Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Abbott a prisoner at HMP Long Lartin on 11 December 2016

A report by the Prisons and Probation Ombudsman
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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*

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 Abbott was found dead in his cell at HMP Long Lartin on 11 December 2016. While he took an overdose of naproxen, Mr Abbott died after inhaling his stomach contents into his lungs. He was 57 years old. I offer my condolences to his family and friends.

Staff identified a number of factors which increased Mr Abbott's risk of suicide when he was first remanded to prison and they managed him appropriately for a number of months. At the time of his death, it was reasonable that staff were no longer managing him under suicide and self harm prevention procedures and it would have been difficult to have identified that he was at imminent risk.

We are, though, concerned that the officer who unlocked Mr Abbott's cell on the morning he died did not check on his wellbeing. While we cannot know whether or not this delay affected the outcome for Mr Abbott, it is critical that prison staff understand what they are required to do during the unlock process, as early intervention might save lives. We are also concerned that nursing staff inappropriately tried to resuscitate Mr Abbott when there were clear signs he was dead.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **October 2017**

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Summary

Events

1. In December 2015, Mr Abbott was remanded to HMP Hewell, charged with murdering his wife. Prison staff immediately began suicide and self-harm prevention procedures, known as ACCT, because of the nature of his offence and low mood. In March 2016, he was transferred to HMP Birmingham, where ACCT monitoring continued.

2. Mr Abbott had no history of mental ill-health or substance misuse. Staff noted he settled in prison and had a job. Although his mood was low from time to time, he never harmed himself in prison, and staff appropriately ended ACCT monitoring on 9 July 2016.

3. On 26 July 2016, Mr Abbott was sentenced to life in prison, with a minimum tariff of 15 years. The mental healthcare team assessed him after he returned from court but raised no concerns. Apart from a short period (5 days) in August when staff again monitored him under ACCT procedures because his mood was low, there were no concerns about him.

4. On 5 October, Mr Abbott was transferred to HMP Long Lartin, where he settled and got a job.

5. On the evening of 10 December, Mr Abbott's friends said he gave them some of his belongings (canteen items and cooking utensils). They thought nothing of his generosity and were not concerned about him.

6. At 8.41am on 11 December, the first anniversary of his offence, an officer unlocked Mr Abbott's cell door but did not disturb him as he appeared asleep. At around 11.29am, a prisoner found Mr Abbott unresponsive and alerted staff. Staff found Mr Abbott unconscious in his bed and believed he was dead. A medical emergency code was called promptly and although Mr Abbott had rigor mortis and blood had pooled in his limbs, healthcare staff carried out cardiopulmonary resuscitation for 13 minutes. Paramedics arrived at 11.53am and confirmed Mr Abbott's death at 11.54am.

Findings

7. Although Mr Abbott had some risk factors for suicide and self-harm based on his offence, there was little to indicate to prison staff that he was at heightened or imminent risk in the period before his death. He did not tell anyone that he intended to take his life, showed no signs of risk or that he was in a state of crisis before his death, and staff were not aware that he had given away his belongings the day before he died. It appears that Mr Abbott had intended to take an overdose of naproxen, though he ultimately died as a result of inhaling his stomach contents into his lungs. We consider that it would have been difficult for staff at Long Lartin to have foreseen or prevented his death.

8. Staff did not check Mr Abbott's wellbeing when he was unlocked on the morning of 11 December. No concerns were raised until three hours later. We cannot say whether this delay affected the outcome for Mr Abbott.

9. Despite the prompt emergency response after staff found Mr Abbott unconscious in his cell, nursing staff unnecessarily tried to resuscitate him when there were clear signs that he had already died.

10. While we acknowledge that there was another emergency incident after Mr Abbott's death, nevertheless the first two officers and first two nurses who responded were not invited to the debrief after Mr Abbott's death as they should have been.

Recommendations

- The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate, in line with NHS England and HM Prisons and Probation Service's resuscitation policy issued in September 2016.
- The Governor should ensure, in line with PSI 08/2010, that all staff, including healthcare staff, are debriefed appropriately after a potentially traumatic incident or death, and that they are offered support.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Long Lartin informing them of the investigation and asking anyone with relevant information to contact him. No one came forward.

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

13. The investigator visited Long Lartin on December 2016. He obtained copies of relevant extracts from Mr Abbott's prison and medical records. He and the clinical reviewer interviewed seven members of staff and two prisoners at Long Lartin.

14. We informed HM Coroner for Worcester of the investigation and sent him a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Abbott's sister to explain the investigation and ask if she had any matters for the investigation to consider. At the time of writing this report, Mr Abbott's sister had not contacted us.

16. Mr Abbott's sister received a copy of the initial report and chose not to comment or provide feedback.

Background Information

HMP Long Lartin

17. HMP Long Lartin is a high security prison in Worcestershire. It has eight main wings and holds up to 622 adult men serving sentences of at least four years. All prisoners are accommodated in single cells. F wing is a standard residential wing for prisoners serving long term sentences. The wing has facilities for prisoners to cook their own food and they have regular periods of association.

HM Inspectorate of Prisons

18. The most recent inspection of Long Lartin in October 2014 assessed the prison as reasonably safe and respectful. Incidents of self-harm were relatively low, although two prisoners had taken their lives since the previous inspection in 2011. Inspectors concluded that support for those in crisis was mixed and case management and care for those at risk of suicide and self-harm needed to improve.

19. Inspectors noted that substance misuse staff worked closely with others to minimise the diversion of medication such as tramadol. About a quarter of patients were prescribed controlled medication and spot checks often found prisoners with medication they had not been prescribed. However, inspectors found that the administration of medication they observed was safe and well supervised. Clinical staff reviewed prescribing practice when required.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure prisoners are treated fairly and decently. The IMB annual report for the year to January 2016 notes no concerns which are relevant to our findings in this investigation.

Previous deaths at HMP Long Lartin

21. Since 2010, there have been fourteen deaths at Long Lartin, including that of Mr Abbott. Four of these were self-inflicted, one was a homicide and the remainder were due to natural causes. We previously recommended that all known risk factors are taken into consideration when assessing a prisoner's risk of suicide and self-harm.

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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

HMP Hewell

23. On 11 December 2015, Mr Paul Abbott murdered his wife. On 14 December 2015, he was arrested and remanded to HMP Hewell. It was his first time in prison. At court, the community psychiatrist nurse noted that Mr Abbott had a high risk of killing himself in prison. He arrived with medication for his type II diabetes (metformin). He had no history of mental health issues, misuse of alcohol or illicit drugs, attempted suicide or self-harm.

24. When he arrived, prison staff noted Mr Abbott's offence. He was in shock, tearful and his mood was low. Mr Abbott told staff that if he had the opportunity, he would take his own life. Staff began suicide and self-harm prevention procedures, known as ACCT, to monitor his risk and agreed to check on him twice an hour. Staff assessed that Mr Abbott should share a cell. The reception nurse noted that Mr Abbott had no history of attempted suicide, self-harm or mental health issues. She referred him to the mental health team because of his offence and low mood and to the prison doctor for his diabetes. Afterwards, the prison doctor prescribed Mr Abbott's metformin.

25. The next day, a mental health nurse assessed Mr Abbott. She noted that he had no history of mental health issues. His mood was low, he was tearful and appeared to be in shock. Mr Abbott said he felt guilty about his offence and had no social network as his two sons did not want anything to do with him. Mr Abbott denied having thoughts of suicide or self-harm. The nurse noted that the mental healthcare team would continue to support Mr Abbott and monitor his mental and physical health closely.

26. Over the following months, staff continued to support Mr Abbott through ACCT monitoring. Mr Abbott got a job and re-established contact with one of his sons. Staff recorded that Mr Abbott had made good progress in prison but they remained concerned about him and his fluctuating moods. This was particularly evident around the time of his wife's funeral in early March 2016. The mental health team continued to support Mr Abbott and he was seen regularly by the primary health team who monitored his diabetes.

HMP Birmingham

27. On 7 March 2016, Mr Abbott appeared at court and was subsequently transferred to HMP Birmingham. Reception staff noted that Mr Abbott was being monitored under ACCT procedures. A nurse and prison doctor saw Mr Abbott as part of the reception screening process to assess his physical and mental health. They raised no immediate concerns but noted that he was not suitable to have his medication in-possession at that time.

28. Staff reported that Mr Abbott settled in well over the next few months. He raised no concerns, worked daily in the prison workshop and got on well with others. On 4 July, Mr Abbott's Incentives and Earned Privileges (IEP) level was upgraded from standard to enhanced because of his good behaviour and attitude.

29. On 9 July, staff stopped ACCT monitoring for Mr Abbott as they felt he was no longer at immediate risk of suicide and self-harm.

30. On 26 July, Mr Abbott attended court and was sentenced to life in prison, with a minimum tariff of 15 years. When he returned to Birmingham, Mr Abbott told staff that he had no thoughts of suicide or self-harm and had expected a lengthy sentence.

31. A mental health nurse assessed Mr Abbott after his court appearance. The nurse noted that Mr Abbott engaged well and was calm during the assessment. He said he was not surprised at the sentence he had received and was glad his trial was over so that he could get on with his prison sentence. He denied thoughts of suicide and self-harm. The nurse noted that Mr Abbott displayed no overt signs of a mental illness and she had no immediate concerns about him.

32. On 1 August, staff noted in Mr Abbott's prison records that he continued to attend work full-time in the prison workshop, was polite and that they had no concerns.

33. On 12 August, an officer from the Offender Management Unit saw Mr Abbott as part of the lifer induction process. He noted that Mr Abbott did not raise any issues but appeared to be struggling emotionally to come to terms with his sentence and being in custody. He reminded Mr Abbott of the support available to him in prison, including the chaplaincy services. Mr Abbott said he was okay and although had previously been in a low mood, had no thoughts of suicide and self-harm. Despite this, he was worried about Mr Abbott and began ACCT procedures, with hourly observations.

34. On 14 August, Mr Abbott was assessed under ACCT procedures, and a case review was held afterwards. Mr Abbott talked about his offence and said that it was his first time in prison. He said that before custody, he had no history of attempted suicide, self-harm or mental health issues. He said he had planned to kill himself after killing his wife, but his son stopped him. He said he had no current plans to kill himself. The ACCT review panel noted that Mr Abbott appeared a little confused about sentence planning but he was polite. Mr Abbott said he had no issues at Birmingham and had a good relationship with other prisoners. They noted an ACCT caremap action for the Offender Management Unit to speak to Mr Abbott to allay his concerns about his life sentence planning. This was immediately facilitated

35. On 16 August, staff stopped ACCT monitoring as they felt Mr Abbott was not at risk of suicide and self-harm. Mr Abbott told staff that he had spoken to his offender manager, was happy and understood his life sentence planning.

36. On 27 September, a prison GP saw Mr Abbott because he complained of a shoulder injury. The doctor prescribed naproxen (an anti-inflammatory medication) and assessed that Mr Abbott was now suitable to hold medication in-possession.

HMP Long Lartin

37. On 5 October 2016, Mr Abbott was transferred to HMP Long Lartin and was housed on D Wing in a single cell. A nurse saw Mr Abbott when he arrived and completed his reception health screen. She noted that Mr Abbott was cheerful

and co-operative. She recorded in his medical record that he had type II diabetes, no history of mental health problems or using illicit drugs or alcohol. The nurse took Mr Abbott's observations and had no concerns. She assessed that Mr Abbott was suitable to continue having his medication in-possession. His prescribed monthly medication included metformin, candesarten (high blood pressure), naproxen (anti-inflammatory medication) and promethiazine (for insomnia).

38. An officer from the Safer Custody department interviewed Mr Abbott to check on his welfare. Mr Abbott told him that he was happy to be at Long Lartin and wanted to settle down and get a job. Mr Abbott engaged well during their conversation and talked openly about his experiences. Mr Abbott said he felt supported and if he had any concerns, he was aware that he could speak to staff or a Listener (a prisoner trained by the Samaritans).

39. On 21 October 2016, a nurse noted that a detailed diabetes care plan had been created for Mr Abbott. It included monitoring his blood pressure, referring him to the podiatry team for foot and nail care, referring him to the optometry team for eye care, including checking him for diabetic retinopathy.

40. On 24 October, Mr Abbott started work in the prison wood workshop. The nurse saw him the next day for his annual diabetes review. Mr Abbott had complied with taking his medication but had not taken his metformin for three months before he was sentenced. His blood glucose level was raised but his blood pressure was within normal limits.

41. On 31 October, a facilitator for the Resolve Offender Behaviour Programme saw Mr Abbott and completed a violence assessment to help the treatment team decide which programme, if any, would be suitable for Mr Abbott as part of his life sentence planning. She told the investigator that Mr Abbott talked openly about his offence, his past, his family and his experience in custody. He said he had not liked being at Hewell or Birmingham but was finding Long Lartin a better experience. Mr Abbott said that in the past he had anxiety and depression but had no current concerns.

November 2016

42. Mr Abbott was accepted on the Resolve Offender Behaviour Programme. On 17 November, the facilitator saw him for a one-to-one session. She noted that Mr Abbott engaged well during the session and talked about a range of life experiences. She had no concerns about Mr Abbott.

43. On 3 November, a prison GP saw Mr Abbott to review his medication because of his raised blood glucose levels. He prescribed gliclazide to help control his blood glucose levels. The healthcare team saw Mr Abbott on16 November (a physiotherapy review for his shoulder pain and podiatry) and on 24 November (an optometry review).

44. On 12 November, Mr Abbott was relocated to F Wing at his own request. In the afternoon, an officer introduced himself to Mr Abbott as his personal officer. The officer told the investigator that he spoke to Mr Abbott regularly. Mr Abbott told him that he was settling well on F Wing. He said that he was diabetic, had a

problem with an ingrown toenail and had applied to be referred to a chiropodist. The officer promised to speak to the healthcare team about his application.

45. On 18 November, Mr Abbott told his personal officer that he was happy that the healthcare team had "sorted out" his feet. Mr Abbott said he was mixing well on the wing and had no concerns.

46. Around 10.00am on 28 November, Mr Abbott used the toilet during a workshop period. Staff heard a "crash" in the toilets and found Mr Abbott lying on the floor. The staff helped Mr Abbott to stand up. Mr Abbott said he had slipped, was okay but had a pain in his back and shoulder. On leaving the workshop (around 11.30am), Mr Abbott complained of having double vision and appeared confused about where he was.

47. A nurse (whom we did not interview as she was on long term sick leave), examined Mr Abbott in the healthcare unit at 12.00pm. She noted that he had slipped on the floor and sustained an injury to the back of his head. Mr Abbott told the nurse that he did not lose consciousness but had felt dizzy and sick. He had some water and said this feeling immediately passed. Mr Abbott said he had a swelling on the back of his head but when she examined him, there was no cut to his scalp and the swelling had subsided. Mr Abbott said he had a pain in his left ear and the nurse referred him to the prison doctor.

48. A prison GP saw Mr Abbott and completed a full neurological examination. He advised Mr Abbott to remain in the healthcare inpatient unit so that the nursing staff could monitor him for a few hours. Mr Abbott refused and said he wanted to return to the wing. The GP recorded that healthcare staff should check on him at 2.00pm, 6.00pm and 9.00pm. A nurse checked Mr Abbott as agreed by the GP, but recorded no concerns.

December 2016

49. On 1 December, the personal officer noted that Mr Abbott had settled well at Long Lartin and he had no concerns about him. Mr Abbott told him that he wanted to get on with his sentence and lead a quiet life while in prison.

50. On 6 December, the facilitator saw Mr Abbott again for a one-to-one Resolve session. Mr Abbott told her that he was struggling with his memory and complained of feeling confused and disoriented at times. He said that he had noticed a gradual deterioration of his memory over the past 12 months while in prison. He did not know what day it was and had forgotten a substantial amount of the session content. She was concerned about Mr Abbott and contacted the mental health team.

51. On 8 December, Mr Abbott attended a Resolve group session. The facilitator noted that Mr Abbott engaged well and said that he was able to relate to some of the material that was being discussed.

52. That day, a mental health nurse assessed Mr Abbott in response to the facilitator's concerns. She told the investigator that Mr Abbott engaged fully in the assessment and had told her that he felt his memory was deteriorating. She noted that Mr Abbott had no history of mental health issues and appeared to be

adjusting reasonably well to prison life, particularly as it was his first time in prison and he had a long sentence.

53. Mr Abbott told the nurse that he was passing his time in prison, attending work regularly, playing pool, watching television and cooking his own meals. Mr Abbott denied any issues with bullying or that he was taking New Psychoactive Substances (NPS). He said his mood was low. She noted that she could find no evidence of mental illness but noted his low mood appeared to be in response to adjusting to his life sentence. Mr Abbott said he had no contact with friends or family. He denied thoughts of suicide or self-harm and said he did not need support from the mental health team. She agreed to review Mr Abbott in a couple of weeks to monitor his progress.

10 December

54. The association period for prisoners started at around 2.00pm on 10 December. A prisoner told the investigator that he played a few games of pool with Mr Abbott. Another prisoner told the investigator that he joined Mr Abbott in the exercise yard at around 4.00pm. They talked about prison life and their families. Mr Abbott told him that it was almost the first anniversary of his offence. He said Mr Abbott appeared his usual self.

55. Around 4.30pm and shortly after he returned to the wing, Mr Abbott visited a prisoner in his cell. He was carrying a large box, which the prisoner said contained canteen items (cereals, sugar and teabags) and Mr Abbott said he could have them. Mr Abbott emptied the items on the bed and said he needed the box for something else. The prisoner had no concerns about Mr Abbott. They had previously exchanged goods and he believed this was another instance of Mr Abbott's generosity.

56. At around the same time, Mr Abbott visited another prisoner in his cell at least twice. During each visit, he gave him some of his personal belongings. The items included two towels, writing materials (A4 paper, folders and envelopes), a bowl, saucepans and some food seasoning (paprika). The prisoner asked Mr Abbott why he was giving away his belongings. Mr Abbott said he had ordered new pans. He thought Mr Abbott's behaviour was a bit unusual but he dismissed these thoughts as he had no concerns about him. Mr Abbott had given him some stamps a few days earlier.

57. Just before prisoners were locked in their cells for the evening, the prisoner said he had collected his evening meal at the same time as Mr Abbott. They walked down the landing together to return to their cells. He had no concerns about Mr Abbott.

58. At 4.50pm, an officer locked the cell doors and completed the evening roll check on F Wing. She raised no concerns and recalled Mr Abbott standing up in his cell when checked.

11 December

59. Staff raised no concerns during the early morning roll check at 5.30am on 11 December. The weekend regime was relaxed, prisoners had been issued with

breakfast packs the night before and there was no expectation that prisoners should be immediately active after being unlocked in the morning.

60. The personal officer started unlocking the cells on F Wing at 8.35am and unlocked Mr Abbott's cell at about 8.41am. When he looked through the observation panel, he said there was not much light but he could see the top of Mr Abbott's head. Mr Abbott was in bed, covered by a blanket and appeared to be asleep. He said he did not see any need to get a response from Mr Abbott and it seemed reasonable to let him sleep as it was the weekend and he did not have to go to work.

61. Two prisoners had separately gone to Mr Abbott's cell to check that he was okay. One went at around 9.30am, and the other at around 10.30am. Both had looked through the observation panel, saw Mr Abbott in bed and believed he was asleep. Neither prisoner considered this unusual because it was the weekend.

62. Prisoners on F Wing started collecting their lunch from around 11.15am. CCTV footage showed that at 11.30pm, a prisoner went to Mr Abbott's cell. He was concerned that as it was nearing the end of lunch being served and Mr Abbott had not collected his meal. He looked through the cell observation panel and noticed Mr Abbott was in the same position as earlier. He shouted through the door to try to get Mr Abbott's attention but got no response. The door was shut but unlocked and so he went into the cell. Mr Abbott failed to respond to his name when called and did not move. He walked slowly towards Mr Abbott and touched the top of his head, which was closest to the door. It was cold. He left the cell to alert prison staff as he believed something was wrong.

63. The personal officer told the investigator that the prisoner told him that something was wrong with Mr Abbott. He and another officer immediately went to Mr Abbott's cell. He said Mr Abbott was lying on his left hand side in the same position as when he unlocked his door that morning. He said Mr Abbott looked dead. Rigor mortis was present, his blood had pooled in his limbs, and his skin was purple and mottled. He immediately called a medical emergency code blue (indicating that a prisoner is unconscious or having problems breathing), which was recorded in the control room log at 11.32am. The officers took no further action as they believed Mr Abbott was dead and cardiopulmonary resuscitation (CPR) would have been futile.

64. A nurse and two healthcare assistants responded to the code blue. The nurse said she arrived at Mr Abbott's cell within two minutes (confirmed by CCTV footage) and her colleagues brought with them a medical emergency bag. Both officers stood outside Mr Abbott's cell and told her that Mr Abbott was dead. She assessed Mr Abbott. She noted he was cold to touch, his skin was purple, and there was clear rigor mortis in his arms and legs.

65. A senior nurse arrived and examined Mr Abbott. She told the investigator that Mr Abbott appeared to be dead. However, both nurses said they felt obliged to try cardiopulmonary resuscitation. The senior nurse and a custodial manager rolled Mr Abbott onto his back. She noted Mr Abbott's limbs were stiff when they moved him. The custodial manager started cardiopulmonary resuscitation by doing chest compressions. The nurses attached a defibrillator to Mr Abbott's chest and tried to insert an airway into his mouth but Mr Abbott's jaw was stiff.

66. The staff continued cardiopulmonary resuscitation for around 13 minutes and stopped at 11.46am, as it was evident that Mr Abbott was dead. At 11.53am, the paramedics arrived and pronounced Mr Abbott's death at 11.54am.

Support for prisoners and staff

67. A Senior Operational Manager debriefed staff involved in the emergency response and offered her support and that of the staff care team. Key staff, including the first two officers and first two nurses who responded to the emergency, told the investigator that they were not invited to the debrief meeting. Staff reviewed prisoners assessed as at risk of suicide and self-harm in case they had been affected by Mr Abbott's actions, and offered support.

Family liaison

68. Two officers were appointed as the prison's family liaison officers. They contacted Mr Abbott's sons, explained the circumstances of his death, and offered their condolences. Mr Abbott's sister took on the responsibilities of the next of kin role and liaised with the prison. Long Lartin contributed to the cost of Mr Abbott's funeral in line with national instructions.

Other information

69. A note, written by Mr Abbott, was found in his cell, wrapped around some toiletries, asking for the items to be handed to a named prisoner. The note wished him "good luck and good bye". No evidence of medication was found.

70. From his medical record, it was noted that Mr Abbott had been issued with the following repeat prescriptions:

- Candesartan 8mg, 1 tablet daily, pack of 28 tablets on 8 December 2016
- Naproxen 250mg, 1 tablet twice daily as required, pack of 28 tablets on 14 November 2016
- Candesartan 8mg, 1 tablet daily, pack of 28 tablets on 10 November 2016
- Metformin 1mg modified release, 1 tablet twice daily, pack 56 tablets on 5 November 2016
- Glicazide 40mg, 1 tablet daily, pack of 28 tablets on 3 November 2016

Post-mortem report and toxicology results

71. The post-mortem examination established Mr Abbott's cause of death as (1a) gastric aspiration; (1b) naproxen ingestion and (2) left ventricular hypertrophy. While it concluded that Mr Abbott had at least 30 naproxen tablets in his stomach, the toxicology results found that naproxen levels in his blood were within therapeutic levels. The pathologist confirmed that the tablets had not been absorbed before Mr Abbott died and that his stomach contents were present in his lungs. It appears that Mr Abbott had inhaled his stomach contents into his lungs, which led to his death. Mirtazapine and promethazine were detected in his blood, consistent with therapeutic levels. The concentration in his blood of metformin was consistent with moderately excessive use of the drug

before his death, though at a concentration far below those typically seen in fatalities caused by the drug.

Findings

Assessment and management of Mr Abbott's risk of suicide and self-harm

72. Prison Service Instruction (PSI) 64/2011 (Safer Custody) and PSI 07/2015 (Early Days in Custody) list a number of risk factors and potential triggers for suicide and self-harm. Mr Abbott had the following significant risk factors when he first arrived at HMP Hewell:

- He had killed his wife;
- He had received a life sentence, with a minimum tariff of 15 years;
- He had wanted to kill himself after killing his wife; and
- His mood was low and he had feelings of depression.

73. On 14 December 2015, staff at HMP Hewell began ACCT procedures because of Mr Abbott's offence and because his mood was low. Staff noted that Mr Abbott was finding it difficult to come to terms with the offence he had committed against his wife. ACCT procedures remained in place after he was transferred to Birmingham in March 2016 until July 2016, when staff assessed that Mr Abbott was no longer at risk. Staff managed Mr Abbott under ACCT procedures again for a very short period in August 2016, shortly after he had received a life sentence. Mr Abbott appeared to be in a low mood and was struggling to understand his life sentence plan. His offender manager rectified this and provided immediate intervention for Mr Abbott by explaining his sentence plan in detail to him. Staff had no further concerns about Mr Abbott's risk. We are satisfied that staff at Hewell and Birmingham appropriately identified Mr Abbott's risk, managed him under ACCT procedures and reasonably decided to end ACCT monitoring once they were satisfied his risk of suicide had reduced.

74. When Mr Abbott arrived at Long Lartin on 5 October, staff raised no concerns about his risk of suicide and self-harm and he appeared to be in good spirits. The healthcare team continued to monitor his diabetes, which appeared well controlled. On 8 December, a nurse assessed his mental health and had no concerns about his risk to himself.

75. There was little indication at Long Lartin that Mr Abbott was at a raised risk of suicide or self-harm in the days before his death, and it would have been difficult for staff to have reasonably predicted his actions. Although Mr Abbott gave away a number of his belongings the night before he was found dead in his cell, staff were unaware of this, prisoners thought it was an act of generosity and he did not tell anyone that he intended to take his life. Mr Abbott died on the first anniversary of his offence, and in a note, found in his cell after he died, he said goodbye to another prisoner. The excessive number of naproxen tablets in Mr Abbott's body after his death suggests that he had tried to take an overdose to end his life. Although the overdose of tablets did not directly cause his death, he died after inhaling his stomach contents into his lungs.

Unlock procedures

76. At unlock, officers should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual says that, "Prior to

unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".

77. Prison Service Instruction 75/2011 on Residential Services says that:

> "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff unlocking them have not noticed that the prisoner had died. This is not acceptable... "
>
> "[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock ...Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example, by obtaining a response during the unlock process."

78. On 11 December, when the personal officer unlocked Mr Abbott's cell he should have checked his welfare and obtained a response from him. As a result, Mr Abbott was not discovered until three hours later. The officer explained that at the weekend prisoners do not have to attend work and many took the opportunity to lie in, and he believed Mr Abbott was asleep. The investigator concluded that it was accepted practice at Long Lartin that staff did not always obtain a response from prisoners at weekends when unlocking cells. While we cannot know whether or not the outcome for Mr Abbott might have been different if he had been found earlier, it is important that prison staff understand the requirement for them to check on prisoners' welfare when they unlock them. Early intervention when a prisoner is found unconscious or in a critical situation might save his life.

79. After the investigator's visit to the prison, the Governor issued a Notice to Staff (159/2017) on 23 June 2017, which reiterated that officers must check prisoners' wellbeing when they unlock cells. We therefore make no recommendation.

Resuscitation

80. Prison and healthcare staff responded quickly to the emergency code blue on 11 December. Prison staff correctly decided not to carry out cardiopulmonary resuscitation because rigor mortis was present. At interview, two nurses were asked why they started cardiopulmonary resuscitation if they believed that Mr Abbott was dead. They both said that they felt obliged to attempt resuscitation. Mr Abbott had clear signs of death: his limbs were cold; he had no pulse, there were signs of rigor mortis and his blood had pooled in his limbs. We understand the commendable wish to try and continue resuscitation until death has been formally recognised, but staff should understand that they are not required to carry out cardiopulmonary resuscitation in these circumstances.

81. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. None of the staff whom the investigator

interviewed were aware of the guidance published in September 2016 by NHS England and HM Prisons and Probation Service which clarified that it was inappropriate to commence cardiopulmonary resuscitation when rigor mortis was present or if blood had pooled in the limbs. We make the following recommendation:

The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate, in line with NHS England and HM Prisons and Probation Service's resuscitation policy issued in September 2016.

Staff support

82. PSI 08/2010 on Post Incident Care and PSI 64/2011 require managers to hold a short debrief meeting before staff go home when they have been involved in a potentially traumatic incident. All staff directly involved in the incident, including healthcare staff, should be invited. Although a debrief took place, contrary to national instructions, the first two officers and first two nurses who discovered Mr Abbott were not invited to the debrief. While we understand that healthcare staff were involved in another emergency incident shortly after Mr Abbott's death, every effort should be made to ensure all staff involved in an incident attend the debrief. We make the following recommendation:

The Governor should ensure, in line with PSI 08/2010, that all staff, including healthcare staff, are debriefed appropriately after a potentially traumatic incident or death, and that they are offered support.

Clinical care

83. The clinical reviewer concluded that Mr Abbott's general standard of healthcare at Long Lartin was equivalent to that he could have expected to receive in the community. He noted that the healthcare team managed Mr Abbott's type II diabetes well and their care met the national standards set by NICE guidelines. Mr Abbott's mental health assessment appears to have been well delivered and despite no evidence of a significant mental health issue, staff had planned further reviews.

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