Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Max Marchant, a prisoner at HMP The Mount, on 25 July 2022

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.

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 Marchant died from synthetic cannabinoid toxicity on 25 July 2022 at HMP The Mount. (Synthetic cannabinoids are psychoactive substances – PS.) He was 26 years old. I offer my condolences to Mr Marchant's family and friends.

We did not find any evidence that Mr Marchant intended to take his life. Mr Marchant had a history of using illicit substances in prison, and his death appears to have been an accidental result of using drugs. The Forward Trust assessed him as at high risk of using PS. Although I am satisfied that Mr Marchant knew the dangers of PS use and that he received good support from his health and well-being worker, I am concerned that he was moved to a wing known to be overrun with PS less than 36 hours before he died. Tragically, the prevalence of PS on his new wing apparently weakened his resolve with fatal consequences.

Mr Marchant was the second of two prisoners at The Mount to die from using PS in July. Two more prisoners there have apparently died from PS in January 2023. In August 2022, HMPPS Substance Misuse Group reviewed the prison's drug strategy. Their report evidenced 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 issue was 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.

We found that Mr Marchant's mental health care was inadequate, and that staff did not take sufficient account of his neurodiversity.

Although it did not affect the outcome for Mr Marchant, 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.

Adrian Usher
Prisons and Probation Ombudsman **March 2025**

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Summary

Events

1. Mr Max Marchant had a childhood diagnosis of autistic spectrum disorder and attention deficit hyperactivity disorder (ADHD). In 2018, he was sentenced to six years for grievous bodily harm with intent.

2. Mr Marchant was released on licence from HMP Chelmsford on 1 October 2021. On 15 November, he was recalled to Chelmsford for breaking the conditions of his release by drinking alcohol. On 13 December, he transferred to HMP The Mount.

3. Mr Marchant had an extensive history of using PS, brewing fermented liquid (known as hooch) for his own use and to sell to other prisoners, damaging prison property, starting cell fires and self-harm by cutting and tying ligatures. He was assessed as unsuitable to share a cell. Mr Marchant owed the prison a significant amount of money for the damage he caused to cell fixtures and fittings.

4. Mr Marchant was found under the influence of PS on four occasions in January and March 2022. From 9 February, he worked with a health and wellbeing practitioner from the Forward Trust substance misuse team and received regular awareness advice on PS and harm minimisation.

5. Mr Marchant was found to have brewed hooch on seven occasions. He spent two periods in the prison's care and separation unit (CSU) and was frequently moved between wings in order disrupt his hooch brewing.

6. Mr Marchant said that his primary reason for brewing hooch was lack of money. Monies he owed for damaging his cells were taken from his prison wages, and as he often did not have employment, he had very little money to spend on items from the prison shop.

7. In April 2022, the prison implemented a plan to give Mr Marchant a job and allow him to keep more of his wages. Mr Marchant responded well to this for several weeks before once again being found in possession of hooch.

8. Mr Marchant spent most of June in the CSU in an attempt to disrupt his hooch brewing. The prison security department requested he be transferred to another prison, and he was accepted at HMP Coldingley. Mr Marchant appeared to do well in the CSU. On 4 July, he returned to a standard wing to await transfer.

9. On 14 July, another prisoner died from PS use. Mr Marchant appeared to have been affected by the death and said it had made him think. On 20 July, he received harm minimisation advice on the dangers of PS use.

10. The same day he was again found in possession of hooch. On 21 July, he completed an in-cell pack on PS with his health and well-being worker. On 23 July, Mr Marchant was moved to Nash A wing because under the prison's health and safety arson policy he needed to be in an anti-barricade cell. Evidence showed that Nash A wing was known to be overrun with PS at the time.

11. At 5.30am on 25 July, the night patrol officer found Mr Marchant unresponsive in his cell. He did not radio an emergency code and there was a significant delay in entering the cell and calling an ambulance. Staff gave Mr Marchant CPR despite clear signs that he had died. Paramedics attended and pronounced Mr Marchant had died at 6.13am.

Findings

12. There was a significant amount of PS in the prison at the time Mr Marchant died, especially on Nash A wing (where he was moved two days before he died). Mr Marchant was assessed as being at high risk of using PS, but no consideration appears to have been given to this risk when moving him to a known PS hotspot.

13. The prison was not doing enough to reduce drug supply and demand. All forms of drug testing were suspended until a few days before Mr Marchant died and only 50% of requested searches took place.

14. Since the death of Mr Marchant and another prisoner, the prison has put a number of extra measures in place to reduce supply and demand, but prison management's efforts are undermined by an ongoing lack of operational staff. In particular, they are still unable to run an effective drug testing programme and complete the number of searches requested. Staff shortages have also resulted in a very limited regime, and this has led to boredom and fuelled the demand for drugs.

15. Mr Marchant 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 25 July.

16. The plan to allow Mr Marchant to keep more of his wages and provide him with a job in April was successful but the plan was not added to Mr Marchant's prison record and the prison's approach to his debt was inconsistent.

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

18. The prison did not have a process for tracking and storing closed ACCT documents.

19. The clinical reviewer found that Mr Marchant's mental healthcare was not equivalent to that he could have expected 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 Governor should ensure that staff consider all of the prisoner's specific known risk factors before transferring them between wings.

- The Governor should ensure that the review of the prison debt strategy considers care planning for known debtors and ensures that all agreed care plans are recorded on the prisoner's record and therefore available for all staff to see.

- 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 and that they should enter cells as quickly as possible if there is reason to consider that a prisoner may be at risk.

- The Head of Safety should ensure that OSG A 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 Head of Healthcare should ensure that:

    - Staff use the alert function on SystmOne to include significant conditions such as ADHD and autism on the patients record.

    - All healthcare staff receive Oliver McGowan mandatory training on learning disability and autism.

    - Staff consider whether a prisoner's neurodiversity presents a barrier to them self-referring to services such as IAPT and psychosocial substance misuse support.

    - All referral forms include learning disability and autism in the list of significant conditions.

The Investigation Process

20. 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. Two prisoners responded and were interviewed.

21. The investigator visited The Mount on 26 July. She obtained copies of relevant extracts from Mr Marchant's prison and medical records. She also obtained CCTV and emergency radio traffic from 25 July. She requested recordings of calls made by Mr Marchant on the prisoner telephone (PIN) system in the month prior to his death. Although a disk was provided some weeks after he died, it was subsequently found to contain only calls from early June. She obtained the Forward Trust's root cause analysis report into Mr Marchant'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.

22. NHS England and NHS Improvement (NHSE&I) commissioned a clinical reviewer to review Mr Marchant's clinical care at the prison. The investigator and clinical reviewer interviewed seven members of staff jointly in August 2022. The investigator interviewed two prisoners in September 2022 and two members of staff in November and December 2022. The clinical reviewer spoke to one member of staff in September 2022.

23. 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.

24. The investigator contacted Mr Marchant's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Marchant's next of kin had a number of questions about his care which we have answered in this report, in the clinical review and in separate correspondence. She provided regular updates to Mr Marchant's next of kin throughout the investigation.

Background Information

HMP The Mount

25. 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 February 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

26. 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 in their cells all day. Ofsted judged the provision of education, work and skills to be inadequate.

27. 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.

Independent Monitoring Board

28. 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

29. Mr Marchant was the second prisoner to die from illicit drug use at The Mount in July 2022. In our investigation into a death on 14 July, we found that there had been a significant amount of PS in the prison at the time and measures brought in to reduce supply and demand were undermined by chronic staff shortages. Two more prisoners died in January 2023, although the cause of their deaths was not established at the time of writing, they are suspected to be substance misuse related. Our investigation into the other prisoner who died in July 2022 made near identical findings in deficiencies in the emergency response and also found that

their mental healthcare was not equivalent to that which they could have expected to receive in the community. We also found weaknesses in mental healthcare in our investigation into a self-inflicted death in March 2022.

Psychoactive substances (PS)

30. 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 Marchant's death

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

32. 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.

33. 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.

34. 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.

Attention deficit hyperactivity disorder (ADHD)

35. Attention deficit hyperactivity disorder (ADHD) is a condition that affects people's behaviour. People with ADHD can seem restless, may have trouble concentrating and may act on impulse. Symptoms of ADHD tend to be noticed at an early age and may become more noticeable when a child's circumstances change, such as when they start school. The symptoms of ADHD usually improve with age, but many adults who were diagnosed with the condition at a young age continue to experience problems. People with ADHD may also have additional problems, such as sleep and anxiety disorders.

Autism Spectrum Disorder (ASD)

36. Autism is a neurodiverse condition. Autistic people may find it hard to communicate and interact with other people, understand how others think and feel, take longer to understand information and do or think the same things over and over. Some autistic people need little or no support and some require daily care and support.

37. Asperger's or Asperger Syndrome was a term used to describe autistic people with above average intelligence.

LeDeR

38. LeDeR is a service improvement programme for people with a learning disability and autistic people.

Inundation point

39. Cell doors have inundation points, a removable bung that allows a hose to be used to spray water into a cell without opening the door.

Assessment, Care in Custody and Teamwork

40. 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.

41. 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

42. Mr Max Marchant had a childhood diagnosis of autistic spectrum disorder and attention deficit hyperactivity disorder (ADHD). In 2018, he was sentenced to six years for grievous bodily harm with intent.

43. From April 2019 to April 2020, Mr Marchant served his sentence at HMP The Mount. He had an extensive history of using PS, brewing fermented liquid (known as hooch), damaging prison property, starting cell fires and self-harm by cutting and tying ligatures. He was assessed as unsuitable to share a cell. Mr Marchant owed the prison a significant amount of money for the damage he caused to cell fixtures and fittings. He was frequently managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT).

44. Throughout 2021, Mr Marchant was managed by the mental health team in HMP&YOI Chelmsford and received regular therapeutic input. He was released on licence from Chelmsford on 1 October 2021. On 15 November, he was recalled to Chelmsford for breaking the conditions of his release by drinking alcohol. On 13 December, a nurse concluded that Mr Marchant was medically fit to transfer to The Mount. He noted in Mr Marchant's prison medical record that he would require mental health input when he arrived there.

HMP The Mount

45. A nurse completed an initial health assessment. Mr Marchant said he had problems with alcohol and drug misuse and had self-harmed within the previous year. She referred him to the mental health and substance misuse teams for assessment. A prison GP continued Mr Marchant's prescriptions for Concerta XL (for ADHD) and quetiapine (an anti-psychotic originally prescribed at HMP Chelmsford for insomnia).

46. On 15 and 17 December, a nurse was unable to review Mr Marchant's mental health because the wing was locked down due to staff shortages. The nurse eventually completed the assessment by telephone on 19 December. Mr Marchant asked for counselling for his anxiety and depression and the nurse sent him a self-referral form for the IAPT service. (Mr Marchant does not appear to have completed this form.) Mr Marchant said he was otherwise well. The nurse added him to the psychiatrist's list for a medication review and discharged him from the mental health service.

47. On 30 December, a Forward Trust worker completed a triage assessment in response to the nurse's referral of 13 December. Mr Marchant denied having any lack of control over alcohol and drug consumption and was deemed unsuitable for structured treatment or further assessment for substance misuse support or the IAPT service.

48. On 1 January 2022, Mr Marchant rang his emergency cell bell. Officers responded and found him unresponsive on his bed. They were worried he was having a stroke and called a code blue emergency. Nurses attended and Mr Marchant came round and admitted he had been smoking PS. The nurses examined him and found no

signs of neurological damage. Mr Marchant was observed every 30 minutes for two hours and then hourly overnight.

49. In response to this, on 4 January, the Forward Trust sent Mr Marchant a service pack containing harm minimisation advice, leaflets on the dangers of PS and hooch and a self-referral form.

50. On 6 January, a consultant forensic psychiatrist reviewed Mr Marchant. He said Mr Marchant was pleasant and calm. Mr Marchant said he felt well on his medication but experienced agitation in the early evening. He noted the rationale for prescribing Mr Marchant quetiapine at Chelmsford was unclear and decided to reduce Mr Marchant's dose gradually and review him in six weeks.

51. On 13 January, an officer suspected Mr Marchant was under the influence of PS. He was put on 30 minute wellbeing checks and after about half an hour he said he was OK. Neither the Forward Trust nor the prison's security department were informed about this as they should have been.

52. Staff found 20 litres of hooch in Mr Marchant's cell on 20 January. Mr Marchant said he had nothing to do and needed money to pay for vape capsules.

53. On 31 January, staff found ten litres of hooch in Mr Marchant's cell in two five litre containers. Mr Marchant broke the glass observation panel in his cell door, made a barricade, threatened to take an overdose and set fire to tissue paper. Staff used the inundation point to try to extinguish the fire, but Mr Marchant obstructed the hose with a bucket. Staff entered the cell and removed Mr Marchant to the care and separation unit (CSU – segregation unit). As they entered the cell, Mr Marchant took an unknown quantity of tablets.

54. A nurse attended Mr Marchant's removal to the CSU and examined him there. He told her he had taken an overdose of quetiapine, naproxen (a painkiller) and omeprazole (for acid reflux, which was not prescribed to him) and complained of a tight chest. She requested an emergency ambulance, and Mr Marchant was taken to hospital. Staff began ACCT monitoring. Mr Marchant returned to prison next day and was placed in the CSU after a nurse judged he was medically fit for segregation.

55. The prison was unable to locate or provide the ACCT document to the investigator. The information relating to ACCT reviews below is taken from Mr Marchant's prison record and clinical record.

56. On 1 February, Mr Marchant was found guilty of breaking prison rules at a disciplinary hearing and punished with seven days cellular confinement and forfeit of privileges. The prison also decided to reclaim money in compensation for the damage to his cell from Mr Marchant's prison earnings.

57. A nurse attended an ACCT review the same day. Mr Marchant was unable to say why he started the fire and took an overdose. He said he had problems with alcohol and drinking was his way of coping with prison life. He denied feeling suicidal and said he was angry and disappointed the hooch had been confiscated. Mr Marchant agreed to work with the Forward Trust on his substance misuse issues.

58. On 2 February, Mr Marchant initially refused to take his Concerta XL, but changed his mind after the mental health team manager spoke to him. Mr Marchant told a senior prison manager that he sometimes 'went blank' and felt unable to control his behaviour. He thought this was due to ADHD. They spoke about Mr Marchant's Buddhism, and she arranged for the Buddhist chaplain to visit him the next day. She said she would contact the Forward Trust to see if they would work with Mr Marchant on his alcohol misuse. ACCT monitoring was stopped on 7 February.

59. On 9 February, a Forward Trust health and well-being worker completed a triage assessment with Mr Marchant. She said Mr Marchant was very frustrated and vented a lot of feelings. He admitted to using PS throughout his current sentence and to using hooch more regularly since his recall. He said he drank alcohol and used cannabis in the community as a form of escape. Mr Marchant completed a questionnaire on his PS use and scored 14/15 indicating he was at high risk from PS. She gave Mr Marchant harm minimisation advice and put him on the list for a full assessment.

60. Later the same day, Mr Marchant broke one of the taps in his cell, causing a flood, and used the tap to break his glass observation panel. He was found guilty of damaging prison property and the cost of replacing the panel was added to the money he already owed to the prison.

61. A prison GP and a nurse reviewed Mr Marchant in the CSU on 17 February. Mr Marchant seemed calm and said he was reading and listening to the radio. The GP said he would further reduce Mr Marchant's quetiapine and that Mr Marchant agreed with this plan. The GP told him that he was changing his prescription from Concerta XL to Delmosart. He explained they were the same drug but a different brand name.

62. On 21 February, Mr Marchant told a nurse during the daily CSU nurse visit that he was frustrated about being in so much debt in prison and that his weekly money was not enough to pay the debt to the prison and buy everything he needed.

63. On 1 March, Mr Marchant moved from the CSU to the Wellbeing Unit – a unit for prisoners who wanted to remain drug free.

64. On 3 March, a well-being worker completed a full assessment of Mr Marchant's substance misuse. Mr Marchant spoke about his use of PS, alcohol and cannabis. He said he struggled to control his impulses around illicit substances even though he knew they were bad for him. He said he had really good support in the community but had given in to temptation to drink alcohol and that had led to his recall to prison. She reiterated harm minimisation and safe use techniques. She completed a recovery plan and arranged to see Mr Marchant again.

65. On 6 March, an officer suspected that Mr Marchant was under the influence of PS in his cell. There was a significant amount of vomit in his cell. He was observed every 30 minutes and the Forward Trust was informed. Despite this, no one from the Forward Trust went to see Mr Marchant.

66. On 16 March, staff found 19 litres of hooch in Mr Marchant's cell in two litre bottles and a bucket after a drug dog indicated his cell during a wing search. Mr Marchant threatened to burn his cell down and later made a barricade. A Supervising Officer

(SO) talked him into removing it and she, a Custodial Manager (CM) and another SO spoke to Mr Marchant in the SO's office. Mr Marchant said he sold hooch for money because any money he might earn from a prison job would be taken in payment for damage he had caused.

67. The CM persuaded Mr Marchant he would be better off working and spending some time out of his cell. She said she would speak to the activities department about finding a job for him.

68. Mr Marchant's ACCT document was re-opened (again we have not seen this document). A nurse attended a review and reported that Mr Marchant said he could not cope in the prison environment sitting in his cell all day doing nothing. The next day, Mr Marchant said he was interested in attending education to take his mind off making hooch.

69. On 22 March, a well-being worker attended an ACCT review. Mr Marchant said he was frustrated that he had no money and owed about £1,000 to the prison. He made hooch to pay for living costs as the money he earned went to pay off his debts.

70. On 23 March, Mr Marchant told a SO that he was in debt to other prisoners for the confiscated hooch and needed to move to a different wing. The next day, four litres of hooch were found in Mr Marchant's cell. Mr Marchant barricaded his cell, tied a ligature to the cell light and threatened to hang himself. Staff persuaded him to remove the barricade and he agreed to move to Dixon wing at the other end of the prison.

71. The next day, a senior prison manager spoke to Mr Marchant about his continued brewing of hooch, barricading and damaging cells. Mr Marchant repeated that his biggest issue was paying off his debts to the prison. She subsequently spoke to a CM and agreed to come up with a support plan for Mr Marchant. (Again, as the prison was unable to provide us with Mr Marchant's ACCT document, we have not seen this.). Mr Marchant was referred to the mental health team for review.

72. At an ACCT review on 25 March, Mr Marchant said he had threatened to hang himself to force move to another wing. A nurse attended the ACCT review. After the review the nurse recorded on SystmOne that he had assessed Mr Marchant and discharged him from the mental health team.

73. A well-being worker also saw Mr Marchant on 25 March. He said he was happy on Dixon wing and had more support there. She reassured him that they could continue to work together even though he had moved. Mr Marchant said making hooch made him anxious and he did not want to make it. His debts were building up and he had threatened self-harmed to force a move to a different wing. He asked to go through the PS in-cell pack with her the following week and she agreed. She said she thought Mr Marchant would always seek illicit substances because of his autistic traits and ADHD.

74. At about 6.00pm the same day, Mr Marchant pressed his cell bell. An officer said Mr Marchant had vomited and was swaying in his cell. He asked her to open the door for some air. She suspected he was under the influence of PS and put him on 15 minute wellbeing observations. She also submitted an information report to the

security department. The Forward Trust records indicated they were not informed. This was the last time Mr Marchant was found under the influence of PS before he died.

75. On 26 March, a senior prison manager told Mr Marchant that she had agreed he could keep £10 a week in his account and, if he worked, he could buy items from the prison shop and use some of his earnings rather than constantly paying off his debts for damage. Mr Marchant subsequently started work as a wing cleaner and painter.

76. The senior prison manager saw Mr Marchant on 1 April. He said he was doing well on Dixon wing and his mental health had improved since he had started work as a wing painter. Mr Marchant talked in detail about his family and his drug use in the community. Mr Marchant said he used PS in prison because it helped him to 'block things out'.

77. On 24 April, an officer said Mr Marchant had worked well for several weeks and had been very helpful and polite.

78. The next day, staff found 51 litres of hooch found in Mr Marchant's cell in two litre and five litre containers and bin bags. The Forward Trust was informed. Mr Marchant was removed from his job the next day.

79. The well-being worker visited Mr Marchant on 27 April in response to the hooch find. He told her he had wanted to make some hooch for his birthday (on 2 May). He was annoyed to lose his job and said he was back to 'square one' with having to make hooch to make money.

80. On 1 May, Mr Marchant broke his observation panel. He told an officer that he was frustrated to be in his cell when others were out. On 5 May, the prison security department received intelligence that Mr Marchant was involved in the production of hooch found in the wing kitchen.

81. The well-being worker saw Mr Marchant on 20 May. He said he was doing well and had last used PS before he moved to Dixon wing. (Although he had been found under the influence on 25 March while on Dixon wing, it seems that it was a relatively settled period for Mr Marchant.). They completed the PS in-cell pack together. Mr Marchant said he was selfish when he used PS and became greedy. He said he felt panicked if he did not have access to PS because he thought it helped him to sleep. He told her about witnessing a PS overdose and finding it traumatic.

82. On 27 May, the security department decided to move Mr Marchant to the CSU for seven days after receiving multiple reports suggesting he was the main supplier of hooch on Dixon wing.

83. On 7 June, staff found 42 litres of hooch in Mr Marchant's cell on Dixon wing, and he returned to the CSU the next day for a security review. The review took place on 10 June, and it was decided that Mr Marchant would remain in the CSU and transfer to another prison because of his persistent hooch brewing. Mr Marchant said he was happy with a move and asked if he could go to Rochester as it was closer for his family to visit. His prison telephone calls (PIN calls) from this period

indicated that he had wanted to move to a different prison and had intended to misbehave until being granted a transfer. Mr Marchant's prison record for the remainder of June showed that he remained on the CSU, his mood was good, and his behaviour was stable.

84. On 24 June, the well-being worker visited Mr Marchant in the CSU for their meeting. He said he was doing well and spending his days eating, training and sleeping. He said he was waiting for a transfer to another prison. Mr Marchant acknowledged his continued hooch brewing and said he would continue to brew it. He said he had trouble looking beyond the present but was getting tired of 'smashing up and fighting'.

85. The well-being worker said she thought Mr Marchant always did well in the CSU because he could not get hold of PS and because he responded well to the daily contact afforded to him by the mandatory checks (prisoners in the CSU are seen daily by the duty governor, the chaplaincy, the IMB and healthcare and there is a higher staff to prisoner ratio than on a standard wing).

86. A CSU planning meeting on 28 June noted that Mr Marchant was due to be transferred to another prison and set the next review for 8 July. On 29 June, a senior prison manager told Mr Marchant he had been accepted at HMP Coldingley and would return to a standard wing to wait transfer.

87. On 30 June, a prison GP saw Mr Marchant for a follow up assessment. He said Mr Marchant seemed well and told him he had been accepted by Coldingley. They discussed a further reduction in quetiapine. Mr Marchant was initially reluctant, but the GP reassured him that it would not affect his sleep.

88. On 4 July, Mr Marchant moved to Fowler, a standard wing. It is not clear from the records why Mr Marchant was moved before the scheduled CSU planning meeting on 8 July.

89. On 20 July, the well-being worker met with Mr Marchant. He said he was concerned at the length of time it was taking for him to transfer to Coldingley. He said he was still abstinent from PS and felt his mental health was getting better. They talked about the death of another prisoner, Mr B, from PS on 14 July. Mr Marchant said he had known Mr B and was shocked by his death. He said it showed that the PS in the prison was "strong", and it had "made him think". Mr Marchant said spending a lot of time in cell made prisoners more inclined to use PS. She reiterated how tolerance levels reduced after periods of abstinence and this increased the risk of harm from using it.

90. Later the same day staff found nine litres of hooch in Mr Marchant's cell. The well-being worker visited him the day after on 21 July. He said he had brewed the hooch to sell not to use. He said he had had a conversation with his mum that day and that had made him feel happier. They completed the Forward Trust's in-cell pack on PS together.

91. On 23 July, Mr Marchant was moved to Nash A wing. Mr Marchant's prison record did not show why he was moved, although the prison clarified at initial report stage that this was because, due to his history of starting cell fires, the prison was required to allocate Mr Marchant to an anti-barricade cell (a cell with a door that can

be opened outwards in order for staff to gain access in case of fire). In July 2022, The Mount had 28 such cells on the standard wings at the top end of the prison (on Fowler, Brister, Lakes and Ellis wings), 486 such cells on the standard wings at the bottom end of the prison (on Howard, Dixon and Nash wings) and 24 in the CSU. We do not know how many such cells were available on each wing on 23 July.

92. A prisoner said he had known Mr Marchant since they were at school together. He was already on Nash A wing when Mr Marchant moved there in the late afternoon of 23 July. He said Mr Marchant looked well, seemed happy and had put on some weight. He helped him move his property into his cell. He said there was a lot of PS on Nash A at that time and he and other prisoners thought a member of staff was bringing the drugs into the prison.

93. The Nash A wing observation book showed more than 20 entries relating to prisoners being found under the influence of PS between 19 and 24 July. A CM told the investigator that there was a lot of PS on Nash A at the time. He said he understood that PS had become cheaper since Mr B **died on 14 July**, and so more people had access to it.

94. Information provided by the prison's security department showed intelligence that PS was being distributed throughout the prison from Nash A and Nash B wings via kitchen workers and other prisoners in trusted jobs.

Events of 24 - 25 July

95. CCTV showed that an officer unlocked Mr Marchant for evening medication at 4.51pm. Mr Marchant returned to his cell from an upstairs landing four minutes later and an officer locked him into his cell for the night. A prisoner said Mr Marchant had visited him just before he was locked into his cell. He thought Mr Marchant did not look well and appeared under the influence of something. CCTV showed Mr Marchant appeared to walk steadily and was not obviously unwell.

96. Operational Support Grade (OSG) A, the night patrol officer, completed the evening roll check at the start of his shift. CCTV showed he checked Mr Marchant twice, at 8.15pm and 8.20pm. CCTV shows that no one checked Mr Marchant again during the night.

97. At about 5.25am, the OSG A started the early morning roll check. CCTV showed he looked through Mr Marchant's observation panel at 5.30am. He said Mr Marchant was laying on the floor of his cell with his head facing the window and it was obvious that something was not right. He banged on the cell door and called Mr Marchant's name but received no response. He said it was his understanding that in this situation he should call for assistance from the night orderly officer.

98. CCTV and radio traffic showed the OSG radioed the communications officer and asked for assistance at 5.32am. He said, "X-ray 2 (the call sign of his radio) can I have some assistance on Nash wing A side on the twos, over."

99. OSG B, the night patrol on Nash Wing B side, heard the radio transmission and joined his colleague outside Mr Marchant's cell. OSG B said he also tried to get a response from Mr Marchant but was unable to. He said Mr Marchant was in an unnatural position on the floor.

100. The night orderly officer also heard OSG A's call and asked for more information. The communications officer asked OSG A twice for more information, but he did not respond. He said at interview that he did not remember hearing the requests. Two minutes later at 5.35am, the communications officer asked OSG A if he could see the prisoner. He said, "I can absolutely see the prisoner I'm just not getting any response from him".

101. At 5.36am, OSG A asked the night orderly officer for permission to enter Mr Marchant's cell using the cell key in his sealed pouch. He said he felt safe to go in because he knew something was wrong and he had OSG B with him. The night orderly officer said he could not enter the cell until staff arrived.

102. OSG B said that when the night orderly officer told them not enter the cell, he decided to collect the defibrillator from the wing office. CCTV showed he left to collect the defibrillator at 5.37am and returned with it at 5.39am. Neither of the OSGs radioed a code blue emergency (indicating that a prisoner is not breathing or unconscious and requiring an ambulance be called).

103. The night orderly officer said he denied OSG A permission to enter the cell because he had said he could see Mr Marchant and he had not called an emergency code. He assumed that if a member of staff could see a prisoner and had serious concerns about him, he would call an emergency code. He said the original call had been for assistance and there was no indication that the situation was an emergency. Due to the amount of PS on Nash A, he had responded to several requests to attend cells that week when prisoners were under the influence and there was no indication that this was anything other than a routine request.

104. Just before 5.41am, the night orderly officer arrived at Mr Marchant's cell with two officers. (He was at the gate end of the prison and Nash is the farthest wing away from the gate. The Mount is large site, and it takes approximately ten minutes to walk from one end of the prison to the other.)

105. Officer A opened the cell and he and Officer B went in. At 5.42, the night orderly officer radioed a code blue emergency. He said it was obvious as soon as he arrived that Mr Marchant had died. Officer A said he touched Mr Marchant's leg to try to get a response from him and it was stiff and cold. He and Officer B turned Mr Marchant over and saw that rigor mortis had set in. Mr Marchant had a vaping device in one hand and a vape capsule in the other. He said they did not start cardio-pulmonary resuscitation (CPR) as Mr Marchant had clearly died.

106. Radio messages showed that that the communications officer asked the night orderly officer if he wanted her to call an ambulance. He confirmed that he did. About a minute later he told the communications officer that Mr Marchant was dead and to call the duty governor. The communications officer asked if he wanted her to call the ambulance or the duty governor first. He told her to call the ambulance. Ambulance records showed the prison called an ambulance at 5.45am and the call was triaged as a category one with a response time target of 15 minutes.

107. The call handler asked the communications officer to attach a defibrillator if one was available. The night orderly officer said he could hear the call over the radio. He had decided not to start CPR as Mr Marchant had died, but changed his mind when he heard this request. Both officers put the defibrillator on Mr Marchant and Officer A

started CPR. The defibrillator checked for a heartbeat and instructed them to carry on with CPR.

108. Paramedics arrived at Mr Marchant's cell at 6.12am and immediately confirmed Mr Marchant had died.

109. Later the same day, the police arrested a member of staff on Nash A wing. At the time of writing the police are still investigating whether they were involved in bringing drugs into the prison. We understand that their investigation has not been evidentially linked to Mr Marchant's death.

Contact with Mr Marchant's family

110. The prison appointed a family liaison officer (FLO). The FLO and the prison chaplain informed Mr Marchant's next of kin of his death in person at their home at lunchtime that day. The prison made a financial contribution to Mr Marchant's funeral in line with national guidance.

Support for prisoners and staff

111. There was no formal debrief for the staff involved in the emergency response. The night orderly officer said he did not receive any support from managers or the prison's Trauma Risk Management (TRiM) team. Officer B said the Deputy Governor and the TRiM team spoke to him that morning.

112. The prison posted notices informing other prisoners of Mr Marchant'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

113. The post-mortem report showed that Mr Marchant died from synthetic cannabinoid toxicity.

Inquest

114. The Coroner's inquest held in March 2025 gave the medical cause of death as synthetic cannabinoid toxicity and concluded Mr Marchant's death was drug related.

Actions taken after the deaths of Mr Marchant and Mr B

115. When Mr Marchant died the prison was in the process of taking a number of actions in response to the death of Mr B on 14 July, including:

- On 14 July 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 drone.

116. 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.
- The approach to debt was not dynamic or linked to the drug strategy or intelligence reports.
- 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).

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

report. The Head of Safety provided us with the prison's debt strategy and confirmed that it was currently under review.

Findings

Drug strategy at HMP The Mount

118. 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.

119. We are extremely concerned that there was an unacceptably high supply of PS in the prison when Mr Marchant and Mr B died in July. Some drug testing re-started after Mr B died but 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 has 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.

120. We are concerned that the prison's efforts are fatally 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, they 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.

121. Crucially, the lack of staff has limited the operation of drug testing programmes. Random and suspicion testing was re-introduced a few days before Mr Marchant died. 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.

122. 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 Marchant 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 consider what additional support can be put in place to address staffing shortages at The Mount and consider, as a matter of urgency, how it can reasonably be expected to deliver an effective drug strategy and regime.

Mr Marchant's PS use, hooch brewing and debt management

PS use

123. We are satisfied that Mr Marchant was well-supported by the well-being worker. Health and wellbeing workers have a target of seeing their clients every 12 weeks and she saw Mr Marchant at least once a month and often more frequently. She also attended his ACCT reviews. We are satisfied that Mr Marchant knew the dangers of PS use. He knew Mr B and had been affected by his death. The well-being worker reiterated harm-minimisation advice and went through information on the dangers of PS use with him only four days before he died. We have not found any evidence that Mr Marchant intended to die on 25 July.

124. We are very concerned that shortly before he died, Mr Marchant was moved to a wing where it was widely known that there was an exceptionally large amount of PS. Mr Marchant was a well-known PS user in prison and was assessed as at high risk of using PS. Mr Marchant's autistic traits and ADHD meant he had poor impulse control and increased the likelihood he would use PS if offered it. We understand that the majority of anti-barricade cells were located on the wings most affected by PS, however with hindsight, consideration should have been given to the risk presented to Mr Marchant before moving him there. The fact that he died less than 36 hours later is stark.

The Governor should ensure that staff consider all of the prisoner's specific known risk factors before transferring them between wings.

Hooch brewing and debts

125. Mr Marchant appears to have been stuck in a cycle of hooch brewing and debt throughout his six year sentence. There is little in Mr Marchant's records to show what efforts the prison made to break this cycle, apart from disruption moves to different wings and two periods in the CSU. Although Mr Marchant seems to have done well in the CSU, partly because of the higher staff to prisoner ratio and mandatory daily checks, segregating prisoners is not a long-term solution to supporting behavioural change.

126. We acknowledge that Mr Marchant also admitted he enjoyed brewing and consuming hooch. Prisoners in any type of debt are vulnerable to pressure. Mr Marchant's debts contributed to keeping him involved in the illegal prison economy which in turn led to the violent and self-harming behaviour that manifested after each hooch find. Unlike most prisoner debt, Mr Marchant's debts were mostly a known quantity because he was in debt to the prison. We consider it should have been easier for the prison to help him manage them and therefore remove perhaps the most significant reason for his persistent hooch brewing.

127. Mr Marchant's longest period on a standard wing without either being found with hooch in his cell or suspected of brewing hooch elsewhere, was between 24 March and 25 April, when the prison implemented a care plan to give him a job and allow him to keep more money each week. We have not seen this plan because the prison lost Mr Marchant's ACCT document (discussed below).

128. Neither have we seen any evidence of reintegration planning when Mr Marchant returned to a standard wing after 29 days in the CSU. We do not know whether the prison considered reinstating the previous care plan, but it seems unlikely as the plan was not part of Mr Marchant's prison record.

129. Mr Marchant returned to brewing hooch less than two weeks after returning to a standard wing. We understand the prison is currently reviewing their debt strategy in line with a recommendation from the Substance Misuse Team and this presents an opportune moment to consider care planning for known debtors. We make the following recommendation:

    The Governor should ensure that the review of the prison debt strategy considers care planning for known debtors and ensures that all agreed care plans are recorded on the prisoner's record and therefore available for all staff to see.

Emergency response

130. 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.

131. 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. The Mount's local guidelines reflect this.

132. OSG A said he understood that, if he found a prisoner unresponsive, he should radio for assistance. He did not give any information about why he needed assistance and said he did not hear requests from the communications officer for further information. He was aware that he could break his sealed pouch and enter a cell if he believed a prisoner's life was at risk. He said he could see that something was not right and described Mr Marchant as laying in unnatural position. He was sufficiently worried to ask to enter Mr Marchant's cell once OSG B joined him, although he did not need permission. When this was denied, OSG B was sufficiently concerned to collect the defibrillator from the wing office.

133. We consider that the situation was sufficiently plain for OSG A to radio a code blue emergency at the outset. He said at interview that he had felt safe to enter the cell because OSG B was also present, but he did not do so. At the least, we consider he should have volunteered more information to allow the night orderly officer to make an informed decision about how to respond, both to his request for assistance and to his subsequent request to enter the cell.

134. OSG A was the night patrol officer on duty when the other prisoner who died at The Mount in July was found unresponsive. In that case he also failed to call a code blue or otherwise effectively communicate the nature of the emergency to the night orderly officer. He told the investigator that no one had spoken to him about his role in the previous death or Mr Marchant's death or given him any advice and guidance about what to do if he found a prisoner unresponsive. This is disappointing, especially as both Early Learning Reviews highlighted his response as a learning point.

135. Staff eventually entered Mr Marchant's cell some 12 minutes after OSG A had found him unresponsive. The communications officer did not ring an ambulance immediately which led to a further delay of three minutes until the emergency services were contacted.

136. 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, Nash Wing is some ten minutes distant at the opposite end. This means that, if a night patrol officer decides not to enter a cell, 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) also have to return to the gate before the ambulance can enter the prison. It is therefore imperative that a code blue is called when there are concerns for a prisoner's safety. This would allow the night orderly officer to consider how to best manage the situation with the staff available to them.

137. Although the significant delay in the emergency response did not affect the outcome for Mr Marchant, 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 and that they should enter cells as quickly as possible if there is reason to consider that a prisoner may be at risk.

The Head of Safety should ensure that OSG A 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

138. 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.

139. Mr Marchant's arms and limbs were completely stiff, which indicated that rigor mortis (stiffness of the limbs after death) was present. Rigor mortis normally sets in between two and six hours after death, indicating that Mr Marchant had been dead for some time when he was found. The night orderly officer and Officers A and B all thought Mr Marchant had died and, correctly, decided not to begin CPR. Matters were then confused by the call-handler asking them to attach a defibrillator and they changed their minds. Call-handlers have a set list to work through as part of their standard response to being told a patient is not breathing, but we accept this would not have been clear to the night orderly officer.

140. We understand the difficulty in decision-making in these circumstances. Clear communication is impaired because the officers at the scene are not in direct contact with the call handler. However, trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased and it is important that staff have confidence not to perform CPR when the signs of death are unequivocal. We repeat the recommendation we made in our investigation into the death of Mr B:

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

141. At the time of Mr Marchant'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.

142. Our investigation into the death of Mr B found that staff did not turn on their body-worn video cameras until a late stage. In this case no one turned on their cameras at all. We therefore repeat our recommendation that:

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

ACCT

143. The prison was unable to find Mr Marchant's ACCT document and reported it as a data loss. Summaries of ACCT reviews should be added to the prisoner's record (NOMIS), however there were few of these and so we have not been able to examine Mr Marchant's ACCT planning. The HMPPS Area Safer Custody early learning review noted that the prison did not have a process in place to track or store ACCT documents once they had been closed. We make the following recommendation:

The Head of Safety should ensure that there is a process in place for tracking and storing closed ACCT documents.

Clinical care

144. The clinical reviewer found that Mr Marchant's mental healthcare was not equivalent to that he could have expected in the community. The mental health team did not take sufficient account of his neurodiversity and did not inform the Forward Trust of Mr Marchant's autism diagnosis. We consider that the impact of his diagnoses of ADHD and autism on Mr Marchant's behaviour in prison, including his hooch brewing and PS use, was not sufficiently considered. His behaviour was treated as a disciplinary matter, and we have seen no evidence that consideration was given to whether he would have benefitted from mental health support. We make the following recommendation:

The Head of Healthcare should ensure that:

- **Staff use the alert function on SystmOne to include significant conditions such as ADHD and autism on the patients record.**
- **All staff receive Oliver McGowan mandatory training on learning disability and autism.**
- **Staff consider whether a prisoner's neurodiversity presents a barrier to them self-referring to services such as IAPT and psychosocial substance misuse support.**
- **All referral forms include learning disability and autism in the list of significant conditions.**

145. The reviewer also identified a lack of evidence-based risk assessment and risk formulation for patients on the mental health team caseload. Interventions were brief and on one occasion a mental health assessment was completed as part of an ACCT review. The weekly multi-disciplinary team meeting was poorly attended and lacked focus.

146. This is the third death at The Mount in 2022 where mental healthcare was found to be inadequate. The clinical review makes recommendations about these issues which the Head of Healthcare will need to address.

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