

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nickolas Fretwell, a prisoner at HMP Elmley, on 16 October 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

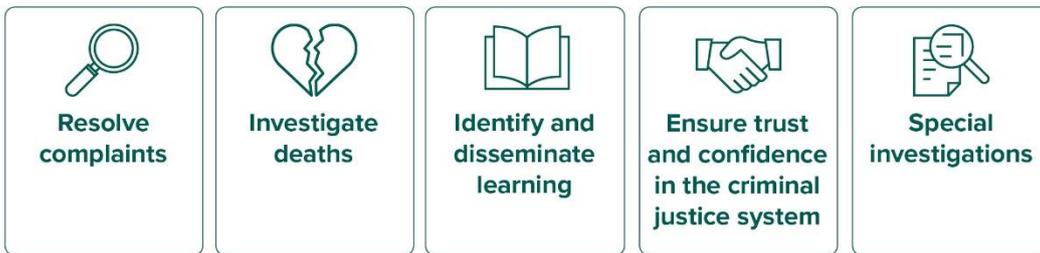
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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



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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Nickolas Fretwell died on 16 October 2024, after he was found unresponsive with a ligature around his neck in his cell at HMP Elmley. Staff tried to resuscitate him but were unsuccessful. He was 49 years old. I offer my condolences to Mr Fretwell's family and friends.

Mr Fretwell was the fourth self-inflicted death at Elmley since October 2021. Up to the end of March 2025, there has been one further self-inflicted death.

Despite Mr Fretwell arriving at Elmley with a suicide and self-harm warning on 14 October, reception staff failed to start suicide and self-harm prevention procedures (known as ACCT) for him. No one started ACCT procedures for Mr Fretwell during his two days at Elmley.

Following an investigation into a previous death at Elmley which found similar failings, I made a recommendation to the Governor in May 2024 to review the training given to reception staff on assessing risk of suicide and self-harm. Despite being assured that there had been a full review of reception procedures and a new process introduced, Mr Fretwell's risk of suicide was not identified, and nothing was put in place to help mitigate his risk.

The identification of risk on reception is a key concern identified repeatedly in my investigations. The Governor of Elmley is not alone in having introduced what appear to be sensible measures to support staff's ability to identify risk that fall short when put to the test. HMPPS must consider, with urgency, what more can be done to support reception staff with this vital task.

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

Adrian Usher
Prisons and Probation Ombudsman

June 2025

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Summary

Events

1. On 14 October 2024, Mr Nickolas Fretwell was remanded in prison charged with violent offences against his partner. He was sent to HMP Elmley.
2. Mr Fretwell arrived with a suicide and self-harm warning in his Person Escort Record (PER). It said that Mr Fretwell was at high risk of suicide, as he had said on numerous occasions that he would kill himself on release from police custody. It also said that Mr Fretwell had a history of self-harm.
3. Mr Fretwell told the reception nurse that he had anxiety and depression and misused alcohol. Both the reception nurse and reception officer said that Mr Fretwell had told them he had no thoughts of suicide or self-harm and that he presented well. Neither started suicide and self-harm prevention procedures (known as ACCT) despite both seeing the PER.
4. Mr Fretwell was placed on an alcohol detoxification programme and admitted to the prison's inpatient unit for hourly monitoring by healthcare staff.
5. On 16 October, during a welfare check, a healthcare assistant saw Mr Fretwell lying face down on his cell floor. The healthcare assistant called to him through the cell door, but Mr Fretwell did not respond. The healthcare assistant went to the office to ask officers for help. Officers entered the cell and found Mr Fretwell had tied a ligature around his neck. An officer radioed a medical emergency code and several healthcare staff attended.
6. Staff tried to resuscitate Mr Fretwell but were unsuccessful. At 1.19pm, a GP declared life extinct.

Findings

7. Reception staff failed to start ACCT procedures for Mr Fretwell. They placed too much reliance on Mr Fretwell's presentation and disregarded his suicide and self-harm warning and multiple risk factors.
8. The prison introduced a "Bus to bed checklist" following a previous death, which requires the reception officer and the officer conducting the first night in prison (FNIP) interview to record whether they have seen the PER and suicide and self-harm warning (if applicable) and note any concerns/actions taken. Neither the reception officer nor the FNIP officer completed the checklist when they processed Mr Fretwell.
9. We have previously identified poor assessment of risk by reception and induction staff at Elmley. In response to a previous recommendation, the prison said it was reviewing reception processes and would deliver more training. It is disappointing that the same issues have arisen in this case. The Governor and Head of Healthcare must do more to ensure that staff are following the correct reception and induction processes and properly consider risk factors for suicide and self-harm, rather than relying on what the prisoner tells them.

Recommendation

- The Governor and Head of Healthcare should implement a robust quality assurance process of reception and FNIP records to ensure that staff are following the agreed processes and recording and considering all risk factors for suicide and self-harm.

The Investigation Process

10. HMPPS notified us of Mr Fretwell's death on 16 October 2024.
11. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator visited Elmley on 29 October. She obtained copies of relevant extracts from Mr Fretwell's prison and medical records.
13. The investigator interviewed six members of staff at Elmley on 19 November and two members of staff over Microsoft Teams on 11 and 29 November.
14. NHS England commissioned an independent clinical reviewer to review Mr Fretwell's clinical care at the prison. She conducted eight joint interviews with the investigator.
15. We informed HM Coroner for Kent and Medway of the investigation. The Coroner gave us the cause of death. We have sent the Coroner a copy of this report.
16. The Ombudsman's office contacted Mr Fretwell's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She asked if staff were aware of his alcohol misuse issues, what support he was offered and if he had missed any hospital appointments. These have been addressed in this report and the clinical review.
17. We shared our initial report with HMPPS and the prison's healthcare provider, Oxleas NHS Foundation Trust. They pointed out some factual inaccuracies which have been amended in this report.
18. We sent a copy of our initial report to Mr Fretwell's next of kin. They pointed out an error in the clinical review which said that Mr Fretwell had no outstanding hospital appointments. This has been amended.

Background Information

HMP Elmley

19. HMP Elmley holds remand and sentenced prisoners in six houseblocks, with a mixture of single and double cells. Oxleas NHS Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

20. The most recent inspection of Elmley was in February and March 2022. Inspectors reported that reception was a busy environment, and new arrivals were treated well and the process was relatively swift. All new arrivals had interviews with an officer and a nurse. However, these lacked sufficient depth to identify risks and vulnerabilities, but this was offset by other opportunities to identify risk through health screening. Around 38% of the population were known to the substance misuse service.
21. Inspectors noted there had been four self-inflicted deaths since the last inspection and that some new prisoners missed important aspects of induction. The prison had begun implementing PPO recommendations, but implementation was not monitored over time to ensure ongoing compliance. Reported self-harm was lower than in most comparable prisons but had increased since the last inspection.
22. In February 2023, HMIP published an Independent Review of Progress. The report said that Elmley faced substantial staff shortages, but leaders were focused on how to make improvements with the resources they had and were delivering more than many prisons with a similar or better staffing position. However, inspectors were not confident that the changes were sufficient to care for prisoners on their first night and early days in custody. Inspectors highlighted the effective changes made to the induction programme which resulted in prisoners being better prepared for assessments.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 October 2024, the IMB noted that the prison was taking steps to improve the process of reception and induction for new prisoners but, from the Board's observations, good practice was not consistently embedded.
24. The Board noted that the prison had recently put in place a revised procedure known as "Bus to Bed", which while in its infancy, seemed to be having a positive effect. Key to reducing risk at the point of arrival was for officers to take note of the Person Escort Record (PER) and the suicide and self-harm warning form, where provided, but because of pressure to get prisoners through reception and onto their houseblock, this did not take place consistently. The Board also noted that incidents of self-harm had risen, and prisoners had reported to IMB members that they felt unsafe due to differing factors which included concerns about their mental health.

The Board found it regrettable that the in-house Listener scheme (prisoners trained by the Samaritans to provide peer support) had ceased as a support mechanism for vulnerable prisoners, who were now directed to the Samaritans.

Previous deaths at HMP Elmley

25. Mr Fretwell was the 12th prisoner to die at Elmley since October 2021. Of the previous deaths, six were from natural causes, three were self-inflicted and two were drug related.
26. We have previously made a recommendation about improving the identification of suicide and self-harm risk during the reception and induction process. In response, the prison told us they were undertaking a review of the early days in custody processes and a formalised process had been introduced to ensure that prisoners received meaningful interactions during their first 48 hours. They also planned to deliver training to all reception and first night centre staff.

Key Events

27. On 14 October 2024, Mr Nickolas Fretwell was remanded in prison, charged with violent offences and coercive behaviour against his partner. He was sent to HMP Elmley. He had previous convictions but had not been in prison for many years.
28. Mr Fretwell's Person Escort Record (PER – a document that accompanies prisoners when they move between police stations, courts and prisons which sets out the risks they pose) contained a suicide and self-harm warning. It said that Mr Fretwell was at high risk of suicide as he had said on numerous occasions that he would kill himself on release from police custody and was being checked every 30 minutes. It noted that on 19 May 2024, Mr Fretwell had punched himself in the head and headbutted the charge desk while in police custody and had said he would self-harm or jump off a bridge when released. The form also noted that Mr Fretwell had Post-Traumatic Stress Disorder (PTSD) and self-harmed by cutting his arms.
29. A Supervising Officer (SO) conducted Mr Fretwell's reception interview when he arrived at Elmley. She said at interview that she thought the PER had mentioned Mr Fretwell's suicidal thoughts from a few months before and when she had asked him about this, he had said he was fine. She said Mr Fretwell had presented well and she found him to be quite jovial. She did not complete a "Bus to bed checklist" for Mr Fretwell, despite being required to do so, because she did not think the checklist was in use at the time. (Following previous deaths at Elmley, the prison introduced a "Bus to bed checklist" in August 2024, which should be completed for each new arrival by the reception SO and the officer who conducts the First Night in Prison (FNIP) review. The reception SO and the FNIP officer must each record whether a PER and suicide and self-harm form was available, whether it was checked, and any concerns/action taken.)
30. A nurse completed Mr Fretwell's initial health screen. At interview he confirmed that he had seen his PER. Mr Fretwell told him he had anxiety and depression, and misused alcohol. He reported that he had been engaging with a community mental health service. He said he had a history of bladder cancer and used a colostomy bag. The nurse noted that Mr Fretwell presented as engaging, calm and coherent and said he had no current thoughts of suicide or self-harm. He incorrectly noted that Mr Fretwell did not have a history of self-harm.
31. An officer completed the FNIP review in the First Night Centre. He noted Mr Fretwell's offences, that he had a history of self-harm, was violent and had health issues. There was no mention of the PER or any notes regarding discussions around thoughts of suicide or self-harm. He did not complete a "Bus to bed checklist" (probably because the SO had not started the checklist as she was supposed to).
32. A GP at Elmley reviewed Mr Fretwell and diagnosed alcohol dependence syndrome. He arranged for him to begin alcohol detoxification and to be admitted to the prison's inpatient department (IPD) for hourly monitoring by healthcare staff.
33. A nurse completed the second reception screen when Mr Fretwell was admitted to the IPD. He noted that Mr Fretwell was mentally stable and had said he had no thoughts of suicide or self-harm.

34. Mr Fretwell was checked hourly overnight, and staff recorded no concerns about him.
35. On 15 October, a nurse completed a mental health assessment. She noted that Mr Fretwell had been diagnosed with PTSD and had been engaging with talking therapies in the community. Healthcare staff scheduled a psychology review for 24 October and completed frequent observations of Mr Fretwell's heart rate, blood pressure and oxygen levels. All were within a satisfactory range.
36. A healthcare assistant completed a substance misuse review. She noted that Mr Fretwell appeared to have a low mood and low self-esteem. Mr Fretwell told her that he had considered suicide when he was drunk but did not think like that when he was sober. She completed a brief interventions and treatment care plan for excessive alcohol consumption.

Events of 16 October 2024

37. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to staff radio communications from 16 October. She also obtained information from the Southeast Coast Ambulance Service.
38. Between 6.00am and 11.00am, three healthcare staff checked Mr Fretwell's clinical observations. A nurse checked them at 6.24am, a healthcare assistant checked them at 9.16am and another nurse checked them at 11.01am. All noted that there were no concerns.
39. CCTV shows that Mr Fretwell went to the dayroom, stopped briefly at the nurses' office and returned to his cell at 10.15am. Staff delivered lunch to his cell at 11.00am.
40. At approximately 12.00pm, the healthcare assistant went to Mr Fretwell's cell door to complete a welfare check. CCTV footage shows him looking through the flap in the cell door. At interview, he said that he saw Mr Fretwell standing by the toilet. When he completed his next welfare check at 12.45pm, he saw Mr Fretwell lying face down on the floor. He called to him, but Mr Fretwell did not respond. CCTV shows that at approximately 12.47pm, he went to the office and asked prison staff to go to the cell with him.
41. CCTV shows at 12.53pm, three prison officers and the healthcare assistant went to Mr Fretwell's cell door. Officer A tried to speak to Mr Fretwell through the cell door. When there was no response, he opened the cell door and went in. He said in his written statement that Mr Fretwell was lying face down on the floor with his feet towards the door. He was not moving, and his face was purple. He radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). In his statement, Officer B said that Mr Fretwell had what appeared to be strips of green bedding wrapped multiple times tightly around his neck. He cut away the ligature and, together with Officer A, they rolled Mr Fretwell onto his back, and he began chest compressions. Healthcare staff quickly responded to the code blue. Officer A also did a round of chest compressions. He said a nurse shouted for them to move Mr Fretwell out of the cell into the corridor for more room.

42. In her interview, a nurse said she was providing lunch time cover in the IPD when she heard the code blue, so she grabbed the emergency bag and went to Mr Fretwell's cell. She said she shouted for staff to move Mr Fretwell out of the cell and into the corridor for more room. Staff moved Mr Fretwell into the corridor and continued chest compressions. She assisted with using the defibrillator and helped with the chest compressions. She said that several nurses and prison officers assisted with rounds of chest compressions.
43. At interview, a GP at Elmley said that when he arrived at the cell, he saw staff performing chest compressions and nurses using an ambu bag (a self-inflating bag used to get air into the lungs during resuscitation). The defibrillator was attached to Mr Fretwell and it advised staff to continue CPR. He inserted an Igel (an airway device to secure and maintain the airway and administer oxygen). However, despite staff's efforts for 29 minutes, there was no response. He declared life extinct at 1.17pm.
44. The ambulance log noted that the 999 call was received at 12.55pm. There were no ambulances available at that time and the ambulance operator advised prison staff to administer CPR until paramedics could get there. CCTV shows ambulance paramedics arrived at 1.25pm. The prison GP had already declared life extinct.

Contact with Mr Fretwell's family

45. The prison appointed a family liaison officer. She and a prison chaplain visited Mr Fretwell's next of kin at her home on 16 October to tell her Mr Fretwell had died and offer support.
46. The prison contributed to the cost of Mr Fretwell's funeral, in line with national guidelines.

Support for prisoners and staff

47. Staff from the safer custody team went to the IPD to offer support to prisoners and staff. Formal postvention procedures (a process devised by HMPPS in conjunction with the Samaritans to ensure staff and prisoners are offered suitable support after certain incidents including unexpected deaths) were not initiated due to local issues at the Samaritans branch closest to Elmley.
48. After Mr Fretwell's death, a prison manager 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.
49. The prison posted notices informing other prisoners of Mr Fretwell'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 Fretwell's death.

Post-mortem report

50. The post-mortem report has not yet been shared with us, but the Coroner has advised that asphyxiation was the cause of death.

Findings

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

51. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), which was in force at the time of Mr Fretwell's death, set out the procedures (known as ACCT) that staff should follow if they identified that a prisoner was at risk of suicide or self-harm. It required all staff who had contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. (The policy has since been superseded by the Prison Safety Policy Framework though ACCT processes remain broadly the same.)
52. PSI 07/2015, Early Days in Custody, sets out guidance and mandatory actions for prison staff during reception, first night in custody and induction. It says that the PER and any other available documentation must be examined in reception to assess the risk of suicide and self-harm. It also references a Reception and First Night Checklist.
53. Mr Fretwell had several risk factors for suicide and self-harm. He had expressed suicidal intent while in police custody before his remand to Elmley, had a history of self-harm, mental health difficulties and alcohol misuse, and had been charged with a violent offence against his partner.
54. Mr Fretwell arrived at Elmley with a PER that set out his risk factors and contained a suicide and self-harm warning. Despite this, neither the reception SO nor the reception nurse started ACCT procedures. They both said that Mr Fretwell presented well and said he had no thoughts of suicide or self-harm and so they considered ACCT procedures were unnecessary.
55. 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.
56. We identified similar issues in our investigation into a self-inflicted death at Elmley in 2023. In May 2024, we issued a recommendation to improve training to reception and induction staff about identifying prisoners at risk of suicide and self-harm. In response, the prison told us they were undertaking a review of the early days in custody processes and a formalised process had been introduced to ensure that prisoners received meaningful interactions during their first 48 hours.
57. Elmley introduced a "Bus to bed checklist" in August 2024, which must be completed by the reception SO and the FNIP officer for each new arrival. The SO and FNIP officer must each record whether a PER and suicide and self-harm form is available, whether it has been checked and any concerns/action taken. Neither the SO nor an officer completed this for Mr Fretwell. When interviewed, the SO said that she thought it had not been in place when Mr Fretwell arrived, but other staff confirmed that it was.

58. It is frustrating that despite previous PPO recommendations about reception and induction processes and Elmley itself recognising that processes need to improve, the same issues persist. In their latest report, the IMB also noted that while it was key to reducing risk for officers to take note of the PER and suicide and self-harm warning, this did not happen consistently. We make the following recommendation:

The Governor and Head of Healthcare should implement a robust quality assurance process of reception and FNIP records to ensure that staff are following the agreed processes and recording and considering all risk factors for suicide and self-harm.

Clinical care

59. The clinical reviewer concluded that the clinical care that Mr Fretwell received at Elmley was of the required standard and equivalent to that which he could have expected to receive in the community.
60. However, the clinical reviewer made four recommendations about responding to medical emergencies. She found that no one appeared to be leading the resuscitation attempt and no privacy screens were used. She also found there was confusion about who was responsible for the daily checks of emergency equipment and some checks had been missed. Although the recommendations are not repeated in this report, the Head of Healthcare will need to address them.

Inquest

61. At the inquest, held from 26 January to 6 February 2026, the jury concluded that Mr Fretwell died by suicide.

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T | 020 7633 4100