

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Aaron Osborne a prisoner at HMP Bristol on 13 April 2017

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 Aaron Osborne was found hanged in his cell on 13 April 2017 at HMP Bristol. He was 31 years old. We offer our condolences to Mr Osborne's family and friends.

When Mr Osborne arrived at Bristol he told a number of staff that he had been in prison before. Despite this, staff in reception failed to identify his previous records which contained important information about his risk factors and his time being managed under suicide and self-harm prevention procedures (ACCT). Despite Mr Osborne telling staff that he had a history of suicide attempts and self-harm and indicating that he was scared and depressed, ACCT procedures were not started when they should have been and opportunities were missed to understand Mr Osborne's risks. When ACCT procedures were started, staff failed to comply with HMPPS policies designed to prevent prisoners from killing themselves.

Mr Osborne had been at Bristol for less than 24 hours when he died and is the third prisoner to die within 48 hours of arriving at Bristol. There have been six self-inflicted deaths at Bristol since 2016 and we are very concerned to have to repeat recommendations that we have made in previous investigations, specifically focussing on the prison's management of the ACCT process and early days in custody.

We note that the prison is reviewing reception procedures in light of the failings identified in this case but we feel that more needs to be done to understand why we are repeating earlier recommendations about the management of suicide and self-harm prevention in Bristol. The Director of South West Prisons should seek assurance on this point.

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

July 2018

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Summary

Events

1. On 12 April 2017, Mr Osborne was sent to HMP Bristol after being charged with robbery and attempted robbery. He had previously spent time at HMP Bullingdon between May and June of 2016 when he was managed under suicide and self-harm prevention procedures (known as ACCT), had spent time under constant supervision and been reviewed by mental health professionals before being discharged into the community.
2. When he arrived at Bristol, Mr Osborne told prison staff that he had been in prison before, but reception staff did not locate his previous prison records and gave him a new prison number. Without access to his previous prison records they did not know that he had been managed under the ACCT process or have information about his risk factors and how they had been managed.
3. Mr Osborne told a nurse in reception that he had a history of mental health problems and suicide attempts and was feeling very anxious with thoughts of deliberate self-harm. The nurse did not start ACCT procedures or refer him to the mental health team.
4. On 13 April, Mr Osborne told an offender supervisor that he was feeling anxious, had suicide plans and was afraid to leave his cell, including for food. He also said that he was anxious because he had not been given his medication. The offender supervisor started ACCT procedures and arranged for healthcare staff to bring Mr Osborne's medication to his cell that afternoon. He left Mr Osborne locked in his cell. He did not ask Mr Osborne why he was anxious to leave his cell.
5. The offender supervisor could not find the supervising officer on the wing, so told an officer that he had locked Mr Osborne in his cell, that he had started ACCT procedures and that staff should observe Mr Osborne three times an hour. The officer did not start ACCT observations. Approximately 45 minutes later, the officer told a second officer that Mr Osborne was being managed under the ACCT process and, incorrectly, that he was associating on the wing. The officer said that he had confused Mr Osborne with another prisoner who was being managed under the ACCT process.
6. The second officer looked for Mr Osborne on the wing and called out his name but could not find him. He looked in Mr Osborne's cell but could not see him. He did not know what Mr Osborne looked like and, as there was no photograph in his prison record, he called reception to ask for one. Reception staff said they did not have a clear picture of Mr Osborne and sent an operational support grade to the wing to take a new photograph. Nobody looked in Mr Osborne's ACCT document which stated that he had been locked in his cell.
7. The second officer phoned the offender supervisor who told him that Mr Osborne was locked in his cell. The second officer ran to Mr Osborne's cell and found him behind a barricade at the back of his cell with a ligature around his neck which was tied to the bed frame. The second officer tried to call an emergency code but the radio network was busy so he told the operational support grade to alert

healthcare staff on the wing. At 4.17pm, the officer successfully called an emergency code and an ambulance was called immediately. Healthcare staff and paramedics tried to resuscitate Mr Osborne, but they were not successful and at 4.49pm, paramedics recorded that Mr Osborne had died.

Findings

8. Staff missed vital information from Mr Osborne's previous medical and prison records which were linked to his previous prison number. Prison staff gave Mr Osborne a new prison number, even though he told them that he had been in prison before. If they had searched the prison information system using his name, date of birth and Police Computer Number, they would have discovered information about his previous time in custody. Reception staff did not ensure that there was a photograph of Mr Osborne on his prison record.
9. Prison staff did not manage Mr Osborne in line with suicide and self-harm prevention procedures. Mr Osborne told a nurse in reception that he had a history of mental health problems and was feeling very anxious with thoughts of deliberate self-harm. Nevertheless the nurse did not consider Mr Osborne as at risk of suicide and self-harm and did not start ACCT procedures or refer Mr Osborne to the mental health team, as she should have.
10. Mr Osborne told an offender supervisor that he was anxious to leave his cell for food or medication but the offender manager, who was focussing on the process of starting suicide and self-harm prevention processes, did not talk to Mr Osborne to find out why he was anxious or investigate further.
11. Although the offender supervisor correctly started suicide and self-harm prevention procedures after Mr Osborne told him that he had plans to kill himself, he left Mr Osborne alone in his cell. Wing staff did not carry out observations as specified in the ACCT document. Staff could not find Mr Osborne to start ACCT observations but did not act on the information provided by the offender supervisor or look in the ACCT document which stated that he had been locked in his cell.
12. There was a slight delay in calling an ambulance; the officer could not call an emergency code because the radio was busy.

Recommendations

- The Governor should ensure that reception procedures operate effectively in line with PSI 24/2011 'Early Days in Custody'.
- The Governor should ensure that all staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, including that:
 - Staff are aware of, consider and record all the known risk factors for suicide or self-harm. They should open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors. When, exceptionally, they decide not to begin ACCT procedures for prisoners with significant risk factors, they should clearly record the reasons.

- Staff do not leave prisoners assessed as at risk of suicide and self-harm alone without a consideration of other options to help protect the prisoner.
- Staff follow the level of observations noted in the ACCT document.
- The Director of South West Prisons should commission a review of the operation of the ACCT process at HMP Bristol. He should assure himself that HMP Bristol has effectively implemented all PPO recommendations into self-inflicted deaths at the prison since 2016 and provide a report to the PPO outlining progress within 3 months of receiving this report.
- The Governor should ensure that all opportunities to identify information indicating potential bullying is fully investigated and that staff consider a range of options to ensure victims are supported, in line with Bristol's local policy.
- The Governor should ensure that there is system in place to accurately record when staff respond to cell bells and that all cell bells are answered within five minutes.
- The Governor should:
 - ensure that the radio network is fully operational at all times so that staff can use their radios to make emergency calls; and
 - provide written guidance to staff on alternative methods for raising the alarm in an emergency if radio communication fails, which includes alerting the control room to immediately call an ambulance and request healthcare attendance and other staff as necessary.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and asking anyone with relevant information to contact her. A member of staff contacted the investigator to share concerns about safety in the prison but wished to remain anonymous.
14. The investigator visited HMP Bristol on 24 April 2017. She obtained copies of relevant extracts from Mr Osborne's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr Osborne's clinical care at the prison.
16. The investigator interviewed 12 members of staff at HMP Bristol on 23 and 24 May and 12 June. The clinical reviewer attended interviews on 23 May and 12 June. The investigator interviewed a further member of staff by phone on 6 July.
17. We informed HM Coroner for Avon of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. One of the Ombudsman's family liaison officers contacted Mr Osborne's father and sister to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Osborne's sister said that she wanted to know:
 - more about reception processes and whether her brother had highlighted any concerns about his wellbeing to staff;
 - whether Mr Osborne had been given withdrawal medication because he had been using drugs in the community;
 - whether the prison knew he had been prescribed antidepressants and whether he had been given this medication;
 - whether Mr Osborne said he had thoughts of suicide or self-harm and if he was placed on any form of monitoring;
 - why staff decided to put Mr Osborne in a single cell when he was low in mood;
 - whether Mr Osborne's mental health was considered or assessed when he arrived at Bristol; and
 - whether Mr Osborne said that he was concerned about being targeted by other prisoners because he was known in the Bristol area and would have been fearful about being in HMP Bristol.
19. Mr Osborne's sister received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Bristol

21. HMP Bristol is a local prison, which can hold up to 614 sentenced and remanded men. Bristol Community Health provides primary healthcare and Hanham Health Services provides GP services. Avon and Wiltshire Partnership provides mental health and psychosocial substance misuse services and Bristol Community Health provides clinical substance misuse services.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Bristol was in March 2017. Inspectors reported that reception processes were generally efficient but there was no opportunity for a private first night interview and prisoners were asked important, sensitive questions in a noisy and open area. Inspectors found that induction was disorganised, delayed and inconsistent, and prisoners indicated that there was a lack of support and advice during their early days in custody. Inspectors were not confident that all risk factors were always identified, and although a new first night assessment process to identify risk factors showed promise, it was not sufficiently embedded or reliable.
23. More than half of prisoners said that they felt unsafe during their time at Bristol, with over a third saying that they currently felt unsafe. Inspectors found that there was little challenge of the perpetrators of violence or support for victims, other than being located on the vulnerable prisoner wing.
24. Inspectors found that the number of recorded self-harm incidents had risen dramatically and was high. The quality of ACCT management was extremely variable, and in too many cases very poor with the level of observations not matching the risk posed.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to July 2016, the IMB reported that they continued to have significant concerns about the safety of prisoners and staff at Bristol. They noted there were gaps in timely completion of ACCT observation notes, the recording of reviews, and any systematic quality assurance by senior staff. The report noted that there were still lessons to be learnt, in particular, the importance of robust assessment procedures in Reception and First Night based on known risk factors.

Previous deaths at HMP Bristol

26. Mr Osborne's death is the sixth self-inflicted death at Bristol since 2016. Previous investigations have raised concerns that reception staff and others who assess risk have not considered and recorded all the known risk factors of newly-arrived prisoners when determining their risk of suicide or self-harm. Previous investigations also recommended that staff should begin ACCT monitoring when appropriate, manage prisoners at risk of suicide and self-harm in line with

national guidelines, and consider whether victims of violence or bullying are at increased risk of suicide or self-harm and are effectively supported and protected with meaningful, long-term solutions, which address their individual situation.

Assessment, Care in Custody and Teamwork

27. 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.
28. 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 multi-disciplinary review meetings involving 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.
29. 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.

Key Events

HMP Bullingdon

30. On 10 May 2016, Mr Aaron Osborne was remanded into custody at HMP Bullingdon on charges of criminal damage and assaulting two police officers.
31. A nurse noted that Mr Osborne had a history of substance misuse, suicide attempts, mental health problems, had recently been admitted to a psychiatric hospital, had repeating suicidal thoughts and was depressed and very anxious. She started suicide and self-harm prevention procedures with hourly observations. Mr Osborne was referred to the GP and primary mental health care.
32. Mr Osborne told a doctor that he would kill himself by hanging, drinking bleach or by an overdose, that he had tried to kill himself twice in the past week and was hearing voices telling him to kill himself or kill others. The doctor noted that Mr Osborne should be admitted to healthcare as an inpatient.
33. During the ACCT process Mr Osborne disclosed that he had started hearing voices two years ago after his wife was raped, had made several suicide plans for while he was in custody and said that when he was released he was 100% certain that he wanted to end his life. He was placed under constant observation and referred to the mental health inreach team.
34. A psychiatrist noted that Mr Osborne had a diagnosis of personality disorder (a disorder in which the individual's personal characteristics cause regular and long-term problems in the way that they cope with life and interact with other people).
35. Staff continued to monitor Mr Osborne under the ACCT process on constant observation until 16 May, when they noted that he was feeling more positive. Mr Osborne remained in healthcare and staff assessed his risk as low and reduced the frequency of observations to hourly. He was subsequently prescribed sertraline (an anti-depressant).
36. Mr Osborne told a nurse that everything was going well but if he returned to prison from his impending court appearance he 'would go mad'. He was referred to the Gloucester Recovery Team with a letter for his GP about his medication. The nurse put an alert on his medical record for staff to fully assess Mr Osborne for thoughts of suicide if he returned to prison from court.
37. On 22 June, Mr Osborne went to court and was released from Bullingdon on bail.

HMP Bristol

38. On 12 April 2017, Mr Osborne was sent to HMP Bristol after being charged with robbery and attempted robbery. His Prisoner Escort Record (PER - which accompanies prisoners on all journeys between police stations, courts and prisons, to communicate risk factors) was not dated but was attached to his remand order that was dated 12 April 2017. The risk indicator form on Mr Osborne's PER was blank.

39. A reception information form in Mr Osborne's prison record noted that he had been in prison before, but an operational support grade (OSG) working in reception, gave Mr Osborne a new prison number (prisoners are given a prison number the first time they arrive in prison). This meant that prison and healthcare staff did not have Mr Osborne's previous prison and medical records. We were unable to interview the OSG because she has left the Prison Service.
40. At 6.26pm, a nurse in reception assessed Mr Osborne. Mr Osborne told the nurse that he had a history of mental health problems and had been treated in the community, but had not been taking his medication. He said that he did not drink alcohol but had used drugs in the past. Mr Osborne told the nurse that he 'did not like how he was feeling at present' and felt mentally unstable, scared of being in prison, low and depressed. The nurse noted 'prisoner has been in prison before'. She said that she only searched for Mr Osborne's medical records using the prison number she had been given by reception staff, so did not know about his previous medical history at Bullingdon. The nurse did not refer Mr Osborne to the mental health team.
41. The nurse recorded that Mr Osborne had 'thoughts of deliberate self-harm' but that he did 'not feel like self-harming or suicide'. She told the investigator that she made two notes in his records because she asked Mr Osborne if he had thoughts of suicide and self-harm and he said yes, but when she asked him if he was intending to self-harm or take his own life at that moment in time, he said no. The nurse did not start suicide and self-harm prevention procedures (known as ACCT). She told the investigator that she would have started ACCT procedures if Mr Osborne had said it was his intent to harm himself.
42. The nurse completed the healthcare section of Bristol's 'First Night Immediate Risk and Needs Assessment' form. She noted that Mr Osborne had no mental health issues to be considered and no current thoughts of suicide or self-harm. She also noted that he had self-harmed six months ago 'but stated no concerns at this time'. The nurse also completed the second part of Mr Osborne's Cell Sharing Risk Assessment (the CSRA assesses a prisoner's risk of violence) and noted that Mr Osborne had mental health concerns, was anxious, and did not want to share a cell with anyone.
43. A prison GP prescribed citalopram (an antidepressant) for Mr Osborne.
44. Two officers working in the First Night Centre completed the CSRA with Mr Osborne. They assessed Mr Osborne's risk of sharing a cell as 'standard' (risk can be assessed as standard or high).
45. One of the officers said that Mr Osborne did not seem anxious and told her he did not have any thoughts of suicide or self-harm, but was feeling a bit low. She said that Mr Osborne told her that he had not been in prison before, even though staff had noted on his First Night Immediate Needs Assessment form that it was not his first time in custody. She said that because Mr Osborne told her he had not been in prison before, she checked his records using the new prison number provided by reception staff. She told the investigator that she went to school with Mr Osborne and was going to complete a conflict of interest form the next day to tell Security that she knew him.

46. The officer said that there were no cells available in the First Night Centre that evening. She noted that Mr Osborne did not want to share a cell and found a double cell for him on G wing that was unoccupied at the time. Prison staff took Mr Osborne to his cell on G wing. He was to have an induction into prison the next day because he had arrived in the evening. A supervising officer told the investigator that when prisoners arrive later in the day, they would have their induction the next day.
47. An OSG working on G wing checked on Mr Osborne during the night. She said the purpose of these checks was to make sure that he was breathing. She did not remember speaking to Mr Osborne that night, but said she would have said hello and asked if he was alright when he arrived on the wing.

13 April

48. Between 11.00am and 12.00pm, Mr Osborne pressed his cell bell alarm four times. Although staff answered his cell bell within a few minutes on three occasions, when Mr Osborne pressed his cell bell alarm at 11.17am staff did not respond until 11.49am.
49. At around 2.40pm on 13 April, a prison offender supervisor went to Mr Osborne's cell to complete a basic custody screen (a basic custody screen identifies any needs a prisoner may have while in custody or before release). When the offender supervisor started asking questions about his offence, Mr Osborne said 'I can't do this.' The offender supervisor asked Mr Osborne what he meant, and he said he was not 100% sure, 'his head wasn't in the right place' and he did not like being in that cell.
50. Mr Osborne told the offender supervisor that he did not feel safe and he would not go out on the landing to collect his food or medication. The offender supervisor thought that he was uncomfortable because the wing was noisy. He did not ask Mr Osborne why he did not feel safe or ask if other prisoners had threatened or bullied him.
51. Mr Osborne told the offender supervisor that he was having thoughts of suicide. He said that he did not like being in prison and had suicide plans, but would not elaborate. He said that he was worried about when he would get his medication so the offender supervisor told him he would look into this and went to speak to healthcare staff in the G wing treatment room.
52. At around 3.00pm, the offender supervisor told a healthcare assistant that Mr Osborne was anxious and afraid to leave his cell and had asked if his medication was ready. He told her that he was worried about Mr Osborne and was thinking about starting ACCT procedures. The healthcare assistant said something like 'if you are considering it then you need to open it'. She said that she asked the offender supervisor if they should refer Mr Osborne to the mental health team, but he did not ask her to do this.
53. The healthcare assistant checked Mr Osborne's medical records, noted that his medication had been prescribed and told the offender supervisor that she would make sure Mr Osborne's medication was taken to his cell as soon as it was ready. She thought this would be in about 45 minutes.

54. The offender supervisor went back to Mr Osborne's cell and told him healthcare staff would bring his medication to his cell later that afternoon. He said that Mr Osborne did not seem as happy about this as he thought he would be. He told Mr Osborne that he had decided to start suicide and self-harm prevention procedures. He locked Mr Osborne in his cell because he said he was afraid to go onto the wing.
55. The offender supervisor said that he would normally speak to the supervising officer on the wing when he started ACCT procedures, but the supervising officer was away from the wing at the time conducting operational duties. Instead, he told Officer A that he was starting ACCT procedures for Mr Osborne, that the officer needed to keep an eye on him, and that Mr Osborne was locked in his cell. He also told the officer that he had set the level of observations at three an hour until staff could assess Mr Osborne under the ACCT process. He stressed to the officer that he was very concerned about Mr Osborne. He also said that Mr Osborne would not leave his cell so staff needed to make sure he got his food.
56. At 3.05pm, the offender supervisor noted in the wing observation book that he had started ACCT procedures for Mr Osborne and that he needed his mental health medication. He recorded that healthcare staff were aware of this and that Mr Osborne was anxious and would not come out of his cell. The offender supervisor said that he did not try to find out why Mr Osborne was anxious to leave his cell because he thought this would be followed up as part of the ACCT process.
57. The offender supervisor asked wing staff if they had a blank ACCT document so he could record these issues formally but there were none on the wing. He went to the Safer Custody office to get an ACCT document. He told the investigator that he completed the document there because it was quieter there than on the wing. He recorded on the Concern and Keep Safe form in the ACCT document that Mr Osborne said he was contemplating suicide because he felt he was not in control of himself. He wrote that Mr Osborne was not coping well with his location, would not leave his cell for food or medication and appeared anxious and emotional, not fully in control of himself, and said he did not like this feeling but could not help it. He recorded that Mr Osborne was desperate for his medication and that he had spoken to healthcare on G wing who confirmed they would bring it to his cell that afternoon. At around 3.30pm, the offender supervisor returned to G wing with the completed ACCT document.
58. Meanwhile, Officer A said that he told Officer B about Mr Osborne being managed under ACCT procedures at approximately 3.20pm. Officer B said that the Officer A told him this at around 3.45pm. Officer B told the investigator that he did not know why he did not check Mr Osborne himself after Officer A spoke to him.
59. Officer B said that Officer A told him that Mr Chapman had left Mr Osborne out of his cell to associate for an hour. Officer A said when he told Officer B that Mr Osborne was out of his cell, he may have confused him with another prisoner who was also being managed under the ACCT process.
60. Officer B looked for Mr Osborne on the wing. He said that there were about 20 prisoners on the landings and, as he did not know what Mr Osborne looked like,

he shouted Mr Osborne's name. There was no response. He went to Mr Osborne's cell and looked through the observation panel but could not see him. Officer B went back to the wing office and asked Officer A if he knew what Mr Osborne looked like. Officer A did not know what Mr Osborne looked like either, so Officer B tried to find a picture of Mr Osborne in his prison record.

61. Officer B said there was no picture of Mr Osborne in his prison record. He told a supervising officer what was happening and called reception to ask them to put a photograph of Mr Osborne on his prison record. An OSG working in reception said that he would arrange this.
62. Officer B went back onto the wing and shouted Mr Osborne's name again. There was still no response. A few minutes later, the OSG arrived on G wing and told Officer B that they did not have a photograph of Mr Osborne in reception so he would take one when they found him.
63. At 4.00pm, a supervising officer noted in the observation book that all staff should observe Mr Osborne and offer support if needed.
64. At 4.13pm, the offender supervisor answered a call from Officer B, who asked where Mr Osborne was. The offender supervisor told Officer B that he had locked Mr Osborne in his cell.
65. Officer B ran to Mr Osborne's cell and unlocked the door. Officer B said there was a blanket hanging on the back of the bed and a cabinet to the right of Mr Osborne so he could not see him until he went to the back of the cell. He found Mr Osborne at the back of the cell facing the wall. He was unconscious and had a ligature made from clothing around his neck that was tied to the top of the bed.
66. Officer B cut the ligature and tried to call an emergency code over the radio but the network was busy and he could not get through. He shouted to the OSG to get healthcare staff, and the OSG ran to the G wing treatment room and said there was a code blue (an emergency code blue indicates a prisoner is unconscious, not breathing or is having breathing difficulties). The healthcare assistant asked if they had missed something on the radio and the OSG told her that the radio was busy. The healthcare assistant and a nurse took the emergency bags and left the treatment room.
67. At 4.17pm, Officer B called a code blue over the radio. The control room called an ambulance immediately. Officer A arrived at the cell followed by Officer C, the healthcare assistant and the nurse. The nurse went into the cell and noted that Mr Osborne was pale, unconscious and not breathing. The healthcare assistant said she could not see Mr Osborne because a cabinet was in the way so she told the two officers standing outside the cell to remove the cabinet. The officers removed the cabinet and Officer B and the nurse moved Mr Osborne into the cell walkway and started resuscitation. The healthcare assistant called over the radio that there was a cardiac arrest and an ambulance was required. She gave Mr Osborne oxygen while the nurse managed his airway and Officer C continued doing resuscitation. Officer B left the cell and helped the other officers lock up the wing.

68. The healthcare assistant prepared the defibrillator machine and attached the pads to Mr Osborne's chest but no shock was advised. An officer who worked as an emergency responder in the community took over giving Mr Osborne oxygen and the healthcare assistant ran to get the emergency drugs bag from D wing. On the way, she ran into a prison paramedic and took his keys and told him to go to Mr Osborne's cell. She collected the emergency bag and returned to the cell and handed the paramedic the equipment.
69. At 4.25pm, ambulance paramedics arrived and continued attempts to resuscitate Mr Osborne. They used a chest compression device and gave him two doses of adrenaline. Mr Osborne did not respond and at 4.49pm, paramedics recorded that Mr Osborne had died.
70. After Mr Osborne's death, a prisoner submitted a confidential complaint to the prison. The prisoner wrote that another prisoner had been bullying the whole wing. He said that this prisoner thought that Mr Osborne had a parcel for him and 'manhandled him in his cell, then started playing with his food, verbally abusing him every chance, then set his minions on him to see if he had that parcel.' The prisoner who made the complaint said that he should have tried to help him but was worried that if he told the officers, they would speak to the prisoner who was bullying others and he would be at risk.

Contact with Mr Osborne's family

71. At 5.00pm, a prison family liaison officer and the Governor went to Mr Osborne's sister's home but a neighbour said that she was out. They phoned Mr Osborne's sister and arranged to meet her at her home and told her that Mr Osborne had died. They offered condolences and support. The prison contributed to the costs of Mr Osborne's funeral, in line with national guidance.

Support for prisoners and staff

72. After Mr Osborne's death, a supervising officer debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
73. The prison posted notices informing other prisoners of Mr Osborne's death, and offering support. The date of Mr Osborne's death recorded on the notice was 17 April instead of 13 April. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Osborne's death.

Post-mortem report

74. Mr Osborne's cause of death was noted as cardiac arrest caused by asphyxia due to hanging. The toxicology report showed that alcohol and drugs did not cause or contribute to Mr Osborne's death.

Findings

Reception processes

75. Prison Service Instruction (PSI) 24/2011 'Early Days in Custody' states that Governors must ensure that Reception operates efficiently and effectively for all prisoners entering the establishment. When Mr Osborne arrived at Bristol, a reception form and his First Night Immediate Needs Assessment recorded that he had been in prison before, and Mr Osborne told the nurse that he had been in prison before when she assessed him in reception. Nevertheless, his previous records were not located and he was issued with a new prison number.
76. Prison staff did not subsequently investigate why Mr Osborne had been given a new prison number and record despite his saying on a number of occasions that had been in prison before. Although the Head of Operations told us that Mr Osborne's surname had a different spelling on the warrant from his previous prison record, the OSG on G wing said that you could find out if a prisoner had been in prison before by searching all prison records using a prisoner's Police National Computer (PNC) number or their name and date of birth. Mr Osborne's PNC number was included on his PER but staff did not search using this information.
77. There was no photograph available to wing staff to help them identify Mr Osborne. PSI 24/2011 states that prisoners should be photographed in accordance with the National Security Framework, and the photograph downloaded onto the prison record. Officer B could not find a photograph of Mr Osborne on his prison record so called reception for a copy. Reception had a photograph of Mr Osborne but it was of poor quality and could not be used so sent an OSG to the wing with a camera to take a new photograph of him.
78. The Head of Operations told us that Bristol's local policy, 'First Night Induction', is subject to review. He also said that following Mr Osborne's death, a new reception checklist had been introduced, which includes mandatory details for reception staff to check when identifying a prisoner, including their PNC number if available.
79. We are nevertheless concerned that reception staff did not use all available information to identify Mr Osborne, and other staff did not investigate why he had a new prison number when he told them that he had been in prison before. As a result, staff did not have access to information linked to his previous prison record and did not know that he had been monitored under constant observation under the ACCT process when he was in prison in 2016. Staff also had more difficulty locating Mr Osborne on the wing because they did not have a photograph of him in his records. We make the following recommendation:

The Governor should ensure that reception procedures operate effectively in line with PSI 24/2011 "Early Days in Custody".

Management of the risk of suicide

80. PSI 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include previous self-harm and suicidal ideation, a history of substance misuse, a history of mental health problems, recent contact with psychiatric services, and the impact of the early days in prison. All of these factors applied to Mr Osborne.
81. Staff failed to identify Mr Osborne's level of risk in reception, and although they correctly began ACCT suicide and self-harm prevention procedures the next day, they were not effectively implemented.
82. We therefore have concerns about the assessment and management of Mr Osborne's risk and the ACCT process.

Assessment of risk

83. When the nurse assessed Mr Osborne in reception, he said that he had a history of mental health problems, suicide attempts and self-harm. He told her that he had thoughts of deliberate self-harm, 'did not like how he was feeling at present' and was feeling mentally unstable, low and depressed. The nurse said that when she asked Mr Osborne about his thoughts of self-harm, he said he was not intending to self-harm or take his own life at that moment in time. The nurse said that she did not consider starting ACCT procedures for Mr Osborne because he said he was not intending to harm himself. Even though Mr Osborne told the nurse that he had been in prison before, she did not investigate further and check for previous medical records to obtain information about Mr Osborne's risk of suicide and self-harm.
84. In April 2014, we published a Learning Lessons Bulletin on 'Risk Factors in Self-Inflicted Deaths in Prison' where we identified that too often, staff place too much weight on how a prisoner 'presented', rather than indications of risk, even where there had been very recent acts of self-harm. In February 2016, we published a Learning Lessons Bulletin on 'Early Days and Weeks in Custody' where we identified failures to identify risk factors and begin ACCT procedures, and that staff need to identify, record and act on all known risk factors during reception and first night.
85. Although the nurse said that Mr Osborne told her he did not intend to harm himself at that time, he had a number of risk factors for suicide and self-harm and we are concerned that she did not start ACCT procedures. As Mr Osborne was not placed under ACCT procedures at this point, opportunities were missed to understand both his existing risk factors and the concerns which he had about living on the wing – issues which we discuss later and which may well have been highly material to his decision to kill himself.

Management of the ACCT process

86. After the offender supervisor decided to begin ACCT procedures, he left Mr Osborne alone in his cell when he went to check on his medication and again when he went to find an ACCT document. The Head of Safer Prisons and Equalities told the investigator that she would expect prison staff to consider whether the prisoner's location was appropriate given how they were feeling,

whether distractions such as a TV or radio would assist, or if the prisoner would be willing to speak to a peer, mentor or a Listener to provide support. A supervising officer said that staff can also ask a colleague to stay with a prisoner if they are concerned about them. Although we understand and commend the offender supervisor's significant efforts to ensure that the ACCT process was initiated and effectively implemented, we are concerned that Mr Osborne was left alone in a locked cell after he said that he was having thoughts of suicide.

87. PSI 64/2011 states that staff responsible for observing at-risk prisoners need to ensure they are familiar with the requirements in that individual's ACCT Plan and that staff must follow the level of observations and conversations as stated in the ACCT. The ACCT plan must be passed in person to the Residential Manager, Daily or Night Operational Manager, while ensuring the prisoner is kept safe, and the Residential Manager, or equivalent, is responsible for ensuring that conversations and observations are completed in line with the requirements set out on the front cover the ACCT Plan.
88. The offender supervisor said that he would normally speak to a supervising officer when he opened an ACCT, but the supervising officer was not on the wing. The offender supervisor wanted to get the information about Mr Osborne to staff quickly, and so spoke to Officer A and told him that Mr Osborne needed to be monitored closely. Officer A did not check on Mr Osborne that afternoon.
89. Although the offender supervisor told Officer A that Mr Osborne was locked in his cell, Officer A mistakenly told Officer B that Mr Osborne was associating on the wing.
90. Wing staff did not carry out observations as indicated in the ACCT document. When staff could not find Mr Osborne, nobody checked the ACCT document and Officer B spent some time looking for Mr Osborne before calling the offender supervisor to get his location.
91. We are concerned that there was a delay in starting monitoring under the ACCT process, that staff did not carry out observations as required in the ACCT document, and that staff did not read Mr Osborne's ACCT document before trying to locate him.
92. We make the following recommendations:

The Governor should ensure that all prison staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, including that:

- **Staff are aware of, consider and record all the known risk factors for suicide or self-harm. They should open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors. When, exceptionally, they decide not to begin ACCT procedures for prisoners with significant risk factors, they should clearly record the reasons.**
- **Staff do not leave prisoners assessed as at risk of suicide and self-harm alone without a consideration of other options to help protect the prisoner.**
- **Staff follow the level of observations noted in the ACCT document.**

93. Given the very troubling similarities with previous deaths at Bristol where we found failings in the management of the ACCT process, and where our recommendations to address those failings were accepted by the Governor, we are particularly exercised to be repeating, again, these recommendations. Given these concerns and the need for genuine and effective action to avoid future deaths, we make the following recommendation:

The Director of South West Prisons should commission a review of the operation of the ACCT process at HMP Bristol. He should assure himself that HMP Bristol has effectively implemented all PPO recommendations into self-inflicted deaths at the prison since 2016 and provide a report to the PPO outlining progress within 3 months of receiving this report.

Violence reduction

94. Mr Osborne told the offender supervisor that he did not feel safe and would not leave his cell for food or medication. The offender supervisor noted in Mr Osborne's ACCT document that he was not coping well with his location, but he did not ask Mr Osborne if he was being bullied or investigate further to find out why he felt unsafe. The offender supervisor said that he noted Mr Osborne's concerns in the ACCT document and thought these would be picked up by the ACCT assessor and case manager.
95. The Head of Safer Prisons and Equalities said that if a prisoner said that they were afraid to leave their cell, she would expect prison staff to speak to them and find out the reasons for this and whether it was because they were being bullied, knew other prisoners on the wing, or were being given a hard time by others. We acknowledge that the offender supervisor was particularly focussed on initiating ACCT activity and that he thought that doing this would result in addressing Mr Osborne's concerns. We note though that the lack of immediate follow-up or action to safeguard Mr Osborne compounded the prison's failure to start those procedures sooner and the evident lack of meaningful interaction with Mr Osborne meant that opportunities to surface issues around violence and potential bullying were missed.
96. A member of staff who was not prepared to provide their name contacted the investigator to register their concerns. They said that staff did not like going to G wing because of the prevalence of violence and bullying. They also expressed a lack of confidence in the ACCT process at Bristol. A prisoner's anonymous complaint suggested that Mr Osborne had been bullied by another prisoner on the wing. Mr Osborne's sister told the PPO that her brother would have been afraid of going to Bristol because he was known in the area. We are concerned that prison staff did not investigate why Mr Osborne was afraid to leave his cell or consider other options to provide him with support.
97. Bristol's local operating procedure 'Violence Reduction and Safer Custody' includes a process map that says that if staff suspect a prisoner is being bullied, they should undertake initial fact finding by talking to the prisoner and record the outcome and any immediate action taken or planned in the observation book, intelligence report and prison record. The staff member must also inform the supervising officer who can consider a range of options including moving the prisoner or further monitoring or increased supervision.

98. We recognise that the circumstances surrounding Mr Osborne's death make it difficult to draw firm conclusions on the extent to which bullying or violence may have been material to his death. Nevertheless, we see significant circumstantial information to register this as a concern. We therefore make the following recommendation:

The Governor should ensure that all opportunities to identify information indicating potential bullying is fully investigated and that staff consider a range to options to ensure victims are supported, in line with Bristol's local policy.

Cell bell response

99. HMIP has an expectation that cell bells should be answered within five minutes. When Mr Osborne pressed his cell bell at 11.17am, there was a delay of 17 minutes before it was reset by staff. The Head of Operations told the investigator that to reset a cell bell, staff need to have a cell bell reset fob. He said that Bristol has noted a problem with cell bell reset fobs not working consistently, and that an officer may have attended Mr Osborne's cell to check on him earlier than 11.49am, but been unable to reset the cell bell because their cell bell reset fob was not working.
100. There is no other evidence that staff visited Mr Osborne's cell on the morning of 13 April in response to the cell bell at 11.17am, or the other three times Mr Osborne activated it. Prisoners have cell call bells to so that they can ask staff for help when locked in their cell. We are concerned that the prison does not accurately record when staff answer a cell bell, and that Mr Osborne may have waited 17 minutes for staff to respond when he activated the cell bell. We make the following recommendation:

The Governor should ensure that there is system in place to accurately record when staff respond to cell bells and that all cell bells are answered within five minutes.

Emergency response

101. PSI 03/2013 'Medical Emergency Response Codes' states that Governors must ensure that emergency protocols enable staff to clearly and concisely convey the nature of the medical emergency simultaneously to all interested parties and contact the communication or control room.
102. When Officer B found Mr Osborne in his cell, he tried to call an emergency code over the radio. He could not call the code because the network was busy, so he shouted to the OSG to tell healthcare located on the wing to attend.
103. Officer D was working in the control room that day and told us that an officer had activated their personal alarm and they were managing this incident at the time Officer B tried to call the code blue. He said that Officer B would have been unable to call the emergency code until there was a gap in the radio transmissions, or the incident was resolved. A minute or so later, Officer B was able to call the code blue and the control room immediately called an ambulance. While we cannot say that it affected the outcome in this case, in an emergency,

even a short delay can have a significant impact on a person's chance of survival. We make the following recommendation:

The Governor should:

- **ensure that the radio network is fully operational at all times so that staff can use their radios to make emergency calls; and**
- **provide written guidance to staff on alternative methods for raising the alarm in an emergency if radio communication fails, which includes alerting the control room to immediately call an ambulance and request healthcare attendance and other staff as necessary.**

**Prisons &
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