

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Georgie Smith, a prisoner at HMP Bristol, on 5 January 2024

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

On 2 January 2024, Mr Georgie Smith was found hanging in his cell at HMP Bristol. He died in hospital on 5 January. He was 18 years old. It was his first time in prison. I offer my condolences to his family and friends.

Mr Smith was a vulnerable young man who struggled with mental health and often used illicit drugs. Prison staff, substance misuse practitioners and mental health staff took action to support Mr Smith and manage his risk of suicide and self-harm. While there was evidence of some good practice, this was at times undermined by a lack of communication and co-ordination.

Mr Smith's death was the ninth self-inflicted death at Bristol in three years. Investigations into four of those deaths found deficiencies in the way the prison managed suicide and self-harm prevention procedures, known as ACCT. While this investigation found evidence of improvement in ACCT processes, there remain areas for focus.

Significantly, prison staff failed to respond to Mr Smith's emergency cell bell shortly before he was found unresponsive. Staff had told Mr Smith to use his cell bell if he felt unable to keep himself safe. Had staff answered the cell bell promptly, the outcome might have been different for Mr Smith. This delay was compounded by a further delay in nurses reaching Mr Smith due to confusion among night staff about who should collect them.

Mr Smith's death also highlights the inequalities in access to phone calls for prisoners and the consequences for prisoners in crisis.

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

Adrian Usher
Prisons and Probation Ombudsman

March 2025

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Summary

1. On 18 August 2023, Mr Georgie Smith was remanded into custody at HMP/YOI Brinsford, charged with robbery, assault, possession of an offensive weapon, dangerous driving and other driving offences. It was his first time in prison, and he was 18 years old.
2. On 21 September 2023, Mr Smith was transferred to HMP Bristol. He had a history of substance misuse, suicide attempts and self-harm in the community. He had been monitored under suicide and self-harm prevention procedures (known as ACCT) at Brinsford but was not assessed as posing a high risk of self-harm when he arrived at Bristol.
3. In October 2023, the mental health team assessed Mr Smith and he also began engaging with substance misuse services. He struggled with drugs and used psychoactive substances (PS, also known as 'Spice'). He raised concerns with staff about feeling under threat from other prisoners and they supported him. In November 2023, prison staff became increasingly concerned by Mr Smith's drug use and deteriorating behaviour. He was supported by ACCT procedures due to suicide attempts by ligature.
4. On 1 January 2024, prison staff again began ACCT procedures due to a further ligature attempt. Following a telephone conversation with his girlfriend, staff were satisfied that Mr Smith did not need constant supervision and four observations each hour were sufficient. Staff told Mr Smith to ring his cell bell if he felt suicidal.
5. At 4.11am on 2 January 2024, Mr Smith pressed his emergency cell bell. It was not answered. During the next ACCT observation check at 4.26am, prison staff found Mr Smith with a ligature around his neck. Nurses and prison staff began CPR, and paramedics later assisted. Paramedics took Mr Smith to hospital, where he died on 5 January 2024.

Findings

6. Prison staff took some positive actions to support Mr Smith and manage his chaotic drug use. Examples of good practice were sometimes undermined by a lack of co-ordination and communication between staff disciplines.
7. ACCT measures were started promptly and appropriately in November 2023 in response to Mr Smith's attempts to harm himself. However, the ACCT care plan failed to capture fully his risks and identify relevant support actions. Observations were reduced too quickly and at times there was an over-reliance on Mr Smith's presentation which contradicted other evidence.
8. Staff appropriately began ACCT measures again on 1 January 2024. The ACCT assessor spent time with Mr Smith to explore the reasons for his distress. Constant supervision was considered but assessed as not needed. Most ACCT observations were undertaken in line with the care plan and Mr Smith was observed overnight as required on the night of 1 January 2024.

9. Mr Smith often acted on advice from staff to press his cell bell when he felt unable to keep himself safe and had done so on previous occasions. When Mr Smith pressed his emergency cell bell at 4.11am on 2 January 2024, night staff failed to respond and did not check Mr Smith until the next ACCT observation interval 15 minutes later. There was no reasonable explanation for staff's failure to respond to Mr Smith's cell bell. One member of staff was dismissed and another resigned.
10. During the emergency response, night duty officers did not understand their responsibilities. This led to a delay in nurses being collected to provide medical help.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide and self-harm in line with the Prison Safety Policy Framework, in particular that ACCT care plans are meaningful and actioned and that observations are set in line with the prisoner's risk.

The Investigation Process

11. HMPPS notified us of Mr Smith's death on 5 January 2024. 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. One prisoner responded.
12. The investigator visited Bristol on 17 January 2024. She obtained copies of relevant extracts from Mr Smith's prison and medical records. The investigator watched CCTV and body worn video camera (BWVC) footage from 1 and 2 January. She visited the wing and cell where Mr Smith resided and obtained information from the East of England Ambulance Service. The investigator reviewed a sample of Mr Smith's telephone calls, including all calls in the week before he was taken to hospital.
13. The investigator interviewed fourteen members of staff and one prisoner at Bristol in February and March 2024. Two interviews were conducted remotely.
14. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.
15. We informed HM Coroner for Avon and Somerset of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.
16. The Ombudsman's office contacted Mr Smith's family to explain the investigation and to ask if they had any matters they wanted us to consider. They asked how long it took prison staff to answer Mr Smith's cell bell on 2 January. We have addressed this in the report.
17. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
18. We also shared the initial report with Mr Smith's family. They did not make any comments.

Background Information

HMP Bristol

19. HMP Bristol is a category B reception and resettlement prison. Oxleas NHS Foundation Trust provide healthcare services, including mental health services. Change, Grow, Live (CGL) provides substance misuse services.

HM Inspectorate of Prisons

20. The most recent full inspection of HMP Bristol was in July 2023. Inspectors reported a higher rate of self-inflicted deaths and recorded self-harm than most other adult male prisons in England and Wales. They found that staff shortages and a lack of purposeful activity and key work (where all prisoners should be offered regular keywork sessions with a named officer to support them and help them settle into prison), undermined leaders' strategies to reduce self-harm among a vulnerable and complex population.
21. Inspectors found a high number of prisoners at risk of self-harm were supported by ACCT procedures. Inspectors reported ACCT care plans were reasonably good but that the reality of daily life on the wings undermined some good early work that went into them. Inspectors reported that oversight of ACCT case management had improved since their last inspection, and robust quality assurance and a programme of staff training were driving improvement.
22. Inspectors reported that emergency cell bells were often left unanswered for long periods. Far fewer surveyed prisoners said their emergency cell bell was answered within five minutes compared to similar prisons.
23. Inspectors found supply and use of illicit drugs remained an issue but identified some progress following a recent prison drug strategy.
24. Following the inspection, HM Inspectorate of Prisons (HMIP) issued an Urgent Notification, a process which allows HMIP to alert the Lord Chancellor if he has an urgent and significant concern about the performance of a prison. A previous Urgent Notification was issued in 2019. As a result, Bristol is receiving additional support and monitoring from regional and national safety teams.

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 2023, the IMB reported an increased number of prisoners supported by ACCT procedures and deficiencies in some ACCT management. The IMB saw delays in answering emergency cell bells. They observed the availability of drugs had increased significantly over the year.
26. The IMB reported there was insufficient staff in the mental health team to support all the mental health needs of all the prisoners. Priority was given to those who are most unwell. They observed good support for prisoners and staff after distressing incidents.

Previous deaths at HMP Bristol

27. Mr Smith was the twelfth prisoner to die at Bristol since January 2021. Of the previous deaths, eight took their own lives. Our reports into four of those deaths found deficiencies in ACCT management which Bristol have since addressed through additional support and training. In 2022, the Acting Ombudsman escalated concerns about this issue and the poor management of ACCT in general at Bristol to the Prison Group Director. He responded in January 2023 detailing additional support and training on managing suicide and self-harm monitoring procedures.
28. There were also two natural cause deaths and one homicide at Bristol during this period. Up until 31 January 2025, one prisoner has died of natural causes at Bristol since Mr Smith's death.

Assessment, Care in Custody and Teamwork

29. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service case management approach 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. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur. As part of the process, a support plan, also known as an action plan, should be put in place. The ACCT plan should not be closed until all the actions of the risk reduction plan have been completed. After closure, a follow-up interview should take place within seven days.
30. 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. The Prison Safety Framework (which replaced Prison Service Instruction (PSI) 64/2011 in January 2025) sets out how staff should operate ACCT procedures.

Psychoactive substances

31. 'Psychoactive substances' is a broad term that refers to a drug or other substance that affects mental process. Synthetic cannabinoids and synthetic opioids (including nitazene) are substances that mimic the effects of traditional controlled drugs such as cannabis, cocaine, heroin and amphetamines. Synthetic cannabinoids and synthetic opioids can be difficult to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.
32. PS can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of these substances can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

Key Events

HMP/YOI Brinsford

33. On 18 August 2023, Mr Georgie Smith was remanded into custody at HMP/YOI Brinsford, charged with robbery, assault, possession of an offensive weapon, dangerous driving and other vehicle related offences. It was his first time in prison. He was 18 years old.
34. Mr Smith struggled with substance misuse in the community. He said it helped him to cope following two bereavements. He had a recent history of self-harm and suicide attempts. He struggled to settle at Brinsford. He was involved in violence as a perpetrator and victim and prison intelligence suggested he was being bullied.
35. During his first night interview, Mr Smith told a prison officer he had attempted suicide in recent months but denied current thoughts of suicide or self-harm. From 27 August to 6 September, prison staff monitored him under ACCT procedures after he harmed himself and said he would end his life if he was not moved to a different wing or to HMP Bristol. He told staff that he felt under threat from other prisoners. Mr Smith said he had support from his partner and prison records show he spoke to Listeners (prisoners trained by the Samaritans to support other prisoners in crisis) twice.
36. On 15 September, staff conducted a welfare check on Mr Smith. He told them he was well, felt happy on the wing and was no longer distressed.

HMP Bristol

37. On 21 September, Mr Smith was transferred to HMP Bristol before a court hearing the following day. The safer custody team at Brinsford shared Mr Smith's ACCT history and relevant records with Bristol's safer custody team.
38. A reception officer interviewed Mr Smith and noted he engaged well and reported no thoughts of suicide or self-harm. He said he felt a lot better at Bristol as his grandfather (who had been unwell) was recovering and he was closer to home.
39. Later that evening, Mr Smith spoke to an Insider (a trusted prisoner who can offer support) and told staff he felt unsafe on the wing due to 'community issues'. He asked to move to A wing. Staff moved him there the following day.
40. On 24 September, reception staff referred Mr Smith to the mental health team because he felt low. The mental health team saw him two days later, but he said he was doing well and did not need mental health support. He said he had attempted suicide in the community but would never do so in prison. He said he had family support at Bristol and declined psychology workshops.
41. On 30 September, Mr Smith was restrained following a social visit. Officers suspected he had hidden drugs and tried to search him. He was taken to the segregation unit as he refused to comply. He then handed over a package and was placed on report pending a disciplinary hearing. He was also restricted to closed visits (supervised visits to prevent physical contact and the passing of items).

42. On 6 October, the substance misuse team accepted a referral for Mr Smith. Prison intelligence indicated Mr Smith may have had a mobile phone and been involved in the prison's drug culture.
43. On 11 October, a substance misuse practitioner completed an initial assessment with Mr Smith. She told the investigator that he engaged well. He told her he had attempted suicide in the community but had no thoughts of hurting himself. Mr Smith said he had used cannabis in his early days in prison and then started using PS (psychoactive substances). He contributed to his substance misuse care plan, and she gave him harm reduction advice. She made a non-urgent referral to the psychology team and asked the mental health team to assess him as his mood was low, he was not sleeping well, he had had two bereavements and he had previously tried to take his life.
44. A worker from the mental health team advised that Mr Smith should make an appointment with the GP to discuss his low mood and sleep issues. She suggested grief counselling. She told the investigator that Mr Smith was signposted to other support services as he did not have a diagnosed mental illness.
45. On 25 October, an assistant psychologist assessed Mr Smith. Mr Smith told her that he had tried unsuccessfully to access mental health support in the community before he came to prison. He said he used drugs due to a lack of support. She referred him to psychosocial intervention and agreed to chase his work induction. She gave him workbooks to complete in his cell. She told us that the team did not have capacity to review work unless prisoners asked for support. There is no evidence Mr Smith asked for support. She told us there was a delay in Mr Smith starting psychosocial groups because the centre, where they were held, was closed. At the time of his death, he had not started them.
46. From the end of October into early November, Mr Smith increasingly struggled to comply with the regime. He received negative behaviour entries for not following staff instructions and being under the influence of drugs (believed to be PS). He was restrained once for being abusive to staff and not complying with instructions.

November 2023

47. On 2 November, a substance misuse practitioner gave Mr Smith a substance misuse relapse prevention workbook. The next day, Mr Smith told the practitioner's colleague he had tried PS once but did not like it.
48. On 4 November, Mr Smith was noted as pushing boundaries and not responding to staff instructions. He had a keywork session in which he said he had no issues on the wing, got on well with his cellmate and had a supportive family. He said he would accept a wing cleaner job. The officer noted Mr Smith appeared well and settled.
49. Later that evening, staff radioed an emergency code blue (used when a prisoner is unconscious or not breathing) after Mr Smith collapsed. Staff suspected he had taken PS. Healthcare staff assisted ambulance paramedics. Mr Smith regained consciousness, said he was fine and refused to go to hospital.

64. On 8 November, Mr Smith told the substance misuse practitioner he had used PS as a 'one-off' as he struggled to sleep. She told the investigator she found that odd as he was using PS during the day. She emailed the assistant psychologist to ask her to help Mr Smith improve his routine. Mr Smith attended a substance misuse group. He initially engaged well but left the session before the end, saying he felt unwell. He refused to attend the next session the following morning.
65. On 9 November, Mr Smith was placed on report after he was involved in an assault on another prisoner. He was referred to Challenge, Support and Intervention Planning (CSIP, a scheme to manage violent prisoners). Staff decided to continue to support him outside the CSIP framework.
50. Mr Smith was taken by ambulance to hospital on 11 November (due to suspected meningitis) and again on 12 November when code blues were called as he had a seizure. A further code blue was called on 14 November, but Mr Smith refused to attend hospital. Staff suspected his seizures were related to PS use.
51. On 15 November, Mr Smith was placed on report after he tried to jump onto the netting (a safety measure between the different landings on the wings to prevent prisoners from falling from height). Staff restrained him. He attended a substance misuse group but was found unconscious in the afternoon. A code blue was called, and medical attention given.
52. On 16 November, Mr Smith had a keywork session. Mr Smith was tearful and said he had inherited debt from his former cellmate which he could not repay. He wanted to stop using PS and return to open visits as he missed his siblings who would not attend closed visits. The session ended early as the officer was needed elsewhere. (Mr Smith did not have a consistent key work officer at Bristol and each session was delivered by a different person.)
53. That evening, Mr Smith was taken to hospital after another code blue. He had vomited and had a seizure. The substance misuse practitioner spoke to Mr Smith and emailed the safer custody and work allocation teams. She said she was concerned about the number of code blues for Mr Smith. She felt one reason he used drugs was boredom. She asked that his work allocation be chased.
54. At 5.42pm on 20 November, staff called another code blue, the sixth in just over two weeks. Mr Smith collapsed and had a seizure, suspected to be drug related. Medical care was given, and Mr Smith was referred to CSIP for a second time as staff were concerned about the frequency of emergency codes being called due to suspected PS use. The CSIP was closed, with actions to support him through behaviour support monitoring (an initiative at Bristol where staff identify key issues for a prisoner under CSIP management and monitor them for seven days when a CSIP is closed).
55. At 9.45pm, prison staff began ACCT procedures after they found Mr Smith had cut his left wrist and tied a ligature around his neck. Observations were set at four per hour and two quality conversations per day.
56. The immediate action plan recorded that Mr Smith remained in a cell on his own due to his age and because there were no other young adults to share with. The officer asked the safer custody team to consider a debt management plan and

asked an officer to support Mr Smith with phone credit (evidence suggests that Mr Smith struggled to manage his phone credit). Healthcare staff tended to Mr Smith's cut and noticed Mr Smith was tearful. He said he felt low but would not hurt himself again as he did not want to distress his family. He said he was in a cell on his own so had nobody to talk to. He accepted a distraction pack (usually including crosswords or other puzzles that can be completed in the cell). He denied thoughts of suicide or self-harm but said he knew he should ring his cell bell if he had any such thoughts.

57. A Custodial Manager (CM) completed Mr Smith's ACCT care plan, noting risk factors of self-harm and substance misuse history, his young age and unwell grandfather. Protective factors identified were family support and Mr Smith's willingness to engage with substance misuse work. Mr Smith was recorded as refusing to contribute to his care plan. One action was set for the CM to 'review for allocations [work] induction'.
58. On the morning of 21 November, Mr Smith told a keyworker that he felt lonely without a cellmate. He was tearful and upset. When a wing move was discussed to help him avoid drugs, he said he wanted to stay on A wing as he had relatives there who were his only support system. He said he would try and avoid using drugs.
59. At 1.45pm, an officer completed Mr Smith's initial ACCT assessment. Mr Smith said he felt much better but had too many thoughts. He told her that he wanted a cellmate as he felt it would help him offload his thoughts and balance his emotions. He said he wanted to engage with therapies, stop taking drugs and keep his mind busy.
60. At 2.30pm that afternoon, the CM chaired Mr Smith's first ACCT case review as case co-ordinator. An officer, Mr Smith and a representative from the mental health team attended. Staff shared safeguarding concerns for Mr Smith about substance misuse and bullying on A wing. They agreed he would remain on A wing but would be moved if there were further concerns.
61. During the review, Mr Smith said he was worried about his ill grandfather and was struggling to process bereavements. He wanted a cellmate as soon as possible and to attend chapel on Sundays. Mr Smith told staff he wanted mental health and substance misuse support. The care plan action on work allocation was updated as complete. No further actions were added, and the team concluded his risk of suicide and self-harm was not high. Observations were reduced to one per hour with three daily quality conversations. A review date of 26 November was set.
62. Over the next two days, Mr Smith appeared more stable. He began sharing a cell. He told staff having a cellmate was stopping him using drugs. He denied thoughts of suicide or self-harm and said he was looking forward to his work induction.
63. On 22 November, Mr Smith told the substance misuse practitioner that he had completed the distraction pack, and he was 'all good'. He said he was still worried about his grandfather and asked about antidepressants. She agreed to speak to the doctor about this.
64. On 23 November, Mr Smith was discussed at a mental health team meeting which the assistant psychologist attended. They talked about him being supported by

ACCT procedures and noted actions as 'therapies wait list, chaplaincy and substance misuse'.

65. On 24 November, Mr Smith's behaviour deteriorated. At 3.30am, he rang his cell bell, and staff saw him acting bizarrely. He told them he was hearing voices telling him to kill his cellmate. Mr Smith was immediately moved to a single cell on B wing.
66. At 5.40pm that evening, staff found Mr Smith with a tight ligature around his neck. They cut the ligature, and a nurse and pharmacy technician gave him medical attention, and he did not require hospital treatment. His ACCT observations were increased to four per hour.
67. At 7.30pm, a CM and a Supervising Officer (SO) on B wing conducted an urgent ACCT review after Mr Smith threatened to kill himself if he was not moved from B wing. He was crying and told staff he was not safe on B wing as he was under threat. Staff noted that he did not like to be alone in a cell and arranged for him to move to C wing to share with a young adult. Mr Smith described himself as 'very content' and agreed this would reduce his risk. The review concluded Mr Smith did not pose a high risk of suicide or self-harm and constant supervision was not deemed necessary. Observations were reduced to two per hour. Mr Smith moved to C wing at 7.49pm.
68. Staff checked on Mr Smith in line with ACCT observation requirements at 9.00pm. Shortly afterwards, his cellmate pressed the cell bell to alert staff that Mr Smith had ligatured using clothing. Mr Smith told staff he was worried about 'non-associates' on C wing, said they would find him dead in his cell and he had had enough. An urgent ACCT review took place. At 9.35pm, Mr Smith was moved to G wing and placed under constant supervision.
69. At 2.55pm on 25 November, Mr Smith attended his ACCT review. A CM attended in place of the case co-ordinator. The assistant psychologist attended with a wing officer. Mr Smith said he struggled on B wing as too many people offered him drugs and prisoners on A wing gave him spice to test. He said he did not like C wing either and had always wanted to be on G wing. He denied any thoughts of suicide or self-harm. He said he did what he needed to do to get on to G wing. He said he had missed his work induction. Staff explained that this would be rearranged. The team concluded Mr Smith's risk of suicide and self-harm was not high and constant supervision stopped. Observations were set at three per hour with two quality conversations per day.
70. On 26 November, Mr Smith told wing staff he wanted a single cell as he felt he was 'high risk'. No further detail was recorded about this. Staff saw Mr Smith interacting well with others all morning. He asked to be moved to a different landing on G wing so he could be nearer to his cousin, and they could attend the gym together. He said this would help his mental health.
71. That afternoon, Mr Smith told staff he was happy to be in a single cell. He was seen on the telephone to his family for most of the afternoon. He told staff he enjoyed being on G wing as his cousin was there. He said the regime was stricter than on other wings.

72. On 27 November, Mr Smith was moved to a single cell on the top landing on G wing as he had asked.
73. At 9.29am on 28 November, Mr Smith refused to go back inside his cell despite verbal encouragement. He became verbally abusive towards staff. He was restrained and placed in his cell and staff placed him on report (pending a disciplinary hearing). Mr Smith then calmed down and apologised to staff. A CSIP referral was completed then closed with an action to progress to behaviour support monitoring.
74. At 9.30am on 29 November, Mr Smith attended an ACCT review with a SO and the substance misuse practitioner. A wing officer and representative from the mental health team provided verbal updates. Mr Smith said he had not used spice since moving to G wing. He said he ligatured on B wing as he wanted to move cells. He explained he felt better on G wing and denied thoughts of suicide or self-harm. He said the mental health team had not yet spoken to him, but he knew who to contact if he felt low. The review noted Mr Smith being in a single cell helped him limit influence from others to use drugs and he had family support on the wing. Mr Smith said he was keen to have a job but worried about attending workshops as he was under threat from others. The SO agreed to add him to the list for a wing role. Mr Smith said his grandfather was better and he had also spoken to his probation officer about his court case. The ACCT was closed, with actions for Mr Smith to continue engaging with the substance misuse team, refrain from using drugs, and for staff to chase the mental health team about psychosocial intervention.
75. Later that day, Mr Smith was discussed at a Safety Intervention Meeting (SIM, a multidisciplinary safety risk management meeting which aims to manage and support prisoners who pose a significant risk of harming themselves or others). Representatives from the safer custody team and other prison departments attended. The SIM recorded that Mr Smith had been restrained because he did not like G wing's regime. They noted Mr Smith was building good relationships with staff. Staff fed back that he wanted to attend education and they had given him an in-cell induction pack as he had missed the induction. Mr Smith had told staff he was happy to engage in anything to get off the wing and he was engaging with the conflict management course. The review discussed Mr Smith's vulnerability due to a recent influx of drugs on G wing.
76. The substance misuse practitioner saw Mr Smith later that afternoon. He told her he had no thoughts of suicide or self-harm. He said he had completed a distraction pack the previous night which had helped him, and he was now working on the wing as a painter and cleaner. Mr Smith said he had smoked cannabis but denied any other drug use. She gave him harm reduction advice.

December 2023

77. In early December, Mr Smith appeared relatively settled on G wing. He refused to attend work and education twice (no reasons for the refusal were recorded) but overall, staff noted an improvement in his behaviour.
78. On 6 December, Mr Smith was discussed at the SIM meeting where the team reflected on his vulnerabilities in prison. They noted his move to G wing was

positive as he was away from negative influences. An action was set to undertake a CSIP review.

79. On 13 December, Mr Smith was discussed again at the SIM meeting. They discussed that Mr Smith worked as a wing cleaner and engaged well with staff. He remained on closed visits but wanted an open visit with his girlfriend. Actions were set for staff to obtain an update about closed visits and to monitor him under behaviour support monitoring.
80. On 14 December, the substance misuse practitioner saw Mr Smith on G wing. He appeared settled and told her he was working as a cleaner and went to the gym every morning. He said his mental health was 'okay' but came in waves. He refused to attend work that afternoon.
81. On 16 December, a SO spoke to Mr Smith following a further CSIP referral. Prison intelligence indicated Mr Smith was under significant threat from prisoners on another wing. Intelligence indicated that he might be in debt due to his drug use. Mr Smith told the SO he had minimal debt and was happy on G wing. The referral was closed.
82. From 19 December, Mr Smith's behaviour rapidly declined. He refused to attend work and on 21 December, staff called a code blue after he was believed to be under the influence of PS. Prison intelligence suggested Mr Smith remained under threat from other prisoners.
83. Two further code blues were called on 24 and 25 December when Mr Smith was found under the influence of drugs, believed to be PS. A wing officer completed a CSIP referral to understand why Mr Smith had started using PS again.
84. On the morning of 27 December, a worker from the substance misuse team spoke to Mr Smith at his cell door about his substance misuse. The worker noted Mr Smith was locked in his cell as staff felt he needed to be away from other prisoners due to his chaotic drug use. Mr Smith told the worker he regularly used PS. He said he felt stressed about his court case and being in prison and the only way out at times was to use drugs. He told the worker he felt a little better as he now had a court date of 3 January 2024. They discussed the dangers of PS and harm reduction measures. The worker returned to check on him the following day.
85. A SO actioned the CSIP referral and spoke to Mr Smith about his drug use. Mr Smith told him it was 'too easy' to use drugs on G wing. However, he said he felt safe and content. The SO gave him further harm reduction advice.
86. On 28 and 29 December, Mr Smith made telephone calls his grandmother and girlfriend. He told them that he had been taken to the segregation unit on Christmas Eve as he was involved in a fight. He said he remained there for three days. This was not true, as Mr Smith remained on G wing. There is no record of him having been involved in a fight.
87. Mr Smith told his girlfriend that he had been suspended from his wing job. He said he loved her and was looking forward to her visiting him the following day. Mr Smith was tearful at times and apologised for not telephoning her over the Christmas

period. He sought reassurance that she would not end their relationship. Mr Smith exhausted his phone credit.

88. On 30 December, Mr Smith was under the influence of PS all day. He missed the social visit with his girlfriend. A further CSIP referral was made. He told staff he had been smoking PS and wanted to stop again.
89. On 31 December, Mr Smith pressed his emergency cell bell eight times between 11.34am and 5.52pm. All were answered within five minutes. There are no records about why Mr Smith pressed his bell.
90. At 8.30pm, Mr Smith had a keywork session. He said he had good family relationships but felt guilty as he had missed a visit with his girlfriend the previous day as he was under the influence of drugs. He said he was happy on the wing and felt safe. Prisoners who were influencing him to take PS had moved wings. He said his mental health was 'alright', but he got low when he had no one to speak to.

Events of 1 January 2024

91. On 1 January 2024, Mr Smith pressed his emergency cell bell three times between 8.23am and 1.29pm. Each time, staff answered within six minutes. There are no records to explain why Mr Smith pressed his bell.
92. A SO was on duty on G wing on 1 January and saw Mr Smith out of his cell. He said he appeared engaging, getting smiles and laughs from others. He did not see anything to suggest Mr Smith was struggling.
93. Cell bell data shows staff responded to a call from Mr Smith's cell at 1.34pm. An officer opened the cell door observation panel and saw Mr Smith suspended from a ligature. The officer immediately went into the cell, removed the ligature and radioed a code blue.
94. The Head of Healthcare responded to the code blue. He told the investigator that Mr Smith was tearful and said prisoners were teasing him that his girlfriend had been promiscuous. He told the Head of Healthcare that he did not want to take his life.
95. The SO immediately began ACCT procedures and spoke to Mr Smith. Mr Smith said he had tried to hurt himself as he heard his girlfriend had been sexually assaulted. He said he felt hopeless and not being able to help his girlfriend made him feel like he did not want to be here.
96. Mr Smith had no phone credit. The SO spent time talking to Mr Smith about what was troubling him. He was aware Mr Smith's girlfriend and mother were significant protective factors so let him use the wing office phone to contact them.
97. Between 3.00pm and 4.00pm that afternoon, the SO supervised Mr Smith while he spoke to his girlfriend by telephone in the wing office. The SO put the speaker on, so he was able to hear everyone. Mr Smith spoke to his girlfriend for around 15 minutes. The SO heard Mr Smith say he wanted to make sure she was okay but went on to accuse her of being unfaithful. The conversation ended amicably with his girlfriend saying everything was fine.

98. Mr Smith then telephoned his mother. The call did not connect, and Mr Smith asked if he could try again the next day. The SO said he was not on duty the next day but promised to pass on the request. Mr Smith appeared calmer. The SO considered these calls mitigated the risk and decided therefore that Mr Smith did not need constant supervision.
99. The SO recorded that Mr Smith would benefit from remaining in a single cell as he was vulnerable to drug use. Mr Smith denied further thoughts of self-harm. He declined a distraction pack and did not want to speak to a Listener. He said he had family support on the wing. ACCT observation intervals were set at three per hour.
100. That afternoon, staff noted that Mr Smith had 'cheered up' following the phone call with his girlfriend, he engaged with his peers and cleaned his cell.
101. Prison intelligence suggests that at 6.00pm, Mr Smith had access to a mobile phone. The SO told the investigation that he had no suspicion that Mr Smith had access to a mobile phone that afternoon because he was so distressed about having no phone credit.
102. Two Operational Support Grades (OSGs) arrived for their night shift between 7.30pm and 8.00pm. OSG A was assigned to G wing and OSG B to A wing. They shared the wing office which adjoins both wings.

Events of 2 January

103. At 2.39am, prisoners in another cell on G wing pressed their emergency cell bell. OSG B told the investigator that OSG A responded. She said he told her the prisoners were being threatening and verbally abusive towards him as they wanted a vape. OSG A made an untimed entry in the wing observation book and reported their behaviour to the control room. The prisoners continued to misuse their cell bell throughout the night, it was ringing constantly from 3.55am.
104. At 4.06am, OSG A carried out Mr Smith's ACCT observation check. He looked through the cell observation panel for around 30 seconds before returning to the office.
105. At 4.11am, Mr Smith pressed his emergency cell bell. CCTV footage of the office shows both OSGs facing away from the cell bell panel, looking at their respective computer screens. Neither responded to the cell bell.
106. OSG A went to Mr Smith's cell at 4.26am. OSG B told us that OSG A had gone to check on prisoners subject to ACCT monitoring. OSG A reset Mr Smith's cell bell on the panel outside his cell and then looked through the observation panel. This was fifteen minutes after Mr Smith pressed his bell.
107. OSG A saw Mr Smith hanging and immediately radioed a code blue (logged at 4.27am). He unlocked Mr Smith's cell. CCTV footage (which showed inside Mr Smith's cell due to the position of the camera) shows Mr Smith suspended from a window bar at the end of his cell. Within a minute, the OSG had cut the ligature from around his neck.

108. At 4.30am, an officer (night deputy manager) arrived and went into the cell. He moved Mr Smith, so he was lying flat on the floor and began cardiopulmonary resuscitation (CPR). Another officer assisted and took over CPR at 4.32am.
109. A nurse and a pharmacy technician were on D wing and heard the code blue. They did not have keys to get through the gates and walked to the bottom of D wing, where they said they would usually be collected by a prison officer. The nurse told the investigator that this was the first time in an emergency that she had reached the bottom floor, and an officer was not already waiting.
110. The nurse heard a further radio transmission that the code blue was a suspended ligature and shouted on the radio for someone to collect them. She told the investigator she felt anxious as she knew the situation was critical. She picked up a defibrillator (a device that can apply an electric charge or current to the heart to restore a normal heartbeat).
111. The night manager arrived and took the nurse and pharmacy technician to Mr Smith's cell. They arrived on G wing at 4.33am, six minutes after the code blue was called. The pharmacy technician ran to get the emergency bag on G wing.
112. The nurse applied the defibrillator which advised no shockable rhythm. She resumed CPR and inserted an airway.
113. At 4.38am, the first ambulance arrived with two paramedics. They took over resuscitation efforts. A second ambulance arrived at 4.43am. The second paramedic crew entered Mr Smith's cell at 4.50am. Paramedics stabilised Mr Smith and he was transferred to hospital at 5.41am and placed in an induced coma.
114. At 7.00pm on 5 January, Mr Smith's life support was withdrawn. He was pronounced dead at 7.27pm. His family was with him when he died.

Information received after Mr Smith's death

115. Prison intelligence reports submitted after Mr Smith's death suggested he was being bullied and was under threat from other prisoners for drug related reasons. Information also suggested Mr Smith had used spice before he hanged himself and had access to a mobile phone on the evening of 1 January.

Contact with Mr Smith's family

116. At 8.40am on 2 January, Mr Smith's mother called the prison's concern line having heard Mr Smith was in a critical condition in hospital. We do not know who told Mr Smith's mother he was in hospital, but it was not through formal communication by the prison. The Governor went to the hospital to speak to her.
117. At 10:30am on 2 January, the prison appointed a family liaison officer (FLO). The FLO and the Governor offered support and spoke to Mr Smith's family at the hospital. The prison contributed toward the cost of Mr Smith's funeral in line with national policy.

Support for prisoners and staff

118. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.
119. After Mr Smith's death, the Governor 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 offered support and continue to do so. During the investigation, most staff said they felt well supported. An officer told us he felt unsupported and was unable to attend the immediate debrief as he was asked to be part of the escort to hospital.
120. The prison posted notices informing other prisoners of Mr Smith's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Smith's death.

Post-mortem report

121. The pathologist gave Mr Smith's cause of death as hypoxic ischaemic brain injury and lower respiratory tract infection. He concluded they were consequences of prolonged cardiorespiratory arrest that followed suspension by a ligature.
122. Toxicology analysis was not undertaken due to samples taken during the post-mortem considered unlikely to be useful in determining whether he was under the influence at the time of suspension.

Inquest

123. At an inquest held between 1 and 12 June 2026, the coroner concluded that Mr Smith died from hypoxic ischaemic brain injury and lower respiratory tract infection, caused by prolonged cardiorespiratory arrest, following suspension by a ligature.
124. The coroner found that the failure to respond to Mr Smith's emergency cell bell caused a significant delay in him receiving life-saving care. They noted that prior to his death, unsatisfactory prison protocols, including inadequate communication and information sharing between prison staff and healthcare, as well as inconsistencies of shift handovers, contributed to a lack of awareness of Mr Smith's risks and specific vulnerabilities.
125. The coroner concluded that Mr Smith's death was misadventure, contributed to by neglect because of gross failure to respond to his cell bell.

Findings

Assessment of Mr Smith's risk

126. Prison Service Instruction (PSI) 64/2011 on safer custody which was in place at the time of Mr Smith's death (since replaced by the Prison Safety Framework, which contains broadly similar guidance) requires that all staff who have contact with prisoners are aware of the risk factors and triggers that might increase the risk of suicide and self-harm and manage prisoners identified as at risk under ACCT procedures. The PSI lists risk factors and states that potential triggers should be continually assessed. In addition to the case coordinator and healthcare staff, staff who support the prisoner must be invited to and attend ACCT case reviews.
127. Mr Smith arrived at Bristol with a number of risk factors: he was just 18 years old; it was his first time in prison, and he had recently had two bereavements. He struggled with substance misuse and had a recent history of suicide attempts and self-harm. His behaviour was unstable and changeable and prison intelligence suggested he was being bullied and threatened by other prisoners.
128. Mr Smith was managed twice under ACCT procedures. A SO appropriately began ACCT procedures on 1 January 2024. He proactively helped Mr Smith access support from his family. He knew that Mr Smith had no phone credit and facilitated phone calls to Mr Smith's girlfriend and mother from the wing office.
129. The SO told us that he initially assessed that Mr Smith needed to be under constant supervision. However, after Mr Smith spoke to his girlfriend, he appeared more settled. The ACCT record noted that Mr Smith engaged with peers and cleaned his cell. He told the SO he had no thoughts of self-harm or plans to end his life and was future-orientated. The SO appropriately considered whether Mr Smith needed constant supervision. He thoroughly assessed Mr Smith's risk and reached a reasonable decision to set observations at intervals of three per hour. He also appropriately considered whether anti-ligature measures (such as removing items from Mr Smith's cell) were needed. As constant supervision was not assessed as necessary, the decision not to use anti-ligature measures was reasonable.
130. However, we note that Mr Smith had a court appearance on 3 January. Court appearances are recognised to increase the risk of suicide and self-harm and staff involved in his ACCT from 1 January had not apparently logged the significance of the date.
131. Mr Smith had previously been monitored under ACCT procedures in November 2023. There were some aspects that were managed well. Prison staff appropriately began ACCT procedures after Mr Smith self-harmed. The immediate action plan detailed support to keep Mr Smith safe overnight. The plan identified concern about Mr Smith's lack of phone credit and his debt. The assessor appropriately liaised with the safer custody team and an officer to put plans in place to help him. The ACCT key information was comprehensive and appropriately identified concerns impacting Mr Smith's wellbeing.
132. Staff worked hard to respond to Mr Smith's changing requests and needs. Mr Smith was moved five times (on three different wings) during the nine days he was

supported under ACCT procedures. Prison staff acted swiftly in response to Mr Smith's threats to kill his cellmate on 24 November 2023, and after he told staff he felt unsafe. Staff acted appropriately and carefully balanced the safety and needs of Mr Smith and other prisoners. These decisions were measured and reasonable.

133. The ACCT care plan identified most of Mr Smith's risk factors, triggers, and protective factors. However, some aspects were not sufficiently detailed. Mr Smith's family support was limited and inconsistent due to lack of social visits and phone credit (his family had refused to visit after he was placed on closed visits and Mr Smith apparently had little money to spend on phone calls). The care plan did not adequately capture Mr Smith's risk: it was not updated during reviews, contained only one action, and did not reflect issues relating to Mr Smith's substance misuse or mental health.
134. During ACCT reviews, Mr Smith raised concerns about his safety and drug use. Although he often made clear statements that he had no intention of hurting himself again, there was overwhelming evidence to suggest otherwise and at times, too much weight was given to Mr Smith's statements that he would not harm himself. Observations were lowered on the expectation that plans to move Mr Smith would reduce his risk rather than after a period of monitoring and support during these transitions.
135. While there was some good practice in caring for Mr Smith, we consider that further focus is required to ensure that ACCT care plans are improved, and we make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide and self-harm in line with the Prison Safety Policy Framework, in particular that ACCT care plans are meaningful and actioned and that observations are set in line with the prisoner's risk.

Co-ordination and communication

136. Several forums tried to support Mr Smith. He was discussed at CSIP, SIM and ACCT reviews. He was engaged with the substance misuse team and known to the mental health team. The regular discussions about how to support him often took place in isolation of each other which meant staff did not always get a full picture of Mr Smith's risk in the absence of key information. For example, during the SIM on 29 November 2023, there was apparently no discussion about Mr Smith being in the ACCT post-closure period.
137. When actions and decisions were made, there appeared to be a lack of co-ordination and communication between departments. This at times led to contradictory plans and messages being given to Mr Smith. For example, during his time on A Wing, a CM told the investigator he fought for him to remain on the wing as his cousin was there to support him. This was reflected in the ACCT review on 21 November 2023. However, when discussed at the SIM shortly afterwards, a plan was discussed to move him to G Wing, where there were believed to be fewer drugs available.

138. Mr Smith had three recorded keywork sessions out of a possible 14 which should have been offered. Each session was with a different officer. Regular sessions with a consistent keyworker may have offered him the support he needed.

Emergency cell bell response

139. PSI 10/2011 on residential services requires staff to respond promptly to calls for assistance. Bristol Residential Services Strategy dated November 2023 sets an expectation that staff provide a 'timely response' to all emergency cell bells. A Local Notice to Staff (LNTS) reiterated that staff must do everything reasonably possible to answer cell bells as soon as possible and within five minutes.
140. The emergency cell bell panel (on the wall behind where staff sit in the wing office) lights up and sounds when prisoners press their cell bell. It shows the exact location of the cell. When more than one cell bell is active at the same time, the panel shows all active cells on rotation every few seconds.
141. Cell bell records show that from 2.39am until around 4.10am on 2 January, two prisoners in another cell constantly pressed their cell bell. The OSGs on night duty appropriately reported this to the control room and recorded it in the wing observation book. After this point, the two OSGs did not respond to the prisoners in the other cell. Mr Smith pressed his cell bell at 4.11am. OSG B told us she only saw one cell showing as having an active cell bell on the panel. She did not know which cell it related to. The OSGs did not respond to Mr Smith's cell bell.
142. Staff had told Mr Smith to press his cell bell if he felt he could not keep himself safe. It is, of course, impossible to know whether the outcome for Mr Smith would have been different had staff responded more promptly to his cell bell that night.
143. Our investigation found that staff understood expectations about responding to cell bells. We conclude that OSG A also understood his responsibilities as evidenced by him responding numerous times to other cell bells that night in a timely manner.
144. OSG A was absent from work for the duration of the investigation and was not interviewed. OSG B told us she only saw one cell number on the panel and thought it was the cell of the prisoners who had been misusing their cell bell. She said that if she had seen a different cell number, she would have told OSG A to check it.
145. The police investigated the staff's failure to respond to Mr Smith's cell bell and took no further action. OSG A's actions were subject to an internal prison investigation, and he was dismissed. OSG B's actions were also investigated. She resigned before the investigation concluded.
146. Since Mr Smith's death, Bristol have undertaken work to improve cell bell management and in light of the progress made we make no recommendation.

Emergency response

147. PSI 24/2011 National Security Framework, Management and Security of Nights requires night staff to be fully briefed and trained in local incident contingency plans. At Bristol, the night deputy manager is responsible for collecting healthcare staff in an emergency.

148. On 2 January, there was a lack of clarity about who was responsible for collecting healthcare staff (who do not carry keys) in an emergency. This led to a delay in healthcare staff arriving at Mr Smith's cell. An officer told us he had not done a night shift at Bristol before and had not received a full briefing. He thought the night manager was responsible for collecting healthcare staff. Since Mr Smith's death, the prison has reviewed healthcare staff's access to all keys overnight and concluded they will not be issued keys. The prison has issued communication to all staff clearly stating the responsibilities of the night managers to collect healthcare staff in an emergency.

Clinical care

149. The clinical reviewer concluded that Mr Smith's care was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She noted the excellent emergency care healthcare provided to Mr Smith on 2 January.
150. The clinical reviewer considered that the mental health team could have had more involvement in regularly reviewing Mr Smith, especially after his ligature attempts. The clinical reviewer made two recommendations, both of which were not related to Mr Smith's death, but which the Head of Healthcare will need to address.
151. While the coroner concluded Mr Smith ultimately died following suspension by a ligature and there were no post-mortem toxicology results to establish if he had used drugs that day, his substance misuse was prolific during his time at Bristol. Officers acted on intelligence about the ingress of drugs, and he also received good care from the substance misuse team. We note there have been no drug related deaths at Bristol since September 2020.
152. The clinical reviewer identified good practice in the substance misuse practitioner's work with Mr Smith.

Access to phone calls

153. Mr Smith, a young man in prison for the first time with some serious vulnerabilities, struggled to manage his phone credit. This meant that his contact with his family and partner – all identified as important sources of support – was limited at times and an additional source of stress.
154. There is strong evidence to support family contact as a protective factor against suicide and self-harm. The Ombudsman has been concerned for some time that the system for prisoner phone calls is sub-optimal and that governors should have greater freedom to allocate phone call minutes to prisoners without them being concerned about the cost. It is crucial that prisoners in crisis can speak to their families. We urge the Director General of HMPPS to take action to resolve the inequalities of phone access for prisoners.

Governor to note

155. PSI 64/2011 required prisons to have procedures in place to inform a prisoner's next of kin or nominated person when a prisoner's physical health unpredictably and/or rapidly deteriorates.

156. Mr Smith's mother rang the prison concern telephone line at 8.40am, already aware that Mr Smith was in hospital. (We do not know who told her but know that members of Mr Smith's family were also at Bristol at the time.) The prison had not yet contacted her some three hours after Mr Smith left the prison in an ambulance and clearly in a serious condition. The Governor should consider the learning from this investigation and ensure that robust procedures are in place to swiftly contact the next of kin when a prisoner is seriously unwell, in line with policy.

Good practice

157. There are several examples of prison staff responding quickly to Mr Smith's requests to move wings, landings and to be closer to family members. They tried to mitigate his risk from other prisoners and vulnerability to drug use. For example, following his ACCT review on 24 November 2023, he was moved to C Wing within twenty minutes. During his time on G wing, he was moved to the fourth floor to be nearer a relative.
158. A SO developed a positive working relationship with Mr Smith. He spent quality time with him on 1 January 2024 to understand his worries. He gave Mr Smith supervised use of the office phone so he could access his external support network.
159. The substance misuse practitioner regularly and consistently worked with Mr Smith on his substance misuse. During her care planning and welfare meetings, she carefully considered all factors relevant to his behaviours and thought broadly about how they interacted with his drug use. She gave Mr Smith materials which she reviewed with him. She raised concerns with the mental health team and chased referrals.

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