Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Brown a prisoner at HMP Lindholme on 24 February 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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 Michael Brown died in hospital on 24 February after being found unresponsive in his cell at HMP Lindholme two days before. He died from bronchopneumonia and the effects of psychoactive substances (PS). He was 51 years old. I offer my condolences to Mr Brown's family and friends.

Mr Brown used PS on a regular basis in prison. From September 2015 onwards, he was found under the influence of PS more than 40 times, including one occasion in March 2017 when he was taken to hospital and placed on a ventilator in the critical care unit because of the effects of PS. Although staff at Lindholme gave Mr Brown significant support for his PS use, he told staff he did not want to stop. The investigation found that the care provided to Mr Brown was equivalent to that which he could have expected to receive in the community.

I am concerned, along with HM Inspectorate of Prisons and the Independent Monitoring Board, that PS use among prisoners at Lindholme is rife. While the prison has taken measures to tackle the issue, more needs to be done. I am increasingly concerned by the number of deaths my office investigates in which PS has played at least some part. Mr Brown's death is another example of how dangerous PS is and how prisons are struggling to reduce PS use.

I am concerned that individual prisons are being left to develop local strategies to reduce the supply and demand for drugs. In my view there is now an urgent need for national guidance on the best measures to combat this serious problem. We have already made a recommendation to this effect to the Chief Executive of HM Prison and Probation Service. We have also written to the Prisons Minister setting out our concerns at the number of drug-related deaths in custody.

I note that Lindholme is one of ten prisons selected for a pilot project to test ways of reducing the availability of drugs and levels of violence within prisons. I am also aware that HM Prison and Probation Service is due to launch a national drugs strategy in autumn 2018. Lindholme needs these initiatives to work to prevent deaths like Mr Brown's.

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 **December 2018**

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Summary

Events

1. Mr Michael Brown was serving a life sentence and was transferred to HMP Lindholme on 8 February 2011.

2. He suffered from schizophrenia but this was well controlled by medication.

3. Mr Brown used psychoactive substances (PS) frequently at Lindholme. From September 2015 onwards, there were over 40 incidents of Mr Brown being found under the influence of PS, including one in March 2017 when he was taken to hospital and placed on a ventilator in the critical care unit because of the effects of PS. Although staff gave him significant support and information about the dangers of continued use, he did not stop.

4. On 22 February 2018, at around 5.05pm, an officer found Mr Brown unresponsive on his cell floor. Staff and paramedics resuscitated him and he was taken to hospital. However, he did not regain consciousness and at 2.33pm on 24 February, he was declared dead.

5. Toxicology tests showed that Mr Brown had used PS before he died and the pathologist concluded that this had contributed significantly to his death from bronchopneumonia.

Findings

6. Despite regular support from the substance misuse service, mental health team and prison staff, Mr Brown continued to use PS. The clinical reviewer concluded he received a good standard of care. However, arrangements for discussing complex cases were disjointed and confused. Mr Brown's substance misuse keyworker first requested a multidisciplinary case discussion eight weeks before he died, yet this meeting was never arranged.

7. Prison staff appropriately radioed a medical emergency response code when they found Mr Brown unresponsive on 22 February. However, there was a delay of four minutes before the control room telephoned for an ambulance, contrary to local and national instructions.

8. We are concerned at the availability of PS at Lindholme. Despite a comprehensive local drugs strategy, it is clear that more needs to be done to limit supply and demand. In our view there is now an urgent need for HMPPS to issue national guidance on this to prisons, rather than leaving individual establishments to develop their own local strategies on a piecemeal basis. We have made a recommendation to this effect to the Chief Executive of HMPPS in a previous investigation and raised our concerns with the Prisons Minister.

Recommendations

- The Governor and Head of Healthcare should ensure there are effective arrangements in place to discuss and support prisoners with complex needs and that these arrangements are understood by all disciplines.

- The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called.
- The Governor should ensure that next of kin details are recorded on reception, reviewed regularly and kept up to date, so that the next of kin can be informed as soon as possible if there is a medical emergency or a death in custody.

The Investigation Process

9. The investigator issued notices to staff and prisoners at Lindholme informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator obtained copies of relevant extracts from Mr Brown's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Brown's clinical care at the prison.

12. Our investigation was suspended between 19 March and 28 June, while we awaited the cause of death and toxicology results.

13. The investigator interviewed six members of staff at Lindholme on 24 and 25 April. The clinical reviewer accompanied her on 25 April. In addition, the investigator interviewed a prisoner by video link on 10 April and seven members of staff by telephone during April and May.

14. We informed HM Coroner for South Yorkshire, East District of the investigation. She gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Brown's family to explain the investigation. Mr Brown's family raised no specific issues for the investigation to consider, but wanted to know how his mental health was managed at Lindholme and if he had continued to misuse illegal substances.

16. Mr Brown's family received a copy of the initial report, but did not identify any factual inaccuracies.

17. The prison also received a copy of the report and did not identify any factual inaccuracies. An action plan for the recommendations is annexed to the report.

Background Information

HMP Lindholme

18. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1000 men. Care UK provides healthcare services and healthcare staff are on duty between 7.30am and 7.30pm every day.

19. In August 2018, the Prisons Minister announced that Lindholme would be one of the prisons participating in the '10 Prisons Project'. The project (with the aid of a £10 million funding injection) seeks to improve safety, security and decency at the prisons by focussing on living conditions, preventing drugs entering the establishments and enhancing leadership training available to Governors and their staff.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Lindholme was in October 2017. Inspectors noted at the previous inspection in March 2016, that the safety of the prison was significantly compromised by the ready availability of drugs and the consequent debt, bullying and violence. The most recent inspection showed that there had been some improvement in safety at Lindholme, and HMIP were able to lift the assessment from 'poor' to 'not sufficiently good'. However, this improvement was because of changes in reception and first night arrangements. Inspectors noted this was not a reflection of any decrease in the amount of violence or the threat posed to the prison by illicit drugs, which remained severe.

21. Over two-thirds of prisoners said that it was very easy or quite easy to get illicit drugs, and almost half to get alcohol. Over a quarter said that they had developed a drug problem while at Lindholme, which was far worse than at similar establishments. The availability and use of psychoactive drugs remained a serious problem. Inspectors noted the substance misuse meeting was only held once every two months and attendance was poor, with no representation from the security department. There was no detailed supply reduction action plan and a lack of a coordinated approach between all key stakeholders. Although inspectors accepted that the lengthy perimeter of the prison was difficult to defend, they found there was a need for a comprehensive, coordinated drug supply reduction plan.

Independent Monitoring Board

22. 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 most recently published annual report for the year ending 31 January 2018, the Board noted the very prevalent use of psychoactive substances by prisoners had remained a major challenge to the day-to-day running and security of the prison, and to the substance misuse team and healthcare generally. The Board commented that staffing levels had increased, but experienced officers continued to leave or retire.

Previous deaths at HMP Lindholme

23. Mr Brown was the thirteenth prisoner to die at Lindholme since February 2015. Of the previous deaths, four took their own lives, four died from natural causes, three were drug related and one is awaiting classification. There have been two deaths since, one drug related and the other self-inflicted. In several of our investigations, we found that there was a delay in control room staff calling an ambulance in response to a medical emergency code.

Assessment, Care in Custody and Teamwork

24. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

25. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular, multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

26. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Safer Custody*.

Incentives and Earned Privileges Scheme (IEP)

27. Each prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are four levels: entry, basic, standard and enhanced.

Integrated Drugs Treatment services (IDTS)

28. The Integrated Drug Treatment System aims to improve the quality of substance misuse treatment available for prisoners, with particular emphasis on those in the early days of custody and improving the integration between clinical and other drug workers. Its main emphasis has been on opiate users in the past.

Psychoactive Substances (PS)

29. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of 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 and a potential for violence. 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.

30. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

31. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

Key Events

32. On 7 November 2002, Mr Michael Brown was remanded to HMP Doncaster, for offences of wounding with intent, threats to kill and false imprisonment. He was sentenced to life imprisonment on 23 March 2003. This was not his first time in prison.

33. Mr Brown spent time at Doncaster and Gartree, before being transferred to Lindholme on 8 February 2011. Until 2015, according to Mr Brown's prison record, he was a polite prisoner who complied with the prison regime and worked well wherever he was employed.

34. Mr Brown had been diagnosed as a paranoid schizophrenic (a chronic mental health disorder where a person loses touch with reality) and was prescribed regular medication to help him manage his symptoms (a depot injection, fluphenazine, which slowly releases antipsychotic medication into the body over a number of weeks). Mr Brown was regularly reviewed as part of the Care Programme Approach. (The CPA is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs.)

35. Mr Brown was frequently found under the influence of illicit substances, usually PS. There were over 40 recorded incidents between September 2015 and when he died in February 2018.

36. On two occasions in 2015 and 2016, Mr Brown self-harmed because he said he was in debt due to his drug use. Prison staff started violence reduction measures on each occasion to support Mr Brown when he found himself in debt: staff moved him between wings on numerous occasions, gave him advice and support on avoiding debt and the substance misuse and mental health teams regularly met with him to discuss his risky behaviour.

37. The Parole Board recommended Mr Brown for open conditions (category D) on 21 November 2016, but because of his continuing drug use, he remained at Lindholme.

38. On 17 March 2017, Mr Brown was taken to hospital and placed on a ventilator in the critical care unit because of the effects of using illicit drugs. When he returned to Lindholme he told staff he did not want to stop using PS.

39. A multidisciplinary team (MDT) case conference was held on 6 April, at the request of the mental health and substance misuse team. The meeting was attended by head of security; area safer custody; mental health team; substance misuse team; safer custody and violence reduction. The review recorded that Mr Brown had come close to death, appeared not to care if he lived or died and that he was being used by other prisoners as a 'guinea pig' for new batches of PS. Staff started ACCT procedures to support Mr Brown, who was assessed at the MDT meeting as at high risk of future overdosing.

40. Mr Brown was located in the segregation unit for his own protection and upgraded to standard IEP. The next day, staff reviewed Mr Brown's ACCT and a Custodial Manager (CM), the ACCT case manager, recorded that Mr Brown had

coped remarkably well and had not experienced any withdrawal symptoms. Staff reviewed the ACCT regularly and closed it on 19 April.

41. Mr Brown continued to be supported by the mental health and substance misuse team. He was returned to A Wing, the recovery wing. At the post-closure review, staff recorded that Mr Brown had made excellent progress and demonstrated an increased awareness of the consequences if he relapsed.

42. On 6 June, staff found Mr Brown under the influence of PS. They downgraded him to basic IEP and moved him to G Wing, a standard residential unit.

43. Staff again found him under the influence of PS on 13 July, and opened an ACCT. Mr Brown said he did not have any thoughts of suicide or self-harm, but staff were concerned about the high level of risk due to his continued drug use. Mr Brown engaged well with the substance misuse team and the ACCT was closed on 20 July.

44. Mr Brown was found under the influence of PS on 26 July. On 4 August, a CM recorded that he had moved back to A Wing after another MDT, but there is no record of when this meeting took place or who attended. Staff upgraded Mr Brown to standard IEP.

45. On 8, 10 and 11 August, staff found Mr Brown under the influence of PS. On 11 August, an officer recorded that Mr Brown was screaming in his cell. When staff responded, they found Mr Brown unconscious and staff were also affected due to inhaling PS fumes. The next day, staff found Mr Brown under the influence of PS twice. An officer noted Mr Brown was not suitable to remain on the recovery wing and he was later moved to J Wing.

46. Mr Brown was placed on report on 14 August for being under the influence five times in the preceding three months and downgraded to basic IEP. On 17 August, staff started ACCT procedures to provide Mr Brown with additional support. Over the next few weeks, Mr Brown's behaviour improved and he remained drug free. He was upgraded to standard IEP on 4 September, but the ACCT remained open.

47. On 15 September, staff found Mr Brown under the influence of PS, and he was downgraded to basic IEP. A Supervising Officer (SO) chaired an ACCT review on 19 September. Mr Brown said he had not used drugs, had no thoughts of suicide or self-harm and was feeling better. A SO chaired an ACCT review on 27 September. He noted a psychiatrist said that Mr Brown struggled spending long periods of time in his cell, and that finding an activity or work placement would be beneficial. Mr Brown said he had fleeting thoughts about wanting to end his life. He recorded Mr Brown had been engaging well with the mental health and substance misuse team, and recorded that his level of risk remained raised.

48. After the meeting Mr Brown was allocated work in the waste management team. There were two further ACCT reviews and it was closed on 10 October, after staff assessed that Mr Brown's risk had reduced. On 12 October, due to his continued compliance and engagement with the substances misuse team, staff upgraded Mr Brown to standard IEP.

49. Between 17 October and 27 November, Mr Brown was found under the influence of PS four times. He was downgraded to basic IEP and removed from his workplace.

50. On 1 December, someone from the substance misuse team met Mr Brown at 12.47pm and reviewed his care plan. The substance misuse team member recorded that they discussed the dangers of his continued PS use, and that she believed Mr Brown's peers took advantage of him by getting him to try new batches of PS. Mr Brown told her he struggled to say no when offered drugs. Mr Brown asked if he could be moved back to A Wing, the drug recovery wing, but he was told he could not because he had failed the programme so many times and been removed from the wing. She arranged to see Mr Brown weekly to offer one-to-one support.

51. On 4 December, a nurse responded to a code blue medical emergency (indicating that a prisoner was unconscious or having problems breathing) as Mr Brown was under the influence of PS. Mr Brown was unconscious in a corridor on J Wing, had vomited, but after 10 minutes became more alert and asked to go back to his cell. The nurse encouraged Mr Brown to drink plenty of water and he was seen by the emergency care practitioner.

52. The substance misuse team member met with Mr Brown on 6 December. He told her other prisoners had given him free PS. She recorded on Mr Brown's medical record 'explained numerous times to Michael the danger of overdose and possibility of death due to his behaviour'. She recorded that she discussed overdose and tolerance levels with Mr Brown, and completed a knowledge worksheet which showed Mr Brown understood the dangers of using PS. On 8 December, an officer recorded Mr Brown had been found under the influence of PS.

53. On 16 December, staff found Mr Brown under the influence of PS on J Wing's exercise yard and a nurse responded to a code blue medical emergency. The nurse recorded Mr Brown was lying on the floor and was incomprehensible. While being assessed, Mr Brown became more alert and he was taken back to his cell, but he refused any further monitoring and told staff he was 'alright'.

54. On 19 December, two medical emergency codes were called when Mr Brown was under the influence of PS. At 9.26am, a nurse assessed Mr Brown in the healthcare unit. His observations were satisfactory and after he assessed him again at 10.03am, Mr Brown was well enough to return to his cell. At 7.28pm, a nurse responded to the second code blue. She treated Mr Brown with a medication used to block the effects of opioids (naloxone) and he responded quickly, so the ambulance which had been requested was cancelled.

55. The substance misuse team member met with Mr Brown the next day at 9.20am. She discussed the four incidents of PS use since their previous meeting and recorded that Mr Brown continued to disregard advice about possible overdose. She sent an email at 2.52pm to substance misuse service manager, outlining her concerns about Mr Brown's continued use of PS, and saying that she was concerned for his safety and wanted his case discussed at a complex case meeting with prison staff. The substance misuse service manager acknowledged

the email at 3.06pm and agreed to discuss Mr Brown's case at the next complex case meeting. A complex case meeting was never held.

56. A SO reviewed Mr Brown's IEP status on 22 December, but kept him on basic because of his continued drug use. On 23 and 26 December, Mr Brown was found under the influence of PS by prison staff and nurses responded to code blue medical emergencies when Mr Brown was found on the floor and had slurred speech. On both occasions an ambulance was requested, but cancelled as Mr Brown recovered quickly.

57. On 28 December, a mental health nurse gave Mr Brown his depot injection. He recorded that Mr Brown appeared settled, kempt and was not under the influence. Mr Brown told him that he was coping in his cell and he gave him some batteries for his radio to help keep him occupied.

58. Mr Brown had his next depot injection on 11 January 2018. There had been no other recorded incidents of him being under the influence of PS and the next day he was upgraded to standard IEP.

59. On 15 January, Mr Brown was moved to A Wing, the drug recovery wing. On 17 January, the substance misuse team member contacted the substance misuse service manager and recorded in Mr Brown's medical record that a complex case meeting still needed to be arranged to discuss Mr Brown's risks and needs.

60. The substance misuse team member met Mr Brown on 18 January. She noted that she was unaware he had been moved to A Wing and that Mr Brown was not on a recovery programme. Mr Brown told her he had not used PS for two weeks and wanted to start the recovery programme. She explained that she needed to safeguard other prisoners on the wing who were on the recovery programme, but agreed, having discussed his case with the substance misuse service manager, that Mr Brown could remain on A Wing until he was reassessed for the recovery programme which was scheduled for 29 January. On 20 January, a nurse treated Mr Brown with naloxone after he was found under the influence of PS. He was downgraded to basic IEP.

61. A psychiatrist assessed Mr Brown on 24 January. He noted Mr Brown claimed to have stopped using PS, but that his account was inconsistent with the medical records. Mr Brown reported that he had no delusional thoughts and the psychiatrist outlined the risks of continuing to use PS while taking other medications. He intended to review Mr Brown 12 weeks later. The next day the mental health nurse administered Mr Brown's depot injection and recorded that his mood was good and he had no apparent thought disorders. Mr Brown told the mental health nurse he was happy to be on A Wing.

62. On 29 January, a CM upgraded Mr Brown to standard IEP as he had not been found under the influence of PS and was 'visibly trying' and worked well with staff and peer mentors. The CM noted, 'Although only a week since Michael was under the influence. This is a long time in his world.'

63. On 2 February at 8.15am, the substance misuse team member telephoned the CM as she had concerns about Mr Brown remaining on A Wing and the effect on other prisoners on the recovery programme. It was agreed that Mr Brown would

remain on A Wing, and she highlighted her concerns about the risk of Mr Brown overdosing. She met with Mr Brown at 9.12am and provided him with information about tolerance levels and overdose and highlighted the dangers and risk of overdose. Mr Brown accepted that he had lapsed and had used PS. He said it was a way of managing day to day prison life. Mr Brown told her that he found work motivating and it gave him structure.

64. On 4 February, Mr Brown was found under the influence of PS. Healthcare staff responded to a code blue medical emergency and he was seen to be fitting and had vomited. He was given naloxone and became more responsive but became aggressive and kicked a nurse. She left the cell for her own safety. He did not require further treatment. However, four prison officers were taken by ambulance to hospital for assessment as they had inhaled toxic fumes. Mr Brown was downgraded to basic IEP.

65. Mr Brown was moved to J Wing (red side) on 5 February. A CM recorded, 'It is not possible for Michael to remain on A Wing, his vulnerabilities make him a target to other prisoners "spice pig" and he will not say no. Staff have tried constantly to keep him safe, tried many motivation tactics to destract (sic) him from substances…' He recorded that a MDT meeting had been organised to discuss Mr Brown's needs and risks and whether he should be transferred to a different prison. There was an exchange of emails between the CM, the substance misuse team member and a senior probation officer at Lindholme about their respective availability. The meeting was scheduled to take place on 7 February but, due to an unrelated incident at Lindholme, it was cancelled. The meeting was not rescheduled and did not take place before Mr Brown died.

66. On 9 February, Mr Brown failed to attend a meeting with the substance misuse team member. On 11 February, an officer found Mr Brown under the influence on the wing landing. Healthcare examined him and when he was responsive they assisted Mr Brown back to his cell. An officer checked on Mr Brown after afternoon exercise and Mr Brown said he was 'fine'. However, when he unlocked his cell door around teatime Mr Brown was on the floor, unresponsive and he radioed a code blue medical emergency. Healthcare staff responded and Mr Brown regained consciousness, did not require hospital treatment and the ambulance was cancelled. Another officer placed Mr Brown on report; he received seven days loss of privileges and 50% stoppage of earnings as a punishment.

67. On 13 February, the psychiatrist and a nurse met and they reviewed Mr Brown's medication and discussed the impact of his continued use of PS. The psychiatrist recorded that Mr Brown 'does have clear diagnosis of schizophrenia and would rapidly deteriorate without medication'. He noted Mr Brown had been stable on his depot injections for a sustained period of time and had the risks of using PS explained to him, which he understood. He noted Mr Brown knew there were serious risks to his health and the potential for fatal interactions if he continued to use PS.

68. Staff at Lindholme hold a weekly Safety Intervention Meeting (SIM), to discuss managing the risks to prisoners or the establishment. The meeting is multidisciplinary and heads of function, including security, safer custody and

healthcare and substance misuse managers attend. On 14 February, Mr Brown was discussed for the first time. The CM and the senior probation officer explained that Mr Brown was at high risk of harm due to his continued PS use and 'has nearly died twice'. The minutes from the SIM meeting show that prison staff were concerned Mr Brown may get into debt and that J Wing had a particular problem with PS at that time (there were 12 incidents of prisoners being under the influence on one side of J Wing the night before the meeting). He explained that Mr Brown had received a lot of support, and suggested consideration should be given to transferring Mr Brown to another prison.

69. A SO was tasked with arranging a MDT meeting with Mr Brown's substance misuse worker, mental health nurse and wing manager to discuss his risks and needs.

70. On 15 February, Mr Brown was placed on report as a homemade pipe which had been used for smoking drugs was found in his cell, which he shared with another prisoner. Mr Brown pleaded not guilty to the charge and said the pipe was not his. The adjudication was adjourned, but not concluded before Mr Brown died.

71. On 21 February, at the regular SIM meeting, the SO's action to arrange an MDT was still outstanding but no explanation was recorded for why it had not yet been held. The action was noted as outstanding. This meeting was not arranged before Mr Brown died.

72. Mr Brown's cellmate told the investigator that Mr Brown smoked PS almost daily and would use the drug whenever he could. He said Mr Brown was ambivalent about the dangers and enjoyed the feeling PS gave him. He said other prisoners often watched Mr Brown when he was under the influence as they found it funny, and would at times look through the cell observation panel 'for a laugh' as Mr Brown was frequently under the influence. He said as far as he knew Mr Brown was not bullied and he was not in debt, but that he would accept drugs off other prisoners and did not care if they watched and laughed at the effects of the drug.

22 February

73. Mr Brown had attended a project all week, facilitated by an external drama group, which focused on substance misuse. CCTV shows that on 22 February, he returned to his cell at 4.31pm. An officer let Mr Brown and his cellmate into their cell, but did not lock the door. The officer told the investigator that he did not observe anything unusual about Mr Brown's behaviour. Mr Brown left his cell at 4.36pm to collect his meal. At 4.44pm, Mr Brown appeared to be dancing outside his cell and he told Mr Brown to go into his cell, but he replied that he had not yet collected his food. CCTV shows Mr Brown went into his cell at 4.49pm and his cellmate followed a few minutes later. The officer locked the cell at 4.52pm.

74. The cellmate told the investigator that when they went into the cell, Mr Brown offered his 'pipe' for him to smoke PS. He said he used the pipe and then gave it back to Mr Brown who continued to smoke. He said because of the effect of PS he was oblivious to what happened next. He said he became aware that someone was banging on the cell door. He said it was another prisoner who he believed had been looking through the panel to laugh at Mr Brown. He told the

investigator that Mr Brown was on the floor, and his head was purple, he assumed because he was not breathing. He said he shouted to the prisoner outside to alert staff and he placed Mr Brown in the recovery position and tried to get him to start breathing by hitting his back.

75. The officer said he saw a prisoner looking through the observation panel of Mr Brown's cell at 5.04pm. He went to the cell, looked through the observation panel and saw Mr Brown on the floor. He opened the cell door, and radioed a medical emergency code blue. He said the top of Mr Brown's head was dark blue, that he was curled up in a ball and covered in vomit. He said his cellmate was standing at the back of the cell, and was rocking; he said he remained that way until healthcare staff arrived.

76. The officer placed Mr Brown into the recovery position and when healthcare staff arrived he took his cellmate out of the cell. A nurse and another nurse responded to the code blue and arrived at Mr Brown's cell at 5.06pm. The nurse recorded 'face purple/blue, no pulse detected, pupils fixed'. Nurses started cardiopulmonary resuscitation (CPR) and asked for a defibrillator, which an officer brought from a different area a short while later. They attached the defibrillator to Mr Brown, which advised he had no shockable heart rhythm. Three nurses who had also responded to the emergency code, continued CPR until the paramedics arrived. Another nurse kept a log.

77. An operational support grade (OSG) in the communications room, recorded that a code red medical emergency (used to indicate severe blood loss) was called over the radio at 5.05pm, but corrected this to a code blue on the log at 5.08pm. Another OSG took over updating the communications log and recorded an ambulance was requested at 5.09pm, which Yorkshire Ambulance Service records confirmed. When paramedics arrived at 5.17pm, they took over Mr Brown's care. Mr Brown was taken to hospital at 5.36pm. He did not regain consciousness and remained in a coma until he died at 2.33pm on 24 February. Mr Brown remained on life support until 11.57am on 25 February, when his organs were donated for transplant.

Contact with Mr Brown's family

78. A duty governor, contacted Mr Brown's family to inform them he had been taken to hospital. There was some delay in identifying the next of kin, as Mr Brown's prison records were out of date. The duty governor obtained contact details of other relatives from the visitor records and they were informed he had been taken to hospital.

79. The prison appointed a family liaison officer and together with a prison manager he visited Mr Brown's family at their home address after his death. The family liaison officer offered condolences and ongoing support to family members. The prison contributed towards the costs of Mr Brown's funeral, in line with national policy.

Support for prisoners and staff

80. A safer custody manager, held a debrief for all staff involved in the emergency response, and with staff who were with Mr Brown when he died.

81. The prison posted notices informing other prisoners of Mr Brown's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Brown's death. The prison held a memorial service for Mr Brown on 24 April.

Post-mortem report

82. A pathologist concluded that Mr Brown died from bronchopneumonia and PS use. The post-mortem report shows that Mr Brown had active bronchopneumonia (inflammation of the lung, usually caused by a bacterial infection) and the toxicology report shows he had recently used PS. The pathologist noted that one of the reported effects of PS is respiratory depression. He considered that the use of PS was likely to have reduced the amount of oxygen to the lung and reduced its natural ability to clear infection. He concluded that PS use contributed significantly to Mr Brown's death.

Findings

Management of Mr Brown's substance misuse and mental health

83. Staff constantly tried to protect and support Mr Brown in relation to his PS use. They gave him advice on the dangers of continued use, moved him numerous times in an attempt to protect him and supported him with violence reduction plans and ACCT procedures. However, he continued to use PS.

84. A substance misuse team member was Mr Brown's keyworker at the time of his death and had worked alongside him previously. She had given Mr Brown lots of information about the risks of taking illicit substances, harm reduction strategies and had consistently tried to motivate him to make positive changes to stop his drug use. Her contacts with Mr Brown were documented comprehensively in his medical record.

85. Mr Brown had a diagnosis of paranoid schizophrenia. He was regularly seen by the in-reach mental health team and attended for his two-weekly depot injections. A psychiatrist and a nurse, Mr Brown's mental health keyworker, both said Mr Brown's mental health was well managed and he presented no issues in relation to his paranoid schizophrenia. The psychiatrist said the risks of stopping Mr Brown's antipsychotic medication were too great, despite his PS use.

86. The clinical reviewer concluded that overall Mr Brown received good care from the substance misuse use and mental health teams, which was equivalent to the service he could have expected to receive in the community.

Coordination of multidisciplinary case discussions

87. The substance misuse team member first requested a complex case review of Mr Brown on 20 December, in response to his increased PS use. A substance misuse team manager, told the investigator that the purpose of a complex case meeting was to provide an opportunity to discuss an individual prisoner's needs with all relevant disciplines and the prisoner, with a focus on a more personalised way of identifying their needs and risks. The expectation was that there would be a representative from the drug strategy and substance misuse teams, residential wings, security, mental and general healthcare. However, she said there had only ever been two complex case meetings held, both prior to the substance misuse team member's request to discuss Mr Brown's case, as it proved impossible to organise attendance. The substance misuse team member had not been informed the complex case meetings had stopped.

88. The substance misuse team member continued to ask for coordinated input from all disciplines involved with Mr Brown. On 17 January, she recorded in the medical record a conversation with the substance misuse team manager '*about taking client to prison complex care meeting. To date, this has not been done and xxx has agreed to chase this up'*. An MDT meeting that was scheduled for 7 February, did not take place. The substance misuse team manager said her team were not informed by prison staff that it had been cancelled and only realised when they arrived for the meeting and nobody else did.

89. Mr Brown was moved to A Wing (the recovery wing) on 15 January but, due to his continued PS use, he was moved to J Wing on 5 February. However, the substance misuse team were not consulted and the substance misuse team manager said decisions about a prisoner's location on the recovery wing were being made unilaterally by the CM, the wing manager.

90. Mr Brown was discussed at a SIM meeting for the first time on 14 February, eight weeks after the substance misuse team member first requested multidisciplinary input. A SO was tasked with organising an MDT meeting, but this did not happen before Mr Brown died because he was unable to establish a date when all disciplines could attend.

91. The investigator was told by healthcare, substance misuse and prison staff that the arrangements for having MDT discussions were confusing, the meetings overlapped in purpose and the biggest obstacle to discussing an individual prisoner's needs was getting people to agree a date and time. All agreed that the SIM meeting was usually well attended by functional heads and provided a forum for joint decision making, which is recorded. We make the following recommendation:

The Governor should ensure there are effective arrangements in place to discuss and support prisoners with complex needs and that these arrangements are understood by all disciplines.

Emergency Response

92. PSI 3/2013 - *Medical Emergency Response* requires prisons to have a medical emergency response code protocol, which contains mandatory instructions for governors and directors to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. Lindholme's local protocol, Notice to Staff 75/2017 issued on 26 June 2017, is clear that an ambulance should be called immediately, when a medical emergency code is radioed, in line with PSI 3/2013. The Notice to Staff also states that this has been agreed with the Yorkshire Ambulance Service NHS Trust, who have said they will always immediately despatch an ambulance even if some details (such as the name or age of the patient, or their specific symptoms) are not known.

93. An officer who discovered Mr Brown radioed a code blue medical emergency promptly and appropriately. An Operational Support Grade incorrectly recorded on the communications log that a code red medical emergency had been called at 5.05pm, because she heard 'red side' on J Wing. She corrected this mistake in the log to code blue at 5.08pm and we are satisfied this was a simple error. She told the investigator that her colleague had taken over updating the log as she was busy transmitting messages over the radio network, but was certain an ambulance was called immediately when the medical emergency was received at 5.05pm. The ambulance service told us they received the first request at 5.09pm, four minutes after a medical emergency was first radioed.

94. Regardless of whether it was a code blue or red, an ambulance should have been requested immediately. Any delay in requesting an ambulance could be crucial. In several of our previous investigations at Lindholme, we found that

there was a delay before control room staff requested an ambulance following an emergency radio message. The OSG was given additional training, but there was a delay in requesting an ambulance in a subsequent death at Lindholme and it is apparent that there is still work to do to ensure staff are aware of their responsibilities in a medical emergency. We therefore make the following recommendation:

The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called.

Informing Mr Brown's next of kin

95. PSI 07/2015, 'Early Days in Custody', sets out the guidance and mandatory actions for prison staff to follow when prisoners arrive at and are inducted into a new prison. This includes that the name and contact details of the prisoner's next of kin must be recorded in their core record and on their electronic prison record.

96. The duty governor on 22 February, checked Mr Brown's prison record and his mother was recorded as his next of kin. He attempted to telephone her to inform her Mr Brown had been admitted to hospital but the number had been disconnected. He obtained details of other family members from Mr Brown's phone records and his visitor list. He told the investigator that he attempted to contact Mr Brown's sister, but there was no answer. He eventually spoke to Mr Brown's aunt, who told him Mr Brown's mother had died around 10 years ago. Mr Brown's aunt contacted other relatives and Mr Brown's sister was informed later the same evening that he had been admitted to hospital.

97. Ensuring that next of kin details are kept up to date is crucial to ensure swift communication in circumstances such as those of Mr Brown. There is no current formalised process for reviewing and updating next of kin details. Therefore, we make the following recommendation:

The Governor should ensure that next of kin details are recorded on reception, reviewed regularly and kept up to date, so that the next of kin can be informed as soon as possible if there is a medical emergency, or a death in custody.

Psychoactive substances at HMP Lindholme

98. The PPO's Learning Lessons Bulletin on PS, issued in July 2015, highlighted that PS was then a source of increasing concern in prisons. Not only does PS use have a profoundly negative impact on physical and mental health, but trading these substances can lead to debt, violence and intimidation. Mr Brown's death is a clear example of how dangerous PS is, and illustrates why prisons must do all they can to eradicate its use.

99. During its inspection of Lindholme in October 2017, HMIP found that more than two thirds of prisoners said it was easy to get drugs at Lindholme. They found that PS was a significant problem at the prison. Besides dangers to both the physical and mental health of prisoners when using illicit drugs, they pose a

threat to an establishment's good order and the trade in illicit drugs can lead to debt, bullying and violence.

100. Lindholme has a substance misuse strategy, issued in August 2017. This includes various actions intended to support those known to use PS, plus additional disciplinary measures to deter drug use. While the strategy includes some action points to reduce supply of PS, HMIP found that there was no detailed supply reduction action plan. Since the inspection, Lindholme has introduced further measures to reduce the supply of PS, including adding additional fences between the wings and outer wall and preventing prisoners accessing other parts of the grounds that are more vulnerable to thrown packages, methods to reduce staff corruption, monitoring of prisoners' mail, analysis of security intelligence and searching of prisoners and their cells. Prisoners found to be under the influence of PS are referred to the substance misuse team and typically seen within 24 hours.

101. We accept that Lindholme has a drug strategy in place and staff are working hard to implement it. Nevertheless, Mr Brown was apparently able to obtain and use PS without difficulty at Lindholme and continued to do so despite being made aware of the dangers and despite losing privileges. It is clear, therefore, that more needs to be done to reduce both the supply and the demand for PS. We are aware that Lindholme is one of ten prisons that has been selected for a pilot project to test ways of reducing the availability of drugs and levels of violence within prisons.

102. Lindholme is not alone in facing this problem – it is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, in the PPO's view there is now an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works.

103. In a recent investigation into a death that involved PS use, we recommended that the Chief Executive of HM Prison and Probation Service should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of deaths she was investigating that were due, or linked, to the use of PS. The Chief Executive has told us that HMPPS plan to issue a national drug strategy in the autumn of 2018. We therefore make no recommendation.

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