Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Scott Fretwell a resident at Highfield House Approved Premises on 3 November 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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

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 Scott Fretwell was found hanged in the garden at Highfield House Approved Premises, Accrington, on 3 November 2015 and died in hospital later that day. He was 44 years old. I offer my condolences to Mr Fretwell's family and friends.

I am satisfied that staff at Highfield House could not have predicted Mr Fretwell's actions, which were sudden and unexpected. However, while this does not appear to have been a factor in his death, I am concerned that Mr Fretwell left HMP Haverigg two weeks earlier without the medication he needed for his mental health and there was a delay in the prison providing information to allow a community prescription.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2016**

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Summary

Events

1. On 20 October 2014, Mr Scott Fretwell was remanded to HMP Preston charged with arson and endangering life. At Preston, a psychiatrist diagnosed Mr Fretwell with bipolar disorder and prescribed antipsychotic medication.

2. On 1 June 2015, Mr Fretwell was convicted and given a two year prison sentence. On 29 June, he transferred to HMP Haverigg. The mental health team at Preston referred Mr Fretwell to the mental health team at Haverigg but no one from the team saw him until 16 September.

3. On 20 October, Mr Fretwell was released on licence. Healthcare staff at Haverigg prepared a seven day supply of Mr Fretwell's medication but he was discharged from the prison without it.

4. Mr Fretwell's probation officer had arranged temporary accommodation at Highfield House Approved Premises in Accrington. When Mr Fretwell arrived without his medication, staff at Highfield House contacted Haverigg for his prescription details, but it took Haverigg four days to respond. He received his medication on 24 October. Mr Fretwell said he felt stable at Highfield House and none of the staff or other residents saw any indication that he was feeling suicidal.

5. In the afternoon of 3 November, another resident found Mr Fretwell hanged from a tree in the garden of Highfield House and raised the alarm. Staff quickly called an ambulance and administered cardiopulmonary resuscitation until paramedics arrived and took over emergency treatment. The paramedics took Mr Fretwell to hospital where he was placed on life support. He died that later that evening.

Findings

6. People with bipolar disorder are at increased risk of suicide compared to the general population but Mr Fretwell had given no indication to staff or other residents that he had thoughts of suicide or was at imminent risk. We are concerned that Mr Fretwell left Haverigg without his medication and there was delay in the prison providing information for a community prescription. While this was unlikely to have affected his mood over a week later, this should not have happened. We do not consider that the staff at Highfield House could have predicted or prevented his actions.

Recommendations

- The Governor of HMP Haverigg and the Head of Healthcare should ensure that appropriate efforts are made to issue prisoners with a supply of their prescribed medication on discharge and that information about prescriptions is supplied to bona fide community agencies promptly when requested, to enable good continuity of care.

The Investigation Process

7. The investigator issued notices to staff and residents at Highfield House informing them of the investigation and asking anyone with relevant information to contact him.

8. The investigator obtained copies of relevant extracts from Mr Fretwell's prison and medical records and from his records at the approved premises.

9. NHS England commissioned a clinical reviewer to review Mr Fretwell's clinical care at HMP Haverigg.

10. In December 2015, the investigator interviewed three members of staff of Highfield House, one former resident, and Mr Fretwell's probation officer. The investigator wrote to another former resident but he did not reply.

11. We informed HM Coroner for Blackburn of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Fretwell's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Fretwell's mother asked if he had been on 'suicide watch' before he died and whether staff at the approved premised monitored CCTV cameras. Mr Fretwell's mother received a copy of the initial report. She did not make any comments.

Background Information

Highfield House Approved Premises

13. Approved premises (formerly known as probation and bail hostels) provide an enhanced level of residential supervision in the community. The National Probation Service, North West Area, manages Highfield House Approved Premises in Accrington, Lancashire. Residents must be aged over 18. Most residents are required to stay as a condition of a court order or prison licence.

14. Highfield House accommodates up to 24 men. Residents are required to sign in and out of the building and adhere to agreed curfews. During induction, staff tell residents about the premises' rules and allocate them a key worker who is their primary contact and who holds one-to-one sessions about the issues in the offender's sentence plan. Residents are responsible for their own health and are required to register at a local GP surgery. As part of the conditions of residence, staff hold all prescribed medicines and issue them as prescribed.

Previous deaths at Highfield House

15. Mr Fretwell's death was the second at Highfield House since the Ombudsman began investigating deaths in approved premises in 2004. The other death was in September 2015, and was from natural causes.

Key Events

16. On 20 October 2014, Mr Fretwell was remanded to HMP Preston, charged with arson and endangering life. This was his first time in prison. He had a history of alcohol and drug abuse. On 1 June 2015, he was convicted and sentenced to two years in prison.

17. Mr Fretwell was under the care of the mental health team at Preston and a psychiatrist diagnosed him with bipolar disorder. The psychiatrist prescribed olanzapine (an antipsychotic medication), which Mr Fretwell took as prescribed.

18. On 29 June 2015, Mr Fretwell transferred to HMP Haverigg. The mental health team at Preston referred him to the healthcare team at Haverigg to ensure that he continued to receive support for his mental health problems. Nurse ,A, a mental health nurse, saw Mr Fretwell in reception at Haverigg and noted that he had been under the care of the mental health team at Preston and was prescribed olanzapine. The nurse referred him to the mental health team. Mr Fretwell continued to receive his medication at Haverigg.

19. On 15 September, Dr A, a prison GP, recorded that Mr Fretwell had not been reviewed since June and had not seen anyone from the mental health team or a psychiatrist since he had arrived at Haverigg. He noted that Mr Fretwell was due to be released on 20 October. The doctor referred him to the mental health team, and prescribed a further month's supply of olanzapine.

20. On 16 September, Nurse B, a member of the mental health team, saw Mr Fretwell. She recorded that Mr Fretwell showed no signs of low mood and assessed that his risk of self-harm and danger to others was low.

21. On 2 October, Nurse C a member of the mental health team saw Mr Fretwell for a mental health review. Mr Fretwell said that he felt very anxious, and was worried about his forthcoming release. He said he wanted an increase in his morning dose of olanzapine as he did not consider the current dose was helping him. Mr Fretwell said that he wanted to have support in the community and have his medication reviewed by a specialist. The nurse recorded that Mr Fretwell showed no obvious signs of psychosis or low mood and that his anxiety was due to his release. She did not arrange a medication review. The nurse assessed that he was not at risk of suicide or self-harm or suicide or a danger to others.

22. The same day, Mr Fretwell signed his licence for release. As a condition of the licence, he was required to be supervised by the probation service from 20 October 2015 to 19 October 2016. He had to report to his offender manager (probation officer), at Blackpool Probation Office, by 1.30pm on 20 October. Mr Fretwell's licence had nine conditions, including to attend all appointments with the community mental health team, a psychiatrist, a psychologist and medical practitioner, and to co-operate with any care or treatment they recommended.

23. On 16 October, Nurse C recorded that she had contacted the community mental health team in Blackpool and referred Mr Fretwell to them in preparation for his release. The nurse also recorded that she had told supervising officer A in the prison's offender management unit, that she had made the referral. The supervising officer told her that Mr Fretwell did not have a confirmed address for

his release. Later that day, Dr A prescribed a week's supply of medication to be given to Mr Fretwell when he was released.

24. On the morning of 20 October, Mr Fretwell was released from Haverigg. He saw Nurse D in the reception area, who recorded that Mr Fretwell had not collected his medication discharge pack and she had advised him to see his GP that day. (The Head of Healthcare at Haverigg told the investigator that prisoners are asked to see the healthcare team before they are released to collect their discharge medication. She believed that Mr Fretwell would have been asked if he wanted to go to the healthcare unit to collect the medication. She said that she assumed that Mr Fretwell chose not to. However, there is no record of this.) Mr Fretwell had a travel warrant to obtain a train ticket to Blackpool and prison staff took him to the train station in a prison vehicle. He did not have his medication.

25. The probation officer met Mr Fretwell at Blackpool probation office. It had been difficult to arrange accommodation for Mr Fretwell due to his offence of arson and the probation officer had arranged a room for him at Highfield House Approved Premises in Accrington until he could find alternative accommodation. Mr Fretwell said that he did not have any medication with him and the probation officer contacted the healthcare team at Haverigg who confirmed that he had not collected his supply. The probation officer said he told them that staff at Highfield House, and the local GP, would probably contact them about this. He gave Mr Fretwell a travel warrant for a train ticket to Accrington.

26. Later that afternoon, Mr Fretwell arrived at Highfield House. Key worker A at Highfield House, met him and explained the rules of the premises. As part of his licence conditions, Mr Fretwell had to be at Highfield House between 8.00pm to 8.00am. He was required to sign in and out each time he left and returned, and to report and sign in each day at 1.00pm. He was also required to register at the local GP surgery. Mr Fretwell told the key worker that he suffered from bipolar disorder and had no thoughts of suicide or self-harm.

27. On 21 October, the probation officer saw Mr Fretwell and recorded that he appeared well. Mr Fretwell said he had registered at the GP surgery but they had refused to give him medication until the prison sent his prescription details. He said that staff at Highfield House had spoken to Haverigg about this. The probation officer recorded that Mr Fretwell understood his licence conditions and agreed that his main objective was to continue to receive mental health support. Mr Fretwell said his main concern was finding somewhere to live. He said his mother, who lived in Spain, was due to visit him. The probation officer arranged to see Mr Fretwell at Highfield House again on 28 October.

28. Key worker B at Highfield House, contacted the healthcare team at Haverigg by telephone and fax on 21 October, to obtain Mr Fretwell's prescription details but they did not arrive.

29. On Friday 23 October, key worker A contacted healthcare staff at Haverigg to chase up Mr Fretwell's prescription details and stressed the urgency. She recorded that the healthcare team had told her that they would send the information to the GP before lunchtime. Mr Fretwell went to the surgery after lunch, but they had still not received any information from Haverigg. She

contacted Haverigg who said they would email the details that afternoon. At 3.00pm, she received Mr Fretwell's prescription details and passed them to the GP surgery, but it was too late for Mr Fretwell to see a doctor that day.

30. On 24 October, Mr Fretwell's mother accompanied him to an NHS walk-in centre in Accrington. He took a copy of the email from Haverigg and the walk-in centre gave him a five day supply of his antipsychotic medication.

31. On 28 October, Mr Fretwell saw key worker A and the probation officer. He said he was anxious and felt isolated. He said he felt guilty and remorseful about his offence. He said he would make an appointment to see a doctor to discuss whether his medication was appropriate and the probation officer told him that he had already been referred to the community mental health team. The probation officer discussed his housing options and arranged an appointment with a housing officer on 4 December.

32. On 29 October, a GP at the local surgery saw Mr Fretwell and prescribed his antipsychotic medication for 28 days.

33. On 30 October, key work A held a key worker review with Mr Fretwell. They discussed activities to help occupy him during the day and she suggested walks, using a gym and art. Mr Fretwell said he did not feel able to go walking as he had poor orientation, he could not use the gym as he had a bad knee, and he had no interest in art.

34. Key worker A told the investigator that Mr Fretwell had settled at Highfield House and appeared relaxed. He left the premises most days and had become friendly with resident A. Mr Fretwell told the key worker that he had bipolar disorder but felt stable, although he said there were days when he felt down and would keep himself to himself.

35. On 3 November, Mr Fretwell signed out of Highfield House at 9.40am and said he was going to the town centre. He signed back in at 12.50pm. Resident B, told the investigator that Mr Fretwell had gone to the town centre with resident A. Resident A had told resident B that he and Mr Fretwell had gone to a pub and Mr Fretwell had drunk a large amount of alcohol. (The investigator wrote to resident A for information but he did not reply.)

36. Supervisor B at Highfield House, started her shift at approximately 2.10pm. She said that when she arrived for work, Mr Fretwell had opened the door for her. She said she thanked him and he smiled.

37. The investigator viewed the CCTV footage recorded by the security camera that covers the fire exit at the rear of Highfield House. This gives a view of a short section of the garden path; the remainder of the path is obscured by bushes. This CCTV is for security and premises staff do not monitor it routinely.

38. At 2.10pm, the CCTV showed Mr Fretwell carrying a chair along the path in the garden, towards the football pitch at the back of Highfield House. At 2.12pm, he walked up and down the path and went out of view in the direction of the football pitch. At 2.14pm, Mr Fretwell appeared in view again and walked slowly up and down the path smoking a cigarette. At 2.15pm, he walked out of view in the direction of the football pitch.

39. At 2.25pm, the CCTV showed resident B on the path, before he suddenly turned round and ran. Resident B told the investigator that shortly before this, he had gone outside to have a cigarette when he noticed what he thought was someone messing about with the squirrels. As he walked closer, he noticed a green chair, which he thought was odd as staff had recently asked him to clean all the chairs and put them away for winter. He said he then saw Mr Fretwell hanging from a tree, by a white rope. Mr Fretwell's head was blue. Resident B ran inside to get help.

40. Key worker A and supervisor B ran to Mr Fretwell and supported his body. Key worker B took two emergency bags, and then took over from supervisor B, who used a knife from the emergency bag to cut the rope. The manager, asked resident B to call an ambulance, while she took a defibrillator to the scene. Key worker B and key worker A started cardiopulmonary resuscitation and attached the defibrillator, which found no shockable heart rhythm

41. Ambulance service records show that they received a 999 call at 2.27pm. Paramedics arrived at Highfield House at 2.35pm and took over the resuscitation effort. They managed to establish a pulse and took Mr Fretwell to Blackburn Royal Hospital. He was admitted to the intensive care unit and placed on life support.

42. At 7.00pm, the operations manager for Lancashire Approved Premises, contacted Mr Fretwell's mother in Spain and told her that Mr Fretwell had been taken to hospital and was in a serious condition. At 10.00pm, Mr Fretwell's mother contacted operations manager to inform her that Mr Fretwell had died at 9.30pm. The operations manager kept in contact with Mr Fretwell's mother in the following days to support her. In line with national instructions, the Probation Service contributed to the costs of the funeral.

Support for residents and staff

43. After Mr Fretwell's death, the operations manager debriefed the staff involved in the emergency response and offered support.

44. The staff told other residents of Mr Fretwell's death and offered support in case they had been adversely affected. Resident B said staff and the community mental health team had supported him.

Cause of death

45. No post-mortem examination was held. The medical certificate of death stated that the cause of death was hypoxic brain damage as a result of hanging. Toxicology results show that Mr Fretwell had drunk a moderate amount of alcohol, but tests for illicit drugs were negative.

Findings

Assessment of risk of suicide at Highfield House

46. Mr Fretwell gave no indication to anyone that he had any suicidal thoughts on 3 November or at any other time while he was at Highfield House. Although Mr Fretwell, because he was bipolar, would always have been a higher risk of suicide than the general population, we do not consider that staff at Highfield House could have predicted that he intended to take his own life or that they could have done anything to prevent his actions.

Clinical Care at Haverigg

47. The clinical reviewer did not consider that the standard of care Mr Fretwell received at HMP Haverigg was equivalent to that he could have expected in the community. Although the mental health team from Preston gave a good handover, and a nurse in reception referred Mr Fretwell to the mental health team when he arrived at Haverigg on 29 May, it was three months later before Mr Fretwell saw a member of the mental health team. While we do not consider that this was a factor in Mr Fretwell's death, the Head of Healthcare at Haverigg should note the failure of the mental health referral system.

48. Staff at Haverigg said it was Mr Fretwell's responsibility to collect his discharge medication but there is no clear record to explain why this did not happen. The Head of Healthcare surmised that Mr Fretwell had probably declined to collect his medication but there is no evidence of this.

49. Prison Service Order 3050- Continuity of Healthcare for Prisoners – requires healthcare staff to "supply medication appropriate to clinical need to ensure supply until a GP prescription can be obtained." Similarly, Prison Service Instruction 72/11, which sets out discharge arrangements, contains a mandatory action that "An adequate amount of any medication which the prisoner is taking, and any current prescription will be issued to the prisoner on discharge at the end of their sentence." We recognise that a GP had prescribed medication for Mr Fretwell's discharge and we also understand that prisoners have a degree of responsibility to collect it. However, we are not satisfied from the evidence available that the prison made active efforts to ensure he had it when he left.

50. The clinical reviewer was concerned that it took Haverigg three days to release Mr Fretwell's prescription information to allow a community prescription. This led to a further delay in Mr Fretwell receiving his medication. Although the clinical reviewer noted that this gap in medication would not have had any detrimental effect on Mr Fretwell's mood and would not have led to a recurrence of psychotic symptoms, this delay should not have happened. We make the following recommendation:

    The Governor of Haverigg and the Head of Healthcare should ensure that appropriate efforts are made to issue prisoners with a supply of their prescribed medication on discharge and that information about prescriptions is supplied to bona fide community agencies promptly when requested, to enable good continuity of care.

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