Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kristopher Tilbury, a prisoner at HMP The Mount, on 24 September 2019

A report by the Prisons and Probation Ombudsman

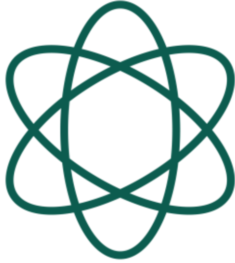
Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T I 020 7633 4100

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

OGL

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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 Kristopher Tilbury died at HMP The Mount on 24 September 2019, of a fatal tachyarrhythmia (a fast heart rate) due to the combined use of synthetic cannabinoid (PS), quetiapine (which he was not prescribed) and alcohol. He was 29 years old. We offer our condolences to Mr Tilbury's family and friends.

There is no evidence that Mr Tilbury intended to take his life at the time of his death. He was fully aware of the risks of using illicit substances and was given support to stop but continued to use them. His death appears to have been the accidental result.

It is extremely troubling that Mr Tilbury was able to access and use illicit substances, including PS, with apparent ease at The Mount, particularly as he lived on a wing for prisoners with substance misuse issues. HM Inspectorate of Prisons and the Independent Monitoring Board have also expressed concern about the availability of illicit drugs at The Mount.

We are concerned about the number of deaths this office investigates in which PS has played a part and about the availability of PS across the prison estate. The Prison Service issued a Prison Drugs Strategy in April 2019 to provide guidance to prison governors on how to tackle the issue. The Mount will need to ensure that local initiatives are developed and implemented to reduce the availability of drugs implemented to.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **July 2020**

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Summary

Events

1. On 31 October 2018, Mr Kristopher Tilbury was remanded to HMP Woodhill. It was not his first time in prison. He had a history of substance misuse (alcohol and drugs – cocaine, cannabis and psychoactive substances (PS)) and had harmed himself once in January 2018. On 23 November, Mr Tilbury was sentenced to eight years in prison.

2. On 10 December, Mr Tilbury was transferred to HMP The Mount, after completing an alcohol detoxification programme at Woodhill. As Mr Tilbury settled into life at The Mount, he admitted to staff that he was using PS and wanted support. He was moved to a wing for prisoners with substance misuse issues.

3. In February 2019, Mr Tilbury was discharged from the substance misuse programme because of his poor attendance and behaviour. The substance misuse team continued to support him, but he continued to use PS even though he said that he was focused on his rehabilitation.

4. At 6.05am on 24 September, a night support officer, who was conducting the roll check, found Mr Tilbury sitting upright on his bed. When the officer could not get a response from Mr Tilbury, he asked the manager in charge of the prison for help. Within two minutes, two prison officers entered Mr Tilbury's cell and found that he was cold and stiff and showed no signs of life. The night support officer informed the control room, and the control room called an ambulance promptly. Staff tried unsuccessfully to resuscitate Mr Tilbury. Paramedics arrived at 6.35am and assessed him but at 6.40.am, they recorded that Mr Tilbury had died.

5. A post-mortem report established that Mr Tilbury died of a fatal tachyarrhythmia due to combined use of PS, quetiapine and alcohol.

Findings

Psychoactive substances, drug and alcohol misuse

6. When Mr Tilbury arrived at The Mount, staff appropriately assessed that he was not at immediate risk of suicide and self-harm. Mr Tilbury appeared to be progressing well at The Mount but, despite a substance misuse strategy in place and support from prison staff who warned him of the dangers of taking PS, he continued to use illicit substances.

7. We are concerned that he was able to obtain illicit drugs with apparent ease at The Mount.

Clinical care

8. The clinical reviewer found that the care that Mr Tilbury received at The Mount was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor should ensure that the key drug issues at The Mount are identified, and that the prison’s local drugs strategy is appropriately revised to address them.
- The Governor should ensure that all staff report and record all instances of prisoners who are found under the influence of illicit substances and refer them promptly to the security team and appropriate prison support services.
- The Governor should ensure that the technical issues with the CCTV are resolved as a matter of priority.

The Investigation Process

9. The investigator issued notices to staff and prisoners at The Mount, informing them of the investigation and asking anyone with relevant information to contact him. No prisoners responded.

10. The investigator visited The Mount on 26 September 2019 and obtained copies of relevant extracts from Mr Tilbury's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Tilbury's clinical care at the prison.

12. The investigator interviewed six members of staff at The Mount in October and November 2019.

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

14. The Ombudsman's family liaison officer contacted Mr Tilbury's family to explain the investigation. Mr Tilbury's mother said that the family had a history of heart complaints and wanted to know if this was related to her son's death. She said that she had spoken to Mr Tilbury on his illicit mobile phone in the afternoon the day before he was found dead in his cell. She had told him the good news that she had been awarded custody of one of his children. She said Mr Tilbury sounded drunk and said he intended to use his phone to "ring around" his friends. Mr Tilbury's mother believed that he made his last phone call at around 2.00am to his ex-partner.

15. Mr Tilbury's mother received a copy of the draft report. She pointed out some factual inaccuracies. This report has been amended accordingly. Mr Tilbury's mother also raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP The Mount

16. HMP The Mount is a medium security prison holding approximately 1,000 men. Hertfordshire Community NHS Trust provides primary healthcare services and GP services. There are daily GP sessions from Monday to Friday, with out of hours provision at other times. No healthcare staff are on duty between 6.30pm and 8.00am. Mr Tilbury lived on the Wellbeing Wing, which aims to help prisoners who need continued support. It also houses the drugs programmes run by Forward Trust.

HM Inspectorate of Prisons

17. The most recent inspection of The Mount was in May 2018. Inspectors reported that levels of violence were comparatively high and mostly related to drugs and debt. They found that less than half of required intelligence-led searches were completed, and most suspicion drug tests were missed. They reported that mandatory drug testing indicated that nearly a third of prisoners were using illicit drugs, and that this undermined the prison's ability to remain safe. Security was generally proportionate, but drugs supply reduction work was weak and not embedded in a wider drug strategy. In their survey, half the prisoners said it was easy to access illicit drugs. The proportion of positive mandatory drug tests, including for PS, was high at 32%.

Independent Monitoring Board

18. 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 most recently published report for the year to February 2019, the IMB noted that drugs were widely available in the prison. They reported that the healthcare team had had another challenging year with the use of PS. They noted that the newly opened Wellbeing Wing which aimed to help prisoners on substance misuse programmes to end their addiction had had teething issues but was achieving some positive results.

Previous deaths at HMP The Mount

19. Mr Tilbury's death was the first drug-related death at The Mount since June 2017. One other prisoner took his own life between June 2017 and September 2019 when Mr Tilbury died. There were no similarities between our findings in our investigation of Mr Tilbury's death and the other investigation. Since Mr Tilbury's death, a prisoner has died from natural causes.

Key Events

20. Mr Kristopher Tilbury had a history of alcohol and substance misuse. On 31 October 2018, Mr Tilbury was remanded to HMP Woodhill, charged with aggravated bodily harm and theft. It was not his first time in prison. He had last been released from custody in August 2018.

21. Mr Tilbury's person escort record (PER) noted that he was dependent on drugs and alcohol. It noted no concerns about his risk of self-harm.

22. During his initial health screen, Mr Tilbury told staff that he was scheduled to return to court for sentencing on 23 November and was detoxing from alcohol and cocaine. Mr Tilbury said that he had harmed himself in 2018 because he had had difficulties getting contact with his children but said that he had no current thoughts of self-harm although this could change if he was sentenced. Staff noted that he was fit to share a cell and noted that harassment protection procedures were in place to prevent him contacting an ex-partner.

23. A nurse completed Mr Tilbury's initial health screen. Mr Tilbury admitted that he heavily used cocaine and drank alcohol daily and explained about the events that led him to self-harm in 2018. He reiterated that he had no current thoughts of suicide or self-harm. The nurse noted that Mr Tilbury engaged well, and he referred him to complete a standard alcohol detoxification programme.

24. On 1 November, a nurse from the mental health team saw Mr Tilbury. She reminded him of the support services available to him and he said that he had no thoughts of suicide or self-harm.

25. Afterwards, a prison GP, who specialised in substance misuse issues, saw Mr Tilbury. He noted that Mr Tilbury would be prescribed alcohol detoxification medication and referred him for psychosocial support and intervention to address his cannabis and cocaine misuse.

26. On 23 November, Mr Tilbury attended court by video-link. He was sentenced to eight years in prison. Afterwards, a nurse completed a welfare check for Mr Tilbury. He told the nurse that he had expected a six-year sentence so was disappointed. However, he said he was okay and that he intended to appeal. He said that he had no thoughts of suicide or self-harm and talked about being around for his children in the future. Mr Tilbury asked for some medication to help him sleep and the nurse prescribed him zopiclone for a couple of nights.

27. In the days that followed, staff reported that Mr Tilbury was positive, a hard worker and showed a good attitude towards helping them with jobs on the wing.

HMP The Mount

28. On 10 December, Mr Tilbury was transferred to HMP The Mount. Mr Tilbury told reception staff that he had no thoughts of suicide or self-harm.

29. A nurse completed his initial health screen. Mr Tilbury confirmed that he had a history of substance misuse, had recently completed an alcohol detoxification

programme and was not taking any medication. He said that he had a family history of stroke.

30. Mr Tilbury lived on B Wing, the induction unit, before being moved to a standard residential unit on 12 December.

31. On 18 December, a nurse from the mental health team reviewed Mr Tilbury's medical record and noted that no concerns had been raised about his mental health and therefore he did not need support from mental health team.

32. An officer had a conversation with Mr Tilbury on 30 December and discussed his sentence progression plan. He noted that Mr Tilbury was polite and engaged throughout their meeting. Mr Tilbury was open about his use of PS in prison and his concern about not being able to stop. He asked if he could be referred to Forward Trust for substance misuse support and if he could be moved to the Wellbeing Wing which aimed to support prisoners with substance misuse issues.

33. On 31 December, Mr Tilbury was moved to the Wellbeing Wing.

34. On 3 January 2019, an officer completed a key worker interview with Mr Tilbury, who was positive about his rehabilitation goals and had already completed a number of education classes. He said that he had not used PS since moving to the Wellbeing Wing and hoped to start a drugs rehabilitation course shortly.

35. On 11 January, a member of the Forward Trust completed a drugs assessment with Mr Tilbury which indicated that he had a severe dependency on illicit substances. She referred Mr Tilbury to complete a Substance Dependence Treatment Programme (SDTP), a three phase 16 to 21-week abstinence-based programme.

36. Mr Tilbury started the SDTP on 21 January. By the end of January, staff reported that Mr Tilbury was not committed to his drug-free rehabilitation because he had failed to attend a number of groups sessions and had not completed all the required self-directed work. This was despite staff giving Mr Tilbury warnings about the consequences of non-attendance.

37. On 15 February, staff issued Mr Tilbury with a prison warning after they had found a mobile phone and charger in his cell. Mr Tilbury attended a disciplinary hearing and was found guilty. His Incentive and Earned Privileges (IEP) level was downgraded from standard to basic for a period of 14 days (until 1 March). He was discharged from the SDTP programme because of this behaviour and his poor attendance on the course. Staff told Mr Tilbury that he could reapply for the course again in three months' time.

38. On 13 March, an officer completed a key worker interview with Mr Tilbury. Mr Tilbury said he was not happy that he had been discharged from the SDTP course and intended to reapply as soon as possible.

39. The member of the Forward Trust noted that when she tried to see Mr Tilbury on 19 March to complete a key work session, he appeared under the influence of an illicit substance. No further information was noted.

40. On 27 March and 11 April, an officer completed key worker sessions with Mr Tilbury, who said that he needed to keep himself busy and to refrain from using illicit

drugs. He hoped to return to education classes and complete the SDTP as soon as possible.

41. Mr Tilbury referred himself to the Prison Advice & Care Trust charity (PACT, which helps prisoners maintain and rebuild their family relationships while they are in custody). Mr Tilbury said that he wanted to have contact with his children.

42. On 3 April, a Family Engagement Manager for PACT spoke to Mr Tilbury. She had looked into Mr Tilbury's family issues and had spoken to Social Services, who said that he was not allowed to see his children. She delivered this disappointing news to Mr Tilbury and noted that he appeared to take the news reasonably well and thanked her for helping him.

43. That day, the member of the Forward Trust tried to conduct a key worker session with Mr Tilbury but noted that he appeared under the influence of an illicit substance. Mr Tilbury denied taking PS but later told her that he had been using PS regularly, as well as mirtazapine (an antidepressant which had not been prescribed to him) at night to help him sleep. The Family Engagement Manager agreed to discuss with colleagues whether to refer Mr Tilbury for one-to-one relapse support.

44. On 19 April, staff recorded in prison records that Mr Tilbury had a "black eye" and submitted a security intelligence report. Mr Tilbury refused to explain how this had happened and said he had fallen over. Staff offered to take him to be examined by healthcare staff, but he refused.

45. On 23 April, an officer saw Mr Tilbury for a key worker session. Mr Tilbury said that he had been attending education classes and was enjoying it. He said he was determined to change his ways and had stopped using illicit drugs.

46. On 2 May, staff reported that Mr Tilbury was seen under the influence of PS. No further information was recorded.

47. On 13 May, Mr Tilbury saw the member of the Forward Trust at a mental healthcare awareness event and told her that he had not used PS for 18 days.

48. On 29 May and 17 June, staff submitted a security intelligence report raising concerns that Mr Tilbury may have a mobile phone. No other information was recorded.

49. During June, staff recorded a number of positive comments about Mr Tilbury in his prison records. They noted that he was engaging with education classes, was doing very well and regularly assisted staff with jobs on the wings. Staff acknowledged that Mr Tilbury had one negative entry recorded about him but were willing to give him a chance and in recognition, upgraded his IEP level to enhanced on 20 June.

50. An officer saw Mr Tilbury on 22 June for a key worker session. Mr Tilbury said that he remained focused on completing his rehabilitation and abstaining from drugs and wanted to gain his educational qualifications.

51. On 24 June, Mr Tilbury moved to another cell on the Wellbeing Wing.

52. The member of the Forward Trust completed a key worker session with Mr Tilbury on 11 July. They discussed Mr Tilbury's recovery from substance misuse and agreed to review his recovery plan the following week.

53. On 26 July, Mr Tilbury failed to attend an Improving Access to Psychological Therapies (IAPT) session designed to help and improve prisoner's mental health. Mr Tilbury did however attend a session on 6 August when a worker who was providing clinical support noted in Mr Tilbury's medical record that he was appropriate, polite, bright and his mental state appeared settled. Mr Tilbury denied current thoughts of suicide or self-harm, denied using illicit substances and said he had never previously had any therapy or counselling. Mr Tilbury said that he was pleased with the progress he had made in prison, had no problems with any other prisoners and just wanted to change his life for the better.

54. On 6 August, the member of the Forward Trust saw Mr Tilbury, who said that he continued to abstain from PS and intended to apply for an Open University course.

55. An officer sent a note to Mr Tilbury on 11 August to introduce himself as his new prison offender supervisor (POM). He suggested a number of courses that Mr Tilbury should consider working towards as part of his sentence plan.

56. An officer recorded that Mr Tilbury had reported several times that his television wires were exposed, and he wanted this fixed. (Prisoners may expose wires on electrical items to obtain a light to smoke PS.) The officer noted that the prison had issues with replacing televisions.

57. A member of the Forward Trust saw Mr Tilbury on 21 August for a family work assessment. She noted that Mr Tilbury had written to his ex-partner in the hope of initiating contact with his children. He said that his eldest son was under the care of social services. She promised to contact the social service worker about him.

58. On 29 August, staff submitted a security intelligence report noting that suspicions had been raised that Mr Tilbury was a drugs runner on the wing. No other information was recorded.

59. On 1 September, an officer recorded that Mr Tilbury was a servery worker, that he also had helped staff with chores on the wing, and he spoke positively about his goals and focusing on his children after he was released from prison.

60. On 7 September, the POM met Mr Tilbury who asked him about his sentence plan. He advised Mr Tilbury that he was doing all the right things and had been working with staff to the best of his ability. He referred Mr Tilbury to be assessed for a course on building better relationships.

61. The Family Engagement Manager saw Mr Tilbury on 18 September. Mr Tilbury told her that his mother had a pending court case to decide on the guardianship of his son. He said that it was possible that his son would be able to live with his (Mr Tilbury's) mother. Mr Tilbury asked her if she would keep in touch with Social Services and update him on the progress of the court case. She noted that Mr Tilbury was in good spirits, and she promised to update him when she had any information.

23 September

62. An officer reported that Mr Tilbury had once again shown positive behaviour on the wing and had worked exceptionally well on the servery that evening.

63. Mr Tilbury's mother told us that she spoke to her son that afternoon on his illicit mobile phone. She passed on some good news to him about the custody of his child. Mr Tilbury was apparently happy about the news that he had received.

64. At 8.10pm, an Operational Support Grade (OSG) arrived for duty and received a handover from the day duty staff. At around 8.30pm, he completed a roll check of the wing, but he said he had no concerns when he checked on Mr Tilbury by looking through his cell door observation panel.

24 September

65. At around 6.00am, the OSG started his roll check of the wing. He told us that when he checked Mr Tilbury's cell, his observation panel was blocked. Mr Tilbury failed to respond when he called to him and banged on his door. He left Mr Tilbury's cell to complete his roll check. He returned after approximately four minutes and again was unable to get a response from Mr Tilbury. He opened the cell door inundation point and saw Mr Tilbury sitting on his bed. Mr Tilbury looked as if he was asleep, with his head tilted downwards, tucked into his chest, and his legs hanging off the side of the bed. The OSG told us that he thought that Mr Tilbury might have been ignoring him. He therefore went to the wing office and phoned the control room.

66. A Custodial Manager (CM) was in charge of the prison that night. He told us that he received a phone call from the OSG to say that something was not right with a prisoner on the Wellbeing Wing, and he asked for staff assistance. He sent his two assistants to investigate.

67. Two officers arrived on the Wellbeing Wing around two minutes later. The OSG was in the wing office and explained the situation to the officers. All three officers went to the cell and tried to get a response from Mr Tilbury, but he did not respond. The officers unlocked the cell door and went in.

68. One officer told us that Mr Tilbury was sitting at a right angle on his bed, wearing a tracksuit bottom but no top. Mr Tilbury showed no signs of life, was very cold and stiff and appeared to have bruising on the skin of his feet, legs and body. There were drugs paraphernalia on a storage unit opposite Mr Tilbury's bed, next to his television. Mr Tilbury had a small mobile phone in his left hand.

69. The OSG shook Mr Tilbury and checked him for signs of life, but found no pulse, noticed he was cold to touch, his skin was mottled, and his fist was clenched. He immediately returned to the wing office and phoned the CM and told him that there had been a "death in custody". The CM immediately told the control room officer to call an ambulance and made his way to the Wellbeing Wing. Ambulance records recorded that the emergency call was received at 6.11am.

70. When the CM arrived at Mr Tilbury's cell, the officers were all standing outside on the landing. He went into Mr Tilbury's cell, checked him for any signs of life but found none. He instructed the officers who had attended the wing to assist, to start

cardiopulmonary resuscitation. One officer said that Mr Tilbury was ice cold. The CM said that he believed that Mr Tilbury had been dead for some time.

71. The officers rotated chest compressions until the ambulance arrived at the cell at around 6.35am. The paramedics examined Mr Tilbury and pronounced him dead at 6.40am.

Other information

72. The drugs paraphernalia found in Mr Tilbury's cell consisted of a milk carton, with a corner cut off and with two small holes in the bottom around which there appeared to be ash. It is thought that this was used to smoke illicit drugs. Above the milk carton, there were two wires hanging out of the live electricity socket in the cell, with one wire dipped in a small plastic container which contained a green liquid thought to be shampoo. Staff told us prisoners heat shampoo and inhale the fumes, a practice known as "shamboiling" or "bubbling". (Ammonium laureth sulfate, an active ingredient in most shampoos, can cause mild hallucinations and euphoria when it reaches boiling point.)

Contact with Mr Tilbury's family

73. A member of the chaplaincy team and an officer were appointed as the prison's family liaison officers (FLOs). At 10.15am, they visited Mr Tilbury's mother, who was his next of kin, to break the news of her son's death. However, no one was home. They tried unsuccessfully to contact Mr Tilbury's mother by phone. Both FLOs returned to visit Mr Tilbury's mother later that day at 6.20pm. They broke the news to Mr Tilbury's mother and other family members who were present. The Mount contributed to the costs of Mr Tilbury's funeral in line with national instructions.

Information received after Mr Tilbury's death

74. Security intelligence submitted after Mr Tilbury's death suggested that after Mr Tilbury had spoken to his mother on his illicit mobile phone, and she told him about the good news that she had custody of his children, he started to celebrate. It was suggested that Mr Tilbury had been drinking and using cocaine and had used an illicit mobile phone to phone other prisoners on the wing. He had also allegedly phoned another prisoner four hours before his death and asked him 'to get the Screws im dying [sic]'. The Intelligence suggested that an officer was asked to check on Mr Tilbury but that this never happened.

75. The police investigating officer informed us that he was unable to download call data from the illicit mobile phone found in Mr Tilbury's cell, and so no phone call information was available.

76. Security intelligence also suggested that Mr Tilbury was heavily involved in the drugs trade on the wing. Security had followed up on this and completed a number of target searches on a number of prisoner cells, but nothing was found. Intelligence reports also suggested that prisoners were now using "D9 Cleaner" agent as an illicit substance – by spraying it on paper and burning and inhaling the fumes. As a precaution, staff have since removed D9 from wings.

Support for prisoners and staff

77. A prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.

78. The Governor issued notices to staff and prisoners informing them of Mr Tilbury's death. Staff reviewed prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Tilbury's death.

Post-mortem report

79. A post-mortem examination and toxicology tests established that Mr Tilbury died of a fatal tachyarrhythmia (a fast heart rate) due to the combined use of synthetic cannabinoids (PS), quetiapine (an antipsychotic drug which had not been prescribed to him) and alcohol.

Findings

Substance misuse

80. The post-mortem report established that Mr Tilbury's death was due to the combined use of PS, quetiapine and alcohol. He had not been prescribed quetiapine and therefore had obtained it illicitly.

81. Mr Tilbury had consistently engaged with the substance misuse team and told staff that he had stopped using illicit substances. He lived on the Wellbeing Wing to support his abstention from illicit drugs. He was last seen under the influence of drugs on 2 May 2019 and since then had told staff that he was not using drugs.

82. We cannot say whether he was in fact continuing to use drugs regularly after 2 May, but it is clear that he used drugs and alcohol immediately before his death. There is nothing to suggest that he wanted to take his life or harm himself and it appears that his death was the accidental result of substance misuse.

83. We are satisfied that Mr Tilbury was aware of the potentially fatal risks of continuing to misuse drugs and that he was given support to stop. We consider that staff could not reasonably have foreseen or prevented Mr Tilbury's death on 24 September.

Responding to incidents of substance misuse

84. On three occasions (19 March, 3 April and 2 May), staff recorded that Mr Tilbury appeared to be under the influence of an illicit substance. On one of these occasions, Mr Tilbury admitted that he had used PS and mirtazapine (an antidepressant which he had not been prescribed). While Mr Tilbury was under the care of the substance misuse team, they did not refer his illicit use of a prescribed medication to the healthcare team, prison staff or the security team. This was a significant missed opportunity to review Mr Tilbury's overall behaviour and consider what additional support or security measures could be put in place to monitor him. We make the following recommendation:

    The Governor should ensure that all staff report and record all instances of prisoners who are found under the influence of illicit substances and refer them promptly to the security team and appropriate prison support services.

85. After Mr Tilbury's death, intelligence was submitted which alleged that Mr Tilbury had phoned another prisoner four hours before his death and asked for help. We were unable to confirm this, however, as no prisoners came forward to be interviewed as part of our investigation. The cell bell system on the unit was of an old design and the prison could not retrieve any information from the system. There is also no CCTV footage available due to a technical issue on the system. In the absence of further evidence, we are unable to say whether or not Mr Tilbury or any other prisoners pressed their cell bells that night or whether staff were informed that he was in distress.

86. We are concerned that the CCTV footage is not available. We make the following recommendation:

The Governor should ensure that the technical issues with the CCTV are resolved as a matter of priority.

Clinical care

87. The clinical reviewer noted that, overall, the health care that Mr Tilbury received was equivalent to that which he could have expected to receive in the community. He initially engaged in substance misuse work and was involved with his care planning, treatment goals and recovery plan. Even after he was discharged from the SDTP programme in February 2019, for not attending sessions and failing to complete course work, substance misuse staff continued to support him.

Drug strategy at HMP The Mount

88. The prison has a substance misuse strategy which sets out a number of actions to reduce the demand for and supply of illicit drugs. Despite this, Mr Tilbury was able to obtain illicit substances with apparent ease. We note that both HMIP and the IMB have expressed concern about the ready availability of drugs at The Mount. We conclude that much more needs to be done to tackle the issue of illicit substances at the prison.

89. Drug taking and trading is a serious problem across much of the prison estate and The Mount is not alone in facing this problem. In April 2019, HMPPS published a National Drug Strategy setting out their plans to reduce substance misuse by sharing best practice and providing direction and detailed guidance for prisons. In relation to reducing the supply of drugs, the new Prison Service strategy says:

"Every prison is different and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

90. We make the following recommendation:

The Governor should ensure that the key drug issues at The Mount are identified, and that the prison's local drugs strategy is appropriately revised to address them.

Inquest

91. The inquest into Mr Tilbury's death was held in August 2023. The conclusion was that his death was a consequence of smoking synthetic cannabinoids and consuming alcohol whilst detained in prison, to which the availability of alcohol and illicit drugs within the Wellbeing Wing contributed.

Prisons & Probation
Ombudsman
Independent Investigations

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

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

T I 020 7633 4100