Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Keith Abbott a prisoner at HMP Haverigg on 15 July 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*

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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 Abbott was found hanged in his cell at HMP Haverigg on 15 July 2016. He was 32 years old. We offer our condolences to Mr Abbott's family and friends.

Despite a police investigation, the circumstances of Mr Abbott's death remain unclear. The post-mortem report found that Mr Abbott was the victim of a serious sexual assault shortly before he died, but the police were unable to determine how or when Mr Abbott was assaulted and no one has been charged.

The circumstances of Mr Abbott's death are deeply troubling. In 2014, HM Inspectorate of Prisons found that the lack of staff supervision in the billeted accommodation at Haverigg was a concern and provided opportunities for bullying and violence. They recommended that staff supervision of the billeted units, particularly unit two where Mr Abbott was located, be improved. Yet two years later staff told us that, although they knew there was violence, drug use and bullying taking place in the billets, they were sometimes unable to go in when prisoners were unlocked because of low staffing levels.

It is clear that the sexual assault suffered by Mr Abbott was not an isolated incident of serious violence. After his death the police launched an operation to investigate a number of serious incidents (including the deaths of Mr Abbott and another prisoner, three alleged sexual assaults, two stabbings and other physical assaults, and an arson attempt). No charges have been brought, apart from one charge of arson, because of a lack of evidence.

It is hard not to conclude that there was an effective loss of control in parts of the prison which allowed acts of serious violence to take place undetected. As a result, it appears that the prison was unable to provide a safe environment for prisoners, to support victims or to identify, challenge or intervene with perpetrators.

We also have a number of other concerns. Although Mr Abbott repeatedly complained that he was hearing voices, his referral to a psychiatrist was never actioned or followed up by the mental health inreach team, and he did not receive any treatment for his mental health problems during the eight months he was at Haverigg. As a result, the treatment he received was not equivalent to that he could have expected in the community.

Mr Abbott had a number of risk factors for suicide and self-harm when he arrived at Haverigg, but there is no evidence that staff considered starting ACCT procedures.

It is also concerning that prison staff did not check Mr Abbott's wellbeing during roll call and unlock on 15 July and that his death, was not, therefore, discovered for over an hour.

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 **January 2018**

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Summary

Events

1. On 9 December 2015, Mr Keith Abbott was charged with robbery and attempted assault. He was detained in hospital under the Mental Health Act because he was assessed as a risk to himself or others. On 19 December, Mr Abbott was released from hospital on bail.

2. On 3 September, Mr Abbott was arrested after failing to attend his court hearing and sent to HMP Liverpool. This was his first time in prison. Mr Abbott told a nurse in reception that he had a history of substance misuse, mental health problems, self-harm and suicide attempts. The nurse referred Mr Abbott to the mental health and substance misuse teams and a GP prescribed methadone and an antidepressant.

3. The next day, staff started suicide and self harm prevention procedures (ACCT) because Mr Abbott said that he was hearing voices telling him to harm himself. Staff monitored Mr Abbott under the ACCT process until 16 October when Mr Abbott said he was no longer having thoughts of self-harm. The mental health and substance misuse teams continued to monitor Mr Abbott. The mental health team referred him to a psychiatrist but Mr Abbott was not assessed while he was at Liverpool.

4. On 21 October 2015, Mr Abbott was sentenced to four years imprisonment, and on 9 November, he was sent to HMP Haverigg. He was located in a single cell in unit two of the 'billets' (detached hut style accommodation previously used as armed forces sleeping quarters). A GP prescribed methadone and a mental health nurse referred Mr Abbott to the mental health team. The next day, a mental health nurse assessed Mr Abbott and referred him to the psychiatrist. Mr Abbott continued to be monitored by the substance misuse team and the GP gradually reduced his methadone dose.

5. On 30 January, Mr Abbott said his mental health had deteriorated and asked to see a doctor. A mental health nurse from the mental health inreach team assessed Mr Abbott and referred him to the GP to discuss medication. He also referred Mr Abbott to the primary mental health team for therapy.

6. On 8 February, a recovery worker reviewed Mr Abbott and referred him back to the mental health inreach team because his mental health was not sufficiently stable for him to start therapy. The same day, a GP assessed Mr Abbott and asked the mental health team to obtain his mental health records from the community and refer him to the psychiatrist for a diagnosis and treatment plan.

7. The mental health nurse from the inreach team reviewed Mr Abbott on 17 February, 25 February and 27 May. At each appointment, he told Mr Abbott to make an appointment to see the GP to discuss mental health medication. There is no evidence that the mental health nurse followed up Mr Abbott's referral to the psychiatrist and Mr Abbott did not see a psychiatrist at Haverigg.

8. On 1 June, the GP noted that the mental health nurse from the inreach team had asked him to review Mr Abbott because of his anxiety. He told the mental health

nurse that Mr Abbott should be referred to the primary mental health team for therapy. The mental health nurse responded that he had referred Mr Abbott to the GP.

9. At around 6.10pm on 14 July, prison staff started locking prisoners in their cells for the night. Staff said that they could not remember locking Mr Abbott's cell or checking on him, but said they did not note anything unusual that evening. At 9.00pm, an operational support grade said that he checked on Mr Abbott and did not notice anything unusual.

10. At 6.00am on 15 July, an operational support grade said he checked Mr Abbott's cell and had no concerns about him. At 7.40am on 15 July, an officer started the morning roll check. The officer said that he thought he saw Mr Abbott in bed and did not notice anything unusual. At approximately 8.05am, officers started to unlock prisoners to go to work. They did not unlock Mr Abbott's cell because he did not have to go to work that day.

11. At approximately 9.00am, three officers started to check the billets to make sure that prisoners had left for work. An officer checked Mr Abbott's cell but could not see him through the observation panel. He unlocked Mr Abbott's cell and saw his legs near the toilet. He thought Mr Abbott was sick so called out to ask if he was okay, but got no response. The officer went into the cell with another officer and they found Mr Abbott kneeling over the toilet with a ligature made from bed sheets around his neck.

12. The second officer called an emergency code and control room staff called an ambulance. The officers checked Mr Abbott's vital signs but found none and thought that he had died so did not start resuscitation. Healthcare staff arrived and also checked Mr Abbott's vital signs and thought that he had died. A GP arrived and confirmed that Mr Abbott had died.

13. The post mortem concluded that Mr Abbott died from hanging. It also found that, shortly before his death, Mr Abbott had been the subject of an extremely violent sexual assault, causing serious internal injuries. Although no traces of illicit drugs were found in Mr Abbott's body, the post mortem identified changes within his heart muscles which suggested that he had taken Spice – a New Psychoactive Substance (NPS) - or had Spice administered to him shortly before his death.

14. The pathologist concluded that he could not exclude the possibility that Mr Abbott's death was the result of an unlawful act.

15. The police subsequently launched Operation Knightsbridge to investigate a number of serious incidents at Haverigg (including the deaths of Mr Abbott and another prisoner, physical assaults including two stabbings, three alleged sexual assaults, and attempted arson). Operation Knightsbridge has now concluded without any charges being brought, apart from one charge for arson.

Findings

16. Despite Mr Abbott telling healthcare staff that he was anxious and hearing voices, he did not see a psychiatrist and was not provided with mental health treatment

during the eight months he was at Haverigg. Our investigation found that there was no multi-disciplinary working between the primary healthcare and mental health teams and that Mr Abbott's referral to the psychiatrist was never actioned or followed up by the mental health inreach team.

17. Mr Abbott had a number of risk factors for suicide and self-harm when he arrived at Haverigg and we consider that staff should have started ACCT procedures.

18. The circumstances around Mr Abbott's death and the serious sexual assault that preceded it are unclear. The pathologist concluded that he could not exclude the possibility that Mr Abbott's death was the result of an unlawful act. The police investigation was unable to determine who assaulted Mr Abbott and no charges have been brought.

19. The assault suffered by Mr Abbott was not an isolated instance of serious violence at Haverigg. There was violence, drug taking and bullying in the billets where Mr Abbott was located. Staff said that they were unable to respond to or prevent these incidents because the billets were difficult to supervise and they usually did not know anything had occurred until after the event. We note that the billets were closed by the Prison Service in October 2016 due to safety concerns.

20. Prison staff did not check Mr Abbott's well being appropriately during roll call and unlock and his death, therefore, went unnoticed for over an hour.

Recommendations

- The Governor should ensure that violence reduction strategies are implemented effectively to provide support for victims and appropriate challenge or intervention with perpetrators.
- The Greater Manchester Mental Health Trust Service Manager should ensure that there is a robust process in place so that appropriate psychiatric referrals are made, actioned and a response received by the primary healthcare team.
- The Greater Manchester Mental Health Trust Service Manager should ensure that the mental health referral system results in the timely review and treatment of prisoners with mental health needs.
- The Greater Manchester Mental Health Trust Head of Healthcare should ensure that there is effective and clear liaison between the primary care providers and the mental health inreach teams.
- The Governor should ensure that staff are aware of, consider and record all the known risk factors for suicide or self-harm. They should open an ACCT whenever a prisoner has significant risk factors. When, exceptionally, they decide not to begin ACCT procedures for prisoners with significant risk factors, they should clearly record the reasons.
- The Governor should ensure that all prison staff are aware of the correct procedures at roll checks and that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

The Investigation Process

21. The investigator issued notices to staff and prisoners at HMP Haverigg informing them of the investigation and asking anyone with relevant information to contact her. One prisoner wrote to us and said that he had been concerned about Mr Abbott before he died because he was not well and did not get his mental health medication.

22. The investigator visited HMP Haverigg on 6 January. The prison sent copies of relevant extracts from Mr Abbott's prison and medical records.

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

24. The investigator was provided with the statements and questionnaires completed by a number of staff and prisoners. She asked to interview a number of staff who had since left the prison or were on long term sick leave.

25. The investigator obtained the contact details of two nurses who had left Haverigg prison and wrote to them asking if they would participate in an interview. One responded. The investigator and the clinical reviewer interviewed three members of staff by phone on 20 July. The investigator interviewed a further four members of staff by phone. Nurse A failed to respond to any attempts to contact him, a substance misuse worker could not be traced and an officer, who was on long term sick leave, could not be contacted.

26. We informed HM Coroner for Cumbria of the investigation and we have given the coroner a copy of this report.

27. One of the Ombudsman's family liaison officers, contacted Mr Abbott's partner's mother to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Abbott's partner wanted to know:

    - whether Mr Abbott had received his mental health medication and the appropriate care for his mental health needs;
    - whether Mr Abbott stopped taking methadone and how this affected him;
    - the schedule for unlocking prisoners in the morning and why Mr Abbott was not found until 9.00am;
    - why staff did not check on Mr Abbott more frequently given his mental health problems and whether any risk assessments were conducted to decide how frequently he should be checked; and
    - whether Mr Abbott was being bullied or was in debt (because he had asked his partner to deposit money in another prisoner's account).

28. Mr Abbott's family received a copy of the initial report. The solicitor representing Mr Abbott's family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

29. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Haverigg

30. HMP Haverigg is a medium secure prison. At the time of Mr Abbott's death, it held around 650 sentenced men. Around 320 prisoners were held in the 'billets' (detached huts containing a bathroom and a communal area, with a hall with cells either side).

31. The billets were closed in October 2016 and the prison can now hold up to 290 men.

32. Cumbria Partnership NHS Foundation Trust provides healthcare services at the prison. The Gables Medical Practice provides GP services. Cumbria on-call medical service provides out-of-hours GP cover.

HM Inspectorate of Prisons

33. HMIP inspected Haverigg in January 2014. The inspectors found that, although most prisoners felt safe, the identification, protection and support of prisoners who were being victimised was poor and opportunities for bullying were evident. This was particularly the case in the billeted units, which had poor external lighting and very limited CCTV coverage. The inspectors observed a lack of supervision on the billeted units, where officers did not patrol landings or other communal areas often enough. Although the inspectors recognised that the physical lay-out (with a number of separate huts and buildings spread over a wide area) made supervision difficult, they said that the lack of officer presence was a concern. There were too many violent incidents with evidence of under-reporting. The inspectors found that staff had to deal with incidents after they happened, with very little evidence of what had occurred. They found too many prisoners who were frightened to leave their cells. The violence reduction policy was not effectively implemented. The inspectors were not assured that unexplained injuries were always identified and there were examples where injuries to prisoners had not been sufficiently investigated. They did not think the prison was on top of the problem.

34. HMIP made a number of related recommendations, including that staff supervision of the billeted units, particularly unit two, should be improved.

35. The most recent inspection of HMP Haverigg was in March and April 2017. Inspectors found that 40% of prisoners said they had felt unsafe at some point at the prison. After the billet accommodation was closed in October 2016, violence had reduced and was lower than in comparable prisons, however the inspectors found that there was not enough support for victims or challenges or intervention with perpetrators of violent incidents, and the revised violence reduction strategy was not being implemented effectively. The integrated mental health team provided a reasonably good and responsive service, despite some staff shortages, and worked closely with the substance misuse team.

Independent Monitoring Board

36. 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 November 2016, the IMB reported that of particular concern was the impact of major organisational change on prisoners, staff and the overall regime occurring as a consequence of unprecedented levels of violence, bullying, sexual assault and drug misuse.

Previous deaths at HMP Haverigg

37. The last self-inflicted death at Haverigg was in 2014 and the investigation identified similar issues in relation to mental health care.

Police investigation and the closure of the billets

38. In October 2016, the National Offender Management Service (now HMPPS) closed the billet accommodation at Haverigg. This was because the safety of prisoners living there could not be assured.

39. After Mr Abbott's death the police launched Operation Knightsbridge to investigate a number of serious incidents at Haverigg, including the death of Mr Abbott, the death of another prisoner (which was NPS-related), physical assaults (including two stabbings), three alleged sexual assaults, and a reported arson attempt

40. The police told us that these had initially been treated as separate incidents until it became apparent that the level and type of violence being reported was similar in nature and indicative of a wider problem. They also told us that the use of Spice (a new psychoactive substance – NPS) appeared to be involved in a number of the incidents, and that the incidents seemed to be particularly prevalent in unit two of the billeted accommodation.

41. In the case of Mr Abbott, the police investigation found that it was clear that he was the victim of a violent sexual assault shortly before he died. The police arrested five prisoners but after reviewing the evidence, it was decided that there was insufficient evidence to refer the matter to the Crown Prosecution Service to consider charges. Although the police carried out extensive enquiries, they were unable to find out how Mr Abbott was sexually assaulted before he died and who assaulted him.

42. In March 2017, the police told the PPO that all lines of enquiry into Mr Abbott's death had been exhausted and they had decided to close their investigation. The wider Operation Knightsbridge was also concluded in June 2017 without any charges being brought, apart from one charge for arson, due to a lack of evidence.

Assessment, Care in Custody and Teamwork

43. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

44. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

45. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New Psychoactive Substances (NPS)

46. 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.

47. 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.

48. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

49. On 9 December 2014, Mr Keith Abbott was charged with attempted robbery and assault. The next day, he was assessed by the Criminal Justice Liaison Team at St Helens Police Station Custody Suite and was referred for a Mental Health Act assessment. A consultant psychiatrist assessed Mr Abbott and admitted him to hospital under section 2 of the Mental Health Act because he was a risk to himself or others.

50. On 19 December, Mr Abbott was discharged from hospital on bail. A psychiatrist noted in his discharge summary that there was no evidence of psychosis and his primary diagnosis was mental and behavioural problems caused by poly-substance misuse.

51. On 26 June 2015, Mr Abbott did not go to his court hearing and a warrant was issued for his arrest.

HMP Liverpool

52. On 3 September 2015, Mr Abbott was arrested and sent to HMP Liverpool. This was his first time in prison.

53. A nurse assessed Mr Abbott in reception and noted that he appeared anxious, was hearing voices, had mental health problems and was taking methadone. The nurse referred Mr Abbott to the mental health team, substance misuse team and to the GP. A GP prescribed sertraline (an antidepressant) and zopiclone (sleeping medication). The next day a specialist doctor prescribed methadone.

54. On 5 September, staff started suicide and self-harm prevention procedures after Mr Abbott said that he was hearing voices telling him to self-harm. They recorded that Mr Abbott should have four interactions with staff during the day and they should observe him hourly at night. Mr Abbott had six case reviews and staff noted obtaining his medication and being reviewed by the psychiatrist as actions on his caremap. Staff initially assessed his risk as raised but on 24 September, assessed it as low and reduced the frequency of observations to three during the day and three times at night. On 16 October, staff decided to end ACCT procedures because Mr Abbott had no thoughts of self-harm. His caremap actions had not been completed.

55. On 21 October, Mr Abbott was convicted of attempted robbery, possessing an offensive weapon in a public place and failure to answer to bail, and was sentenced to four years imprisonment.

56. Mr Abbott continued to be monitored by the substance misuse and mental health teams. On 26 October, staff discussed Mr Abbott at a mental health referrals team meeting and referred him to the psychiatrist, but he did not see the psychiatrist at Liverpool.

HMP Haverigg

57. On 9 November 2015, Mr Abbott was transferred to HMP Haverigg and located in a single cell in unit two of the billeted accommodation. A prison GP, noted that Mr Abbott was taking 50ml of methadone and prescribed methadone. A

substance misuse worker, reviewed Mr Abbott and gave him a drug test. Mr Abbott tested positive for methadone and she noted that he would be assessed by the substance misuse team.

58. A mental health nurse assessed Mr Abbott who said he had a history of mental health problems, substance misuse and self-harm and had previously taken an overdose of diazepam (used to treat anxiety disorders). Mr Abbott said that he had heard voices in the past that told him cut his wrists. He said that he did not have thoughts of suicide or self-harm. He referred him to the mental health team but there is no evidence that he considered starting ACCT procedures.

59. A nurse assessed Mr Abbott in reception. Mr Abbott told her that he heard voices all the time and was able to control them, but it was very tiring. She noted that Mr Abbott had no thoughts of suicide or self-harm and that he wanted to start taking quetiapine (an antipsychotic) because it had worked for him in the past. She noted that a nurse would review Mr Abbott the next day.

60. On 10 November, a mental health nurse assessed Mr Abbott. Mr Abbott told him that he had a history of mental health problems and heard voices. Mr Abbott said that he found the voices distressing and they gave him low self-esteem, but that he was used to them and would not act on them. Mr Abbott said that he had used drugs, including heroin and cocaine, before he came to prison and used to take quetiapine. He said that he stopped taking quetiapine because he had heart palpitations from taking illicit drugs with this medication.

61. The nurse noted that the secondary mental health team would monitor Mr Abbott and he would be reassessed in six weeks time. He referred Mr Abbott to the psychiatrist and noted that medication would need to be considered as early as possible because without his medication, there would be a high risk that his mental state would get worse. There is no evidence that the nurse considered starting ACCT procedures for Mr Abbott.

62. On 12 November, a prison GP prescribed 50ml of methadone for Mr Abbott and noted that he was waiting to see the mental health team and the psychiatrist.

63. On 18 November, a substance misuse worker assessed Mr Abbott. Mr Abbott told her that he had been taking methadone for approximately nine years and wanted to reduce his methadone dose slowly. Mr Abbott said that his mental health had become worse about 18 months ago, and that he used to cut his arms when he heard voices telling him to self-harm. He said that he had also attempted suicide by overdosing on medication or tying himself to train tracks. He told her that he could now manage his mental health and did not listen to the voices. She noted that Mr Abbott did not have thoughts of suicide or self-harm, that he would ask for help if he was struggling to cope and that he would continue to work with the substance misuse team to reduce his methadone dose. There is no evidence that she considered starting ACCT procedures.

64. On 24 November, a prison GP noted that he would reduce Mr Abbott’s methadone dose by 1ml per week.

65. On 7 December, a substance misuse worker reviewed Mr Abbott and noted that he was doing well in reducing his methadone dose and was happy to keep

reducing it by 1ml each week. She completed an activity that identified Mr Abbott's strengths. Mr Abbott said that he found it good to talk to someone and wanted to look at coping mechanisms in his next session. She noted that she would review Mr Abbott every six to eight weeks.

66. On 30 January, Mr Abbott told wing staff he wanted to see a doctor. He said that he needed an appointment as soon as possible because his mental health had become worse and the voices he had been hearing were really bad. He said that he had thought there was someone in his cell the night before and was on his hands and knees looking for someone who was not there. Mr Abbott said that he was not going to work because he was worried he would do something stupid. He said that he did not want to get into trouble for not going to work.

67. On 22 January, a substance misuse worker reviewed Mr Abbott who told her that he wanted to reduce his methadone dose by 3ml each week. He said that he wanted to reduce his dose more quickly because he was sick of being addicted to drugs. Mr Abbott asked about moving to the recovery wing in the prison and told her that he would only move if he did not have to share a cell. He told her that his mental health would get worse if he had to share a cell. Mr Abbott told her that prison had helped him a lot because he had tried to stop taking drugs in the community but there were too many temptations. She noted that she would review Mr Abbott in four weeks time.

68. On 1 February, Nurse A, in the secondary mental health team, made two entries in Mr Abbott's medical record. At 10.52am, he noted that wing staff had phoned him after Mr Abbott said he was hearing voices. Nurse A assessed Mr Abbott during an emergency appointment and Mr Abbott told him that he was hearing voices but could not say if he was hearing his own voice. He said that he was struggling with anxiety and felt paranoid that people were out to hurt him. Nurse A noted that Mr Abbott appeared anxious and was fidgeting but had no signs of psychotic symptoms or thoughts of suicide or self-harm.

69. Nurse A spoke to a prison GP about prescribing sertraline (an antidepressant), and the prison GP noted that he would make a GP appointment for Mr Abbott to discuss medication. Nurse A recorded that he would continue to assess Mr Abbott's mood and behaviour and refer him to the primary mental health team for psychosocial intervention (activities used to change behaviour, emotions or feelings). A therapist recorded that he had added Mr Abbott to the primary mental health waiting list.

70. At 4.20pm on 1 February, Nurse A made a second entry in Mr Abbott's medical notes after a workshop instructor phoned healthcare staff because Mr Abbott had not come to work. The workshop instructor wanted to know if Nurse A had said that Mr Abbott could rest in his cell that day. Nurse A noted that he had assessed Mr Abbott after he came to healthcare at 9.30am and said he was having paranoid thoughts that had increased in the past few days and were making him feel uncomfortable. He said that the voices were related to 'emotional anxiousness'. Nurse A noted that Mr Abbott had asked if he could have permission to rest in his cell, and that he had agreed to this because Mr Abbott was paranoid and this would prevent him from getting into a fight. He noted that he would continue to assess Mr Abbott's mood while he was waiting to

see a psychiatrist. There is no record that Nurse A told wing staff that Mr Abbott had permission to rest in his cell. On 4 February, Mr Abbott refused to go to work but no further action was taken.

71. On 8 February, a recovery worker reviewed Mr Abbott who said he was feeling very anxious because he was still hearing voices. He said that he felt stable when he first arrived in prison but his mental health had become worse and he was now hearing strangers' voices as well as his grandmother's voice. She noted that Mr Abbott's main concern was hearing voices and that his mental health would need to be more stable before he could benefit from therapy. She referred Mr Abbott to the secondary mental health team for a full mental health assessment and noted that he would be reviewed in four weeks.

72. The same day, a prison GP asked the mental health team to get Mr Abbott's community mental health records and arrange a psychiatry appointment because Mr Abbott did not have a clear diagnosis. He noted Mr Abbott's anxiety issues and that he was hearing voices and seeing things, but that Mr Abbott said he could cope with his symptoms. He told the investigator that Mr Abbott did not ask for drugs but wanted a diagnosis and a treatment plan. He said that he remembered this appointment because Mr Abbott did not demand drugs, which was quite unusual for prisoners. He noted that Mr Abbott had permission to rest in his cell for two weeks.

73. On 9 February, a mental health nurse asked Nurse A to review Mr Abbott because he was still hearing voices. She asked Nurse A to speak to a prison GP after the review. The next day, Nurse A noted that he went to Mr Abbott's wing but prison staff told him that Mr Abbott said he would prefer to go to work than to wait for the mental health team. Nurse A asked the officer to put in writing that 'Mr Abbott did not want to engage' and rescheduled the appointment.

74. On 17 February, Nurse A assessed Mr Abbott following the receipt of his community medical records the previous day. He recorded that he had assessed Mr Abbott because a prison GP was concerned that he was hearing voices. He noted that the assessment was a routine review for prisoners on the mental health inreach team caseload. Nurse A noted that Mr Abbott would 'continue to engage in therapeutic intervention based on empathy and trust', and would benefit from medication to reduce the symptom of hearing voices. He told Mr Abbott to book a GP appointment to get treatment for his low mood.

75. The same day, Mr Abbott did not attend work. Prison staff phoned healthcare staff who said that they had not given permission for Mr Abbott to rest in his cell. This was despite a prison GP noting on 8 February that Mr Abbott had permission to rest in his cell for two weeks.

76. On 25 February, Nurse A made two entries in Mr Abbott's medical record. At 5.29pm, he recorded that he had reviewed Mr Abbott at 3.10pm, who told him that he had spoken to a prison GP on 8 February. Nurse A noted that Mr Abbott had signs of anxiety and was biting his finger, was restless and had palpitations. He said that he was struggling for the last three days in his cell because he was hearing voices and saw a white ghost talking to him. Nurse A reassured Mr Abbott and told him to book another appointment with the GP so he could get

treatment for his anxiety. Nurse A noted that Mr Abbott had no thoughts of suicide or self-harm.

77. At 5.52pm, Nurse A made a second entry in Mr Abbott's medical record. He noted the previous care plan for Mr Abbott and that he should report any change in his mood or behaviour while he was waiting to see the GP. He noted that he would review Mr Abbott again on 30 June.

78. On 9 March, a prison GP noted that Mr Abbott wanted to stop smoking and gave him some nicotine patches. His mental health problems were not noted at this appointment.

79. On 23 March, a substance misuse worker reviewed Mr Abbott and recorded that he was in good spirits and wanted to reduce his methadone dose. He asked if he could reduce his dose more slowly because he was starting to feel the effects and was tempted to use drugs again. A prison GP reviewed Mr Abbott's medication and slowed down his methadone reduction.

80. On 31 March, Mr Abbott stopped taking methadone and had withdrawal symptoms of stomach cramps and pain, and was given pain medication. A prison GP gave Mr Abbott medication to help with the symptoms of withdrawal.

81. On 7 April and 21 April, a prison GP reviewed Mr Abbott and noted that he was struggling with his withdrawal. He noted that Mr Abbott only wanted to take panadol (pain medication) and gave him some zopiclone. There is no record that he spoke to Mr Abbott about his mental health problems at these appointments.

82. On 20 April, a substance misuse worker noted that Mr Abbott was struggling without methadone and he told her that he had used subutex (a drug used to treat opiate addiction). He said that he wanted to go back on methadone because he had reduced his dose too fast. She made an appointment for Mr Abbott to see the GP the next day. On 21 April, a prison GP prescribed 10ml of methadone for Mr Abbott. The next day, a prison GP treated Mr Abbott for ear pain. As with his last three appointments, the prison GP did not note whether he had spoken to Mr Abbott about his mental health problems.

83. On 28 April, Nurse A spoke to wing staff because Mr Abbott had asked to see the mental health team. Wing staff told Nurse A that Mr Abbott was at work and he noted that he would reschedule the appointment.

84. On 10 May, a substance misuse worker recorded that Mr Abbott had not come to his last two review appointments. She discharged him from the substance misuse team caseload and wrote him a letter saying that he could ask to see her again if he wanted support in the future.

85. On 27 May, Nurse A made an entry in Mr Abbott's medical record that was identical to the entry he made on 25 February. He added to the note that Mr Abbott had reasonable insight into his anxiety and the plan was to book an appointment with the GP and 'task the GP to prescribe an antidepressant'. The investigator was unable to speak to Nurse A to ask why he repeated this entry in Mr Abbott's records.

86. On 1 June, a prison GP received a message from Nurse A about Mr Abbott's increased anxiety. He noted that Mr Abbott had recently stopped taking methadone. A prison GP sent a message to Nurse A asking him to refer Mr Abbott to the primary mental health team because the first intervention for anxiety should be therapy and not medication. Nurse A replied 'Thanks, however I have highlighted him as a concern to you.' The next day, a nurse noted that she had received a referral for Mr Abbott to the Mental Health Recovery and Rehabilitation Service.

87. On 4 July, Mr Abbott told a nurse that he felt nauseous. She told him to return to healthcare if the nausea continued, and said that he could rest in his cell until the next day.

14 July

88. From 4.15pm on 14 July, prisoners in billet accommodation were on association (when prisoners are allowed out of their cells to socialise with each other). During association, prisoners can leave their cells but the billets stay locked. Prisoner A said that he was drinking illicit alcohol ('hooch') with Mr Abbott until about 4.30pm. Prisoner A said that some other prisoners B, C and D, were also drinking hooch with Mr Abbott. Prisoner A said that Mr Abbott wanted some alcohol to have in his cell that night but he would not give him any.

89. Prisoner B said he was in the gym from about 4.15pm until 5.00pm. He did not mention drinking hooch with Mr Abbott in his statement to police. Prisoners C and D also did not mention drinking alcohol with Mr Abbott that afternoon.

90. Prisoner E said that Mr Abbott had been told something about his partner and thought she was going to leave him. He said that Mr Abbott had hooch in his cell and told him that afternoon that he was going to 'get pissed on hooch' that night. He said that Mr Abbott seemed down about his partner and that he did not have his medication.

91. Prisoner B said that he walked with Mr Abbott to the dining hall to collect their dinner. Prisoner B took his dinner back to the billet to eat. He said he did not see Mr Abbott eat his dinner but saw him during association time on the landing. He said that he did not see Mr Abbott with anyone else on the landing and thought that he seemed a bit down.

92. Prisoner F said that he went to Mr Abbott's cell and they had a cup of tea together that afternoon. He said Prisoner B was also in Mr Abbott's cell but he did not remember Mr Abbott having any hooch. At 5.45pm, officers came to the billet to start locking prisoners in their cells. Prisoner F said that he thought Mr Abbott seemed fine.

93. At 6.10pm, a prison manager and an officer started locking up three billets, including the billet where Mr Abbott's was located. The prison manager and officer went to each billet and asked the prisoners to go into their cells. They said they checked each cell, spoke to the prisoners, and tried to get a response before closing and locking the cell door. Once the prisoners were locked in their cell, they counted the prisoners. The prison manager and the officer checked that the roll count was correct and then an officer signed the roll check sheet.

The prison manager said that he did not know Mr Abbott but there was nothing unusual about the lock up with any of the prisoners that night.

94. At around 9.00pm, two operational support grades checked prisoners in Mr Abbott's billet. An operational support grade said that the purpose of these checks was to make sure the prisoner was in their cell and was okay, but that he did not need to get a response from the prisoner. He said that visibility through the observation panel was not great, but he used a torch and tried to be as sure as possible that the prisoner was okay. He said that he could not remember if he or his colleague checked Mr Abbott's cell that night, but nothing unusual was noted during the checks.

15 July

95. At around 6.00am, the two operational support grades did their morning check of the prisoners. One operational support grade said that the other checked Mr Abbott's cell and said that he was okay and everything was fine.

96. At approximately 7.40am, Officer A started the morning roll count on Mr Abbott's billet. He said that he went to each cell and looked through the observation panel to check that the prisoner was in their cell. He said that he also checked that there were no concerns about the prisoner or the condition of the cell.

97. Officer A checked Mr Abbott's cell and said he noticed nothing unusual. He said that there was light coming through the window so he could see into the cell without a torch or the night light. He said that the door was locked and there was nothing blocking his view of the cell, but the observation panel was scratched and the view into the cell was not very clear. He also said that he could not see the toilet area from the door because there was a screen around that area.

98. Officer A said that he normally checked if the prisoner was in their bed, and he thought that he saw Mr Abbott in his bed when he looked through the observation panel that morning. He said that there was something about the way the bed looked, like a shadow on the bed, which made him think he saw a prisoner in the bed. He said that he did not notice anything usual that drew his attention to any of the cells on Mr Abbott's billet that morning. He said that prisoners stayed locked in their cells until the roll count was finished.

99. At around 8.05am, officers started to unlock the cells of prisoners who were going to work. Prisoner F said that after unlock, he went to Mr Abbott's cell and looked through the observation panel. He said that he could not see Mr Abbott in the cell but the room was dark and he thought he was still in bed.

100. At approximately 9.00am, Officer A, Officer B and Officer C started checking the billets to make sure that all prisoners who were unlocked had left for work. Officer A said that staff had a list of prisoners that did not need to be unlocked for work. He said that Mr Abbott must have been on the list because his cell was locked. Officer A said that this check was also to make sure that the remaining prisoners were present and locked in their cells. Officer A started checking the billet and went to Mr Abbott's cell first. He said that each cell had a main lock and a courtesy lock. The main lock could only be unlocked by prison staff. Prisoners were given a key to their cell that locked and unlocked the courtesy

lock. The courtesy lock could only be unlocked after prison staff had unlocked the main lock. Officer A said that when he checked Mr Abbott's cell, both the main lock and the courtesy lock were in the locked position.

101. Officer A looked through the observation panel but could not see Mr Abbott in the cell. He said that he thought this was unusual because a prisoner should be in their cell if the main lock is engaged. He unlocked the cell and opened the door a few inches and saw the lower half of a prisoner's legs coming out from the toilet cubicle. Officer A thought that the prisoner was unwell and was leaning over the toilet being sick. He stayed in the doorway and asked the prisoner if he was okay, but he did not respond or move. Officer A said that he did not go into the cell alone because he thought the prisoner might have taken NPS which can make people unpredictable and violent. He called out to Officer B and said there was a possible code blue (an emergency code that indicates a prisoner is not breathing) and asked her to come into the cell with him.

102. Officer A and B went into the cell and Officer C stayed at the door. Officer A asked the prisoner if he was okay and then went to the front of the toilet cubicle. He saw Mr Abbott in a kneeling position in front of the toilet with his back to him. Mr Abbott did not respond so Officer A told Officer B it was a code blue.

103. At 9.01am, Officer B radioed a code blue. Officer C stayed at the door to the cell to speak to control room and healthcare staff over the radio. At 9.02am, Officer C asked for an ambulance and for the duty governor to come to Mr Abbott's cell.

104. Officer A and B then noticed that Mr Abbott had a ligature made from a green bed sheet around his neck that was tied to the top of the left side wall of the toilet cubicle. Officer A lifted Mr Abbott under his arms to hold his weight while Officer B cut the ligature. She noted that the ligature was deeply embedded in Mr Abbott's neck. Officer A moved Mr Abbott between the toilet and the bed and tried to put him on his back. The officers noted that Mr Abbott felt cold and was very stiff, there was dried blood under his nose and the lower parts of his body were purple. Officer A said that he tried to get Mr Abbott in a position to start resuscitation but, when he put him on the floor, his body stayed in the same kneeling position. He checked Mr Abbott's neck for a pulse but could not find one and said to Officer B, 'He's gone'. Officer A said that he decided not to start resuscitation because he was sure Mr Abbott was dead.

105. Officer D and Officer A covered Mr Abbott's body with a blanket and asked Officer B to leave the cell. A few minutes later, a nurse arrived at Mr Abbott's cell and Officer A told her that Mr Abbott had died. She checked Mr Abbott but could not find a pulse and noted that he was not breathing, his pupils were fixed and dilated, his body was stiff and he was purple in colour. She asked a GP to attend.

106. At 9.06am, a prison GP arrived at Mr Abbott's cell. He noted that Mr Abbott's pupils were fixed and dilated, and that he was cold to touch, bluish in colour and his body was stiff. At 9.07am, he recorded that Mr Abbott had died. At 9.35am, the paramedics arrived and three minutes later, they confirmed that Mr Abbott had died.

Contact with Mr Abbott’s family

107. At 12.30pm, a prison manager and a prison family liaison officer went to Mr Abbott’s partner’s home. At 4.30pm, they went to her address and met Mr Abbott’s partner and his sister and told them that he had died. They offered condolences and support. The prison contributed to the costs of Mr Abbott’s funeral, in line with national guidance.

Support for prisoners and staff

108. After Mr Abbott’s death, the 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.

109. The prison posted notices informing other prisoners of Mr Abbott’s death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Abbott’s death.

Post-mortem report

110. The post-mortem report found that Mr Abbott’s cause of death was hanging. The pathologist concluded that Mr Abbott could have died as early as around 7.00 to 8.00pm on 14 July and up to and around 1.00am on 15 July.

111. The post-mortem also found that, shortly before his death, Mr Abbott had been the subject of a very serious sexual assault with an object forcibly inserted into his rectum, causing serious internal damage. The pathologist said that this would have caused Mr Abbott ‘immense pain and suffering ‘. He concluded that it was most likely that Mr Abbott had died ‘some minutes’ but ‘possibly up to an hour’ after the assault.

112. Although no traces of illicit drugs were found in Mr Abbott’s body, the post-mortem identified changes within his heart muscles which supported the view that he had taken Spice – a New Psychoactive Substance (NPS) - or had Spice administered to him shortly before his death. The toxicology report showed that Mr Abbott had drunk a moderate quantity of alcohol before he died.

113. The post-mortem also noted unexplained marks on Mr Abbott’s ankles and peculiarities in the construction of the ligature.

114. The pathologist said that the police had shown him a video in which another prisoner had been suspended by his feet from the ceiling and seriously sexually assaulted, and that he could not exclude the possibility that Mr Abbott had been involved in a similar episode. He went on to say that he could not exclude the possibility that Mr Abbott’s death by hanging was the result of an unlawful act.

Police investigation and the closure of the billets

115. After Mr Abbott’s death the police launched Operation Knightsbridge to investigate a number of serious incidents at Haverigg (including the deaths of Mr Abbott and another prisoner, two stabbings, three alleged sexual assaults and an arson attempt).

116. In the case of Mr Abbott they found that it was clear that he was the victim of a violent sexual assault shortly before he died. The police arrested five prisoners but after reviewing the evidence, it was decided that there was insufficient evidence to refer the matter to the Crown Prosecution Service to consider charges. Although the police carried out extensive enquiries, they were unable to find out how Mr Abbott was sexually assaulted before he died and who assaulted him.

117. In March 2017, the police told the PPO that all lines of enquiry had been exhausted and they had decided to close their investigation. The wider investigation, Operation Knightsbridge, has also now concluded without any charges being brought, apart from one charge for arson.

118. The National Offender Management Service (now HMPPS) closed the billet accommodation at Haverigg in October 2016. This was because the safety of prisoners living there could not be assured.

Findings

119. A number of significant changes have occurred at Haverigg since Mr Abbott's death. The billet accommodation was closed in October 2016. There have also been changes to the primary care and mental health teams to promote multi-disciplinary working. Our findings and recommendations are made in light of these changes.

Violence reduction

120. Mr Abbott was the victim of a serious sexual assault before he died. The police conducted a criminal investigation but did not find out who was responsible for assaulting Mr Abbott or when and how the incident took place.

121. The post-mortem findings suggest that the sexual assault happened shortly before prisoners were locked in their cells on the night of 14 July. Mr Abbott had suffered serious internal injuries which the pathologist said would have caused him 'immense pain and suffering'. It seems surprising, therefore, that the officers say they noticed nothing unusual when they locked the prisoners up.

122. In its inspection of Haverigg in January 2014, HMI Prisons identified the opportunities for bullying and the lack of staff presence in the billeted units as a concern. The inspectors did not consider that Haverigg was on top of the problem. In its report, published in May 2014, HMIP recommended that staff supervision of the billeted units, particularly unit two where Mr Abbott was located, should be improved.

123. Haverigg's local policy 'Safer Custody Policy & Violence Reduction Strategy – March 2015' states that all incidents of violence and serious anti-social behaviour will be investigated thoroughly and all incidents of violence whether suspected or proven will be reported. It states that unexplained injuries must be reported and victims should be supported by opening a support document, which should be used in all cases of suspected and proven anti-social behaviour.

124. A number of prison staff told the investigator that they had concerns about the safety of both staff and prisoners in the billets at the time of Mr Abbott's death because they were difficult to supervise. A Supervising Officer (SO) said the nine billets (huts) in unit two, where Mr Abbott was located, held 198 prisoners and were supervised by four to six staff. Officer A said that each billet contained approximately 20 prisoners and was essentially a self-contained community, which made it difficult to maintain the safety and security of the environment. The SO said that there was no CCTV in the area and a number of blind spots.

125. Officer A said that while staff were aware that there was violence, NPS use and assaults on the billets, they found it difficult to take any action because they were not able to witness the incidents. He said that because of staffing levels, officers were sometimes unable to go onto the billets when prisoners were unlocked. Prisoners knew this, and would often shout a code word before staff went onto the billets to warn other prisoners. This meant that staff only knew something had happened because they found a prisoner who had been assaulted or was under the influence of NPS. He said that the abuse started out as minor incidents, such as drawing on the person, but then it got worse and there were

reports of prisoners being urinated on or tied up and hung from the ceiling. (The pathologist who carried out Mr Abbott's post mortem, had seen a video of one such incident and said he could not rule out similar behaviour prior to Mr Abbott's death.)

126. A SO said staff first became aware of problems on the billets in September 2015 when an intelligence report was submitted stating that a prisoner had been assaulted by a group of prisoners. He said that staff did not know about the seriousness of these incidents until the police investigation.

127. A nurse said that there were many assaults in the prison around the time that Mr Abbott was at Haverigg. She said that there were a lot of unusual incidents and prisoners would go to healthcare and say that they had slipped in the shower. She said she reported these incidents to the prison but prisoners would either not say anything or tell staff that nothing had happened.

128. The police carried out an investigation – Operation Knightsbridge – into the deaths of Mr Abbott and another prisoner, physical assaults including two stabbings, three alleged sexual assaults and an arson attempt at Haverigg in June and July 2016. A number of these incidents involved the use of NPS and occurred in unit two of the billets.

129. Given the evidence from staff, Operation Knightsbridge, and the circumstances of Mr Abbott's death, it is difficult to avoid the conclusion that insufficient action had been taken to improve staff supervision and prisoner safety at Haverigg, particularly in the billeted units, following HMIP's findings and recommendations in 2014. It is a cause for very serious concern that this situation appears to have been allowed to continue.

130. The most recent HMIP inspection of Haverigg in March and April 2017 found that 40% of prisoners said they had felt unsafe at some point. The inspectors found that, after the billet accommodation was closed in October 2016, reported violence had reduced and was now lower than in comparable prisons. Despite this, the inspectors found that there was not enough support for victims, or appropriate challenge or intervention with perpetrators of violent incidents and that the revised violence reduction strategy was not being implemented effectively. Inspectors recommended that a clear plan should be introduced to address prisoners' perceptions of safety, and the safer custody team should ensure that the local strategy is effectively implemented to provide adequate support for victims, challenge perpetrators, and address any underlying causes of violent incidents.

131. The sexual assault on Mr Abbott was not the cause of his death. However, it is clear from the post-mortem that the two occurred very closely together and are very likely to have been linked. We are extremely concerned about the level of violence at Haverigg prior to Mr Abbott's death and the evident lack of managerial grip in the prison and beyond. Although violence has reduced since the closure of the billet accommodation, there is more work to be done to ensure that prisoners are safe. We support the inspectorate's findings and make the following recommendation:

The Governor should ensure that violence reduction strategies are implemented effectively to provide support for victims and appropriate challenge or intervention with perpetrators.

Bullying

132. Mr Abbott's partner's asked whether he was being bullied or was in debt because he had asked her to deposit money in another prisoner's account.

133. Asking family members to pay money into another prisoner's account often indicates that a prisoner is in debt (often drug-related) and debt is often associated with bullying. However, although there was intelligence that prisoners on Mr Abbott's billet were being bullied over debts, there was no intelligence that Mr Abbott himself was being bullied or that he was under threat. Officer A told us that she did not think Mr Abbott was being bullied because, as an enhanced prisoner under the IEP scheme, he had been offered the opportunity to move to better accommodation in the prison but said that he wanted to stay in the billet.

134. In the absence of clear evidence one way or another, we cannot make a finding about whether Mr Abbott was being bullied or not. It follows that we cannot say whether the sexual assault Mr Abbott suffered shortly before his death was a one-off incident or part of a pattern of bullying.

Mental health care

Delays in referral to the psychiatrist

135. Although Mr Abbott repeatedly told healthcare staff that he was hearing voices, he was not seen by a psychiatrist during the eight months he was at Haverigg or the 10 months he was in prison. A nurse first referred Mr Abbott to the psychiatrist on 10 October 2015. On 1 February 2016, Nurse A noted that Mr Abbott was waiting to see the psychiatrist but there is no evidence that any action was taken to arrange an appointment. On 8 February, a prison GP asked the mental health team to obtain Mr Abbott's community mental health records and arrange a psychiatry appointment because Mr Abbott did not have a clear diagnosis. There are no further notes about Mr Abbott's referral to the psychiatrist in his medical records, despite Mr Abbott telling healthcare staff that his mental health had deteriorated and he wanted help.

136. A prison GP told the investigator that in 2016 the psychiatrist visited the prison once a fortnight and there was a six to nine month waiting list. He thought that, if the case was urgent, the secondary mental health team should have prioritised Mr Abbott's appointment.

137. The clinical reviewer noted that 'although waits for specialist appointments are common in the community, a wait of ten months is not equivalent care' and that 'consultant-led mental health services are covered by the NHS 18 week maximum waiting time'. The clinical reviewer recommended that the prison should consider 'how waiting lists for referrals to psychiatry are actioned' and that 'the Head of Healthcare and Senior Administration staff should review the process of referral to specialist and consultant-led services to ensure they meet

the NHS standard of a maximum of eighteen weeks'. We share the clinical reviewer's concerns and make the following recommendation:

The Greater Manchester Mental Health Trust Service Manager should ensure that there is a robust process in place so that appropriate psychiatric referrals are made, actioned and a response received by the primary healthcare team.

Failure to monitor and provide treatment

138. Mr Abbott was very anxious, hearing voices and seeing things in his cell and asked the GP and mental health team for help because his mental health was deteriorating.

139. Mr Abbott did not receive treatment for his mental health problems at Haverigg although he was referred to the mental health team on several occasions. Although the GP, recovery worker and reception nurse all referred Mr Abbott to the mental health team for management, each time Nurse A reviewed Mr Abbott, he referred him back to the GP to discuss medication to treat his low mood. Nurse A reviewed Mr Abbott on 17 and 25 February and told him to book an appointment to see the GP to get medication to treat his low mood. This was despite Mr Abbott telling Nurse A that he had already spoken to a prison GP about medication on 8 February when they discussed referral to the psychiatrist so he could get a diagnosis and treatment plan. Mr Abbott was not reviewed by the mental health team between February and May 2016. The last contact Mr Abbott had with the mental health team was on 2 June.

140. A prison GP told the investigator that he thought Mr Abbott was being managed by the mental health team. He said that he would only follow up and review a prisoner's records if he had specific concerns about them, and he said he did not have concerns about Mr Abbott.

141. The clinical reviewer noted that despite Mr Abbott being seen by a mental health nurse after showing symptoms of anxiety, saying that he was hearing voices, and asking for antipsychotic medication, 'he was not prescribed medication or monitored on a regular basis'. We share these concerns and we make the following recommendation:

The Greater Manchester Mental Health Trust Service Manager should ensure that the mental health referral system results in the timely review and treatment of prisoners with mental health needs.

Clinical supervision

142. The clinical reviewer noted that Nurse A's notes were 'difficult to understand' and concluded that it was clear from Mr Abbott's medical records that 'the nurse assigned to Mr Abbott was not managing Mr Abbott's case effectively'.

143. Nurse A is no longer working at Haverigg. The investigator contacted him to ask him to attend an interview, but Nurse A did not respond. The clinical reviewer recommended that the Head of Mental Health should review the policies and procedures in place to ensure that managerial and clinical supervision of all

nurses, including those on temporary or agency contracts, is effective.' We share the clinical reviewer's concerns and support the recommendation.

Multi-disciplinary working

144. The clinical reviewer concluded that there was 'no real evidence of multi-disciplinary working or communication between the substance misuse team, the GP and mental health services' and that communication between Nurse A and a prison GP was 'by the task manager on SystmOne (the medical record system) rather than face to face communication'. The clinical reviewer's report concluded that 'communication and inter-disciplinary team working were unsatisfactory'.

145. A prison GP acknowledged that there had been a gap between mental health and physical health services when Mr Abbott was at Haverigg. He also described communication difficulties with the mental health team. He said that he had never met the psychiatrist and that morning meetings with the mental health nurse did not always happen. He said that rather than coming and speaking to him about prisoners, a lot of interactions with mental health staff were through the medical record system. He said that because he was not meeting with mental health staff regularly, there was a gap between the services.

146. A prison GP said that the relationship with mental health has changed significantly since Mr Abbott's death. They now have a shared care plan in place and a new psychiatrist has reduced the waiting list for prisoners. He said that he attends a weekly multi-disciplinary meeting with psychiatry, secondary mental health, primary mental health and the substance misuse team to discuss the management of individual prisoners.

147. The clinical reviewer concluded that the Head of Healthcare should review the arrangements in place to ensure there is effective multi-disciplinary communication. We make the following recommendation:

The Greater Manchester Mental Health Trust Head of Healthcare should ensure that there is effective and clear liaison between the primary care providers and the mental health inreach teams.

Assessment of the risk of suicide and self-harm

148. Prison Service Instruction (PSI) 64/2011 'Safer Custody' lists a number of risk factors and potential triggers for suicide and self-harm. Any member of staff who receives information, including that from external agencies, or observes behaviour, which may indicate a risk of suicide or self-harm must open an ACCT.

149. When Mr Abbott arrived at Haverigg, he had a number of risk factors for suicide and self-harm, including a history of self-harm and suicide attempts, mental health problems, substance misuse and recent contact with psychiatric services. We consider that even though Mr Abbott said that he did not have thoughts of suicide or self-harm, he had a number of risk factors and staff should have started ACCT procedures when Mr Abbott arrived at Haverigg. We make the following recommendation:

The Governor should ensure that staff are aware of, consider and record all the known risk factors for suicide or self-harm. They should open an ACCT whenever a prisoner has significant risk factors. When, exceptionally, they decide not to begin ACCT procedures for prisoners with significant risk factors, they should clearly record the reasons.

Unlock procedures

150. PSI 2011/10 'Residential Services' states that there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock. The Prison Officer Entry Level Training (POELT) manual states:

> "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."

151. On 14 July, Mr Abbott was locked in his cell around 6.10pm. Prison staff told us that they checked on him at approximately 9.00pm and 6.00am and did not notice anything unusual. At 7.40am, Officer A said he checked on Mr Abbott during the morning roll count. He said that he thought he saw Mr Abbott in bed, but the post-mortem report states that Officer A could not have seen Mr Abbott in his bed at 7.40am because he had been dead for some time. At 8.05am, Mr Abbott was not unlocked with other prisoners because he was not going to work. Prison staff did not get a verbal response from Mr Abbott to check his welfare during roll check or unlock procedures. His body was not, therefore, found for over an hour. This did not make any difference in Mr Abbott's case as he had been dead for some time, but this kind of delay could be critical in other cases.

152. While we understand that staff will not necessarily want to wake prisoners early in the morning, it is essential that staff satisfy themselves that a prisoner is alive and well, and take some action if there is no sign that the prisoner is breathing. We make the following recommendation:

The Governor should ensure that all prison staff are aware of the correct procedures at roll checks and that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

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