Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Frith, a prisoner at HMP Berwyn, on 14 November 2020

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Robert Frith was found dead in his cell at HMP Berwyn on 14 November 2020. He had suffocated himself by placing a plastic bag over his head. He was 65 years old. I offer my condolences to Mr Frith's family and friends.

Mr Frith arrived at Berwyn on 9 November, having been remanded for allegedly kidnapping a child. It was his first time in prison. He was a heavy drinker in the community and was showing some alcohol withdrawal symptoms.

Staff assessed that Mr Frith was not at risk of suicide or self-harm. However, there is little evidence that staff had given proper consideration to the nature and high public profile of Mr Frith's offence. I have recommended that reception procedures are reviewed to ensure that staff fully consider all risk factors.

Mr Frith was concerned about being unable to telephone his partner due to the prison's security restrictions on his phone. The restrictions were lifted on 13 November, but it appears Mr Frith was unaware of this as he had not read the electronic message sent to him. I have recommended that in future, direct contact is made with prisoners about phone restrictions and the lifting of them, so they understand how they can contact family and friends. This is particularly important for prisoners who are in prison for the first time.

The clinical reviewer found that Mr Frith received a good standard of care for his alcohol withdrawal and that his mental health needs were assessed appropriately.

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

Sue McAllister CB
Prisons and Probation Ombudsman **June 2021**

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Summary

Events

1. On 9 November 2020, Mr Robert Frith was remanded in prison custody, charged with kidnap of a child. This was his first time in prison.

2. When Mr Frith arrived at Berwyn, staff noted that he had no history of attempted suicide or self-harm and he told them he had no thoughts of suicide.

3. Mr Frith had a long history of alcohol dependence and was prescribed medication to manage his withdrawal. He was monitored regularly by healthcare staff.

4. Mr Frith told staff that he was anxious as it was his first time in prison and he had been unable to speak to his partner (one of his co-defendants). He also did not have the contact details for his brother as his phone had been taken by the police when he was arrested.

5. Shortly after 8.25am on 14 November, an officer unlocked Mr Frith's cell. He saw Mr Frith was in bed but when he called out, Mr Frith did not respond. When he checked on Mr Frith, he realised that he had a plastic bag over his head. He removed the bag and called for staff assistance. Another officer radioed a medical emergency code at 8.27am. Staff did not attempt to resuscitate Mr Frith as it was clear he was dead. At 8.50am, a paramedic confirmed Mr Frith's death.

Findings

6. While we accept that Mr Frith arrived with no self-harm warning forms and had no known history of self-harm, we are concerned that reception staff did not give proper consideration to the nature of his offence, which had attracted media interest. We found that the reception procedures for screening those who may be at risk of suicide and self-harm were not sufficiently robust. The form completed by prison officers had closed questions that required a simple yes or no response and little space to record further information or prompt further consideration of known risk factors.

7. The clinical reviewer concluded the care Mr Frith received for his physical and mental health care, as well as his withdrawal from alcohol, was equivalent to that which he would have expected to receive in the community.

8. Mr Frith did not make any telephone calls while he was at Berwyn, because of security restrictions placed on his PIN phone (the prison phone system). We found that he was not properly informed of the decisions to restrict his calls, although we cannot say if this had any bearing on his decision to take his own life.

9. We are also concerned that Mr Frith's cell was in a poor state when he was placed there.

Recommendations

- The Governor should review the first night assessment booklet to assist staff in identifying other risk factors or triggers that could indicate risk of suicide and self-harm.
- The Governor should ensure that OMU staff:
  - make direct contact with a prisoner to explain any restrictions and to tell them when they are lifted; and
  - alert wing staff to the sharing of any potential bad news, so that they can manage this appropriately and provide additional support, if necessary.
- The Governor should ensure that:
  - cell conditions are properly checked and documented;
  - repairs are promptly reported and fully documented and that there is a clear audit trail showing when the fault has been reported and when it has been resolved; and
  - prisoners are not placed in cells that do not meet the minimum requirements, in accordance with PSI 17/2012.
- The Head of Healthcare should ensure that:
  - healthcare staff working at Berwyn have timely access to advice, support and guidance from on call healthcare managers; and
  - appropriate measures are put in place to offer support to healthcare staff following their involvement in significant incidents.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Berwyn, informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded, but one later refused to be interviewed.

11. The investigator obtained copies of relevant extracts from Mr Frith's prison and medical records. Health Inspectorate Wales commissioned a clinical reviewer to review Mr Frith's clinical care at the prison.

12. The investigator and clinical reviewer jointly interviewed seven members of staff on 21 December and a prison manager on 8 January 2021. The investigator also interviewed a prisoner, probation officer and prison chaplain. All the interviews were conducted by telephone because of the restrictions imposed in response to COVID-19.

13. We informed HM Coroner for North Wales (East & Central) of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.

14. The PPO's family liaison officer contacted Mr Frith's brother to explain the investigation and to ask if he had any matters that he wanted us to consider. Mr Frith's family raised no issues.

15. Mr Frith's brother received a copy of the initial report. He did not identify any factual inaccuracies.

16. The prison also received a copy of the report and corrected the name of the organisation that commissioned a clinical review. No other factual inaccuracies were identified. An action plan for the recommendations is annexed to the report.

Background Information

HMP Berwyn

17. HMP Berwyn is a newly built category C training prison near Wrexham. It opened in 2017 and is designed to hold around 2,100 men. Berwyn is comprised of three house-blocks or units – Alwen, Bala and Ceiriog – each divided into eight communities. Healthcare services are provided by Betsi Cadwaladr University Health Board.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Berwyn was in March 2019. Inspectors reported that arrangements for the reception and induction of new arrivals were impressive and first night interviews effectively identified immediate needs and risks. However, arrangements to support and safeguard those who were vulnerable were not very good.

19. Inspectors noted that 85% of prisoners said their cell was clean on their first night. They found the dedicated first night centre provided a comprehensive and well-coordinated induction, which was a safe place for prisoners to settle, and included training on how to use the prison issue laptop computer, to access finances, make requests and other services.

20. Inspectors found that strategic management of suicide and self-harm was under-developed and triggers that could increase the risk of suicide and self-harm were not always identified.

Independent Monitoring Board

21. 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 29 February 2020, the IMB noted that its overall judgement in relation to the effective and efficient operation of Berwyn was that it was still a work in progress, and was continually evolving and improving.

Previous deaths at HMP Berwyn

22. Mr Frith was the sixth prisoner to die at Berwyn since November 2018. Of the previous deaths, four were from natural causes and one was drug-related. There were no similarities between our findings in our investigation into Mr Frith's death and our investigation findings in the previous deaths.

Assessment, Care in Custody and Teamwork

23. 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. Guidance on ACCT procedures is set out in Prison Service Instruction

(PSI) 64/2011, Managing prisoners at risk of harm to self, to others and from others (Safer Custody).

Key Events

24. On 9 November 2020, Mr Robert Frith was remanded in prison custody, charged with the kidnap of a child, and sent to HMP Berwyn. This was his first time in prison.

25. Mr Frith arrived at Berwyn around 2.40pm. On his Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons which sets out the risks they pose), court staff had recorded that Mr Frith was alcohol dependent and withdrawing, and that he was due to appear at Caernarfon Crown Court on 7 December.

26. An officer completed Mr Frith's first night in custody assessment. She noted that Mr Frith had thought he would get bail but as the case was high profile, he had been remanded. She noted he had no thoughts of self-harm or suicide and was aware of the support available. The officer completed the cell sharing risk assessment (CSRA) and again recorded that Mr Frith had no thoughts of self-harm or suicide.

27. A nurse completed Mr Frith's initial healthscreen. The nurse noted Mr Frith had no relevant mental health history and no current thoughts of self-harm or suicide. She recorded that Mr Frith was a heavy smoker and had previously used cannabis but he declined to be referred for help. She referred Mr Frith to the prison GP because he was alcohol dependent.

28. A prison GP examined Mr Frith and continued the detoxification medication started while he was in police custody (chlordiazepoxide and thiamine twice daily).

29. Mr Frith was moved to Ceiriog Wing, the reverse cohorting unit (RCU), in line with COVID-19 measures. (Newly arrived prisoners are located in the RCU for 14 days to prevent the spread of COVID-19.) He was allocated a single cell. Healthcare and prison staff checked Mr Frith during the night.

30. On 10 November, a prison GP reviewed Mr Frith. He noted there was no evidence of over sedation or alcohol withdrawal, and that Mr Frith was in good spirits and was not suicidal.

31. Later that morning, a nurse completed the second healthcare screening. She noted that Mr Frith's mood was normal. In line with the alcohol detoxification care plan, healthcare staff observed Mr Frith over the next four days to ensure he was not over-sedated.

32. An officer noted in Mr Frith's prison record that Mr Frith was worried about his partner, who was a co-defendant, and that chaplaincy staff had been asked to see him. (A prison chaplain, visited Mr Frith that morning.) The officer noted that Mr Frith said his first night had gone well, that he had no issues, did not feel suicidal and had been made aware of how to contact safer custody if he did have any concerns.

33. That afternoon, a member of staff from the substance misuse team, spoke to Mr Frith over the in-cell telephone. He outlined his drinking history and told her he was concerned about his partner, who had also been arrested. Mr Frith was unsure if he would benefit from support, but they agreed that the substance misuse team

would contact him again. She encouraged Mr Frith to speak to wing staff about contact with his partner.

34. On 11 November, there were no concerns noted by prison or healthcare staff.

35. On the afternoon of 12 November, a healthcare support worker noted that Mr Frith appeared short of breath when he was collecting his medication. She spoke to a nurse and she went to Mr Frith's cell to take his clinical observations. She noted Mr Frith was jumpy and anxious and he told her he had panic attacks and was worried as it was his first time in prison; he said he usually dealt with these feelings by consuming alcohol. He also said he liked reading and she explained how he could order some books. Mr Frith's observations were within normal range, although his blood pressure was slightly elevated so her referred him to the prison GP.

36. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. Mr Frith did not make any telephone calls. He told staff that he wanted to contact his partner, who had also been remanded, but contact was not authorised until the day before he died.

37. On 13 November at 11.09am, a probation officer recorded on Mr Frith's prison record that restrictions had been made on Mr Frith's PIN phone, to prevent him contacting his co-defendants (including his partner). However, restrictions on contacting his partner were later removed, although any telephone and written contact would continue to be monitored. The probation officer said she updated the entry on Mr Frith's prison record at 1.49pm to say that she had sent a message to Mr Frith via the prisoner kiosk, which is accessed through a device in a prisoner's cell, to tell him this. She did not speak directly to Mr Frith and he did not read this message.

38. At 3.16pm, a healthcare support worker completed Mr Frith's observations. She noted that he seemed a little drowsy, but not sedated. He said he felt mildly anxious but had no other concerns. Mr Frith's blood pressure was a little high, but there were no other physical health concerns noted.

39. An officer assisted with evening medication, which was dispensed between 4.30pm and 5.10pm. He said he did not recall anything out of the ordinary or unusual about Mr Frith and did not note any change in behaviour or anything to cause concern. At around 5.30pm, the officer locked Mr Frith in his cell for the night.

Saturday 14 November

40. Closed circuit television (CCTV) shows the last roll check for the night was completed by an operational support grade (OSG), at 4.59am. The OSG can be seen shining a torch into Mr Frith's cell. She said that she saw Mr Frith in bed under the covers.

41. At around 8.10am, wing staff started to unlock cells on Ceiriog Wing for those prisoners who required medication. Due to the COVID-19 restrictions, prisoners were unlocked in small groups in a controlled manner. CCTV shows the officer unlocked Mr Frith's cell at around 8.25am. The officer called Mr Frith's name several times but did not get a response. He entered the cell, called again as he approached Mr Frith, shook his foot and shoulder but there was no response. The officer pulled back the duvet and found Mr Frith lying on his front with a plastic bag over his head; his hands were clasped around the bag forming a seal around his

neck. The officer ripped and removed the bag; he briefly left the cell and shouted for staff assistance before going back to Mr Frith.

42. Four officers who were all close by responded. An officer radioed a code blue medical emergency (used to indicate a prisoner is unconscious or having breathing difficulties) at 8.27am. An officer activated his body worn video camera (BWVC). Healthcare staff were in the nearby medications room and a healthcare assistant, responded immediately, closely followed by two nurses.

43. Staff did not attempt cardiopulmonary resuscitation (CPR) as there were obvious signs that Mr Frith had been dead for some time: he had rigor mortis, his blood had pooled, and he was very cold.

44. Welsh Ambulance Service records show they received a request for an ambulance at 8.28am. When paramedics arrived on Ceiriog Wing, they examined Mr Frith and at 8.50am, confirmed he was dead.

After Mr Frith's death

45. Mr Frith's cell was reported to be in a poor condition, with graffiti on the walls. The investigator was not provided with photographs of the cell but from the BWVC footage it was possible to view part of the cell and there is evidence of some writing. North Wales Police were contacted, and they reviewed the images taken by the attending police officers after Mr Frith's death. They noted there was graffiti on the walls, including a drawing of a car and a gun.

Contact with Mr Frith's family

46. Berwyn appointed a Supervising Officer (SO) as the family liaison officer (FLO). When Mr Frith arrived at Berwyn, he said his brother was his next of kin but he did not know his contact details because the police had his mobile telephone. The FLO therefore contacted North Wales Police, and they notified Mr Frith's family of his death.

47. A prison manager, and later the FLO, contacted Mr Frith's family to explain the circumstances of his death and offered their condolences and ongoing support. The prison manager also contacted HMP Styal, where Mr Frith's partner was being held. The duty governor informed Mr Frith's partner of his death with the assistance of a prison chaplain.

48. In line with Prison Service instructions, the prison contributed towards the costs of Mr Frith's funeral, which was held on 4 December.

Support for prisoners and staff

49. The deputy governor, and other senior managers held a hot debrief with all staff involved in the emergency response. Most staff said they felt well supported and the Post-Incident Care Team spoke to everyone involved and the TRiM (trauma risk management) manager advised staff of additional support available via the Regional Safety Team.

50. Healthcare staff told the investigator that support from the on-call healthcare manager could have been better and they did not feel sufficiently supported, although they felt well supported by prison staff. All staff were invited to attend a

TRiM meeting facilitated by the Regional Safety Team, and those who attended said it was very helpful.

51. The prison posted notices informing other prisoners of Mr Frith's death and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Frith's death.

Post-mortem report

52. The post-mortem report gave Mr Frith's cause of death as plastic bag suffocation. The toxicology report noted therapeutic levels of Mr Frith's prescribed medication.

53. The pathologist noted that external examination did not reveal any assault injuries, restraint injuries or defensive injuries.

Findings

Assessment of Mr Frith's risk of suicide and self-harm

54. Prison Service Instruction (PSI) 64/2011, *Managing prisoners at risk of harm to self, to others and from others* (*Safer Custody)*, lists several risk factors and potential triggers for suicide and self-harm. Mr Frith had some risk factors: it was his first time in prison, he was charged with a serious offence and if found guilty faced a long prison sentence, and he was withdrawing from alcohol. In addition, he was not able to contact his partner due to security restrictions, or any other family member as he did not have access to their contact details.

55. Mr Frith did not arrive with any risk warning form and had no known history of self-harm or suicide attempts. He told prison and healthcare staff that he had no thoughts of harming himself. However, he had been charged with a very serious offence, the kidnap of a child, which had received media attention. We consider that the reception process at Berwyn needs to improve to highlight those who, despite their presentation, may be at heightened risk based on the nature of their offence or other risk factors.

56. In a thematic report about risk factors in self-inflicted deaths published by the Prisons and Probation Ombudsman in 2014, we identified that too often reception assessments place too much weight on staff's perception of the prisoner and do not consider all relevant information. We reinforced these messages in another learning lessons bulletin, issued in February 2016, about early days and weeks in custody.

57. A prisoner's presentation can reveal something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically. Berwyn's 'First Night in Prison Booklet' has several closed tick box questions about thoughts of self-harm and suicide. These questions do not require staff to explore the information further and do not provide any guidance on what other factors may be relevant to the assessment or which may increase risk, as set out in PSI 64/2011. We therefore make the following recommendation:

    The Governor should review the first night assessment booklet to assist staff in identifying other risk factors or triggers that could indicate risk of suicide and self-harm.

Clinical care

58. The clinical reviewer concluded that Mr Frith's clinical care was equivalent to that which he could have expected to receive in the community.

Physical health

59. Mr Frith's physical health needs were appropriately managed. The initial healthscreen was thorough. Mr Frith was referred to the prison GP, who met face-to

face with him, and he had a second healthscreen the day after he arrived. Mr Frith was offered various health screenings and vaccines, as well as support to stop smoking, but he declined.

Mental health

60. The clinical reviewer found that there was evidence of appropriate and timely assessment and observation of Mr Frith's mental state by healthcare staff. He considered that relevant steps were taken to assess for any current risks of self-harm or suicide.

Substance misuse

61. Mr Frith had a significant history of alcohol dependency, which the clinical reviewer concluded was appropriately managed. Mr Frith was assessed during his first and second healthscreen, as well as by the prison GP. Withdrawal medication prescribed in police custody was continued and he was observed regularly as part of his care plan. Mr Frith was referred to the substance misuse service for further support. Although Mr Frith declined support, the team continued to offer their availability to him.

Access to the telephone

62. Mr Frith did not make any telephone calls during his time at Berwyn. He mentioned to prison and healthcare staff that he was anxious and keen to speak to his partner, but there were restrictions placed on him.

63. PSI 49/2011 – *Prisoner Communication Services*, sets out the requirements for all prisoner communication, including telephone use. The PSI says, '*The checking of social numbers must be proportionate to risk and checked as necessary in accordance with the NSF [National Security Framework] and as set out in the local security strategy.*'

64. Due to the nature of Mr Frith's alleged offence, for security reasons, his contact telephone numbers had to be verified before he could use his PIN phone (the prison phone system which only allows prisoners to ring authorised numbers)..

65. On 13 November, a member of staff from the Offender Management Unit (OMU), who completed the application for restrictions to be placed on Mr Frith's PIN phone, contacted him via an electronic message to update him on the restrictions imposed. Because he did not read the message, Mr Frith would have been unaware that the restriction on contacting his partner had been removed. He may have been reassured had he read the message.

66. She said she did not consider contacting Mr Frith directly using his in-cell telephone to tell him this, as sending an electronic message was the process that had always been followed at Berwyn. She said in hindsight she thought prisoners should be spoken to in future rather than just receiving a written message as this would allow for questions or concerns to be discussed.

67. We cannot know what contributed to Mr Frith's decision to take his own life. However, this was his first time in prison, he was not familiar with the restrictions and regime at Berwyn and he had no contact with his partner. Although the

restrictions on his PIN were in line with national guidance, we found that this could have been better explained to Mr Frith. We recommend:

The Governor should ensure that OMU staff:

- **make direct contact with a prisoner to explain any restrictions and to tell them when they are lifted; and**
- **alert wing staff to the sharing of any potential bad news, so that they can manage this appropriately and provide additional support, if necessary.**

Cell condition

68. PSI 17/2012 - *Certified Prisoner Accommodation*, sets out the minimum requirements for a cell to be occupied by prisoners. Mr Frith's cell on Ceiriog Wing was reported to be in a poor state. The investigator viewed BWVC footage which shows there was some graffiti on the walls, but she could not see the whole cell. We were not provided with photographs of the cell and were unable to establish why the graffiti had not been removed before Mr Frith was placed there.

69. Regardless of how or when the damage occurred, the walls were not in an acceptable state from the time that Mr Frith went into the cell on 9 November. We consider that the condition of the cell was unacceptable and not in accordance with PSI 17/2012. We do not consider that any prisoner should have been placed in a cell like this, as it may have a negative impact on their mental health. We make the following recommendation:

The Governor should ensure that:

- **cell conditions are properly checked and documented;**
- **repairs are promptly reported and fully documented and that there is a clear audit trail showing when the fault has been reported and when it has been resolved; and**
- **prisoners are not placed in cells that do not meet the minimum requirements, in accordance with PSI 17/2012.**

Staff support

70. Healthcare staff involved in the emergency response said that they needed advice from their managers following Mr Frith's death, but that the on-call healthcare manager had not responded. The staff who attended the emergency response said that they had received good support from their prison colleagues but felt that support from their healthcare service had been lacking. We therefore recommend:

The Head of Healthcare should ensure that:

- **healthcare staff working at Berwyn have timely access to advice, support and guidance from on call healthcare managers; and**

- **appropriate measures are put in place to offer support to healthcare staff following their involvement in significant incidents.**

Inquest

71. The inquest into Mr Frith's death concluded in February 2025. Mr Frith's death was due to plastic bag suffocation.

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