

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Mehretab Zemicael, a prisoner at HMP The Mount, on 16 June 2023**

**A report by the Prisons and Probation Ombudsman**

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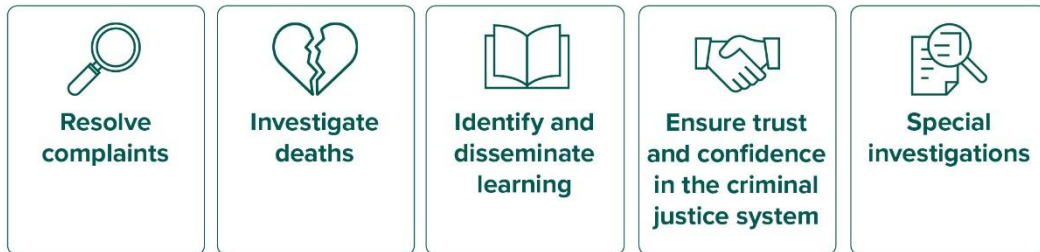
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## OUR VISION

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



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

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

Mr Mehretab Zemicael was found hanged in his cell on 16 June 2023 at HMP The Mount. He was 52 years old. I offer my condolences to Mr Zemicael's friends.

Mr Zemicael had been in prison since February 2014, serving a life sentence for murder. He had been at HMP The Mount since July 2018, and was described as a model prisoner. Staff were not concerned about his well-being or about his risk of suicide and self-harm. Mr Zemicael had never been subject to suicide and self-harm monitoring (ACCT) at The Mount and his death came as a shock to staff.

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 2024**

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## Summary

### Events

1. Mr Mehretab Zemicael was serving a life sentence for murder with a tariff of 15 years. He had been in prison since 19 February 2014. Mr Zemicael was an Eritrean national, having originally entered the country illegally, and he had no contact with his family. He was transferred to HMP The Mount in July 2018.
2. At the time of his index offence, Mr Zemicael was diagnosed with complex psychological and mental health issues, and while in prison he worked with mental health staff and a psychiatrist. Mr Zemicael displayed no behaviour of concern, and his condition was said to have been well managed, to the point that his medication had been reduced to a very low dose.
3. Mr Zemicael settled in well at The Mount. He gained employment in the kitchens, a role he would continue to fulfil for the majority of his time at the prison. He received consistent positive comments from prison staff about his behaviour and attitude and no concerns were raised about his well-being. He lived on an enhanced wing for prisoners aged over 50.
4. In March 2023, he was involved in an altercation with another prisoner over a game of pool. As a result, he lost privileges, had to move wing and lost his job. Despite this, staff continued to report that Mr Zemicael was well behaved, and he raised no concerns with staff.
5. On 16 June, Mr Zemicael spent the majority of the day in his cell as he was not working that day. At 4.00pm that afternoon, prisoners alerted staff that they could not get into Mr Zemicael's cell. When staff managed to open the door, they found Mr Zemicael lying face down on the floor with a ligature around his neck. Mr Zemicael could not be resuscitated and was pronounced dead at 5.01pm.

### Findings

6. During his time at The Mount, Mr Zemicael was never subject to suicide and self-harm monitoring (ACCT). The investigation found no evidence that his behaviour or presentation had ever indicated he was at a raised risk of suicide and certainly none in the days before his death, which came as a great shock to staff.
7. The clinical reviewer concluded that the physical and mental health care Mr Zemicael received at The Mount was partially equivalent to what he could have expected to receive in the community. The clinical reviewer considered that healthcare staff should have completed a formulation of risk, in line with the National Institute for Health and Care Excellence (NICE) 'self-harm: assessment, management and preventing recurrence' (2022), to determine whether Mr Zemicael needed a supportive care plan following his altercation with another prisoner on 12 March 2023.

## The Investigation Process

8. HMPPS notified us of Mr Zemicael's death on 18 June 2023.
9. 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 him. Two prisoners responded, one prisoner responded in writing and stated what he had seen on 16 June, but he did not wish to be interviewed. Another prisoner left a telephone message asking the investigator to speak with him when he visited The Mount.
10. The investigator visited The Mount on 29 June. He obtained copies of relevant extracts from Mr Zemicael's prison and medical records. During the visit on 29 June, he visited the wing where Mr Zemicael had lived. He spoke with prisoners who had known Mr Zemicael to ask if they had any relevant information to share, no one wished to be interviewed.
11. The investigator spoke to the prisoner who had requested to see him during his visit. The prisoner was not able to share any relevant information to assist with the investigation.
12. NHS England commissioned a clinical reviewer to review Mr Zemicael's clinical care at the prison. He and the investigator completed joint interviews with two members staff on 17 August, by Microsoft Teams.
13. We informed HM Coroner for Hertfordshire of the investigation. The coroner gave us the results of the post-mortem report and toxicology examination. We have sent the coroner a copy of this report.
14. The prison and Coroner confirmed that Mr Zemicael had no identified next of kin. The prison had liaised with the Immigration Service and Eritrean Embassy staff to try to locate any next of kin for Mr Zemicael, without success.
15. An inquest into Mr Zemicael's death was concluded on 14 November 2025 and concluded that his death had resulted from suicide.

## Background Information

### HMP The Mount

16. HMP The Mount is a medium security prison holding approximately 1,000 men. Practice Plus Group provides primary healthcare and GP services. Hertfordshire Partnership University NHS Foundation Trust provides mental health services.

### HM Inspectorate of Prisons

17. The most recent inspection of HMP The Mount was in March 2022. Inspectors found that the prison was dealing with significant weaknesses identified in previous inspections, but prisoners were more positive about many aspects of their care.
18. Inspectors carried out a review of progress at The Mount on 6 to 8 February 2023. They noted that it was disappointing to find very little progress had been made throughout much of 2022, but there were some early indications that a newly appointed Governor, who took up the post in December 2022, was starting to give The Mount the direction the prison needed. They cited examples of more effort to engage positively with staff and improve staff retention. They also reflected on 'reasonable progress' with respect to living conditions on the residential units, some positive work to encourage prisoners to maintain contact with their families and more support for those at risk of suicide and self-harm.

### Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2023, the IMB reported that during the year, the prison had gone from a lockdown regime to a more relaxed regime during the summer months when slowly the COVID-19 restrictions were being eased. Also, due to the shortage of prison officers and other staff, prisoners were still experiencing limited opportunities for education, programmes and activities.
20. The IMB commented that staffing levels had not improved through the year despite a national recruitment programme. This had resulted in a lack of access to activities and programmes. Despite the low staffing levels, the IMB noted that The Mount had its capacity increased, resulting in single cells being converted to double cells.

### Previous deaths at HMP The Mount

21. Mr Zemicael was the fourteenth prisoner to die at The Mount since August 2020. Of the previous deaths four were self-inflicted, four were drug related and five were attributed to natural causes. Up to the end of 2023, there has been one self-inflicted death since Mr Zemicael's death. As a result of the number of self-inflicted deaths, The Mount is receiving support and monitoring from HMPPS headquarters.

## **Assessment, Care in Custody and Teamwork**

22. 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.
23. 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

24. Mr Mehretab Zemicael was an Eritrean national who had arrived illegally in the UK. In 2009, Mr Zemicael spent three months in prison for possession of a bladed weapon.
25. On 19 February 2014, Mr Zemicael was arrested for murder. At the time of the offence, Mr Zemicael had been using illicit drugs regularly and was under the care of the community mental health team. He had been diagnosed with paranoid schizophrenia and schizoaffective disorder and had suffered poor mental health since the age of 17. Prior to being sentenced, Mr Zemicael spent time at a medium secure mental health unit, so a full assessment of his mental health could be completed. It was concluded that his mental health issues were not as severe as initially thought and that he did not need to be sectioned under the Mental Health Act. He was prescribed antipsychotic medication and was discharged and remanded HMP Belmarsh.
26. When he arrived at Belmarsh, Mr Zemicael was placed on ACCT monitoring for a short period as a safeguard. He was subsequently found guilty of murder and sentenced to life imprisonment, with a tariff of 15 years.
27. On 29 August 2014, Mr Zemicael was transferred to HMP Swaleside. In July 2015, Mr Zemicael was subject to suicide and self-harm prevention measures, known as ACCT, after he complained of hearing voices. He was supported by the mental health team and the ACCT was later closed.
28. On 6 July 2018, Mr Zemicael was transferred to HMP The Mount.
29. During his initial health screen, Mr Zemicael told the nurse that he had attempted suicide in a hospital while in the community, but he had no current thoughts to harm himself. Mr Zemicael was assessed as not suitable to share a cell. On 9 July, the nurse referred Mr Zemicael to the prison's Mental Health Inreach team.
30. Mr Zemicael was prescribed antipsychotic medication, Amisulpride, he had been taking since 2009, to help manage some of the symptoms (which included hearing voices and auditory hallucinations). Mr Zemicael remained largely symptom free during his time at The Mount. Initially, the mental health team saw him every month and the visiting psychiatrist saw him every six months. Because Mr Zemicael was not presenting with any symptoms and he remained stable, in July 2020, his meetings with the mental health team were reduced to every three months. In October 2020, he was discharged from the mental health caseload, but he continued to see the psychiatrist every six months.
31. Mr Zemicael settled in well at The Mount. He lived on Dixon wing and gained employment in the kitchens. During 2018, he received positive reports about his behaviour and no concerns were raised about him. He was not subject to ACCT monitoring at any point during his time at The Mount.
32. During 2019, Mr Zemicael had 12 key work sessions during which he raised no concerns. He spoke about his job in the kitchens, and he received no negative comments about his behaviour. The entries during 2020 and 2021 continued to be

positive. Mr Zemicael had regular contact with his keyworker and continued his employment in the kitchens.

33. On 27 August 2022, Mr Zemicael moved to Narey wing, an enhanced wing for prisoners aged 50 and over. The enhanced incentives and earned privilege (IEP) scheme is the highest level a prisoner can achieve, based on their behaviour and engagement with offending behaviour. It allows them more time out of cell, as well as increased access to personal money and personal items.
34. An officer who had known Mr Zemicael for two years while he had been located on Dixon wing, made an entry on his record when he left the wing. He wrote that Mr Zemicael had a 'brilliant attitude and good nature, which he always showed towards staff, particularly new staff'. He also said that Mr Zemicael was always polite and brought a 'good dynamic' to Dixon wing.
35. An officer was assigned as Mr Zemicael's keyworker when he moved to Narey wing. He had regular contact with him, during which Mr Zemicael reported that he had no issues and was continuing to work full time in the kitchens. On 20 December, during a keyworker session, Mr Zemicael spoke about a possible transfer to another prison to break up his sentence, and the officer provided him with the relevant application form to complete.
36. On 28 November 2022, the consultant psychiatrist saw Mr Zemicael and they agreed to reduce his Amisulpride medication from 100mgs twice daily to 100mgs daily. This decision was based Mr Zemicael's continued mental health stability and the recognition that the last time he had been very unwell was when he had first arrived in prison. His next review was arranged for six months. Mr Zemicael's last appointment with the psychiatrist was on 25 May 2023. The psychiatrist noted that Mr Zemicael's mental health was 'unremarkable' and that if his mental health remained stable, he would seek to stop his antipsychotic medication at the next appointment in five to six months' time.

## January – 16 June 2023

37. Between January and February, the keyworker completed two keyworker sessions with Mr Zemicael, and he again raised no concerns. He recorded that Mr Zemicael had been polite and respectful and his conduct on the wing was said to be excellent.
38. At 4.50pm on 12 March, an officer was alerted to an altercation happening in the wing pool room. When he entered the room, a prisoner had hold of Mr Zemicael's arms and claimed that Mr Zemicael had struck him with a pool cue. On further investigation, it appeared that the altercation was over a game of pool and that Mr Zemicael was the aggressor.
39. Mr Zemicael was placed on report. His incentives level was also reviewed in line with the local policy, and he was downgraded to the standard regime. As a result, Mr Zemicael no longer met the criteria for Narey wing, and he was moved back to Dixon wing on 17 March. He was also removed from his position in the kitchens, as his behaviour went against the compact of his employment. Mr Zemicael was said to have been apologetic for his actions and accepted the measures taken. At the disciplinary hearing, Mr Zemicael pleaded not guilty, and the case was dismissed as

it was not possible to be certain who had started the argument. Although the disciplinary charge was dismissed, Mr Zemicael was considered to have broken the compact for living on Narey wing and was unable to return for the time being.

40. Despite Mr Zemicael's behaviour being 'out of character' there is no indication that any further referral to his psychiatrist or assessment by the mental health team was considered, to identify whether the reduction in his anti-psychotic medication had led to any possible deterioration in his mental well-being.
41. Mr Zemicael settled back on to Dixon wing and although he was initially unemployed, staff recorded that he volunteered to clean the yard to keep himself busy, and they did not raise any concerns about his behaviour. Mr Zemicael was later allocated part-time work in the bicycle repair shop.

### Events of 16 June 2023

42. On the morning of 16 June 2023, Mr Zemicael was not required to attend work and he spent most of the day in his cell. Staff told Mr Zemicael that he had been assessed as suitable to take part in the Thinking Skills Programme (an offending behaviour programme) and had been added to the waiting list.
43. At 1.55pm, an officer went to Mr Zemicael's cell to ask if he wanted to attend the Roman Catholic service, but he declined and thanked her for asking. She had no concerns about Mr Zemicael at that time.
44. At 2.20pm, Mr Zemicael pressed his cell bell, and a Supervising Officer (SO) answered it straightaway. He said that Mr Zemicael asked him when full time workers would be unlocked for association, and he told him that it would be around 3.00pm. CCTV shows an unidentified member of staff unlocking all other prisoners to collect their meals at 4.00pm. CCTV shows that the member of staff unlocked Mr Zemicael's door and opened it very slightly without looking through the observation panel or speaking to Mr Zemicael.
45. At around 4.05pm, a prisoner can be seen on CCTV at Mr Zemicael's cell door looking in through the observation panel. The prisoner is then joined by two other prisoners who can be seen trying to push against the door. One of the prisoners then leaves to go and alert staff.
46. An officer said that she was approached by a prisoner who told her that she needed to follow him immediately. She ran with the prisoner to Mr Zemicael's cell, where she said she saw prisoners pushing against the door. Although at this stage she did not know what the situation was, she said that she pressed her personal alarm at 4.08pm, as she knew she required additional staff to attend.
47. As the door was pushed, the officer said that she was able to gain entry and found Mr Zemicael lying face down on the floor with a bit of green bedding loosely wrapped around his neck. (It appears that Mr Zemicael had attached the ligature to the top of the cell door, and it was dislodged when the door was opened, causing Mr Zemicael to fall to the ground.) The SO who responded to the officer's personal alarm, attended the cell at 4.10pm, and immediately radioed a medical emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties). Staff began CPR. Communications room staff called an ambulance at 4.12pm.

48. Healthcare staff attended and attempted to resuscitate Mr Zemicael. They attached a defibrillator, but it advised that there was no shockable rhythm. Treatment continued until the first paramedics arrived at 4.29pm, followed by another crew at 4.36pm. Mr Zemicael did not respond and at 5.01pm, it was confirmed that Mr Zemicael had died.

### **Contact with Mr Zemicael's family.**

49. Mr Zemicael had no identified next of kin and had not received any visits or made any phone calls during his time in prison. His family lived in Eritrea, and the prison consulted Embassy officials in an attempt to trace his family, without success.
50. The prison arranged and met the costs of Mr Zemicael's funeral, in line with national policy.

### **Support for prisoners and staff**

51. After Mr Zemicael's death, a governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support and names of staff involved were shared with the local TRIM practitioner.
52. The prison contacted the local branch of the Samaritans. Listeners were also made available on Dixon wing to speak to prisoners and those immediately involved in assisting the staff. The prison posted notices informing other prisoners of Mr Zemicael's death and offering further support if required. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm and those in the post-closure phase of the ACCT in case they had been adversely affected by Mr Zemicael's death.

### **Post-mortem report**

53. The pathologist gave Mr Zemicael's cause of death as hanging. Toxicology tests carried out identified no illicit substances in his blood.

## Findings

### Assessment of risk

54. Mr Zemicael had been in prison since 2014 and was serving a life sentence of at least 15 years. He was Eritrean and had no contact with his family or friends while he was in prison. He made no phone calls and received no visits. However, he had not been considered at risk of suicide or self-harm since 2015. He had been at The Mount since 2018 and seemed settled and happy there. He received regular keywork and was well liked by staff who described him as a model prisoner.
55. In March 2023, Mr Zemicael fought with another prisoner and as a result, had to move wing, lost his enhanced status and his job in the kitchen. This was an apparently out of character incident and after the altercation, staff reported he settled. No one recorded any concerns about Mr Zemicael between March and his death on 16 June. We found no indications that staff should have considered him at a raised risk of suicide. His death came as a shock to those who knew him.

### Clinical care

56. The clinical reviewer concluded that the physical and mental health care Mr Zemicael received at The Mount was partially equivalent to what he could have expected to receive in the community.
57. The clinical reviewer considered that healthcare staff should have completed a formulation of risk, in line with the National Institute for Health and Care Excellence (NICE) 'self-harm: assessment, management and preventing recurrence' (2022), to determine whether Mr Zemicael needed a supportive care plan following his altercation on 12 March 2023. The clinical reviewer found that there was no analysis of the out of character incident given that his antipsychotic medication had been reduced approximately four months earlier. Nor was there any analysis of the potential impact of the loss of regular activity for Mr Zemicael. The clinical reviewer has made recommendations about formulation of risk, ensuring relevant health records are available and identified health interventions are planned, carried out and reviewed, which we do not repeat here but which the Head of Healthcare will wish to address.

### Good practice

58. During his time at The Mount, Mr Zemicael received regular keywork and benefited from consistency with his assigned keyworker, and clear, meaningful records were maintained of those contacts. It was clear from the investigation that, in addition to the delivery of keywork, staff knew Mr Zemicael well and there was evidence that they had developed a respectful relationship with him.

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