Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nathan Herbert, a prisoner at HMP Doncaster, on 23 September 2019

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 Nathan Herbert died on 23 September 2019, after he was found hanging in his cell at HMP Doncaster. Mr Herbert was 44 years old. I offer my condolences to Mr Herbert's family and friends.

Mr Herbert was subject to Prison Service suicide and self-harm procedures (known as ACCT) when he first arrived at Doncaster in June and again for a few days in early July. I am satisfied that there was no indication that Mr Herbert was at imminent risk of suicide when he died in September. However, I do have some concerns about how Mr Herbert's ACCT was managed before that.

I have concluded that Mr Herbert received good clinical care, although a missed appointment with a GP was not followed up as it should have been. It is also worrying that toxicology results showed that before he died Mr Herbert had taken several prescription drugs that he had not been prescribed. However, I am satisfied that Doncaster are making good efforts to address the drug supply problem and I have not made a recommendation about this.

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 **July 2020**

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Summary

Events

1. On 26 June 2019, Mr Herbert was recalled to custody having broken the conditions of his licence and on 27 June, he was taken to HMP Doncaster. Mr Herbert told a nurse that he used heroin and crack cocaine in the community. He was prescribed methadone and engaged positively with substance misuse work while at Doncaster.

2. Mr Herbert also said that he had recently taken several intentional drug overdoses, so the nurse started Prison Service suicide and self-harm monitoring procedures (known as ACCT). Staff closed his ACCT the next day. The ACCT was re-opened on 2 July, the day after Mr Herbert tied a ligature around his neck and climbed over the railings, but closed again three days later when Mr Herbert said his issues had been resolved.

3. On 9 July, a GP prescribed Mr Herbert promethazine for anxiety. She arranged to review him on 29 August, but Mr Herbert did not attend this appointment.

4. On 10 July, a nurse from the mental health team assessed Mr Herbert and continued to see him regularly. Aside from ongoing relationship difficulties, staff and prisoners said that Mr Herbert seemed settled at Doncaster.

5. From mid-September, Mr Herbert rang his ex-partner an increasing amount. In calls to friends he said that he was upset about the breakdown of his relationship and had thought about hanging himself. The prison was not monitoring his calls and therefore did not know about these conversations. On 22 September, Mr Herbert's ex-partner visited him. Afterwards he seemed upset and prisoners and staff tried to comfort him. He rang his ex-partner that evening and was distressed during the calls.

6. The next day, Mr Herbert's friend said that he seemed his usual self and he had no concerns about him. Mr Herbert rang his partner several times after he was locked in his cell that evening and said he was going to kill himself.

7. At 9.50pm, an officer found Mr Herbert hanging in his cell. Staff cut him down and attempted to resuscitate him. Paramedics took over his treatment but he was pronounced dead at 10.32pm.

8. The post-mortem report concluded that Mr Herbert's cause of death was hanging. The toxicology report found mirtazapine, amitriptyline, olanzapine and buprenorphine in his system at therapeutic levels. He had not been prescribed these medications.

Findings

9. We are satisfied that staff could not have been expected to predict or prevent Mr Herbert's actions on 23 September. He hid the extent of his distress from others.

10. While it was reasonable that Mr Herbert was not subject to ACCT procedures when he died, we have some concerns about the management of these procedures when he arrived at Doncaster. His ACCT was closed the day after

his arrival, despite his recent suicide attempts, a case review was not held as scheduled, healthcare staff were not present when the ACCT was closed and the ACCT was not immediately re-opened after another act of self-harm.

11. The clinical reviewer concluded that the clinical care Mr Herbert received was of a good standard and at least equivalent to that he could have expected to receive in the community. Her only concern was that no one followed up when Mr Herbert did not attend a GP appointment.

12. While we are concerned Mr Herbert obtained drugs which he had not been prescribed, we are satisfied that Doncaster is taking necessary steps to address this issue.

Recommendations

- The Director and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, in particular that:
    - staff adequately consider all risk factors before closing ACCTs;
    - ACCT reviews take place as scheduled; and
    - ACCT reviews are multidisciplinary, with healthcare staff in attendance where appropriate.

- The Head of Healthcare should ensure that all staff are aware of the process for rebooking appointments when prisoners do not attend clinical appointments.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact her.

14. The investigator visited Doncaster on 1 October 2019. She obtained copies of relevant extracts from Mr Herbert's prison and medical records.

15. Due to an extended period of sick leave, this investigation was then reallocated to another investigator. We apologise for the resulting delay in issuing this report. The investigator interviewed eight members of staff and one prisoner at Doncaster in March 2020.

16. NHS England commissioned an independent clinical reviewer to review Mr Herbert's clinical care at the prison. They jointly interviewed healthcare staff.

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

18. One of the Ombudsman's family liaison officers contacted Mr Herbert's ex-partner, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Herbert's ex-partner asked whether Mr Herbert's risk of self-harm had been assessed appropriately. She also wanted to know whether he had been referred for mental health support. These questions are answered in the report.

19. Mr Herbert's ex-partner received a copy of the initial report. They did not make any comments.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies although one recommendation was withdrawn as a result of their feedback.

Background Information

HMP Doncaster

21. HMP Doncaster is a local prison, operated by Serco. It holds up to 1,145 prisoners who have been remanded in custody or sentenced. Care UK provides clinical services. The prison directly employs qualified paramedics as part of their healthcare team, and they respond to emergency calls in the prison.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Doncaster was in September 2019. Inspectors were concerned by the increased levels of self-harm and the six self-inflicted deaths there had been since their previous inspection in 2017. They noted that not all the PPO's recommendations in response to these deaths had been appropriately addressed. Inspectors noted that some ACCT documents continued to be of poor quality and they were not confident that staff understood how to identify and manage risk. Managers continued to try to improve the quality of these documents. Inspectors were also concerned that there was no Listeners scheme in place, although prisoners could access the Samaritans via their in-cell telephones

23. Most prisoners said that they had positive relationships with staff. Inspectors noted that the key worker scheme was promising but contact was often too infrequent and key workers often changed.

24. Inspectors found that health services had improved overall, including clinical and psychosocial substance use treatment services. There was effective communication between healthcare staff, prison staff and community services. Inspectors noted, however, that there were vacancies in the mental health team and the team was not sufficiently staffed to manage their caseload. They worked well with substance misuse practitioners.

Independent Monitoring Board

25. 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. No IMB report was produced for the reporting year 2017-2018 or 2018-2019.

Previous deaths at HMP Doncaster

26. Mr Herbert was the fourteenth prisoner to die at Doncaster since September 2017. Five of the previous deaths were self-inflicted and eight were due to natural causes. There have been three further deaths since that of Mr Herbert, two of which were self-inflicted and one was due to natural causes.

27. Previous investigations have raised issues about the quality of ACCT management at Doncaster and following up missed healthcare appointments. These issues are raised again in this report.

Assessment, Care in Custody and Teamwork (ACCT)

28. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

29. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

The key worker system

30. The key worker system is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the system should work are set out in HMPPS's *Manage the Custodial Sentence Policy Framework*. This says:

- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
- Key workers must have completed the required training.
- Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
- Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

Key Events

31. On 5 June 2019, Mr Nathan Herbert's offender manager applied to have Mr Herbert recalled to prison as he had broken the conditions of his licence and was wanted by police in relation to a robbery. On 11 June, Mr Herbert's licence was revoked. He was unlawfully at large until police arrested him on 26 June. On 27 June, he was taken to HMP Doncaster.

32. During his initial health screen, Mr Herbert's urine tested positive for heroin and crack cocaine. He told a nurse that he had stopped taking methadone six weeks ago when he "went on the run" from the police. Mr Herbert said he had tried to take his own life several times in the last month by overdosing on heroin, but he had no current thoughts of suicide or self-harm. The nurse referred Mr Herbert to the GP and substance misuse service. The nurse also started Prison Service suicide and self-harm monitoring procedures (known as ACCT) due to his concerns about Mr Herbert's recent intentional overdoses and low mood.

33. An Advanced Nurse Practitioner (ANP) from the substance misuse service, assessed Mr Herbert. Mr Herbert told the nurse that he had last smoked psychoactive substances (PS) three days ago and injected heroin and crack cocaine two days ago. The nurse prescribed Mr Herbert methadone and healthcare staff monitored his withdrawal symptoms in line with policy.

34. During an ACCT assessment on 28 June, Mr Herbert told a Custodial Operations Manager (COM) that he was upset as he had split up from his partner. He said that he had taken an overdose but had no current suicidal thoughts and was glad that he had not died. He told the COM that he now had contact with his ex-partner and was getting help with his drug use. She noted "*relationship breakdown*" on the ACCT cover under the section *triggers/warning signs to prompt immediate case review*.

35. After the assessment, a COM chaired Mr Herbert's ACCT review. Mr Herbert said that his ex-partner was now supporting him and he felt better in prison. Those present assessed Mr Herbert as a low risk and closed his ACCT. They noted on the caremap that Mr Herbert needed to contact his ex-partner, be compliant with his detox and be referred to the mental health team. All these actions were marked as complete. Mr Herbert moved from the induction wing to a single cell on the detox wing.

36. On 29 June, the ANP continued Mr Herbert's gabapentin prescription for sciatica (nerve pain). She noted that she was unable to prescribe the same dose as he had received in the community as he was also prescribed methadone. The nurse referred him to the GP.

37. On 1 July, Mr Herbert tied a noose around his neck and climbed over the railing. He said he had done so because his medication had been stopped. Healthcare staff agreed to review Mr Herbert's medication and he climbed back over the railings. No one considered re-starting ACCT monitoring.

38. At 8.45pm, the ANP spoke to Mr Herbert about his prescription of gabapentin and explained that this needed to be reviewed by a GP given his current

prescription of methadone. Mr Herbert was agitated and walked away. The nurse sent an urgent task to the GP.

39. On 2 July, at 8.15am, a substance misuse practitioner assessed Mr Herbert. He knew Mr Herbert from previous sentences and continued regular contact after this initial meeting. Mr Herbert discussed his continued relationship difficulties with his ex-partner.

40. In the afternoon, an ANP reviewed Mr Herbert's gabapentin prescription. Mr Herbert said that he had been sleeping badly since his gabapentin had been reduced in prison. The nurse prescribed him zopiclone (a sleeping tablet) for three days and booked him in for a GP review of his pain management.

41. At 2.00pm, staff reopened Mr Herbert's ACCT because he had tied a noose round his neck the day before. Mr Herbert thanked staff for resolving his medication issue and said he had no current thoughts of self-harm. Staff assessed him as a raised risk to himself and set observations at once per hour.

42. On 5 July, a COM chaired an ACCT review with another COM and Mr Herbert. Mr Herbert said that since his medication issues had been resolved, he had no thoughts of self-harm and was happy for the ACCT to be closed. Staff assessed Mr Herbert as a low risk to himself and closed the ACCT.

43. On 9 July, a GP saw Mr Herbert. She told the investigator that Mr Herbert did not seem to be in pain. She referred him for physiotherapy and did not increase his gabapentin prescription. She prescribed him promethazine for ten days to try to lessen his anxiety until he was assessed. She also offered him sleeping tablets but he declined these. She booked Mr Herbert for a review with her on 29 August.

44. On 10 July, a PCO introduced himself to Mr Herbert as his key worker. Mr Herbert said he felt safe on the wing and had good support from his ex-partner. The next day, a COM completed Mr Herbert's ACCT post-closure review. Mr Herbert said that his ex-partner was supporting him and he did not have any issues.

45. On 11 July, a nurse from the mental health team assessed Mr Herbert. The nurse noted that Mr Herbert said he had no current thoughts of suicide or self-harm, although they discussed his recent overdose attempts in the community. The nurse said Mr Herbert's separation from his partner was "worrying him a lot". He used standard mental health tests, which indicated that Mr Herbert had a mild to moderate level of anxiety and a moderately severe level of depression. The nurse told the investigator that this was not unusual for a prisoner with substance misuse issues while they stabilised. He referred Mr Herbert to an ANP to consider whether Mr Herbert needed to be prescribed antidepressants and to the chaplain for bereavement work.

46. On 12 July, an ANP assessed Mr Herbert who said he was still having difficulty sleeping. They discussed Mr Herbert's mood but he said he did not want to take antidepressants. The nurse advised him to contact the team if he changed his mind and continued Mr Herbert's prescription of promethazine.

47. Throughout July, August and the beginning of September, Mr Herbert continued to engage positively with substance misuse services.

48. On 23 August, Mr Herbert's ex-partner visited him. The internal investigation completed after Mr Herbert's death noted that he was upset after this visit. A PCO spoke to him in his cell about how to cope with the breakdown of a relationship. Mr Herbert did not say that had any thoughts of self-harm or suicide. (This information is also taken from the internal investigation.)

49. On 29 August, Mr Herbert did not attend his appointment with a GP. This appointment was not rebooked and it is not known why Mr Herbert did not attend. On 30 August, Mr Herbert told a PCO that his ex-partner continued to support and visit him and he had no issues.

50. On 3 September, a nurse reviewed Mr Herbert. (The nurse had been on leave for the whole of August.) Mr Herbert said his ex-partner continued to support him and he had no thoughts of suicide or self-harm. The nurse told the investigator that Mr Herbert looked better and seemed more settled. The nurse booked his next appointment with Mr Herbert for 29 October and intended to consider his discharge from the mental health team at that stage.

51. A prisoner who knew Mr Herbert from previous sentences, said that around this time, Mr Herbert had told his ex-partner to move on with her life. She had told Mr Herbert that she had done so. The prisoner told the investigator that Mr Herbert knew that the relationship was over, but he still hoped that they could be reconciled. He said that Mr Herbert was a private person and officers would not have necessarily known when he was upset.

52. On 15 September, Mr Herbert telephoned his ex-partner 94 times. These calls were unanswered. He continued to telephone his ex-partner regularly over the next few days but she did not answer. On 16 September, Mr Herbert tested negative for drugs (apart from methadone which he was prescribed) during a random mandatory drug test.

53. On 20 September, Mr Herbert rang a friend. (Mr Herbert's calls were not being monitored and therefore staff were not aware of the content of his calls at the time. The prison provided the investigator with summaries of his last telephone calls after he died.) Mr Herbert told his friend that he was upset as his partner had left him and was in another relationship. He said he had nothing left and had had enough of "it all". On 21 September, Mr Herbert rang another friend and told him that his ex-partner was in another relationship, he had been crying, had no future and had thought about hanging himself.

Sunday, 22 September

54. On 22 September at 1.00pm, Mr Herbert's ex-partner visited him. She left the visit early. The investigator watched the CCTV footage of when Mr Herbert was leaving the visit (the actual visit was not covered by CCTV). Mr Herbert appeared agitated, was pacing and had his hands on his face and head. A PCO who had known Mr Herbert for several years from working in the visits area, spoke to him and Mr Herbert assured the PCO that he was okay.

55. Mr Herbert asked a PCO to lock him in his cell. The PCO told the investigator that Mr Herbert seemed "really, really frustrated" and had "stormed" past her to his cell, which she thought was very unusual. He said that he needed to be alone and did not want to talk to her. She locked Mr Herbert in his cell and asked the prisoner to speak to him.

56. The prisoner told the investigator that Mr Herbert had accepted that his relationship with his ex-partner was over. He said that Mr Herbert cried and was "gutted". He tried to reassure him and told him that he had friends in Doncaster.

57. The PCO returned to Mr Herbert's cell after around 30 minutes to see how he was and to complete a key working session with him (she had recently been allocated as his keyworker). She said that Mr Herbert seemed "down". She asked Mr Herbert if he felt safe, and he replied that he was not "in the mood to talk today". The PCO asked if she could help, but Mr Herbert said he did not want help.

58. That afternoon, Mr Herbert ate his dinner with other prisoners in the association area. The PCO said that he was laughing and said that there were "plenty more fish in the sea." The PCO said that he seemed to have accepted his relationship with his ex-partner was over and she did not have any concerns about him.

59. Mr Herbert telephoned his ex-partner three times. He was very distressed and said that he could not cope knowing she had another partner. She said that it was over. During the second call, both were upset and crying and he referred to "doing something daft". In the final call, he left a voicemail, apologising for upsetting her and saying that he still needed her as a friend.

Monday, 23 September (Mr Herbert's birthday)

60. On 23 September, the prisoner said that he saw Mr Herbert during the day and he seemed his usual self.

61. The investigator watched the CCTV from 6.38pm. Mr Herbert was unlocked at 6.54pm. An officer gave him a birthday card from his ex-partner and he spoke to staff and prisoners. No one had any concerns about him. At 7.22pm, Mr Herbert said that he was ready for bed and a PCO locked him in his cell. At 8.05pm, Mr Herbert telephoned his ex-partner and spoke to her for 13 minutes. He said he knew that their relationship was over and he could not cope anymore. A PCO checked all the prisoners as part of her roll count. At 8.39pm, she got to Mr Herbert's cell. In her statement, she said that Mr Herbert said hello and was writing something.

62. At 8.45pm and 8.52pm, Mr Herbert rang his ex-partner. He said he was going to kill himself. She urged him to think about his sons before taking his own life. At 8.56pm, Mr Herbert called his ex-partner again and left a voicemail in which he said that his death would be on her conscience. At 8.58pm, he tried to call her again, but there was no reply.

63. Two PCOs repeated the roll check which had been incorrect earlier. At 9.50pm, a PCO got to Mr Herbert's cell. She looked through the observation panel and saw Mr Herbert hanging from a ligature tied to a privacy screen. She shouted to the second PCO who was at the door within seconds, looked through the

observation panel and told the second PCO to unlock the cell door. The second PCO radioed a code blue. Staff in the control room immediately telephoned an ambulance.

64. Both PCOs went into the cell, a PCO supported Mr Herbert's weight while a PCO used an anti-ligature knife to cut Mr Herbert down. The PCOs laid Mr Herbert on the floor and put him in the recovery position. They wiped liquid from Mr Herbert's mouth and tried to find a pulse, but could not. They were joined by officers and nurses, who started resuscitation and attached a defibrillator. Paramedics arrived at 10.04pm and took over resuscitation efforts, but at 10.32pm they pronounced Mr Herbert had died.

65. Staff found a note in Mr Herbert's cell on top of a pile of clothes. The note stated that Mr Herbert wanted to be buried in those clothes. Police told the investigator that Mr Herbert had left another note which they had taken as evidence. Despite several requests, the investigator has not seen this note.

Contact with Mr Herbert's family

66. The prison's family liaison officer (FLO) and the Director arrived at Mr Herbert's ex-partner's address at 12.50am. They broke the news of Mr Herbert's death to her and offered their condolences.

67. The FLO stayed in contact with Mr Herbert's ex-partner over the following days and offered a financial contribution to Mr Herbert's funeral in line with Prison Service policy.

Support for prisoners and staff

68. After Mr Herbert's death, a COM 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.

69. The prison posted notices informing other prisoners of Mr Herbert'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 Herbert's death.

Post-mortem report

70. The post-mortem report concluded that Mr Herbert's cause of death was hanging.

71. The toxicology report noted the presence of the following drugs at therapeutic levels: methadone, gabapentin, promethazine, mirtazapine (an antidepressant), amitriptyline (an antidepressant), olanzapine (an antipsychotic) and buprenorphine (used to support prisoners detoxing). Mr Herbert was prescribed methadone, gabapentin and promethazine, but was not prescribed the other medications.

Findings

Assessment and management of risk

72. Staff assessed Mr Herbert as presenting a risk to himself when he first arrived at Doncaster on 27 June and he was subject to ACCT support for less than 24 hours. Mr Herbert had several factors which increased his risk to himself according to Prison Service Instruction (PSI) 64/2011, *Safer Custody*, including his recall, his recent overdoses and relationship breakdown. Although it had no bearing on his death, we are concerned that, given these factors, staff closed Mr Herbert's ACCT less than 24 hours after he arrived at Doncaster.

73. On 2 July, staff reopened Mr Herbert's ACCT, the day after he had tied a noose round his neck and climbed over a railing. This was an apparent protest that he had not been prescribed sufficient gabapentin for his back pain. We are concerned that, following this incident, it took staff nearly 24 hours to reopen the ACCT. This should have been done immediately.

74. The next ACCT review was scheduled for 4 July but did not take place on that day and there is no record to indicate why. Staff closed Mr Herbert's ACCT on 5 July. No healthcare staff were present. We consider that they should have been given the ACCT had been opened in response to a medication issue.

75. We make the following recommendation:

The Director and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, in particular that:

- **staff adequately consider all risk factors before closing ACCTs;**
- **ACCT reviews take place as scheduled: and**
- **ACCT reviews are multidisciplinary, with healthcare staff in attendance where appropriate.**

76. Mr Herbert took his own life over two months after his ACCT was closed. All staff we spoke to said that he was a positive, settled prisoner who assisted both staff and other prisoners. No one considered that he was a risk to himself.

77. Mr Herbert's key worker had tried to speak to him when he was upset following a visit with his partner on 22 September, but he had not wanted to talk at that time. We consider it good practice that she enabled Mr Herbert's friend to talk to him instead. Although Mr Herbert told his friend that he was very upset during their conversation, he was seen laughing with other prisoners later that day, and his friend said he seemed his normal self the following day (the day he killed himself).

78. It is evident from his phone calls that Mr Herbert was very distressed about the breakdown of his relationship with his ex-partner and, when he spoke to her on the phone just before he died, he talked of ending his life. His phone calls were not being monitored, so staff did not know about these conversations. We are satisfied that Mr Herbert hid the full extent of his distress from staff and other prisoners. In these circumstances, we do not consider that staff could have been expected to predict or prevent Mr Herbert's actions that evening.

Clinical Care

79. The clinical reviewer concluded that the clinical care Mr Herbert received was of a good standard and at least equivalent to that he would have received in the community.

80. Mr Herbert was referred to the mental health team, assessed and attended a follow up review. The clinical reviewer concluded that his mental health care was appropriate. The clinical reviewer also concluded that he received timely and comprehensive support and treatment in relation to his substance misuse.

81. Mr Herbert was prescribed gabapentin for his back pain in line with NHS England guidelines. He was referred to a physiotherapist but he did not attend any of these sessions.

82. A GP said that when Mr Herbert did not attend his appointment with her on 29 August, she filled in a form and, at the time, assumed that support staff would rebook his appointment with her. However, since Mr Herbert's death, she has found that this is not the case and she needs to rebook the appointment herself if a prisoner does not attend. The GP said that more clarity was needed about rebooking missed appointments. This was a missed opportunity to engage with Mr Herbert. We make the following recommendation:

The Head of Healthcare should ensure that all staff are aware of the process for rebooking appointments when prisoners do not attend clinical appointments.

Drug strategy

83. The toxicology report detected mirtazapine, amitriptyline, olanzapine and buprenorphine in Mr Herbert's system after he died. He had not been prescribed these medications. While they were only present at a therapeutic level and did not cause Mr Herbert's death, we are concerned that he was able to obtain such medication and about the potential impact it may have had on his mental health.

84. There was no intelligence that Mr Herbert was obtaining drugs illicitly and we are satisfied that staff could not have been expected to suspect Mr Herbert. Staff said that he engaged in work to address his substance misuse positively and they had no concerns about him in this regard. Mr Herbert had a mandatory drugs test on 16 September which tested negative for buprenorphine. It did not test for the other drugs he obtained illicitly.

85. Doncaster's Substance Misuse Strategy says that Care UK and Serco will work closely together on medicine management to ensure that tradeable medication is managed and supplied effectively. Officers supervise medication queues to try to prevent prisoners trading medication. However, some prisoners have medication in their own possession in their cell safes and this is another potential route of supply. A Drug Strategy Manager told the investigator that they were very aware of the issue of trading prescribed medication at Doncaster, particularly when there were shortages of other illegal drugs at the prison.

86. While it seems most likely that Mr Herbert got these drugs from prisoners to whom they had been prescribed, there is also the possibility that they entered the

prison illegally. When HM Inspectorate of Prisons inspected Doncaster in September 2019, they noted that a wide range of actions had been taken to address drug supply and demand at the prison. We conclude that Doncaster is taking the necessary steps to try to address this issue and we therefore make no recommendation about this.

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