

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Moss a prisoner at HMP Featherstone on 18 February 2017

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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.

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

Mr Christopher Moss barricaded himself in his cell at HMP Featherstone on 18 February 2017. Staff found him unresponsive in a pool of blood when they entered his cell and, despite attempts to resuscitate him, Mr Moss was pronounced dead by paramedics. The post-mortem found that Mr Moss died from drug poisoning and that blood loss from a self-inflicted wound may have been contributory. He was 51 years old. I offer my condolences to Mr Moss' family and friends.

It has been difficult for us to form a view on exactly what led to Mr Moss' death and whether or not he intended to take his own life. While the post-mortem found that Mr Moss died from drug poisoning, there is insufficient evidence to say whether he took an intentional overdose. Our investigation identified a number of factors that may have contributed to Mr Moss' death, including his prescribed medication, his mental health and threats of violence made against him. However, we have been unable to establish the extent to which these factors played a part in his death.

Mr Moss was a trusted prisoner who worked regularly in the prison's Visits Centre. Security staff became aware that Mr Moss was being pressured by other prisoners to bring drugs into the prison. We are concerned that staff did not adequately support Mr Moss as soon as they became aware that he was being threatened, nor did they record this information appropriately.

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
Acting Prisons and Probation Ombudsman

November 2017

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Summary

Events

1. On 16 May 2014, Mr Christopher Moss was remanded to prison for conspiracy to supply class A drugs. He was sentenced to 90 months imprisonment on 6 March 2015. On 14 April 2015, Mr Moss was transferred from HMP Birmingham to HMP Featherstone. The reception officer noted that he had a history of heroin misuse and he declared a disability due to back pain. There were no concerns about suicide or self-harm.
2. On 17 August, Mr Moss saw a doctor because he was having trouble sleeping. The doctor prescribed 25mg amitriptyline (an antidepressant that can also be used to treat chronic back pain). A few days later, on 21 August, Mr Moss was seen by a mental health nurse after he reported struggling with anxiety and low mood. The nurse increased his dose of amitriptyline to 75mg and made a review appointment for the mental health team to consider ongoing support. This appointment was cancelled in error and never took place.
3. On 8 February 2016, a doctor increased Mr Moss' daily dose of amitriptyline to 100mg after he complained of worsening back pain. On 1 November, a different doctor increased the daily dose again to 125mg.
4. Mr Moss started working at the Visits Centre in October 2016, but he was temporarily suspended between 18 December 2016 and 7 January 2017 after staff suspected that he was being pressured to bring drugs into the prison. A security investigation took place and Mr Moss returned to the Visits Centre on 8 January. No one recorded the alleged threats or details of the investigation.
5. On 24 January, Mr Moss reported to staff at the Visits Centre that he had found some drugs in the Visits Centre toilets. Security staff questioned Mr Moss but he said he did not know anything about the drugs. He was again temporarily suspended from his job, returning to work on 5 February. On 13 February, he was suspended again after security information came to light that he was still being pressured to bring drugs into the prison.
6. On 16 February, Mr Moss reported to prison staff that he was being threatened by another prisoner. He asked to be moved to the segregation unit. Staff suggested he stay where he was and they would monitor him more closely, or he could move to another house unit. He said he did not want to move. The prisoner suspected of threatening Mr Moss was moved to another house unit the following day.
7. On 17 February, Mr Moss named another prisoner who he said was threatening him because he was no longer working in the Visits Centre. Staff again offered him a move to another house unit but he declined.
8. On 18 February, Mr Moss asked a prison officer to escort him back to his cell after he had collected his medication as he was in fear for his safety. Mr Moss told staff, including the duty governor, that he was being pressured into bringing drugs into the prison when he was working in the Visits Centre. The duty governor said that Mr Moss was worried that he might be being paranoid as he

said he thought someone had spiked his cigarette with “Spice” (a new psychoactive substance). Mr Moss did not want to move to another house unit, so he stayed in his cell.

9. At around 4.00pm, Mr Moss pressed his cell bell. Staff attended and saw that Mr Moss had a small cut to his head but he did not say how he had received the cut. An officer told Mr Moss that he would get healthcare staff to see him. While waiting for healthcare to arrive, Mr Moss barricaded the cell door with his furniture. Staff managed to gain access and found Mr Moss unresponsive, lying on the floor in a large pool of blood. Staff and paramedics tried to resuscitate Mr Moss but they were unable to do so and he was pronounced dead at approximately 4.57pm.

Findings

10. The post-mortem found that Mr Moss died from amitriptyline and dihydrocodeine poisoning, both of which had been prescribed to him on a daily basis. The clinical reviewer was satisfied that Mr Moss’ medication dosages were not inappropriate and healthcare staff had no concerns about Mr Moss’ compliance with taking his medication daily. Therefore, while we accept that there were high levels of prescription medication found in Mr Moss’ body, we have been unable to establish whether he took an intentional overdose of his medication and, if so, how he achieved this. The post-mortem also found that blood loss from a self-inflicted cut at the back of Mr Moss’ leg may have been a contributory factor in his death. We are satisfied that Mr Moss cut himself, which caused significant blood loss. However, we have been unable to form a view on exactly what led to Mr Moss’ death and whether or not he intended to take his own life.
11. We found that Mr Moss was not adequately supported by the prison when staff suspected that he was being pressured by other prisoners to bring drugs in via the Visits Centre. Staff failed to record and investigate the suspected threats being made to Mr Moss. Once Mr Moss told staff about the threats, staff did offer him support and moved the alleged perpetrator from the unit. However, no one acted in line with the prison’s Violence Reduction Strategy to ensure that Mr Moss’ allegations were formally recorded and investigated within 72 hours.
12. We are concerned that Mr Moss was never seen by the mental health team, in spite of being referred by a nurse in August 2015 after she prescribed medication (amitriptyline) for anxiety. It appears the follow up appointment was cancelled in error and Mr Moss was discharged without ever having been seen. Although two separate doctors increased the amitriptyline dosage on two further occasions (albeit for pain relief), no one assessed Mr Moss’ mental health or picked up that his earlier referral to the mental health team had not been actioned. We accept that Mr Moss’ anxiety symptoms were low level and he never indicated he was at risk of suicide and self-harm. Nevertheless, we do have concerns that the mental health referral was never followed up and that no one asked Mr Moss about his emotional wellbeing before increasing his medication.
13. We found that there was a short delay in staff entering Mr Moss’ cell after he barricaded the door with his furniture because the wrong type of anti-barricade equipment was initially used. While this delay is unlikely to have affected the outcome for Mr Moss, any delay could be critical in future cases.

Recommendations

- The Governor should ensure that allegations of violence, bullying, or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected.
- The Governor and Head of Healthcare should ensure that there is a robust system in place for reviewing appointments and medication before prisoners are discharged from the mental health team.
- The Governor should ensure that staff are fully aware of the procedures for dealing with barricade incidents, that these procedures are appropriate for the design of the unit, and that the correct anti-barricade equipment is readily available.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Featherstone informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
15. The investigator obtained copies of relevant extracts from Mr Moss' prison and medical records.
16. NHS England commissioned a clinical reviewer to review Mr Moss' clinical care at the prison.
17. The investigator interviewed nine members of staff at HMP Featherstone. The clinical reviewer separately interviewed two members of healthcare staff by telephone. The interviews took place between March and August 2017.
18. We informed HM Coroner for South Staffordshire District of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.
19. One of the Ombudsman's family liaison officers contacted Mr Moss' daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Moss' daughter said she wanted to meet with the investigator, along with other members of her family. The investigator and family liaison officer visited Mr Moss' daughter at home in May 2017, where they also met with her mother and Mr Moss' brother. The family had a number of concerns and queries, including:
 - whether the prison had investigated any threats made towards Mr Moss;
 - details of the reasons for removing Mr Moss from his job in the Visits Centre in the weeks before his death; and
 - concerns about the support offered to them after Mr Moss' death, including issues arising from their visit to see his cell and contact with the Governor.
20. Mr Moss' family received a copy of the initial report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Featherstone

21. HMP Featherstone is a medium security, Category C, prison holding nearly 703 convicted men. Healthcare services are provided by Care UK.

HM Inspectorate of Prisons

22. The most recent inspection of Featherstone was in November 2016. Inspectors reported “a shocking worsening of standards” since the last inspection in 2013 and, in particular, a sharp decline in safety, which they assessed as poor. They noted that levels of violence and intimidation were very high. This was linked to drugs and debt and too little was being done to reduce drug supply. Inspectors found no evidence of a violence reduction action plan and said there were too many prisoners self-isolating due to fear. The inspectors noted that, unusually, staff and prisoners spoke openly about what they perceived to be a lack of leadership and direction within the prison.

Independent Monitoring Board

23. 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 October 2016, the IMB was concerned about the extent of the availability of illegal substances and, in particular, a worrying increase in the use of more traditional hard drugs as well as new psychoactive substances (NPS). They noted the effect of these substances on prisoners’ behaviour and health, and that debt and consequent bullying were ongoing issues. They were concerned about the level of violence and the resulting damage to both persons and property.

Previous deaths at HMP Featherstone

24. Mr Moss’ death was the fourth self-inflicted death at Featherstone since April 2014. In a previous investigation into the death of a man in 2015, we found that Featherstone did not investigate fully or adequately address violence and substance misuse issues.

New Psychoactive Substances (NPS)

25. New psychoactive substances, previously known as ‘legal highs’ are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
26. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of

the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

Key Events

27. On 6 March 2015, Mr Christopher Moss was sentenced to 90 months imprisonment for conspiracy to supply class A drugs and remanded to HMP Birmingham. Mr Moss had been remanded to prison for these offences since 16 May 2014 and he had also been in prison for similar offences in the past.
28. On 14 April, Mr Moss was transferred from Birmingham to HMP Featherstone. The reception officer noted that he had a history of heroin misuse and he declared a disability due to back pain. He was seen by a nurse and a doctor as part of the reception process. The doctor prescribed dihydrocodeine pain relief for his back. There were no concerns about suicide or self-harm.
29. On 5 June, Mr Moss was temporarily transferred back to Birmingham. There were no concerns recorded during his time at Birmingham and he was returned to Featherstone on 10 June.
30. Mr Moss' prison record shows that he was unable to work due to his back pain and spent most of his time in his cell. There are limited entries on his prison record other than to say that he was a polite and quiet man who conformed to the regime.
31. On 17 August, Mr Moss was assessed by a prison GP after he said he was having trouble sleeping and this was making him irritable. The GP prescribed 25mg amitriptyline (an antidepressant that can also be used to treat the symptoms of chronic back pain), which Mr Moss said he had used in the community. He noted on Mr Moss' records that there were no other signs of depression.
32. On 21 August, a mental health nurse assessed Mr Moss after he said he was struggling with anxiety and low mood. She recorded that there were no concerns about self-harm. Mr Moss' assessment score fell below the threshold for referral to the mental health team but she felt that the team could offer him support to help him sleep and reduce his anxiety so she booked a further review appointment for him. She also increased his dose of amitriptyline to 75mg as she was aware that this medication could also help his back pain. She noted that Mr Moss would be taken onto the mental health team's caseload and she prepared a care plan that included monitoring the effects of his medication over the next few months. However, Mr Moss was never seen by the mental health team again and she discharged him from her caseload on 14 February 2016 on the basis that he was "self-managing". She told the clinical reviewer that Mr Moss should have had a follow up appointment during the second week of September, but it appeared that the appointment was accidentally deleted.
33. On 8 February 2016, Mr Moss saw the prison GP again as his back pain had worsened. The GP increased his dose of amitriptyline to 100mg. There is no evidence that he assessed Mr Moss' mental health or the effects of his medication at this appointment.
34. On 14 October, Mr Moss started work in the prison Visits Centre. The Centre manager described Mr Moss as a quiet man who was very pleasant and

- hardworking. She had no concerns about him in the time that he worked at the Centre.
35. On 1 November, Mr Moss saw a prison GP about his back pain. The GP had previously treated Mr Moss and was aware of his medical history. Mr Moss told him that his back pain was getting worse, so he increased his amitriptyline to 125mg daily and advised Mr Moss that this could be increased to 150mg if necessary. He did not assess Mr Moss' mental health at this appointment.
 36. Mr Moss was temporarily suspended from his job at the Visits Centre between 18 December 2016 and 7 January 2017 because security staff suspected that he was being pressured by other prisoners to bring drugs into the prison. The Head of Safer Custody told the investigator that Mr Moss was interviewed by the Head of Security and another member of the security team. She said that Mr Moss admitted that he was being asked to bring unauthorised items into the prison but he did not say what the items were. She said that, following a security investigation, Mr Moss returned to the Visits Centre on 8 January on the understanding that he would tell staff if he was being pressured to bring anything into the prison. She told the investigator that she was aware of the security investigation at the time but had not realised that details of the investigation and the alleged threats against Mr Moss had not been documented.
 37. On 24 January, Mr Moss reported to the Centre Manager that he had found some packages under a toilet brush in the Visits Centre. She said that she did not know what the packages contained, but suspected they were drugs. She said that Mr Moss was very upset and quite shaken, saying that he did not want to get into trouble as it was nothing to do with him. She alerted security staff and they took the packages away. Mr Moss was interviewed by a security manager and a supervising officer on house unit 6. The security manager told the investigator that both he and the supervising officer knew Mr Moss from previous sentences and they believed him to be a trustworthy and compliant prisoner. They spoke to him informally about the drugs he had found and he denied any involvement, saying that he was not under threat from anyone to bring drugs into the prison. He said he believed Mr Moss and he recorded their discussion in his prison record and in a security intelligence report. He said that the Head of Security made the decision to temporarily suspend Mr Moss from working at the Visits Centre as a security measure to safeguard him from any threats or intimidation.
 38. Mr Moss returned to work at the Visits Centre on 5 February. However, on 13 February, he was suspended again. The Centre Manager said that she arrived at work on 14 February to hear that Mr Moss had been collected from the Visits Centre by two members of staff the previous day. She did not know what had happened or why he was no longer able to work there, but she did not see him again after that. No one recorded this information but the Head of Safer Custody told the investigator that this was because security information had come to light that Mr Moss was still being pressured to bring drugs into the prison.
 39. On 16 February, Mr Moss spoke to two officers and said that he was being threatened. He was not specific about the nature of the threats or the perpetrator. He asked for a move to the segregation unit but one officer told him it would be

safer for him to remain on the house unit and assured him that staff would monitor him. He told Mr Moss to speak to staff if he had any further concerns and he recorded this in the wing observation book. Mr Moss later told an officer the name of the prisoner who he said had been putting pressure on him to retrieve packages from the Visits Centre when he was working there. The officer offered to move Mr Moss to a different house unit but he said that would make things worse and he preferred to stay where he was if he could not go to the segregation unit. The officer updated the wing observation book, made a note in his prison record and also submitted a security intelligence report naming the alleged perpetrator.

40. On 17 February, the prisoner that Mr Moss alleged was threatening him was moved from house unit 6. Later that afternoon, Mr Moss told an officer that another prisoner was threatening him. The officer told the investigator that he made checks with security to see if there was any link between the two prisoners that Mr Moss said were threatening him, but he was told there was no link. He recorded the conversation in the wing observation book and submitted a further security intelligence report. He said he had no proof that Mr Moss was being threatened by the prisoner. He said that he expected a Violence Reduction representative would come to speak to Mr Moss to get more information about the threats, but he did not think this would happen for a few days as it was the start of the weekend. Other than recording this information, he did not put anything specific in place to support Mr Moss before he went off shift that day.
41. At around 9.10am on 18 February, Mr Moss went to collect his medication from house block 7 but he asked an officer to escort him back to house block 6 as he said he was in fear for his safety. The officer took Mr Moss back to house block 6 and explained to staff what had happened. The duty governor spoke to Mr Moss along with a custodial manager. The custodial manager told the investigator that Mr Moss did not mention the names of any prisoners who were threatening him. He said that Mr Moss was worried that he might be being paranoid as he said he thought someone had spiked his cigarette with "Spice" (a new psychoactive substance). Mr Moss was again offered a move to another house unit, but he said he did not want to move and he returned to his cell. An officer recorded this interaction in the wing observation book but he did not mention the possible use of Spice. He checked on Mr Moss at 12.20pm as he had not collected his lunch. Mr Moss said he did not want any lunch but said he was fine.
42. At around 4pm, Mr Moss rang his cell bell and an officer went to his cell. He opened the door and saw Mr Moss sitting on his bed pointing to his forehead where there was a small cut with blood trickling down his face. He said that Mr Moss did not say anything to him but he assumed that Mr Moss had made the cut himself. He told Mr Moss that he would get someone from healthcare to look at the cut and he left his cell. He went to tell a colleague, who then went to check on Mr Moss. The colleague said that Mr Moss did not tell him what had happened so he thought he might want to speak to someone from healthcare. He left the cell and radioed for healthcare staff to attend. He did not call an emergency code at that point as he did not think it was an emergency that required staff to attend, only a member of healthcare staff.

43. Staff went back to check on Mr Moss a few minutes later at around 4.07pm to find that he had barricaded the door with his furniture and he was not responding when they called to him. A nurse arrived at the cell around 4.12pm to find staff pushing the cell door. He was able to look through a gap in the door and saw a large pool of blood on the floor so he realised it was an emergency and told officers to radio a code red (an emergency code which tells the control room to call an ambulance as a prisoner is bleeding). The ambulance log shows that an ambulance was called at 4.13pm. Staff attempted to get into the cell using a hydraulic door jack at around 4.19pm, but this equipment was unsuitable for the type of door on house unit 6. Staff eventually gained access to the cell at approximately 4.22pm by using a Hooley bar (a type of crowbar) to force the door open. Staff brought Mr Moss onto the corridor and started cardiopulmonary resuscitation (CPR).
44. The nurse told the investigator there was a large pool of blood in the cell but they could not see where this blood was coming from as Mr Moss had only two small cuts – one on his head and one on his wrist. Paramedics arrived at the cell at 4.28pm and continued with attempts to save Mr Moss' life but they were unable to resuscitate him and he was pronounced dead at 4.57pm. The nurse said that it was only after Mr Moss had died that those involved in the emergency response noticed the blood was coming from a cut at the back of his leg.

Contact with Mr Moss' family

45. On 18 February at 8.00pm, the deputy governor and a prison chaplain visited Mr Moss' mother at her home to tell her about her son's death. Mr Moss' brother was also present at the time. The prison contributed to the cost of Mr Moss' funeral, in line with national instructions.
46. The prison appointed a Family Liaison Officer (FLO), who initially offered support and provided information to the family. She went on annual leave on 26 February and handed over the case to the deputy FLO. On her return from annual leave, she was told that the family wished to retain the deputy FLO as their liaison officer, so she had no further contact with the family in this role.
47. A date was arranged for the family to visit Mr Moss' cell and collect his belongings but this was rearranged at the family's request. The Governor was away on annual leave on the rearranged date and he was therefore unable to meet the family.
48. Mr Moss' family expressed concern that they did not feel adequately supported by the prison and this resulted in a degree of tension between the prison and the family, especially Mr Moss' daughter. The Governor wrote to Mr Moss' daughter inviting her to come to the prison to discuss her concerns, but she did not reply.

Support for prisoners and staff

49. After Mr Moss' death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

50. The Governor posted notices informing other prisoners of Mr Moss' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Moss' death.

Post-mortem and toxicology reports

51. A post-mortem examination established the cause of Mr Moss' death as dihydrocodeine and amitriptyline poisoning. The toxicologist informed the investigator that it was possible that the level of dihydrocodeine found in Mr Moss' blood could have been achieved through his normal prescribed dosage, but that the level of amitriptyline was considerably higher than that which could have been achieved through his normal dosage. There was no trace of new psychoactive substances.
52. In his initial report, the pathologist made no mention of the cut to the back of Mr Moss' leg or to his significant blood loss (although he did mention the wounds to Mr Moss' head and wrist, which he found likely to be self-inflicted on the basis that there was no evidence of assault or restraint by a third party). After the investigator sought clarification, the pathologist provided an amended post-mortem report, stating that blood loss from the leg wound, which in spite of being a very subtle wound would have resulted in profuse bleeding, may have been a contributory factor. Subsequently, the pathologist confirmed that the leg wound was likely to have been self-inflicted.

Findings

Circumstances of Mr Moss' death

53. The post-mortem report found that Mr Moss had died from amitriptyline and dihydrocodeine poisoning.
54. Mr Moss had been prescribed dihydrocodeine for back pain and amitriptyline initially for insomnia and irritability, but later for back pain. The clinical reviewer noted that the dosages of both drugs were at the limit of prescribing guidelines, and that the two drugs should be used together with caution, but that he could not say that the dosages were inappropriate. He said that there was no suggestion in the months before his death that Mr Moss had suffered any contraindications as a result of his medication.
55. The toxicologist told us that the level of dihydrocodeine found in Mr Moss' blood could have been achieved through his normal prescribed dosage, but that the level of amitriptyline was considerably higher than that which could have been achieved through his normal dosage. This suggests that Mr Moss had taken an excess of amitriptyline and possibly also of dihydrocodeine, either by secreting and hoarding some of his prescribed medication, or by obtaining the drugs illicitly in the prison.
56. Although Mr Moss was prescribed both drugs, he did not have them in his possession and had to attend the medication hatch on a daily basis to receive them. The Head of Healthcare told the investigator that Mr Moss would have been required to take his medication, with a glass of water, in the presence of a nurse. The clinical reviewer advised that the amitriptyline was administered in syrup form so would have been impossible to secrete. The Head of Healthcare said that the reason these drugs are administered on a daily basis, rather than being in prisoners' possession, is that they can be misused and sold to other prisoners and there is also a risk of overdose. She said there were no reported concerns that Mr Moss was not taking his medication as prescribed. We found no evidence that Mr Moss had been secreting and hoarding his medication, although it remains a possibility that he did so.
57. Mr Moss could have obtained the drugs illicitly in the prison. However, we have seen no evidence to suggest that he was securing other prisoners' prescribed medication.
58. Taken in the round, there is insufficient evidence for us to reach a conclusion as to whether Mr Moss took a fatal overdose or, if he did so, whether accidentally or with the deliberate intention of taking his life.
59. There is evidence that Mr Moss was in an emotionally aroused state on the day of his death. He said he was being threatened and that he was in fear for his safety, although he also said he was not sure if his fears were real or the result of paranoia. He also barricaded himself in his cell and cut himself which indicates a distressed state. It is possible that that this behaviour was a response to being

bullied and threatened by other prisoners, but it is also possible that Mr Moss was suffering a breakdown in his mental health.

60. We found no evidence that Mr Moss had used any illicit substances during his time at Featherstone beyond the concern he expressed that he may have unwittingly smoked a cigarette 'spiked' with Spice. Mandatory drug test results on his prison record were negative. The toxicology report showed no traces of new psychoactive substances
61. The cut to Mr Moss' leg was almost certainly self-inflicted and caused significant blood loss and this, together with the barricading, could suggest that he intended to take his life. However, if Mr Moss was distressed or mentally unwell he may not have appreciated that he was putting himself at risk by cutting and barricading, and the pathologist described the cut to Mr Moss' leg as "very subtle" which may suggest that Mr Moss did not intend to cause himself significant harm.
62. Having assessed CCTV footage, the post-mortem report, and staff statements, we found no evidence of assault or third party involvement in Mr Moss' death. Mr Moss reported fears for his safety on the morning of his death so he remained in his cell from approximately 9.30am. Two officers both went to Mr Moss' cell on separate occasions after he pressed his cell bell at around 4pm. They both saw that he had a small cut to his head but saw no sign of life-threatening injuries or significant blood loss. CCTV showed that no one else went into Mr Moss' cell. Additionally, the police had no suspicions about assault or third party involvement in Mr Moss' death. The pathologist found that wounds on Mr Moss' head, wrist and to the back of his leg were all likely to have been self-inflicted.
63. In summary, Mr Moss died from amitriptyline and dihydrocodeine poisoning, both of which he was prescribed at dosages that were not inappropriate. Although the post-mortem indicated that an overdose was the likely cause of death, there is insufficient evidence to show where or how Mr Moss obtained the means to overdose, or whether he overdosed accidentally or with the intention of taking his life.

Investigating and recording threats of violence

64. Featherstone's Violence Reduction Strategy requires that any allegation of violence, bullying or intimidation should be investigated within 72 hours. The Head of Safer Custody said that a support document should be opened as soon as an allegation is made, but our investigation found that staff failed to do this on at least five occasions in Mr Moss' case.
65. We found evidence that security information regarding threats against Mr Moss came to light in December 2016. This resulted in him being removed from his job at the Visits Centre, apparently to safeguard him from further threats, but this information was not recorded anywhere. Consequently, staff on the house unit were not aware that Mr Moss was being threatened and there was nothing in place to support him. Similarly, when Mr Moss was removed from the Visits Centre on 13 February, security staff believed that he was being threatened but

this information was not recorded anywhere or shared with staff on the house unit.

66. We found that no one opened the required support document when Mr Moss told staff on the house unit on 16, 17 and 18 February that he was being threatened. We are satisfied that steps were taken to remove the alleged perpetrator from the house unit and that the allegations were appropriately documented, but we are concerned that the prison's own policy was not followed. We therefore make the following recommendation:

The Governor should ensure that allegations of violence, bullying, or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected.

Assessing and monitoring Mr Moss' mental health needs and risk of self-harm

67. When Mr Moss reported low mood and anxiety in August 2015, a nurse was sufficiently concerned to increase his antidepressant medication and to offer him further support from the mental health team, even though he did not strictly meet the criteria. We are concerned that the follow up appointment was cancelled in error and that Mr Moss was discharged from her caseload in February 2016 without ever having been seen again. She discharged Mr Moss on the basis that he was "self-managing", in spite of no one from the mental health team having seen him after August 2015 when the initial referral was made by her.
68. Amitriptyline is primarily an antidepressant but can also be used for pain relief. In Mr Moss' case, it was initially prescribed at a low dose for insomnia and, when the nurse increased the dosage, she recorded in a care plan that its use as an antidepressant should be monitored. There were further significant increases in the dosage of amitriptyline as pain relief for Mr Moss' back pain but its use as an antidepressant was never reviewed or monitored.
69. We accept that Mr Moss' discharge from the mental health team was more than a year before his death and that he was displaying low levels of anxiety at that time. However, we are concerned that, in spite of a nurse setting up a care plan and making a mental health review appointment for him, this appointment was accidentally deleted and his mental health was never assessed again. We are further concerned that there were significant increases in his medication which, although primarily prescribed for back pain, had initially been prescribed as an antidepressant. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that there is a robust system in place for reviewing appointments and medication before prisoners are discharged from the mental health team.

Response to the barricade incident

70. We found that there was a delay in staff entering Mr Moss' cell after he barricaded the door with his furniture because the wrong type of anti-barricade equipment was initially used. The standard equipment (a hydraulic door jack) was unsuitable due to the design and material of the cell doors on house unit 6. Staff eventually gained entry using a Hooley bar (a heavy-duty crowbar) but this

resulted in a delay of around three minutes. We cannot say if this delay would have altered the outcome for Mr Moss but any delay in an emergency situation can be critical. We therefore make the following recommendation:

The Governor should ensure that staff are fully aware of the procedures for dealing with barricade incidents, that these procedures are appropriate for the design of the unit, and that the correct anti-barricade equipment is readily available.

Family liaison and support

71. Mr Moss' family were unhappy with the way they felt they were treated by the prison. This included the prison's contact with the next of kin, the change of Family Liaison Officer, and the fact that the Governor was not present when they visited Mr Moss' cell. This resulted in a degree of tension when the family tried to communicate their concerns to the prison but we found evidence that the prison tried to defuse the situation and to offer appropriate support. The Governor sent letters to each individual family member expressing his condolences and a memorial service was held at the prison. He also wrote to Mr Moss' daughter inviting her to come to talk to him about her concerns, but she did not reply. It is unfortunate that difficulties arose in the relationship between the family and the prison and that the family did not feel supported at such a difficult time. However, our investigation found that, overall, the prison tried to accommodate the wishes of the family as far as their protocol and operational factors allowed. We therefore consider that the prison's liaison and support for the family was adequate and we make no recommendation on this point.

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