Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Tyrone Beresford, a prisoner at HMP The Mount, on 14 July 2022

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

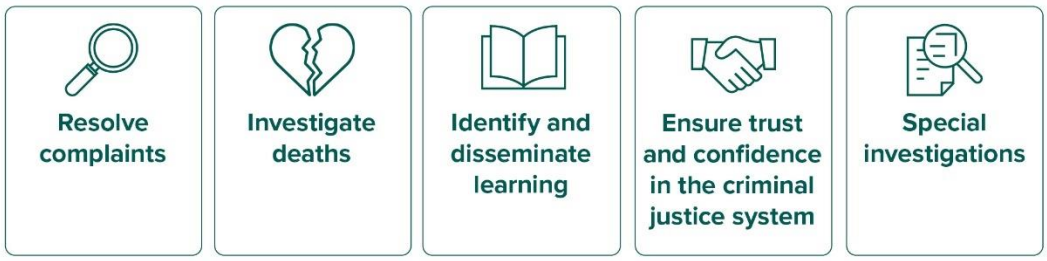
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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.

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 Beresford died from acute cardio-respiratory failure as a consequence of using synthetic cannabinoids on 14 July 2022 at HMP The Mount. (Synthetic cannabinoids are psychoactive substances – PS.) He was 31 years old. I offer my condolences to Mr Beresford's family and friends.

We did not find any evidence that Mr Beresford intended to take his life at the time of his death. Mr Beresford had a history of using illicit substances in prison, with periods of abstinence, and his death appears to have been an accidental result of using drugs. Two days before he died, he was sacked from his job as a kitchen worker after intelligence indicated that he was both using drugs and using his position to distribute drugs throughout the prison. I am satisfied that Mr Beresford knew the dangers of PS use and he received good support from his health and well-being worker.

Mr Beresford was the first of two prisoners at The Mount to die from using PS in July. Two more prisoners have apparently died from PS in January 2023. In August 2022, HMPPS Substance Misuse Group reviewed the prison's drug strategy. Their report showed evidence of significant amounts of PS in the prison and found that many improvements were needed to reduce supply and demand. The prison has introduced new measures in response and work is ongoing. I acknowledge that this is an area with constantly evolving challenges and more can always be done. However, there are a number of factors that mean that PS is likely to be especially prevalent at The Mount and I am extremely concerned that unless more is urgently done to reduce drugs at the prison, more prisoners will die there. Ongoing staff shortages perpetually undermine the prison's efforts to reduce supply and demand. This was an issue highlighted both by HM Chief Inspector of Prisons and HMPPS Substance Misuse Group. It is therefore imperative that the Director General for Prisons considers how the prison can reasonably deliver an effective drug strategy in these circumstances.

Although it did not affect the outcome for Mr Beresford, the emergency response was poor. The first member of staff on scene did not call an emergency code, there was a significant delay before an ambulance was called and staff tried to resuscitate him despite the presence of rigor mortis.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **September 2023**

Summary

Events

1. Mr Tyrone Beresford had a history of drug and alcohol misuse, violence, anxiety and depression. In 2018, he was sentenced to five years and six months imprisonment. On 1 November 2019, Mr Beresford transferred to HMP The Mount.

2. Mr Beresford was found under the influence of PS seven times between December 2019 and October 2020. From February 2021, he worked consistently with a health and well-being worker from the Forward Trust. He also worked with a restorative justice worker between June and December 2021.

3. On five occasions between November 2019 and November 2021, Mr Beresford asked for some talking therapy to help with his anxiety and depression. In November 2021, he completed a self-referral to the IAPT service. He was seen in response 197 days later in May 2022 and declined to engage with the service.

4. From December 2021, there were a number of indications that Mr Beresford was again active in prison drug culture, including that the relatives of other prisoners were paying him money in April 2022.

5. On 12 July, Mr Beresford was removed from his trusted job in the prison kitchen after intelligence was received that he was using and conveying PS.

6. At 5.03am on 14 July, Mr Beresford was found unresponsive in his cell. Officers entered the cell 15 minutes later and began cardiopulmonary resuscitation (CPR). Paramedics attended and confirmed that Mr Beresford had died.

Findings

7. There was a significant amount of PS in the prison at the time Mr Beresford died and the prison management was not doing enough to reduce supply and demand. All forms of drug testing were suspended and only 50% of requested searches took place.

8. Since the death of Mr Beresford and another prisoner, the prison has put in place a number of extra measures to reduce supply and demand, but their efforts are undermined by an ongoing lack of operational staff. In particular, they are unable to run an effective drug testing programme and complete the number of searches requested.

9. Mr Beresford was promptly and appropriately removed from his job after intelligence was received that he was using PS and using his trusted job to convey drugs to others, however there was no process in place to offer him support and assess his risks or any potential consequences he might face.

10. Mr Beresford understood the dangers of PS use and received good support from his health and well-being worker. We found no evidence that he intended to die on 14 July.

11. The night patrol officer did not radio a code blue emergency when he found Mr Beresford unresponsive. There was a significant delay before entering Mr Beresford's cell and an ambulance was called. Staff gave Mr Beresford CPR despite clear signs he had died. Body worn video cameras were not operated in line with national guidance.

12. The IAPT service was under resourced and had long waiting lists. Mr Beresford was offered an assessment 197 days after he completed a self-referral form. The counselling service provided by the Chaplaincy was also not running at the time and this left a gap in service.

13. The clinical reviewer found that Mr Beresford's mental healthcare was not equivalent to that which he could have expected to receive in the community.

Recommendations

- The Director General of Prisons should urgently consider what additional support can be put in place to address staffing shortages at The Mount and how the prison can reasonably be expected to deliver an effective drug strategy and regime.

- The Head of Safety and the Forward Trust Team leader should ensure that prisoners who lose their jobs due to intelligence that they are using or conveying drugs are properly supported and risk-assessed.

- The Governor should ensure that all staff are made aware of and understand their role and responsibilities during medical emergencies, including that they should radio a code blue emergency if they are concerned a prisoner is not breathing.

- The Head of Safety should ensure that the OSG understands his responsibilities if he finds a prisoner unresponsive.

- The Governor should review the numbers of night orderly staff and consider stationing one or more assist night orderlies at the further end of the prison to minimise delays in entering cells at night.

- The Governor should ensure that all staff are given clear guidance about and understand the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council guidelines.

- The Governor should ensure that staff operate their body-worn video cameras in line with national guidance.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP The Mount informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded and was interviewed.

15. The investigator visited The Mount on 26 July. She obtained copies of relevant extracts from Mr Beresford's prison and medical records. She also obtained CCTV, body-worn camera footage and emergency radio traffic from 14 July and calls made by Mr Beresford on the prisoner telephone (PIN) system. The investigator obtained the Forward Trust's root cause analysis report into Mr Beresford's death and HMPPS Substance Misuse Group's drug diagnostic report on The Mount, both produced in September 2022. Further information was provided by the Deputy Governor, the Head of Safety, the drug strategy manager, the security department and the Forward Trust.

16. NHS England commissioned a clinical reviewer to review Mr Beresford's clinical care at the prison. The investigator and clinical reviewer interviewed five members of staff jointly in July and August 2022. The investigator interviewed three members of staff in July, August and November 2022. The clinical reviewer spoke to one member of staff in September 2022.

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

18. The Ombudsman's acting family liaison officer contacted Mr Beresford's grandparents to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Beresford's grandparents said they wanted to know what had caused Mr Beresford's death. We have answered their question in this report.

Background Information

HMP The Mount

19. HMP The Mount is a medium security prison holding about 1,000 men. Practice Plus Group provide physical and mental healthcare. The Forward Trust is contracted to provide psycho-social substance misuse services and, since April 2020, mental health support under the Adult Improving Access to Psychological Therapies programme (IAPT). IAPT offers solution focussed cognitive behavioural therapy (CBT) sessions. Counselling services are provided by the prison Chaplaincy.

HM Inspectorate of Prisons

20. The most recent inspection of HMP The Mount was in March 2022. Inspectors were concerned about the shortage of officers available to deliver a meaningful regime or ensure prisoner access to activities or appointments. Many prisoners were locked up all day. Ofsted judged the provision of education, work and skills to be inadequate.

21. Steps to disrupt the supply of drugs were having a positive impact and far fewer men said they were easy to get hold of (29% compared to 50% at the previous inspection), but intelligence-led drug testing was yet to restart and less than half the requested cell searches were completed. Additional steps had been taken, including improved information sharing with the local police and greater use of CCTV around the perimeter wall. The prison photocopied all incoming mail and drug detection dogs were at the prison every day. Management of intelligence information was very good with prompt analysis.

22. Only 13% of prisoners surveyed said it was easy to see a mental health worker. Psychology vacancies had proved difficult to fill and there was a gap in services. Demand for the IAPT team far exceeded its capacity to respond with a significant waiting list, some of whom had waited for over a year. Inspectors found that the IAPT service was under-resourced.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2022, the IMB echoed HMIP's concerns that staffing levels had resulted in very limited time out of cell and access to the gym, showers and social time. Considerable progress to prevent illicit items from entering the prison was made under the restrictions imposed during the COVID pandemic. The introduction of staff and visitor searching, screening of incoming mail and greater vigilance of the perimeter had all contributed to this.

Previous deaths at HMP The Mount

24. Mr Beresford was the second prisoner to die from illicit drug use at The Mount. The previous death was in 2019. In that case we found that information about the

prisoner's drug use was not shared with prison staff, health care or security staff. We also concluded that the prison needed to do more to tackle the availability of illicit drugs and should revise its drug strategy. Ten days after Mr Beresford's death, another prisoner died after using illicit drugs. Another two prisoners died in January 2023 and although the causes of death had not been identified at the time of writing, they are suspected to be substance misuse related. Our investigation into a self-inflicted death in March 2022 also found the mental healthcare was not equivalent to that which the prisoner could have expected to receive in the community.

Psychoactive substances (PS)

25. PS (formerly known as 'legal highs') continue to be a serious problem across the prison estate. They can be difficult to detect and can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

Measures to reduce supply and demand for drugs in place at The Mount before Mr Beresford's death

26. Enhanced gate procedures were introduced in May 2021. Since then, all staff and visitors are searched, have their bags searched and walk through an airport style X-ray portal.

27. All prisoner mail is photocopied, checked by drug dogs and suspicious mail is put through narcotics trace detection equipment (Rapiscan machine). The prison holds a database of contaminated Rule 39 mail (confidential legal mail). All cards and photographs sent to prisoners must be sent via online delivery and printing services. Staff mail is logged and recorded.

28. Drug dogs, a regional resource, are based in the prison. Cell searches are requested for prisoners with supporting intelligence of drug involvement. All prisoners found under the influence are added to the daily briefing sheet, given mandatory drug tests and receive a Code Blue Pack from the Forward Trust substance misuse team. This contains information on the substance involved, harm minimisation advice and a self-referral form.

29. A dedicated constable from the local police attends a quarterly police and prison tasking meeting. All drug-related information reports are disseminated to the police.

Key Events

30. Mr Tyrone Beresford had a history of drug and alcohol misuse, violence, anxiety and depression. He served a number of short sentences in young offender institutions as a teenager. In 2010, aged 19, he was assessed at Broadmoor secure hospital and diagnosed with severe dissocial personality disorder. Mr Beresford was a patient of Lambeth Community Personality Disorder Service in between prison sentences. He was released from HMP Wayland in July 2013.

31. In August 2018, Mr Beresford was remanded to HMP Thameside and subsequently sentenced to five years and six months imprisonment. On 1 November 2019, Mr Beresford transferred to HMP The Mount.

2019 - 2020

32. On 4 November 2019, the doctor prescribed Mr Beresford sertraline (an antidepressant) and propranolol (for anxiety). The same day, Mr Beresford was referred to the Forward Trust substance misuse services after he expressed an interest in drug and alcohol programmes.

33. On 14 November, he attended a mental health assessment and asked for some information on cognitive behavioural therapy to help with his anxiety. He was referred to the IAPT service and remained under the GP and primary mental health team for mood and antidepressant medication reviews.

34. On 18 November, a substance misuse recovery worker from the Forward Trust visited Mr Beresford to assess him. Mr Beresford said that he no longer wished to engage in work on his drug and alcohol issues. The recovery worker told him he could self-refer if he changed his mind.

35. On 4 December, Mr Beresford self-referred to the Forward Trust. He said that he had changed his mind and wanted to engage with services. On 17 December, he was found under the influence of psychoactive substances (PS). There is no evidence the Forward Trust were aware of this incident and Mr Beresford was not seen in response as he should have been. Incidents of prisoners being found under the influence should be reported on the prison's daily briefing sheet, which the Forward Trust has access to. On 21 December, Mr Beresford completed another self-referral form.

36. On 30 January 2020, he was discharged from primary mental health after he did not attend three successive mood and medication review appointments and stopped collecting his Sertraline. On 6 February, the Forward Trust assessed Mr Beresford in response to his self-referral. The assessment indicated high treatment needs and noted Mr Beresford was at risk of using PS. Mr Beresford was added to the waiting list for the Substance Disorder Treatment Programme (SDTP). On 13 February, Mr Beresford failed a mandatory drug test for PS. His Forward Trust recovery worker does not appear to have been informed.

37. On 9 March, Mr Beresford started the SDTP but was deselected from the course on 13 March because he refused to move to the wing where the course took place. He said subsequently that he preferred to complete shorter programmes and courses.

38. In June, Mr Beresford asked to resume antidepressants and the doctor re-prescribed sertraline. In July, he started work in the prison's DHL workshop (DHL supply and manage the distribution of prison shop items and provide workshop employment in some prisons).

39. Mr Beresford was found under the influence of PS on 18 August and lost his job in the DHL workshop on 19 August. He was again found under the influence of PS on 26 August, 18 and 23 September. Despite the Forward Trust being made aware of these incidents via the daily briefing sheet, no one saw Mr Beresford in person to give him harm minimisation advice and offer interventions. Mr Beresford spent a period in the prison's care and separation unit (CSU – segregation unit) to help him stabilise after his prolonged period of PS use.

40. On 24 September, Mr Beresford told Supervising Officer (SO) A that he had started using PS after some bad news and was now addicted to it. He said he used it as a form of escapism from prison. Mr Beresford said he would like a job to 'get him back on track'. He was added to the waiting list for a job in the DHL workshop and for a wing cleaning job. The SO also referred Mr Beresford to the Forward Trust. On 25 September, the Forward Trust became aware from the daily briefing sheet that Mr Beresford had been under the influence on 23 September. As his allocated worker was not working that day, a health and well-being worker was instructed to see him in person to give harm-minimisation advice, which she later did.

41. On 30 September, Mr Beresford returned to a standard wing. On 16 October he was found under the influence of PS again. This is the last time Mr Beresford was found under the influence of PS before his death. He was not seen by the Forward Trust and there is nothing in their records to suggest they knew about this.

42. In November, Mr Beresford told staff that he intended to detoxify from PS. He was given a trusted job as wing painter and cleaner and received a number of positive entries in his prison record about his work and behaviour.

2021

43. Mr Beresford's positive behaviour continued throughout January 2021. On 17 February, the Forward Trust allocated a health and well-being worker. Mr Beresford's new health and well-being worker some five months after his last contact with the service (the Forward Trust's target is to see all prisoners on their caseloads at least every 12 weeks).

44. The health and well-being worker reviewed Mr Beresford's recovery plan with him on 22 February. Mr Beresford said he would like to complete some in-cell packs on substance misuse. She agreed to begin keywork sessions with Mr Beresford once he had completed his in-cell packs.

45. In April, Mr Beresford started the Building Better Relationships (BBR) programme (a 28-session programme for men who have been violent in their relationships) run by the prison psychology department.

46. On 7 April, Mr Beresford completed in-cell packs on coping with triggers, relapse prevention and PS. On 26 April, he and his health and well-being worker discussed models of addiction and how fasting during Ramadan helped him control his urges.

47. The health and well-being worker said Mr Beresford enjoyed the 'high' of drug-use and thought it expanded his consciousness as he had out of body experiences on PS**.** This desire came into conflict with his Muslim faith and the tension between the two was an ongoing struggle for Mr Beresford. She said Mr Beresford had the capacity to reflect on his drug use and understood the dangers of PS. She did not think he was trapped in a cycle of addiction. She thought that he chose to use drugs because he enjoyed the effect they had on his mind.

48. On 7 May, Mr Beresford reported a deterioration in his mental health. Nurse A assessed him on 28 May. Mr Beresford said he was overthinking everyday tasks and said he felt self-conscious and critical of himself. On 8 June, the nurse discharged Mr Beresford from the mental health service after he was unable to find him on the wing for a follow-up appointment.

49. On 22 June, Mr Beresford met another worker from the charity Belong, to discuss his participation in the restorative justice programme. They began working together on 15 July and discussed the impact of trauma and how Mr Beresford might move away from violence as a way of dealing with conflict. During July, Mr Beresford completed the Building Better Relationships course.

50. On 27 July, Mr Beresford told his health and well-being worker that he felt angry, bored and depressed without the high of smoking PS. They discussed Narcotics Anonymous (NA) and agreed Mr Beresford would begin the 12-step addiction recovery programme. She set Mr Beresford some reading goals from the NA book for discussion at their next session.

51. Towards the end of July, Mr Beresford started working in the DHL workshop again. On 9 August, he was removed from the workshop after he attempted to steal a tin of mackerel. Later that day he was verbally abusive to Officer A and offered to fight him in his cell. The officer charged him under prison disciplinary procedures.

52. On 10 August, the health and well-being worker completed a new risk assessment on Mr Beresford. She identified custodial substance misuse, self-reported anxiety and personality disorder among Mr Beresford's risks.

53. On 12 August, Mr Beresford verbally abused Officer A again and received a second prison disciplinary charge. He was moved to the CSU and on 25 August, he assaulted a member of staff. The worker from charity Belong saw him weekly in the CSU to discuss his violent behaviour. She described Mr Beresford as almost 'manic' during this period. She said he was at risk of using drugs or being violent when things were not going well for him.

54. On 26 August, Mr Beresford told his health and well-being worker that when he became frustrated his chosen methods of release in prison were either violence or drug use. These gave him a "buzz" and were a temporary release. He said he was currently using the "high" of violence instead of using drugs. They agreed to wait until Mr Beresford returned to a standard wing before having the planned 1:1 session on the 12-step programme.

55. On 28 August, Nurse B from the mental health in-reach team assessed Mr Beresford in the CSU. He was angry and accused the mental health team of doing nothing for him since he arrived at The Mount. He said his mental health had

deteriorated and he wanted some therapeutic input. The nurse referred to him to psychology and the IAPT service. She concluded that Mr Beresford was not suffering a psychotic episode and therefore discharged him from the mental health team. He returned to a standard wing on 31 August.

56. On 9 September, Mr Beresford started the 12-step programme with the health and well-being worker. He said he was frustrated at having no job since being removed from the DHL workshop.

57. On 8 October 2021, Mr Beresford asked Officer A if he could return to the CSU because he was feeling anxious and was worried he would go back to 'a bad place' and behave inappropriately to staff. The next day he told Officer B that he was very frustrated and was getting 'to boiling point' emotionally. He said he wanted some talking therapy and Officer B said she would talk to the mental health team. Mr Beresford said he thought he had been prematurely discharged from the mental health team caseload and his mental health was declining.

58. Mr Beresford saw the prison Imam that day and they talked and prayed together. Wing staff gave Mr Beresford extra cleaning responsibilities over this period in order to give him something positive to focus on and Mr Beresford appeared to respond well to this. The worker from charity Belong saw him on her return from annual leave and said he was in good spirits and worked well in their sessions.

59. On 29 October, Mr Beresford saw the health and well-being worker again. She said he reflected well on his glorification of his drug use, and they agreed to work more on regulating his emotions without resorting to drugs.

60. On 1 November, Mr Beresford completed a self-referral form for the IAPT service. IAPT records indicated he had symptoms of depression. On 4 November, the IAPT team sent him a safety pack and a letter confirming he was on their waiting list. On 21 November, a member of the IAPT service telephoned Mr Beresford in his cell for a well-being check. Mr Beresford said he was sleeping better but was anxious and "over-thinking". He accepted in-cell packs on sleep, dealing with stress/anxiety and dealing with negative thoughts.

61. On 7 December, Mr Beresford told the worker from charity Belong that he had been struggling with the amount of time he was spending in his cell as part of further measures to stop the spread of COVID-19. She said she would try to see him more regularly as Mr Beresford benefitted from talking. On 10 December, Mr Beresford told her he no longer wanted to work with her. On 13 December, he explained to her that he was upset at not being re-categorised to Category D (deemed suitable for a prison with minimum security) and wanted to deal with his feelings on his own. On 30 December, Mr Beresford threatened to stamp on a prison drug dog on his wing.

January - July 2022

62. On 17 January 2022, Mr Beresford told the health and well-being worker that he was trying to regulate his behaviour to get a positive outcome at his upcoming parole hearing. He thought he would be very volatile if he did not get the outcome he wanted. He said he thrived on the high he got from behaving chaotically.

63. On 21 January, Mr Beresford was moved to the CSU following intelligence that he was inciting other prisoners to violence and had claimed that he and another prisoner would “run this place”.

64. Mr Beresford returned to a standard cell on Dixon Wing on 25 January. On 27 January, Officer C became Mr Beresford’s keyworker. In February, Mr Beresford became a wing cleaner and then servery worker on Dixon Wing. The officer said Mr Beresford was a good worker and very helpful to staff. He saw him daily on the servery and could not remember Mr Beresford asking him for help with any issues. He had not known Mr Beresford was a PS user.

65. On 22 February 2022, the security department received intelligence that Mr Beresford had asked a member of staff to bring in some seasoning, “just a little bit, a sprinkle”, to help with the bland food. This was presumed to be a reference to PS.

66. On 31 March, Mr Beresford and the health and well-being worker discussed managing his addiction to highs from drug use and violence. Mr Beresford said he was currently abstinent from drugs, and she gave him harm-minimisation advice. She said she would try to provide him with more information to understand his personality disorder.

67. On 24 April, Mr Beresford asked Officer C if he could be considered for a job working in the prison kitchens. The officer agreed to contact the activities department but reminded Mr Beresford that he needed to have worked in a trusted job on the wing for three months in order to qualify for a trusted job off the wing.

68. On 28 April, the Financial Intelligence Unit (FIU) informed prison security that Mr Beresford was receiving money from the relatives of other prisoners. (This can sometimes be a sign of involvement in conveying illicit items, like drugs, in prison.) There is no evidence that this information was shared with the Forward Trust, or that they had any expectation that they would be informed of intelligence of this nature.

69. On 17 May, 197 days after his self-referral was received, a member of staff from IAPT attempted to assess Mr Beresford but he said he no longer wanted to engage with the service. She did not record Mr Beresford’s reasons or whether she explored them with him.

70. In June, Mr Beresford began working in the prison kitchen bringing the food trolleys over to Dixon Wing.

71. On 6 June, Mr Beresford and the health and well-being worker talked about the impact of PS and alcohol use on his spiritual, physical and mental health with a particular emphasis on drug-induced psychosis. Mr Beresford said he did not want to use PS but he did crave alcohol. He asked for more information on the effects of PS on the brain. She said she would send him some information and they agreed to have another session in six – ten weeks.

72. Mr Beresford’s prison record showed a number of positive entries in June. He was noted to be a good worker and helpful to staff and other prisoners. On 18 June, Officer C noted that Mr Beresford was in a good mood and seemed very positive.

73. On 21 June, CM A, the Dixon Wing manager, asked the worker from charity Belong to speak to Mr Beresford because he appeared to be struggling with his thoughts and he had previously benefitted from working with her. Mr Beresford said he had been in a much better frame of mind since starting a job in the prison kitchen as he was able to get off the wing. The worker from charity Belong said she would visit him at some point to go through some strategies to manage his negative thoughts.

74. At interview, the worker from charity Belong said she had noticed that Mr Beresford appeared to have some 'sway' with other prisoners on the wing and appeared to think of himself as a 'big fish'. She said other prisoners that were known for causing trouble had simply moved from a bench when Mr Beresford wanted to sit on it. She asked Mr Beresford what was going on, but he said he did not know what she was talking about. The worker spoke to officers on the wing, but they told her that Mr Beresford was a wing cleaner, and his behaviour was not unusual.

75. On 5 July, the catering manager, noted on Mr Beresford's prison record that he had been working in the prison kitchen for several weeks and was a good worker.

76. On 11 July 2022, Mr Beresford spoke to a friend on the prison telephone (PIN) system. He said he was confident of getting parole and talked about his plans for the future.

77. Also on 11 July, the Dixon Wing observation book showed a prisoner told a member of staff that Mr Beresford was getting PS from prisoners on Nash Wing who worked in the kitchens and was bringing it back to Dixon Wing. The prisoner said Mr Beresford was using PS and selling it to two other prisoners who were then selling it on. The member of staff sent an information report to the prison security department.

78. The next day, on 12 July, a security analyst, emailed the activities department and asked that Mr Beresford be removed from his job in the kitchens. The same day she wrote a letter to Mr Beresford telling him he had been removed from work due to security intelligence. Neither we nor the prison were able to identify whether anyone sat down with Mr Beresford and discussed the loss of his job or considered whether he would be at risk as a result.

79. The worker from charity Belong said she was on annual leave that week. She said that losing his job would have been a trigger for Mr Beresford and, had she known and been at work, she would have gone to see him. The health and well-being worker said she did not know at the time that Mr Beresford had been sacked on suspicion of conveying and using drugs. There was no expectation at the time that the Forward Trust should be informed in these circumstances unless the prisoner was a peer support worker.

80. The prison security hub manager said Mr Beresford was the eleventh prisoner since 8 June to have been removed from their job due to intelligence they were conveying illicit substances.

81. Prisoner A said he had known Mr Beresford for about four months on Dixon Wing. He said he knew Mr Beresford drank hooch in prison but had not known he used PS. He did not know why Mr Beresford had lost his job. He said Mr Beresford usually kept himself fit but the last conversation he had with him he had noticed Mr

Beresford was not training. He said there was always PS in the prison but in June and July the problem had been worse. He said the lack of time prisoners had out of their cells, which was only two hours a day in July, always made PS use worse.

Events of the evening of 13 July 2022

82. CCTV showed another prisoner outside Mr Beresford's door between 6.18pm and 6.21pm. At 6.20pm, the other prisoner reached up to the top of Mr Beresford's door. At 6.30pm, he returned to Mr Beresford's cell briefly. At 6.34pm, the same prisoner returned to Mr Beresford's cell and appeared to pass something through the gap on the right-hand side of the door. He left at 6.37pm.

83. At 8.15pm, CCTV showed the OSG, the night patrol officer, began the evening roll check. At 8.21pm, the OSG checked Mr Beresford's cell by looking through the observation hatch. Despite our request, the prison did not provide CCTV between 9.00pm and 5.00am and there are no cell bell records because the system does not provide reports so we are unable to confirm whether Mr Beresford pressed his bell that night.

Events of 14 July 2022

84. The OSG was the night patrol officer on Dixon Wing that night. He said he was aware that there was a problem with PS in the prison at that time. He had not come across any unresponsive prisoners that week or during any previous night duty at The Mount since he became an OSG about a year previously. At night, OSGs on wings do not carry cell keys but have a key in a sealed pouch for use in an emergency. The OSG said he was aware that he could break the seal on his cell key to enter a cell at night to preserve life but had never had to do so.

85. CCTV showed the OSG started his morning roll count at 5.00am. At 5.03am, he looked through Mr Beresford's observation panel. He said Mr Beresford was lying in bed on his left-hand side, with his upper body positioned as if he had leaned out of bed to be sick. The OSG said he could not see any movement in Mr Beresford's chest or back to indicate he was breathing. He called Mr Beresford's name and knocked at his cell door, but Mr Beresford did not respond.

86. The OSG said he did not know Mr Beresford and was not sure what the situation was. He said some prisoners liked to 'play up' especially if they did not want to speak to officers. He said he knew something was not right, but it was not obvious to him what the problem was. He did not know whether Mr Beresford was being sick and did not want to acknowledge him in that moment. He decided to telephone CM B, the night orderly officer and tell her he had an unresponsive prisoner.

87. CCTV showed the OSG left Mr Beresford's cell to call CM B at 5.05am. He told her that he had an unresponsive prisoner. The CM recalled that the OSG also said that he could not see any movement in Mr Beresford's chest.

88. The CM said she was in the gate at the opposite end of the prison from Dixon Wing. She was aware there had been a lot of PS in the prison, so she checked Mr Beresford's electronic prison record to see if he had any recent entries about PS use and found none. She said the OSG was very calm and did not convey any sense of emergency or alarm.

89. The CM then made her way from the gate to Dixon wing at the other end of the prison. On the way she radioed Officer D, Officer E and Officer F, the assist night orderly officers, and told them to meet her at Dixon Wing.

90. CCTV showed the CM arrived at Mr Beresford's cell at 5.17am. She said she waited for the assist night orderly officers to arrive at 5.18am and they entered the cell. The CM said that three officers must be present before a cell can be opened in night state as this is the minimum number necessary for use of force. She said the first person on scene should make a dynamic risk assessment about whether to enter the cell for preservation of life. In this case, because the OSG had decided not to enter the cell before she got there, she waited for the other officers.

91. The CM said Mr Beresford was slumped on his bed. There was a lot of vomit around him and he had blood coming from his nose and eyes. She said she tried to get a response from Mr Beresford by talking loudly to him and shaking him. She felt for a pulse in his neck and thought she felt one but when she checked his wrists, he was cold and she could not feel a pulse. When the officers lifted Mr Beresford on to the floor, they realised he was very stiff and they could not straighten his body.

92. The CM radioed a code blue emergency and asked for an emergency ambulance. East of England Ambulance Service records showed the 999 call was received at 5.19am. A first responder was dispatched immediately with response category 1 (the highest priority for life threatening conditions).

93. The CM said she asked Officer D to get a defibrillator from the wing office. CCTV showed Officer D left the cell at 5.22am. He returned at 5.24am without the defibrillator and left almost immediately with Officer E. The CM said she thought that Officer D had not been able to find the defibrillator because he was in shock.

94. CCTV showed Officer E returned with the defibrillator at 5.25am. The CM said that when they attached the pads to Mr Beresford’s chest, she noticed a lot of bruising on his abdomen. She said it was also the first time she had been involved in an emergency response, she felt panicked and did not consider at the time that Mr Beresford might have already died. The defibrillator indicated they should perform cardio-pulmonary resuscitation (CPR) and the CM and Officer F took it in turns to do chest compressions.

95. For technical reasons, we were not able to view the body worn video camera footage. The HMPPS early learning review showed that a camera was activated at 5.25am as CPR began and the footage indicated that Mr Beresford had died, and rigor mortis was present.

96. East of England Ambulance records showed the first responder arrived at the prison at 5.31am.

97. CCTV showed the first responder and Officer D arrived at Mr Beresford’s cell at 5.48am. Ambulance records showed that Mr Beresford had, “Obvious rigor mortis to both arms and post-mortem lividity to front of torso. Pupils fixed and dilated” confirming that Mr Beresford had died.

Contact with Mr Beresford's family

98. The prison appointed a family liaison officer. The family liaison officer and the prison chaplain, informed Mr Beresford's grandparents of his death in person at their home that morning. The family liaison officer later returned Mr Beresford's property to his grandparents.

99. The prison made a financial contribution to Mr Beresford's funeral in line with national guidance.

Support for prisoners and staff

100. After Mr Beresford's death, the prison's Trauma Risk Management (TRiM) team debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The CM said that she had organised TRiM support for her colleagues but had not received any support herself.

101. The prison posted notices informing other prisoners of Mr Beresford'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 his death.

Post-mortem report

102. The Post-mortem report showed that Mr Beresford died from acute cardio-respiratory failure as a consequence of using synthetic cannabinoids.

Actions taken after Mr Beresford died

103. The prison took a number of actions in response to Mr Beresford's death including:

- On the day of Mr Beresford's death, the Governor issued a Prisoner Information Notice (PIN) on PS awareness, warning prisoners that the ingredients of PS changed constantly and listing warning signs of intoxification.
- An amnesty on illicit substances was brought in for the remainder of 14 July and all-day 15 July. No one handed anything in.
- On 17 July, the prison resumed intelligence-led and random drug testing.
- Prisoners found under the influence had their cells searched without supporting intelligence, on the grounds of safety.
- The Forward Trust prioritised checking all prisoners suspected of using drugs and delivered direct harm minimisation advice.
- Between 19 July and 11 August, nine prisoners were removed from their jobs following intelligence that they were conveying drugs.

- On 28 July, the prison conducted a lockdown search of Nash Wing. Fermenting liquid, paper suspected to contain PS and other evidence of illicit substances was found.

- The windows of the Annexe were sealed after intelligence indicated that drugs were being sent in through them via drones.

104. In August, the HMPPS regional drug lead requested a full diagnostic review of the prison's drug strategy by HMPPS Substance Misuse Group. The diagnostic team made 20 recommendations to improve the prison's drug strategy. Significantly they found that:

- Evidence indicated an extensive supply of PS in the prison.

- The drug strategy was not fully developed and was not a 'live' document.

- There was no specific PS strategy.

- Intelligence analysis was good.

- The prison's significant staffing issues undermined their efforts to reduce supply and demand and made a 'whole prison approach' extremely difficult. In particular, the lack of prison regime fuelled the demand for drugs.

- Mandatory drug testing was suspended due to lack of staff. (This has since resumed but at the time of writing a maximum of 17 tests had been completed each month.)

- Wing Intelligence Liaison Officers (WILOs) who might plug the intelligence gap caused by the lack of mandatory drug testing were not operating due to staff shortages.

- Conveyance of drugs by staff was a considerable risk due to their inexperience and vulnerability to organised crime (over 70% of staff had less than two years' experience).

105. The drug strategy manager was appointed in November 2022, provided us with the prison's current drug strategy and their action plan in response to the diagnostic report.

Inquest

106. The Coroner's inquest into Mr Beresford's death was heard in November 2024 and the verdict was

1a Acute cardiorespiratory failure due to or as a consequence of

1b Synthetic cannabinoids

Findings

Drug strategy at HMP The Mount

107. We acknowledge the huge challenges inherent in preventing drugs entering The Mount. PS is especially prevalent in Category C prisons because their lower security measures and stable population allows for the maintenance of distribution networks. The Mount also has a large perimeter and is situated in an open and accessible rural area vulnerable to 'throw-overs' and drones. The proximity of the M25 places it at the junction of prominent County Lines routes. The illicit drugs market in prison is controlled by organised crime gangs and the scale of the problem requires a co-ordinated approach. Although it is clear that some things are being done very well at The Mount, including the analysis of intelligence and the system for checking the validity of legal mail, the threat from drugs is constantly evolving and more can always be done.

108. We are extremely concerned that there was an unacceptably high supply of PS in the prison when Mr Beresford and another prisoner died in July. Drug testing had not re-started after the COVID-19 pandemic and fewer than half the requested cell searches were being completed. HMPPS Substance Misuse Group concluded that the prison could do much more to reduce supply and demand, especially for PS. The prison accepted all 20 recommendations from the diagnostic report and produced a 'live' action plan to drive progress towards achieving them. The newly appointed drug strategy manager is now working to coordinate a whole prison approach. Although it is too early to see the impact of these new measures, we are satisfied that the prison is trying to make meaningful progress to reduce supply and demand. In particular, we note they have:

- Added counter-corruption training to the monthly staff training schedule.
- Issued a protocol for prisoners found under the influence of illicit substances.
- Started reviewing all prisoners in high-risk roles every six months.

And are planning to:

- Ban staff from bringing in paper other than their official diaries.
- Require legal visitors to bring in laptops and not paper records.

109. We are concerned that the prison's efforts are undermined by their chronic staffing issues. Staffing was highlighted as a key concern by HMIP with 40% of staff unable to be deployed to operational duties and a high number of staff left within their first year. The diagnostic report also highlighted staff retention as a key issue, as 70% of staff had under two years' experience. The Mount is currently 30 officers below their profile of 180. At the time of writing 50% of officers were not available for operational duties. In October 2022, prison management introduced an emergency regime based on a re-profile of 150 staff. This has allowed consistent delivery of some work and activities but is by no means a permanent or desirable long-term solution. A consistent regime is critical to reducing the demand for drugs by alleviating boredom through purposeful activity.

110. Crucially the lack of staff has limited the operation of drug testing programmes. Random and suspicion testing was re-introduced a few days after Mr Beresford died. Had it been in place sooner, some of the intelligence received that he was involved in drug culture could have been tested.

111. Mandatory drug testing resumed in October for the first time since the COVID-19 pandemic. However, the highest number of mandatory tests completed in a single month at the time of writing was 17 out of a population of just over 1,000 men. This means that information reports relating to substance misuse are not being properly tested and there is a consequent intelligence gap. The WILO role that might help to plug this gap is not operating due to lack of staff.

112. The prison is also unable to undertake sufficient searching and fully support the regional dog team. We consider that without these critical pillars of supply reduction, the prison will be unable to gauge the true nature and scale of their drug problem and their efforts will continue to be undermined. The prison has introduced some new measures in response to HMIP's recommendation on staffing, however, almost a year later, progress has been limited and they remain some distance from recruitment targets. It seems likely that two more prisoners have died from the effects of PS since Mr Beresford and another prisoner died. We are extremely concerned that unless more is done urgently to reduce the flow of drugs into the prison, more prisoners will die. We recommend that:

The Director General of Prisons should urgently consider what additional support can be put in place to address staffing shortages at The Mount and how the prison can reasonably be expected to deliver an effective drug strategy and regime.

Mr Beresford's removal from his job on 12 July

113. We consider that Mr Beresford was promptly and appropriately removed from his job after intelligence was received that he was using PS and using his trusted job to convey it to others. While we cannot say that it affected the outcome for Mr Beresford, we are concerned that no one appears to have spoken to him about this, offered him support or assessed any potential risks to him. Evidently Mr Beresford's risk of using drugs and being violent increased after he suffered personal setbacks. He twice lost his job in the DHL workshop and each time he went through a significant period of increased drug taking or violent behaviour.

114. Prisoners in jobs allowing movement around the prison and outside the wings are especially vulnerable to pressure to become involved in drug culture. Mr Beresford was the eleventh prisoner since 8 June to lose his job because of intelligence relating to drugs, a further nine prisoners were removed for the same reason in the month after he died. As with Mr Beresford, losing such a job can be a trigger for a number of risk-taking behaviours. We recommend that:

The Head of Safety and the Forward Trust Team leader should ensure that prisoners who lose their jobs due to intelligence that they are using or conveying drugs are properly supported and risk-assessed.

Mr Beresford's substance misuse support

115. Prior to Mr Beresford's reallocation to the health and well-being worker in February 2021, there were a number of deficiencies in the support he received from the substance misuse team. Mr Beresford was assessed 46 days after he self-referred in 2019 and no harm-minimisation was given despite his history of substance misuse and assessment that he had high treatment needs. He was not seen after being found under the influence in December 2019 or after he failed a mandatory drug test in February 2020. He was not seen in person until the fourth time he was found under the influence between 18 August and 23 September 2020, and not at all after he was found under the influence in October 2020. Mr Beresford's original health and well-being worker resigned in Autumn 2020, but he was not reallocated a worker or given a welfare-check for five months until the health and well-being worker took over.

116. We have seen the root cause analysis report completed by the Forward Trust and are satisfied that remedial measures have been put in place, including development of a process to monitor the number of prisoners found under the influence multiple times in a single month. The prison has also since issued a protocol for dealing with prisoners found under the influence and is currently reviewing it to test its efficacy.

117. We are satisfied that Mr Beresford knew the dangers of PS use. He received good support from the health and well-being worker and the worker from charity Belong to understand the behavioural issues that led him to use drugs and violence. We have not found any evidence that Mr Beresford intended to die on 14 July. Sadly, despite periods of abstinence, it appears that Mr Beresford was ultimately unable to overcome his addiction to the 'high' he associated with drug use. We therefore make no recommendation.

Emergency response

118. Prison Service Instruction 03/2013 requires governors to have a two code medical emergency response system based on the instruction. As is usual, The Mount use code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance.

119. Prison Service Instruction (PSI) 24/2011 gives national guidance for entering cells at night. The PSI says that under normal circumstances, the night orderly officer must give authority to unlock a cell at night and a cell opened with a minimum number of staff (according to local risk guidelines) present. However, the PSI goes on to say, that the preservation of life must take precedence over this. Where there is or appears to be threat to life, staff may open and enter cells on their own if they feel safe to do so, having performed a dynamic risk assessment and informed the control room.

120. The Mount's local guidelines specify a minimum of 2/3 members of staff must be present, one of which should be the night orderly officer. The preservation of life must take precedence but night staff should not take any action that they feel would put themselves or others in unnecessary danger.

121. CCTV showed the OSG tried to gain a response from Mr Beresford for over a minute before he decided to telephone the CM. He said he could not see any sign that Mr Beresford was breathing but did not call a code blue emergency because he could not be sure what the problem was. He returned to the cell three minutes later and looked through the observation panel, left again and then returned after 30 seconds and spent a further three minutes trying to get a response from Mr Beresford. During this time Mr Beresford's presentation did not change.

122. We understand that the OSG had not previously found a prisoner unresponsive, and we accept that he did not feel safe to enter the cell on his own. However, we consider that, as he was unable to see Mr Beresford breathing or elicit any kind of response, he should have erred on the side on the side of caution and called a code blue emergency when he first discovered Mr Beresford. He should certainly have called one at 5.08am when he returned to the cell after three minutes and found the situation had not changed. The OSG said that no one had since discussed his role that night with him.

123. The CM acknowledged that the OSG had told her that he could not see Mr Beresford breathing but said that his tone did not indicate that the situation was an emergency. At interview she said she appreciated with hindsight that she should not have paused to check Mr Beresford's prison record before going to Dixon Wing. We do not know the substance of their conversation, but we consider that the information that Mr Beresford was not breathing should have prompted a more urgent response from the CM.

124. The Mount covers a very large site. The night orderly officer and the assist night orderly officers are usually based at the gate end of the prison. Even at a fast walk, Dixon Wing is some ten minutes distant at the opposite end. This means that, if a night patrol officer decides it is not safe for them to enter a cell on their own, there is already a significant delay built in before the cell will be entered. It also means that, if it is left to the night orderly officer to attend the scene before a code blue is called, they (or one of their assists) have to return to the gate before the ambulance can enter the prison. We consider this is another reason why if there is any doubt that a prisoner is breathing it should be presumed to be an emergency. This would allow the night orderly officer to consider how to best manage the situation with the staff available to them.

125. The CM believed erroneously that three staff were required before a cell could be opened at night. According to The Mount's local instructions, she and the OSG could have entered Mr Beresford's cell before the assist night orderly officers arrived. In cases where a prisoner is not breathing every second is crucial to preservation of life. Staff eventually entered Mr Beresford's cell some 15 minutes after he was first found unresponsive. The CM has since received advice and guidance from managers about her role that night.

126. Although the significant delay in the emergency response did not affect the outcome for Mr Beresford, it is important that all staff understand their roles in a medical emergency. We make the following recommendations:

The Governor should ensure that all staff are made aware of and understand their role and responsibilities during medical emergencies, including that

they should radio a code blue emergency if they are concerned a prisoner is not breathing.

The Head of Safety should ensure that the OSG understands his responsibilities if he finds a prisoner unresponsive.

The Governor should review the numbers of night orderly staff and consider stationing one or more assist night orderlies at the further end of the prison in order to minimise delays in entering cells at night.

Resuscitation

127. In September 2016, the National Medical Director at NHS England wrote to Heads of Healthcare for prisons to introduce new guidance to help staff understand when not to perform cardiopulmonary resuscitation (CPR). This guidance was designed to address concerns about inappropriate resuscitation following a sudden death in prison. It was taken from the European Resuscitation Council Guidelines which states, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile." The European Guidelines were updated in May 2021, but the same principles apply.

128. Mr Beresford's arms and limbs were completely stiff, which indicated that rigor mortis (stiffness of the limbs after death) was present. The CM said she saw dark bruising on the right side of his abdomen which was almost certainly post-mortem blood pooling. Rigor mortis normally sets in between two and six hours after death, indicating that Mr Beresford had been dead for some time when he was found.

129. All the staff present were clearly in shock and it was their first experience of such a scenario. We understand this and the wish to continue resuscitation until death has been formally recognised, but trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. The guidance highlights that resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile. The guidelines give examples of futility as including the presence of rigor mortis. We make the following recommendation:

The Governor should ensure that all staff are given clear guidance about and understand the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council guidelines.

Body-worn video cameras

130. At the time of Mr Beresford's death guidance on operating body-worn video cameras was contained in Prison Service Instruction (PSI) 04/2017. Recording of incident response is mandatory and staff must give reasons for any failure to record an incident wholly or partially in their written statements. When attending incidents where a prisoner is receiving life-saving medical intervention and there is no threat to the safety of others, staff must maintain audio capture but consider non-intrusive video capture of the medical intervention. The guidance is the same in the policy framework issued in September 2022.

131. In this case no one turned on their camera until part way through the incident and written reasons for this were not given in staff statements as they should have

been. Although we were unable to view the footage for technical reasons, we understand from the early learning review that it contained graphic images of Mr Beresford rather than non-intrusive capture and an audio commentary. We therefore recommend that:

The Governor should ensure that staff operate their body-worn video cameras in line with national guidance.

Clinical care

132. The clinical reviewer concluded that the mental healthcare Mr Beresford received at The Mount was not equivalent to that which he could have expected to receive in the community. The nurse that assessed Mr Beresford on arrival failed to recognise his history of mental illness and substance misuse. The clinical reviewer identified a lack of evidence based risk assessment and risk formulation for patients on the mental health team caseload. Interventions were brief and Mr Beresford was discharged from the mental health team on one occasion because a nurse could not find him on the wing. This was not in line with standard failure to attend policies.

133. The deficiency in mental health support was compounded by long waiting lists for the Forward Trust run IAPT service and the absence of a counselling service provided by the Chaplaincy. Mr Beresford asked for talking therapy on five occasions between his arrival at The Mount and November 2021. Records indicated he was referred twice to IAPT without response in 2019 and 2021. He was eventually seen in May, 197 days after completing a self-referral. HMIP reported in March that the IAPT service was under resourced and this is still the case.

134. This is the second death at The Mount in 2022 where mental healthcare was found to be inadequate. Although we do not think in this case that it directly affected the outcome for Mr Beresford. The clinical review makes recommendations about these issues which the Head of Healthcare will need to address.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100