

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

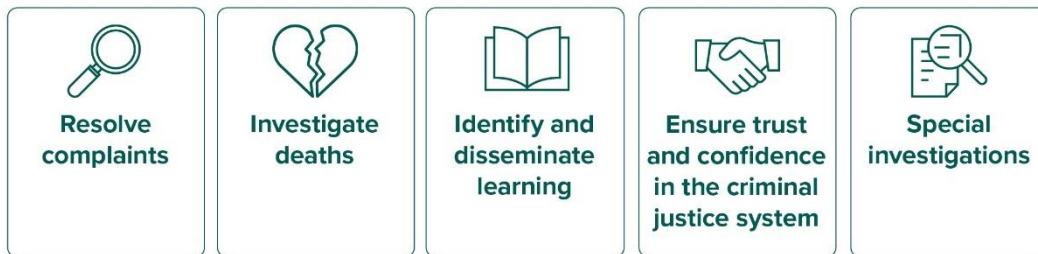
# **Independent investigation into the death of Mr Stephen Skinner on 20 January 2023, following his release from HMP Forest Bank**

**A report by the Prisons and Probation Ombudsman**

## 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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## Summary

1. 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.
2. Since 6 September 2021, the PPO is investigating post-release deaths that occur within 14 days of the prisoner's release.
3. If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
4. Mr Stephen Skinner died from drug toxicity on 20 January 2023 following his release from HMP Forest Bank three days earlier. He was 44 years old. We offer our condolences to his family and friends.
5. Mr Skinner had a history of heroin and crack cocaine misuse and committed crime to feed his habit. At Forest Bank, Mr Skinner engaged with the substance misuse team and received a methadone prescription. On release, healthcare staff referred Mr Skinner to the community substance misuse service where he continued to receive his methadone prescription. Mr Skinner was offered but declined to have naloxone (used to counter the effects of opioid misuse) on release from Forest Bank.
6. Mr Skinner told his community offender manager that he was going to live with his friend in Ashton-under-Lyne, an address which was not approved as suitable. Mr Skinner's community offender manager referred him to the local council for accommodation and in the days before he died researched the suitability of ABEN (homelessness provision in the centre of Ashton-under-Lyne) as an alternative address.
7. On 20 January, Mr Skinner was found unresponsive at his friend's house in Ashton-under-Lyne. Ambulance paramedics confirmed that he had died. Police officers found evidence that Mr Skinner used drugs at the premises. They found no evidence of third-party involvement and no evidence that Mr Skinner intended to take his own life. A pathologist said that Mr Skinner's blood contained potentially fatal levels of morphine, pregabalin (an anti-convulsant/anti-epileptic drug which can be prescribed for anxiety) and methadone.
8. We did not find any issues of concern with the services provided by HMP Forest Bank or the Probation service.

## The Investigation Process

9. On 13 February 2023, the PPO was notified of Mr Skinner's death.
10. The PPO investigator obtained copies of relevant extracts from Mr Skinner's prison and probation records.
11. We informed HM Coroner for Manchester South of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
12. The Ombudsman's family liaison officer wrote to Mr Skinner's father to explain the investigation and to ask if he had any matters he wanted us to consider. He had no specific questions.
13. We shared the initial report with HM Prison Service and the Probation Service (HMPPS). There were three factual inaccuracies, and this report has been amended accordingly.
14. We shared the initial report with Mr Skinner's father. He did not respond.

## Background Information

### HMP Forest Bank

14. HMP Forest Bank is a reception prison holding around 1,470 men in Manchester, run by Sodexo Justice Services. It serves the courts of Greater Manchester and the wider Northwest region. In April 2023, the primary care and clinical substance misuse services contract passed to a new provider Spectrum Community Health CIC.

### HM Inspectorate of Prisons

15. The most recent inspection of HMP Forest Bank was an independent review of progress in January 2023. Inspectors reported that there had been a substantial reduction in the availability of drugs, weapons and mobile phones since the inspection and measures to disrupt and repel the large number of items thrown over the prison walls had been mostly effective. However, the threat posed by the ingress of drugs remained and the mandatory drug testing failure rate was among the highest for this type of prison, at over 30% for the previous six months, with cannabis being the prevalent drug of choice.
16. Inspectors reported that Forest Bank was not fulfilling its purpose as a reception prison with a resettlement function. There was no dedicated support for the increasing remand and unsentenced population which had increased to around 45% at the time of the inspection and had since increased to 57% at the time of this report.

### Probation Service

17. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

### HM Inspectorate of Probation

18. The most recent inspection of the Northwest division of the National Probation Service was in July 2020. Inspectors reported that the overall rating for the division was good. Inspectors reported that although leaders had tried to mitigate the stress of high workloads, they remain high for too many probation officers. Inspectors reported that the division's approach to ensuring that it provided services that addressed the needs of those subject to supervision was encouraging. Effective partnership work had enabled several local co-commissioned projects to address areas linked to offending.

## Key Events

19. On 7 December 2022, Mr Stephen Skinner was remanded to HMP Dovegate. On 15 December, he was convicted of theft and sentenced to twelve weeks in prison. That day he was transferred to HMP Forest Bank.
20. Mr Skinner was managed by the Integrated Offender Management Unit (IOM). (IOM is a multi-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together.)
21. Mr Skinner told a nurse at his initial health screen that he had a history of heroin and crack cocaine use.
22. On 16 December, a nurse completed a substance misuse clinical management plan and noted that Mr Skinner was prescribed 30mls of methadone.
23. That same day, a medical administrator referred Mr Skinner to Tameside Change Grow Live (CGL- drug and alcohol service) and completed an initial substance misuse assessment. Mr Skinner told her that he used heroin (three bags a day) and crack cocaine (five bags a day). He said that he had used cannabis and psychoactive substances (PS) but not regularly. He told her that he was stable on his current dose of methadone.
24. Mr Skinner was already allocated a community offender manager (COM).
25. On 19 December, Mr Skinner was allocated a prison offender manager (POM).
26. On 29 December, the COM invited Mr Skinner to the monthly Forest Bank Surgery with professionals from Tameside Borough Council, taking place on 10 January 2023. She said that this would be an opportunity to discuss his release planning.
27. On 30 December, the COM emailed a criminal justice recovery worker from CGL and asked him to book an appointment with Mr Skinner for his release. On 5 January 2023, she told the CGL worker that, on the day of Mr Skinner's release, she would like a joint appointment with him to continue Mr Skinner's release planning.
28. On 6 January, a worker from Ingeus, (who deliver services across employment, health, justice and youth, helping people find jobs, improve skills and support their health and wellbeing) met Mr Skinner and told him that he could support him with finding accommodation. Mr Skinner declined any support and told the worker that he was going to live with his friend in Ashton-under-Lyne.
29. On 8 January, a nurse reviewed Mr Skinner's substance misuse clinical management plan. Mr Skinner told her that he was stable on his current methadone dose and agreed to engage with the community substance misuse team on his release.
30. On 9 January, a probation officer was allocated as Mr Skinner's pre-release resettlement officer. That same day, the COM asked police officers to carry out an

intelligence check on the address Mr Skinner had given in Ashton-under-Lyne. Police checks showed that it was not a suitable release address for Mr Skinner.

31. On 10 January, a medical administrator saw Mr Skinner to complete his substance misuse release plan. She noted that Mr Skinner did not engage well and was not willing to explore release coping strategies. She discussed harm reduction, including lowered tolerance levels and told him that if he did go back to using illicit drugs to make sure that he used small amounts, that he did not mix drugs, and that he did not inject drugs. Mr Skinner told her that he had his mother and CGL for support. She sent the release plan to Tameside CGL.
32. On 10 January, Mr Skinner went to the planned IOM meeting, where they discussed Mr Skinner's release. Mr Skinner said that he did not care if the address where he intended to live on release had been approved because he was only on a six-week licence.
33. On 11 January, the pre-release resettlement officer saw Mr Skinner for a pre-release assessment. Mr Skinner told him that he would either live with his parents or at his friend's house in Ashton-under-Lyne. Mr Skinner said that he was claiming benefits before he was sent to prison and the officer gave him advice on how to start a new claim. Mr Skinner said that he committed crime to fund his drug habit and used crack cocaine and heroin daily in the community, was working with the substance misuse team and was receiving a methadone prescription. Mr Skinner declined support from the mentoring service and declined to complete offence related work.
34. On 12 January, a nurse noted that Mr Skinner declined naloxone on release but was aware of the risk of overdose.
35. On 13 January, the pre-release resettlement officer completed a referral for Mr Skinner to receive mental health support in the community and a referral for help in completing his benefits claim.
36. On 16 January, the COM completed a duty to refer (DTR- The Homelessness Reduction Act 2017 requires prisons and probation services to refer anyone who is homeless or at risk of becoming homeless within 56 days to a local housing authority) to Tameside Borough Council as she had currently not approved an address for him to live. She said that Mr Skinner did not engage in an assessment with Tameside Borough Council, so there was no decision about the priority to house him.
37. That same day the pre-release resettlement officer saw Mr Skinner and said that he would continue to support him after his release.
38. On 17 January, the day of Mr Skinner's release from Forest Bank, he received his daily dose of methadone and his methadone prescription. Mr Skinner's licence conditions required him to report to his COM at the Ashton-under-Lyne Probation Office at 1.00pm.

## Post-release

39. At 1.30pm, Mr Skinner went to the probation appointment. Because he arrived late, the duty probation officer saw Mr Skinner. A CGL worker was also present. The duty probation officer explained the terms of his licence which included that Mr Skinner attend appointments to address his substance use and to comply with any requirements to address his drug and offending behaviour problems. Mr Skinner signed the probation induction paperwork. The duty probation officer told Mr Skinner that his parents' address was not suitable as a place to live. Mr Skinner gave him the contact details of his friend, to check the address where he intended live.
40. Mr Skinner said that he had received a methadone prescription in prison but did not have a bridging prescription, so the CGL worker found a seven-day pharmacy to create the bridging prescription until his next medical appointment, which he booked for 24 January. The duty probation officer made another appointment to see Mr Skinner that same day. He planned a home visit to Mr Skinner's friend's address.
41. A probation service officer later went to assess the friend's address for suitability. He described the address as unkempt and cluttered. The occupier, Mr Skinner's friend, said that he knew Mr Skinner and was aware of his history. The COM concluded that the address was not approved but could not get hold of Mr Skinner to tell him this. She said that had she spoken to him, she would have directed him to the ABEN homelessness housing provision.
42. Later that day, the COM emailed the housing department at Tameside Borough Council to follow up on the DTR she had submitted.
43. On 18 January, probation staff called Mr Skinner to tell him he could stay at ABEN, but the call went to answer phone.
44. Later that day the pre-release resettlement officer telephoned Mr Skinner, but he did not answer the call.
45. On 19 January, Mr Skinner saw a worker at CGL in Ashton-under-Lyne and told him that he had lost his mobile telephone and sim card and couldn't remember when he had his next appointment with them. The worker told Mr Skinner when his next CGL and probation appointment was and gave him an appointment slip.

## Circumstances of Mr Skinner's death

46. At about 9.00am on 20 January, paramedics went to Mr Skinner's friend's address in Ashton-under-Lyne after Mr Skinner's friend found him unresponsive, cold and with blue lips. At 9.41am, the paramedics confirmed that Mr Skinner had died.
47. A Detective Inspector (DI) went to the address. The DI found a small pipe under Mr Skinner's body and Mr Skinner's friend gave police officers an empty packet of pregabalin and alprazolam (a fast-acting potent tranquiliser). The DI saw other medication packets in the room, prescribed to Mr Skinner's friend. Mr Skinner's friend said that he and Mr Skinner had taken pregabalin and alprazolam the previous evening, and that Mr Skinner had taken more at around 6.00am that morning.

48. The DI found no evidence of third-party involvement and no evidence that Mr Skinner intended to take his own life.

### **Post-mortem report**

49. A post-mortem examination established that Mr Skinner died from drug toxicity.
50. Toxicology tests showed that Mr Skinner had taken morphine (taken as heroin), pregabalin, cocaine, methadone, alprazolam, clonazepam and diazepam (both tranquilizers of the benzodiazepine class) and paracetamol. A pathologist said that Mr Skinner's blood contained potentially fatal levels of morphine, pregabalin and methadone.

### **Inquest**

51. The inquest, held on 27 June 2023, concluded that Mr Skinner's death was drug related.

### **Support for staff**

52. After Mr Skinner died a senior probation officer offered the COM support and explained that the employee assistance programme (PAM) was available.

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

53. Police officers told Mr Skinner's father that he had died.

### **Findings**

#### **Substance misuse services**

54. Mr Skinner had a history of substance misuse. At Forest Bank he engaged with the substance misuse service and received methadone which he said kept him stable. Healthcare staff completed a substance misuse assessment and a substance misuse clinical management plan. Mr Skinner agreed to engage with the community substance misuse team who he saw on the day of his release from Forest Bank.
55. On 12 January, a nurse offered Mr Skinner naloxone for release, but he declined to accept it.

#### **Accommodation**

56. Mr Skinner's community offender manager, the prison resettlement officer and the IOM team tried to support Mr Skinner to find suitable accommodation. However, Mr Skinner was clearly intent on returning to live with his friend, despite the address being unsuitable and not approved. We do not think that staff could have done any more to ensure that Mr Skinner had somewhere safe to stay on release.

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