Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Wallwork, a prisoner at HMP Forest Bank, on 10 July 2024

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 His Majesty's 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.

Mr Stephen Wallwork was found unresponsive in his cell on 10 July 2024, at HMP Forest Bank. He was 34 years old. A post-mortem was unable to ascertain the cause of his death. Toxicology results showed that he had used synthetic cannabinoids some time before he died, but there is no certainty that it played a role in his death. I offer my condolences to Mr Wallwork's family and friends.

Mr Wallwork arrived at Forest Bank the night before he died, having spent the previous two years at HMP Wymott. We do not know when or how he obtained synthetic cannabinoids, and it is possible that he brought them with him from Wymott. On his arrival at Forest Bank, staff did not properly search Mr Wallwork or his property in line with national policy and neither prison complied with national guidance on the volume of property a prisoner is allowed to keep in their possession.

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 **August 2025**

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Summary

Events

1. On 14 May 2021, Mr Stephen Wallwork was recalled to prison, having breached the conditions of a release licence, and taken to HMP Forest Bank. He spent time at HMP Risley, HMP Liverpool and, on 31 August 2022, he was transferred to HMP Wymott.

2. On 9 July 2024, Mr Wallwork appeared at Wigan Magistrates' Court (for offences committed in 2021) and after his court appearance was taken to Forest Bank.

3. Mr Wallwork had a long history of mental health issues, including depression and anxiety, for which he was prescribed medication. Mr Wallwork disclosed some historical substance misuse, but there was no evidence that he used illicit drugs following his recall.

4. When he arrived at Forest Bank, a nurse recorded that Mr Wallwork's clinical observations were all normal. Mr Wallwork appeared calm and polite, and the nurse noted his mental health history and referred him to the mental health team. Mr Wallwork left reception and moved to an induction wing. He was allocated a cell on his own.

5. At around 8.11am on 10 July, healthcare staff found Mr Wallwork unresponsive in his cell. They did not attempt to resuscitate him as Mr Wallwork showed signs he had been dead for some time. Paramedics attended and, at 8.40am, pronounced life extinct.

6. The post-mortem was unable to ascertain the cause of Mr Wallwork's death, but toxicology examinations found he had recently used synthetic cannabinoids.

Findings

7. We do not know how or where Mr Wallwork obtained the drugs that he had used in the period before his death. On arrival at Forest Bank, he was not searched in line with national policy. He also had in his possession a large amount of consumables (which could have been used to conceal an illicit substance) which were not searched as they should have been. Mr Wallwork had more in-possession property than is usually allowed, and neither Wymott nor Forest Bank adhered to national guidance on volumetric control.

8. Although both Wymott and Forest Bank have worked to reduce the supply of drugs, several staff at Wymott told us that staff searching was intermittent.

9. The clinical reviewer concluded that Mr Wallwork received a good standard of healthcare.

10. Staff did not properly check Mr Wallwork's welfare when they unlocked his cell on the morning of his death.

Recommendations

- The Governor of HMP Wymott and Director of HMP Forest Bank should ensure that national guidance on volumetric control is properly implemented, including the amount of consumables a prisoner is allowed to have in their possession.

The Investigation Process

11. HMPPS notified us of Mr Wallwork's death on 10 July 2024.

12. 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 her. No one responded.

13. The investigator visited Forest Bank on 16 July. She obtained copies of relevant extracts from Mr Wallwork's prison and medical records and spoke to a prisoner that arrived with Mr Wallwork.

14. NHS England commissioned a clinical reviewer to review Mr Wallwork's clinical care at the prison. He and the investigator interviewed 11 members of staff at Forest Bank and Wymott in August and September. In addition, the investigator spoke to a prison officer and probation officer from Wymott.

15. We suspended our investigation between September 2024 and January 2025, pending confirmation of the cause of death and toxicology results.

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

17. The Ombudsman's office contacted Mr Wallwork's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Wallwork's mother said that she had received very good support from the prison family liaison officers. She asked whether Mr Wallwork had left a note or letter. She also asked the following questions, which have been answered in the clinical review report:

    - What was known about Mr Wallwork's mental health history, and should he have been admitted to hospital under the Mental Health Act?
    - Did Mr Wallwork receive regular health check-ups because of the medication he was prescribed?
    - What time were medications given to Mr Wallwork (as they helped him sleep)?
    - Were healthcare staff aware of the family history of heart disease?

18. Mr Wallwork's mother received a copy of the report, and she did not identify any factual inaccuracies.

19. Forest Bank and Wymott prisons also received a copy of the report. In response to their feedback, we have amended the name of the healthcare provider at Wymott.

Background Information

HMP Forest Bank

20. HMP Forest Bank holds adult men both on remand and sentenced and young prisoners between the ages of 18-21. The prison serves the courts of Greater Manchester.

21. The prison is managed and run by Sodexo Limited. They were also responsible for the provision of primary healthcare services, including primary mental health services, inpatient facilities, and substance misuse services within the prison, until 1 April 2023, when Spectrum Community Health became the primary healthcare provider.

HMP Wymott

22. HMP Wymott is a medium security prison in Lancashire for adult men. Most prisoners are serving sentences of four years or longer. Healthcare services are provided by Practice Plus Group. There is 24-hour nursing cover.

HM Inspectorate of Prisons

HMP Forest Bank

23. The most recent inspection of Forest Bank was in February 2022. Inspectors noted that in late 2021, HM Prison and Probation Service (HMPPS) issued Sodexo with a formal rectification notice over their concerns about the safety of prisoners and the conditions in which they were being held. Inspectors reflected this was a concerning step, but there was clear evidence that the company had responded quickly and positively.

24. Leaders focused their attention on the main security risks, including the supply of drugs and illicit items, organised crime and staff corruption. Illicit items, such as mobile phones and drugs, had entered the prison in very large numbers, primarily in parcels thrown into exercise yards. The availability of so many illicit items had significantly undermined the safety and good order of the prison. New priorities focused on improving safety had been identified but still needed more development to ensure their implementation was sufficiently robust. Inspectors found more also needed to be done to make sure newly received prisoners were properly supported and inducted.

25. In January 2023, inspectors completed an Independent Review of Progress at Forest Bank. There had been a substantial reduction in the availability of drugs, weapons and mobile phones since the last inspection. 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.

HMP Wymott

26. The most recent inspection of HMP Wymott was in December 2023. Inspectors reported the influx of drugs remained a serious problem. It was a cause of debt that resulted in prisoners self-isolating and self-harming because of their fears of violence. There were limited resources available to keep drugs out of the prison with no scanners, systematic checks on staff or adequate technology to reduce the frequent arrival of contraband-laden drones over the large perimeter fence.

Independent Monitoring Board

HMP Forest Bank

27. 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 2023, the IMB noted that Forest Bank could expect up to 30 new prisoners (both remanded and sentenced) daily. All incoming prisoners pass through the reception area. New prisoners follow a thorough reception process before being situated on an induction wing. Overall, the IMB found that the reception area was operated well, with experienced, dedicated staff. However, this was affected by late evening and weekend arrivals.

28. The IMB reported that Forest Bank continued to take a proactive stance against contraband, focusing on the supply of drugs and illicit items, organised crime and staff corruption. They noted that an intelligence-based approach was taken to address the rise in contraband and illicit items found to be smuggled into the prison by visitors and members of staff. All staff members were supported and trained in anti-corruption, as well as in professional standards. The IMB reported that during their Sodexo induction, external operators given access to the prison and operational and non-operational staff were trained and encouraged to confidentially report any concerns over illicit items or staff corruption using intelligence reports. The IMB noted that various measures had been introduced to improve the overall security and good order of the prison. The prison had installed additional netting over the exercise yards up to the roof, making it harder to throw over contraband from adjoining parkland. This followed the fitting of new, improved windows, making it significantly harder for prisoners to retrieve ‘throwovers’. The IMB also reported that, on occasion, the prison would undertake sniffer dog operations, at times in conjunction with Greater Manchester Police. The IMB concluded that, despite these measures, contraband and illicit items were still entering the prison through other avenues.

HMP Wymott

29. In its latest annual report for the year to May 2024, the IMB expressed concern about spikes in the use of illicit substances, particularly following reported drone drops. They noted that the area search team visited regularly, and the Board recognised that much was being done to try to reduce the use of illicit drugs, including the work of the drug and alcohol rehabilitation service (DARS) team.

Previous deaths at HMP Forest Bank

30. Mr Wallwork was the 15th prisoner at Forest Bank to die since July 2021. Of the previous deaths, eleven were from natural causes, one was self-inflicted, one drug related, and one is awaiting classification. To the end of March 2025, there have been five more deaths; two self-inflicted, two awaiting classification and one due to natural causes. There are no significant similarities between Mr Wallwork's death and the previous deaths at Forest Bank.

Searching

31. Guidance on searching is set out in the Searching Policy Framework, including the mandatory requirements that all establishments are expected to adhere to. Every establishment must have a searching process, usually set out in a Local Searching Policy (LSP), the contents of which are made available to staff, visitors and prisoners.

32. As part of a Level B rub down search, prison officers ask the person to empty their pockets and then rub down their collar, shoulders, arms, body and legs. A Level A rub down search requires prison officers to undertake, in addition to the measures of Level B, a visual observation of the mouth, nose and ears and check the person's hair; both types of rub down search require staff to also use a handheld metal detector.

33. A full search includes removal of clothing and visual observation of intimate body parts. At no time would a prisoner be completely naked during a full search and staff do not have the legal authority to intrude into any bodily orifices.

Key Events

34. On 22 August 2018, Mr Stephen Wallwork was sentenced to four years in prison for robbery, driving offences and possession of cannabis. On 24 August 2020, he was released on licence from HMP Hindley, but, on 14 May 2021, was recalled to prison for committing further offences. He was taken to HMP Forest Bank.

35. On 28 June 2022, Mr Wallwork was sentenced to 51 months in prison for affray. He spent time at HMP Risley, HMP Liverpool and, on 31 August 2022, was transferred to HMP Wymott.

36. Mr Wallwork had a history of anxiety and depression and, in February 2020, was diagnosed with emotionally unstable personality disorder (EUPD, which affects how you think, feel and interact with other people and can cause emotional instability, upsetting thoughts and acting without thinking). Mr Wallwork was prescribed mirtazapine (an antidepressant) and quetiapine (typically used as an antipsychotic but also prescribed to treat anxiety). Mr Wallwork did not have this medication in his possession and collected it each day to take as prescribed.

37. Although Mr Wallwork disclosed that he had previously taken illicit substances (cannabis and cocaine), he said he had not done so since 2019. There is no evidence in his record that he had used drugs since 2019.

38. During his time in prison, Mr Wallwork was supported via the Prison Service's suicide and self-harm prevention measures (known as ACCT) on at least 15 occasions. On several occasions, Mr Wallwork self-harmed by cutting himself and told staff that he struggled with his mental health. Staff often noted that his behaviour was out of frustration or motivated by wanting to disrupt the prison regime or obtain additional phone credit so he could speak to his family. Mr Wallwork told staff that he did not know why he acted in this way.

39. In May 2024, Mr Wallwork was placed on ACCT procedures twice. He told staff that he had taken an overdose of paracetamol and had swallowed razor blades. Mr Wallwork later admitted to staff that both of these claims were untrue, that he had no intention to harm himself, and that he wanted to disrupt the regime as he was annoyed that his home-made weights had been removed from his cell. The ACCTs were closed, and no further concerns were noted.

40. Mr Wallwork had a release date of 15 July 2024. He told staff that he felt positive about being released and had lots of support from his family. However, on 5 July, Mr Wallwork appeared via videolink at Wigan Magistrates' Court charged with wounding with intent, conspiracy to supply Class B drugs and malicious communications, all offences allegedly committed in 2021. The case was adjourned until 9 July, and staff informed Mr Wallwork that he would no longer be released.

41. On 9 July, a nurse assessed Mr Wallwork before he left Wymott to attend court. His clinical observations were normal. Reception staff searched Mr Wallwork before he boarded transport to court (a Level B rubdown search). He had all his possessions with him as is standard practice when prisoners are appearing in court (in case they are remanded to a different prison or released from court). There is no record that the search identified anything illicit.

42. Mr Wallwork appeared at Wigan Magistrates Court, who transferred his case to Bolton Crown Court where he was due to appear on 13 August. Before he left court at 5.00pm, staff gave Mr Wallwork his medication.

Arrival at Forest Bank – 9 July

43. At around 5.25pm, Mr Wallwork arrived at Forest Bank. A Senior Prison Custody Officer (SPCO) spoke to Mr Wallwork as he arrived in reception. A Prison Custody Officer (PCO) searched Mr Wallwork (a Level B rubdown search) and placed him in a holding cell. There is no record that the search identified anything illicit.

44. Two PCOs checked and searched Mr Wallwork's property, which they logged onto a property card. (They did not search Mr Wallwork's consumables: items such as salt, spices and protein powder. In line with practice, the consumables were also not logged on Mr Wallwork's property card.) Mr Wallwork had a body scan, and nothing was detected. There was no vape listed on his property card. Staff told us that if Mr Wallwork bought a vape at a previous prison through the canteen then he could keep it in his possession, and it would not be searched. (Mr Wallwork's records indicate that he vaped in prison.) The amount of property reception staff allowed Mr Wallwork to take to his cell far exceeded the amount normally allowed (known as volumetric controls) set out in HMPPS Prisoners' Property Policy Framework.

45. At 6.44pm, Mr Wallwork telephoned his partner. He sounded positive and reassured her saying his court appearance went better than he had expected. The call lasted two minutes.

46. At 7.00pm, a nurse completed Mr Wallwork's initial health screen. She recorded that all his clinical observations were within the normal range, that Mr Wallwork had no thoughts of suicide or self-harm, and no concerns about his mental health. She did not record any substance misuse issues. She noted Mr Wallwork's diagnosis of EUPD and referred him to the mental health in-reach team for assessment.

47. The nurse completed a medication in possession risk assessment (IPRA) to determine the risks associated with Mr Wallwork holding medication in his cell (rather than having daily supervised medication which he was required to take in front of a nurse). She concluded that Mr Wallwork could not have his medication in possession.

48. A GP at Forest Bank did not meet Mr Wallwork but reviewed and prescribed his medications. (Although these were prescribed, they were not dispensed to Mr Wallwork that night due to the time of his arrival.)

49. At around 8.00pm, Mr Wallwork loaded his property onto a trolley and a PCO escorted him and another prisoner to H1 unit. (E1 unit is the general induction wing and H1 typically for those with substance misuse issues. Mr Wallwork and the other prisoner were located on H1 due to a shortage of induction beds on E1.) When they arrived at H1, all prisoners had already been locked in their cells for the night.

50. A SPCO issued Mr Wallwork with a bedding pack, and, at 8.05pm, he was placed in a single cell. A minute later, the SPCO returned and gave Mr Wallwork a 'brew pack' (containing tea and other basic items). A couple of minutes later, the SPCO

unlocked Mr Wallwork so he could collect some hot water and gave him a television. He then locked Mr Wallwork in his cell for the night.

51. At 9.34pm, an Operational Support Officer (OSO) completed a count of all prisoners and did not report any problems. There were no other additional checks made on Mr Wallwork during the night.

Events of 10 July

52. The investigator watched the CCTV and listened to staff radio communications. She also obtained information from the Northwest Ambulance Service. The following account has been taken from all sources. There is no body worn video camera (BWVC) footage as staff did not activate their cameras.

53. At 4.49am, the OSO completed a routine count of all prisoners and did not report any problems. He did not remember what he saw when he looked into Mr Wallwork's cell.

54. At 7.32am, a PCO unlocked Mr Wallwork's door. He did not look in the cell and quickly moved on to the next cell. He said he believed he had heard a response when he unlocked the door and said good morning. Nobody went into Mr Wallwork's cell.

55. At 8.11am, two nurses arrived at Mr Wallwork's cell to complete his secondary health screen. Nurse A went into the cell as she could not immediately see Mr Wallwork. She walked towards his bed and noticed that he was hanging out of the bed slightly, that his head was discoloured and there was a small pool of blood on the floor. She touched Mr Wallwork; she described him as cold and stiff and recognised immediately that he was dead. She told the other nurse and the PCO, who was walking past the cell. The PCO radioed a code blue medical emergency (used to indicate when someone is unresponsive or not breathing) and an ambulance was requested. The nurses did not attempt resuscitation because Mr Wallwork was clearly dead.

56. At 8.37am, paramedics arrived at Mr Wallwork's cell. They recorded that Mr Wallwork had rigor mortis (when the body stiffens several hours after death) and hypostasis (blood pooling due to a lack of circulation) and that he had appeared to have vomited blood. At 8.40am, they pronounced life extinct. Staff found a vape in Mr Wallwork's hand.

Contact with Mr Wallwork's family

57. Forest Bank appointed two family liaison officers. Together, at around 11.00am, they arrived at the home of Mr Wallwork's mother and stepfather, his next of kin, to break the news of his death. They offered their condolences and ongoing support. In line with Prison Service instructions, the prison contributed towards the costs of Mr Wallwork's funeral, which was held on 14 August.

Support for prisoners and staff

58. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

59. The Head of Residence 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 and TRiM (trauma management) also offered support. Nobody informed the OSO that Mr Wallwork had died, and he found out when other colleagues told him. A TRiM member contacted him several weeks after Mr Wallwork's death, which he said was helpful.

60. The prison posted notices informing other prisoners of Mr Wallwork'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 Mr Wallwork's death. Samaritans and Listeners were quickly notified of the death and provided support to prisoners.

Post-mortem report

61. The post-mortem report concluded that the cause of Mr Wallwork's death was unascertained. The post-mortem did not identify any issues with Mr Wallwork's heart. However, the pathologist noted that cardiac conduction disorders may run through families and encompass several differing conditions which are not detectable at post-mortem examination. These cardiac conduction disorders may produce few or no symptoms, only manifesting as sudden unexpected death.

62. Toxicology results identified that Mr Wallwork had a synthetic cannabinoid in his blood, indicating that he had taken it sometime before he died. While the use of synthetic cannabinoids has been linked to adverse cardiac events, and Mr Wallwork may have experienced effects associated with its use, the pathologist found that there is no certainty that it played a role in his death. Toxicology could not determine when he had taken the drug.

63. Mr Wallwork's prescribed medications were detected at therapeutic levels.

Findings

64. Mr Wallwork's cause of death was recorded as unascertained. He did not leave a note or letter and there is nothing to indicate that he took his own life or was at increased risk of suicide and self-harm in the time before he died. The post-mortem report found that, although he had used synthetic cannabinoids in the time before he died, there was no certainty that this contributed to his death. The pathologist also noted that it was possible, but not certain, that a cardiac conduction disorder might have played a role in Mr Wallwork's death.

Clinical care

65. The clinical reviewer found that Mr Wallwork received a good standard of care and equivalent to that which he could have expected to receive in the community.

Physical healthcare

66. Mr Wallwork did not have any known long-term health conditions. There was a reported family history of heart issues but no clinical evidence to suggest that Mr Wallwork had heart disease. Mr Wallwork had regular physical health checks to monitor the effects of the medication he was prescribed.

Substance misuse

67. Post-mortem and toxicology results indicated that Mr Wallwork had used synthetic cannabinoids sometime before his death and therefore had access to them while in prison. Mr Wallwork's cause of death is unascertained, but he was found with a vape in his hand (often used to smoke illicit substances). Police took the vape for testing, but at the time of issuing our report had not received the results.

68. Mr Wallwork had a history of using illicit substances in the community and disclosed that he had used substances in the past while in prison, although there is no record of him being under the influence or using drugs since 2019. He was not under the care of substance misuse services at Wymott or Forest Bank prior to his death.

Searching

69. We do not know where, when or how Mr Wallwork acquired synthetic cannabinoids, and it is possible that he brought them with him from Wymott. He arrived at Forest Bank, via court, with a large amount of property, including numerous open tubs of spices, rice and protein powders purchased from the prison canteen, which he took with him to his cell. The consumables were not searched at either Wymott or Forest Bank, although Mr Wallwork's clothing and stored property were checked against his property cards.

70. HMPPS Searching Policy Framework sets out the minimum levels of searching required. In places it is not clear what level of search should take place (such as when a prisoner leaves for court and might then return to a different prisoner). We contacted the Policy Lead for Security Practice, Procedures and Capability about her understanding and expectations. She told us that the policy framework is currently being revised. She said that:

- When a prisoner is discharged to court, current policy leaves the searching requirement to local risk assessment. (Wymott conducted a Level B rub down search in line with their local policy, which meets this requirement.) She said that the revised policy framework will seek to mandate either a Level B or Level A search upon discharge to court.

- On return from court, the current policy is not explicitly clear. The Lead said that the "Reception return – returns with non-prison escorts" line should apply, which states that a full search must be conducted in these circumstances. She said that the new framework will be strengthened to make clear that this includes returns from court. (Forest Bank conducted a Level B search when Mr Wallwork arrived from court.)

- The Lead said that Mr Wallwork's consumables should have been searched on his return to prison. (This is in line with the current policy framework, which says that on transfer-in from another prison, a prisoner's in-possession property must be searched.)

71. It does not therefore appear that Mr Wallwork or his property were searched in line with policy expectations when he arrived at Forest Bank from court. Given that the Searching Policy Framework is currently being reviewed to ensure that prisons have clearer guidance, we do not make a recommendation. However, the Director will wish to ensure, in the meantime, that Reception staff understand their responsibilities and the searching requirements for newly arrived prisoners.

Property in possession

72. HMPPS Prisoners' Property Policy Framework, sets out the expectations for limits on property to ensure safety and security and so that all property can be transferred with a prisoner on their movement to another establishment. This 'volumetric control' is applicable to all establishments. A prisoner's total property, whether held in possession or in storage, must fit into two standard size volumetric control boxes (a volumetric control box is 70cm x 55cm x 25cm and has a maximum weight of 15kg per box), plus half a volumetric control box for consumable items. (The overall amount of property held by a prisoner must be within volumetric control limits unless there are exceptional circumstances where a governor permits a prisoner to exceed these limits, which was not the case for Mr Wallwork.) Mr Wallwork had significantly more property in his possession when he arrived at Forest Bank.

73. The Head of Operations at Wymott said that volumetric control at Wymott is not scrutinised as it should be due to staff shortages, so prisoners often have more property in their possession than prison rules stipulate.

74. The Head of Residence at Forest Bank, said that they allowed prisoners to keep in their possession the consumables that they arrive with from other establishments, if they had been purchased via the prison shop. An SO said that while volumetric control measures were in place at Forest Bank, it was not uncommon for prisoners to arrive with more and be allowed to keep excess property in their possession.

75. We do not know how or where Mr Wallwork acquired drugs, or when he may have consumed them. We found that neither Wymott nor Forest Bank followed the national guidance on volumetric control. One way Mr Wallwork could have hidden

drugs was in the large quantity of consumables he had in his possession. We make the following recommendation:

The Governor of HMP Wymott and Director of HMP Forest Bank should ensure that national guidance on volumetric control is properly implemented, including the amount of consumables a prisoner is allowed to have in their possession.

Governor of HMP Wymott to Note

Measure taken to reduce illicit substances

76. We acknowledge the challenges in preventing drugs entering prisons and the positive steps that Wymott and Forest Bank have taken to reduce supply and demand.

77. Forest Bank have introduced enhanced physical security in the form of new windows and vertical netting across wings which has seen a significant reduction in over the wall conveyance and drone activity. Forest Bank has also introduced enhanced measures to address the increasing problem of psychoactive substances. All prisoner social mail is photocopied and, since January 2024, all parcels are checked before they enter the prison. The prison has enhanced gate security so that all staff and visitors should be searched on entry and there is a body scanner in reception to search prisoners on an intelligence-led basis. Forest Bank have three officers embedded in intelligence and liaison roles at the prison and liaise with the local neighbourhood policing team.

78. The Drug Strategy Lead at Wymott confirmed that, together with HMP Garth (a prison opposite Wymott) and Lancashire Police, they are working together to disrupt and prevent illicit substances entering the prisons via drones. He said that drone drops were a significant issue, but police were very responsive when informed there is vehicular or drone activity near the perimeter walls. He said that while some outward facing cells had grills to help prevent drones, not all cell windows did. Wymott have manufactured metal grills for all windows, but despite several applications for funding to install them on all windows, they have yet to be successful as other prisons have been prioritised. He said that he has requested a visit by the National Drug Diagnostic Team to help support Wymott in tackling the ingress of illicit substances, but to date this has not happened.

79. In their inspection on December 2023, HMIP identified the serious level of drugs finding their way into Wymott. They reported that Wymott do not have scanners and do not undertake systematic checks on staff. During interviews we were told by several different members of staff, including the Head of Safety, that checks on staff were very infrequent. Although staff corruption is only one way drugs are brought into an establishment, the deterrent through searching should be increased. We do not make a recommendation on this occasion, but it is something the Governor will want to address.

Director of HMP Forest Bank to Note

First night procedures

80. When a new prisoner arrives at Forest Bank, the receiving wing should complete a '1st night officer checklist', a set of questions to ascertain if the newly arrived prisoner has any specific needs or concerns or requires additional observations during their first night (additional observations are completed at 10.00pm, 12.01am, 2.30am & 5.00am). The SPCO explained that he did not complete this form for Mr Wallwork due to the time he arrived on the unit, but that he was satisfied there were no immediate issues. While there is no evidence that Mr Wallwork did require additional monitoring, without this check being complete he did not have the opportunity to share any concerns he might have had and the option for additional monitoring was not properly considered.

81. Another Head of Residence investigated the actions of the SPCO on the night Mr Wallwork arrived. On 1 October, the SPCO received formal advice and guidance about the requirement to complete first night checks. Given that Forest Bank have already investigated his actions, we do not make a separate recommendation.

82. The Head of Residence also completed a review of the induction process at Forest Bank. At the time of Mr Wallwork's death, unit staff completed inductions. However, a new standalone group of induction officers is now in place, in addition to unit staff, who complete the first night inductions. The induction officer now works in Reception from 5.00pm to ensure inductions, and the associated checklist, are completed before the prisoner moves to the wing. Any arrivals into the Reception area after 8.00pm have their first night checklist completed by the reception officers or the night staff.

83. Given Forest Bank have already addressed the issues around the first night induction, we do not make a recommendation.

Unlock procedures

84. When officers unlock cells, they should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states:

> "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

85. Prison Service Instruction 75/2011, on Residential Services, requires all prisons to have a clearly understood system in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock.

86. On 10 July, when the PCO unlocked Mr Wallwork's cell, he did not check his welfare or obtain a response from him. (Mr Wallwork was found dead around 40 minutes later.) While it would have made no difference to the outcome for Mr Wallwork, a proper welfare check should have meant that he was found sooner.

Forest Bank identified this oversight and conducted an internal investigation. On 16 August, the PCO received formal advice and guidance on ensuring unlock procedures are completed in line with national guidance. Given the Director's response, we do not make a recommendation.

Inquest

87. The inquest into Mr Wallwork's death concluded in October 2025. The inquest found his death to be unascertained, and recorded an open verdict.

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Independent Investigations

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