Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jonathan Pisani, a prisoner at HMP/YOI Forest Bank, on 19 January 2022

A report by the Prisons and Probation Ombudsman

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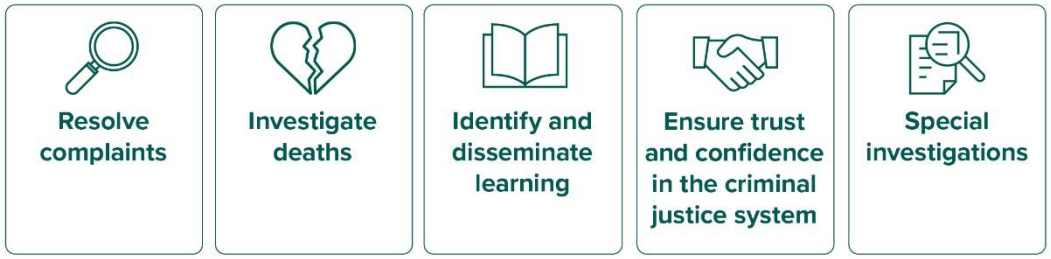
OUR VISION

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

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.

If my office is to best assist HMPPS in ensuring the standard of care received by those within service remit is appropriate, then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Jonathan Pisani died of drug toxicity on 19 January 2022, at HMP Forest Bank. Mr Pisani was 46 years old. I offer my condolences to Mr Pisani's family and friends.

Mr Pisani had been at Forest Bank since 13 January, during which time he had been receiving both alcohol and drug detoxification. He had a history of illicit drug and alcohol use, but no concerns were raised about him using illicit substances during the short period he was in prison. He was said to have been compliant with his detox regime. HM Chief Inspector of Prisons and the Independent Monitoring Board both found that substance misuse treatment at Forest Bank was good, and our investigation identified no shortcomings in the treatment offered to Mr Pisani.

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

Adrian Usher
Prisons and Probation Ombudsman **March 2024**

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Summary

Events

1. On 13 January 2022, Mr Jonathan Pisani was recalled to prison for failing to comply with his licence conditions and was sent to HMP/YOI Forest Bank. He was 46 years old. He had only been in the community for nine days prior to his recall.

2. Mr Pisani had a history of alcohol and drug misuse. At Forest Bank, he engaged with the substance misuse team and was placed on a substance misuse and alcohol detoxification programme. Staff gave him advice about the risks of drug and alcohol misuse and harm minimisation.

3. Over the next five days, the substance misuse team saw Mr Pisani twice a day to monitor his withdrawal symptoms and to prescribe methadone. During this time, Mr Pisani did not raise any concerns about his physical well-being. Staff had no reason to believe that Mr Pisani was using illicit drugs during his time at Forest Bank.

4. On the evening of 18 January, Mr Pisani's cell mate fell asleep at around 8.00pm and said that, before going to sleep, he had smoked some 'Spice' (a type of psychoactive substance (PS)). He said that Mr Pisani had not joined him in smoking any illicit substances that night or at any other time while they had been sharing a cell.

5. At approximately 7.05am on 19 January, Mr Pisani was found unresponsive in his cell. Rigor mortis was present, and he was not given cardio-pulmonary resuscitation. At 9.34am, a GP confirmed that Mr Pisani had died.

6. A post-mortem examination gave Mr Pisani's cause of death as drug toxicity.

Findings

7. Mr Pisani was appropriately identified as requiring alcohol detoxification and placed on the prison's substance misuse programme on his reception into prison. All treatment provided to Mr Pisani was in line with the National Institute for Clinical Excellence (NICE) guidelines.

8. Mr Pisani showed signs that he had been dead for some time when he was found unresponsive in his cell. Prison nurses were correct not to begin cardio-pulmonary resuscitation in order to preserve Mr Pisani's dignity.

9. The clinical reviewer concluded that the clinical care Mr Pisani received at Forest Bank was of a good standard and equivalent to that which he could have expected to receive in the community.

The Investigation Process

10. We were notified of Mr Pisani's death on 19 January 2022. 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. No one responded.

11. The investigator contacted Forest Bank and obtained copies of relevant extracts from Mr Pisani's prison and medical records.

12. The investigator interviewed eight members of staff at Forest Bank on 19 and 20 April 2022.

13. NHS England commissioned a clinical reviewer to review Mr Pisani's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff at Forest Bank on 19 and 20 April 2022.

14. We informed HM Coroner for Greater Manchester West District of the investigation. The Coroner gave us the results of the post-mortem examination and toxicology tests. We have sent the Coroner a copy of this report.

15. The Ombudsman's family liaison officer contacted Mr Pisani's next of kin, his mother, to explain the investigation and to ask if she had any matters, she wanted the investigation to consider. Mr Pisani's mother asked:

    - what position was Mr Pisani in when he was found?
    - did the prisoner sharing the cell hear anything?

    We have answered these questions in this report and have sent the family a copy.

Background Information

HMP Forest Bank

16. HMP/YOI Forest Bank holds up to 1,460 adult and young adult men both on remand and sentenced. The prison serves the courts of Greater Manchester.

17. The prison is managed and run by Sodexo Limited, who are also responsible for the provision of primary healthcare services, including primary mental health services, inpatient facilities, and substance misuse services within the prison.

HM Inspectorate of Prisons

18. The most recent inspection of HMP/YOI Forest Bank was in May 2019. Inspectors reported that since their last inspection in 2016, mental health care had improved, despite a high demand for support. Integrated substance misuse services (ISMS) were very good. New referrals were seen within five days and there was a robust system in place for urgent referrals.

Independent Monitoring Board

19. 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 2020, the IMB reported that ISMS had continued to provide support to prisoners. The focus during the pandemic had been on completing assessments and release planning, however existing prisoners on the caseload had still received 1-1 reviews or telephone welfare checks.

Previous deaths at HMP Forest Bank

20. Mr Pisani was the tenth prisoner to die at Forest Bank since February 2019. Of the previous deaths, four were natural causes, two were self-inflicted deaths and three were thought to be drug related. There were no direct similarities between Mr Pisani's death and the previous deaths.

The key worker scheme

21. The HMPPS key worker scheme is intended to be an important means of reducing violence and self-harm in prisons. Under the Offender Management in Custody model, each prison officer is the named key worker for five or six prisoners and should be allocated an average of 45 minutes per week to spend on key work duties with each prisoner, including having regular meaningful conversations with each prisoner.

Psychoactive Substances (PS)

22. Psychoactive substances (formerly known as ‘legal highs’) are a problem across the prison estate. They are difficult to detect and can affect people in several ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain, a potential for violence and sudden death. 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.

Key Events

23. On 24 August 2021, Mr Jonathan Pisani was convicted of firearm offences and sentenced to 15 months in prison. On 4 January 2022, he was released from prison, but was recalled nine days later for breaching his licence conditions. He was sent to HMP/YOI Forest Bank.

24. When he arrived at Forest Bank on 13 January, Mr Pisani's person escort record (PER) indicated that he had self-harmed in prison in September 2021. The PER also highlighted that he was detoxing from alcohol and was an illicit drug user. His health needs were identified as a personality disorder, asthma, and alcoholism and that he would need to be reviewed for alcohol withdrawal.

25. At 1.04pm, a nurse completed a health screen. She noted in his medical record that Mr Pisani had been living rough, had self-harmed two months ago and had been sectioned under the Mental Health Act in the past. Mr Pisani told her that he suffered with psychosis, bi-polar disorder, and manic depression. Mr Pisani denied any thoughts of suicide or self-harm.

26. The nurse completed an alcohol screen, which indicated that Mr Pisani needed treatment to alleviate the symptoms of alcohol detoxification. She also completed a drug screening. Mr Pisani said that he had used psychoactive substances (PS), cannabis, cocaine, crack cocaine, amphetamines and heroin. He also said that he had recently been admitted to hospital and was treated for haematemesis (vomiting blood). Mr Pisani listed his prescribed medications as olanzapine, mirtazapine, propranolol, simvastatin, thiamine, and Ventolin (An inhaler to treat asthma). Urine sample results showed that Mr Pisani was positive for cannabis, cocaine, opiates, and methadone. She referred Mr Pisani to the prison's In-Reach Substance Misuse Service (ISMS).

27. A nurse completed a secondary drug and alcohol screen. She noted his physical and mental health history, and his alcohol and drug consumption. Mr Pisani told her that he had recently used crack cocaine, heroin and cannabis. Mr Pisani was prescribed methadone in the community, but when she asked him about this, he could not remember how much he was prescribed or when he last had this.

28. Mr Pisani said that since being released from prison on 4 January, he had drunk one litre of vodka and six cans of strong cider daily. He had last had an alcoholic drink the previous day and considered himself an alcoholic. Mr Pisani told the nurse that when he did not drink, he was prone to seizures.

29. The nurse recorded that during her contact with Mr Pisani, he was calm, polite, and answered all the questions appropriately and that ISMS would see him twice a day for alcohol and opiate withdrawal reviews. She prescribed the medications Mr Pisani had received in the community and also chlordiazepoxide to help with the symptoms of alcohol detoxification. The methadone regime began on 13 January. Mr Pisani was prescribed 10mls, then 20mls on 14 January and 30mls for the following four days. National Institute for Health and Care Excellence (NICE) indicates that the recommended initial dose is 10–30 mg/day and the incremental increase for any one day should be no more than 10 mg. The total weekly increase

over the first week should be no more than 30 mg above the starting dose. Mr Pisani's treatment was within these guidelines.

30. Mr Pisani was allocated a cell on residential wing H1, which is a first night centre for prisoners under the care of the substance misuse service. Staff observed him hourly between 8.00pm and 5.00am as part of the first night procedures and they did not report any concerns.

31. At 8.30am on 14 January, a nurse visited Mr Pisani in his cell to conduct withdrawal observations. These observations were carried out around the same time each day between 14-19 January and recorded daily.

32. At 10.11am on 14 January, a Prison Custody Officer (PCO) completed Mr Pisani's induction. She recorded that Mr Pisani knew how to get help if he needed additional support. She explained the key worker role to Mr Pisani and that the keyworker would be there to support him during his time at Forest Bank. She told Mr Pisani that he would be allocated a key worker once he had completed the induction and would then have weekly contact. There were no further entries in Mr Pisani's prison records to indicate that prison staff had any meaningful contact with him after his induction, or that he had been allocated a key worker.

33. That afternoon, a nurse completed a secondary health screen. The purpose of the secondary screen is to obtain a more in-depth medical history, to add to information already obtained at reception. She recorded that Mr Pisani asked her about being prescribed promazine (an anti-psychotic medication). She noted that in the past, a psychiatrist had seen Mr Pisani and that they had increased his olanzapine (another anti-psychotic medication). She noted that there was no family history of chronic illness, although there was a family history of depression. On 18 January, after receiving confirmation that Mr Pisani was engaged with the Community Mental Health Team, the mental health team at Forest Bank added him to their caseload and placed him on the waiting list to see a psychiatrist.

34. At 10.57am on 18 January, a worker from the ISMS visited Mr Pisani to complete an assessment and provide awareness about illicit drug use. He recorded that the aim of his contact with Mr Pisani was to explain the risks of overdose, using PS, and blood borne viruses and to be able to administer naloxone (a drug that can reverse the effects of opiate overdose) if needed and to improve his general health and well-being.

35. The ISMS worker recorded that Mr Pisani said that he was unsure whether he was on a fixed term recall or standard recall. He confirmed with the Offender Management Unit that Mr Pisani was a standard recall. This meant that Mr Pisani would be released from prison on his licence expiry date, which was 27 August 2022.

36. Mr Pisani told the ISMS worker that he was waiting to be seen by the mental health team, but that he had no thoughts of self-harm. He said that he just wanted to stabilise on the detox regime. The worker said that when he spoke to Mr Pisani, he had no reason to believe that he was under the influence of any substances and that Mr Pisani did not mention feeling unwell.

37. Mr Pisani shared a cell. His cell mate said that on the evening of 18 January, he had gone to sleep early at around 8.00pm as he was detoxing, and that Mr Pisani was sitting on his bed watching television. Mr Pisani's cell mate said that before going to sleep he had used a homemade pipe, made from the handle of a disposable razor to smoke some PS. He said that Mr Pisani had not smoked any illicit substances that night or at any other time while they had been sharing a cell. Staff were not required to check Mr Pisani during the night.

Events of 19 January

38. At approximately 7.05am, a Healthcare Assistant (HCA), a smoking cessation support worker, and a student nurse arrived on H wing to complete checks on prisoners undergoing substance detoxification.

39. The HCA said that although this was not his primary role, he was sometimes asked to complete routine observations when there were staff shortages. When they arrived at Mr Pisani's cell, he unlocked the door. Mr Pisani's cell mate asked if he could go and collect some water. The HCA said no, and that staff would collect this for him. The HCA then shouted to Mr Pisani to get up and have his blood pressure taken. Mr Pisani did not respond. Mr Pisani's cell mate also shouted to him to wake up, but again, he did not respond. The HCA approached the bed and shook Mr Pisani's leg, it felt stiff. He pulled the covers from around Mr Pisani's head and saw blood on his face, mostly around his nose and mouth. The HCA was not carrying a radio, and so told the student nurse to alert the wing staff and ask for medical assistance.

40. The nurse went to the wing office and told a PCO that they had attempted to wake a prisoner but had no response and asked him to attend the cell. The PCO went with the nurse to Mr Pisani's cell and, as he entered the cell at 7.08am, he saw Mr Pisani and radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties) as it was clear to him that this was a medical emergency. Control room staff called an ambulance immediately.

41. The PCO tried shaking Mr Pisani and checked for a pulse, but there were obvious signs of rigor mortis. Another nurse arrived at the cell. She noted that Mr Pisani was pale in colour, had a mottled appearance and that there were blood-stained secretions around his mouth and nose. She recorded that Mr Pisani was unresponsive and there was no pulse or respiratory effort. She said that with the help of the PCO they attempted to move Mr Pisani to the floor, but it was clear that rigor mortis was present.

42. More nursing staff arrived and following a discussion about Mr Pisani's presentation and the presence of rigor mortis, they decided not to perform CPR as he was clearly dead.

43. The prison updated the ambulance service and informed them that Mr Pisani had died and that there were signs of rigor mortis. As a result, the ambulance service downgraded the call. A GP at Forest Bank pronounced Mr Pisani dead at 9.34am. Paramedics then arrived at approximately 9.42am.

Contact with Mr Pisani's family

44. The prison appointed a family liaison officer and a deputy. At 10.10am on 19 January, they attended Mr Pisani's mother's home address to inform her of her son's death and the process that would follow.

45. The prison contributed to the costs of the funeral in line with national policy.

Support for prisoners and staff

46. After Mr Pisani's death, a senior manager held a debrief with those 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.

47. The prison posted notices informing other prisoners of Mr Pisani's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by the death.

48. Staff told us that they had felt supported by the prison and were fully aware of how to access support should they need it.

Post-mortem report

49. The pathologist gave Mr Pisani's cause of death as multiple drug toxicity. The toxicology report indicated that Mr Pisani had a combination of prescribed drugs and traces of illicit drugs in his system, which indicated earlier use. This is in keeping with Mr Pisani's disclosure that he had taken drugs in the community.

50. Both the post-mortem and toxicology reports reported on the interaction between the combination of drugs in Mr Pisani's system and how these could have had an effect on his central nervous system and cause respiratory depression. The reports also noted that while no psychoactive substances were identified, it was not clear to what extent the toxicology test was able to check for this particular range of substances, and therefore the use of PS could not be completely ruled out.

51. An inquest was completed on 13 March 2024. The coroner gave a narrative conclusion that, Jonathan Paul Pisani died at some point between 8:00pm 18 January 2022, and 7:05am on the 19 January 2022, at HMP Forest Bank Prison, H1 Cell 005. The cause of death was multiple drug toxicity.

Findings

Substance misuse care

52. Mr Pisani had a long history of illicit substance misuse. The clinical reviewer noted that he had received care from various drug support services in prison and in the community and had completed several detoxification programmes.

53. At reception, urine samples were appropriately taken in order to identify any drugs in Mr Pisani's system as well as a full assessment of his prescribed and illicit drug use. An alcohol assessment was also completed, which identified Mr Pisani as requiring medication to assist with his withdrawal symptoms. The detoxification treatments provided were in line with National Institute of Clinical Excellence (NICE) guidelines.

Resuscitation

54. In September 2016, the National Medical Director at NHS England wrote to Heads of Healthcare for prisons to introduce new guidance to help staff understand when not to perform cardiopulmonary resuscitation (CPR). This guidance was designed to address concerns about inappropriate resuscitation following a sudden death in prison. It was taken from the European Resuscitation Council Guidelines which states, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The European Guidelines were updated in May 2021, but the same principles apply.

55. Evidence from the PCO and nurse indicated that clear signs of death were present including rigor mortis. The decision not to give Mr Pisani CPR was appropriate and in line with national guidance.

Clinical care

56. The clinical reviewer concluded that the clinical care Mr Pisani received at Forest Bank was of a good standard and equivalent to that which he could have expected to receive in the community.

Other learning

57. At Forest Bank, while some staff are required to carry a radio, there are sufficient additional radios that any staff can carry one if they wish. The HCA was not carrying a radio on the morning of 19 January when he conducted the checks on H wing. This meant that there was a short delay between him realising Mr Pisani was not breathing and a code blue emergency being called.

58. At interview, the HCA said that he was not required to carry a radio and chose not to carry one because he wanted to make the radios available to those staff who needed them. He said that although he did not usually carry out the task of completing welfare checks on prisoners who were detoxing, his role as smoking cessation advisor meant that very often, he would be the first person to visit a cell occupied by those who had entered prison custody the day before. He also said that only two weeks before the interview, he had discovered another prisoner who had died, while carrying out his role as smoking cessation advisor. The Director and

Head of Healthcare will wish to consider whether staff conducting welfare checks should be required to carry a radio.

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