Substances (NPS)

25. NPS, described in the Psychoactive Substances Act 2016, are an increasing 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 NPS 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.

26. In July 2015, we published a Learning Lessons Bulletin about the use of 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 NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

27. Her Majesty's 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. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

28. Mr Rawlinson had been released from prison on licence on 26 April 2016, but his licence was revoked the following day and he was taken to Forest Bank. He had a history of drug use, and intelligence indicated his previous involvement in the prison drug culture. He also had a history of mental health concerns. A nurse conducted a reception health screening, and no physical health concerns were identified.

29. Mr Rawlinson was working with the drug recovery team. A drug recovery worker referred him to the mental health team on 4 May 2016, but there is no further information to suggest that this was followed up.

30. Mr Rawlinson was assessed as being a high risk for sharing, so had been placed in a single cell. Notes on his prison record indicate that he was quiet and compliant with the prison regime. Although he said that he was keen to work with drug recovery services and was on a methadone treatment programme, he initially found it difficult to engage in reducing his methadone prescription. In October, however, he seemed to undergo a change in motivation. He applied to move to the Eden Unit, the prison's detoxification wing, where he would be able to progress with his recovery programme. On 18 October he began to reduce his methadone prescription by 5mls per week.

31. After being recalled, Mr Rawlinson had been reluctant to engage with probation services, attaching to them a degree of blame for his recall. His offender supervisor in prison had made appointments that Mr Rawlinson did not attend. When he did not attend a scheduled meeting on 4 November, his offender supervisor went to see him. He explained that he ought to engage as he had a parole hearing approaching. Mr Rawlinson therefore began to discuss arrangements for his eventual release.

32. By 8 November 2016, Mr Rawlinson had reduced his methadone prescription to 20mls per week. The rate of reduction was slowed to a further reduction of 2mls per week.

33. Mr Rawlinson worked in the kitchens. Although reports showed a positive attitude to his work, intelligence indicated that he and another prisoner were bringing illicit substances back from work. During a cell search on 29 November prison staff found some tablets in his cell and he was given an official warning.

34. On 13 December, Mr Rawlinson agreed to continue reducing his methadone until his prescription reached 2mls per week.

35. On 19 December, the Parole Board notified Mr Rawlinson that they had recommended he be released to a Probation Service Approved Premises on 6 February. The following day, his offender supervisor told Mr Rawlinson that the Board had amended this date to 13 February because of the availability of places in the hostel. Mr Rawlinson accepted the change because he wanted to go to a specific hostel.

36. On 28 December, Mr Rawlinson asked to see a prison GP. He said that he was having trouble with the slow rate of his methadone reduction. He was due to be released six weeks later, and wanted to be clean of methadone by that time. The

doctor ended his methadone and prescribed lofexidine - medication that reduces the symptoms of drug withdrawal while detoxifying.

37. Intelligence reports from late December and early January indicated that prisoners, including Mr Rawlinson, were bringing drugs back to the Eden Unit from their places of work, or not taking their medication but selling it on. On 10 January, Mr Rawlinson was taken off the drug treatment Reduction and Motivational Programme. The programme leader said that his constant negativity was having a detrimental effect on the group, and that he was not showing the level of motivation expected of prisoners on the Eden Unit.

38. On 11 January, Mr Rawlinson told a Healthcare Assistant (HCA) and the Deputy Recovery Lead that he was struggling with his detoxification programme. On 13 January, he told a member of the Independent Monitoring Board that he was using as much illicit subutex as possible as he approached the end of his sentence. Later that day, Mr Rawlinson met his offender manager and his offender supervisor to discuss his release and licence conditions. His offender manager told him that he would live at an approved premises in Bury, but Mr Rawlinson said that he had problems with some people in that area. She said she would change the allocation.

39. On 16 January, Mr Rawlinson told a HCA that he was anxious at the prospect of release and had been buying subutex on the wing. A drug test confirmed the presence of subutex in Mr Rawlinson's system. Mr Rawlinson told a prison GP that he wanted to go back on methadone. He said he was due for release in four weeks' time and did not feel that he could abstain from drugs. The GP put Mr Rawlinson back on a prescription for methadone.

40. On 28 January, Mr Rawlinson was working in the kitchen. At 2.30pm, he went to get his medication then returned to work. At 4.30pm, as he was eating his dinner, the kitchen supervisor noticed that he appeared very drowsy. He asked Mr Rawlinson what was wrong, and Mr Rawlinson said that his medication had made him tired. The supervisor said it was not safe to work in the kitchen if he felt so tired, so told him to go back to his wing. Shortly before 5.00pm, Mr Rawlinson arrived back on the Eden Unit. An officer spoke to him and thought he appeared drowsy. She asked him if he was feeling alright and whether he had taken anything he should not have taken. He denied taking anything illicitly but said he was on some quite strong prescribed medication. She asked a nurse if she would check him. The nurse saw that he looked tired and asked him if he was okay. Mr Rawlinson told her that he was back on a prescription of methadone and, with his other medication, this was making him tired. He denied taking anything he should not have taken. She did not think he was exhibiting signs of drug use and saw no reason to be concerned. Mr Rawlinson said that he was going to go to bed soon. The nurse told two officers that Mr Rawlinson was fine and that she would see him again the following morning and refer him to the doctor for a medication review. One officer asked the nurse if she needed to complete a Prison Service Injury to Inmate form and was told not.

41. Prisoners were associating on the wing until, at approximately 5.00pm, staff began to return them to their cells. At 5.07pm, Mr Rawlinson's door was locked.

42. Officer A said in interview that after prisoners had been locked away at 5.15pm, she twice went to Mr Rawlinson's cell to check on him. The first time she asked him if

he was alright and he said that he was. The second time was shortly before she finished her shift at 7.45pm. He was asleep, so she made a noise and noted that he moved in response.

43. The prisoners housed either side of Mr Rawlinson's cell both told the investigator that they did not hear anything from Mr Rawlinson's cell during the night. The night officer on the Eden Unit came on duty at approximately 8.00pm. Although there was nothing noted in the wing observation book, Officer A told her that there were suspicions that Mr Rawlinson might have taken an illicit substance. The night manager therefore went to check on Mr Rawlinson. The light in his cell was on, and he was sitting on a chair beside the bed, where he had fallen asleep sideways onto the bed, facing the door. She noted that he was breathing and saw no reason to be concerned so left him to sleep. When conducting a roll count at approximately 10.00pm, she checked Mr Rawlinson again. He was still asleep and, again, she noted that he was breathing. She checked on him on further occasions during the night, not noting any reason for concern. CCTV footage showed that when conducting the roll count at 5.14am, she paused outside Mr Rawlinson's cell for a minute. She said in interview that she was again checking his breathing, and that she could hear him snoring. He was seated in the same position, but his arms had moved. Before going off duty at 6.00am, she checked Mr Rawlinson once more, and again noted his chest moving and heard him breathing.

44. At 8.00am, officers began to unlock prisoners and at 8.06am Officer B reached Mr Rawlinson's cell. He saw Mr Rawlinson slumped across his bed. He appeared to have something in his mouth. CCTV footage shows that Officer B looked through the observation panel for about 20 seconds before Officer A joined him, and 15 seconds later they opened the cell door. Officer B said he called to Mr Rawlinson but could not get a response. Officer A used her radio to call a code blue emergency. (A code blue indicates a prisoner who is unconscious or having difficulty breathing.) Officer B checked Mr Rawlinson for a pulse but was unable to find one. A Senior Prison Custody Officer had responded to the emergency call and, together, they moved Mr Rawlinson to the floor and placed him in the recovery position. As they did so, some liquid came out of Mr Rawlinson's mouth.

45. A Senior Prison Custody Officer who that day was orderly officer (responsible for the day to day running of the prison) responded to the emergency call and arrived on the Eden Unit at the same time as a nurse. He sent a radio message for all available nursing staff to attend the Eden Unit. The control room log showed that the code blue call, his radio call, and the control room call to the ambulance service were all made at 8.06am. The patient assessment records also showed that nursing staff arrived at 8.06am. The nurse assessed Mr Rawlinson and found that he was not breathing. Staff began to perform cardiopulmonary resuscitation (CPR) to try to revive him. They continued to do so until ambulance paramedic staff arrived at 8.23am and took over medical care. At 8.51am Mr Rawlinson was pronounced dead.

Contact with Mr Rawlinson's family

46. One of the prison's chaplains was appointed as family liaison officer. He identified Mr Rawlinson's mother as his next of kin, and travelled to her home to inform her of

Mr Rawlinson's death that morning. In line with Prison Service policy, Forest Bank contributed to the costs of Mr Rawlinson's funeral.

Support for prisoners and staff

47. After Mr Rawlinson's death, one of the prison's managers 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.

48. The prison posted notices informing other prisoners of Mr Rawlinson's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Rawlinson's death.

After Mr Rawlinson's death

49. When prison staff cleared Mr Rawlinson's cell, they found three wraps of a green substance. Tests showed these to be a synthetic cannabinoid, a New Psychoactive Substance (NPS) sometimes known as 'Spice'.

Post-mortem report

50. The post-mortem report showed that Mr Rawlinson died of bronchopneumonia, further to multiple drug toxicity. Toxicology reports showed the presence of a number of drugs in Mr Rawlinson's system, not all of which had been prescribed to him.

Findings

Risk assessments

51. There were no mentions of Mr Rawlinson in the wing observation book after the new book was opened on 12 January. Mr Rawlinson did not use his cell call bell after 19 January. There were no indications that Mr Rawlinson was being bullied or in debt, and none of the prisoners the investigator spoke to had seen anything to indicate this. Although he had been managed under Prison Service measures to support prisoners at risk of self-harm in the past, there had been no concerns that he was a risk to himself since he arrived at Forest Bank.

52. Prisoners on the Eden Unit, a drug recovery unit, are subject to voluntary drug tests. If a prisoner fails two tests, then the assumption is made that he is not committed to his recovery and consideration will be given to removing him from the unit.

53. Mr Rawlinson admitted to a member of the IMB, a healthcare assistant and a doctor that he had been taking illicit drugs. Prisoners on the Eden Unit told the investigator that Mr Rawlinson used drugs. He had been trading tobacco in exchange for medication from two other prisoners on the Eden Unit and, after his death, NPS was found hidden in clothing in his cell.

54. We are concerned that there is insufficient co-ordination between the recovery team and the security team. Mr Rawlinson, by his own admission, was using illicit drugs from mid-December to mid-January. There was intelligence to suggest that Mr Rawlinson was trading drugs, and prisoners said that they were fairly certain that he was taking substances that were not prescribed to him. IMB records show that he failed a drug test on 7 January, but custody records indicate that this was not the case.

55. Despite this, it appears that Mr Rawlinson was only subject to a drug test while on the Eden Unit on one occasion, and how that information was disseminated is unclear. A full picture must be available to allow the security department and others to properly assess and understand the issues raised. We make the following recommendation:

    The Director and Head of Healthcare should remind staff to submit intelligence reports for all concerns relating to the suspected misuse of prescribed and non-prescribed drugs so that appropriate action can be taken.

Healthcare

56. On admission to HMP Forest Bank, Mr Rawlinson was not identified as having any physical health concerns. Despite having previously been diagnosed with a personality disorder and being reviewed by a mental health nurse on reception, Mr Rawlinson did not have any mental health referral. A prison doctor re-prescribed his mental health medication and listed him for a mental health review. His recovery worker also said that she would refer him to the mental health team. There is, however, no indication that Mr Rawlinson had any further mental health input during his time in Forest Bank. During that time he did not exhibit any signs of

being in mental health crisis; had he done so it is likely that the oversight would have been identified and addressed. It is of concern that the referral was missed, but as it was nine months before Mr Rawlinson died and there were no indications of serious mental health issues in the meantime, we do not make a recommendation on this occasion.

57. The clinical reviewer concluded that Mr Rawlinson suffered from ongoing mental health concerns, in addition to his addiction, but while at Forest Bank only his addiction was addressed. She also noted that he did not have a medication review during his time there and was not consulted about the reduction of his medication. While his substance misuse management appears to have been good, with frequent interaction with healthcare staff, the documentation relating to his monitoring was less so. The clinical reviewer concludes that because of this, the healthcare given to Mr Rawlinson was not equivalent to that which he could have expected in the community.

Evening and night of 28-29 January

58. On 28 January Mr Rawlinson was at work in the kitchen. The investigator asked to interview the kitchen supervisor, but he did not respond to attempts to contact him. Some prisoners said that when Mr Rawlinson arrived back on the Eden Unit from the kitchens, he was staggering and falling and was clearly under the influence of an illicit substance. CCTV footage does not support this account, nor does the testimony of the prison officers on the wing. They were, though, concerned that Mr Rawlinson looked drowsy and asked a nurse to assess him. She did so, and was also not overly concerned at his presentation. She told the officers that she would check on him the following morning. An officer asked if she needed to complete an Injury to Prisoner form and was told that this was not necessary. After this, Officer A checked on Mr Rawlinson at least twice, and briefed the night officer when handing over to her.

59. Staff acted reasonably in concluding that Mr Rawlinson was not in any imminent danger and acted appropriately in addressing the concerns which they had. However, there is little written evidence to reflect those concerns, the consideration staff gave and the actions they took. A nurse visually assessed Mr Rawlinson but did not give him a more comprehensive assessment. She did not note her assessment on Mr Rawlinson's medical record. Neither she nor officers noted their concerns on his prison record in the wing observation book.

60. The clinical reviewer noted that healthcare staff should be reminded of the importance of documenting clinical interactions with prisoners in their records. We agree, and are disappointed not to have seen any reference to a need to check on Mr Rawlinson in the wing observation book. It is noteworthy that both Officer A and the night officer did check on him. And, from the night officer's observations, he was still alive when she conducted her last check at 6.00am. When Officer B felt Mr Rawlinson's neck for a pulse, he noted that he was not cold. It is therefore unlikely that the absent documentation made any difference to the outcome. However, we make the following recommendation:

The Director and Head of Healthcare should remind staff of the importance of making proper records of any concerns about prisoners.

61. The clinical reviewer identified a number of issues which the Head of Healthcare should address.

Emergency response

62. When Officers A and B unlocked Mr Rawlinson's cell with concerns, they immediately called the appropriate response. Other staff, including healthcare, responded quickly and the clinical reviewer noted that the emergency medical response was appropriate. The control room logs show that an ambulance was called without delay. The times on the control room log for the emergency call, the call for nursing staff, and the time that the ambulance was requested have all been altered from their original times and overwritten to make them all show the same time, 8.06am. Northwest Ambulance Service, however, has confirmed that the call for the ambulance was received at 8.06am, so it would appear that this was simply a correction of an error. We nevertheless make the following recommendation:

    The Director should remind staff that documentary evidence should not be altered. Any errors should be clarified separately.

63. When the prison officers found Mr Rawlinson, Officer B noted that he had no pulse. They did not check whether he was breathing, but placed him in the recovery position. While we appreciate that prison discipline staff are not healthcare professionals, this is not an appropriate response in the circumstances.

    The Director should ensure that staff who have contact with prisoners are aware that the recovery position is only appropriate for prisoners who are unconscious but breathing. Cardiopulmonary resuscitation should be delivered when a prisoner is unconscious and not breathing.

Inquest

64. The inquest into Mr Rawlinson's death concluded on 26 April 2023. The conclusion was that Mr Rawlinson died from Bronchopneumonia, which he was predisposed to by the combined effect of prescribed medication and his use of non-prescribed (illicit) medication.

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Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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T l 020 7633 4100