Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Carl Kent, a prisoner at HMP Dartmoor, on 21 May 2020

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Carl Kent was found hanged in his cell at HMP Dartmoor on 21 May 2020. He was 42 years old. I offer my condolences to Mr Kent's family and friends.

In the three weeks leading to his death, Mr Kent uncharacteristically started to demonstrate paranoid behaviour. He regularly used psychoactive substances (PS) and healthcare staff suspected that he was in withdrawal. Prison staff were appropriately monitoring Mr Kent under suicide and self-harm prevention procedures, known as ACCT, when he died. However, I am concerned that staff underestimated his risk of suicide by focussing on substance misuse and not taking into account several other important risk factors.

No one assessed Mr Kent's risk of suicide and self-harm after he was sentenced to a further six-year sentence on 13 May, as they should have done.

I am also concerned that there is no record that prison staff recorded information from prisoners that indicated Mr Kent might have been considering taking his own life. We have raised the issue of recording risk indicators with Dartmoor before, as recently as December 2019. The prison has committed to improving its practices and training staff. In light of this commitment, I have not made another recommendation. However, I will do so if the problem recurs.

Prison staff appropriately referred Mr Kent to the mental health team on two occasions, but I am concerned that he was not offered an assessment.

I am also concerned that the manager who recorded on Mr Kent's ACCT record that he had completed a 'management check' on 21 May, did not make it clear that he had not checked on Mr Kent. This resulted in Mr Kent being checked 15 minutes later than he should have been. We cannot know whether his death would have been prevented if he had been checked sooner but he would have been discovered earlier.

Not all staff involved in the emergency response had up-to-date training in first aid. I am satisfied, however, that this did not affect the outcome for Mr Kent.

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 **October 2021**

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Summary

Events

1. On 9 March 2019, Mr Carl Kent was remanded to HMP Preston, charged with burglary. (He was subsequently sentenced to four and a half years in prison on 5 April.) He moved to HMP Dartmoor on 9 July.

2. Mr Kent had a history of mental health and substance misuse problems and used psychoactive substances (PS).

3. On 17 September 2019, Mr Kent told a GP that he was withdrawing from PS and had previously attempted suicide while doing so. The GP altered his medication.

4. On 12 May 2020, a probation officer referred Mr Kent to the mental health team after he presented with paranoia. However, they decided that he did not need any input.

5. On 13 May, Mr Kent appeared in court by video link and received a further six-year sentence.

6. On 19 May, prison staff referred Mr Kent to the mental health team again as Mr Kent continued to have paranoid thoughts about his food being 'spiked'.

7. On 20 May, staff started suicide and self-harm prevention measures, known as ACCT, after Mr Kent smashed his cell observation panel and made superficial cuts to his wrist.

8. At 12.21pm on 21 May, a mental health nurse completed a triage assessment and concluded that Mr Kent was withdrawing from PS. At 2.00pm, a supervising officer (SO) chaired a first ACCT case review and assessed Mr Kent as at high risk of suicide and self-harm because of his PS use. Staff were to check him twice an hour.

9. A prisoner told the investigator that at 6.12pm he told an officer that Mr Kent had shouted to him from his cell window that he was going to kill himself. Three other prisoners also told us that Mr Kent had been telling prisoners and staff that he would not be there tomorrow.

10. At 10.30pm, an operational support grade (OSG) conducted an ACCT check on Mr Kent. At 10.40pm, a Custodial Manager (CM) noted 'management check' in Mr Kent's ongoing ACCT record. The OSG timed her next check on this entry.

11. At 11.15pm, the OSG conducted an ACCT check and discovered Mr Kent with a ligature around his neck. She radioed a medical emergency code blue and tried to unlock the cell. An officer arrived and helped her to open the door. The OSG cut the ligature and the officer checked Mr Kent's vital signs. At 11.19pm, the CM arrived and started cardiopulmonary resuscitation (CPR). Paramedics arrived and continued with resuscitation efforts but at 11.41pm they pronounced that Mr Kent had died.

12. The post-mortem report concluded that although PS was found in Mr Kent's blood, it did not cause or contribute to his death.

Findings

13. Mr Kent had a number of factors which increased his risk of suicide, including a previous suicide attempt, PS use and the fact that he had recently received an additional six-year sentence. We found that staff failed to consider all these factors as part of their assessment of risk and only considered his substance misuse.

14. Although prisoners said that they reported concerns about Mr Kent to staff and told them that he was talking as though he was considering taking his own life, we are concerned that there is no evidence that prison staff recorded this information or considered taking any action as a result. We raised concerns about record keeping in December 2019, and the prison has committed to improving.

15. On 21 May, the CM recorded that he had checked Mr Kent's ACCT document but did not see him in person. The OSG timed her next check based on time of his entry rather than on the time she last checked him herself. This meant that Mr Kent was not seen for 45 minutes. We cannot know whether his death could have been prevented if the OSG had checked him sooner, but he would have been discovered earlier.

16. We are concerned that Mr Kent did not have a health assessment after he was sentenced by video link.

17. An increasing number of prisoners are being sentenced by video link and we consider that national guidance should be reviewed to ensure that prisoners at risk of suicide and self-harm after a court appearance by video link are assessed.

18. The clinical reviewer found that not all aspects of the care that Mr Kent received at HMP Dartmoor were equivalent to that which he could have expected in the community. She considered that mental health staff should have conducted an initial assessment and liaised more closely with prison staff.

19. Not all staff involved in the emergency response had up-to-date first aid training

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff:
    - consider all relevant information when identifying a prisoner's risk of suicide and do not rely solely on his behaviour and comments;
    - record any information about a prisoner's wellbeing in the ACCT ongoing record;
    - are aware of procedures for conducting ACCT observations at night and base their observations on the last time that an observation was conducted; and
    - indicate in the ACCT ongoing record whether a management review included an observation.

- The Director General of HMPPS should review PSO 3050 and PSI 07/2015 to ensure that prisoners who attend court by video link are assessed for their risk of suicide and self-harm and seen by healthcare staff in the same way as prisoners attending court in person.
- The Head of Healthcare should:
  - review the mental health referral and triage process to ensure that assessments are based on all available information; and
  - ensure that prison staff are involved in case discussions when they report concerns about a prisoner's deteriorating mental health.
- The Governor should ensure that operational staff have up-to-date training to administer basic life support in an emergency.

The Investigation Process

20. The investigator issued notices to staff and prisoners at HMP Dartmoor informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded.

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

22. The investigator interviewed five prisoners and seven members of staff between 12 June and 23 July 2020. All the interviews were conducted by telephone because of the COVID-19 pandemic restrictions.

23. NHS England commissioned a clinical reviewer to review Mr Kent's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

24. We informed HM Coroner for Exeter and Greater Devon District of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

25. The Ombudsman's family liaison officer contacted Mr Kent's sister to explain the investigation and to ask if there were any matters that she wanted us to consider. Mr Kent's sister did not raise any specific concerns.

26. Mr Kent's sister received a copy of the initial report. She did raise any further issues, or comment on the factual accuracy of the report.

27. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Dartmoor

28. HMP Dartmoor holds up to 640 adult male prisoners. Healthcare services are provided by Care UK and mental healthcare is provided by Devon Partnership Trust.

HM Inspectorate of Prisons

29. The most recent inspection of HMP Dartmoor was in August 2017. Inspectors reported that, overall, the prison was well managed and there was reasonable access to health services. They considered that the operation of ACCT procedures needed improvement but that prisoners managed under the process received good care. Peer support arrangements were good. Inspectors noted that action had been taken to implement and regularly review the PPO's recommendations.

Independent Monitoring Board

30. Each prison 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 September 2019, the IMB reported that illicit drug use continued to be the main cause of violence and debt at Dartmoor. The Safer Custody department had developed a process to identify prisoners at risk of self-harm and held regular meetings to monitor safety issues. The IMB also noted that the quality of information recorded in ACCT records had improved.

Previous deaths at HMP Dartmoor

31. Mr Kent was the eighth prisoner to die at Dartmoor since May 2018. Of the previous deaths, five were from natural causes and two were self-inflicted. We have previously made a recommendation about the need for staff to record information about a prisoner's risk of suicide or self-harm.

Assessment, Care in Custody and Teamwork (ACCT)

32. ACCT is the Prison Service care planning system used to support prisoners at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce risk and how best to monitor and supervise the prisoner. 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 carried out at irregular intervals to prevent a prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

33. 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 on the caremap have been completed. 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.

Key Events

34. On 9 March 2019, Mr Carl Kent was remanded to HMP Preston, charged with burglary, and on 5 April he was sentenced to four and a half years in prison.

35. Mr Kent had a history of mental health and substance misuse problems for which he was prescribed mirtazapine (an antidepressant), olanzapine (an antipsychotic) and methadone (for opioid dependence). The mental health team assessed him after he reported that he had tried to take his life in 2018, but they did not consider that he needed ongoing support. Despite engaging with the substance misuse team, Mr Kent regularly used illicit psychoactive substances (PS) at Preston.

HMP Wymott

36. On 22 May, Mr Kent was moved to HMP Wymott. The substance misuse team reviewed him regularly, but he continued to use PS and spent time in the segregation unit due to drug and debt-related issues. Mr Kent also made a superficial cut to his right arm after a period of anxiety about his PS debt and threatened to hang himself when he was unable to spend time with a prisoner who was due to transfer to another prison. Prison staff monitored Mr Kent under ACCT procedures.

37. On 8 July, Mr Kent spent the night at HMP Bristol on his way to HMP Dartmoor, where he was transferred for security reasons.

HMP Dartmoor

38. When Mr Kent arrived at Dartmoor on 9 July, a nurse completed his initial health screen. He recorded Mr Kent's history of mental health problems and said that he had attempted suicide by hanging within the last year. The nurse requested a GP review and referred Mr Kent to the mental health and substance misuse teams. The next day, a prison GP prescribed olanzapine and mirtazapine.

39. On 12 July, Mr Kent failed to attend a mental health triage assessment. A mental health nurse recorded that Mr Kent had told officers on the wing that he did not feel that he needed mental health support. The following day, a nurse conducted a secondary health screen and recorded that Mr Kent had a family history of depression.

40. On 16 July, a substance misuse recovery worker assessed Mr Kent who admitted to taking PS the previous day. She advised him how to minimise harm from using substances and completed a safety plan. She also noted that Mr Kent did not report any thoughts of suicide or self-harm.

41. On 7 August, Mr Kent's allocated keyworker visited him on the wing and recorded that he had settled in well and had secured a prison job in the carpentry workshop.

42. On 17 September, Mr Kent asked prison GP to increase his mirtazapine and olanzapine. He said that had not taken PS for six days and that he had previously tried to take his own life while withdrawing from PS. The GP recorded that it was not appropriate to increase both medications but that he could increase mirtazapine

and reduce olanzapine. Mr Kent agreed to switch doses and the GP arranged to review him in four weeks.

43. On 17 October, a prison GP reviewed Mr Kent and recorded that he presented as happy and calm. Mr Kent said that he had reduced his PS use to once a week and agreed to continue with the medication.

44. On 20 October, a prison chaplain visited Mr Kent and informed him that his father had died. He offered his condolences and support and Mr Kent asked to attend his father's funeral. On 4 November, the keyworker visited Mr Kent for a keywork session. Mr Kent agreed to try bereavement counselling, and a prison chaplain referred him.

45. On 5 November, a recovery worker reviewed Mr Kent and noted that he presented with slurred speech and red eyes. Mr Kent admitted to using PS. She spoke to him about the risks of taking PS in addition to his methadone prescription and advised him how to minimise the harm caused from substance misuse.

46. On 6 November, Mr Kent was transferred to HMP Liverpool to attend his father's funeral. He returned to Dartmoor on 7 November and chaplaincy staff offered him support.

2020

47. On 7 January 2020, an officer visited Mr Kent for a keywork session and recorded that he was due to start work in the laundry. Mr Kent told her that he had not started bereavement counselling and that he did not want to know his position on the waiting list as he was dealing with it.

48. On 19 January 2020, intelligence records indicated that Mr Kent would be paid 'two cards' of PS by an unknown prisoner to assault a member of staff when the next batch of PS arrived. The following day, a recovery worker conducted a voluntary drug test (VDT) and recorded that Mr Kent tested positive for methadone, but negative for all other substances. (VDTs do not test for PS.)

49. On 22 January, a nurse reviewed Mr Kent's medication and recorded that Mr Kent did not report any illicit drug use and had recently tested positive for methadone only.

50. On 16 February, an officer visited Mr Kent to introduce himself as his new keyworker. He recorded that he already knew Mr Kent quite well from working on his wing and that Mr Kent was waiting to attend court for an outstanding offence.

51. On 5 March, a recovery worker introduced herself to Mr Kent as his new recovery worker and conducted a 13-week review. She noted that he engaged well and did not present as under the influence of drugs. She conducted a VDT and recorded that he only tested positive for methadone.

52. On 10 April, the recovery worker reviewed Mr Kent on the wing. She recorded that he said he was feeling well and did not report any concerns about his welfare or methadone prescription. She also noted that there were no signs of sedation or illicit substance use.

Events from 4 to 19 May

53. On 4 May, officers conducted a search of Mr Kent's cell and found an improvised bladed weapon and quantity of tablets. The matter was subsequently referred to the police for investigation.

54. On 12 May, a probation officer visited Mr Kent for a review but was unable to proceed because he presented as paranoid. She recorded that Mr Kent said that prisoners working in the kitchen were 'spiking' his food in retaliation for him telling prisoners 'not to buy bad Spice'. ('Spice' is a type of PS.) She told wing staff and spoke to a mental health nurse, who listed Mr Kent for a review.

55. Later that day, the team leader for mental health reviewed Mr Kent's medical record and chaired a multidisciplinary team meeting (MDT), which was attended by the probation officer and the recovery worker. The team leader noted that the attendees did not consider that mental health input was needed and that there were no concerns about Mr Kent's risk to himself. However, there is no record that they considered his history of suicidal ideation and self-harm.

56. On 13 May, an officer took Mr Kent to a video link suite so that he could attend a court hearing. Mr Kent was sentenced to an additional six years in prison for grievous bodily harm. The officer told us that he spoke to Mr Kent afterwards and Mr Kent said he "got a result" as he had been expecting a longer sentence of 10 to 14 years.

57. On 14 May, prison intelligence records show that Mr Kent told staff that his food was being 'spiked' with Subutex (a medication used to treat opiate addiction) and threatened to smash his cell or go on the netting to get a cell move.

58. On 15 May, an officer submitted an intelligence report after Mr Kent told him that an officer had brought PS into the prison and arranged for it to 'land with him'. He said it was a bad batch intended to do him harm and make it look like he killed himself. Three days later, Mr Kent told an officer that an officer had 'put a hit on him', and he submitted an intelligence report.

59. On 19 May, a mental health nurse noted that she had received a mental health referral from an officer stating that Mr Kent was presenting as paranoid. She added him to the list for a review.

Events on 20 May

60. At 1.30pm, a prison investigator for Devon and Cornwall Police told Mr Kent that he may need to interview him about the weapon found in his cell, but Mr Kent declined an interview. In his police statement, the investigator said that Mr Kent said words to the effect of, "I have been in prison a long time, so I know the score and I have a lot more things going on than worrying about this".

61. At around 5.00pm, Mr Kent damaged his cell observation panel and made cuts to his right arm. An officer started ACCT procedures and recorded that Mr Kent was becoming increasingly paranoid. At 5.30pm, a Supervising Officer (SO) agreed an immediate action plan that included a safer cell (a cell specifically designed to

minimise ligature points), twice hourly observations and a mental health referral. Mr Kent moved to the safer cell at 5.37pm.

Events on 21 May

62. At 9.10am, an officer visited Mr Kent to conduct an ACCT assessment. He recorded that Mr Kent was paranoid and said that he had tuberculosis, hepatitis C and COVID-19. He asked Mr Kent if he had any current suicidal thoughts and he said that he wanted to live but felt he would die soon due to being 'spiked'. He added that he had lost his mother, father and brother and had nothing to live for.

63. At 12.16am, a recovery worker recorded that she had spoken to Mr Kent earlier that morning and he said that he was being 'spiked' by someone. He also told her that he 'felt strange, not Covid strange' and asked for a blood test to check if there was something in his system. She suggested that he apply to see healthcare.

64. At 12.21pm, the team leader for mental health recorded that prison staff had referred Mr Kent to the mental health team due to ongoing concerns about his presentation. She noted that Mr Kent was withdrawing from PS and was stressed about an additional assault charge. She concluded that the mental health team would not add Mr Kent to their caseload but would work with the substance misuse team and support him through the ACCT process. However, there is no record that she considered that Mr Kent had previously told healthcare staff that he had tried to take his life while withdrawing from PS.

65. At 2.00pm, a SO chaired an ACCT case review which several members of staff attended, including a mental health nurse and two representatives from the substance misuse team. The SO recorded that Mr Kent was emotional and said that he felt under threat on the wing. He asked to be moved to another wing, but the SO noted that it was too late in the day. Attendees assessed Mr Kent as at high risk of suicide and self-harm and decided that he should continue to be monitored twice an hour. Two actions were recorded in the caremap. These were to arrange a wing move for Mr Kent when space became available and for him to have a drug test.

66. At 2.30pm, a mental health nurse recorded that she had attended Mr Kent's ACCT review and that he told staff that his "head was gone" and that he was "hearing voices". Mr Kent said he had not taken PS for three weeks and asked for a drug test to check whether he had been 'spiked'. He said that he had been taking more than his prescribed amount of medication and the nurse noted that she would inform the primary care team. She also noted that Mr Kent complained about being in a safer cell and said that he would be able to keep himself safe if he moved.

67. At 3.00pm, a recovery worker visited Mr Kent to test his urine for drugs and he tested negative. She recorded that Mr Kent was relieved at the result. At 3.13pm, Mr Kent returned to his standard cell, which had been repaired.

68. At 3.29pm, prison PIN phone records indicate that a phone call, which lasted 3 minutes 49 seconds, was made using Mr Kent's PIN phone. It was later found that a prisoner with a known history of drug-related offences made the call.

69. At 3.32pm, a nurse recorded that he had spoken to the mental health nurse, and noted that Mr Kent would continue to keep and administer his medication in his cell. He also noted that the mental health team would review the suitability of the arrangement using the ACCT process.

70. A prisoner told the investigator that at around 4.00pm, Mr Kent walked through the servery and shouted, "I won't be here tomorrow". He said that an officer was present and would have overheard him. Two other prisoners told us that Mr Kent was telling prisoners and staff throughout the day that he would not be there tomorrow. Prison staff did not record these comments.

71. At about 5.00pm, Mr Kent went to the wing office and spoke to a SO. The SO told the investigator that Mr Kent was crying and remained convinced that prisoners were 'spiking' his food. He said that a CM (Custodial Manager) joined them part way through their conversation and that Mr Kent's demeanour changed as the conversation progressed and he calmed down. He said that Mr Kent told them that he had eaten some chips, which they laughed about, and asked for an inter-prison phone call to his brother, which the CM authorised for the next day.

72. A friend of Mr Kent's told the investigator that at 6.00pm, Mr Kent shouted to him out of his cell window and said he was going to kill himself. The friend said that he pressed his cell bell and told an officer. The cell bell record shows that his cell bell was activated at 6.12pm and reset at 6.15pm, but we have been unable to establish who he spoke to.

73. At 6.30pm, an officer conducted an ACCT check. He recorded that Mr Kent said he was in major debt and was expected to pay the next day. He said that he could not pay what he owed and that a wing move had fallen through.

74. At 7.00pm, the officer conducted an ACCT check and noted that he spoke to Mr Kent and reassured him that he would be going to the segregation unit for a disciplinary hearing in the morning and would be able to speak to a prison manager about his concerns.

75. At 7.35pm, an operational support grade (OSG) conducted an ACCT check and recorded that Mr Kent said his "head had gone" and that he "feels like he does not want to be here anymore". Mr Kent also said he had difficulty sleeping and she advised him to speak to healthcare staff about it and to press his cell bell if he needed anything.

76. At 8.00pm, the OSG conducted an ACCT check and Mr Kent told her that he was being moved after his disciplinary hearing. She told him that prisoners are not told when they are being moved and that he should stay calm and think about what he would like to say in the morning. Between 8.36pm and 9.30pm, she conducted three ACCT checks and recorded that Mr Kent was pacing around his cell. She told us that Mr Kent said he was OK but that he did not give her his full attention. At 10.00pm, she conducted an ACCT check and recorded that Mr Kent was sitting on his bed, reading a letter. At 10.30pm, she conducted another ACCT check and recorded that Mr Kent was lying in bed, watching TV.

77. At 10.40pm, a CM obtained an update about Mr Kent from the OSG and recorded 'management check' in Mr Kent's ongoing ACCT record. He did not see Mr Kent in person.

78. At 11.15pm, the OSG looked through Mr Kent's cell observation panel to conduct an ACCT check and saw him slumped beside his bed, with a ligature around his neck that was tied to the window. She tried to get a response from Mr Kent by banging on the cell door and radioed a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing difficulties). She broke the security seal on her key pouch so that she could enter the cell but was unable to unlock the door.

79. In the meantime, another OSG and an officer responded to the code blue and made their way to the wing. The OSG went to the wing office to collect a defibrillator and the officer went to Mr Kent's cell, where she found the first OSG trying to open the door. The officer unlocked the door and they both entered the cell. The OSG cut the ligature and the officer checked Mr Kent's vital signs. At that point, the other OSG arrived with the defibrillator.

80. At 11.19pm, a CM arrived. He removed the remaining part of the ligature from around Mr Kent's neck, requested an ambulance, used a defibrillator and started cardiopulmonary resuscitation (CPR). At 11.31pm, paramedics arrived at Mr Kent's cell. They took over resuscitation efforts. At 11.41pm, a paramedic pronounced that Mr Kent had died.

Contact with Mr Kent's family

81. At around 12.55am, a prison manager arrived at the prison to support staff. A safer custody administrator told us that staff tried to contact Mr Kent's named next of kin overnight but were unsuccessful.

82. At 8.15am on 22 May, the prison appointed a prison chaplain as the family liaison officer. She tried unsuccessfully to contact a friend of Mr Kent, whom he had named as his next of kin. The police went to the address in Blackpool, but the resident did not know Mr Kent.

83. In the meantime, the prison chaplain established that Mr Kent had a brother in another prison and that his brother had named a sister as his next of kin. She spoke to prison managers about contacting someone other than the named next of kin and they contacted the regional management team for advice.

84. At 9.09am on 23 May, the prison chaplain received a call from a chaplain at another prison who asked if they could inform Mr Kent's brother of his death. She said that she was not aware that he had two brothers and that they were still trying to identify a next of kin. At 9.35am, she spoke to the other chaplain and he said that having received authorisation from regional management, he had spoken to both prisons overnight. She noted that one of Mr Kent's brothers in prison had been informed but did not have a contact number for their sister.

85. At 11.05am, the prison chaplain confirmed that Mr Kent's other brother had been told and agreed for their sister's details to be passed on to the police, which was done that afternoon. At 3.43pm, Mr Kent's sister phoned the prison as her brother

had broken the news to her. At 3.45pm, she returned her call, explained that the police had planned to inform her in person and offered support.

86. The prison chaplain provided ongoing support to Mr Kent's sister until his funeral, which took place on 10 June. The Prison Service contributed towards its cost in line with national policy.

Support for prisoner and staff

87. Following Mr Kent's death, a prison manager offered support to the staff involved in the emergency response.

88. The prison posted notices informing other prisoners of Mr Kent'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 Kent's death.

Post-mortem report

89. The post-mortem report established that Mr Kent died from hanging.

90. Routine post-mortem toxicology tests found mirtazapine, olanzapine and methadone present at therapeutic levels, and also detected a type of PS. The pathologist noted that it could not be determined when or how Mr Kent took PS or how much he took and concluded that substance misuse did not cause or contribute to his death.

Events after Mr Kent's death

91. Staff found two letters in Mr Kent's cell after his death. In the first letter, he said that his food had been 'spiked' for six weeks because he had been telling prisoners not to buy PS as it was rat poison and cockroach killer. He said that he would tell them everything he knew when he was in the segregation unit and felt safe. In his second letter, he wrote, "I had to do this, I put my hands up, I done wrong in my life…I have no choice as tomorrow when they ship me out, they're going to get me, I'm dead anyway".

Findings

Management of Mr Kent's risk of suicide and self-harm

92. Prison Service Instruction (PSI) 64/2011 on safer custody lists several risk factors and potential triggers for suicide and self-harm. Mr Kent had a number of these risk factors, including previous self-harm with suicidal intent, a history of mental health problems, bereavement of a family member, substance misuse and court appearances/sentencing.

93. Although we are satisfied that staff appropriately began ACCT procedures when Mr Kent presented as paranoid and harmed himself the day before he died, we have some concerns about the management of the ACCT process.

Assessing the level of risk

94. PSI 64/2011 requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only one piece of evidence in assessing risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm.

95. During the first ACCT case review on 21 May, attendees appropriately assessed Mr Kent's risk of suicide as high. A SO told the investigator that Mr Kent did not report any thoughts of suicide or self harm and that he ticked 'high risk' as he was concerned Mr Kent would test positive for illicit substances and was "thinking ahead". However, we are concerned that there is no record that attendees at the case review considered Mr Kent's mental health history, his previous attempt to take his own life, his recent additional six-year sentence or that he told the ACCT assessor he had nothing to live for. We consider that they assessed him as high risk without fully considering all his risk factors and, as a consequence, underestimated his risk of taking his own life.

96. Prison staff did not re-assess Mr Kent's risk when he saw a SO in the wing office at around 5.00pm on 21 May. The SO told us that Mr Kent was crying when he arrived and remained adamant that his food was being 'spiked' despite receiving a negative drug test. He said that he did not consider holding a further ACCT review as Mr Kent calmed down after a while, said that he had eaten something and asked for an inter-prison phone call. He also said that he was satisfied that the level of ACCT observations was appropriate.

97. We are concerned that in assessing Mr Kent's risk to himself, staff did not fully consider all the risk factors involved and relied too heavily on his demeanour and assurance that he did not have suicidal thoughts. They also did not explicitly take into account his past behaviour, which meant that staff agreed to move him out of the safer cell without knowing all the information. It is critical that all risk factors are identified and considered so that staff can ensure that a prisoner's level of risk is

judged holistically. We are concerned that this did not happen in Mr Kent's case and that staff misinterpreted his risk.

Recording and sharing information

98. PSI 64/2011 also highlights the importance of sharing information to enable early intervention and prevention and to promote prisoners' wellbeing. It notes that it is vital that the ACCT record contains information about the wellbeing of a prisoner to ensure that the risk is being managed appropriately.

99. A prisoner says he told an officer at about 6.00pm on 21 May that Mr Kent was saying he was going to kill himself. This is corroborated to some extent by the fact that cell bells records show he pressed his bell and spoke to a member of staff at about this time. We are concerned that this important information about Mr Kent's risk was not recorded and shared.

100. We are also concerned that there is no record that Mr Kent was saying that 'he would not be there tomorrow' despite the accounts of several prisoners that he said this in front of staff. Recording known risks ensures that staff are aware of all the information and helps them make a balanced decision. We consider that staff should have at least recorded the information in Mr Kent's ACCT record. This was particularly important considering Mr Kent's increasingly paranoid behaviour and might reasonably have prompted a review of his risk.

Management checks and ACCT observations

101. PSI 64/2011 says that staff must follow the level of observations stated on the ACCT document and must record these immediately or as soon as reasonably practical. When a CM recorded in the ACCT ongoing record that he had conducted a management check at 10.40pm, he did not record whether he had seen Mr Kent. The CM told the investigator that he did not look through the observation panel on Mr Kent's cell door as he would usually, as the OSG was returning from conducting her 10.30pm observations. He said that the OSG updated him about Mr Kent's paranoid behaviour, and he did not feel the need to check on him as she said that he seemed a lot more settled than he had earlier.

102. The OSG told us that a manager would normally check prisoners subject to an ACCT but that she had just checked on Mr Kent when the CM arrived. When asked whether a manager would normally look in the cells, she said: "Not necessarily, I don't think. I'm not sure". When she conducted her next ACCT check she based her timing on the CM's entry and not the last time that she saw him. This meant that a member of staff did not check on Mr Kent for 45 minutes.

103. While we are satisfied that the CM's decision not to check on Mr Kent was reasonable in the circumstances, we are concerned that the OSG did not check on him sooner. We consider that if she was not sure if the CM saw Mr Kent, she should have based her timing on her last check. We also consider that it would have been helpful if the CM had made it clear in the ACCT ongoing record that he had not checked on Mr Kent.

104. We cannot know whether Mr Kent's death could have been prevented if he had been checked 15 minutes earlier, but he would have been discovered sooner. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff:

- **consider all relevant information when identifying a prisoner's risk factors and not rely solely on his behaviour and comments;**
- **record any information about a prisoner's wellbeing in the ACCT ongoing record;**
- **are aware of procedures for conducting ACCT observations at night and base their observations on the last time that an observation was conducted; and**
- **indicate in the ACCT ongoing record whether a management review included an observation.**

105. We previously made a recommendation in December 2019 to address Dartmoor's failure to ensure that staff record information about prisoners' risk of suicide or self-harm. In response, Dartmoor told us that they held ACCT training for prison staff in October 2020 and that healthcare staff were due to have ACCT training in December 2020. The prison also told us that although the COVID-19 pandemic has meant that it has not been possible to hold face-to-face safer custody meetings, the team sends out a monthly data presentation, which includes learning bulletins for managers to share with their staff. On that basis, we have not made a recommendation in this case.

Assessing prisoners sentenced by video link

106. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners says that events such as attending court or sentencing at court are factors that may have a significant impact on the health of a prisoner. When prisoners pass through reception on their return from court, prisons are required to have protocols in place to assess and identify the risk of suicide and self-harm. When Mr Kent appeared in court on 13 May, he did so by video link. As Mr Kent did not leave the prison, he did not pass through reception afterwards.

107. For prisoners sentenced by video link, PSO 3050 says that a system should be in place to allow prisoners access to a healthcare review if they request one or identify as needing support. PSI 07/2015 on early days in custody also says that there must be arrangements in place to assess prisoners whose status or demeanour may have changed after a court appearance by video link.

108. The lead mental health told us that there was no routine assessment of prisoners following an appearance by video link, unless healthcare staff were alerted to any concerns. This indicates a reliance on observing physical distress, instead of considering the actual risk factors. We do not consider that it is sufficient to offer a prisoner being sentenced by video link the opportunity to see a member of

healthcare staff if they wish. We consider that they should be screened automatically as they would be if they had attended court in person.

109. An increasing number of prisoners are being sentenced by video link, especially during the COVID-19 pandemic. We therefore consider that national guidance should be reviewed to ensure that processes are in place for assessing prisoners at risk of suicide and self-harm after a court appearance by video link. We make the following recommendation.

The Director General of HMPPS should review PSO 3050 and PSI 07/2015 to ensure that prisoners who attend court by video link are assessed for their risk of suicide and self-harm and seen by healthcare staff in the same way as prisoners attending court in person.

Clinical care

110. The clinical reviewer found that Mr Kent received a good standard of care from the substance misuse team, but that some aspects of the clinical care that Mr Kent received at Dartmoor were not equivalent to that which he could have expected in the community. Most relevant to Mr Kent's death is the fact that mental health staff decided on 12 May not to conduct an initial mental health assessment.

111. The clinical reviewer considered that mental health staff failed to identify Mr Kent's mental health history and previous suicide attempt while withdrawing from PS. This information was available to healthcare staff and we therefore consider that a more thorough triage process would likely have resulted in a mental health assessment. Had the information been identified, it would have added value to the ACCT process by providing historical context. Healthcare staff must base their decisions on historical, and not just current, information.

112. The clinical reviewer also considered that healthcare staff should have liaised more closely with prison staff. This was particularly important as Mr Kent's behaviour had changed dramatically in a short period and prison staff were becoming increasingly concerned about him. He had been referred to the mental health team twice in a short period – 12 and 19 May – because of concerns about his paranoia. The team lead mental health told us that, on reflection, they only had 'snap shots' of what was going on and there was probably a lot of information that was not communicated in its entirety.

113. While we cannot be certain that a thorough mental health triage process, an initial mental health assessment and better communication between staff would have changed the outcome for Mr Kent, in other circumstances, it could be critical. We therefore make the following recommendation:

The Head of Healthcare should:

- **review of the mental health referral and triage process to ensure that assessments are based on all available information; and**

- **ensure that prison staff are involved in case discussions when they report concerns about prisoners' deteriorating mental health.**

114. The clinical reviewer also highlighted several other areas for improvement, such as initial reception screens, record keeping and learning disability pathways, that the Head of Healthcare will need to address.

Emergency response

115. In line with PSI 03/2013 on medical response codes, Dartmoor's local policy instructs staff to use a code blue when a prisoner is unconscious or having breathing difficulties. Calling an emergency code should automatically trigger the control room to call an ambulance.

116. We commend the OSG for responding quickly when she found Mr Kent hanging. She radioed the correct medical emergency code, she was trying to open the cell door to enter the cell when an officer arrived, and she cut Mr Kent's ligature. Another OSG promptly retrieved a defibrillator and the CM appropriately started CPR.

117. The control room log indicates that a code blue was radioed at 11.15pm but the ambulance log states they received a call at 11.18pm. While this corresponds with the time that the CM requested an ambulance, he told us that control room staff told him that an ambulance was already on its way. We consider that the time difference between the ambulance and control room logs was likely to have been a result of the information being taken from different sources.

118. However, we are concerned that the OSG and officer were not trained in first aid and that the other OSG's first aid training had expired in February 2020. While we consider that this did not affect the outcome for Mr Kent, the ability of prison staff to administer emergency first aid in future cases could be crucial to saving a prisoner's life. We therefore make the following recommendation:

The Governor should ensure that operational staff have up-to-date training to administer basic first aid.

Psychoactive substances

119. Post-mortem toxicology results found the presence of PS in Mr Kent's system. However, the post-mortem report was unable to determine when or in what quantity Mr Kent took PS or whether he was experiencing any adverse effects at the time of his death. The pathologist therefore concluded that substance misuse did not contribute to Mr Kent's death.

120. We are satisfied that the substance misuse team at Dartmoor reviewed Mr Kent frequently, created a safety plan, provided appropriate harm minimisation advice when he presented under the influence of PS and liaised with the mental health team when he began to display paranoid behaviour. We are also satisfied that since Mr Kent's death, the prison has conducted a comprehensive review of its local drug strategy.

Inquest

121. At the inquest, which took place between 23 and 27 June 2025, the Coroner concluded that Mr Kent died of suicide.

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