Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Angela Montgomery, at HMP Low Newton, on 25 February 2024

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.

Ms Angela Montgomery died on 25 February 2024 at HMP Low Newton. She died from drowning in a prison bath after taking a large number of antidepressant tablets. She was 51 years old. I offer my condolences to Ms Montgomery's family and friends.

Ms Montgomery was subject to suicide and self-harm monitoring (known as ACCT) for some of the time she was in prison, although she generally assured staff that she did not want to die. Ms Montgomery's final ACCT had been closed for almost a month by the time of her death.

Aspects of the ACCT process were managed poorly. Ms Montgomery had made a comment to a nurse that she would drown herself if she had the chance, but the comment was not reported to ACCT case managers. There was also little input from healthcare staff to ACCT reviews even though Ms Montgomery was receiving support from a psychology support worker. It also seems likely that Ms Montgomery was able to stockpile a large amount of medication that she had been receiving daily under supervision.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **October 2024**

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Summary

Events

1. On 30 December 2023, Ms Angela Montgomery was recalled to custody at HMP Low Newton for breaching licence conditions by harassing neighbours. She had been released on licence a week earlier having served a 12-week sentence for harassment, contrary to a restraining order.

2. A reception officer started prison suicide and self-harm procedures (known as ACCT) when Ms Montgomery said that she had thoughts of suicide.

3. On 31 December, Ms Montgomery told a nurse that she would drown herself if she had the chance. The nurse did not note this comment in Ms Montgomery's ACCT or tell her ACCT case manager. Staff closed the ACCT on 11 January 2024.

4. Ms Montgomery was briefly supported through ACCT on two further occasions in January.

5. At 10.07am on the morning of Sunday 25 February, Ms Montgomery went into the landing bathroom to have a bath (the bathroom had three shower cubicles and a bath which was behind a privacy screen).

6. At just before midday, officers began locking prisoners in their cells ahead of the lunchtime patrol period. Officers could not find Ms Montgomery but when they went into the bathroom, they saw her completely submerged in the bath. They lifted her from the bath and started cardiopulmonary resuscitation (CPR). Nurses arrived one minute later and gave oxygen.

7. Paramedics arrived at 12.11pm and took charge of Ms Montgomery's care. At around 12.38pm the paramedics ceased efforts to try to resuscitate Ms Montgomery and pronounced that she had died.

8. The post-mortem examination found that Ms Montgomery had 24 prescribed venlafaxine (an antidepressant) tablets in her stomach.

Findings

9. Ms Montgomery's comment about drowning herself was not reported to staff responsible for managing her ACCT.

10. Healthcare staff input into Ms Montgomery's ACCT reviews was inadequate.

11. Ms Montgomery was able to accumulate a large number of venlafaxine tablets that she was receiving under supervision.

Recommendations

- The Governor and Head of Healthcare should ensure that:
    - ACCT reviews are multidisciplinary,
    - healthcare staff adequately consult clinical records before contributing to an ACCT review and record their contribution afterwards, and
    - ACCT case managers accurately record the name of healthcare staff from whom they gain input before an ACCT review.
- The Head of Healthcare and the Governor should ensure that staff adhere closely to protocols to limit prisoners' ability to conceal and divert supervised medication.

The Investigation Process

12. HMPPS notified us of Ms Montgomery's death on 27 February 2024.

13. The investigator issued notices to staff and prisoners at HMP Low Newton informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded who he interviewed by telephone.

14. The investigator visited Low Newton on 6 March. He obtained copies of relevant extracts from Ms Montgomery's prison and medical records. He also interviewed two prisoners.

15. The investigator interviewed seven members of staff at Low Newton on 6 and 7 May 2024.

16. NHS England commissioned an independent clinical reviewer to review Ms Montgomery's clinical care at the prison. The investigator and the clinical reviewer conducted joint interviews with healthcare staff.

17. We informed HM Coroner for County Durham and Darlington of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent him a copy of this report.

18. We contacted Ms Montgomery's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He asked:

    - What were the circumstances surrounding his sister's death and did another prisoner speak to her when she was using the bath?
    - What care was she receiving for her mental health problems and was this care appropriate?
    - Why was she in possession of a large number of antidepressant tablets?
    - Why was she allowed to bathe unsupervised?

19. We have answered these questions in the report.

20. We shared our initial report with HM Prison and Probation Service (HMPPS) and with Ms Montgomery's brother.

21. HMPPS did not find any factual inaccuracies and they provided an action plan in response to our recommendations.

22. Ms Montgomery's brother did not inform us of any factual inaccuracies.

Background Information

HMP Low Newton

23. HMP Low Newton is located near Durham and holds women on remand and those serving both short and long sentences including some high security prisoners. Physical healthcare services are provided by Spectrum Community Healthcare CIC and mental health provision is provided by Tees, Esk & Wear Valleys NHS Foundation Trust.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Low Newton was in June 2021. Inspectors found that relationships between staff and prisoners were excellent with 85% of women saying that staff treated them with respect and 88% saying they could turn to a member of staff if they had a problem. Inspectors noted that recorded self-harm was lower than at most similar women's prisons. Inspectors found that while the day-to-day care provided to women in crisis was good, there were some key weaknesses in ACCT case management. They noted that ACCTs did not always consider the full range of risk factors and care plans were not always proactive and well used.

25. Inspectors noted that staffing vacancies had presented challenges to the healthcare team, although inspectors found that patients with long-term conditions were managed well with appropriate care plans.

Independent Monitoring Board

26. 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 February 2023, the IMB wrote that it believed Low Newton to be a reasonably safe prison for prisoners and staff and that staff were vigilant, but not oppressive. The IMB noted a decrease in the number of self-harm incidents compared to the previous year. although more ACCTs had been opened compared to the previous year. The IMB concluded that this reflected a greater willingness among staff to use ACCT procedures in supporting prisoners.

Previous deaths at HMP Low Newton

27. Ms Montgomery was the second prisoner to die at Low Newton since February 2021. The previous death was a death from natural causes in August 2022. In that case, the prisoner was in possession of medication not prescribed to her (as well as illicit drugs), although it was likely that she had smuggled them into the prison when she first arrived.

Assessment, Care in Custody and Teamwork

28. 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. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

29. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan 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

30. On 22 December 2023, Ms Angela Montgomery was released on licence from HMP Low Newton where she had been serving a 12-week sentence of imprisonment for harassment of a neighbour in breach of a restraining order.

31. On 30 December, Ms Montgomery was remanded back to Low Newton for breaching the terms of her licence through further alleged acts of harassment.

32. At a reception health screen on arrival at Low Newton, Ms Montgomery said that she was 'all right' about being back in custody and had no thoughts of suicide or self-harm. A doctor re-prescribed Ms Montgomery's various medicines, including two antidepressants, venlafaxine and nortriptyline. Ms Montgomery did not hold these medicines in-possession, but attended a medication hatch each day where she was required to swallow the tablets in front of a nurse. Ms Montgomery's medical record noted that she had been diagnosed with alcohol induced epilepsy in 2001. Healthcare staff did not discuss this with her or start a care plan.

33. Ms Montgomery then saw a reception officer and said that she had thoughts of suicide following an upsetting Christmas and difficulties with her neighbours. The officer started prison suicide and self-harm support and monitoring procedures, known as ACCT.

34. On the morning of 31 December, Nurse A, saw Ms Montgomery for a secondary health screen. The nurse noted that Ms Montgomery was being supported on an ACCT and, in answer to a question about whether she had thoughts of suicide, noted that Ms Montgomery said that she would drown herself if she had the chance.

35. A few minutes later, Mental Health Nurse B, recorded that she had received a telephone call from Supervising Officer (SO) A asking for someone from healthcare to attend an ACCT review that afternoon. The nurse noted that her shift was due to finish at midday so she would not be able to attend (nor was any other mental health nurse on duty that afternoon). The nurse told the investigator that she told the SO that she could telephone healthcare later on to ask if someone from the primary care team would be able to attend. The nurse could not recall seeing the comment about Ms Montgomery drowning herself if she had the chance. Nurse A did not tell prison staff about Ms Montgomery's comment or record it in her ACCT document.

36. SO A chaired an ACCT review with Ms Montgomery that afternoon. Ms Montgomery said that she did not want to die, but felt hopeless and believed she had been 'set up' by her neighbours. Ms Montgomery said that she wanted to see the mental health team and wanted to move to A wing as that was where she felt most comfortable. She said that she had a sense of loss about being back in prison.

37. SO A said that as there was no mental health nurse at the ACCT review it would not be appropriate to close the ACCT. The SO kept the ACCT open and arranged for Ms Montgomery to be observed three times during the day and four times through the night. The SO wrote a care plan that included for Ms Montgomery to preferably move to A wing and for her to receive appropriate support in coming to terms with being back in prison.

38. In email correspondence, the SO told the investigator that she spoke to two nurses in the morning about Ms Montgomery. She said that Nurse B told her that there were no mental health nurses on duty to attend the ACCT review, but she gave her the name of a nurse with whom Ms Montgomery had worked in the past. The SO thought it would be helpful if the same nurse could work with her again during this sentence. The SO said that the other nurse, Nurse C, told her that Ms Montgomery was having a medication review with the pharmacist in a few days' time. The SO said that neither of the nurses told her that Ms Montgomery had spoken about drowning herself. She said that she would have explored the comment at the review had she been told. (The investigator was not able to check Nurse C's recollection as she was no longer employed at Low Newton.)

39. On 5 January, staff discussed Ms Montgomery at the safety intervention meeting (SIM) due to her being a new reception being supported by ACCT. The minutes of the SIM did not detail any discussion about plans for Ms Montgomery's support.

40. SO B chaired Ms Montgomery's next ACCT review later that day. SO C also attended. SO B noted that there was no representative from the mental health team as Ms Montgomery was not on their caseload. At the review Ms Montgomery said that she was feeling much better and was hoping to see the mental health team that week. She also said that she was hoping to start working again as a wing cleaner, as she had done the last time she was in Low Newton. SO B kept the ACCT open with the same level of observations.

41. On 9 January, a psychological wellbeing practitioner saw Ms Montgomery for a mental health assessment. Ms Montgomery had asked to see the psychological wellbeing practitioner as she had offered her support the previous time she was in Low Newton. Ms Montgomery had declined help at that time as she was on the point of being released from custody. The psychological wellbeing practitioner noted that Ms Montgomery had harmed herself in the past by cutting, the last time had been a year earlier and also said that she often thought that she would be better off dead. Ms Montgomery said she had had such thoughts for a long time but also said that she had no present plans to act on those thoughts. At the end of the assessment Ms Montgomery agreed to a programme of low intensity cognitive behavioural therapy (CBT) sessions (CBT entails the patient talking through their problems to gain awareness and to derive solutions to problematic thinking).

42. On 11 January, SO C chaired Ms Montgomery's next ACCT review. She said that she continued to have some good days and some bad days, but that was completely normal for her. She said that she was keeping herself busy by completing distraction packs (such as puzzles and colouring exercises), which she enjoyed. She said that she had no thoughts of suicide or self-harm. The SO noted that the ACCT could be closed. The SO made no reference to any healthcare attendee. He told the investigator that he always contacted healthcare for their input, but if the prisoner was not on the mental health team workload, they would not normally attend reviews. The SO said that in future he would record this contact with healthcare including the name of the person to whom he had spoken.

43. On 15 January, Ms Montgomery moved to a single cell on the ground floor on A wing.

44. On 18 January. SO D saw Ms Montgomery for an ACCT post-closure review (a check one week after an ACCT has been closed to review the prisoner's wellbeing). Ms Montgomery said that she was depressed and suicidal. She said that she was due to attend court on 29 January and was unsure what she might do if she was remanded back in custody. The SO reopened Ms Montgomery's ACCT.

45. On 19 January, Ms Montgomery was again discussed at the SIM due to her ACCT being re-reopened.

46. Later that day, SO C chaired an ACCT review with Ms Montgomery. Nurse D also attended. The SO asked Ms Montgomery about the events that led to her ACCT being reopened the previous day. Ms Montgomery said that she was 'pissed off' as she believed that she had been 'set-up' by her neighbours leading to her being remanded back into custody. She said though that she was due in court at the end of the month and was hopeful that she would be released from custody. She said that she was not suicidal and dealt with unpleasant thoughts by hitting her mattress. Staff present closed the ACCT.

47. Nurse D did not make an entry in Ms Montgomery's medical record about the ACCT review and acknowledged that she should have done. She told the investigator that she recalled the review and Ms Montgomery did not report any thoughts of suicide or self-harm, although she was bored from not having a job and was also frustrated about being in prison.

48. On 30 January, Ms Montgomery attended a video-link plea and trial preparation hearing and was remanded in custody until her next hearing on 19 March. Officer A noted that Ms Montgomery had been in tears during the hearing and at the conclusion. Ms Montgomery's solicitor said that he was concerned that she might harm herself. The officer spoke to Ms Montgomery, who then started crying and said, 'I don't want to be here, I don't know how much more I can take'. The officer re-opened Ms Montgomery's ACCT.

49. On 31 January, SO E chaired an ACCT review with Ms Montgomery and Officer B. The SO said that before the review she went to the healthcare unit to ask if a mental health nurse would attend the review, but she was told that Ms Montgomery was not on the mental health team workload so one would not attend. The SO said that Ms Montgomery engaged in the review. She said that she was due in court in six weeks' time and was hopeful that she would be released from custody. She also said that she was going to apply for a job to keep herself busy. She said that she felt safe in prison and was content on A wing as the prisoners there focused on their own issues and left one another alone. The SO closed Ms Montgomery's ACCT.

50. On 7 February, SO E saw Ms Montgomery for an ACCT post-closure review. Ms Montgomery said that she had good days and bad days and dealt with the bad days by either keeping busy or sleeping. She said that she was seeing the mental health team and was looking forward to getting a job. The SO noted that the ACCT did not need to be re-opened.

51. On 13 February, Ms Montgomery started working as a wing cleaner.

52. Officer C was Ms Montgomery's key-worker and he saw her several times for key-worker sessions (the key-worker scheme allocates officers dedicated time to spend

with individual prisoners, focussing on their development). The officer's last keywork meeting with Ms Montgomery was on 15 February. The officer noted that Ms Montgomery was pleased that she had started working. He noted that keeping busy helped her frame of mind and the pay also allowed her to buy items from the prison shop. The officer told the investigator that he was shocked when he learned of Ms Montgomery's death as he had expected her to get on with her sentence until her release.

53. On 16 February, Ms Montgomery met the psychological wellbeing practitioner for a CBT session. The psychological wellbeing practitioner told the investigator that Ms Montgomery was tearful at the start of the session as she had heard that people in the community had been posting negative comments on Facebook about her and her deceased mother. The psychological wellbeing practitioner said that she asked Ms Montgomery about options for dealing with these issues and she said that she wanted to get back into the community and to repair her relationships with people. The psychological wellbeing practitioner said that she advised Ms Montgomery about 'grounding' techniques, including mediation and her mood lifted. At the end of the session Ms Montgomery said that was looking forward to taking a bath.

54. The psychological wellbeing practitioner went to see Ms Montgomery on 23 February for another CBT session but Ms Montgomery said that she did not want to talk that day. However, she also said that she was fine, was not thinking about harming herself and they agreed to meet again the following week.

55. A prisoner told the investigator that she had met Ms Montgomery before at Low Newton. She said they had a good relationship and while Ms Montgomery was quite reserved when in a group, she would open up in one-to-one situations. She said that Ms Montgomery never said anything to suggest she intended to take her life.

56. Ms Montgomery made no telephone calls while at Low Newton and she received no visits.

Events of 25 February

57. The investigator watched CCTV footage, body worn video camera footage (BWVC) and listened to radio transmissions relating to the emergency response. The following account is based on these sources, in addition to the written accounts from staff and staff interviews.

58. A second prisoner told the investigator that she had heard Ms Montgomery sobbing in her cell the previous evening and she asked her on 25 February if she was okay. She said that Ms Montgomery looked terrible and said that she had chest pain.

59. The second prisoner told the investigator that she also spoke to Ms Montgomery that morning. She said that Ms Montgomery was chatty and she asked to borrow some skin oil.

60. At around 9.50am on 25 February, Officer D went to Ms Montgomery's cell while making routine security checks of all cells. Ms Montgomery said that she wanted to have a bath and the officer told her that she would unlock her in around 10 minutes time. The officer briefly re-locked Ms Montgomery's door and carried on making security checks on the other cells.

61. At around 10.00am, Officer D unlocked Ms Montgomery's cell and told her she could use the bath. The officer noted that there was nothing about Ms Montgomery's demeanour that was unusual or out of character for her. (Prisoners without any specific risk factors were allowed unsupervised use of the baths.)

62. CCTV shows that Ms Montgomery went into the bathroom at 10.07am. At 10.32am, another prisoner went into the bathroom and came out again one minute later. She told the investigator that she had gone into the bathroom to ask Ms Montgomery for a vape. Ms Montgomery told her that she would give her a vape after she had had her bath. She said that she did not walk around the privacy screen, so she did not see Ms Montgomery. (The privacy screen obscures the bath from the rest of the bathroom.)

63. At around 11.55am, Officer D and Officer E started locking up prisoners on the A-1 landing for the lunch-time routine check. Ms Montgomery was not in her cell and another prisoner said that she thought she was in the bathroom. Officer D looked into the bathroom, but she did not see Ms Montgomery. The officer told the investigator that she was going to check if Ms Montgomery had gone to another landing but realised that that would be unusual behaviour for her, so she immediately returned to the bathroom. As she walked into the bathroom she saw clothing to the side of the privacy screen and then saw Ms Montgomery submerged under water in the bath. The officer called to Officer E and radioed a medical emergency code blue (to signal a prisoner with breathing difficulties). Staff in the control room noted that the code blue call was made at 11.59am and they immediately requested an ambulance.

64. BWVC footage shows that Officer D lifted Ms Montgomery from the bath without delay and placed her on the floor. Officers checked for a pulse and found none, so started CPR. Nurses arrived within around a minute and gave Ms Montgomery oxygen. On several occasions staff can be heard on the recording saying that there was water coming out of Ms Montgomery's mouth. Staff can also be heard discussing whether to use a defibrillator, but concluded that they could not do so as there were puddles of water on the bathroom floor.

65. Paramedics arrived at 12.11pm. They asked staff to move Ms Montgomery from the bathroom to the landing and they took charge of her care. At around 12.38pm, the paramedics ceased efforts to resuscitate Ms Montgomery and pronounced that she had died.

Contact with Ms Montgomery's family

66. Ms Montgomery had given as next of kin the neighbour with whom she had been in dispute and who had filed a restraining order against her. Low Newton asked the police to help identify Ms Montgomery's biological family and on 28 February, they confirmed that she had a brother who lived in Leeds. One of Low Newton's family liaison officers, telephoned Ms Montgomery's brother at 11.00am. He confirmed that the police and the Coroner's officer had already told him about his sister's death. He also said that there were two other brothers and he had informed them of the news.

67. Low Newton contributed to the cost of Ms Montgomery's funeral in line with national instructions.

Support for prisoners and staff

68. After Ms Montgomery's death, Custodial Manager (CM) A debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. Staff were offered further support from the care team and the Trauma Risk Management (TRiM) team.

69. Staff spent time with prisoner A as she was very upset at Ms Montgomery's death. Low Newton's managing chaplain spoke to all of the prisoners from Ms Montgomery's landing, and they were all then taken to reception where they were given hot drinks and offered support from Listeners (prisoners trained by the Samaritans to provide confidential peer support). Staff made welfare checks on all the prisoners on the other landings on A wing. All prisoners assessed as being at risk of suicide or self-harm were reviewed in case they had been adversely affected by Ms Montgomery's death and observations on all these prisoners were raised to four times an hour pending further review.

Post-mortem report

70. Ms Montgomery's toxicology report noted that 24 venlafaxine tablets were found in her stomach at post-mortem examination. The report noted that the level of venlafaxine in Ms Montgomery's blood was well above the level expected with therapeutic use, but was also significantly below concentrations reported in fatalities attributed to venlafaxine toxicity (therapeutic use means a level consistent with that given to successfully treat an illness). The toxicology report also noted that Ms Montgomery's blood sample contained a level of nortriptyline that substantially exceeded that expected with therapeutic use. The report noted however that nortriptyline is prone to post-mortem redistribution (post-mortem redistribution refers to changes in drug concentrations after death so that the levels detected might not accurately represent the dose taken by the patient).

71. The pathologist noted that his principal findings included that Ms Montgomery had bleeding into her lungs, had 24 venlafaxine tablets in her stomach and had evidence of brain damage caused by interrupted blood flow to the brain. The pathologist explained that his post-mortem findings were consistent with death by drowning due to the effects of venlafaxine. The pathologist added that his conclusion on cause of death was largely based on the circumstances of Ms Montgomery's death, rather than on any positive post-mortem findings. He explained that typical post-mortem findings of drowning are froth in the main airways and over-expanded lungs. However, both of these presentations are eliminated by CPR.

Findings

Management of Ms Montgomery's risk of suicide and self-harm

72. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists risk factors and potential triggers for suicide and self-harm. It says 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. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.

73. Ms Montgomery made various comments while at Low Newton indicating that she was at potential risk of suicide. She specifically said on 31 December that she would drown herself if she had the chance, she said on 9 January that she had had long term thoughts that she would be better off dead, she said that she felt depressed and suicidal on 18 January, and when she was remanded back into custody at a court hearing on 30 January, said she did not know how much more she could take.

74. However, at her ACCT reviews Ms Montgomery generally assured staff that she had no suicidal intentions and at her final ACCT review on 31 January said that she was hopeful about being released from custody at her next court appearance in six weeks' time.

75. While the psychological wellbeing practitioner's evidence might indicate that Ms Montgomery's final ACCT would have been closed on 31 January even had she attended the review, we are very concerned about the clear failures in communication between healthcare and discipline staff throughout Ms Montgomery's time in Low Newton. The first omission was on 31 December when healthcare staff failed to tell discipline staff that Ms Montgomery had said that she would drown herself if she could. The Head of Healthcare, told the investigator that he had spoken to both Nurse A and Nurse B about the actions they should have taken. He said that Nurse B was receiving ongoing supervision about her future practice.

76. There was then no healthcare representative at Ms Montgomery's next two ACCT reviews on 5 January and 11 January. On 5 January, SO B noted that he had been told that Ms Montgomery was not on the mental health workload, and SO C said that he was told the same for the review on 11 January, although he made no record of this at the time.

77. Nurse D did attend the ACCT review on 19 January, but she failed to make an entry about the review in Ms Montgomery's medical record.

78. For the ACCT review on 31 January, SO E again noted that she was told (we do not know by who) that Ms Montgomery was not on the mental health team workload. This was despite the fact that Ms Montgomery was seeing the psychological wellbeing practitioner.

79. The head of healthcare told the investigator that a mental health nurse will attend initial ACCT reviews if there is a nurse available and will attend future ACCT reviews if the prisoner is on the mental health team caseload. He said that if the prisoner's is not on the mental health team caseload, but they have primary health needs, a primary care nurse will attend future ACCT reviews. He said that attendance at following ACCT reviews should be discussed at the end of each review. He also said that where healthcare staff are contacted by an SO for attendance at an unscheduled ACCT review, he would expect the nurse to check the prisoner's records to advise the SO of the prisoner's medical issues and to document that contact.

80. As none of the SOs noted any names of healthcare staff to whom they might have spoken, we were unable to verify their evidence. We also note that their evidence is in clear contradiction to the head of healthcare's evidence. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **ACCT reviews are multidisciplinary,**
- **healthcare staff adequately consult clinical records before contributing to an ACCT review and record their contribution afterwards, and**
- **ACCT case managers accurately record the name of healthcare staff from whom they gain input before an ACCT review.**

81. After Ms Montgomery's final ACCT was closed on 31 January, she said nothing further to staff to suggest she might be at risk and, in general, seemed happy that she had started working again as a wing cleaner. However, her actions in apparently accumulating an extensive amount of medication would suggest that she had been planning to harm herself. Staff were unaware of this and we consider that overall there was little to indicate that Ms Montgomery was at imminent risk of suicide when she died.

Medication distribution

82. As already noted, Ms Montgomery was found at post-mortem examination to have 24 venlafaxine tablets in her stomach. She was prescribed this medication but did not have it in her possession. She attended the medication hatch daily to be given her tablet by a nurse who would then ask her to drink a cup of water. However, the head of healthcare said that HMPPS policy stresses that the mouth is deemed an intimate area and with the exception of just two opiate based medicines, prisoners were not routinely asked to open their mouths to check they had swallowed prescribed medication. He said that if the nurse was concerned that a prisoner had not swallowed her medication, the nurse would alert the officer supervising the medication queue. It is common practice for prisoners to attempt to conceal medication, often with the intention of trading the medication with other prisoners. Similarly, prisoners are also known to trade medication they hold in possession.

83. It is possible that Ms Montgomery obtained the tablets from another prisoner who had the medication in possession, although given the number of tablets, it seems more likely that Ms Montgomery was able to divert the tablets when issued them

each day. If this was the case, it demonstrates substantial weaknesses in the supervision of medication. Following Ms Montgomery's death, Low Newton has started using two officers to supervise medicine distribution, one officer to manage the queue and one officer to view each prisoner as they receive and take their medication. We make the following recommendation:

The Head of Healthcare and the Governor should ensure that staff adhere closely to protocols to limit prisoners' ability to conceal and divert supervised medication.

Access to baths

84. The investigator spoke to the Governor about access to baths at Low Newton. He said that he had learned that prisoners with healthcare needs were assessed and supervised in using the bath in the healthcare unit but there was no similar system for prisoners on standard wings who had no apparent disabilities or other healthcare needs. In response, the Governor removed access to the baths at Low Newton other than the bath in healthcare. In light of the action already taken by Low Newton, we make no recommendation of our own.

Clinical care

85. The clinical reviewer found that the care Ms Montgomery received at Low Newton was not of a satisfactory standard and was not equivalent to that which she would have received in the community. The clinical reviewer noted that Ms Montgomery had alcohol induced epilepsy, but this condition was not fully assessed, and no care plan was constructed to mitigate any risks. The clinical reviewer also noted that Ms Montgomery had no mental health care plan.

86. The clinical reviewer was also concerned about aspects of the healthcare input in Ms Montgomery's ACCT management including poor communication, inconsistent attendance at ACCT reviews and a failure to document attendance. The clinical reviewer was also concerned about the robustness of medicine distribution at Low Newton (and about which we have already made a recommendation). The clinical reviewer made five recommendations which the Head of Healthcare will need to address.

Good practice

87. We commend Low Newton for the efforts made to support other prisoners following Ms Montgomery's death. We consider this to be an example of best practice.

Inquest

88. An inquest into Ms Montgomery's death held between 24 to 28 August 2026 concluded that her cause of death was suicide from drowning. The inquest jury found that a contributory factor was that Mr Montgomery's statement to a nurse that she would drown herself if she could was not shared with officers and no action was taken upon the statement.

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Independent Investigations

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