

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Jamie Osborne a prisoner at HMP Lewes on 12 February 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## 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 Jamie Osborne was found hanged in his cell in at HMP Lewes on 12 February 2016. He was 19 years old. I offer my condolences to Mr Osborne's family and friends.

Mr Osborne was a vulnerable and challenging young man who had been assessed as at high risk of suicide by psychiatrists. However, we identified a number of areas for improvement in his care at Lewes, some of which repeat findings from previous investigations into deaths at the prison. First, I am concerned that staff did not take account of Mr Osborne's previous history, or information about his risk of suicide that accompanied him when he first arrived at Lewes. Second, when his risk was later identified, after he unsuccessfully tried to hang himself, the resulting self-harm prevention procedures were not managed fully in line with national policy. Third, despite his complex needs, it is disappointing that staff did not consider managing him using enhanced case management which would have brought a more co-ordinated approach to managing a troubled young man such as Mr Osborne.

Finally, the process for transferring prisoners under the Mental Health Act, which resulted in a delay in referring Mr Osborne for a place at a suitable secure hospital was mismanaged. As a result, the clinical reviewer concluded that Mr Osborne's health care was not equivalent to that which Mr Osborne could have expected in the community. Had the process been better and successfully managed, the outcome for Mr Osborne might have been very different.

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

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

**October 2016**

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# Summary

## Events

1. Mr Osborne had served short prison sentences at HMP Lewes in 2014 and 2015. His youth offender worker had assessed him as at risk of suicide and self-harm, due to his age and vulnerability and told prison staff that his community GP had prescribed medication for depression. In August 2015, Mr Osborne was charged with several burglary and theft offences and remanded to HMP Elmley. He was transferred to Lewes later the same month.
2. On 17 November, the mental health in-reach team assessed Mr Osborne as staff had concerns about his behaviour and his cellmate had reported that he had cut his arm. Mr Osborne told them he was frustrated at being in prison and did not want their help. Although the in-reach team were unable to assess him fully, they concluded that there were no significant signs of mental ill health or an increased risk of suicide or self-harm. In spite of Mr Osborne's actions and frustration at being in prison, no one considered starting the Prison Service suicide and self-harm prevention procedures known as ACCT. The next day, Mr Osborne tried to hang himself. Prison staff resuscitated him and he was treated in hospital. He returned to Lewes on 20 November.
3. When Mr Osborne returned to Lewes, staff began the ACCT procedures and admitted him to the healthcare unit. Mental health assessments in late November concluded that he should be transferred to a secure mental health unit, but a suitable place was not found. Mr Osborne remained in the healthcare unit and ACCT monitoring continued until his death.
4. At around 6.55am on Friday 12 February, a nurse found Mr Osborne hanged in his cell. Staff and paramedics were unable to resuscitate him and, at 8.23am, recorded Mr Osborne had died.

## Findings

5. When Mr Osborne arrived at Lewes, the reception nurse who conducted his health screen did not review his previous history or properly consider his risk of suicide and self-harm.
6. There were a number of failings in the management of ACCT procedures. Staff did not consider all of Mr Osborne's risk factors when assessing his risk of suicide, and so did not set observation levels to reflect that risk. The ACCT caremap was not updated and reviewed at each case review and did not include specific actions to reduce Mr Osborne's risk. Clinical observations during the night were at regular and predictable intervals, something we have criticised before at Lewes, and a mental health nurse did not consider the assessment of two psychiatrists that Mr Osborne as at high risk of suicide just days before he died.
7. Mr Osborne had been identified as requiring further assessment and treatment at a secure mental health unit at the end of November 2015. Prison healthcare staff did not properly understand the process for transferring prisoners to a hospital under the Mental Health Act. Although efforts were made to secure a place for Mr Osborne,

the prison did not inform the Ministry of Justice Mental Health Casework Section about the need for a transfer until early February 2016.

8. Healthcare staff were on hand when Mr Osborne was discovered hanged in his cell and responded quickly. The paramedics arrived within minutes of being called. However, as identified in other deaths at Lewes, healthcare staff need to use agreed emergency medical codes so an ambulance is requested immediately in life-threatening emergencies.

## Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular:
  - All known risk factors of newly-arrived prisoners should be considered and recorded when determining risk of suicide and self-harm, using all available information such as that from Person Escort Records.
  - They should set effective caremap objectives which are specific, time bound and meaningful, aimed at reducing risk and updated at each case review.
  - Case reviews should record and take into account all known risk factors and triggers and set a level of observations which appropriately reflects that risk.
  - ACCT observations should be at irregular, unpredictable intervals.
  - Staff should review risk and consider whether to hold a case review whenever an event occurs which indicates an increase in risk.
  - They should ensure that there is no confusion between ACCT observations and routine healthcare observations.
  - They should involve the prisoner's family when it would be beneficial.
- The Governor and Head of Healthcare should ensure that staff are aware of and appropriately use the enhanced case management approach for suicidal prisoners with complex needs.
- The Governor and Head of Healthcare should ensure that healthcare staff understand the process for transferring prisoners under the Mental Health Act and that they inform NHS England and the Ministry of Justice Mental Health Casework Section promptly when a prisoner is assessed as requiring such a transfer.
- The Governor and Head of Healthcare should ensure prisoners at risk of suicide or self-harm are not placed on the basic level of the IEP scheme unless all other options have been considered and excluded, and there are fully documented reasons to explain the exceptional circumstances.
- The Governor and Head of Healthcare should ensure that staff use an appropriate code to communicate a medical emergency, even when a prisoner is in healthcare, so the control room know to call an ambulance immediately.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at Lewes, informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded.
10. The investigator visited Lewes on 15 February, and obtained copies of relevant extracts from Mr Osborne's prison and medical records. She spoke to several prisoners and staff in the healthcare unit.
11. NHS England commissioned a clinical reviewer to review Mr Osborne's clinical care at the prison.
12. The investigator interviewed eight members of staff and a prisoner at Lewes in April and another member of staff by telephone in May. Four of the interviews with healthcare staff were conducted with the clinical reviewer. The investigator also interviewed Mr Osborne's brother by video link.
13. We informed HM Coroner for East Sussex of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Osborne's family to explain the investigation. Mr Osborne's family had a number of questions and concerns about his care in prison. They wanted to know why healthcare staff had not prescribed medication for Mr Osborne, how decisions about the level of observation and risk were made and if staff had been adequately trained, why transfer to a secure mental health unit was so delayed and if any attempt had been made to contact his family while Mr Osborne was at Lewes.
15. Mr Osborne's family received a copy of the initial report. While Mr Osborne's family remain unhappy with the standard of care Mr Osborne received at Lewes, they did not highlight any factual inaccuracies within the report.
16. The prison also received a copy of the report and did not identify any factual inaccuracies in the report.

# Background Information

## HMP LEWES

17. HMP Lewes is a local prison serving the courts of East and West Sussex and holds up to 692 men. Sussex Partnership NHS Foundation Trust provides primary care services. Healthcare staff are on duty at the prison at all times.

## HM Inspectorate of Prisons

18. The most recent inspection of Lewes was in January 2016. Inspectors reported that Lewes held a lot of young adults and levels of violence were high. Although levels of self-harm were relatively low, staff had not received ACCT refresher training in the previous three years. Inspectors noted poor and inconsistent case management, caremaps did not reflect issues identified in assessments and were not updated and attendance at case reviews was poor. Serious incidents of self-harm had not been investigated and prisoners subject to ACCT told inspectors they did not feel well cared for. Inspectors found little mental health staff input for those prisoners with mental health needs.

19. Inspectors reported that, overall, Lewes provided good primary and secondary mental health services. However, a shortage of custody staff affected the delivery of a therapeutic regime in the healthcare unit for patients with complex mental health needs. Too few prison staff had mental health awareness training.

## Independent Monitoring Board

20. 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 January 2016, the IMB identified low staff numbers had been a serious concern, but had improved. They noted the poor quality of ACCT was being addressed, and improvements had been made.

21. The IMB noted there has been an increase in the number of prisoners with mental health problems. They found the healthcare team were skilled in assessing and caring for those prisoners, with an excellent referral system to local secure units (although referral to non-local locations was more difficult).

## Previous deaths at HMP Lewes

22. There were two self-inflicted deaths in July 2012. The findings from these investigations had some similarities with the circumstances of Mr Osborne's death. We made recommendations that the management of prisoners being managed on an ACCT in the healthcare unit should comply with national guidelines, observations should not be at regular intervals and healthcare staff should use agreed medical emergency codes. Despite Lewes accepting these recommendations, we find the need to repeat them.

## Assessment, Care in Custody and Teamwork

23. 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.

24. 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.
25. 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.

### **Transfers of prisoners to hospital under the Mental Health Act**

26. When a prisoner has a mental illness that requires detention in a hospital for medical treatment, and the prisoner urgently needs that treatment, the prison can arrange for them to transfer to hospital under section 48 or 49 of the Mental Health Act 1983. PSI 50/2007 (Transfer of Prisoners To and From Hospital Under Sections 47 and 48 of the Mental Health Act 1983) and the NHS England 'Good Practice Guide – The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act' set out the process.
27. Before the prisoner can be transferred to hospital, two doctors (one of whom must be a mental health specialist; section 12 approved) must provide reports stating that the prisoner meets the criteria for transfer. The reports must not be more than two months old. The prison's mental health in-reach team sends the reports to the Ministry of Justice Mental Health Casework Section, who review the request and issue a transfer warrant. The transfer warrant, which is valid for 14 days, allows the prisoner to be transferred to hospital under the direction of the Secretary of State.
28. When a prisoner is identified as suitable for transfer to hospital, the NHS England Health and Justice Commissioning Team appoints an NHS England case manager to lead on this process and quickly locate and access a hospital bed. If the local service does not immediately have a bed space for the prisoner, the NHS England case manager should identify the most clinically appropriate alternative service. The NHS England guidance recommends that all prisoners needing transfer are transferred within 14 days.

### **Incentives and Earned Privileges Scheme (IEP)**

29. Each prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are four levels, entry, basic, standard and enhanced.

## Key Events

30. Mr Jamie Osborne had served short sentences at HMP Lewes in 2014 and 2015, for burglary, theft offences and breach of a community order. His youth offender worker had assessed him as at risk of suicide and self-harm, due to his age and vulnerability. He told prison mental health staff that he had problems controlling his anger, but had no thoughts of suicide or self-harm. He also said that he used illicit drugs, including new psychoactive substances (NPS).
31. During that time, Mr Osborne had reported hearing voices and thought that other people could read his mind. He also admitted deliberately cutting himself. He said his community GP had prescribed anti-psychotic medication (quetiapine). The mental health team had assessed Mr Osborne and found no psychotic symptoms or clear evidence of mental health issues and a prison doctor recorded that he was mentally stable, with no evidence of psychosis or paranoia. Mr Osborne was briefly supported by Prison Service suicide prevention measures (known as ACCT). (Lewes could not find this ACCT document.) Mr Osborne was released from Lewes on 28 May 2015.
32. On 3 August, Mr Osborne was remanded to HMP Elmley, charged with burglary and theft. At his initial health screen, Mr Osborne said that he had no thoughts of suicide or self-harm, or any physical or mental health problems. A nurse noted that Mr Osborne interacted well, he had good eye contact and appeared relaxed. There is no evidence the information from his previous time in custody was considered.
33. Mr Osborne went to court on 18 August for an alleged drug offence committed in July 2015. The court granted bail for this offence, but Mr Osborne remained on remand for the burglary and theft offences and was taken to HMP Lewes. His Person Escort Record (PER - which accompanies prisoners on all journeys between police stations, courts and prisons, to communicate risk factors) flagged he was at risk of self-harm.
34. At an initial health screen, a mental health nurse noted no concerns about Mr Osborne's physical or mental health problems. However, she incorrectly noted that he had not previously been prescribed medication for mental health problems. She told the investigator she did not recall Mr Osborne and could not remember if she had checked the previous records, but would have recorded any concerns.
35. At a disciplinary hearing on 21 August, conducted by a senior manager, Mr Osborne received a punishment of 14 days cellular confinement for disobeying an order (he had been asked to move to A Wing but refused as he told staff he had problems on that wing). A nurse assessed him as fit for segregation and noted there were no signs Mr Osborne was acutely unwell. Lewes did not provide a complete set of adjudication papers so we do not know what information was considered by the senior manager.
36. On 17 September, Mr Osborne appeared in court for burglary and drug offences, and went back to Lewes on remand. (In the following months, Mr Osborne had several other court appearances for additional offences.)
37. On 18 September, a Supervising Officer (SO) wrote in Mr Osborne's prison record that his behaviour had been 'odd', he had been rude and had threatened to harm her.

There were no other entries on Mr Osborne's prison record until 8 October, when an education worker recorded that he had made inappropriate sexual comments to female staff. Mr Osborne apologised for his behaviour and said he wanted to stay in education.

38. On 30 October, Mr Osborne, who was standard on the IEP scheme, received a warning for constant misuse of his cell bell. (He had received a similar warning in August.) An officer also noted he had made inappropriate sexual comments.
39. As a result of making sexualised comments to a female prison officer and a drug and alcohol recovery worker, Mr Osborne was referred to the mental health in-reach team. On 2 November, a community psychiatric nurse (CPN) was due to assess him. Before doing so, she spoke to an officer, who said that she had noticed a change in his behaviour. She mentioned that he had pressed his cell bell and told her that he had been sick. He had a handful of food, which he started to eat with his fingers. The officer said she did not know if there was something wrong with him, or if he was just immature.
40. The CPN nurse noted that Mr Osborne had been hostile and irritable in police custody, but he had declined to be assessed by the police and court liaison and diversion service (PCLDS – who identify offenders who have mental health, learning disability or substance misuse vulnerabilities). She noted that he had not had any contact with the mental health and learning disabilities services in Sussex and had not been managed under the Care Programme Approach (CPA). (The CPA is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.)
41. On 3 November, an occupational therapist from the mental health in-reach team assessed Mr Osborne. She noted wing staff's concerns about his odd behaviour, such as wandering around the wing and making inappropriate comments to female staff. Mr Osborne was hostile and angry during the assessment. He told her that he was tired of prison, resented prison staff reading his letters and did not understand why prison officers were concerned about him, as he was not suicidal or self-harming. The assessment ended as he would not cooperate, but he was told that he could speak to someone from the in-reach team if he changed his mind. The mental health in-reach team discussed Mr Osborne at their meeting the next day and discharged him, as the assessment did not identify any acute mental health needs.
42. On 16 November, Mr Osborne asked his personal officer to check his records, as he believed his release date was 20 November. (Personal officers should get to know prisoners they are responsible for, act as a first point of contact for any problems, help with resettlement issues and make regular entries in prison records about their progress.) He explained to Mr Osborne that he was being held on two remand warrants. He noted that Mr Osborne did not accept the answer and was angry.
43. The next day, Mr Osborne's cellmate reported concerns about his behaviour. He said that Mr Osborne had carved a 'tag' on his arm and said he could see women in their cell. A CPN and a psychologist assessed Mr Osborne that day. They noted he appeared hostile, guarded and did not think he had any mental health issues. Mr Osborne told them he was 'rapping' and was not talking to himself. He said he had drawn the smiley face on his arm with a pen, but the nurse noted it looked like it had been cut into his arm. He was angry that he had been remanded and declined any

further mental health input. She concluded it was difficult to assess if Mr Osborne was psychotic, but that he did not have signs of overt thought disorder. She reviewed the cell sharing risk assessment (CSRA) which is designed to assess a prisoner's risk of violence towards a cellmate in a locked cell. Mr Osborne was assessed as high risk, which meant he had to live in a single cell.

44. After the assessment, an officer noted in Mr Osborne's prison record that staff should be aware that Mr Osborne may 'flare up' if he was not released. A further entry by a custodial manager noted Mr Osborne displayed 'some poor and concerning behaviour. In-reach have made High Risk [in respect to sharing a cell] and are looking to monitor him'.
45. Although the CPN noted she had informed a senior prison officer of the concerns about Mr Osborne's behaviour and that his case would be discussed at their team meeting, no one considered opening an ACCT. She told the investigator that, although Mr Osborne had self-harmed, she did not think his actions presented any further risk.
46. On 18 November at around 10.30am, an officer discovered Mr Osborne suspended by a kettle lead attached to his bed. The officer requested help, cut the lead and lowered him to the floor. Staff performed cardiopulmonary resuscitation and Mr Osborne started to breathe. Healthcare staff stabilised him until an ambulance took him to hospital.
47. An officer began ACCT suicide and self-harm prevention procedures and recorded that Mr Osborne had made a serious suicide attempt.
48. The prison informed Mr Osborne's father that he had been taken to hospital. At his father's request, Mr Osborne's brother, a prisoner at HMP Rochester, was also informed that he had tried to take his own life.
49. The hospital placed Mr Osborne in an induced coma and treated him in the intensive care unit. Tests confirmed there was no long-term brain damage, but the hospital advised he should have a psychiatric assessment. Mr Osborne told prison escort staff that if he was not released from prison he would hang himself.
50. Mr Osborne was returned to Lewes on 20 November and admitted to the healthcare inpatient unit. Staff assessed him as at a very high risk of suicide or self-harm and constantly supervised him, which meant he was watched at all times. He was given anti-rip clothing (special clothing made of material extremely difficult to tear into strips to create ligatures). There is no information in his records as to when he resumed wearing his own clothes. Staff began to manage him under the CPA and produced a care plan, mental health assessment and a risk assessment.
51. On 21 November, an officer carried out an ACCT assessment. Mr Osborne said he had tried to hang himself, as he thought he should have been released and that it was a spur of the moment decision. He said that he was glad to be alive, although unhappy he was still in prison. He said he would feel better if he had a television (it was not clear from the records why Mr Osborne did not have a television) and could speak to his father and brother. He did not want to speak to a Listener or Samaritans (Listeners are prisoners trained by the Samaritans to support other prisoners). The officer assessed Mr Osborne was at high risk of suicide or self-harm.

52. The ward manager of the inpatient unit was assigned as Mr Osborne's ACCT case manager, and chaired an ACCT review later the same day. He recorded on Mr Osborne's caremap that he should be assessed by a psychiatrist and staff should talk to Mr Osborne about his current situation to reduce his risk. The issues identified by an officer, about having a television and speaking to his family, were not included. Mr Osborne remained in a high observation cell and on constant supervision. Staff continued to manage Mr Osborne under ACCT procedures until his death. The ward manager attended six of the 19 ACCT case reviews.
53. On 23 November, the ward manager chaired an ACCT case review, attended by two officers and Mr Osborne. The caremap was not updated, but the review decided Mr Osborne's risk had reduced as he said he no longer had thoughts of suicide and wanted to work with staff to return to a residential wing. The review panel assessed Mr Osborne as a raised risk of suicide or self-harm and his observations were reduced to every 15 minutes.
54. On 24 November, an officer noted in Mr Osborne's prison record he had made inappropriate comments to female staff. Staff warned him that the television he had just received would be removed if his behaviour did not improve.
55. During a ward round in the healthcare centre on 25 November, Mr Osborne told the visiting consultant forensic psychiatrist at Lewes he wished he had been left to die and still wanted to kill himself. He sharpened a plastic knife and initially refused to hand it to staff. (A secretary and not the psychiatrist entered this information on the medical record.)
56. A nurse noted that she had conducted an ACCT case review "during ward round". No officers or Mr Osborne attended the review. She updated Mr Osborne's caremap and indicated the psychiatrist had completed a psychiatric review. She also noted that Mr Osborne had threatened to kill himself if his television was removed. Mr Osborne's risk remained unchanged as raised, and observations were to continue every 15 minutes.
57. The psychiatrist's report, dated 26 November, concluded Mr Osborne required urgent treatment in a mental health unit. (In a subsequent investigation, Sussex Partnership Trust identified that it had been agreed Mr Osborne would be transferred to Oak Ward, a medium secure unit (MSU). However, the Trust had found that the psychiatrist had not completed the appropriate assessment.) The same day, Mr Osborne attended the occupational therapy group, but was asked to leave when as his behaviour became too difficult to manage.
58. On 27 November, an officer noted in Mr Osborne's prison record that his cell should be unlocked by two officers, because he had made threats to stab staff and continued to be inappropriate to female staff. The prison did not provide any evidence of a formal assessment and decision for a controlled unlock. Mr Osborne sometimes refused to have a shower or exercise, as he was unhappy about this requirement.
59. The same day, a healthcare assistant noted in the medical record that officers had removed Mr Osborne's television, furniture and switched off the water as he had flooded his cell. They gave back his television and furniture the next day and an officer noted that his behaviour had improved.

60. On 30 November, a manager chaired an ACCT review, attended by the personal officer, a mental health nurse and Mr Osborne. Mr Osborne said that he had no thoughts of suicide or self-harm and that his actions had been a 'one off'. He said he wanted to return to a residential wing. The manager noted 'clearly has mental health issues and remains sexually inappropriate to females'. He reviewed the caremap and noted Mr Osborne's behaviour remained threatening and that he was waiting for a transfer to hospital. No specific actions were recorded, and he described Mr Osborne as 'impulsive and thought disordered'. Observations were reduced to hourly, although Mr Osborne remained in a high observation cell.
61. Throughout his time at Lewes, Mr Osborne continued to make inappropriate sexual comments to female staff. He heard voices, became agitated and spoke to himself. He was often hostile and abusive to staff, threatening to assault them (face to face and in imaginary conversations). He believed that staff were mistreating him by taking away his television and appeared not to be remorseful or understand the perspective of others.
62. On 1 December, a specialist registrar in forensic psychiatry assessed Mr Osborne. He asked the psychiatrist if he could move back to a residential wing and said he believed staff found trivial reasons to take things from his cell. The psychiatrist planned to discuss Mr Osborne with his colleague.
63. On 2 December, a nurse chaired an ACCT review, attended by Mr Osborne and two unnamed officers. Mr Osborne's level of risk and hourly observations remained unchanged. Later that day, Mr Osborne threatened two nurses when they asked him to turn down the volume on his television. Officers removed his television, but returned it the next day.
64. On 4 December, Mr Osborne spoke to his brother. The brother told the investigator that Mr Osborne had said he was lonely, no one cared about him and he wanted to transfer to Rochester because he missed him. He had also told his brother that he had to fight to keep his television and that he needed help. He felt that his brother did not seem himself, and although he was worried about him, he did not think he wanted to kill himself. He told the investigator that he had tried again to speak to Mr Osborne, but was unable to, which had distressed him greatly. He gave the investigator copies of letters he and his brother had sent to each other; there was nothing in these letters which suggested Mr Osborne intended to kill himself.
65. The only evidence of contact between Mr Osborne and his brother was provided by Rochester, there is no detailed record of the inter-prison telephone call in Mr Osborne's prison record, or reference to it in the ACCT document. A nurse noted in the medical record Mr Osborne used the telephone to make a long call (although does not say who with), and that Mr Osborne had been very settled, polite and appropriate with staff.
66. On 7 December, a referral meeting agreed that Mr Osborne did not meet the offending criteria for a medium secure unit, because his offending (burglary and theft) did not pose a serious risk of harm to the public. Those present thought Mr Osborne's needs would be best met in a psychiatric intensive care unit (PICU) or low secure unit. (The ward manager referred Mr Osborne for a PICU assessment on 11 December.)

67. A mental health nurse chaired an ACCT review that day, with two officers and Mr Osborne. Although it is recorded the caremap was reviewed, there is no evidence to support this. His risk and observations remained the same and it was noted that he continued to be at risk due to his 'unpredictable and impulsive behaviour'.
68. On 8 December, a psychiatrist completed a second assessment which agreed with his colleague's view that Mr Osborne required urgent medical treatment in a secure mental health unit. (A checklist was completed on 9 December, which noted these reports had been sent to the Ministry of Justice Mental Health Casework Section (MoJ MHCS), but the investigator was told this checklist had been completed in anticipation of a bed being secured for Mr Osborne.)
69. The same day, an officer reduced his IEP status from standard to basic and removed his television, due to his continued threats to female staff and poor compliance. This decision was never reviewed and Mr Osborne remained on basic IEP until he died. While it is recorded that he had a television at times, there is no consistent evidence of how frequently Mr Osborne had the opportunity to socialise with other prisoners, exercise, and use the showers and telephone. An officer returned his television on 11 December, but warned him it would be removed if he became abusive.
70. On 13 December, an officer chaired an ACCT case review with a mental health nurse, a healthcare assistant and Mr Osborne. The officer recorded observations were to continue at '5 daily/nightly conversations due to impulsiveness' (although the previous review had noted hourly observations). An entry on Mr Osborne's medical record by the healthcare assistant, noted the officer would help Mr Osborne make contact with his family and new solicitors. However, this was not recorded on the caremap, and there is no evidence of any action on this. There is no record that the review considered Mr Osborne's basic IEP status, how his challenging behaviour was assessed or managed in the context of his mental health, or the impact of him effectively segregating himself in his cell.
71. Mr Osborne made several written complaints, alleging that he had been mistreated by being locked up and having his television taken away. On 14 December, a member of the offender management unit responded to an undated complaint by Mr Osborne that he should have been released from prison. She detailed Mr Osborne's cases and explained why he was being held on remand.
72. On 18 December, Mr Osborne was angry and abusive as he wanted to leave his cell for a shower, but two officers were not available to unlock him. A mental health nurse chaired an ACCT review with a healthcare assistant, an officer and Mr Osborne. There is no record or evidence that the caremap was reviewed. There was no change in Mr Osborne's level of risk or observations. The nurse recorded 'not seen this week in HCC [healthcare] by psychiatrist but still waiting transfer to hospital'.
73. On 21 December, staff decided that he would no longer have to be unlocked by two officers, but warned him not to be abusive to female staff. (This was rescinded two days later as he raised a fist to an officer.) An ACCT case review was chaired by a nurse, with an officer and Mr Osborne. Although not recorded on the ACCT document, it was noted on the medical record that observations were set at three daily and three nightly. They reviewed the caremap and noted that Mr Osborne's

mood had improved but he was still chaotic. An action was added for all staff to provide ongoing support and boundaries. There is no evidence of what information was considered at the review or the reason why Mr Osborne's reduced level of observations reflected a reduction in his risk. This was the last time the caremap was reviewed.

74. On 23 December, two charge nurses from PICUs in Sussex assessed Mr Osborne. They concluded he had 'multiple difficulties interacting with the world', but did not present with a treatable mental illness which met the criteria for admission to the PICU (and admission to a secure hospital could worsen his condition with a change in environment). (The Sussex Partnership Trust investigation concluded that it was unlikely this assessment could have determined if Mr Osborne could be treated, which was the purpose of an admission, and that Mr Osborne did meet the acceptable admission criteria for a PICU.)
75. On 24 December, Mr Osborne threw a plate at an officer and stabbed him in the back with a pen. A nurse noted Mr Osborne did not remember the assault when she asked him about it 20 minutes later.
76. On 26 December, staff updated Mr Osborne's CPA care plan, noting that he was calmer, but he had twice assaulted staff when he felt his needs were not being met. It was also recorded that he was waiting to be admitted to hospital.
77. A mental health nurse chaired an ACCT review on 29 December, with an officer and Mr Osborne. No changes in risk or observations were noted. She recorded Mr Osborne was angry at being kept in the healthcare inpatient unit and remained unpredictable and impulsive.
78. On 5 January, an ACCT case review was held. The case review record was not signed, but it appears to have been chaired by a visiting psychiatrist, with a nurse, two officers and Mr Osborne. Mr Osborne engaged well. He declined anti-psychotic medication and was desperate to return to a residential wing. The panel assessed that Mr Osborne's risk had reduced and was now low, and observations were reduced to two during the day and two at night. There is no record of what information influenced the decision to reduce Mr Osborne's risk. The psychiatrist added that Mr Osborne's psychiatric assessment would continue in hospital, although there was no obvious psychosis.
79. On 12 January, a nurse chaired an ACCT review, with an officer and Mr Osborne. The nurse noted Mr Osborne denied any thoughts of self-harm, appeared impulsive and did not want to engage. Mr Osborne's level of risk and observations remained the same.
80. A care plan update on 17 January, noted that Mr Osborne had become more unsettled and he was still waiting for a hospital place. On 18 January, a referral meeting discussed the possibility of Mr Osborne getting a place in a low secure unit through Alpha & Partnerships (providers of low and medium secure mental health care facilities and services) as Sussex had no available beds. A referral was made for Mr Osborne to be assessed.
81. On 19 January, the ward manager attempted to conduct an ACCT case review, but Mr Osborne refused to engage. The next day, a nurse reconvened the review, with

an officer and Mr Osborne. The nurse recorded Mr Osborne was 'still responding to auditory hallucinations', that he was non-committal and hostile throughout the review and did not comment when asked if he had any thoughts of suicide or self-harm. The review decided the ACCT should remain open 'due to serious suicide attempt', but his level of risk (low) and observations remained unchanged.

82. Towards the end of January, staff noted that Mr Osborne had become 'invisible', had little engagement with staff and was isolated, watching television much of the time.

83. On 25 January, a referral meeting discussed Mr Osborne and, on 26 January, staff from Cygnet Unit, a low secure unit in Stevenage tried to assess Mr Osborne, but he would not speak to them. (At a subsequent meeting on 1 February, it was recorded that they were waiting for Cygnet Unit to confirm when they had a place for him.)

84. The ward manager held ACCT case reviews on 27 January and 3 February, attended by other healthcare staff and Mr Osborne. At the first review, he noted that Mr Osborne did not want to be involved in the process and, 'Awaiting transfer to hospital under the mental health act ... Unsure of risk status'. The level of risk and observations remained unchanged, (two daily/nightly observations). He added 'subject to hourly HCC obs'. This referred to the fact that healthcare staff routinely checked all prisoners in the inpatient unit every hour, on the hour, and this was noted on a healthcare observation record.

85. On Friday 5 February, the ward manager emailed the Ministry of Justice Mental Health Casework Section to inform them that Mr Osborne required a transfer under s48 of the Mental Health Act. He attached two assessment reports (dated 26 November and 8 December) and a list of Mr Osborne's previous convictions. He also confirmed that Mr Osborne had been offered a bed at Cygnet low secure unit, Stevenage, under the care of a psychiatrist.

86. On Monday 8 February, the Mental Health Casework Section informed Lewes that the s48 assessment reports were out of date (they are only valid for two months), and Mr Osborne had to be reassessed by two independent doctors before they could issue a warrant for transfer.

87. On 9 February, two consultant psychiatrists independently assessed Mr Osborne. Both psychiatrists concluded Mr Osborne required urgent treatment and wrote reports describing him as 'grossly psychotic... he remains at high risk of suicide' and noting that 'his psychotic disorder will deteriorate further without intervention, leading to a further exacerbation in risks'. The ward manager emailed the reports to the Mental Health Casework Section the same day.

88. An ACCT case review was due on 10 February. A nurse told the investigator that the meeting had not been held, as there were not enough officers available to open his cell. (There is no record of when the two person unlock was reinstated.) She had asked another nurse and a healthcare assistant for their views during the day and had spoken to Mr Osborne through his cell hatch. She noted on the ACCT document that his risk of self-harm or suicide remained low (Mr Osborne had been assessed as low risk since 5 January) and the frequency of ACCT observations remained unchanged, together with hourly healthcare observations. She noted that Mr Osborne was waiting to be transferred to hospital and, in the summary of the review, recorded 'Jamie unable to participate in process, he doesn't think he is

unwell and remains annoyed to be kept in HCC [healthcare centre]. Jamie wishes to return to the wing. Became hostile and refused to converse asked for hatch to be closed'. She did not review the medical records and was unaware that, the day before, two psychiatrists had assessed Mr Osborne's risk of suicide as high.

89. On 11 February, the referral co-ordinator from Mental Health Casework Section informed the ward manager that because of the violent incident when Mr Osborne had stabbed a prison officer he might need to transfer to a medium secure unit. He reiterated that Mr Osborne was unwell and needed urgent treatment.
90. The same day, the ward manager recorded in Mr Osborne's medical record that he 'remains low profile' and only interacted with staff when he wanted something. He added that Mr Osborne had refused exercise, but collected his meals. There were six entries in the ACCT document that day. The first at midnight by a nurse, which noted 'awake pacing cell'. The next two at 5.00am and 7.00am (asleep in bed). At 9.55am, Mr Osborne was sitting on his bed listening to music and, at 11.30am, asleep. A nurse noted at 5.00pm that he had stayed in his cell all afternoon and denied he was talking to himself when asked.
91. Two nurses started night duty at around 7.00pm. At 7.30pm, one recorded Mr Osborne was awake, and talking to himself.

#### **Friday 12 February**

92. According to the healthcare hourly observation record, Mr Osborne was awake from 11.00pm until the last check at 6.00pm. Both nurses described Mr Osborne's behaviour during the night as difficult and that he appeared distressed. A nurse made an entry on the ACCT document at midnight, noting Mr Osborne was awake and recorded in the medical record at 2.58am, 'Minimal interaction with staff. Asked for one bowl of hot water and settled for the night. Not responding as much as previous nights'.
93. Another nurse's entry in the ACCT document at 5.30am noted, 'Jamie has not slept and has been very disturbed'. At 5.37am, she wrote in the medical record, 'Just after 5 Jamie began banging around his cell, chucking furniture around. He was shouting and appeared quite distressed. Hatch was opened to see if he was OK, as he appeared to be crying'. (Both nurses told the investigator they had never known Mr Osborne to be tearful.) Mr Osborne was abusive and spat at one nurse and she closed the hatch. There was no other recorded contact with Mr Osborne after 6.00am.
94. A nurse started work at around 6.55am. She then began the routine check of every cell before the morning handover. When she got to Mr Osborne's cell and looked through the door observation panel (which was smeared with toothpaste), she saw him sitting on the floor, hanging by a sheet attached to the sink taps.
95. The nurse did not have a radio. She shouted for assistance and an officer who was a short distance away responded immediately. She radioed to request urgent assistance at 6.58am, but did not use an emergency medical code. The officer unlocked the cell, but Mr Osborne had used two lockers to form a barricade, so it took a few minutes to move them out of the way. They went into Mr Osborne's cell, cut the sheet and lowered Mr Osborne to the floor. There were no signs of life and

they started cardiopulmonary resuscitation (CPR). A portable defibrillator indicated there was no shockable rhythm, but CPR continued until paramedics arrived.

96. South East Coast Ambulance Service confirmed they received a request for an emergency ambulance at 7.05am, seven minutes after the request for urgent assistance. Paramedics arrived at Lewes at 7.09am and at 8.23am, they recorded that Mr Osborne had died.

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

97. A family liaison officer at Lewes and her deputy left the prison that morning to break the news of Mr Osborne's death to his family and offer condolences. Lewes contributed towards the costs of Mr Osborne's funeral, in line with national instructions.

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

98. After Mr Osborne's death, the duty governor debriefed the staff involved in the emergency response. She offered her support and that of the staff care team.

99. The prison posted notices informing other prisoners of Mr Osborne's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Osborne's death.

### **Post-mortem report**

100. A pathologist concluded that Mr Osborne had died from hanging. A toxicology report confirmed there were no substances in Mr Osborne's blood at the time of his death.

# Findings

## Management of Mr Osborne's risk of suicide and self-harm

101. Mr Osborne had been identified as at risk of suicide and self-harm during previous prison sentences in 2014 and 2015 and, for a short time, he was managed under the ACCT suicide and self-harm prevention procedures. The PER that accompanied him to Lewes on 18 August noted this risk, but health screens after he arrived did not take account of his previous history or identify any concerns.
102. Prison Service Instruction (PSI) 64/2011 about safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. The risk factors were also listed in our thematic report published in 2014. Those that applied to Mr Osborne included impulsiveness; previous self-harm; young age; history of mental health problems; lack of social support; recent contact with psychiatric services; a history of substance misuse; irrational behaviours; and transfer to another prison. There is no evidence that staff fully considered these risk factors or the need to start the ACCT procedures when he arrived at Lewes.
103. Although prison staff began the ACCT procedures after Mr Osborne attempted to hang himself on 18 November and this continued until he died, the ACCT procedures did not effectively support him as the overall management of the ACCT was poor and was not fully in line with PSI 64/2011. Caremaps should reflect the prisoner's needs, level of risk and the triggers of their distress. Instructions say they should aim to address issues identified in the ACCT assessment interview and later reviews, and consider a range of factors including health interventions, peer support, family contact and access to diversionary activities. Each action on the caremap should be tailored to the individual needs of the prisoner, be aimed at reducing risk and be time bound. We do not consider there were appropriate caremap actions aimed at reducing Mr Osborne's risk.
104. Staff only updated Mr Osborne's caremap sporadically, and it was not reviewed after 21 December. It contained no direct actions to help progress his transfer to a secure hospital, the main thing that could have helped to reduce his risk. During his ACCT assessment, Mr Osborne had said that he wanted contact with his family, but his caremap contained no specific action to help with this. (Lewes had no record of the inter-prison telephone call with his brother on 4 December, although somebody must have facilitated the contact at Lewes.) Most of the staff interviewed did not know Mr Osborne wanted to have contact with his brother or that they had regularly exchanged letters. PSI 64/2011 instructs that staff must consider involving the prisoner's family or next of kin, if that would be beneficial.
105. Some of Mr Osborne's case reviews were not multi-disciplinary and decisions not adequately or accurately recorded. The case review due two days before Mr Osborne died did not actually take place due to a shortage of officers to open his cell. Instead, a nurse updated the ACCT document after speaking to Mr Osborne through his cell hatch. The level of required ACCT observations was not always clear, observations at night were not irregular and unpredictable and there appeared to be confusion between ACCT observations and the routine hourly observations on all inpatients. There is little evidence of the decision-making in case reviews and the

rationale for reducing Mr Osborne's level of risk, other than the length of time the ACCT had been in place. We make the following recommendation:

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

- **All known risk factors of newly-arrived prisoners should be considered and recorded when determining their risk of suicide and self-harm, using all available information such as that from Person Escort Records.**
- **They should set effective caremap objectives which are specific, time bound and meaningful, aimed at reducing risk and updated at each case review.**
- **Case reviews should record and take into account all known risk factors and triggers and set a level of observations which appropriately reflects that risk.**
- **ACCT observations are at irregular, unpredictable intervals.**
- **Staff review risk and consider whether to hold a case review whenever an event occurs which indicates an increase in risk.**
- **They should ensure that there is no confusion between ACCT observations and routine healthcare observations.**
- **They should involve the prisoner's family when it would be beneficial.**

106. In our Learning Lessons Bulletin about young adult prisoners, published in August 2014, we identified that challenging behaviour can mask vulnerability and that managing risk of suicide and self-harm, treating mental health and managing behaviour needed to be better integrated to ensure a balanced, holistic and consistent approach. Under Prison Service procedures, prisons have the discretion to manage the most severely disruptive, volatile and difficult to manage prisoners using an enhanced case review process. Mr Osborne might have benefitted from the enhanced ACCT case management process, which brings with it a higher level of coordination between the different teams involved in the prisoner's care. Mr Osborne's complex needs might have benefitted from this approach, but this does not appear to have been considered.

107. The ward manager told the investigator that he had considered using the enhanced case management system, but there is no record of this in the ACCT case reviews. He told the investigator that mental health nurses working with Mr Osborne focussed on clinical care and recording rather than the ACCT, and accepted the ACCT should have been managed better, in line within national instructions.

108. More effective management of the ACCT procedures would have resulted in a more coordinated approach to managing Mr Osborne's self-harm, mental health and disruptive behaviour. Had Mr Osborne been managed by an enhanced case review team, this would have brought together multi-disciplinary team members with broader experience of dealing with complex cases. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff are aware of and appropriately use the enhanced case management approach for suicidal prisoners with complex needs.**

## **Mental health**

109. When Mr Osborne arrived at Lewes on 18 August, a nurse did not check his records and was therefore unaware he had previously been prescribed quetiapine. Mr Osborne was not prescribed medication at Lewes. The Sussex Partnership Trust investigation identified there was no evidence a resident psychiatrist had reviewed Mr Osborne since 8 December, although a psychiatrist did attend an ACCT case review on 5 January. He recorded that Mr Osborne had declined medication, but there is no information what medication was considered, or if Mr Osborne understood the potential benefit.
110. In January 2016, we published a thematic review of lessons to be learned from our investigations into self-inflicted deaths in prisons, where mental health issues were involved. In the report, we noted that where a secure hospital had been identified as the best environment to deliver appropriate care for acutely ill prisoners, we would expect all possible steps to be taken by the prison and the hospital to ensure this takes place within the 14 day target. We also noted that prisons need to be extra vigilant about the care of prisoners who are being considered for, or are awaiting transfer to a secure hospital.
111. PSI 50/2007 (Transfer of Prisoners To and From Hospital Under Sections 47 and 48 of the Mental Health Act 1983) and NHS England's 'Good Practice Guide – The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act' outline the process for transferring a prisoner to hospital under the Mental Health Act. The NHS guidance recommends that all such transfers take place within 14 days of the Secretary of State issuing a warrant for transfer. In October 2007 a revised version of 'Procedure For The Transfer Of Prisoners To And From Hospital Under Sections 47 And 48 Of The 'Mental Health Act (1983)' was issued. This document acknowledges there had been unacceptable delays in transferring prisoners, and provides a best-practice flowchart for all key stakeholders.
112. Unsentenced prisoners, such as Mr Osborne have to meet two criteria before they can be transferred to a secure mental health unit:
- The prisoner is suffering from mental illness or severe mental impairment of a nature or degree which warrants detention in a hospital for medical treatment.
  - The prisoner is in need of urgent treatment (the person would have required inpatient treatment had they been in the community).
113. Two independent reports by a medical practitioner, one of whom has to be approved under Section 12(2) of the Mental Health Act (1983), need to assess the same form of mental disorder and the need for inpatient treatment before the Secretary of State will issue a warrant for transfer. These assessments are valid for two months. The PSI and best-practice flow-chart clearly state that the MoJ Mental Health Casework Section (MHCS) must be informed when a prisoner is first assessed as needing to transfer to a mental health unit.

114. Healthcare staff at Lewes first identified the need for Mr Osborne to transfer to hospital on 26 November. The investigator saw evidence that a checklist had been incorrectly endorsed on 9 December to say the MoJ MHCS had been informed Mr Osborne needed a bed and that the two psychiatrist reports had been sent, when they had not. His prison medical records are incomplete and do not provide clear evidence of the decisions about his assessment. The Sussex Partnership Trust found in their investigation that the assessment for a transfer to a medium secure unit did not give a clear view on the level of security Mr Osborne required, but the decision not to admit him to Oak Ward was clinically sound.
115. We are concerned that healthcare staff at Lewes did not fully understand the process for transferring prisoners under the Mental Health Act. No one at Lewes notified NHS England (who then identify the Responsible Commissioner and allocate a case manager) or the Ministry of Justice (who can also help to identify appropriate alternative inpatient facilities) until 5 February 2016. As a result, the processes for identifying an available place in a secure mental health unit were delayed. The investigator was told it was common practice not to submit the information requesting transfer until a place had been secured and staff incorrectly believed they should not contact the mental health casework unit until that time. The delay at this stage of the process was particularly tragic, as a place for Mr Osborne had been identified for the day he died - 12 February.
116. The clinical reviewer concluded that the care Mr Osborne received at Lewes was not equivalent to that he could have expected in the community. She identified that Mr Osborne had psychosis when he took his life, but the Care Programme Approach was inadequately implemented - the care plan was not updated, there was no risk assessment or risk management plan and he was not on medication. She commented that consistently documented examinations of his mental state would have identified a pattern of deterioration of his psychosis. The procedure for transferring Mr Osborne to hospital under s48 of the Mental Health Act 1983 was not followed in full, and contact with the Ministry of Justice and NHS England Health & Justice Commissioning Team should have been made earlier. She also found that clinical entries in Mr Osborne's medical records were inadequate, so some information was not available to healthcare staff.
117. The clinical reviewer concluded that although there were challenges in finding a suitable place for Mr Osborne, if the procedures for the transfer of prisoners to a mental health unit had been strictly and successfully followed, the outcome for Mr Osborne might have been different. We make the following recommendation:
- The Governor and Head of Healthcare should ensure that healthcare staff understand the process for transferring prisoners under the Mental Health Act and that they inform NHS England and the Ministry of Justice Mental Health Casework Section promptly when a prisoner is assessed as requiring such a transfer.**
118. The clinical reviewer has made a number of additional recommendations that the Head of Healthcare will need to address.

## Managing difficult behaviour

119. Mr Osborne was placed on the basic level of the IEP scheme on 8 December 2015, because he had accumulated a number of warnings for threatening staff, abusive language and not obeying orders. Lewes' IEP policy states there should be a review after seven days and afterwards at 14 or 21-day intervals depending on the prisoner's behaviour. Mr Osborne remained on the basic regime until he died. There was no record of any formal review, as the local policy requires. Because Mr Osborne had been assessed as at risk of suicide and self-harm, he was sometimes allowed to keep his television but other restrictions, including spending more time locked in his cell, applied. Withdrawing from the prison regime can be a sign that an individual is at heightened risk of suicide or self-harm. No account seems to have been taken of the effect on Mr Osborne of effectively self-segregating when he refused to shower or exercise and there was no evidence of what was done to encourage him to engage and socialise.

**The Governor and Head of Healthcare should ensure prisoners at risk of suicide or self-harm are not placed on the basic level of the IEP scheme unless all other options have been considered and excluded, and there are fully documented reasons to explain the exceptional circumstances.**

## Emergency Response

120. PSI 3/2013 requires prisons to have a medical emergency response code protocol, which states how staff communicate the nature of a medical emergency, and that the control room calls an ambulance immediately when a code is used. Lewes issued their local protocol (183/2014) on 19 November 2014, which reflects national guidance. The protocol states that a code blue should be used if a prisoner is found unconscious or not breathing.

121. A nurse radioed for urgent assistance at 6.58am, when she discovered Mr Osborne, but did not use a medical emergency response code. The control room did not call an ambulance immediately. South East Coast Ambulance Service confirmed that they received the call for an ambulance at 7.05am, seven minutes after Mr Osborne was found hanged. The ambulance arrived at Lewes within a few minutes of the request. Any delay in calling an ambulance when there is a medical emergency could be crucial. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff use an appropriate code to communicate a medical emergency, even when a prisoner is in healthcare, so the control room know to call an ambulance immediately.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations