

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Zachary Mockford, a prisoner at HMP Channings Wood, on 27 July 2019

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

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Zachary Mockford was found hanging in his cell at HMP Channings Wood on 24 July 2019. He was resuscitated, but he died in hospital on 27 July, having never regained consciousness. He was 25 years old. I offer my condolences to Mr Mockford's family and friends.

Mr Mockford was monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT) from 28 June until 22 July. Even though he was found hanging two days later, I am satisfied that the decision to stop ACCT monitoring on 22 July was a reasonable one and that there was little indication that Mr Mockford was at risk of suicide at that time.

It is possible that Mr Mockford used psychoactive substances (PS) before he tried to hang himself, but we cannot be sure as no toxicology samples were taken for testing.

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

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**June 2020**

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# Summary

## Events

1. On 30 May 2019, Mr Zachary Mockford was remanded in prison custody, charged with creating indecent images of a child. This was his first time in prison. He was sentenced to nine months in prison on 28 June. He was moved to HMP Channings Wood on 8 July.
2. Mr Mockford was subject to suicide and self-harm prevention procedures (known as ACCT) when he arrived at Channings Wood. (The ACCT procedures were started at his previous prison on 28 June, after Mr Mockford had made some minor scratches to his arm after attending court and being sentenced.)
3. At an ACCT review on 9 July, Mr Mockford spoke about the importance of his relationship with his partner. A mental health nurse at the review made an entry in his medical record that he might be at risk if the relationship ended.
4. On 12 July, Mr Mockford told staff that he had received a letter from his partner ending their relationship. A supervising officer said that he told a mental health nurse about the letter on 15 July, but the mental health nurse said he did not find out about the letter until after Mr Mockford's death.
5. Staff decided to stop the ACCT procedures on 22 July.
6. During a roll check at around 3.00pm on 24 July, an officer found Mr Mockford hanging from a ligature attached to the bed frame. He had a homemade pipe (for smoking drugs) by his side. The officer entered the cell and called a medical emergency code. Officers and nurses responded promptly and began cardiopulmonary resuscitation (CPR).
7. Paramedics arrived at 3.17pm and established a pulse. Mr Mockford was taken to hospital and placed in intensive care. He died in hospital on 27 July.
8. The cause of death was given as hypoxic brain injury caused by hanging. No toxicology tests were carried out, so it is unknown whether Mr Mockford had taken any illicit substances before he was found hanging.

## Findings

9. We consider that the decision to stop ACCT monitoring on 22 July was a reasonable one. It appeared that Mr Mockford had settled in well and that he was coping with the news that his partner had ended their relationship. We consider that there was little indication that Mr Mockford was at risk of suicide at that time.
10. There was a conversation between a supervising officer and a mental health nurse before an ACCT review on 15 July, but neither recorded exactly what was said. We have been unable to establish whether the supervising officer told the nurse about the letter from Mr Mockford's partner. We consider that this was important information about Mr Mockford's level of risk and there should have been a record made if this information was passed to a nurse.

11. Although all the actions on Mr Mockford's ACCT caremap had been completed when staff decided to stop ACCT procedures, the supervising officer did not sign and date the paperwork to confirm this.

## **Recommendations**

- The Governor and Head of Healthcare should ensure that staff record the details of any significant information passed to staff from other disciplines.
- The Governor should ensure that all ACCT documentation is properly completed.

## The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Channings Wood informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
13. The investigator obtained copies of relevant extracts from Mr Mockford's prison and medical records. He interviewed 12 members of staff and two prisoners at Channings Wood between 11 September and 2 October 2019.
14. NHS England commissioned an independent clinical reviewer to review Mr Mockford's clinical care at the prison. They jointly interviewed clinical staff.
15. We informed HM Coroner for Plymouth, Torbay and South Devon of the investigation. The Coroner provided us with the cause of death. We have given the Coroner a copy of this report.
16. We contacted Mr Mockford's next of kin to explain the investigation process and to ask if she had any matters she wanted the investigation to consider. Mr Mockford's next of kin raised a number of matters which, due to a breakdown in communication in our office, were not passed to the investigator and not therefore considered during the original investigation. We apologise unreservedly to Mr Mockford's next of kin for this oversight. The matters raised by Mr Mockford's next of kin were:
  - a. Why did the prison tell her father on 24 July that the situation was not urgent and that did not need to visit his grandson that day?
  - b. Was his mental health properly assessed at Channings Wood?
  - c. Why were ACCT procedures stopped on 22 July?
  - d. For how long was Mr Mockford alone on the afternoon of 24 July?
  - e. How was it possible for him to hang himself?
  - f. Why did certain prison officers keep coming into the intensive care unit at a hospital even after he had been declared brain dead?
17. We have answered the next of kin's questions in separate correspondence to her.

## Background Information

### HMP Channings Wood

18. HMP Channings Wood is a medium secure training and resettlement prison near Newton Abbot, which holds just over 700 men. The residential units are known as living blocks (LBs) and almost 300 men are held on LB1, LB5 and LB7 which hold vulnerable prisoners who might be at risk due to the nature of their offences or for other reasons. Care UK provides healthcare services.

### HM Inspectorate of Prisons

19. The most recent inspection of HMP Channings Wood was in September 2018. Inspectors found that LB1, where Mr Mockford was located, was a squalid environment where prisoners were often subject to theft and intimidation from other prisoners. Inspectors concluded that the mix of sex offenders and mainstream vulnerable prisoners on LB1 failed to safeguard the sex offender population. Inspectors found that the quality of ACCT documents was poor with weak assessments, inconsistent case management, poorly attended reviews and inadequate care plans. Inspectors also saw instances where required ACCT observations had not taken place.

### Independent Monitoring Board

20. 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 31 August 2018, the IMB reported that incidents of both bullying and violence had increased during the year with prisoners reporting regularly that they felt unsafe.

### Previous deaths at HMP Channings Wood

21. Mr Mockford was the seventh prisoner to die at Channings Wood since July 2017. Of the previous deaths, one was self-inflicted, three were from drug overdoses and two were from natural causes. There are no similarities between our findings in the investigation into Mr Mockford's death and our investigation findings in respect of the previous deaths.

### Assessment, Care in Custody and Teamwork

22. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Checks made on prisoners should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key Events

23. On 30 May 2019, Mr Zachary Mockford was remanded in custody, charged with creating indecent images of a child, and sent to HMP High Down. This activated an earlier suspended sentence for similar offences. This was his first time in prison.
24. On 10 June, Mr Mockford was moved to HMP Lewes.
25. On 28 June, Mr Mockford was taken to Southampton Crown Court where he was sentenced to nine months in prison. His conditional release date was 13 October 2019.
26. Mr Mockford was taken from court to HMP Winchester. On his arrival at Winchester, Mr Mockford was found to have harmed himself by making some minor scratches to his left arm while on the transport van. Staff at Winchester started suicide and self-harm prevention procedures (known as ACCT).
27. An officer carried out an ACCT assessment interview with Mr Mockford on 29 June. Mr Mockford said that he had scratched his arm to relieve his stress and although he felt suicidal, he said that he did not want to die. In answer to a question about reasons for living, Mr Mockford said that he had a partner, but had lost contact with his biological family due to being abused as a child.
28. A Supervising Officer (SO) chaired an ACCT review with Mr Mockford that afternoon. The SO noted that Mr Mockford presented and interacted well at the review. Mr Mockford said he was concerned that he currently had no contact with his partner. He said that he did not have her telephone number, but he had written to her. Mr Mockford said that he would harm himself to relieve stress and he had attempted suicide in the past. The SO continued the ACCT monitoring, but he did not complete the paperwork to indicate his assessment of Mr Mockford's level of risk of further acts of self-harm.
29. Mr Mockford was still being monitored under ACCT when he was moved to HMP Channings Wood on 8 July. On his arrival, an entry was made in his medical record that he was receiving a daily dose of 100 milligrams of sertraline, an antidepressant.
30. Mr Mockford was moved to Living Block 1 (LB1 - one of the three living blocks that holds vulnerable prisoners).
31. On 9 July, an SO chaired an ACCT review with Mr Mockford. A nurse was also present. The SO noted that Mr Mockford appeared calm and relaxed. He said that he was not worried about being in Channings Wood, although he was concerned about the distance his partner would have to travel to visit him. Mr Mockford said that his partner had supported him through previous problems including drug misuse and homelessness. He said that his partner was his main reason for not harming himself again. Mr Mockford said that his mother had recently sent him a birthday card and he said that while he had not had much recent contact with her, he wanted to redress this. Mr Mockford said that he was keen to get a prison job and he spoke about his future plans. He said that he did not want to kill himself. The SO assessed Mr Mockford's level of risk as low.

32. The nurse told the investigator that Mr Mockford was very relaxed at the review. She said that she saw he had some superficial self-harm wounds to his arm and another on one of his cheeks. He spoke about having unstable emotions and poor coping strategies and about the importance to him of the support of his partner. He said that he had no other family support. She said that she warned Mr Mockford about the danger of over-reliance on his partner and asked him what would happen if the relationship ended. She said that Mr Mockford was fairly certain that the relationship would survive but she made an entry in his medical record to say that he could be at risk if the relationship ended. She said that Mr Mockford was discussed at a multidisciplinary team meeting several days later where it was decided that the mental health team would not take on his care and he would remain under the care of the primary care team.
33. Mr Mockford's next ACCT review was at 9.00am on 12 July. The review was chaired by a different SO to the one who chaired the review on 9 July and he was accompanied by another SO. The SO told the investigator that he believed he had briefly met Mr Mockford on his first arrival at Channings Wood, although the ACCT review on 12 July was their first proper interaction. The SO said that he contacted the healthcare unit to see if there was a nurse available to attend the review, but the nurses were issuing medication at the time so the review went ahead without healthcare input. The SO noted in his summary of the review that Mr Mockford engaged well, but said he was struggling because he did not have his partner's telephone number so he had still not spoken to her. Mr Mockford also said he was worried that he would be homeless on his release from prison and that he suffered from trauma related to events from his childhood. Mr Mockford spoke about self-harm, which he explained was something he did as a coping mechanism. The SO said that despite Mr Mockford's immediate problems, he seemed quite stable. The SO scheduled Mr Mockford's next ACCT review for 19 July.
34. Following the review, the SO spoke to one of the clerical staff to set up telephone numbers on Mr Mockford's account. The SO also referred Mr Mockford to 'Catch 22' for assistance with accommodation on release and referred him to Cruse for support with his childhood problems.
35. The SO said that he was told on the afternoon of 12 July that Mr Mockford had received a letter from his partner ending their relationship. The SO took Mr Mockford to his office so they could speak in private. The SO said that Mr Mockford was quite tearful and he acknowledged that he would be at more risk of harming himself if he remained in a single cell. The SO moved Mr Mockford into a shared cell and increased his ACCT observations to one an hour pending his next ACCT review. The SO told the investigator that it would not be possible to arrange a multidisciplinary review over the weekend but he arranged an ACCT review for Monday 15 July. He told Mr Mockford to call into his office in the meantime whenever he wished to.
36. The same SO who chaired the ACCT review on 12 July also chaired the review on 15 July, and he was again accompanied by another SO. The SO noted that he received an oral contribution from a nurse (a mental health nurse). The SO said that Mr Mockford had settled well over the weekend and he reported having received good support from his cellmate. Mr Mockford asked if he could be re-

triaged by the mental health team and the SO spoke to the nurse about that. The nurse said that Mr Mockford had been diagnosed with emotionally unstable personality disorder (EUPD) and was receiving medication, but he was unsure if he was going to be kept on the mental health team caseload. The SO said that he sent a referral for Mr Mockford to be re-triaged and he printed off a leaflet about EUPD which he gave to Mr Mockford.

37. The SO assessed Mr Mockford's risk as lowered and reduced his ACCT observations to three at night and two in the day (together with one meaningful interaction during the day). The SO told the investigator that he told the nurse about the letter Mr Mockford had received from his partner. (The SO did not record that he told the nurse of this.)
38. The nurse told the investigator that he never met Mr Mockford and explained that when asked to provide an oral contribution to an ACCT review, the practice was to check the prisoner's healthcare triage assessment and to check the outcome of the multidisciplinary team meeting review deciding on the prisoner's ongoing care. He said that in Mr Mockford's case, he would have advised the SO that Mr Mockford had not been taken on by the mental health team. The nurse said that the SO did not tell him that Mr Mockford had received a letter from his partner ending their relationship and it was only after Mr Mockford's death that he learned of the letter.
39. On 19 July, Mr Mockford asked to move to a new cell. He said that his cellmate snored at night which was keeping him awake and had also found out about his offence. Mr Mockford was moved to a different cell with a new cellmate.
40. The cellmate told the investigator that Mr Mockford had had a panic attack on the first evening that they shared a cell but he had soon calmed down so there had been no need to call a nurse. After this, Mr Mockford had seemed happy. He spoke about his partner ending their relationship but he believed they would get back together after he had completed his sentence. He said that he believed Mr Mockford had possibly bought some codeine illicitly from another prisoner and he was under pressure to repay the debt.
41. An officer told the investigator that he worked as an induction officer on LB1 so he knew Mr Mockford from the time of his first arrival at Channings Wood. The officer spoke about an entry in Mr Mockford's ACCT on 21 July when they had a lengthy conversation about Mr Mockford's concerns about the support he might have on leaving prison, including the possibility that he might not have very much money. Mr Mockford also spoke about being happy with his new cellmate.
42. The officer told the investigator that on 22 July, Mr Mockford asked him for a movement slip to attend a Lesbian, Gay, Bisexual and Transgender (LGBT) event that was taking place on 26 July and he said that he identified as being bisexual. The officer said that there was a prisoner who worked as a safer custody representative, and who was openly gay, so he asked him to speak to Mr Mockford.
43. The prisoner told the investigator that he spoke to Mr Mockford on 22 July when the officer told him that Mr Mockford was possibly worried that he was trying too hard to fit in with the rest of the prisoner population. He asked Mr Mockford

whether he had any difficulties and said that he would be able to advise him about any support services that might be available. Mr Mockford said that he was struggling with the breakdown of the relationship with his partner as well as other difficulties in his life. Mr Mockford also said that he was bisexual and they spoke about the LGBT event on 26 July which they were both going to attend. They also discovered that they were each attending a Catch 22 meeting, also arranged for 26 July. He said that although Mr Mockford questioned what he had to look forward to after prison, he also spoke about plans he had to take an Open University degree and to pursue a career in psychology. He said that they spoke for around 40 minutes and after their meeting the prisoner told the officer that Mr Mockford appeared positive about his future.

44. The same SO who chaired the ACCT reviews on 12 and 15 July said that he was on duty during the weekend of 20 and 21 July and he spoke to Mr Mockford many times in those days. Mr Mockford was associating with other prisoners and he said that he felt very settled on LB1 where he had a good group of friends. He asked if he could remain on LB1 throughout his time in Channings Wood, but the SO explained that he was on the waiting list to move to LB5, which was for enhanced prisoners (prisoners who worked and who were well behaved). The SO told the investigator that Mr Mockford was very focused on the future. Mr Mockford asked for the ACCT procedures to be stopped but the SO told him that it was not possible to arrange a multidisciplinary review at a weekend, so the review would have to wait until the Monday.
45. Mr Mockford's next ACCT review was held on the afternoon of Monday 22 July, as scheduled. The same SO chaired the review and Mr Mockford and a second SO also attended. The nurse provided an oral contribution. The SO said that Mr Mockford was very positive. He noted that Mr Mockford had applied for a job and was hoping to hear that week where he would be working. Mr Mockford said that he had no thoughts of suicide or self-harm. The SO noted that everyone agreed that ACCT procedures should be stopped. The SO said that at the end of the review, Mr Mockford shook his hand and thanked him for the support he had received from all the staff. (Although all three actions on Mr Mockford's ACCT support plan (caremap) had been completed, the SO did not confirm this on the form.)
46. Mr Mockford applied for a job in the prison's wood mill on 22 July. He was sent a response on 24 July telling him that he would start work on Monday 29 July.

### Events of 24 July

47. Mr Mockford's cellmate said that after lunch on 24 July he left the cell at 2.00pm to go back to work and that Mr Mockford seemed well.
48. An officer said that he began a roll check (count of prisoners) just before 3.00pm. When he looked into Mr Mockford's cell, he saw him slumped on the floor with what appeared to be a homemade pipe to his side. The officer said that it appeared that Mr Mockford was under the influence of 'Spice' (a type of psychoactive substance – PS).
49. The officer went into the cell and then saw that Mr Mockford was suspended from a ligature that was tied to the upper handrail of the bunk bed. Mr

Mockford's legs were on the floor but the ligature was bearing most of his weight. The officer cut the ligature close to where it had been tied to the bed and then cut the remnants of the ligature from Mr Mockford's neck. The officer said that he radioed a medical emergency code blue (used to indicate a prisoner is unconscious or having breathing difficulties) but he did not hear the alarm being sounded so he repeated the call.

50. The officer said that a second officer was further down the landing so he called to him for assistance. The second officer did not immediately respond to his call so he called to him again. The officer said that they pulled Mr Mockford onto the landing where there was more room and after checking whether he was breathing, they began efforts to resuscitate him. He said that he and the second officer took turns in giving chest compressions.
51. The investigator viewed the CCTV footage which shows the officer entering Mr Mockford's cell at 2.58pm before stepping out of the cell 14 seconds later and shouting for help. He then went back into the cell before stepping out again 12 seconds later to shout again for help. The second officer came to the cell at 2.59pm.
52. The second officer told the investigator that when he heard the first officer calling his name, he was unsure what was happening, but he stepped out of the wing office and when he heard the first officer calling his name a second time he could see from the officer's face that something serious had happened. The second officer said that when he saw Mr Mockford he noted that the ligature had made a deep indentation to his neck and he appeared lifeless. The second officer said that after they had moved Mr Mockford to the landing and checked if he was breathing, they tried to resuscitate him. An SO also helped.
53. A paramedic employed at Channings Wood responded to the code blue alarm and arrived at the cell at around 3.02pm. He told the investigator that the three officers were carrying out chest compressions to an excellent standard so he told them to continue while he inserted an airway tube to help supply oxygen. He inserted a cannula and gave adrenalin to try to restart Mr Mockford's heart. He also checked Mr Mockford with a defibrillator, which advised that no shock could be given and that chest compressions should be continued.
54. Ambulance paramedics were called when the code blue call was made and they arrived at Mr Mockford's cell at 3.17pm. The paramedics assisted with the efforts to resuscitate Mr Mockford and a pulse was established. Mr Mockford was taken to hospital at around 4.00pm and was placed in intensive care. He remained in intensive care until he died on the afternoon of 27 July.

### **Contact with Mr Mockford's family**

55. The Governor telephoned Mr Mockford's mother at 4.30pm to inform her that her son was seriously ill in hospital. Mr Mockford's mother did not understand from the call that the situation was so serious that she needed to attend immediately. She said that her father also spoke to the Governor and he also understood that an urgent visit was unnecessary. Mr Mockford's mother said that the family planned to visit on 25 July and at 2.00am that day she received a telephone call from the hospital to say that it was urgent that the family should visit. The family

travelled to the hospital and Mr Mockford's mother was in the hospital when he died.

56. Channings Wood contributed to the cost of Mr Mockford's funeral in line with national instructions.

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

57. A functional head at Channings Wood, debriefed the staff who were involved in the response when Mr Mockford was found. The staff care team also offered support.
58. The prison posted notices informing other prisoners of Mr Mockford's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Mockford's death.

### **Cause of death**

59. Mr Mockford's cause of death was given as hypoxic brain injury following asphyxiation from hanging. As he died in hospital and his cause of death was known, no post-mortem examination was conducted, and there were no toxicological tests for the presence of drugs or other substances.

# Findings

## Assessment of Mr Mockford's risk of suicide and self-harm

60. ACCT procedures were started for Mr Mockford on 28 June, after he cut his arm while being transferred from court to Winchester. The ACCT was still open when Mr Mockford was moved to Channings Wood on 8 July. Mr Mockford's first ACCT review at Channings Wood was chaired by an SO who only met him once, but all three of his further reviews were chaired by the same SO: this included the review on 15 July that was brought forward after Mr Mockford's partner ended their relationship.
61. The SO wrote detailed records of the ACCT reviews and it is clear that he established a good relationship with Mr Mockford. Mr Mockford asked the SO over the weekend of 20 and 21 July for the ACCT procedures to be stopped but The SO told him that a multidisciplinary review would have to be held before any decision was taken. The SO chaired a multidisciplinary review on 22 July when staff decided to stop ACCT procedures.
62. Although Mr Mockford was initially upset when his partner ended their relationship, he appeared to have come to terms with the news quite quickly and in fact seemed hopeful that he could resurrect the relationship after completing his sentence. Mr Mockford settled quickly at Channings Wood and he spent most of his time out of his cell engaging with other prisoners. Based upon a balanced assessment of Mr Mockford's apparent risk factors, we consider that the decision to stop ACCT procedures on 22 July was reasonable.

## *Communication between teams*

63. The SO telephoned a nurse before the ACCT review on 15 July for his oral contribution. The SO told the investigator that he told the nurse about the letter that Mr Mockford received from his partner. However, the nurse told the investigator that the SO did not tell him about the letter. Neither the SO nor the nurse recorded any detail of their conversation. Given the absence of any recording, we cannot say whether or not the letter was discussed. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff record the details of any significant information passed to staff from other disciplines.**

## *Management of ACCT procedures*

64. ACCT procedures should not be stopped until all actions in the caremap support plan have been actioned. Mr Mockford had three actions in his caremap and all had been completed by 22 July, however the SO did not sign and date the paperwork to confirm this. We make the following recommendation:

**The Governor should ensure that all ACCT documentation is properly completed.**

## Mr Mockford's possible use of illicit substances

65. When an officer found Mr Mockford hanging, he initially thought he might be under the influence of an illicit substance, such as 'Spice' (a psychoactive substance), as he saw what appeared to be a homemade pipe on the cell floor. It is possible that Mr Mockford might have been under the influence of an illicit substance when he tied the ligature, but no blood samples were taken for testing so we do not know whether he had any illicit substances in his system when he was found hanging.
66. Mr Mockford was not known to the substance misuse team as he was never seen to be under the influence of any substances while in custody, nor did he seek help for any substance misuse problems. We are unable to say whether Mr Mockford used any illicit substances that day.
67. Mr Mockford's cellmate told the investigator that he thought Mr Mockford had bought codeine from another prisoner and was under pressure to repay the debt. We found no evidence that Mr Mockford was in debt to other prisoners or that he was being bullied.

## Clinical care

68. The clinical reviewer found that Mr Mockford received comprehensive reception and secondary health screening in the three prisons he attended and was appropriately referred to mental health services. The clinical reviewer found that Mr Mockford was promptly and comprehensively reviewed by the mental health teams and was discharged from their care as he was not found to have significant mental health needs.
69. The clinical reviewer noted that no concerns were identified in either Mr Mockford's physical or mental health and his overall conclusion was that Mr Mockford received a good standard of care that was equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.

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