Investigation into the circumstances surrounding the death of a man at HMP The Mount in October 2007

Report by the Prisons and Probation Ombudsman for England and Wales

July 2008

This is the anonymised version of a report of an investigation into the death of a man who was found hanging in his cell at HMP The Mount on 7 October 2007. The man was a life sentence prisoner and was 35 years old. He had been in custody for six years and at The Mount for two.

I offer my sincere sympathies to the man's family, friends and all those affected by his loss.

The investigation was conducted by two of my senior investigators. The Deputy Ombudsman, accompanied my investigators on one of their visits to The Mount. A clinical review into the care received by the man while he was in prison was undertaken by an Independent Health Clinician for the West Hertfordshire Primary Care Trust (PCT). I am grateful to the clinical reviewer for conducting this. I must also thank the Governor and staff of The Mount for their assistance and co-operation with the investigation process.

I am pleased to say that the man received a high level of individual care and support at The Mount, and I commend the staff for this. However, my report includes six recommendations. In particular, I refer to the design of the cells where the man was discovered. A further recommendation refers to the possible extent of illicit alcohol brewing at the prison.

My report also raises concerns to whether the man was the subject of bullying to pay for drug debts. I note from The Mount's own document, Safer Custody Research Findings 2007, that drug and debt related problems represent by far the most frequent causes of bullying. Few prisoners said they would report this to staff. They felt staff either did not care or would do nothing about it. This could give some insight into the position the man might have found himself in.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2008**

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SUMMARY

The man arrived at HMP The Mount in October 2005, having been in custody since 2001. He was on a life sentence and had transferred from another prison to continue with rehabilitation programmes. Alcohol, drug misuse and a propensity for violence were all risk factors in his offending.

The man had had two episodes of self harm in 2001 and 2002. On both occasions a self harm form (F2052SH, later replaced by the Assessment, Care in Custody and Teamwork (ACCT) document) was opened, and he was monitored accordingly.

No more risks were identified until September 2007 when the man harmed himself by cutting his wrist. An ACCT document was opened immediately. The man later disclosed that he did not feel suicidal and had cut himself out of frustration because he had not been given the right amount of medication prescribed for depression.

I judge that the man received a great deal of support and care from staff to manage his frustrations. At the time he was on Dixon wing, which staff and prisoners alike describe as busy and noisy. As part of the man's ACCT care and support plan, he transferred to the newly built Narey wing on 17 September 2007.

The man's ACCT document was closed on 19 September. He attended the review meeting along with wing staff, a representative from healthcare and the safer custody officer. It was noted that his mood had much improved. Staff also commented on how well he seemed to be doing on the new wing.

No further concerns were raised about the man's wellbeing. He was last seen alive when he was checked by the night patrol officer shortly after 8.30pm on 6 October 2007, and gave no cause for concern. However, during roll check the following morning, the man could not be seen in his cell through the door observation panel. It was first thought that he was in the shower area, which was obscured from sight. However the night patrol officer received no response after repeatedly banging the cell door and calling out. The alarm was raised, and other staff attended the wing and entered the man's cell where they found him hanging in the shower cubicle area. Resuscitation was not attempted as rigor mortis had already set in. The paramedics formally pronounced his death.

After the man's death, evidence suggested that he might have been in debt for receiving drugs from other prisoners. This could have resulted in his being bullied, although he himself never reported it.

My report includes six recommendations.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened by one of my investigators on 10 October 2007, when he visited The Mount. He met the Governor and the deputy governor. Notices of the investigation and terms of reference had already been sent to the prison and invited anyone with any information to contact my investigators. Two prisoners subsequently came forward and were interviewed, as were members of staff.

2. During his initial visit, my investigator also met representatives of the local branch of the Prison Officers' Association (POA) and the Head of Healthcare. My investigator visited Dixon and Narey wings, where the man had been located, and met separately with a representative of the Independent Monitoring Board (IMB) who raised concerns about the new cell design on Narey wing. My investigator, accompanied by a second investigator and Deputy Ombudsman, returned later to the prison to conduct interviews.

3. A clinical review was commissioned from West Hertfordshire Primary Care Trust (PCT) to assess the man's medical care. Unfortunately, there was some delay in the completion of this review, partly because the PCT was unable to find a suitable clinician. The PCT eventually appointed a clinical reviewer, to whom I am most grateful. However, I do hope that the PCT has now put in place a system better designed to facilitate any future requests for clinical reviews.

4. One of my family Liaison Officers made contact with the man's mother to tell her about our investigation. On 18 December 2007, my family liaison officer and investigator visited the man's mother and sister at their home. The man's mother raised the following questions in relation to her son's death, and I hope I have addressed them fully in my report:

    - They had sent the man a considerable amount of money (more than £500) over an approximately three month period whilst he was at the Mount. The man had not told them why he needed the money.

    - The family suspected the man was involved in drugs and debt and this might have been worrying him. They are concerned that it was not noticed by the prison because the large amounts of cash enabled him to pay any debts.

    - The family wondered whether he was having trouble with someone on Dixon wing who was then moved to Narey wing.

    - The man had told them that he had three more years to serve in prison.

HMP THE MOUNT

5. The Mount is a category C training prison, five miles from Hemel Hempstead. It opened in 1987 as a young offender institution and changed its role to that of an adult establishment in 1990. The Mount's operational capacity is 764 prisoners.

6. Healthcare is open from 7.45am to 5.15pm on weekdays. Prisoners can report sick either first thing in the morning or at lunchtime. During these times they can be seen by the nurse or the pharmacist. A range of healthcare resources is accessible for prisoners, but there is no inpatient facility. Two doctors from a local NHS practice hold clinics every weekday morning. Prisoners can report 'special sick' at any time and another doctor visits the prison in the afternoon for 'special sick' and new receptions. Out of hours cover is provided by an on-call doctor. An in-house pharmacist is employed on a full time basis.

7. The Mount has eight wings. The man was initially located on Dixon wing, which is a normal residential wing and houses short and long term prisoners on enhanced and basic incentives and earned privileges scheme (IEP) levels. Prisoners on this wing also have their own cell keys. Narey wing, where the man was later located, is a new build wing. Long term and life sentence prisoners were being relocated to Narey wing at the time of this investigation.

8. An unannounced inspection of The Mount by HM Chief Inspector of Prisons, Ms Anne Owers, was carried out in September 2006. In relation to doctor and nurse appointments, Ms Owers noted: "The appointment system worked well, although there were some delays in appointments because of the mass movement system for prisoners. However, prisoners were seen quickly and without due delay. Prisoners who requested appointments with the GP or nurse were generally seen at the next available appointment, usually the following day". Ms Owers' report also noted that The Mount had made very impressive progress since its previous announced inspection in October 2004.

Adjudication

9. An adjudication is an internal hearing into breaches of prison discipline.

Assessment, Care in Custody and Teamwork (ACCT)

10. As at all prisons, ACCT has been introduced at HMP The Mount to monitor and support prisoners assessed as at risk of suicide or self harm. (The previous system was known as the F2052SH procedure.) Once placed on ACCT, the prisoner is observed at pre-determined intervals according to the perceived level of risk.

11. Each prisoner is assessed within 24 hours and then reviewed further at intervals decided on an individual basis. The ACCT guidance says that,

to be effective, the review should involve the people who know the person at risk or are involved in their care.

12. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. It is for the case review team to decide the most appropriate place to locate an individual prisoner.

Canteen

13. Prisoners can obtain various foodstuffs and other items as canteen from the prison shop. They also have access to a water boiler and are provided with a weekly tea pack, bread and other food items. Prisoners use money from their prison cash account to purchase canteen items.

Counselling, Assessment, Referral, Advice and Throughcare (CARATS)

14. Organisations specialising in the treatment of substance abuse have drugs workers based in most prisons. CARATS workers can run programmes, and offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATS is voluntary.

Incentives and Earned Privileges Scheme (IEPS)

15. The IEPS was introduced to encourage and reward good behaviour in prisons. There are three levels - Basic, Standard and Enhanced. Incentives include access to in-cell television, more private cash to spend, wearing own clothes, more time out of cell, and community visits. The man was on the enhanced IEP level.

Induction

16. Having gone through the reception process, prisoners at The Mount are located onto the New Arrivals and Assessment Centre (NAAC), Howard Induction wing. Prisoners receive their induction here and the facilities and the regime of the prison are explained. After a suitable period on the induction wing, they are re-allocated to a regular residential wing.

Insiders and Listeners

17. As is the case at most prisons, The Mount relies on experienced prisoners as Insiders and Listeners. Insiders welcome new prisoners, highlight any concerns and explain the processes the newcomers will encounter in the early days of custody. Listeners assist those prisoners who require additional support at any time in their period in custody. They are provided with training from the Samaritans to support them in this role. Confidentiality is a main feature of this role.

Lifer manager

18. Prisoners on an indeterminate or life sentence are assigned a lifer manager to work with them through their sentence, and to assess and meet their different needs. This will include target setting, sentence planning and preparing reports for parole hearings.

Medication management in prison - In-possession medication (IP)

19. Prisoners should be provided with a health service that is equivalent in quality and range to that in the wider community. Prison Service Instruction 028/2003, A Pharmacy Service for Prisoners, provides that medicines in use, together with associated monitoring and administration devices, should normally, and as a matter of principle, be held in the possession of the prisoners themselves. Each prison should have a policy and risk assessment criteria for determining on an individual basis when medicines may not be held in possession.

Mental health in-reach

20. The in-reach team offers a mental health service for all prisoners who have enduring mental illness. They also treat and support prisoners in crisis situations. They also support prisoners who are on ACCT documents, and attend most ACCT review meetings.

Release on licence (Parole)

21. Prisoners may be released early on licence subject to the decisions of the Parole Board. The Board makes its decisions on the basis of reports by prison and probation staff. The decision to grant or not grant release on licence is based on an assessment of the extent of their risk and the way in which it can be managed. This is informed by the nature of the prisoner's offence, their home circumstances, their plans for release, and their behaviour and engagement in rehabilitative programmes in prison.

Personal officers

22. Every prisoner is assigned a personal officer. Their role is to meet with the prisoner on a regular basis and to discuss any issues or concerns the prisoner may have.

Roll check

23. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur on a number of specified occasions during the day and night, and staff must sign that the roll is correct

Private cash / private spends

24. Prisoners are not allowed to retain notes or coins in their possession. Money may be sent to the prisoner, preferably by postal order or cheque made payable to the Governor. There are no limits on the amount of private cash a prisoner can have but, since the introduction of IEPS, there are limits on how much can be spent. The following currently applies to The Mount:

    - There is no 'cap' but all single amounts over £100 are reported to security.
    - There is no limit on how much money a prisoner can send out.
    - The weekly automatic transfer of money to the spend account for enhanced prisoners is £23. Prisoners can accumulate up to 10 times this amount in their spend account before private cash ceases to be transferred into it (earnings are unaffected).
    - There is no limit on how much of their spends a prisoner can use each week in the canteen.

25. My investigator identified that the man received around £470 from his family between April and October 2007. In addition, he received weekly earnings of approx £13. The prison has a record of all the transactions he made during the period. Including his canteen and telephone credit, this amounted to approximately £580.

Violence Reduction Strategy

26. The Prison Service has a specific policy on reducing violence which also incorporates policy on dealing with bullying. The policy states that everyone has the right to feel safe and free from physical, emotional or psychological intimidation and all prisons are required to have in place a local Violence Reduction Strategy. This strategy must make clear that all forms of violence, including bullying, will be challenged and there should be monitoring systems in place to record all incidents of violence (including bullying) and identify any emerging patterns.

KEY FINDINGS

Prior to the man's arrival at The Mount

27. In December 2000, the man was arrested and charged with committing two violent offences. In June 2001, he admitted to the offences at court. Because he had committed a similar offence and been convicted in 1991, the man met the criteria for a discretionary life sentence. The court sentenced him to life imprisonment with a tariff (minimum period) of three years and seven months. That minimum period would expire in July 2004. The court identified that alcohol, drug misuse and a propensity for violence were contributory factors to the man's offences.

28. Following his conviction, the man was transferred to HMP Wormwood Scrubs. He went through the normal prison reception screening process. The man was interviewed by the healthcare nurse and disclosed that he had recently taken opiates and cocaine. He was referred to CARATs for substance misuse advice. He was also referred to a psychiatrist for a mental health assessment because his mood was low and he had difficulty managing his anger. A F2052SH document (later replaced by the ACCT) was opened and he was transferred to the detoxification unit for a period before being moved on to a normal residential wing in a shared cell.

29. The man was seen by the outreach team and it was agreed that he should continue to see CARATs workers and the outreach team every week. During his time at Wormwood Scrubs, The man was seen by healthcare regularly to review his medication of chlorpromazine (an anti-psychotic drug) and amitriptyline (most commonly used for the treatment of depression). Both medications were prescribed to help his mood and to improve his sleeping.

30. In March 2002, the man transferred to HMP Swaleside where he would start his offence related rehabilitation programmes. He went through the prison reception screening process and was later located to a shared cell in a normal residential wing. The man disclosed that he had no present thought of self harm.

31. The man's behaviour at Swaleside was reported by staff as generally satisfactory. He participated with the rehabilitation programmes, was on the voluntary drug testing unit and had produced negative test results, and was on the enhanced level of IEPS. However, he did subsequently incur two adjudications, one of which was for possessing fermenting liquid (hooch).

32. The man continued to receive medication for his low mood and sleeping problems, and attended the Community Psychiatric Nurse (CPN) clinic regularly for reviews. He later had two episodes of self-harming. The first occurred in August 2002. He said it had occurred because he was miserable and depressed. The second, in October 2002, was carried out

whilst under the influence of alcohol. On both occasions the man used a blade to make cuts to his forearm. A F2052SH document was opened to monitor and support him on both occasions.

33. When the man attended the CPN review clinic in November 2002, it was noted that his mood was much more stable. He continued to receive repeat medication of chlorpromazine and amitriptyline. The man seemed more settled and expressed no more thought of self harm. This continued for the rest of his time at Swaleside, although he attended healthcare for a number of physical ailments.

34. As part of the man's life sentence plan to address his offending behaviour, he completed a number of rehabilitation programmes and his progress was continually assessed. By January 2005, the Parole Board recognised that he still needed to be assessed for the Cognitive Self Change Programme (CSCP) or the Controlling Anger and Learning to Manage it (CALM) course, for lifer victim awareness, and the alcohol and drug awareness programme. The latter two courses were not available at Swaleside, and so it was recommended that the man progress to a category C prison to complete the remaining courses. As a consequence, when the man's Parole Board Review was held in April 2005, release or moving to open conditions was not recommended.

The man's arrival at The Mount on 4 October 2005

35. The man was transferred to The Mount on 4 October 2005. He again went through the normal prison reception screening process. Here he said that he was feeling much better, was not depressed and had not self harmed for three years. He disclosed that he had lost some weight and was fully aware of healthy eating. He was now only taking the prescribed amitriptyline, which he said was keeping him well. The man was later located to Howard wing, the induction wing for new prisoners.

36. Only a day later (5 October 2005), the man moved to Dixon wing, a normal residential wing. The following day, the reception officer had a long chat with the man because he was quiet and seemed a little disorientated. The man told the reception officer that he felt his move from Swaleside had been too rushed. He also felt pressurised at being moved so quickly from Howard to Dixon wing. It felt to him as if his induction programme was being hurried. During their conversation, the man mentioned that he had had a history of self harm and depression, although he said he currently felt free of any such thoughts. The man declined the reception officer's offer of a referral to the healthcare unit, saying he had no need to see them.

37. The reception officer suggested to the man that his induction be put on hold until he had settled in at The Mount. Later that afternoon, the reception officer spoke to the wing manager. The wing manager spoke with the man later that day and told him she had arranged for his induction to be deferred until 17 October to give him time to settle. The

man was happy with this and the wing manager arranged to speak with him again in a week's time. The next day (8 October), the wing manager noted in the man's wing history sheet that he had been polite to her and appeared to be much more settled.

38. A mental health in-reach referral meeting took place on 7 October at which the team discussed the man. He was currently stable on his medication and it was agreed that he should receive support through Primary Care, and that it was not necessary for the In-reach team to take any further action with him at this time.

39. On 12 October, staff had cause to speak to the man. He was upset because healthcare had refused to issue his medication. Wing staff discovered that the man was not due further medication for another day. This was explained to him and he soon calmed down. Over the coming months, the man settled into the prison regime. He raised no particular concerns with staff and was often described as a quiet.

40. The man had previously complained of having abdominal pain and a subsequent ultrasound examination showed that he had gallstones. On 5 September 2006, he attended day surgery at a local hospital for a medical procedure. When he returned to prison, staff allowed him to use the office telephone to contact his mother to reassure her that he was okay. He was checked hourly overnight by the night duty officer and made an uneventful recovery from his operation.

41. On 26 September, the man was referred to healthcare after reporting that he had felt depressed since having his operation. He said he was neither eating nor sleeping well, although had no thoughts of self harm. He was seen by the prison doctor who referred him back to the In-reach team.

42. The man was later seen and assessed by the In-reach team manager, on 10 October 2006. The in-reach team manager told my investigators that the man was not interested in engaging with him at that particular time. He recorded that the man was worried and depressed by his present circumstances and his uncertainty about getting released on licence. The man told him that he had been refused parole, had been in prison for about six years and was still without a release date. The man also complained about the high level of noise on Dixon wing. He said that both these issues made him feel stressed.

43. The man also mentioned to the in-reach team manager that, when his family came to visit, it sometimes made him feel worse because he was not able to be there to support them outside. The In-reach team manager told my investigators that the man categorically said he had no suicidal intentions or thoughts of self harm. He noted the man was still taking amitriptyline 75mg at night, and recommended that he be referred back to the Primary Care team for a review of his dosage. He also made

a referral for the man to see the prison doctor to be assessed for a relaxation group.

44. The man's mood was assessed by the doctor the following month on 8 November. His medication dosage was increased to 100mg at night. When the man attended the doctor's clinic for a review approximately four weeks later, his mood was better, he appeared stable and said he was happy on the new dosage.

45. On 15 December 2006, the man attended healthcare with a small testicular lump and was referred for an ultrasound scan. The ultrasound examination took place on 19 January 2007 and a diagnosis of a cyst was made. No treatment was required and reassurance was given.

46. The man attended healthcare regularly over the following months for reviews of his anti-depressant medication and for other minor healthcare problems. This included him being risk assessed for in-possession medication (IP). He was trusted to take his medication as prescribed and given seven days medication at a time.

47. At the beginning of March 2007, the man learned that his father had died. The Chaplain delivered the news and offered him bereavement support. The man was later permitted to attend his father's funeral which was held on 8 March. No concerns were reported regarding the man's behaviour throughout the ceremony. The Chaplain told my investigators that the man was pleased to be able to attend his father's funeral, and he continued to offer support to the man after this period.

48. A fellow prisoner on Dixon wing, told my investigators that he got to know the man quite well whilst they were on the wing. He said he felt that there was a change in the man's mood after his father had died. The man seemed depressed, agitated and withdrawn. The prisoner also believed that the man had got himself into debt on the wing by buying heroin from other prisoners. This was brought to the prisoner's attention because, as a consequence, the man would borrow his canteen when he had used his own to pay back debts.

49. A second prisoner also told my investigators that the man had borrowed canteen from him on occasions. The second prisoner said he believed that the man had got himself into debt due to being given heroin by other prisoners.

50. Many of the comments in the man's wing history sheets throughout 2006/07 show that he was a polite and well behaved individual. Comments included: "another good week from the man, polite to staff" and "always on time at lock up and maintains excellent behaviour". There are no records to indicate that the man approached any member of staff to disclose any concerns or issues. Staff continually noted his helpfulness around the wing.

51. The man was interviewed on 12 April 2007 by the prison psychologist regarding a recent psychology report (disclosed to him in December 2006) and his forthcoming parole review hearing. The man said he was happy with the report.

52. On 9 May, the man attended his Parole Board Hearing. This was his third review. On this occasion the Board acknowledged the good progress he had made at The Mount. He had remained free of adjudications and enjoyed enhanced status. He had completed a number of courses and programmes, although he had not undertaken any offence related work on violence. The next available course was the CALM programme, which was scheduled to take place in June. The Parole Board therefore deferred until November 2008 a decision on whether the man would be moved to open prison conditions or released on licence. The Board would then review the progress he had made.

53. The wing manager told my investigators that the man was disappointed at this outcome, but did not appear angry or devastated. The wing manager explained that if a prisoner was refused parole once they reached their tariff, further review dates were set by the Ministry of Justice Lifer Section. In general terms, Parole Board hearings took place every two years. She also confirmed that the man had spent a considerable time in prison and was fully aware of how the parole system operated.

54. The man commenced the CALM course in June 2007. On 26 July, a wing officer told my investigators that she spoke with the man because he appeared very quiet and withdrawn. The man said that he was approaching the end of his CALM course and had been finding it difficult. His tutors were aware of this and had allowed him extra time to complete the work. The wing officer also offered her support and told my investigators she kept an extra eye on the man after this point.

55. The wing officer said that the man was always polite, worked in the servery and was generally quite a happy person. He had a few selected friends and tended to socialise with other lifers. He liked a laugh, and was quite a funny person who had gained the nickname “Asbo” from other prisoners on the wing. The wing officer said that, if the man was not happy, staff would soon know just because of the type of person he was. For example, there were days when the man asked to be locked up early because he said he had had enough of socialising with other prisoners. Throughout her contact with him, the wing officer also said that the man showed no sign of taking drugs or being bullied.

56. On 29 July, the man was the subject of a random mandatory drug test (MDT). He tested positive for opiates and was placed on a disciplinary report to face adjudication. He later wrote as part of his written representation for the adjudication that he had taken what he thought were painkillers that were given to him by another prisoner. He wrote that he was truly sorry for his actions.

57. After the discovery of the man's positive MDT, he was referred to see a CARATs worker. The man met with the CARATs worker on 7 August. She introduced herself and explained her role in reference to the man's MDT failure. The man told the CARATs worker that his positive MDT was due to being on prescribed co-codomol. He said he had appealed against the charge and his solicitor was dealing with the matter.

58. The CARATs worker and the man discussed the courses he had already completed. They now included the alcohol and offending behaviour course and the CALM course, of which he was two sessions away from completion. The man said he was enjoying the CALM course although it was difficult at times. In interview, the CARATs worker described the man as quiet throughout the meeting and said that he raised no concerns. It was agreed that they would meet again to review his progress in November.

59. The man successfully completed the CALM course on 11 August. The wing officer noted in the man's wing history sheet that he appeared relieved at this and was now looking forward to moving to Narey wing, the new wing for life sentence and long term prisoners. A week later (19 August 2007), it was noted that the man's mood was low and he remained in his cell a lot of the time. When asked, the man said he was worried about his forthcoming adjudication.

60. On 25 August, the wing officer again commented that the man was looking forward to moving to Narey wing. She noted in his wing history sheet, "I think the man's had enough of Dixon." The man told the wing officer that the reason he wanted to leave Dixon wing was because it was too noisy for him. The wing officer said in interview that the man was anxious to move to the new wing, which was originally supposed to have opened at the end of July. The opening had been continually delayed, adding to the man's frustration.

61. The wing manager was also the lifer manager and so she had frequent contact with the man. He spoke to her about his past alcohol abuse, and how he was feeling better now so that it was not an issue. He later told her that he was fed up and stressed and could not wait to move to Narey wing. Although the wing manager said that the man did not want her to "make a fuss of him", he told her that he had pinched the insides of his arms a few times as a self-harming mechanism to release his stress. With the man's knowledge, the wing manager spoke with the safer custody senior officer and arranged for her to speak to the man. The man was shown some techniques to use to help him relieve stress, including some relaxation CDs. The wing manager also arranged for the man to attend relaxation classes. The man later told the wing manager that he found all of this helpful.

62. In a bid to alleviate some of the man's frustration, the wing officer made a tentative arrangement with the senior officer on Fowler wing for him to

be temporarily relocated there for a couple of weeks until Narey wing opened. When this was broached with the man, he refused saying that he wanted to remain on Dixon as that was where his friends were. He said that he was happy to remain there until Narey wing opened.

63. The man's adjudication took place on 1 September. The charge of providing a positive MDT for opiates (heroin) was proven and resulted in 14 days cellular confinement, stoppage of earnings at 60 per cent, loss of canteen and loss of association. All the punishments were suspended for four months.

64. On 6 September, the man collected his medication from healthcare. When he returned to his cell, he discovered that there were four tablets missing. He immediately informed a wing officer who reassured him that the shortfall would be made up if an incorrect quantity had been given. The healthcare unit was contacted and, following discussion with the head of healthcare, it was agreed that as the man was considered a trusted prisoner he would be issued the four tablets. In the meantime, apparently in reaction to the thought of being without some medication for a day or so, the man returned to his cell and self harmed by cutting his left wrist.

65. A senior officer told my investigators that sometimes it was difficult to judge the man's mood because he spent a lot of time alone in his cell. Generally he was in a good mood, but staff often relied on other prisoners to tell them when he was not. When the man returned to his cell on this occasion, it was a prisoner who told the senior officer that the man had self harmed. The prisoner actually dressed the man's wound first and then alerted staff. The man was subsequently taken to the healthcare unit.

66. A nurse treated the man in the healthcare unit. It was a superficial wound which he cleaned, glued and steri-stripped. The man told the nurse that he had self harmed for three reasons. First, because he had not received the right amount of medication. The second issue was that the man was finding it difficult to cope on Dixon wing because it was very rowdy and there were problems on the wing. Lastly, the man disclosed that he had some family problems, although he would not elaborate on them.

67. Following the man's act of self harm, an ACCT document was immediately opened and the man attended an ACCT assessment interview. He said that when he informed staff that four tablets were missing from his medication, he was made to feel as if he was lying. This caused him to cut his wrist out of frustration. He also said he felt anxiety at the thought of just having two days worth of his medication. However, the man said that he had no intention of taking his life.

68. Afterwards, the man was returned to his cell, and hourly observations and staff interaction began. Access to the phone was arranged should

he wish to use it. The man was also reminded of the services of the Listeners who were available to talk with him at any time. As the man was in a single cell, staff arranged for a good friend of his to speak with him to help his mood.

69. The next day (7 September 2007), an ACCT review took place. The man was present together with a senior officer, the Safer Custody Officer and the In-reach manager. The in-reach manager told my investigators that the man said he had self harmed as an emotional release, which he had now achieved. The man had said he was adamant that he had no further thought of self harm, did not want to commit suicide and wanted the ACCT document to be closed. The man said he was still generally unhappy on Dixon wing, and was waiting for his transfer to Narey wing.

70. The staff at the review meeting noted that the man now appeared in quite a cheerful mood. He disclosed that there were times when his mood was low, especially after visits from his family, but he was always cooperative with staff. He had attended the first week of his Relaxation Course and agreed to attend for the next three weeks. A computerised cognitive behavioural therapy (CCBT) training course, Beating the Blues, had also been arranged for him to attend. (This is a computer based confidential course designed to help individuals reduce their stress and anxiety levels.)

71. The outcome of the man's ACCT review was thought to be positive. Although the ACCT document was to remain open, it was to coincide with his pending move to the new wing. His observation levels were reduced to one in the morning, afternoon and evening, and three times during officer patrol state. The man was reminded again of the services of the Listeners and the In-reach team.

72. On 9 September, the wing officer spoke with the man who again said he had had enough of Dixon wing, describing it as loud and containing dirty and angry prisoners. There was no doubt that the man was anxious to leave the wing.

73. The chaplaincy plays an active role in checking prisoners who are on an open ACCT. The Chaplain, who had met the man before, spoke to him to see how he was and to offer support. The man told him that he wanted to leave Dixon wing where he was unhappy. He gave no particular reason why he wanted to move. The Chaplain said he would try and expedite matters on the man's behalf by speaking with the wing manager.

74. In order to try to keep the man active and to improve his mood, the wing officer obtained permission for him to assist with the last minute preparations for the new wing. There were a number of items of furniture to be taken from various parts of the prison and a selected group of staff and prisoners were chosen to do this. The wing officer thought this would be a good motivation and give the man something to

do, as well as taking him out of Dixon wing except for lunchtime. The safer custody officer told my investigators that she spoke to the man whilst he was doing the work. He was thoroughly enjoying being a part of setting up the new wing. The wing manager described the man as much like his old self whilst doing the work.

75. On 17 September, the man was eventually relocated to the new Narey wing. Because of his good behaviour and assistance in getting the wing up and running, he was allowed to choose which cell he would occupy. He was located next door to a third fellow prisoner, whom the man considered to be a good friend. No more concerns were noted about the man's well-being.

76. A further ACCT review took place on the morning of 19 September attended by In-reach community psychiatric nurse, the wing manager, the safer custody manager and the man. Other than the man, none of them had attended the previous ACCT review. The In-reach community psychiatric nurse told my investigators that, although the In-reach team do not normally attend ACCT reviews, they like to take an active role in supporting safer custody and to work together as a team.

77. The In-reach community psychiatric nurse said that the man appeared very well, bright and cheerful at the review. He was happy to be on Narey wing and invited the staff to see his new cell. He said that his cell had a nice view and he had his own shower. He also said he had no more thoughts of self-harm and wished to continue his Relaxation and CCBT courses.

78. The review agreed that the man's ACCT document should be closed and it was noted:

> "ACCT closed – he is much more positive in his state of mind no thoughts of self harm, happy to continue with relaxation classes. Arrangements have been made with workshop 8 for the man to resume work from 24/9/07. The man intends to take up the CBT when he has completed relaxation classes. Happy that there are staff he is comfortable approaching with any issues."

As is normal, a post closure ACCT meeting was scheduled (for 17 October) to see how the man was progressing.

79. The Chaplain visited the man on Narey wing after the review. He described the man as more positive and chatty than when they last spoke.

80. On the following day (20 September), the man collected his week's supply of medication as usual, doing the same on 27 September and 4 October.

81. On 21 September, it was noted that the man was now working in the servery, was polite and cooperative, and no concerns were identified. Because of the design of Narey wing, the acoustics were quieter and the man was said to be integrating with other prisoners. A week later, on 28 September, he was presented with a certificate of achievement for his completion of four sessions of the Relaxation course for dealing with anxiety, problem solving and assertiveness.

82. The man wrote a letter to his mother on 1 October. This was disclosed to my investigating officers after his death. He explained that he had not made any telephone calls to his family because he felt it was easier for them, as well for him, if no contact was made. This extended to his visiting rights. The man said that he felt he would not be released from prison within the next three years. He claimed he was drug free but had no money, was in debt and felt like a tramp. As a result, the man said he had borrowed things off other prisoners.

83. On 4 October, the man spoke to the safer custody officer. The man was out on association and said that he was really enjoying being on the new wing. He joked with the safer custody manager and said he had no issues or concerns. This was of course in contrast to what the man had written to his mother just days earlier.

The night of 6 - 7 October

84. The prisoner in the cell next door to the man was his friend. This prisoner told my investigators that he last spoke with the man around 6.00pm on the evening of 6 October. He said the man seemed fine and they had spoken about Christmas. The last thing the man asked was whether the wing manager had checked his observation panel, which he confirmed. The prisoner said that, after lock up, he and the man tended to continue their conversations, although on this particular evening the man was quiet. The prisoner said this did not concern him, and he believed that the man might have taken his medication early which was not unusual.

85. A prison officer commenced his night duty shift at around 7.45pm on the evening of 6 October. He told my investigators that he relieved the day staff after the roll check had been completed. The Night orderly officer also commenced his night duty at the same time, and they received a handover from the senior officer on the day shift. The two officers completed a roll check around the prison, double locking prison gates for security reasons. Throughout the night, the prison officer on night duty said he would be on hand to assist the night orderly officer in carrying out any duties around the prison.

86. An Operational Support Grade (OSG) began his night duty shift at 8.30pm. He told my investigators that one of his first tasks is to complete the roll check of the wing. (The roll check would also be repeated the following morning between 5.00am and 6.00am.) When

the OSG arrived at the man's cell, he looked through the observation panel where he saw the man seated on the floor watching television. The cell light was off. He knocked on the door and asked the man how he was. Although the man acknowledged the OSG's presence by looking at him, he did not respond. The OSG said that everything looked normal within the cell. As the man was no longer on an ACCT document, the OSG had no reason to make any further checks on him throughout the night. There were no concerns reported on the wings that night.

87. The officer on night duty told my investigators that, from around 10.00pm, he and the night orderly officer checked all the wings at regular intervals to make sure that everything was calm. With regard to Narey wing, the officer said no concerns were reported by the OSG.

The morning roll check on 7 October, cell C1 Narey Wing

88. Having had a quiet night, the OSG commenced the morning roll check at around 5.30am. He started from wing A through to B and C and so on. When he arrived at the man's cell, he looked through the observation panel but could not see the man on his bed which had lots of pictures scattered on it. The OSG knocked on the door and called out the man's name to get a response but did not receive one. He knocked repeatedly but obtained no reply.

89. The OSG told my investigators that it was not unusual for a prisoner to be in the shower area. It was not possible to see into the showers on Narey wing from the cell observation panel. The OSG said that prisoners at times sat on the toilet and would not reply to calls from staff.

90. The OSG also confirmed to my investigating officers the procedures in regard to entering a cell during the night time period. He said that, if he could see a prisoner was trying to harm himself or was in a life threatening situation, he would go into the cell having considered the risks to himself and security of the prison. Before doing so, he would inform the control room to gain permission. The OSG night patrol staff do not hold keys to cells but carry a sealed pouch with a cell key which is only to be used in emergencies.

91. The OSG decided to continue with his roll check, and to return to the man's cell after a minute or so to recheck. He returned and knocked on the cell door several times but the man was nowhere to be seen or heard. The OSG immediately made his way to the office to telephone the control room and inform them.

92. The night orderly officer told my investigators that it had been a fairly quiet night. He confirmed that at around 5.50am, whilst in the gate house, he received a phone call from the OSG who informed him that he had got no response from cell C1. The night orderly officer told the OSG to make as much noise as possible to try to get a response from the

prisoner inside. Having carried out this instruction, the OSG still obtained no reply from the man.

93. The night orderly officer told the OSG that he should wait for him to arrive on the wing before going into the man's cell to check on his wellbeing. The night orderly officer was still concerned about the safety implications of one officer being alone on the wing and entering the cell unaccompanied. The night orderly officer and the two officers on night duty made their way immediately to the man's cell on Narey wing. This took no more than two minutes.

94. When they arrived, the night orderly officer looked through the observation flap and banged on the cell door. He could see through the observation panel that the bed was straight ahead and that, to the right, the shower door was open. The night orderly officer asked the second of the officers on night duty to unlock the door. The second officer went into the cell followed by the night orderly officer and the first officer on night duty. All three officers and the OSG had had first aid training, although the second officer on night duty and the night orderly officer last completed their training over four years previously.

95. As the officers looked into the shower cubicle, they saw the man hanging. The ligature was attached to a metal bar that went across the top part of the shower cubicle. The night orderly officer immediately used his radio to contact the control room and raise the alarm and call for an ambulance. In the meantime, the second officer on night duty and the night orderly officer supported the man's body and the first officer used his fish knife (a specifically designed cut down tool) to cut the ligature. The man was wearing his boxer shorts and tee shirt. He was laid on the bed by the officers. The first officer on night duty told my investigators that the ligature looked as if it was a white thin shoe lace. The pictures on the man's bed appeared to be of his family members.

96. The night orderly officer said that their initial reaction was to commence cardio pulmonary resuscitation (CPR). The second officer first examined the man for signs of life. He told my investigators that the man's "torso lacked colour, his body was bloodshot" and rigor mortis had set in. He described the man's body as stiff, cold and clammy. The night orderly officer concurred that the man showed no signs of life.

97. The officers then left the cell to await the ambulance and police. The ambulance arrived at the prison at 6.16am and the two paramedics were escorted by the first prison officer to the man's cell. Following their examination, the paramedics pronounced the man's death at 6.30am.

After the man's death

98. The prison's death in custody contingency plan was activated and the man's cell was sealed to await the arrival of the police. All the necessary agencies were informed and the first officer on night duty was given the

role of log keeper for the cell. The OSG and the first officer returned to the wing office and started to trace the details of the man's next of kin. The Governor, Deputy Governor and Independent Monitoring Board were also informed.

99. The police arrived at 6.48am and examined the man's cell. They found a note written by the man in which he appeared to indicate that he intended to take his own life. Arrangements were made for the man's body to be removed from the prison by the undertakers.

100. The Staff Care Team and the Chaplain were deployed and immediately began supporting staff who were on duty.

101. A hot debrief meeting for the night duty staff was conducted at 8.50am by the Deputy Head of Operations. A few staff were absent because they were being interviewed by the police. Staff present spoke about the events of the morning. A number commented on the lack of visibility in the new cells on Narey wing. Staff were reminded about the support mechanisms in place, and all involved when the man was discovered were offered taxis home if they did not wish to drive. (The latter was especially good practice that I draw to the attention of the Prison Service's Safer Custody and Offender Policy Group.)

102. As the time for the general unlock of prisoners was approaching, the deputy head of operations and the wing manager spoke individually to each prisoner on Narey wing to inform them of the man's death. The prisoner who was the man's friend was the first to be told and was very shocked to learn the news. An officer was left with him for support whilst the deputy head of operations and the wing manager continued telling other prisoners.

103. Later in the day, all prisoners on open ACCT documents were interviewed and offered further support. A member of the healthcare team and chaplaincy attended each review. The deputy head of operations conducted a further hot debrief at around 5.45pm to ensure that staff were aware of the events of the day and to identify any concerns.

104. The wing manager informed my investigators that she was approached by a Narey wing prisoner after the man's death. He told her that the man had been in debt to other prisoners on Dixon wing, and they had been sending messages to the man on Narey wing demanding payment. The wing manager passed this information to the prison security department. The wing manager did not know the reason for the debts.

105. The deputy governor arrived at the prison at 8.20am, having already been told of the man's death. He immediately gathered information about the man's next of kin. Together with the Chaplain, he left the prison at 9.30am and drove to London to break the news to the man's family. They arrived at the man's mother's house at 10.30am but got no

response. They decided to go to the man's sister's address, which was only minutes away. The news was broken to the family who were given relevant information about what would happen next. The chaplain also offered to return to see the family at any time to offer support.

106. Throughout my investigation, the chaplain continued to offer support to the family, which included conducting the man's funeral. A memorial service was held within the prison at a later date that was attended by the man's family. The Chaplain also arranged for the man's personal possessions to be returned to the family.

107. From prison records and intelligence, it was found after his death that the man had arranged for three separate payments (totalling £182.90) to go to a woman. The payments were noted on the prison records as going to his sister's new baby, but the man's sister confirmed to my investigators that she had not received any money. The information was subsequently passed to prison security and the police liaison officer who are looking into the matter separately from this investigation.

Post mortem and toxicology report

108. The post mortem and toxicology report confirmed that the cause of the man's death was hanging. The examination also found that the man was not under the influence of any common recreational drugs. However, he had a blood alcohol level of approximately 180 milligrams per 100 millilitres, which is associated with drunkenness in a person with average tolerance to alcohol. The man had also taken amitriptyline and chlorphenamine (an antihistamine).

109. The clinical reviewer has confirmed that the man commenced chlorphenamine in May 2007. Chlorphenamine is antihistamine used for the treatment of allergic reactions such as hay fever, insect bites and food allergies. The man was prescribed this for urticaria (a skin condition) on his arms. He was prescribed 4mg (one tablet) three times a day. He was given seven days supply each week, with the last issue of 21 tablets given on 4 October. The recommended dosage of this medication is 4mg every four to six hours with a maximum of 24mg daily.

110. The port mortem report states that alcohol, amitriptyline and chlorphenamine are all depressant drugs and will have a sedative effect. When present in the bloodstream at the same time, the drugs interact causing an increase in the level of sedation.

The design of the cells in Narey wing

111. My investigator visited Narey wing and confirmed that it was not possible to see within the shower area by looking through the observation panel from outside the cell. A number of staff told my investigators that, prior to the opening of Narey wing, they had raised concerns about the absence of a sight line into the shower. The safer custody manager also

expressed her disquiet with senior management. The concerns were also raised at a security meeting before the wing was opened.

112. The safer custody manager told my investigators that, as a consequence, a protocol was put in place that any prisoners on open ACCT documents would be reassessed to establish whether the new wing would be the appropriate location. The man met this criterion as he was on an open ACCT. However, it was considered a major part of his ACCT careplan to be moved to the new wing as this was expected to reduce his risk of self harm. These cells however are not designated safer cells.

113. My investigators contacted the Prison Service's Safer Custody and Offender Policy Group concerning the design of Narey wing. (The Mount played no part in its design, which was managed by the Prison Service centrally.) The Safer Custody and Offender Policy Group subsequently reported that the design of the wings had now evolved and the metal bar in the shower had been designed out.

114. In respect of the existing accommodation at The Mount, Safer Custody and Offender Policy Group have said that there are resource implications of changing the existing accommodation. It is said not to be possible to change it at the current time.

Additional hot debrief meeting

115. The deputy head of operations held a further staff debrief meeting on 5 November 2007 to allow those who were not present previously the opportunity to raise any concerns. The police liaison officer reported that around four pairs of shoe laces were found in the man's cell. He described this as unusual. No other concerns were raised, but again staff were offered the support of the Care Team.

ISSUES RAISED IN THE INVESTIGATION

Clinical Care

116. The man was in prison continuously between 4 January 2001 and 7 October 2007. He had frequent contact throughout with healthcare professionals both for his physical and mental healthcare needs. In addition, he had contact with CARATs workers at all three prisons where he was held.

117. The clinical review generally endorses the view I have formed that the man was well supported at The Mount by wing and healthcare staff who provided a high standard of care. None of the professionals identified concerns about alcohol or misuse of prescribed medication.

118. The man had a history of self harm including the incident in September 2007 when he cut his wrists. The man attributed this to anxiety, frustration and depression. At no time did the man directly express suicidal thoughts.

119. After the man self harmed, an ACCT document was opened, an ACCT careplan was put in place, and he was monitored accordingly. He continued to receive his weekly repeat prescriptions. Given that one of these medications was for depression, a risk assessment should have been carried out to determine if it was safe for him to hold his own medication in possession.

The Governor and PCT should ensure that prisoners on ACCT are reassessed before they are allowed to retain their own medication.

Induction

120. Induction is fundamental to ensuring that prisoners settle into the prison regime and are made aware of the care and support mechanisms that are in place. The Mount has clear induction procedures. These state that prisoners should spend a suitable amount of time on the induction wing. Unfortunately, this did not apply to the man as he was moved off the induction wing to a normal residential wing within 24 hours of arrival. Although I do not believe this was connected to his death, the Governor will wish to review arrangements to ensure that all prisoners receive an adequate induction.

Why did the man believe that he would serve another three years in prison?

121. In the man's letter to his mother of 1 October 2007, he was despondent about his life in prison and when he would be released. At his parole hearing in May 2007, he was told that his position would next be reviewed in approximately 18 months. There is no evidence to suggest that he had been told a timeframe of three years would apply.

The man's MDT history whilst at The Mount

122. The man was randomly drug tested four times during his time at The Mount. The tests were on 5 October 2005 (reception test), 16 June 2007, 16 July 2007 and 2 October 2007. The only failure was the test on 16 July and the man later admitted that he had taken heroin. His use of heroin corroborates evidence elsewhere in my report that the man was using drugs, although the extent of his use is unknown. Given that he tested negative at an MDT five days before his death, and that no drugs were found in his body at post mortem, it is possible he used drugs as a coping mechanism whilst on Dixon wing. His use of drugs seems to have ceased once he moved to Narey wing, although he had already accumulated debts.

The man's use of alcohol at The Mount

123. Alcohol was one of the factors identified by the court when he was sentenced as contributing to his offending behaviour. But throughout my investigation, there was no evidence to suggest that the man had drunk alcohol or been observed as being under the influence. However, on receipt of the post mortem results that showed alcohol in his bloodstream, my investigators contacted The Mount's security department. They reported that there was no further information or intelligence relating to the man and the brewing or use of alcohol.

124. Although alcohol was not an identified concern during the man's time at The Mount, the fact that he was able to consume a considerable amount of alcohol in the hours before his death raises both safety and security issues. I have recorded elsewhere in this report that the man received an adjudication at Swaleside early in his sentence for fermenting liquids (hooch), so he was obviously familiar with how to make it. But there is no evidence that it was he who brewed the alcohol found in his bloodstream.

125. The manufacture of hooch is an age-old tradition amongst prisoners. However, its potential for encouraging disorder, debt and illness need no elucidation.

The Governor should investigate the extent of alcohol production at The Mount and establish a plan to deal with the findings.

Was the man being bullied?

126. In his final letter to his mother, the man wrote that he had no money and had borrowed things off other prisoners. Peer evidence suggests that he had got into debt to pay for drugs. I think it probable this was one of the reasons the man was so anxious to move from Dixon wing to the new Narey wing. Having said that, he was offered the opportunity to move

temporarily from Dixon wing but declined. Furthermore, he gave no indication to staff that he did not get on with any prisoners on Dixon wing. Nor was there evidence to suggest the man was unhappy after moving to Narey wing.

127. The man made extensive use of his earnings as well as that money sent in by his mother. Prisoners do not handle cash, but whether the man used his canteen purchases as currency is not known. However, it is a possibility that cannot be ruled out. Prisoners frequently swap their personal belongings or use them as barter.

128. The man had frequent interactions with staff. They observed him in both low and high moods. On no occasion did he express concerns to staff about being bullied, but this is not to say that it did not occur. The Mount's own document, Safer Custody Research Findings 2007, suggests that problems relating to drugs or to debt represent by far the most common causes of bullying. It is important that staff try and build an environment where prisoners feel safe and confident to approach staff with any concerns.

The Governor should remind both staff and prisoners about the prison's violence reduction policy.

First Aid

129. Although two of the officers who first arrived at the man's cell had not had first aid refresher training for over four years, this did not affect the initial care that the man received as other staff were present.

130. In respect of the number of staff who are first aid trained, the deputy head of operations has confirmed that a first aid training programme, including refresher training, was in the process of being rolled out at the time of this investigation.

Care and Support

131. My report indicates that staff had built up a fairly good rapport with the man. This was evidenced by the support offered throughout his time in prison, and in particular when he felt anxious whilst undertaking the CALM course and waiting for Narey wing to open. The chaplaincy also played an important role in offering support to the man before his death, and to his family afterwards. The latter was confirmed by the man's mother when my investigators and FLO visited her.

The Governor should commend relevant staff for the care and support they offered to the man throughout his time at The Mount.

132. Senior staff on duty and the Care Team played an active role in addressing staff needs following the man's death. As I have noted earlier, this thoughtfully included arranging transport for staff who were in

shock following the discovery of the man hanging. I commend the prison for the care and support that was offered. This included holding a further debrief meeting.

The Governor should commend senior colleagues and the Care Team for the care and support offered to staff. I was particularly impressed by the kindness shown in arranging transport for those staff most affected.

The design of Narey wing

133. The new Narey wing is a modern design with in-cell shower facilities that are not present in the older wings. I fully acknowledge the importance of privacy, and en-suite shower facilities provide a benefit of particular value for long-term and life sentence prisoners. However, as presently configured, the result is an area of the cell that is partly obscured to staff when looking through the observation panel. Self-evidently, there is a balance to be drawn between privacy and propriety and the needs of security and safety. It is essential that those prisoners allocated to Narey wing are appropriately risk-assessed.

134. In addition, the shower frame in the cells in Narey wing has a metal bar across the top to which the man tied the ligature. The flaw in this design was highlighted by staff before the wing was opened, and measures were put in place to risk assess any prisoner on ACCT who was to be located on the wing.

135. I am aware that the Prison Service's Safer Custody and Offender Policy Group has already taken forward the matter of the cell design, and I am pleased to learn that it will not form any part of future building specifications. I would, however, welcome feedback on what action, if any, can be taken as regard to the current situation at The Mount - in particular, whether the metal bar can be designed to be collapsible. Whilst I am aware of the financial constraints facing the Prison Service, and that most prison cells contain many other potential ligature points, the metal bar across the shower frame is a weakness in the design of Narey wing that should be addressed as a matter of some urgency.

The Governor should ensure the continued risk assessment of prisoners on Narey wing, giving due consideration to the cell design. The Area Manager should review whether the metal bars in the shower frame can be removed or re-designed.

CONCLUSION

134. This investigation has shown that staff offered good support to the man throughout his time at The Mount and tried to manage his anxiety and depression. On the whole, this appears to have worked well.

135. The man's frustrations stemmed from his concerns about how much of his indeterminate sentence he would serve and what seems likely to have been the accumulation of debts for drugs. According to the man's peers, these drug debts resulted in him being bullied, although this was not something he ever brought to the attention of staff.

136. Although the man had a history of self harm, there is no evidence to suggest that he had ever threatened to take his own life. When he did self harm in September 2007, an ACCT document was opened immediately along with a careplan to support him. One of his major hopes was to be located to the new Narey wing, and this was addressed by staff and was soon followed by the closure of the ACCT.

137. The man's alcohol consumption, mixed with his prescribed medication, may possibly have had a negative effect on his mood.

138. I do not think that staff had any reasonable grounds for thinking the man was at particular risk at the time it appears he took his own life. However, the design of the new cells in which the man was located does present a risk both to safety and to security. Resources and other priorities allowing, I hope this can be addressed by the Prison Service.

RECOMMENDATIONS

1. **The Governor and PCT should ensure that prisoners on ACCT are reassessed before they are allowed to retain their own medication.**

2. **The Governor should investigate the extent of alcohol production at The Mount and establish a plan to deal with the findings.**

3. **The Governor should remind both staff and prisoners about the prison's violence reduction policy.**

4. **The Governor should commend relevant staff for the care and support they offered to the man throughout his time at The Mount.**

5. **The Governor should commend senior colleagues and the Care Team for the care and support offered to staff. I was particularly impressed by the kindness shown in arranging transport for those staff most affected.**

6. **The Governor should ensure the continued risk assessment of prisoners on Narey wing, giving due consideration to the cell design. The Area Manager should review whether the metal bars in the shower frame can be removed or re-designed.**