

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bradley Sprackling, a prisoner at HMP Forest Bank, on 27 March 2021

A report by the Prisons and Probation Ombudsman

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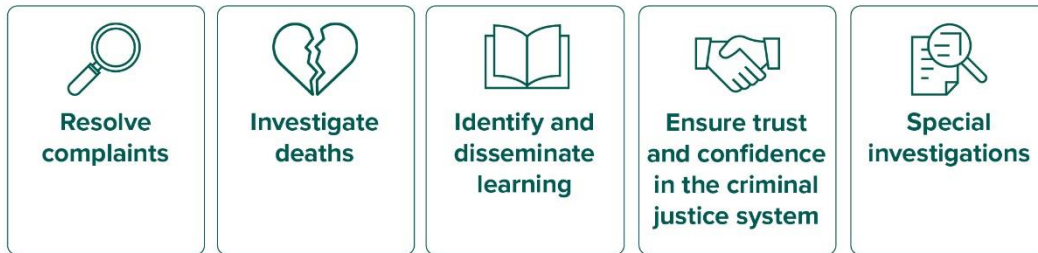
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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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 Bradley Sprackling died at HMP Forest Bank on 27 March 2021. The cause of his death was drug toxicity from a combination of cocaine and prescription medication. He was 36 years old. I offer my condolences to Mr Sprackling's family and friends.

Mr Sprackling received a good standard of clinical care, equivalent to that he could have expected to receive in the community. He also received consistent clinical and psychosocial support to help address his substance misuse issues. However, it is of concern that he was able to obtain illicit drugs and prescription-only medication and that information about a suspicious substance found in his cell was not shared with the substance misuse service. It is also unclear why the intended suspension of his job for possessing contraband was not enforced.

I am also concerned that there were significant gaps in conducting welfare checks. Mr Sprackling does not appear to have received the weekly well-being checks, which were in place to help prisoners cope with the COVID-19 regime restrictions. In addition, on the morning of his death, the officer who unlocked Mr Sprackling's cell did not check that he was alive and well, and his failure to report for work appears to have gone unnoticed. Mr Sprackling was found unresponsive almost two hours later when other prisoners became concerned and alerted staff. In spite of the Director's positive response and fresh guidance after I raised this issue in a previous investigation, this investigation identified a similar failing and further action is needed to ensure staff understand the importance of such checks.

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

May 2022

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Summary

Events

1. Mr Bradley Sprackling had been at HMP Forest Bank since 28 August 2020, serving a two-year prison sentence for assault, affray and damaging property.
2. Mr Sprackling had a history of alcohol and drug misuse. At Forest Bank, he engaged with the clinical and psychosocial substance misuse teams and received timely and regular support, with repeated advice on risks and harm minimisation. Mr Sprackling insisted throughout that he was not using illicit drugs.
3. Targeted searches of Mr Sprackling's cell, in January and March 2021, led to disciplinary charges for possession of a mobile phone, SIM cards and a green plant-like substance suspected to be drugs. (The latter charge was dropped due to an administrative error.) One of the intended penalties, suspension from his job as a prison orderly, was not enforced.
4. At around 8.00am on 27 March, a prison custody officer (PCO) unlocked Mr Sprackling's cell door so that he could go to work. Mr Sprackling did not leave the cell and prisoners who checked on him assumed he was still asleep. Just before 10.00am, his friends became concerned and alerted a PCO, who went into the cell and found him unresponsive. A medical emergency was then called. A nurse examined Mr Sprackling and found extensive rigor mortis, suggesting that he had been dead for some time. As there were clear signs of death, resuscitation was not attempted.
5. A post-mortem examination indicated that Mr Sprackling had died from mixed drug toxicity, a combination of cocaine and six prescription-only medications.

Findings

6. We agree with the clinical reviewer's conclusion that Mr Sprackling received a good standard of clinical care and substance misuse support, equivalent to that he could have expected to receive in the community.
7. Only two of the drugs found in Mr Sprackling's system had been prescribed to him. Given the range of substances he was able to obtain, we consider that Forest Bank needs to do more to prevent the trading of illicit drugs and diverted medication.
8. Operational staff took action after finding contraband in Mr Sprackling's cell, but they did not share with the substance misuse service that they had found a substance suspected to be drugs. Such information might have been helpful to his recovery worker, particularly as Mr Sprackling had persistently denied that he was using illicit drugs.
9. There is no record of the reason why staff decided not to enforce the suspension of Mr Sprackling's job after illicit items were found in his cell.
10. Forest Bank had a local policy to provide weekly, documented COVID-19 well-being checks, to help mitigate the adverse impact on prisoners of restricted regimes during the pandemic. Although Mr Sprackling received checks after specific events,

such as court hearings, there is no evidence in his record of any weekly welfare checks.

11. The PCO who unlocked Mr Sprackling's cell on the morning of his death did not comply with the mandatory requirement to conduct a welfare check, and staff seemed to be unaware that he had failed to report for work. Almost two hours passed before he was found dead.
12. After receiving a medical emergency response code, staff in the communications room did not automatically contact the ambulance service. They waited for a PCO to confirm that an ambulance was required. Although the delay of three minutes did not impact on the outcome for Mr Sprackling, it could be critical in a future emergency.

Recommendations

- The Director and Head of Healthcare should ensure that there are effective processes in place to reduce the availability and use of illicit drugs, including diverted medication.
- The Director should ensure that relevant security information about individual prisoners and links to substance misuse is shared appropriately with the substance misuse teams.
- The Director should ensure that all decisions on disciplinary action and punishments are fully documented.
- The Director should ensure that staff conduct and document weekly well-being checks for all prisoners, in line with the local protocol and relevant national guidance.
- The Director should ensure that when a cell door is unlocked, staff satisfy themselves of the well-being of the prisoner and that there are no immediate issues that need attention. Staff should be reminded of the importance of such checks.
- The Director should ensure that staff in the communications room request an ambulance immediately when a medical emergency code is called.

The Investigation Process

13. Notices were issued to staff and prisoners at HMP Forest Bank informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Sprackling's prison and medical records.
15. NHS England commissioned an independent clinical reviewer to review Mr Sprackling's clinical care at the prison.
16. The investigator and clinical reviewer jointly interviewed four members of healthcare staff on 20 and 22 September 2021. The interviews were conducted by telephone because of the COVID-19 restrictions in place.
17. We informed HM Coroner for Greater Manchester West District of the investigation. The coroner gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
18. The Ombudsman's family liaison officer contacted Mr Sprackling's next of kin, his mother, to explain the investigation. Mr Sprackling's mother had no specific matters for the investigation to consider.
19. We sent a copy of our initial report to Mr Sprackling's mother. A solicitor acting on her behalf confirmed they found no factual inaccuracies.
20. We shared the report with HM Prison and Probation Service. They found no factual inaccuracies and accepted our recommendations.

Background Information

HMP Forest Bank

21. HMP Forest Bank is a local prison in Salford, serving courts in north-west England. It holds 1,460 remanded and sentenced men. The prison is managed by Sodexo Justice Services, who also provide primary health care services, as well clinical and psychosocial substance misuse care.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Forest Bank was in May 2019. Inspectors noted that health services had improved since the last inspection, with evidence of learning from deaths in custody and serious untoward incidents.
23. Inspectors found that security arrangements were well managed and drug supply reduction measures were broadly effective. Although many prisoners suggested it was easy to obtain illicit drugs, positive mandatory drug tests were around 15% lower than at most comparable prisons. Substance misuse services were very good and there was effective multi-agency working and information sharing between the substance misuse team, healthcare department and the prison.

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 October 2020, the IMB reported that due to the COVID-19 pandemic, the substance misuse team mainly focussed on initial assessments and release planning. However, existing clients continued to receive one to one reviews or telephone welfare checks. There had been an increase in contraband thrown into the exercise yard, as visits had been restricted.

Previous deaths at HMP Forest Bank

25. Mr Sprackling was the sixth prisoner at Forest Bank to die since March 2019. Three of the previous deaths were due to natural causes, one was self-inflicted, and one has yet to be classified. There have since been four deaths, three from natural causes and one self-inflicted. We have previously raised with Forest Bank the importance of checking the welfare of prisoners when unlocking cells and the need to comply with emergency response procedures. It is disappointing that we must do so again.

Key Events

26. Mr Bradley Sprackling was remanded to HMP Forest Bank on 28 August 2020. It was not his first time in prison. (He was later convicted of assault, affray and damaging property and sentenced to two years imprisonment.)
27. At an initial health screen, a nurse noted that Mr Sprackling's physical health problems included sciatica and a leg injury. He also had mental health problems, including anxiety and depression. She sent a routine referral to the mental health team, but there is no evidence that Mr Sprackling was seen as a result of this.
28. Mr Sprackling had a history of alcohol and crack cocaine misuse. He reported drinking two bottles of spirits and four bottles of wine daily, as well as smoking up to £500 of crack cocaine. Mr Sprackling was placed on an alcohol detoxification regime; a substance misuse management plan was created; and he was referred to the substance misuse service. A secondary health screen was completed on 29 August.
29. Mr Sprackling lived on the recovery wing which supports prisoners with detoxification, stabilisation and abstinence.
30. At a substance misuse assessment on 3 September, Mr Sprackling said that his main concern was alcoholism. Key workers from both the clinical substance misuse team and the psychosocial substance misuse service were allocated to him for support. Over the following months he had several one to one sessions, in which he received advice on relapse prevention, overdose awareness and harm reduction. He also requested and completed in-cell workbooks. Mr Sprackling appeared to engage positively with the teams and repeatedly said that he was not using illicit drugs.

2021

31. The prison key work scheme had been suspended for all but priority prisoner groups (such as those at risk of suicide or self-harm) after confirmation of the COVID-10 pandemic in March 2020. The prison reintroduced the scheme on a limited basis of one session per month and Mr Sprackling was allocated a key worker in January 2021. She unsuccessfully tried to contact him on his in-cell telephone on 7 January.
32. On 18 January 2021, a security intelligence report indicated that a financial transaction between another prisoner and Mr Sprackling might be linked to drug dealing. The next day, officers searched his cell and found two SIM cards and a wrap of "green veg matter". (Possession of mobile phones in prison is illegal and often linked to drug dealing.)
33. Mr Sprackling was noted to have been removed from his job. The charge relating to the SIM cards was proved at a disciplinary hearing on 21 January and the penalty was the temporary loss of several privileges. Prison managers did not proceed with the charge on the green substance found, as the date of the charge had been incorrectly entered as '2012' rather than '2021' and the proceedings were therefore considered to be flawed.

34. On 3 February, Mr Sprackling and his prison key worker had their first meeting (by in-cell telephone). They discussed the regime, Mr Sprackling's well-being and the importance of maintaining family connections during the restrictions caused by the COVID-19 pandemic.
35. At a substance misuse monitoring session on 25 February, Mr Sprackling maintained that he had not used illicit substances, although he admitted he had been tempted and had resisted the offer of pregabalin on the wing. The recovery worker warned him about the consequences of using medication that had not been prescribed to him. At a further meeting on 8 March, Mr Sprackling said he had "absolutely no desire" to return to illicit drug use.
36. Mr Sprackling's last substance misuse meeting before his death, was on 21 March. His key concern was that the pain relief prescribed for sciatica was ineffective, so the recovery worker referred him to the prison GP for review.
37. On 22 March, a conversation during a monitored telephone call led to suspicion that Mr Sprackling had a mobile phone. Officers conducted a cell search the same day, and a phone was found. Mr Sprackling was nominally suspended from his job as a prison orderly and given a warning under the incentives policy. He was also placed on report, but he died before the adjudication hearing took place.

Events of 26/27 March

38. The last time Mr Sprackling was known to be alive was between 7.00pm and 8.30pm on 26 March, when two prisoners, in neighbouring and opposite cells respectively, spoke to him through their doors. The PCO who conducted the night and early morning roll checks (count of prisoners) signed to confirm they were satisfied that all prisoners were alive.
39. At approximately 8.00am on 27 March, a PCO unlocked Mr Sprackling's cell so he could go to work as a cleaner. (It is unclear why the suspension of his employment had not been enforced.) In a statement, she said that Mr Sprackling did not leave the cell, but she did not consider this unusual as cleaners often had a 'lie in' at weekends.
40. Two prisoners who were also cleaners went to the cell (separately) shortly afterwards. Mr Sprackling appeared to be sleeping and did not respond when they called to him. One prisoner locked the cell door by reaching through the hatch, so he would not be disturbed. The other prisoner said that he was concerned, as Mr Sprackling usually came to his cell to ensure that he was awake and ready for work, as he was new to cleaning and not yet used to getting up early. He added it was unusual for Mr Sprackling to stay in bed. The prisoners said they checked him a few times.
41. Accounts of the detail and sequence of events vary. At around 9.50am, both prisoners became concerned about the lack of response from Mr Sprackling and alerted a PCO. All three went into the cell and found Mr Sprackling unresponsive. The PCO radioed a code blue emergency (which indicates that a prisoner has breathing difficulties or is unconscious) and more officers attended. The control room telephoned the ambulance service at 9.55am, after the PCO confirmed that an ambulance was required.

42. A nurse was the first nurse to arrive at the cell. She noted that Mr Sprackling was cold, with pooling of blood on his right side. When she tried to rouse him, she found extensive rigor mortis, suggesting he had been dead for at least two hours. Three other nurses attended, and they decided as a group that attempting resuscitation would be inappropriate.
43. A rapid response paramedic arrived just after 10.00am and agreed with the nurses' decision. He noted that there was no obvious evidence of substance misuse. The paramedic confirmed Mr Sprackling's death at 10.10am.

Contact with Mr Sprackling's family

44. The prison's family liaison officer telephoned Mr Sprackling's mother at 11.15am, to break the news of Mr Sprackling's death and offer support. He gave further information and advice over the following weeks. The family liaison officer also spoke to Mr Sprackling's brother.
45. In line with national policy, the prison contributed to the costs of Mr Sprackling's funeral, which was held on 13 May.

Support for prisoners and staff

46. After Mr Sprackling's death, a prison manager debriefed both the operational and healthcare staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and were aware of how to access formal support. A member of the staff care team attended. The key issue highlighted at the debrief meeting was the need for staff to get a response from prisoners at welfare checks. The nurses had an additional healthcare debrief.
47. The prison posted notices informing other prisoners and staff of Mr Sprackling's death and offering support.

Post-mortem report

48. The post-mortem report concluded that the cause of Mr Sprackling's death was drug toxicity (cocaine, benzodiazepine, pregabalin, gabapentin, buprenorphine, mirtazapine and nortriptyline) with cardiomegaly (enlarged heart).
49. The pathologist commented that sedating drugs pose a major risk to life due to their depressant effect on the areas of the brain which control breathing and, when taken simultaneously, respiratory depression might be considerably increased.
50. Post-mortem tests confirmed that Mr Sprackling was positive for COVID-19. The pathologist noted that microscopic examination of his lungs showed no significant respiratory infection, therefore COVID-19 was not listed as either a cause of, or a contributory factor to his death.

Findings

Clinical care

51. The clinical reviewer identified no significant physical or mental healthcare concerns. She noted that Mr Sprackling had not been seen by the mental health team, despite a referral when he first arrived at Forest Bank. However, she was satisfied that given his engagement with the substance misuse services, he did not require additional mental health support and if a need had been identified, it was possible for him to be re-referred.
52. The clinical reviewer concluded that Mr Sprackling's clinical care and substance misuse support at Forest Bank was of a good standard, equivalent to that he could have expected to receive in the community. She made no recommendations.

Drug supply

53. The investigation found that Forest Bank has a current, comprehensive Integrated Substance Misuse Strategy to help reduce the demand for and the supply of illicit drugs. It covers both clinical and non-clinical interventions, emphasising the prison's collaborative and multidisciplinary approach. It also suggests strong links between the prison and the substance misuse teams.
54. Of the seven substances found in the toxicology tests after Mr Sprackling's death, one (cocaine) was an illegal drug and two were among his prescribed medication. As the remainder had not been prescribed to him, he appears to have obtained them illicitly.
55. In a previous investigation into a drug-related death at Forest Bank, we found that the prison had implemented several measures to reduce the supply of drugs. However, given the range of substances detected, we remain concerned about the availability of illicit and diverted medication. We recommend:

The Director and Head of Healthcare should ensure that there are effective processes in place to reduce the availability and use of illicit drugs, including diverted medication.

Support for substance misuse and action on intelligence reports

56. Mr Sprackling lived on a dedicated unit for prisoners with substance misuse problems. Throughout his time at Forest Bank, he willingly and consistently engaged with the clinical and psychosocial teams. At meetings with recovery workers, he maintained that he was not using illicit drugs.
57. The prison's Substance Misuse Strategy states that prisoners in trusted positions should be monitored and reviewed regularly. Wing staff recorded no suspicious activities relating to illicit substances until a few weeks before Mr Sprackling's death, when security staff monitoring his phone calls were concerned that he might have contraband or be involved in drug use or dealing.

58. While we are satisfied that staff proactively supported Mr Sprackling and acted immediately on security information suggesting he might be linked to illegal activities, we consider that the discovery of the suspicious substance in Mr Sprackling's cell should have been shared with the substance misuse services.
59. As an orderly and trusted prisoner, Mr Sprackling had greater access to other cells and prisoners, as well as communal areas of the prison. Such freedom possibly increased his access to illicit drugs and other items. While we found no direct evidence as to how Mr Sprackling obtained illicit drugs, given the gravity and potential risks associated with mobile phones in prison and the second discovery of illegal items within a short period, we consider that the rationale for allowing him to continue his job should have been documented to ensure that the risks of undertaking those duties had been considered. We recommend:

The Director should ensure that relevant security information about individual prisoners and links to substance misuse is shared appropriately with the substance misuse teams.

The Director should ensure that all decisions on disciplinary action and punishments are fully documented.

COVID-19 well-being checks

60. Forest Bank has a detailed local protocol on well-being checks during COVID-19, which aims to minimise the possible adverse impact of restrictions on prisoners during the pandemic. It emphasises the importance of building relationships to improve safety and states that each prisoner should receive a weekly well-being check, which should be recorded in their personal records.
61. Mr Sprackling had two targeted well-being checks in September 2020 and one in January 2021, following court hearings and a family member's concern that he might be vulnerable to self-harm. There is no record of him receiving the routine weekly well-being checks. As key work sessions were limited during the pandemic, we believe that there should have been a greater effort to provide those checks. We recommend:

The Director should ensure that staff conduct and document weekly well-being checks for all prisoners, in line with the local protocol and relevant national guidance.

Unlock procedures and welfare checks

62. Prison Service Instruction (PSI) 75/2011, Residential Services, says:

“Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight ... but staff unlocking them have not noticed that the prisoner had died. This is not acceptable.

“The appropriate arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.”

63. At the time of Mr Sprackling's death, Forest Bank's local policy, set out in Director's Instruction 24 Residents' Welfare Checks stated that, without exception, each time an officer unlocks a cell they should observe the resident and obtain a response, to ensure the safety of both staff and residents. The guidance had been issued in 2019, to address the findings of a previous PPO investigation. It was updated and reissued on 26 April 2021, with the same expectations that staff should await an acknowledgement from each prisoner after unlocking a cell.
64. We are concerned that no welfare check was conducted when Mr Sprackling was first unlocked, an issue also identified in the debrief after his death. As he was expected to go to work and cleaning is a supervised activity, it is surprising that staff did not check on him during the intervening two hours. The comment that some cleaners get up later at weekends suggests it was not unusual for men to be left to sleep unchecked. The delay in finding him was attributed to two of the three staff on duty not knowing the individuals or regime very well, as they did not work on the landing.
65. Welfare checks are essential to the safety and well-being of all prisoners, not least for those vulnerable to substance misuse. We repeat our previous recommendation:

The Director should ensure that when a cell door is unlocked, staff satisfy themselves of the well-being of the prisoner and that there are no immediate issues that need attention. Staff should be reminded of the importance of such checks.

Emergency response

66. PSI 03/2013 on Medical Emergency Response Codes and Forest Bank's local protocol set out the actions staff should take in a medical emergency. The instructions state that if an emergency code is called over the radio network, an ambulance must be called immediately.
67. Entries in the communications room log indicate that the PCO radioed a code blue at 9.52am and an ambulance was requested at 9.55am, only after the PCO confirmed that it was required. While this delay did not affect the outcome for Mr Sprackling, it could be critical in future emergencies. We recommend:

The Director should ensure that staff in the communications room request an ambulance immediately when a medical emergency code is called.

Inquest

68. The inquest, which concluded on 5 December 2023, gave a narrative conclusion as follows:

The deceased died as the consequence of cardio-respiratory failure and an episode of vomiting having recently ingested an unknown quantity of illicit and previously prescribed medications acquired and taken in circumstances that remain unclear.

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