	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Governor, HMP The Mount, Molyneaux Avenue, Bovingdon, Hemel Hempstead, Hertfordshire** 2. **The Secretary of State for Justice, Ministry of Justice, 102 Petty France, Westminster, London**
1	**CORONER** I am JONATHAN STEVENS, Assistant Coroner, for the coroner area of Hertfordshire
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 24th September 2019 Senior Coroner Geoffrey Sullivan commenced an investigation into the death of KRISTOPHER COREY JAMIE LEE TILBURY [age 29]. The investigation concluded at the end of a jury inquest on 31st August 2023. The conclusion of the jury at the inquest was that death was a consequence of smoking [redacted] and consuming alcohol whilst detained in prison, to which the availability of alcohol and illicit drugs within the Wellbeing Wing contributed.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of death recorded by the jury at the inquest were that Kristopher Corey Jamie Lee Tilbury died of respiratory depression as a consequence of smoking [redacted] and consuming alcohol whilst detained in his prison cell at HMP The Mount between the evening of 23rd September/early morning of 24th September. He was found with a mobile phone in his hand and drug paraphernalia nearby in his cell with the smell of [redacted] in the air. The jury also recorded that despite Mr Tilbury's known drug and alcohol issues and residing on the prison's additionally supported Wellbeing Wing, drug paraphernalia was found in his cell including [redacted] and evidence of 'shamboiling'.
5	**<u>CORONER'S CONCERNS</u>** Mr Tilbury was serving an 8 year prison sentence. At the inquest evidence was heard from his Probation Officer/Prison Offender Manager that Mr Tilbury recognised and accepted that his drug and alcohol issues had been the trigger to his offending and that he was keen to get support to help him address these issues so that he could rebuild his life upon release. He was placed on the 'Wellbeing Wing' so he could have better support for his issues. During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. –

(1) In May 2018 (16 months *before* Mr Tilbury's death) HMP the Mount was subject to an inspection by HM Inspectorate for Prisons. The Inspectors found 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 drugs 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. The inspectors found that drug supply reduction work was weak and not embedded in the wider strategy, and that half of the prisoners said it was easy to access illicit drugs. The proportion of positive mandatory drug tests, including for psychoactive substances ([redacted]), was high at 32%.

(2) In the report of the Independent Monitoring Board for the year to February 2019 it was noted that drugs were widely available in the prison.

(3) Mr Tilbury died on 24th September 2019 and was found dead in his cell. The medical cause of his death was established by the pathologist at the inquest as respiratory depression caused by the combined use synthetic cannabinoids and alcohol.

(4) The Prisons and Probation Ombudsman carried out an independent investigation into the death of Mr Tilbury on 24th September 2019 at the Mount. The report was produced, as a result of this investigation, in March 2020. The report concluded that it was extremely troubling that Mr Tilbury was able to access and use illicit substances, including Psychoactive Substances, with apparent ease at The Mount, particularly as he lived on a wing for prisoners with substance misuse issues. The report concluded that much more needed to be done to tackle the issue of illicit substances at the prison, and the Governor should ensure that key drug issues at the Mount are identified and that the prison's local drug strategy be appropriately revised to address them

(5) Since the death of Mr Tilbury, and the Prisons and Probation Ombudsman's, report four other prisoners have died at HMP The Mount as a result of taking [redacted], namely:

a. Prisoner X [redacted] – died on 14th July 2022
b. Prisoner Y [redacted] – died on 25th July 2022
c. Prisoner Z [redacted] – died on 6th January 2023
d. Prisoner W [redacted] – died on 26th January 2023

(6) At the inquest the court heard evidence from prison officers that they encountered 'spice' every day in the prison and the problem of drugs in the prison in seems to be the same as it was in 2019.

(7) At the inquest the Head of Safety at HMP The Mount advised the court that the percentage of positive Mandatory Drug Tests in 2023 (at the date of the inquest) was 26.21% (compared to 32% in 2018).

[redacted]The Head of Safety advised that drugs are brought into HMP The Mount by a number of ways [redacted]

(9) Four years after the death of Mr Tilbury, drugs and alcohol are still widely available in HMP The Mount, and continue to create a significant risk of future

	deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 3rd November 2023. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: (i) [redacted] (Mr Tilbury's mother) (ii) The Prison & Probation Ombudsman (iii) The Forward Trust (iv) Practice Plus Group I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**8th September 2023** **SIGNED**