Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Frejus a prisoner at HMP Nottingham on 9 October 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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

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 Frejus died after he cut his throat on 9 October 2018 while a prisoner at HMP Nottingham. He was 29 years old. I offer my condolences to his family and friends.

Mr Frejus had been at Nottingham for less than three weeks when he took his life. He had a number of risk factors for suicide and self-harm: he was a Polish national whose English was limited; this was his first time in prison; and he was showing signs of possible mental health problems. I am concerned that when staff monitored him under suicide and self-harm prevention procedures, known as ACCT, they did not use an interpreter during his only ACCT review, and they stopped monitoring him prematurely before he had had a mental health assessment. We also found deficiencies in the way staff managed the ACCT procedures.

Mr Frejus appeared in court the day before he died. I am concerned that prison staff failed to assess his risk of suicide and self-harm when he returned from court and that information about his mental health and increased risk was not considered. As a consequence, staff missed an opportunity to monitor him under ACCT procedures.

Over the last three years, my office has repeatedly recommended that HMP Nottingham should ensure that staff assess risk appropriately, improve the quality of ACCT procedures and tackle failures in delivering mental health services. The prison has accepted these recommendations and agreed to take action to implement them.

Following its inspection of Nottingham in January 2018, HM Inspectorate of Prisons (HMIP) concluded that Nottingham had repeatedly failed to implement our recommendations after previous deaths in custody and that the prison was 'fundamentally unsafe'.

I am, therefore, very concerned that this investigation has identified many of the same failings. I have drawn this worrying situation to the attention of the Prison Group Director for North Midlands.

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 **October 2019**

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Summary

Events

1. On 20 September 2018, Mr Robert Frejus, a Polish national whose English was limited, was remanded to HMP Nottingham charged with burglary and assault. Staff at the prison started suicide and self-harm prevention procedures, known as ACCT, that day but stopped monitoring him two days later.

2. Mr Frejus was referred to the prison's mental health team. Although he was scheduled to have an assessment on 28 September, it was delayed until 5 October so that an interpreter could be present.

3. On 8 October, Mr Frejus appeared at court and dismissed his legal team. When he returned from court, he was not seen by a nurse. The court's liaison and diversion practitioner emailed the mental health team at Nottingham to tell them that he believed that Mr Frejus was more paranoid than he had first thought and that arrangements should be made for him to see a doctor as he might need mental health treatment. The email was not opened until the following day (by which time Mr Frejus was dead).

4. At around 8.15am on 9 October, Mr Frejus's cellmate raised the alarm after he discovered Mr Frejus bleeding profusely. An officer who was unlocking cells nearby, did not immediately radio for emergency assistance or go into the cell but left to seek further assistance. When staff went into the cell, they did not start resuscitation efforts as it was clear that Mr Frejus had died. The prison's paramedic later confirmed Mr Frejus's death.

Findings

1. When Mr Frejus arrived at Nottingham, the reception nurse did not have access to all the relevant information that arrived with him from the criminal justice liaison and diversion team (CJLT) who had seen him at the police station.

2. ACCT procedures were appropriately opened when Mr Frejus arrived at Nottingham. However, we consider that staff stopped ACCT procedures prematurely after only two days at the review on 22 September, despite no interpreter being present, Mr Frejus having a number of risk factors and not yet having had a mental health assessment.

3. There were also deficiencies in the way that the ACCT procedures were managed which meant that staff could not have fully understood Mr Frejus's risks.

4. Staff failed to assess Mr Frejus when he returned to Nottingham from court the day before his death although he had dismissed his legal team at court, which was a potential sign of paranoia, and was upset.

5. The officer who went to Mr Frejus's cell when the alarm was raised, should have gone into the cell straight away and radioed a medical emergency code promptly rather than leaving to find staff to help him.

6. The clinical reviewer concluded that the care that Mr Frejus received at Nottingham was of mixed quality, and some aspects were not equivalent to that which he could have expected to receive in the community.

7. The clinical reviewer was concerned that clinical staff from the CJLT could not access prison medical records and that a nurse completing mental health assessments at the prison was not appropriately qualified.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national guidelines, ensuring that:
  - reviews take place within 24 hours of ACCT procedures starting;
  - case reviews are multidisciplinary, with staff who have had previous contact with the individual, such as key workers or the ACCT assessor, where appropriate;
  - caremap actions are specific, meaningful, tailored to the individual to reduce their risk and completed before ACCT monitoring is stopped;
  - post-closure reviews take place within seven days of closure, and take into account any events which have taken place since ACCT procedures stopped; and
  - staff take action to mitigate against significant risk factors before considering whether to stop ACCT monitoring.

- The Governor should ensure that if a prisoner is not fluent in English or his level of English is unknown:
  - staff check with the prisoner if he needs an interpreter; and
  - interpreters are used in all ACCT assessments and reviews.

- The Governor should ensure that all prison staff:
  - call an appropriate medical code as soon as they find a prisoner in a life-threatening situation, even if the radio is busy; and
  - enter a cell as quickly as possible when a prisoner’s life is in danger.

- The Head of Healthcare, the Manager of the CJLT and the NHS England Commissioners should ensure that CJLT staff can access SystmOne to maintain a full, contemporaneous record of events.

- The Head of Healthcare should ensure that nurses who complete mental health assessments are appropriately qualified and skilled.

- The Governor and Head of Healthcare should ensure that reception healthcare staff have access to all relevant information about new prisoners, including police custody records when available, so that they can complete a thorough health assessment.

- The Governor and Head of Healthcare should ensure that prisoners returning after a court appearance, police questioning or other temporary absence are screened to assess their risk of suicide or self-harm.
- The Prisons Group Director for North Midlands should satisfy himself that effective action is being taken to implement the PPO's recommendations about the quality of ACCT assessments and reviews at Nottingham.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Nottingham informing them of the investigation and asking anyone with relevant information to contact him.

9. The investigator visited Nottingham on 17 October 2018. He obtained copies of relevant extracts from Mr Frejus's prison and medical records.

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

11. The investigator interviewed eleven members of staff and two prisoners, some jointly with the clinical reviewer. The investigator also obtained translations of Mr Frejus's telephone calls on 8 October (which were made in Polish).

12. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation. We have sent the Coroner a copy of this report.

13. We contacted Mr Frejus's wife to explain the investigation and ask if she had any matters she wanted the investigation to consider. She had no specific questions.

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

Background Information

HMP Nottingham

15. HMP Nottingham is a local prison holding a maximum of 1,000 men and young adult prisoners on remand, convicted or sentenced. The prison serves the courts of Nottinghamshire and Derbyshire. Nottinghamshire Healthcare NHS Foundation Trust provides health services, including mental health services.

16. In August 2018, Nottingham was selected to be part of the "10 Prisons Project", which seeks to improve safety, security and decency in the prisons involved. The project is focusing on improving living conditions, preventing drugs from entering the establishments and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Nottingham in January 2018 and found that the prison was "fundamentally unsafe". Key findings from the inspection included:

- over two thirds of prisoners had felt unsafe during their stay at the prison;
- levels of self-harm were very high and had increased since the last inspection; and
- Nottingham had repeatedly failed to embed improvements in response to previous PPO recommendations.

18. On 18 January 2018, HMIP invoked the Urgent Notification (UN) process which committed the Secretary of State to respond publicly to the concerns raised within 28 calendar days. The Secretary of State did so on 12 February.

Independent Monitoring Board

19. 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 their annual report for the year to February 2018, they noted that staffing levels had improved but that the healthcare team did not have a full complement of staff. The IMB noted concerns about the way in which ACCT procedures were operated.

Previous deaths at HMP Nottingham

20. Mr Frejus was the tenth prisoner to take his own life at Nottingham since June 2016 and was one of four prisoners to do so in 2018. In addition to these deaths, there has been one homicide, two deaths from natural causes and one drug-related death at Nottingham since 2016.

21. Nottingham has previously agreed to implement our recommendations about the premature closure of ACCT procedures in two previous investigations, the poor assessment of risk in three investigations and the overall quality of ACCT procedures in three investigations.

Assessment, Care in Custody and Teamwork (ACCT)

22. 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.

23. 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 (a plan of care, support and intervention) should be put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. After closure, a follow-up interview should take place within seven days.

24. 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. Prison Service Instruction (PSI) 64/2011 on safer custody sets out how staff should operate ACCT procedures.

Key Events

25. On 18 September 2018, Mr Robert Frejus, a Polish national who had lived in the United Kingdom since 2016, was arrested for burglary and assault and was taken to a police station.

26. At the police station he was seen by a healthcare practitioner from the Criminal Justice Liaison and Diversion Team (CJLT), which aims to divert those with mental health needs away from the criminal justice system to care and treatment from the health and social care sector. She used a Polish interpreter to speak to him.

27. She recorded in Mr Frejus's police custody medical record that Mr Frejus told her that he feared that people were conspiring to kill him and were attempting to get his girlfriend on their side. He said that before his arrest he had been to a gym, however he thought he was under threat and ran out of the gym, jumped over a fence and smashed a window to gain access to someone's house and hid in a bathroom so the gang could not kill him. He said that a Polish man, who he thought was a policeman, had taken all his documents. He believed that he saw people who were after him in cars from a distance. He also described feeling under threat from people in a supermarket car park, who were waving red flags, which he believed meant they were Muslim and that they were going to kill him. He said a large black man, who looked like the "grim reaper" or an executioner, had stared at him, which he thought meant that he was going to be beheaded.

28. She concluded that Mr Frejus may be paranoid as he had had a psychotic episode before his arrest and had told her that he had smoked cannabis the previous evening. She referred Mr Frejus for a mental health assessment after she noted concerns that the police and his solicitors had raised about his welfare. Mr Frejus's English was limited, and she noted that he would need an interpreter. (The assessment did not take place.)

29. On 20 September, Mr Frejus appeared at court. The person escort record (PER, a document that accompanies prisoners between police custody, courts and prisons and which sets out their risks) noted that he said he had bone cancer and depression and understood little English. A court custody officer asked him about his risk of self-harm. The officer noted that Mr Frejus was "just scared".

30. Mr Frejus was remanded into custody at HMP Nottingham. A nurse completed an initial health screen using an interpreter. The nurse had access to documents about Mr Frejus but told the investigator that he did not recall seeing the police custody medical record which CJLT had completed. Mr Frejus denied thoughts of suicide or self-harm but was anxious because he feared that he would be killed. The nurse said that he could not recall if Mr Frejus had any mental health issues. He described Mr Frejus as paranoid and noted that it was his first time in prison and that he had a history of cannabis and amphetamine misuse. The nurse referred Mr Frejus to a prison GP and the mental health team for further assessment.

31. An officer completed a first night safer custody interview and assessed Mr Frejus's risk using an interpreter. Mr Frejus told her that he could not recall if he had previously self-harmed but that his wife and family had noticed a change in his mental health. He told her that he had suicidal thoughts, that he felt "crazy" and "was losing his mind". She started ACCT procedures. Mr Frejus was checked once an hour.

32. Mr Frejus spent his first night in a shared cell on the prison's first night centre. An officer (whose signature is illegible in the ACCT record) noted that he saw a prison GP, although there is no evidence in his medical records that he did.

33. On 21 September, an officer (whose identity is unknown) noted that Mr Frejus had asked to make a phone call.

34. At 11.30am, an officer assessed Mr Frejus under ACCT procedures, using an interpreter. Mr Frejus said that it was his first time in custody, he felt low, he was not sleeping or eating and felt anxious about being threatened by a gang in the community. Mr Frejus said that he had harmed himself in the past when he felt low but he had no current thoughts of self-harm. He said that he wanted to telephone his wife who he said would support him while in prison.

35. During the day, an officer received information from a CJLT mental health practitioner based at Bridewell Police Station. He said that he believed that Mr Frejus had paranoid thoughts and might have mental health issues. He said that Mr Frejus spoke little English and that his mental health had not been assessed in police custody as planned, but that the CJLT team would assess him when he next appeared in court. The officer passed the information to the prison's mental health team and to the supervising officer on Mr Frejus's wing.

36. On 22 September, a Supervising Officer (SO) and a mental health nurse held Mr Frejus's first ACCT review. They did not use an interpreter. The SO noted that Mr Frejus engaged well in "broken English" and told the investigator that his English was not perfect but was good enough to get the information required. He noted that Mr Frejus had said that he feared people in the community (but provided no further information about this). He noted that Mr Frejus calmed down when he was told that he would be safe in prison. Mr Frejus said that he had no thoughts of suicide or self-harm but wanted to speak to his wife by telephone as he missed her. The SO reminded Mr Frejus of the support networks available to him and noted the support from his family.

37. The SO did not record Mr Frejus's level of risk, but he and the mental health nurse decided to stop ACCT monitoring. A post-closure review was scheduled for 29 September. The SO completed the caremap and noted that Mr Frejus had received a telephone call to his wife and had been referred to the prison's mental health team.

38. The mental health nurse told the investigator that at first, Mr Frejus did not understand the ACCT review, and she had to explain to him that it was about his risk of suicide, which surprised him. She noted in his medical record that Mr Frejus initially said that he did not speak English but was able to discuss quite complex matters. She said that Mr Frejus was tearful when he showed them a picture of his baby son which he kissed and was happy when he was told that

he would be able to telephone his wife. She said that Mr Frejus did not present with any mental health issues, other than sadness because he was away from and missed his family.

39. On 24 September, a prison GP assessed Mr Frejus. He described Mr Frejus's English as "pretty good" but used an interpreter. The GP noted that Mr Frejus was upset and cried while kissing a picture of a baby. The GP said that while Mr Frejus was speaking Polish to the interpreter, he said in English, "Help me, help me." The GP said that although Mr Frejus was anxious and distressed, he did not give the impression of being deluded. Mr Frejus told the GP that he had bone cancer, blood in his urine and anal pain. He planned for blood tests to be carried out and referred him to the mental health team for an assessment.

40. On 25 September, an officer noted that Mr Frejus's solicitor had contacted the prison to say that he spoke little English and had mental health issues, and to ask the prison to facilitate a visit from his family. (a family engagement manager, confirmed that this had been done.)

41. On the morning of 28 September, the GP reviewed Mr Frejus, again using an interpreter. He noted that Mr Frejus's blood results showed no signs of cancer and that Mr Frejus was more settled and calmer than when he had last seen him.

42. That afternoon, a learning disabilities nurse from the prison's mental health team, was due to assess Mr Frejus. However, the nurse received a telephone call from another nurse from the CJLT who suggested that they should jointly assess Mr Frejus, using an interpreter. Mr Frejus's mental health assessment was therefore rebooked for 1 October. The learning disabilities nurse told Mr Frejus that his assessment had been postponed and noted that he had understood. The nurse told the investigator that Mr Frejus laughed and joked with his cellmate and that he gave him no cause for concern.

43. A Listener (a prisoner trained by the Samaritans to offer confidential support to other prisoners) on Mr Frejus's wing, told the investigator that Mr Frejus spoke and understood very little English. He said that Mr Frejus never talked about suicide or self-harm. Mr Frejus's cellmate, said that Mr Frejus cried a lot, read the Bible and was paranoid that the police and judiciary were "out to get him". He said that he did not think that Mr Frejus was bullied or in debt.

44. A newly qualified officer on D Wing, told the investigator that Mr Frejus had trouble speaking English and although he was frustrated by this, he was quite happy on the wing. The officer said that Mr Frejus would have asked if he needed something, got on well with his cellmate and there was nothing to indicate that Mr Frejus could not look after himself.

45. On 1 October, a nurse rang the prison to say that he was unable to book an interpreter for Mr Frejus's mental health assessment that day. He asked for it to be rescheduled to 5 October. There is no evidence that Mr Frejus was told that the assessment date had been postponed.

46. On 5 October, two nurses assessed Mr Frejus, using an interpreter. A nurse subsequently recorded the assessment in Mr Frejus's medical record. Mr

Frejus said that he had split up with his wife about a year earlier and had started to have problems with a gang who wanted to kill him about this time. He said that he was sleeping and eating well and got on with staff and other prisoners. He said that on the day that he was arrested, he had 'snorted' illicit drugs for the first time, but that he had been using cannabis for about eight months. Mr Frejus said that he had not previously been prescribed medication for mental health issues. A nurse noted that he did not present with any psychotic symptoms and denied thoughts of suicide or self-harm.

47. A nurse told the investigator that he believed that Mr Frejus had experienced drug-induced paranoid psychosis and that he would likely need a psychiatric report to assess his fitness to plead. The nurse said that he and the learning disabilities nurse discussed their assessment but did not agree a plan as it was late in the day.

Events of 8 and 9 October 2018

48. At 7.00am on 8 October, Mr Frejus telephoned his wife, and told her that he had been woken early to go to court. He told her that they would never see each other on a visit and that she was not to trust anyone.

49. A nurse assessed Mr Frejus and noted that he had no outstanding hospital appointments and was fit to appear at court that day. Mr Frejus then appeared at court about an offence that he had committed on 16 September.

50. In court, Mr Frejus saw his solicitor, was refused bail and was remanded to appear at court on 18 October. A court officer noted that there was no need to complete a suicide and self-harm warning form for him. Mr Frejus returned to his cell at Nottingham. At 11.43am, he briefly spoke to his wife again, and told her how much he loved her.

51. At 3.12pm, Mr Frejus telephoned his wife. He told her that "they" were doing everything to "fuck him up". His wife challenged him about why he had told his solicitor that he did not want to be represented by him. Mr Frejus said that it was "the guards" who had messed everything up for him by taking his letters, in which he had complained about them, and that officers had planted mobile phones in his cell. (There is no evidence to confirm either of these allegations.) Mr Frejus repeatedly told his wife that he loved her and that the prison was trying to destroy him and move him to a psychiatric hospital. Mr Frejus became very agitated during the call and his wife tried many times to calm him.

52. At 3.24pm, Mr Frejus's solicitor emailed a nurse to say that Mr Frejus had dispensed with his services. The solicitor said that he had spoken to Mr Frejus's wife, who was worried about Mr Frejus's decision to dismiss his legal team and would talk to him about it.

53. At 3.54pm, the nurse emailed the solicitor to say that he had planned to speak to Mr Frejus's wife later that day and hoped that she could reassure her husband. The nurse said that when he had assessed Mr Frejus, he had not appeared to be completely open and he feared that Mr Frejus might mask his symptoms if a psychiatrist assessed him. The nurse said that Mr Frejus might have paranoid psychosis due to his drug use. The nurse said that he would tell

the prison mental health team so they could bring forward his appointment with a psychiatrist.

54. At 4.02pm, the nurse emailed the learning disabilities nurse to say that Mr Frejus had wanted to sack his solicitor and that he believed that Mr Frejus was more paranoid than he had first thought. He asked for a doctor to see Mr Frejus as he might need further treatment. The learning disabilities nurse did not open the email until he returned to work the next morning, by which time Mr Frejus had died. He did not make a record of it in Mr Frejus's medical records.

55. At 5.06pm, the nurse emailed Mr Frejus's solicitor to say that he had spoken to Mr Frejus's wife who said that he had never used drugs in the past, she suspected that he was not mentally well, and she had doubts about the feelings of persecution that he described. The nurse said that he would contact the prison's mental health team the next day as Mr Frejus should respond quickly to medication if he had drug-induced psychosis.

56. The nurse told the investigator that he had no concerns about Mr Frejus's risk of suicide or self-harm as he had recently denied having suicidal thoughts. He said that nothing in the message from the solicitor made him think that Mr Frejus's risk had changed but that Mr Frejus was probably more psychotic than he had appreciated.

57. At 9.22pm, Mr Frejus made a brief call to his wife. He told her that he would call his girlfriend. Two minutes later, he spoke briefly with his girlfriend. Several minutes later, Mr Frejus made a further two calls to his wife, again telling her that he loved her. His wife told him to stay calm and said that she had spoken to his solicitor and doctor. Mr Frejus again repeated his belief that he would be sent to a psychiatric hospital.

58. In his interview with the investigator, Mr Frejus's cellmate described Mr Frejus as angry and upset when he returned from court. He said that he initially did not want to talk but later cheered up. He said that Mr Frejus was happier after he had made phone calls that evening. He said that Mr Frejus went to bed at around 9.30pm, and after praying, he went to sleep.

59. At around 1.30am on 9 October, Mr Frejus turned his cell light on and off briefly. The cellmate said that he saw Mr Frejus standing at the cell's sink washing himself before changing the sheets on his bed. The cellmate described the process as "a ritual". He said that Mr Frejus ate cereal and then went to bed. He said that he last saw Mr Frejus alive when he turned the television off at about 1.50am.

60. The cellmate who occupied the bottom bunk, said that he woke at around 8.15am to find blood on his pillow and the cell wall. He said that when he got out of bed, he saw that Mr Frejus had wrapped himself in a sheet which was covered in blood. He said that he banged the cell door to alert staff and rang the cell bell.

61. An officer was unlocking cells nearby and heard the cellmates calls for assistance. He said that the cellmate was distressed and told him that Mr Frejus was bleeding. The officer said that he was initially confused by the

situation. He tried to call a medical emergency code red several times (to indicate that a prisoner is bleeding and his life is threatened) but struggled as other officers were talking over the radio at the time. The officer said that his first instinct was to get help so he left the cell and ran down the stairs to the wing office. He said that he had been taught at training school not to go into a cell alone. At 8.17am, the officer successfully radioed a medical emergency code red and an ambulance was called.

62. When the officer got to the wing office, he told a Custodial Manager (CM), a SO and another officer what had happened. The officers went to the cell. The CM briefly spoke to the cellmate before unlocking the cell door and going into the cell, followed by the other officers. The CM found Mr Frejus lying on his front, wrapped in a sheet. He had intended to carry out cardiopulmonary resuscitation (CPR) but he could not find a pulse and it became clear to him that Mr Frejus was dead.

63. The prison's emergency paramedic, arrived at the cell, with an emergency bag, around a minute after the emergency call had been made. He told the investigator that Mr Frejus had lost a significant amount of blood, and that it was clear that he had died from a deep wound to his neck and that any efforts to revive him would be futile. He said that he saw the handle of a prison issue razor, which he assumed had been used to cause the wound, under Mr Frejus's chest. He said that he asked for the ambulance to be stood down.

64. After Mr Frejus's death, a Polish consulate official identified some graffiti that Mr Frejus had drawn on the wall of his cell. According to the cellmate, Mr Frejus had drawn it around a week before his death. The official said that it was addressed to his wife and son and said, "I love you."

Contact with Mr Robert Frejus' family

65. The Governor of Nottingham broke the news of Mr Frejus's death to Mr Frejus's wife later that day. A chaplain was appointed as the family liaison officer. Nottingham contributed to the costs of Mr Frejus's funeral in line with national instructions.

Support for prisoners and staff

66. The Head of Residence 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 them support.

67. The Governor issued notices to staff and prisoners informing them of Mr Frejus's death. Staff reviewed prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Frejus's death.

Post-mortem report

68. A post-mortem examination found that Mr Frejus died of an incised wound to the neck. Toxicology results established that Mr Frejus had not taken any substances that could be expected to have caused or contributed to his death.

Findings

Management of risk of suicide and self-harm

69. Prison Service Instruction (PSI) 64/2011 on safer custody requires staff to start ACCT procedures when they receive information about a prisoner which may indicate that he is at risk of suicide or self-harm. Staff at Nottingham appropriately monitored Mr Frejus under ACCT procedures when he arrived at Nottingham. However, there were deficiencies in the way that staff operated ACCT procedures.

ACCT reviews

70. PSI 64/2011 states that the first ACCT review should take place within 24 hours after ACCT procedures have started. Mr Frejus's review did not take place until two days after monitoring began.

71. PSI 64/2011 states that ACCT reviews should be multidisciplinary, where possible. However, only two members of staff attended Mr Frejus's first and only ACCT review, and neither had had contact with him previously. There is no record that anyone with any previous contact with Mr Frejus, such as the ACCT assessor or a keyworker, were invited to attend or contribute to the review. This meant that the two members of staff present could not have fully appreciated Mr Frejus's risks and were only partly equipped to understand his difficulties.

Caremaps

72. PSI 64/2011 says that case managers must complete caremaps with actions aimed at reducing the risk of suicide and self-harm. At the first ACCT review on 22 September, a SO added two actions to Mr Frejus's caremap, the first that Mr Frejus should be given a phone call to his wife and the second that he should be referred to the prison's mental health team. At the review, both actions were marked as having been completed although this was not the case. The PSI makes it clear that ACCT procedures should not be stopped until all caremap actions have been completed. Although Mr Frejus had been referred to the mental health team, he had not yet been assessed by the mental health team and the ACCT monitoring was, therefore, stopped prematurely

Post-closure review

73. PSI 64/2011 states that a post-closure review must take place within seven days of ACCT procedures ending. Mr Frejus stopped being monitored under ACCT procedures on 22 September, but his post-closure review did not take place as scheduled on 29 September. This meant that staff did not consider how or whether Mr Frejus had progressed.

Risk factors

74. PSI 64/2011 provides examples of risk factors that might increase a prisoner's risk of suicide and self-harm. A number of these risk factors applied to Mr Frejus. It was his first time in prison, he feared for his safety, he was a foreign national, his English was limited, he was visibly emotional, he had not had

contact with his family, he showed recent signs of mental illness and told staff, that he felt “crazy” and “was losing his mind”. Although a SO said that they considered Mr Frejus’s level of risk during his ACCT review, he did not record this in the ACCT document.

75. Mr Frejus’s risk factors remained unchanged after the first ACCT review and his mental health had not yet been assessed. We therefore consider that ACCT monitoring should not have been stopped at the first review by two members of staff who had had no previous contact with him and who did not use an interpreter. Staff stopped ACCT procedures prematurely, despite Mr Frejus exhibiting a high number of risk factors. The clinical reviewer concluded that Mr Frejus’s risks meant that it would have been prudent for ACCT monitoring to continue until the planned mental health assessment had been completed. We agree. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national guidelines, ensuring that:

- **reviews take place within 24 hours of ACCT procedures starting;**
- **case reviews are multidisciplinary, with staff who have had previous contact with the individual, such as key workers or the ACCT assessor, where appropriate;**
- **caremap actions are specific, meaningful, tailored to the individual to reduce their risk and completed before ACCT monitoring is stopped;**
- **post-closure reviews take place within seven days of closure, and take into account any events which have taken place since ACCT procedures stopped;**
- **staff take action to mitigate against significant risk factors before considering whether to stop ACCT monitoring.**

76. We are very concerned that we have made eight recommendations in the last three years about the need to improve the quality of ACCT risk assessments and reviews at Nottingham. Although all our recommendations have been accepted, it is clear from the failings in this case that more needs to be done to embed the necessary learning. We make the following recommendation:

The Prisons Group Director for North Midlands should satisfy himself that effective action is being taken to implement the PPO’s recommendations about the quality of ACCT assessments and reviews at Nottingham.

Interpretation services

77. Prison Service Instruction (PSI) 64/2011 requires staff to consider using an appropriate interpretation service for prisoners who do not speak English so they can participate in the ACCT process. It says:

> “All members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in

particular, when conducting assessments of risk and / or during the risk management process."

78. Mr Frejus's English was limited. Most members of staff we interviewed at Nottingham agreed that he did not fully understand English. Staff, therefore, used an interpreter for his first night interview, ACCT assessment and several healthcare assessments.

79. However, we are concerned that Mr Frejus's first and only ACCT review was completed without using an interpreter and there is no record that staff considered using one for the review. An SO and the mental health nurse said that they were confident that Mr Frejus understood them. Although they were aware that they could use the telephone language interpretation service, they did not think it necessary.

80. This meant that Mr Frejus would not have been able to express himself fully during the review and that the SO and the mental health nurse could not have properly understood his issues to adequately assess his risk or fully identify his needs. We make the following recommendation:

The Governor should ensure that if a prisoner is not fluent in English or his level of English is unknown:

- **staff check with the prisoner if he needs an interpreter; and**
- **interpreters are used in all ACCT assessments and reviews.**

Emergency response

81. An officer, who had only qualified as an officer three weeks before, said that when Mr Frejus's cellmate told him that Mr Frejus was covered in blood, he was initially confused about the situation. He said that he did not go into the cell straightaway as he had been taught not to do so unless other officers were present. He said that he tried several times to radio a code red but was unable to as other staff were talking over the radio. He left the cell to seek help from staff in the wing office.

82. Nottingham's suicide and self-harm policy, which was published in 2017, says that emergency codes should be called during to communicate a life-threatening emergency. It says that the orderly officer's permission to enter a cell is only required during the night state. In this case, however, the officer was in the process of unlocking prisoners for the morning regime.

83. We recognise that it can be difficult for staff, especially those who are newly qualified, to make instant decisions in such distressing circumstances. However, when there is a potentially life-threatening situation, it is essential for officers to act quickly and exercise good judgement. While we understand the need for officers not to put themselves in danger or risk the security of the prison, we consider that the officer should have immediately called a code red and gone into Mr Frejus's cell to help him without leaving to seek assistance. The delay in calling a code red led to a delay in calling an ambulance.

84. Although the delay in calling an emergency code and entering Mr Frejus's cell would have made no difference to the outcome for him, it may be critical in another emergency. We therefore make the following recommendation:

The Governor should ensure that all prison staff:

- **call an appropriate medical emergency code as soon as they find a prisoner in a life-threatening situation, even if the prison radio is busy; and**
- **enter a cell as quickly as possible when a prisoner's life is in danger.**

Clinical care

85. The clinical reviewer concluded that the care that Mr Frejus received was of a mixed quality, and that some aspects were not equivalent to that which he could have expected to receive in the community. He made a number of recommendations which the Head of Healthcare will need to address. He had no concerns about the physical healthcare that Mr Frejus received and said that the emergency response when called was well delivered. However, he identified some deficiencies in Mr Frejus's care.

Mental health

86. The clinical reviewer noted that Mr Frejus's mental health assessment was initially planned to take place within five working days of his referral and said that the planned use of an interpreter was good practice. However, making arrangements for an interpreter to attend delayed the assessment by over a week. The use of Language Line, a telephone interpreting service, would have ensured an earlier assessment.

87. A nurse from the CJLT did not have access to SystmOne, the electronic medical database for prisoners, and was therefore unable to add an entry about the mental health assessment of 5 October. Instead, he was reliant on the learning disabilities nurse from the to do this on his behalf. When the investigator interviewed a nurse, it became clear that his recollection of the assessment differed from the entry which the learning disabilities nurse from recorded in SystmOne. We share the clinical reviewer's view that would be helpful for CJLT staff to have access to SystmOne when assessing prisoners to ensure that a full, contemporaneous record is maintained and to see what other healthcare interventions are taking place to inform their assessment.

88. The clinical reviewer was also concerned about the difference between a nurse and the learning disabilities nurse from recollection of the assessment they conducted. He questioned whether the learning disabilities nurse who was a learning disability nurse rather than a mental health nurse, had the appropriate skills and relevant qualifications to assess Mr Frejus's mental health. We make the following recommendations:

The Head of Healthcare, the manager of the CJLT and the NHS England Commissioners should ensure that CJLT staff can access SystmOne to maintain a full, contemporaneous record of events.

The Head of Healthcare should ensure that mental health nurses are appropriately qualified and skilled to complete mental health assessments.

Reception healthcare screening

89. PSI 07/2015 on early days in custody requires reception staff to examine the PER and any other available information and interview the prisoner to assess his risk of suicide and self-harm.

90. Although a nurse recognised that Mr Frejus had limited English and used an interpreter, he told the investigator that he could not remember seeing the police custody medical record which would have alerted him to Mr Frejus's potential paranoia. While it is not clear whether this information was available to the nurse, it is critical that healthcare staff assess prisoners thoroughly, using all available information. We make the following recommendation:

The Governor and Head of Healthcare should ensure that reception healthcare staff have access to all relevant information about new prisoners, including police custody records when available, so that they can complete a thorough health assessment.

Communication of changes in behaviour and assessment on return from prison

91. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners says that events such as attending court, sentencing at court or being questioned by police might have a significant impact on a prisoner's health. PSI 07/2015 on early days in custody says that there must be arrangements in place to assess prisoners whose status or demeanour may have changed after a court appearance.

92. Mr Frejus dismissed his legal team and appeared paranoid when he appeared at court on 8 October. There is no evidence that anyone at the prison spoke to Mr Frejus after he returned from court to assess whether he was at risk of suicide or self-harm or needed to see the healthcare team.

93. We were told that there is no routine assessment in reception at Nottingham for prisoners returning after a temporary absence, unless the police or escort contractors request it. We agree with the clinical reviewer that this was a missed opportunity to identify Mr Frejus's risk, as Mr Frejus's cellmate reported that he was upset when he returned. We make the following recommendations:

The Governor and Head of Healthcare should ensure that prisoners returning after a court appearance, police questioning or other temporary absence are screened to assess their risk of suicide or self-harm.

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