Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Brown, a prisoner at HMP High Down, on 16 January 2025

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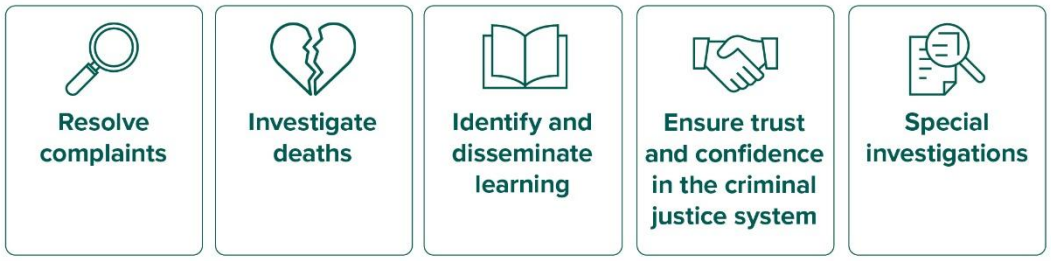
OUR VISION

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

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. 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.

3. On 23 August 2023, Mr Daniel Brown was remanded to HMP Wandsworth for sexual offences. On 25 January 2024, he was sentenced to four years in prison. On 19 April, Mr Brown transferred to HMP High Down.

4. On 16 January 2025, Mr Brown died in hospital of multi organ failure caused by necrotising pneumonia. Mr Brown had been an inpatient for around three weeks when he died. He was 32 years old. We offer our condolences to Mr Brown's family and friends.

5. Mr Brown did not name a next of kin and none could be identified following his death.

6. The PPO investigator investigated the non-clinical issues relating to Mr Brown's care. We did not find any non-clinical issues of concern.

7. NHS England commissioned an independent clinical reviewer to review the clinical care Mr Brown received at High Down. The clinical reviewer's report is attached as Annex 1. The clinical reviewer concluded that the clinical care Mr Brown received at High Down was not of the required standard and therefore not equivalent to that which he would have received in the community.

8. The clinical reviewer noted that there was a progressive decline in Mr Brown's physical health from September 2024. She found that there were several missed opportunities for timely intervention, a lack of clinical escalation and a failure to act on deteriorating clinical observations in line with national guidelines. The clinical reviewer concluded that Mr Brown's physical deterioration was visible and measurable, with clear clinical markers indicating the need for intervention that were not acted upon.

9. We make the following recommendations:

   The Head of Healthcare should ensure that all staff are trained in the use of National Early Warning Score (NEWS2) and understand their responsibilities regarding clinical escalation processes.

   The Head of Healthcare should ensure that there is a clear follow-up process when a prisoner with known vulnerabilities misses a healthcare appointment.

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The Head of Healthcare should review local processes to ensure that prisoners requiring clinical follow-up are properly identified.

10. We shared the initial report with HMPPS and the prison's healthcare provider, North West London NHS Foundation Trust. They found no factual inaccuracies. The healthcare provider provided an action plan which is annexed to this report.

11. The inquest into Mr Brown's death concluded on 11 May 2026, and recorded a verdict of natural causes.

Adrian Usher **December 2025**
Prisons and Probation Ombudsman

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