Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Brown a prisoner at HMP Dovegate on 25 December 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 Robert Brown died of aspiration of his stomach contents (breathing vomit into his airways), caused by the use of synthetic cannabinoids, on 25 December 2018 at HMP Dovegate. He was 54 years old. I offer my condolences to his family and friends.

Mr Brown used illicit drugs in prison. Although he said that he was motivated to stop, he was suspected of trading and using drugs.

I am satisfied that prison, healthcare and substance misuse staff encouraged Mr Brown to address his drug taking and offered structured support.

However, the apparent ease with which he appeared to obtain drugs suggests that much more needs to be done at Dovegate to stop the flow into the prison. The prison will need to reassess their approach in line with the Prison Service's recently published Prison Drugs Strategy.

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 **September 2019**

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Summary

Events

1. Mr Robert Brown had spent several periods in prison and had a long history of drug and alcohol misuse. On 16 February 2018, he was released on licence. Four days later he was recalled to prison and was charged with causing death by dangerous driving. In April, he was transferred to HMP Dovegate and was sentenced to nine years in prison.

2. At his reception health screen, nurses noted that he had a history of post-traumatic stress disorder (PTSD), drug and alcohol problems, severe depression, anxiety, agoraphobia and panic disorder. He had a history of self-harm and had been monitored under suicide and self-harm prevention procedures, known as ACCT, during previous prison sentences.

3. Four days after his arrival at Dovegate, Mr Brown was found unresponsive after using psychoactive substances (PS). A substance misuse practitioner assessed Mr Brown, created a care plan and held regular reviews with him. In September, he tested positive for PS on two occasions. Intelligence reports suggested that he was also involved in drug trading and that his mother was paying money into the bank accounts of prisoners suspected to be involved in drug trading.

4. At 9.00am on 25 December, an officer found Mr Brown unresponsive on his bed. Attempts to resuscitate him were unsuccessful and a paramedic confirmed his death at 9.33am. Toxicology tests found that Mr Brown had used PS in the hours before his death.

Findings

5. The post-mortem and toxicology examinations established that Mr Brown died from aspiration of his gastric contents (breathing vomit into his lungs) as a result of using PS.

6. There is nothing to suggest that Mr Brown intended to take his life or that his death was anything other than accidental.

7. The clinical reviewer said that, overall, Mr Brown's physical healthcare was equivalent to that which he could have expected to receive in the community.

8. The clinical reviewer is satisfied that healthcare staff appropriately referred Mr Brown to the substance misuse service, and that he received clinical and psychosocial support to help address his substance misuse.

9. However, we are concerned that prison staff did not follow some of the specified procedures to address Mr Brown's drug use and did not tell his substance misuse worker that he had twice tested positive for PS in September.

10. We are concerned that Mr Brown was apparently able to access drugs without difficulty at Dovegate. While we acknowledge the prison's attempts to limit the supply of drugs, we believe that Mr Brown's death shows that further work is required.

11. Mr Brown was monitored under ACCT procedures from his arrival at Dovegate until May 2018. We are satisfied that staff had no reason to consider he posed a risk to himself after this and that it was appropriate for ACCT procedures to have ended. We are, however, concerned that healthcare staff did not participate in or contribute to the ACCT reviews. Although we are satisfied that this did not contribute to Mr Brown's death, it could make a difference in other cases.

Recommendations

- The Director should ensure that the key drug issues at Dovegate are identified and that the prison's local drugs strategy is revised by September 2019 to address these key issues.
- The Director should ensure that prisoners suspected of using PS, or other illicit substances, are managed in line with the local drug strategy.
- The Director and Head of Healthcare should ensure that healthcare staff are involved in ACCT reviews whenever possible.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Dovegate informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded with general observations about the drug problems at HMP Dovegate.

13. The investigator visited Dovegate on 3 January 2019. She obtained copies of relevant extracts from Mr Brown's prison and medical records.

14. The investigator interviewed six members of staff and one prisoner at Dovegate on 31 January 2019.

15. NHS England commissioned a clinical reviewer to review Mr Brown's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.

16. We informed HM Coroner for Staffordshire South of the investigation. We suspended our investigation from 17 January 2019 until 3 June when we received the results of the toxicology and the post-mortem examinations from the Coroner. We have sent the Coroner a copy of this report.

17. The investigator contacted Mr Brown's mother to explain the investigation and to ask if she had any matters that she wanted us to consider. She asked:

    - what time Mr Brown had died;
    - what time he had been unlocked;
    - whether someone had harmed Mr Brown in retaliation for a drug debt or because of his offence; and
    - whether media reports were true that Mr Brown was found with drugs in his hand and cell.

    We have addressed those questions in this report.

18. Mr Brown's mother received a copy of the initial report. She pointed out one factual inaccuracy. This report has been amended accordingly. Mr Brown's mother also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Dovegate

20. HMP Dovegate is a category B prison run by Serco. The main prison holds up to 933 prisoners who are on remand or have been sentenced. There is also a therapeutic community, separate to the main prison, which holds up to 200 prisoners. Care UK provide healthcare services.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Dovegate was in May and June 2017. Inspectors reported that the availability of illicit substances was considerable and the prison needed a more effective approach to reduce the supply of drugs. Although inspectors noted that managers had acted on this, evidence suggested that drugs and alcohol were still too readily available.

22. Inspectors said that the management of security intelligence reports had improved. They noted that they were efficiently collated and analysed and staff had completed a substantial number of intelligence-led searches. They also found that substance misuse interventions to help reduce demand were excellent, with a wide range of one-to-one and group-based approaches.

Independent Monitoring Board

23. 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 30 September 2017, the IMB reported that the prison was settled and reasonably calm and health services were generally better than before. Intelligence reporting had improved, but the use of psychoactive substances (previously known as 'legal highs') was still high.

Previous deaths at HMP Dovegate

24. Mr Brown's death was the eighth at Dovegate since December 2016. One of the previous deaths was drug-related.

Assessment, Care in Custody and Teamwork

25. 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. 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.

Psychoactive substances (PS)

26. PS (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.

27. In July 2015, we published a Learning Lessons Bulletin about the use of PS 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.

28. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

Incentives and Earned Privileges scheme (IEP)

29. 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.

Key Events

30. Mr Robert Brown had many previous convictions for which he had served time in prison. On 20 November 2017, he was sentenced to six months in prison, charged with possession of a bladed article and failing to surrender to court bail proceedings. He was sent to HMP Hewell.

31. On 16 February 2018, Mr Brown was released on licence. However, on 22 February, Mr Brown was arrested for two counts of causing death by dangerous driving and other driving offences. His licence was revoked the next day and he was recalled to Hewell. At Hewell prisoners threatened Mr Brown because of the details of his offence and he had to remain in his cell for his own protection. He was transferred to HMP Dovegate on 12 April on security grounds. On 27 April, he was sentenced to nine years in prison.

32. Mr Brown had a history of personality disorder, post-traumatic stress disorder (PTSD), drug and alcohol problems, severe depression, anxiety, agoraphobia and panic disorder. He also had a history of attempted suicide and self-harm and had previously been monitored under suicide and self-harm procedures, known as ACCT.

33. When Mr Brown arrived at HMP Dovegate, he was subject to ACCT monitoring as he had thoughts of self-harm due to his latest offence. A nurse completed Mr Brown's initial health screen when he arrived. She noted that he was not allowed to keep and administer any medication as he had a history of trading his medications with other prisoners. She noted that when Mr Brown arrived, he was subject to ACCT monitoring but that she had no concerns about him harming himself. She completed a mental health referral because Mr Brown's records indicated that he had had previous contact with mental health services.

34. On 16 April, prison staff radioed a medical emergency code blue when they found Mr Brown unresponsive in his cell, having vomited and with drug paraphernalia on his cell floor. Staff lifted him onto his bed and he became responsive. A nurse attended, checked his observations and confirmed that he was under the influence of drugs. She advised wing staff to monitor him. Staff reduced his IEP level to basic for 28 days. This triggered a referral to the Substance Misuse Service (SMS).

35. As a result, a substance misuse worker saw Mr Brown on 23 April. Mr Brown denied that drug paraphernalia had been found in his cell and said that he did not have any concerns about drugs. She explained the risks of overdose.

36. Staff ended ACCT procedures on 1 May 2018. On 2 May, the substance misuse worker booked Mr Brown on to the substance misuse programme which began that day. Mr Brown told her that he was a recovering alcoholic and had used crack cocaine and cannabis daily, but said he had not taken any substances for the last three months. He said that he wanted to exercise and work with the mental health team. He said that he wanted to be drug-free and felt anxious and depressed about his current offence. He said that he had smoked cigarettes daily for the past 20 years but had used nicotine patches to stop smoking. She noted Mr Brown did not disclose any self-harm thoughts and she created a substance misuse care plan.

37. On 3 May, an intelligence report noted that in the previous month, Mr Brown had been linked to discussions about smuggling PS onto the wing.

38. On 14 May, prison staff upgraded Mr Brown to the standard IEP level. On 15 May, Mr Brown applied to be referred to the mental health team. A nurse placed him on the waiting list.

39. On 30 May, Mr Brown met the substance misuse worker and told her that his mental health was declining and that he was waiting to see the mental health team for medication. She told him that she would check on his referral and suggested counselling sessions.

40. As a result of the substance misuse worker's check, a mental health nurse reviewed Mr Brown the next day. She noted that Mr Brown had a history of illicit drug and alcohol misuse. She noted that he was on the waiting list for a triage appointment with the primary mental health team and was already receiving quetiapine (an antipsychotic) and mirtazapine (an antidepressant) to treat emotionally unstable personality disorder, depression and anxiety. She recommended that Mr Brown should remain on the mental health waiting list and that he should see a prison GP the next day (as an appointment was already booked).

41. A prison GP saw Mr Brown, as arranged, on 1 June. He noted that Mr Brown wanted to take pregabalin for his anxiety and panic attacks. The prison GP agreed and made it clear that any attempts to misuse the medication would mean that it would be immediately stopped. (Pregablin is abused and traded in prison because of its euphoric effects.)

42. On 9 June, an intelligence report noted that Mr Brown might be arranging for drugs to be brought onto the wing.

43. On 19 June, Mr Brown asked a prison GP to increase his prescription of pregabalin. The prison GP did not increase his prescription but agreed that Mr Brown could continue to receive pregabalin.

44. At his review with the substance misuse worker on 22 June, Mr Brown told her that he was drug-free and he agreed that counselling might help him as he had flashbacks about his offence. On 1 July, a nurse noted that Mr Brown had tried to conceal his pregabalin and he was given a warning. It was not however stopped.

45. On 11 July, an intelligence report noted that Mr Brown was suspected of trading his trainers for PS.

46. On 18 July, a nurse reviewed Mr Brown's mental health. She noted that she would discuss his case at the mental health multidisciplinary team meeting as he had asked to see a psychiatrist. After that meeting, she added Mr Brown to the waiting list.

47. On 3 August, a prison GP saw Mr Brown who agreed to try amitriptyline (an antidepressant), with a view to stopping his pregabalin.

48. In August, an intelligence report noted that Mr Brown was suspected of paying for PS. On 21 August, after a routine cell search, Mr Brown's kettle was found to be "stripped" (where the wires are exposed so they can be used to light illicit drugs). A Prison Custody Officer (PCO) gave him a negative entry under the IEP scheme. There is no record of any follow-up action.

49. A team leader from the secondary care mental health team, completed a review with Mr Brown on 29 August. She said that he should be referred to a psychiatrist.

50. On 31 August, an intelligence report noted that Mr Brown was suspected of paying £50 for drugs.

51. On 5 September, Mr Brown had a mandatory drug test and tested positive for PS. An intelligence report noted that Mr Brown may have a drug debt and be spending more time in his cell for self-protection.

52. On 7 September, Mr Brown told staff that he was under threat from four prisoners on his wing for illicit drug use, obtaining vapes and due to the nature of his offence. He said that his debt was for £180 and if he did not pay, he would be assaulted. He said that he wanted to move to another wing. A member of staff from the Safer Custody Team discussed this with him and arranged for him to move to another wing. He also had a meeting with his substance misuse worker but details of that meeting only noted that Mr Brown had complained about problems receiving his medication.

53. A specialist trainee forensic psychiatrist, reviewed Mr Brown on 13 September. She decided that he did not need ongoing input from a psychiatrist as he should remain under the care of the secondary care mental health team.

54. On 15 September, a security report noted that Mr Brown had failed another mandatory drug test as PS was detected. There is no record of any follow-up action.

55. On 16 October, a senior nurse reviewed Mr Brown's mental health. He told her that he had recurrent nightmares about his latest offence but that his counselling sessions helped. She scheduled another appointment in one month to review progress and mental health, but this never happened. Mr Brown continued with his substance misuse counselling sessions until 29 November. He refused to attend his 13 December substance counselling session as he said he felt unwell.

Events of 24 and 25 December 2018

56. On 24 December, CCTV footage shows Mr Brown moving around the wing throughout the day. At approximately 5.00pm, staff locked prisoners into their cells. At 5.09pm, an officer locked Mr Brown's cell door. At 5.15pm, the footage shows that the last person to speak to Mr Brown was another prisoner. The prisoner spoke to Mr Brown at his cell door and appeared to slide something under his door. He then walked away. The prisoner told the investigator that he could not recall what he said to Mr Brown and that he did not pass anything under his door. He said if he had passed anything, it would have been a note.

57. CCTV footage shows that at approximately 5.12am on 25 December, a PCO shone a torch through the observation flap in Mr Brown's cell door while conducting a roll check of all prisoners. She did not report any concerns about Mr Brown. CCTV footage shows that a PCO completed the next check at approximately 7.00am.

58. At just after 9.00am, a PCO unlocked Mr Brown's door. He looked through the observation hatch and saw Mr Brown slumped on his bed, with vomit and blood on the floor. The PCO radioed a medical emergency code blue (to indicate breathing difficulties). He also shouted to a second PCO to assist him at the cell.

59. The second PCO arrived and entered the cell. She touched Mr Brown's face and she felt his neck for a pulse but he was cold. At that point, a Custodial Operations Manager (COM) and a third PCO entered the cell, and the second PCO left the cell.

60. In his written statement, the COM said that he heard the code blue radio call and went to the wing. He said that when he went to Mr Brown's cell, he saw him upright on his bed and described his arms and head as blue. He noted that Mr Brown had an adapted asthma inhaler beside him which appeared to have been used for drugs. We do not know if this was tested for drugs. The COM and the third PCO moved Mr Brown on to the floor and started cardiopulmonary resuscitation (CPR).

61. A nurse heard the code blue over the radio and made his way to Mr Brown's cell. He saw two officers completing CPR. The nurse used a suction unit to clear the vomit from Mr Brown's mouth and nose and a defibrillator was used. The defibrillator did not detect a shockable rhythm. A senior nurse also arrived and saw the staff doing CPR. She said that Mr Brown was cold to touch and rigor mortis was present in his arms. She told staff to stop the resuscitation attempt as there was no signs of life and it appeared that Mr Brown had been in the same position for several hours.

62. Paramedics arrived at 9.28am, and at 9.33am, they declared that Mr Brown had died.

Contact with Mr Brown's family

63. When Mr Brown died on 25 December 2018, the prison appointed a PCO as the family liaison officer (FLO) and a second PCO as the deputy family liaison officer. An assistant director, and a COM visited Mr Brown's mother that day to break the news and offer their condolences and support. The next day, both FLO's visited Mr Brown's mother to offer support.

64. Mr Brown's family arranged, and the prison contributed towards Mr Brown's funeral which was held on 17 January 2019.

Support for prisoners and staff

65. After Mr Brown's death, an assistant director 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 also offered support.

66. The prison posted notices informing other prisoners of Mr Brown'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 Brown's death.

Post-mortem report

67. Post-mortem toxicology tests found PS in Mr Brown's system.

68. The post-mortem report concluded that the cause of Mr Brown's death was the aspiration of gastric contents (breathing stomach contents into his lungs) and the use of a synthetic cannabinoid (a form of PS, commonly known as 'spice' or 'mamba').

69. The pathologist noted that the use of PS had probably caused Mr Brown to vomit and had reduced the "gag" reflex, resulting in Mr Brown breathing vomit into his lungs. Congestion of the lungs may have caused some blood to be expelled before vomiting.

70. The pathologist found no evidence of assault or restraint and no evidence of recent injury.

Findings

Drug strategy at HMP Dovegate

71. Within four days of arriving at Dovegate, Mr Brown was found unresponsive in his cell after using PS. We are concerned that he was able to obtain PS so soon after arriving at the prison. We note that following an inspection at Dovegate in June 2017, HM Inspectorate of Prisons was concerned about the ready availability of illicit drugs.

72. Dovegate's local drug supply reduction policy, issued in 2017, acknowledges the difficulties of preventing drugs getting into the prison and sets out processes such as drug detection and drug testing.

73. We are concerned that although Dovegate has a comprehensive strategy and a number of processes in place to tackle the supply and demand for drugs, Mr Brown was able to obtain illicit drugs throughout his time at Dovegate and was also suspected of being involved in the drugs trade. This suggests that much more needs to be done to tackle substance misuse at Dovegate.

74. Drug taking and trading 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, the PPO has called for HMPPS to provide prisons with national guidance and evidence-based advice on what works. We welcome the fact that such guidance was issued in April 2019, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

75. In relation to reducing the supply of drugs, the new Prison Service strategy says:

> "Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

We therefore recommend that:

The Director should ensure that the key drug issues at Dovegate are identified and that the prison's local drugs strategy is revised by September 2019 to address these issues.

Action on intelligence reports and suspected PS use

76. Dovegate's local violence reduction strategy specifies the steps to be taken when staff suspect PS use and when a prisoner fails a PS test. These emphasise the need to support the prisoner before taking punitive measures and say that the prisoner should complete a PS awareness course, and that his IEP level should not be downgraded to basic after a first PS incident. Staff may also consider

whether to downgrade a prisoner to basic IEP level for a shorter period than usual if they agree to engage with the substance misuse team.

77. We are concerned that Mr Brown was not managed in line with the prison's local drug strategy.

78. Although Mr Brown was appropriately referred to the substance misuse service after being found under the influence of PS soon after his arrival, he did not complete a PS awareness course and staff downgraded his IEP level to basic immediately after this first PS incident.

79. When Mr Brown tested positive for PS twice in September 2018, there is no evidence that any meaningful action was taken, other than that he was downgraded on the IEP scheme. The substance misuse worker said that apart from the initial referral in April, she never received any notifications from prison staff to say that Mr Brown had been found under the influence of drugs or had tested positive for drugs.

80. Intelligence also linked Mr Brown to the illicit use and supply of PS, and various suspicious drug-related activities, including trying to conceal his pregabalin, and suggested he might be the victim of drug-related bullying and threatening behaviour. Drug tests and cell searches resulted in confirmation that Mr Brown was not drug-free. There was also intelligence that his mother was paying money into the bank accounts of prisoners suspected of drug trading. We accept that it was difficult for staff to act immediately on uncorroborated intelligence but we would have expected further monitoring to have taken place. There is no evidence that this happened.

81. We are also concerned that, although CCTV showed a prisoner at Mr Brown's cell door the evening before he died, no one at Dovegate had spoken to him to find out if he had passed anything to Mr Brown or the nature of the conversation at his cell door.

82. We make the following recommendation:

The Director should ensure that prisoners suspected of using psychoactive substances, or other illicit substances, are managed in line with the local drug strategy.

Support for substance misuse

Clinical and psychosocial support

83. Mr Brown had a long history of substance misuse in the community and in prison. When he arrived at Dovegate, he denied any substance misuse problems. However, when he had his first PS incident a few days later, nurses automatically referred him to the Substance Misuse Service.

84. The service developed a recovery care plan and met Mr Brown regularly to support him. The substance misuse practitioner, regularly reviewed his progress and risks. She updated his care plans and repeatedly gave him advice on risks and how to minimise harm. Mr Brown did not tell her that he was using PS. She told the investigator that Mr Brown had discussed his trauma but not his coping

mechanisms nor his substance misuse. When Mr Brown said he was having nightmares and flashbacks about his offence, substance misuse staff arranged counselling for him. The substance misuse worker said that she was unaware that Mr Brown had tested positive for PS twice in September 2018.

85. The clinical reviewer noted that Mr Brown's substance misuse issues at Dovegate included him trying to conceal and divert his prescribed pregabalin. Two prison GPs spoke to him about his prescribed medication and they told him that his medication would be stopped if he was suspected of misusing it. Four weeks later, he was caught trying to conceal his medication. Healthcare staff issued a written warning and switched him to alternative medication. We are satisfied that this was appropriate in the circumstances.

86. The clinical reviewer said that there was a delay of 14 weeks from Mr Brown's mental health referral before he saw a psychiatrist. Mr Brown never received a formal diagnosis of his mental health issues at Dovegate but was already having counselling through the SMS team. His one-to-one monthly mental health intervention started in October 2018 but his second appointment for November was not scheduled. However, as soon as healthcare staff realised this, an appointment was scheduled for the end of December 2018.

87. We agree with the clinical reviewer that this was not an ideal situation but Mr Brown was having one-to-one counselling with the substance misuse practitioner and at that time, there were no new concerns about his mental health.

Clinical care

88. The clinical reviewer is satisfied that when Mr Brown arrived at Dovegate, a nurse properly assessed him. We agree with the clinical reviewer that the substance misuse consultations were of a good standard and were well documented. Mr Brown engaged positively with the substance misuse service but did not disclose when he had used illicit substances.

89. The clinical reviewer considered that overall, Mr Brown's physical healthcare was of a reasonable standard, equivalent to that which he could have expected to receive in the community. However, she identified some deficiencies in provision and has made recommendations, which the Head of Healthcare will need to address.

Management of risk of suicide and self-harm

90. Prison Service Instruction (PSI) 64/2011 on safer custody lists a number of risk factors and potential triggers for suicide and self-harm. These include recall to custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse, and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening suicide and self-harm prevention procedures (known as ACCT) if necessary.

91. It appears that Mr Brown was affected by the offence (causing death by dangerous driving) which led to his recall to prison, both because the

circumstances played on his mind and because it made him the focus of threats from other prisoners.

92. Staff identified that this could put Mr Brown at risk of suicide or self-harm and we are satisfied that Mr Brown was appropriately managed under ACCT procedures from the time he arrived at Dovegate on 12 April until 1 May 2018. We are also satisfied that staff had no reason to consider that Mr Brown posed a risk to himself after the ACCT was closed, and that there is nothing to suggest that his death was anything other than accidental.

93. However, we are concerned that there is no record that healthcare staff participated in or contributed to the ACCT reviews. Although this did not affect the outcome for Mr Brown, it could be crucial in other circumstances. It is important that relevant healthcare issues and concerns are shared to help make informed decisions. We therefore recommend that:

The Director and Head of Healthcare should ensure that healthcare staff are involved in ACCT reviews whenever possible.

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