

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Gareth Frew a prisoner at HMP Exeter on 18 October 2017

**A report by the Prisons and Probation Ombudsman**

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

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We are:

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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 Gareth Frew was found hanged in his cell at HMP Exeter on 18 October 2017, four days after he arrived at the prison. He was 48 years old. I offer my condolences to his family and friends.

Although staff at Exeter appropriately identified that Mr Frew was at risk of suicide and self-harm, there were deficiencies in the way they monitored his risk during the short time he was at the prison. Mr Frew's only case review was poorly managed, observation levels did not reflect his risk and the caremap was ineffective.

The day before he died, officers should have taken Mr Frew's behaviour more seriously and been proactive in taking action to identify and address his needs. We are also concerned that no one called a medical emergency code when Mr Frew was found.

Although staff identified Mr Frew's significant mental health needs when he arrived at Exeter, they failed to refer him urgently to the prison's mental health team. This meant that Mr Frew's mental health was not fully assessed until 48 hours after he arrived at the prison. The clinical reviewer concluded that this was not equivalent to the care that he could have expected to receive in the community.

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**

**October 2018**

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# Summary

## Events

1. On 14 October 2017, Mr Gareth Frew was remanded to HMP Exeter, charged with arson and assault. He had a long history of paranoid schizophrenia and self-harm and had previously been hospitalised under the Mental Health Act.
2. Mr Frew arrived at Exeter with a suicide and self-harm warning form and staff began monitoring him under suicide and self-harm prevention procedures (ACCT) and checked him hourly. At his initial health screen, healthcare practitioners noted his diagnosis of schizophrenia. Two days later, the mental health team assessed him.
3. At an ACCT review on 15 October, Mr Frew's risk of suicide and self-harm was considered low and his observations were reduced significantly. Over the following days, Mr Frew appears to have kept to himself and raised no concerns with officers. On the day that he died, staff observed that he had blocked his observation panel and placed furniture behind his cell door, which was later removed.
4. At around 7.18pm, on 18 October, an officer found Mr Frew hanged in his cell. Staff and paramedics tried unsuccessfully to resuscitate him. At 7.55pm, paramedics confirmed that Mr Frew had died.

## Findings

5. Mr Frew was subject to ACCT monitoring at the time of his death. There were deficiencies in the way staff operated ACCT procedures, particularly in the case review and in setting the level of ACCT observations for Mr Frew which, at the time of his death, did not reflect the risk he posed to himself. We found that some newly promoted supervising officers had not received the mandatory national ACCT case manager training.
6. There were some deficiencies in the operation of the prison's personal officer scheme.
7. Although it is unlikely to have changed the outcome for Mr Frew, a medical emergency code blue was not called, as it should have been, when Mr Frew was found hanging in his cell.
8. The clinical reviewer found that Mr Frew's significant mental health needs were not assessed until 48 hours after he arrived at Exeter, and that this was not equivalent to the care that he could have expected to receive in the community. He identified a number of other health-related concerns, which the Governor and Head of Healthcare will need to address.

## Recommendations

- **The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular, that:**

- Case reviews are multidisciplinary, include all those involved in a prisoner's care and that healthcare staff attend all first case reviews.
  - Staff read the ACCT document and familiarise themselves with all relevant issues and known risk factors before holding reviews and ACCT case reviews should assess and record the level of risk, taking into account all risk factors.
  - The frequency of observations reflects the prisoner's risk and is adjusted when that risk changes.
  - There are procedures in place to check the quality of ACCT procedures, identify bad practice, learn lessons, and where appropriate, provide staff refresher training on suicide and self-harm prevention procedures
  - All newly promoted supervising officers receive the national ACCT case manager training as soon as possible.
  - Clinical staff review ACCT documentation frequently and, in particular, that mental health staff consult and review ACCT documentation at each contact with a prisoner and make a detailed contemporaneous record of their consultation with the prisoner in both the medical records (SystemOne) and the ACCT document.
- The Governor should ensure that the personal officer policy is effective in providing meaningful support to prisoners, particularly in relation to the identification, discussion and recording of significant events, and that contacts take place at a frequency in line with the policy.
  - The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use the appropriate emergency medical code to communicate the nature of the emergency effectively.
  - The Head of Healthcare should ensure that staff contact the prison's mental health team to request an urgent assessment if they identify that a new prisoner has significant mental health issues.
  - The Head of Healthcare and the Governor should review the provision of mental health services to ensure there is adequate cover throughout the week, including on Sundays, and address the apparent anomaly that commissioned services are not available when they should be.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Exeter informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Frew's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Frew's clinical care at the prison.
12. The investigator interviewed 18 members of staff and one prisoner, some jointly with the clinical reviewer.
13. We informed HM Coroner Exeter and Greater Devon District of the investigation. We have sent her a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Frew's family to explain the investigation and to ask if they had any matters, they wanted the investigation to consider. Mr Frew's family asked how staff at Exeter dealt with Mr Frew's mental health issues and medication.
15. Mr Frew's family received copies of the initial report. Mr Frew's family raised a number of issues that do not impact on the factual accuracy of this report.

## Background Information

### HMP Exeter

16. HMP Exeter is a local prison holding about 560 men. The prison primarily serves the courts of the South West. Dorset Healthcare University Foundation Trust provides health services. Healthcare staff are on duty 24 hours a day. Exeter has been a smoke-free prison since early 2016. The prison offers a full mental health service through its mental health in-reach team which is commissioned seven days a week, but we were told no service is, in fact, provided on Sundays.

### HM Inspectorate of Prisons

17. The most recent inspection of HMP Exeter was in August 2016. Inspectors reported that there were high levels of self-harm and that the quality of ACCT procedures was variable. Inspectors reported that although staff were determined to provide a decent and respectful environment for the men in their care, too many prisoners felt unsafe. Inspectors found that the healthcare team, including the mental health team, provided a comprehensive approach to complex and serious illness.

### Independent Monitoring Board

18. 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 ending December 2016, the IMB said that Exeter was a well-run establishment in which staff made genuine efforts to treat prisoners with dignity and respect. The IMB reported their concerns that the needs of prisoners with serious mental ill health could not be met despite commendable efforts by staff.

### Previous deaths at HMP Exeter

19. Mr Frew's death was the ninth prisoner to take his life at Exeter since November 2015. In two of these deaths in December 2015 and June 2016, we were concerned about the management of suicide and self-harm procedures. Exeter agreed to implement the recommendations we made, and we are therefore concerned that we must make a similar recommendation in this report. In an investigation report we issued in June 2016, we found deficiencies in how Exeter operated their personal officer scheme, and despite a previous recommendation, we have the same concerns in this report. There have been two further self-inflicted deaths at Exeter since Mr Frew's death.

### Assessment, Care in Custody and Teamwork

20. 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.
21. 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 multidisciplinary review meetings with 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.

22. 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.

### **Community Treatment Order**

23. The Mental Health Act provides for community treatment orders (CTO) which allow patients hospitalised under the Mental Health Act to receive supervised treatment in the community rather than in hospital. Such patients must adhere to certain conditions such as taking their medication or living at a specified address.

# Key Events

## Background

24. Mr Gareth Frew had a long history of paranoid schizophrenia and self-harm. He had significant mental health issues and had been admitted to hospital under the Mental Health Act a number of times. Mr Frew had previously spent time in prison and had recently been discharged from hospital under a community treatment order (CTO).
25. On 13 October 2017, Mr Frew was charged with arson, assault and criminal damage. While he was in police custody, a mental health practitioner and Mr Frew's community psychiatrist agreed that Mr Frew could not be managed safely in mainstream community mental health services. They concluded that Mr Frew should be remanded into prison custody until his appearance in court.

## HMP Exeter

### 14 October 2017

26. On 14 October, Mr Frew was remanded into custody at HMP Exeter. Court staff completed a suicide and self-harm warning form because he was behaving strangely and refused to answer if he had any thoughts of suicide or self-harm. Mr Frew was put in a cell in court with CCTV and checked intermittently before his transfer to HMP Exeter.
27. The reception officer at Exeter completed a first night interview and assessed his risk. The officer noted that Mr Frew had arrived at the prison with a suicide and self-harm warning form, had been diagnosed with schizophrenia and had said he wanted to die. The officer said that Mr Frew was very angry that he had been sent to prison, as he was the subject of a CTO. Mr Frew gave no details of a next of kin and declined the offer of a phone call. (Mr Frew made no telephone calls during his time at Exeter.) As Exeter has a no smoking policy, Mr Frew bought several e-cigarettes to last until he could see the prison's smoking cessation team.
28. At around 3.15pm, a prison GP assessed Mr Frew, who said that he was taking a number of medications including amisulpride, an antipsychotic, for schizophrenia and diazepam. The GP gave Mr Frew diazepam to minimise any behavioural deterioration, and a request was made to obtain Mr Frew's community medical records from his GP to confirm his prescription of antipsychotics.
29. At 4.00pm, the reception officer who had initially assessed that Mr Frew was not at risk of suicide or self-harm, started ACCT procedures, and a Supervising Officer (SO) spoke to Mr Frew and completed an immediate action plan. The SO told Mr Frew what support was available, including access to the Samaritans and Listeners (prisoners who are trained by the Samaritans to offer confidential support to other prisoners). He told him that he would be checked hourly until he was assessed further. Mr Frew told the SO that he should not be in prison, was tired, wanted to sleep in his cell and did not need a prison induction. The SO recorded that Mr Frew had a poor attitude, was rude and blamed staff for his situation.

30. At around 5.00pm, a mental health nurse assessed Mr Frew at an initial health screen. The nurse noted that his behaviour was very odd, he was angry, apathetic and uninterested. The nurse noted that Mr Frew was unkempt, had had recent contact with psychiatric services and was taking antipsychotics. Mr Frew told the nurse that he had previously self-harmed, had suicidal thoughts and should never have been sent to prison. The nurse referred Mr Frew to the prison GP.
31. The reception officer completed a cell sharing risk assessment. Although she initially considered that Mr Frew's risk to other prisoners was low, his risk was later changed to high because of his mental state and psychosis and on the advice of the healthcare team. Although Mr Frew was not undergoing any detoxification treatments, she allocated Mr Frew a single cell on the prison's detoxification wing as she thought that he was detoxing from alcohol.
32. Mr Frew was checked hourly over night. Although he initially complained about the quality of his e-cigarettes, he subsequently slept throughout the night.

### 15 October 2017

33. At 8.55am, an officer tried to assess Mr Frew under ACCT procedures, but he refused to engage as he said he had not had a breakfast pack. When he was returned to his cell, Mr Frew slammed the cell door shut. The officer gave Mr Frew a breakfast pack. Although Mr Frew was then happy to proceed with the ACCT assessment, the officer was unable to continue as he had to carry out other duties. Mr Frew raised no concerns with staff during the morning and at lunchtime, left his cell to collect his lunch.
34. Although Mr Frew had said the previous day that he did not want an induction, the reception officer said that she tried to collect Mr Frew for his induction in the afternoon. She said that he was on the landing having a cup of tea. She described him as a completely different person, that he engaged well and said he would make his own way to induction after he had collected his medication. Although the records for that day do not make it clear if Mr Frew went to his induction, an officer noted the next day that Mr Frew had completed his second day of induction.
35. At 3.00pm, an officer assessed Mr Frew under ACCT procedures. He said that Mr Frew refused to engage fully and did not make sense when answering questions. Mr Frew told the officer that he was schizophrenic, was hearing voices and could not distinguish what was real. Mr Frew told the officer that he should have been sectioned under the Mental Health Act. Mr Frew told the officer that he had no current thoughts of suicide or self-harm.
36. At 3.30pm, a SO, Mr Frew's offender supervisor, and an officer held Mr Frew's first ACCT review. The officer told the SO before the review that he had not been able to assess Mr Frew as he was not making sense. He said that Mr Frew needed to be assessed by the mental health team. The officer told us that he could not recall being invited to the review.
37. The SO noted that during the review, Mr Frew came across as "very sensible" and was "fully aware of where he was". The SO told us that Mr Frew was really

positive, happy and had good eye contact and that his demeanour made him question why he was being monitored under ACCT procedures. Mr Frew said that he had said he wanted to die due to the voices in his head and that coming into prison had been overwhelming. Although the SO noted that Mr Frew was a lot more settled and had no thoughts of self-harm, the officer concluded that ACCT monitoring should continue until the mental health team had assessed him. The officer said that Mr Frew was happy to talk during the review and raised no issues. The SO considered that Mr Frew's risk of suicide and self-harm was low and reduced his observations to one "decent conversation" during the day and three observations at night. He completed the caremap, noting that Mr Frew had been referred to the prison's mental health team. He scheduled a further review for 20 October.

### 16 October 2017

38. On 16 October, a mental health nurse assessed Mr Frew. Mr Frew told him that he had been diagnosed with schizophrenia when he was 19 years old. He said that he had heard voices for over a year and that his neighbours had been sending messages from their computers directly to his brain. Mr Frew told the nurse that he had set fire to his flat because of the voices in his head which were calling him a paedophile. The nurse noted that it sounded as though Mr Frew had locked himself in his bedroom at the time of setting the fire and had to be rescued by police.
39. Mr Frew told the nurse that at first, he had been terrified about coming to prison as he feared being attacked, but he felt safer in his cell than in the community. Mr Frew said his antipsychotic medication had not been working as the dosage had been reduced because it was affecting his liver. He said that he would not take it if it were prescribed again. Mr Frew denied thoughts of suicide or self-harm. The nurse made plans to discuss Mr Frew's treatment plan and suitability of his medication with the prison's consultant psychiatrist.
40. In a statement written after Mr Frew's death, the prison's consultant psychiatrist said that the nurse sought her view on changing Mr Frew's medication. She said she concluded that Mr Frew should continue with his current medication, prescribed by his community mental health team, as they knew him best and she had no clinical reason to challenge their prescription. The psychiatrist and the nurse also agreed that Mr Frew was appropriately located in a single cell and was being supported by ACCT procedures. The psychiatrist accessed Mr Frew's community mental health records, which confirmed her conclusions about him.
41. At 1.30pm, an officer spoke to Mr Frew and noted that he was concerned about getting his medication. He told Mr Frew that his medication was delayed as his community GP had to confirm that it had been prescribed to him. He noted that Mr Frew was happy with the explanation.
42. At 3.35pm, a prison GP reviewed Mr Frew's community GP medical records. These confirmed his diagnosis of schizophrenia and that he had been prescribed antipsychotic medication. She re-prescribed the antipsychotics and stopped the diazepam (which had been prescribed until his antipsychotic medication had been confirmed).

43. Mr Frew went to the medication hatch for his medication later that afternoon. However, he refused to take the antipsychotics that the GP had prescribed. He told the nurse that he wanted diazepam instead. When the nurse told Mr Frew that this would not be possible, he walked away without medication.

#### **17 October 2017**

44. On the morning of 17 October, the consultant psychiatrist told a nurse that she had obtained further clinical records about Mr Frew which she had added to his medical record. They discussed what action they might take if Mr Frew continued to refuse his antipsychotic medication. The psychiatrist confirmed that he should continue with his current medication and that the mental health team would review his case in depth the following week.
45. At around 10.30am, Mr Frew attended a smoking cessation clinic, where he was assessed by a healthcare assistant. He said that Mr Frew was very quiet but pleasant and polite during the assessment. He noted that Mr Frew was a heavy smoker and prescribed him nicotine replacement substitutes, including lozenges and a two-week supply of nicotine patches. He explained to Mr Frew the value of nicotine patches on the wings. He told Mr Frew that other prisoners might harass him for the patches or want to trade them, and that he should not tell other prisoners that they had been prescribed.
46. At 11.25am, an officer spoke to Mr Frew. The officer noted that he had a general discussion with him about what was happening on the landings and that Mr Frew appeared calm and engaged well.
47. At 2.53pm, a member of the safer custody team explained his role as the wing representative for violence reduction, the support available for prisoners who felt intimidated or were being bullied and that the prison had a zero-tolerance policy towards violence. He noted that Mr Frew raised no concerns about his personal safety.
48. At 4.00pm, Mr Frew failed to attend for his secondary health screen.
49. At 5.00pm, an officer noted that she had spoken to Mr Frew when he had collected his dinner, and they had talked about how busy it had been on the wing that day. She noted that Mr Frew spoke about his nicotine patches, and that he wanted to keep them a secret from other prisoners as he knew “what happened on the wing”. She said that she took this to mean that Mr Frew knew other prisoners might try and take his nicotine patches from him. She said Mr Frew was in “great humour”, was polite and raised no issues.

#### **18 October 2017**

50. An officer said that on the morning of 18 October, officers noted that Mr Frew had pushed his locker in front of his cell door. At 2.00pm, she noted in Mr Frew’s ACCT record that he had said he wanted to remain behind his cell door and did not want to collect his lunch as he felt unsafe. The officer noted that Mr Frew would not explain why. She noted that staff had collected Mr Frew’s lunch and that he thanked them for this. She said that Mr Frew had expressed no thoughts of self-harm. The officer told the investigator that because of Mr Frew’s concerns, she and the other officers checked that he was okay more frequently than the

level of observations set in his ACCT records. She said that although Mr Frew blocked his observation panel, he removed the blockage when staff asked him to do so.

51. At around midday, a nurse visited Mr Frew in his cell to persuade him to take his medication. Mr Frew swore at him, told him that he did not want to speak to him and asked him to go away. The nurse said that Mr Frew was pacing up and down in his cell, and later noted that Mr Frew was isolating himself, blocking his cell door and covering his observation panel. The nurse told the investigator that he was unable to assess Mr Frew and therefore could not assess whether he had suicidal intentions at that time.
52. The nurse said that he went to the wing office to speak with officers about Mr Frew's behaviour. He spoke to a female officer to see if Mr Frew's behaviour had changed or deteriorated and to raise his concerns that Mr Frew was blocking his observation panel and was not taking his medication. The nurse could not recall who he spoke to. He said that the officer told him that officers were aware Mr Frew was blocking his door and observation panel but were not worried as he was leaving his cell to collect his food and drinks. The nurse later recorded his conversation with wing staff in Mr Frew's medical record. He said that he had asked staff to encourage Mr Frew to leave his cell to take his medication but had not made an entry in his ACCT document. The nurse talked to a colleague from the mental health team about Mr Frew. She said that she would add him to her caseload and discuss his case with the consultant psychiatrist.
53. An officer said that Mr Frew stayed in his cell most of the day and kept to himself. At around 3.30pm, he noticed that Mr Frew had blocked his door with a locker. Another officer explained to him that it was because Mr Frew felt threatened on the landing from some of the other prisoners. He offered to bring Mr Frew's food to him as he did not want to leave his cell. Mr Frew accepted the offer. At around 5.00pm, the officer said that when he was unlocking prisoners to collect their evening meal, Mr Frew told him that he had changed his mind and now wanted to collect his evening meal. He watched Mr Frew leave the cell to collect his meal and continued unlocking the other prisoners.
54. Officer A arrived on the wing at around 4.30pm. He said that he went into Mr Frew's cell at around 5.07pm and noticed that he had pushed a locker against his cell door. He said that the door was ajar, with the locker at an angle to the door, and that it was still possible to enter the cell. He said that he asked Mr Frew why he had tried to block the cell door. Mr Frew did not answer but instead asked what time his evening meal was. He told Mr Frew that he could collect it. When he did, the officer moved the locker to its correct place before leaving the cell. He said that this was the only contact he had with Mr Frew and that he was not aware that Mr Frew was subject to ACCT procedures.
55. At 5.05pm, CCTV footage showed two unidentified prisoners at Mr Frew's cell door. They appeared to talk to him.
56. At 5.10pm, Officer B noted that Mr Frew had told her that he felt better and wanted to collect his evening meal and go to bed. The officer noted that he raised no "negative" issues. At around 5.20pm, Mr Frew was locked in his cell.

57. At around 5.48pm, Officer B carried out her early evening roll check which included checking that Mr Frew was in his cell. The officer said that she saw Mr Frew standing in the middle of his cell, eating.
58. CCTV shows that at 6.53pm, Officer A stopped outside Mr Frew's cell. He told the investigator that he could not recall this or what Mr Frew was doing.
59. At 7.17pm, Officer A checked on Mr Frew during his evening roll check. The officer looked through the observation panel and saw Mr Frew hanging from the window bars at the back of the cell. Mr Frew had used torn prison bedding to make a ligature. He radioed for immediate healthcare assistance and said that he had found a prisoner hanging in his cell.
60. Office A went into the cell immediately, supported Mr Frew's waist and cut the ligature. Another officer arrived and the officers lowered Mr Frew to the floor. Officer A checked for signs of life but found none. He started cardiopulmonary resuscitation by giving Mr Frew chest compressions while another officer provided breaths. A SO arrived soon afterwards and helped with resuscitation efforts. An officer said that Mr Frew felt neither warm nor cold and described his skin as grey. The officers continued trying to resuscitate Mr Frew.
61. At 7.19pm, a nurse arrived at the cell, with other members of the healthcare team who had brought the emergency response equipment. The nurses attached a defibrillator, which was unable to find a shockable rhythm, and advised the staff to continue in their efforts to resuscitate Mr Frew.
62. South West Ambulance Service records and prison radio traffic indicate that an ambulance was called at 7.20. At 7.28pm, paramedics arrived and continued resuscitation efforts. They were not able to resuscitate him, and a prison GP confirmed Mr Frew's death at 7.55pm.

### **Information after the incident**

63. After Mr Frew's death, two intelligence reports were submitted which noted that prisoners had reported that Mr Frew had been bullied for his nicotine patches. This evidence is unsubstantiated and was not known to prison staff at the time of Mr Frew's death. (Although Mr Frew had a two-week supply of nicotine patches, none were found in his cell after his death. This suggests that he might have been bullied by other prisoners for them.)
64. A prisoner told the investigator that Mr Frew had been trading his nicotine patches, that prisoners would gather round his cell door asking for them and that others took the patches from him. He described Mr Frew as a vulnerable man who other prisoners took advantage of. He said that he had seen officers move prisoners away from Mr Frew's cell. He said he did not speak much to Mr Frew but said that Mr Frew told him that he was frightened of being beaten up and wanted to stay in his cell.

### **Contact with Mr Frew's family**

65. Mr Frew left no next of kin contact details. With the help of Devon and Cornwall Police, the Governor of Exeter broke the news of Mr Frew's death to his daughter

on the morning after his death. The prison offered to contribute to the cost of Mr Frew's funeral in line with national policy.

### **Support for prisoners and staff**

66. The Head of Reducing Reoffending debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support. Officers checked on prisoners assessed as at risk of suicide and self-harm in case they had been affected by the news of Mr Frew's death.

### **Post-mortem report**

67. The post-mortem examination established the cause of Mr Frew's death as hanging.

# Findings

## Management of risk of suicide and self-harm

### *ACCT reviews*

68. PSI 64/2011 requires that healthcare staff are told when ACCT procedures start and that they are invited to the first case review to provide input to the review process. No healthcare staff attended Mr Frew's first case review. A SO said that he was not aware that it was mandatory for healthcare to attend.
69. In our thematic report about risk factors in self-inflicted deaths, published in April 2014, we found that risk assessments too often placed insufficient weight on a prisoner's known risk factors and too much weight on staff perceptions of the prisoner's behaviour and demeanour. Prisoners intent on suicide rarely say so. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.
70. There was no meaningful discussion in Mr Frew's case review of issues that might affect his level of risk, such as the nature of his offence (arson), his diagnosis of paranoid schizophrenia and that he heard voices. As a result, the case review failed to address Mr Frew's needs and level of risk effectively or take practical steps to address any underlying issues.
71. Although Mr Frew continued to be monitored under ACCT procedures until his mental health assessment, his second case review was not scheduled until five days later. This should have been scheduled sooner and, for example, it would have been more appropriate if it had taken place after Mr Frew's mental health assessment, particularly as he had been hearing voices and found the thought of prison overwhelming.
72. We are concerned that a nurse did not review Mr Frew's ACCT document before each of his contacts with him. When Mr Frew blocked his observation panel and placed furniture behind his cell door, neither the nurse nor wing officers noted his actions in his ACCT document. We are troubled that Mr Frew's behaviour did not trigger an urgent ACCT review to consider appropriate responses to this behaviour.
73. By not holding a review, staff missed an opportunity to assess the reasons for Mr Frew's actions, to consider additional support, and most importantly, to reassess the risk Mr Frew posed to himself, especially as he had told a wing officer that he did not feel safe. If a review had taken place that day, we consider it likely that Mr Frew's behaviour and actions would have prompted staff to put in place more measures to manage his risk, not least by increasing his observations.

### *Observations*

74. Mr Frew had recently expressed suicidal thoughts, had significant mental health issues, had recently arrived at the prison and had not been assessed by the mental health team. We are concerned therefore that a SO assessed his risk as low during the ACCT review on 15 October, and that he reduced Mr Frew's observations to one conversation during the day and three observations at night.

We consider that this level of observation was too low and did not appropriately reflect his risk at that time.

#### *Suicide and self-harm (SASH) case manager training*

75. We were told that Exeter has recently experienced a shortage of supervising officers who are trained to undertake the role of ACCT case manager. This led to existing managers being overstretched.
76. To address this, Exeter secured regional office agreement to carry out local ACCT case manager training. A SO had received this local training, not the mandatory national training for ACCT managers. We understand Exeter's reasons for this course of action but note the potential deficit this may have created. Given we have identified significant deficiencies in the way staff operated ACCT procedures and given what we were told, we therefore consider that all newly promoted supervising officers, including the SO, should receive the national mandatory ACCT case manager training as soon as possible.

#### *General conclusions about ACCT procedures*

77. Staff judgement is fundamental in operating ACCT procedures. The system relies on staff using their experience and skills, as well as local and national assessment tools to determine risk. While a prisoner's presentation is important and reveals something of their level of risk, it is only a reflection of their state of mind at the time and should be considered as a single piece of evidence when judging risk. Staff should consider all risk factors to ensure that a prisoner's level of risk is judged holistically. Staff did not use the ACCT procedures appropriately or interact sufficiently effectively with Mr Frew to identify his risk, needs and issues. We consider that more could have been done to ensure that he received more appropriate support. While we cannot know whether this might have changed the outcome for Mr Frew, Exeter did not identify or manage his risk effectively. Exeter have previously accepted our recommendations intended to address the quality of ACCT procedures, and we are concerned that we must repeat them in this report. We recommend, again, that:

**The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular, that:**

- **Case reviews are multidisciplinary, include all relevant people involved in a prisoner's care and that healthcare staff attend all first case reviews.**
- **Staff read the ACCT document and familiarise themselves with all relevant issues and known risk factors before holding reviews and ACCT case reviews should assess and record the level of risk, taking into account all risk factors.**
- **The frequency of observations reflects the prisoner's risk and is adjusted when that risk changes.**
- **There are procedures in place to check the quality of ACCT procedures, identify bad practice, learn lessons, and where**

appropriate, provide staff refresher training on suicide and self-harm prevention procedures

- All newly promoted supervising officers receive the national ACCT case manager training as soon as possible.
- Clinical staff review ACCT documentation frequently and in particular, that mental health staff consult and review ACCT documentation at each contact with a prisoner and make a detailed contemporaneous record of their consultation with the prisoner in both the medical records (SystemOne) and the ACCT document.

### Personal officer scheme

78. Exeter's current personal officer scheme policy, which has been in operation since July 2013, states that the role of a personal officer includes identifying and managing risk, giving information and advice and providing pastoral care to prisoners. The policy sets out a personal officer's responsibilities which include introducing themselves to prisoners, engaging and initiating a meaningful conversation with the prisoner at least once every two weeks. The policy states that if a prisoner is being monitored under ACCT procedures, personal officers must speak with the prisoner every day that they are on duty, record their contact in the ACCT document and either attend or contribute to ACCT case reviews.
79. Despite this, Mr Frew's allocated personal officer did not introduce himself or interact with him on a daily basis as he should have, given that Mr Frew was subject to ACCT procedures. There is no evidence that the officer was invited to attend or contribute to Mr Frew's ACCT case review on 15 October, as he should have been, even though he was working on the wing that day.
80. We note that HMP Exeter is in the process of introducing the 'keyworker' scheme, an expectation of which is that wing staff have allocated time with prisoners every week. Until the keyworker scheme is fully in operation, we recommend that:

**The Governor should ensure that the personal officer policy is effective in providing meaningful support to prisoners, particularly in relation to the identification, discussion and recording of significant events, and that contacts take place at a frequency in line with the policy.**

### Emergency response

81. PSI 03/2013 on medical emergency response codes requires Governors and Directors to have a protocol to provide guidance on communicating the nature of a medical emergency, the type of equipment to take to the incident and that there are no delays in calling an ambulance. It says that if a medical emergency code is radioed, an ambulance must be called immediately.
82. Exeter's local policy requires that the use of the medical emergency codes comply with PSI 03/2013. This requires that staff should radio a code blue when a prisoner has difficulty breathing or is unconscious and ensure that an emergency ambulance is automatically called. The local policy says that staff

should, where appropriate ask for emergency medical help using a code blue when they discover a suicide attempt.

83. Officer A's immediate actions were commendable, particularly the speed with which he entered Mr Frew's cell, called for medical and other assistance and his attempts to resuscitate Mr Frew. It is apparent, though, that there was a delay of some two minutes in calling a code blue medical emergency. We feel obliged to note that this failure to comply with national policy meant the control room did not call an ambulance immediately. While the failure to radio an immediate code blue did not affect the outcome in this case, in another emergency it could do. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use the appropriate emergency medical code to communicate the nature of the emergency effectively.**

## Clinical care

### Mental health referral

84. When Mr Frew arrived at Exeter, he was assessed by both the prison GP and reception nurse. The clinical reviewer noted his concerns that neither of them referred Mr Frew for an urgent mental health assessment, which would have been appropriate as he had paranoid schizophrenia. All new prisoners should be assessed by the prison's mental health team on arrival at the prison. Mr Frew was not assessed due to the number of new prisoners arriving at Exeter and the reduced number of mental health team staff working on Saturdays (when Mr Frew arrived), a situation that a nurse said was not unusual. As mental health services were not available at Exeter on Sundays, Mr Frew was not reviewed by the mental health team until the Monday, around 48 hours after his arrival at the prison.
85. In his clinical review, the clinical reviewer said it was difficult to compare Mr Frew's situation, where he did not receive an urgent mental health assessment, with a community situation. However, he said that community mental health services were available seven days a week and a significant deterioration in a patient's mental health, as a result of a stressful event, may result in a referral to mental health services at any time, including during a weekend. We note that although mental health services for Exeter are commissioned seven days a week, in practice mental health services are not available at the prison on Sundays. In light of this, the clinical reviewer concluded that the care Mr Frew received at Exeter was not equivalent to that which he could have expected to receive in the community. We agree with him and recommend that:

**The Head of Healthcare should ensure that staff contact the prison's mental health team to request an urgent assessment if they identify that a new prisoner has significant mental health issues.**

**The Head of Healthcare and the Governor should review the provision of mental health services to ensure there is adequate cover throughout the**

**week, including on Sundays, and address the apparent anomaly that commissioned services are not available when they should be.**

#### **Other clinical issues**

86. The clinical reviewer concluded that although their attempts were unsuccessful, nursing staff arrived promptly and took over life support effectively.
87. He made a number of other findings and recommendations in his clinical review. Although these are unlikely to have affected the outcome for Mr Frew, the Head of Healthcare at Exeter will need to address the clinical reviewer's findings.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations