Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Ryan, a prisoner at HMP Bristol, on 29 January 2023

A report by the Prisons and Probation Ombudsman

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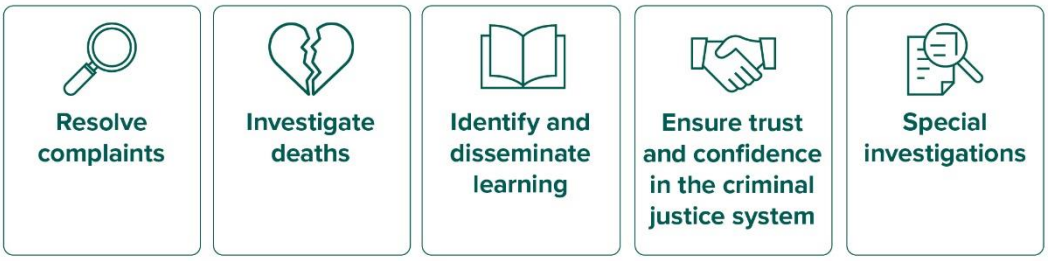
OUR VISION

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

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.

Mr Colin Ryan was found hanging in his cell at HMP Bristol on 29 January 2023. Staff and paramedics tried to resuscitate him but were unsuccessful. Mr Ryan was 53 years old. I offer my condolences to Mr Ryan's family and friends.

Mr Ryan's death was the fifth self-inflicted death at Bristol in three years. There have been four self-inflicted deaths since.

Mr Ryan had threatened suicide if remanded to prison and was being monitored under suicide and self-harm prevention procedures (known as ACCT). He should have been checked three times an hour but had not been checked for over an hour when he was found hanging. The officer responsible for the missed checks resigned from the Prison Service before disciplinary action could be taken against him.

Previous investigations at Bristol have found that ACCT checks were not always being carried out properly. Last year, the Acting Ombudsman escalated concerns to the Prison Group Director about this issue and the poor management of ACCT in general at Bristol. I understand that due to the number of self-inflicted deaths at Bristol in the last 12 months, the prison has been receiving additional support and training on managing suicide and self-harm monitoring procedures. The Prison Group Director needs to satisfy himself that these measures have addressed the ongoing issues.

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 **July 2024**

Contents

Summary

Events

1. On 28 January 2023, Mr Colin Ryan was remanded in prison, charged with threatening behaviour, and sent to HMP Bristol. He arrived at around 3.30pm.

2. Mr Ryan had threatened to kill himself if remanded to prison. Reception staff at Bristol started suicide and self-harm monitoring (known as ACCT) as soon as he arrived. They set observations at three an hour.

3. Staff checked on Mr Ryan three times an hour until 7.43am on 29 January. This was the last recorded ACCT check.

4. At around 8.50am, an officer went to Mr Ryan's cell to carry out an ACCT check. The officer could not see Mr Ryan when she looked through the observation panel. She tried to get a response from him, but when he failed to respond, she entered the cell. She found him slumped on the floor with a ligature tied around his neck and attached to the window.

5. Staff cut the ligature and started CPR, which was continued by ambulance paramedics when they arrived. However, resuscitation attempts were unsuccessful and at 9.23am, paramedics pronounced that Mr Ryan had died.

Findings

6. Staff correctly started ACCT procedures when Mr Ryan arrived at Bristol. We consider that three observations an hour was a reasonable frequency and in line with Mr Ryan's assessed risk.

7. The officer responsible for failing to do the ACCT checks was suspended pending an investigation, but he resigned before disciplinary action could be taken.

8. We have raised concerns about the failure to carry out and record ACCT observations properly in two previous investigations into deaths at Bristol in 2020 and 2021. Despite being told that measures had been taken at Bristol to improve quality assurance of ACCT, including checking that ACCT observations are carried out as agreed, we have again found issues with this aspect of ACCT management.

9. There have been four further self-inflicted deaths at Bristol since Mr Ryan's death which has resulted in the prison receiving further support and training on ACCT management from HMPPS headquarters. Senior managers will need to review and monitor the impact of this additional support to satisfy themselves that the measures have addressed the ongoing issues with poor ACCT management.

Recommendations

- The Prison Group Director for Avon, South Dorset and Wiltshire should satisfy himself that meaningful improvements have been made to the management of ACCT procedures at Bristol.

The Investigation Process

10. HMPPS notified us of Mr Ryan's death on 29 January 2023.

11. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Ryan's prison and medical records.

13. The investigator interviewed seven members of staff between 23 March and 26 April.

14. NHS England commissioned an independent clinical reviewer to review Mr Ryan's clinical care at the prison. She jointly conducted all but one of the interviews.

15. We informed HM Coroner for Avon of the investigation. He provided us with the toxicology report but has not yet provided us with the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Ryan's next of kin, his parents, and also his ex-partner and son, to explain the investigation and to ask if they had any matters they wanted us to consider. The solicitor representing Mr Ryan's ex-partner and son asked questions about Mr Ryan's healthcare which are addressed in the clinical review report.

17. We shared our initial report with HMPPS. They found no factual inaccuracies. They provided an action plan which is annexed to this report.

18. We sent a copy of our initial report to Mr Ryan's parents and to the solicitor representing Mr Ryan's ex-partner and son. The solicitor responded with a query about the contents of one of the interview transcripts, which said that there was a note in Mr Ryan's cell. This had been incorrectly transcribed and has been corrected.

Background Information

HMP Bristol

19. HMP Bristol serves the local courts and holds up to 614 adult men. Oxleas NHS Foundation Trust provides healthcare services and Doctor PA provides GP services. Change, Grow, Live (CGL) provides non-clinical substance misuse services.

HM Inspectorate of Prisons

20. The most recent full inspection of HMP Bristol was in June 2019. Inspectors reported that levels of self-harm had increased and were far higher than at most other local prisons. Incidents of self-harm were not routinely investigated to understand the underlying causes and there was not an effective strategy to reduce levels of self-harm. Important recommendations from PPO reports into recent self-inflicted deaths had not been implemented effectively. Inspectors found that the number of prisoners being supported using suicide and self-harm procedures (ACCT) was extraordinarily high, which compromised the quality of care given.

21. HMIP carried out a Scrutiny Visit at Bristol in September 2020. Inspectors reported that the ACCT management had been transformed since their last inspection. ACCTs were now used more appropriately, and few prisoners were left on open ACCTs for long periods. Prisoners they spoke to who were on ACCT felt well supported. The quality of ACCT documentation had improved but some were still below standard. They found poor care plans, reviews that were not sufficiently multidisciplinary and entries that were predictable and repetitive. The prison was aware of this and implementing measures to improve the quality of entries.

Independent Monitoring Board

22. 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 31 July 2022, the IMB reported that incidents of self-harm had reduced, and the number of prisoners supported by ACCT had fallen. Prisoners at risk of suicide and self-harm were monitored weekly.

23. The IMB reported that the prison's health provision was good and appeared commensurate with that available in the community.

Previous deaths at HMP Bristol

24. Mr Ryan was the eighth prisoner to die at Bristol since January 2020. Of the previous deaths, four were self-inflicted, one was drug related and two were from natural causes. There have been four self-inflicted deaths since Mr Ryan's death. As there have been six self-inflicted deaths at Bristol in the past 12 months, the prison is receiving additional support and monitoring from HMPPS headquarters.

25. In previous investigations, we raised concerns about the quality of ACCT management at Bristol, including not carrying out ACCT observations properly.

Despite Bristol having introduced measures in 2020 to improve ACCT procedures, we continued to raise the same concerns and recommended that the Prison Group Director for Avon, South Dorset and Wiltshire should write to the Ombudsman setting out what was being done to improve ACCT management at Bristol. He responded in January 2023 and set out a range of measures including training and quality assurance.

Assessment, Care in Custody and Teamwork

26. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

27. As part of the process, a care plan (plan of care, support and intervention) is put in place. The ACCT should not be closed until all the actions on the care plan have been completed. 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.

Key Events

28. On 28 January 2023, Mr Colin Ryan was remanded in prison charged with threatening behaviour. He was sent to HMP Bristol. He had been in prison before but not for over 25 years.

29. Mr Ryan arrived at Bristol at around 3.30pm. Mr Ryan's Person Escort Record (PER – a document that accompanies the prisoner between police custody, courts and prisons which sets out the risks they pose) said that Mr Ryan had threatened to kill himself if remanded. An officer started suicide and self-harm procedures (known as ACCT) and set observations at three an hour.

30. A nurse carried out the reception health screen. She recorded that Mr Ryan said he did not want to see her as he would be dead by the end of the week. She recorded that he was high risk (for cell sharing) due to his bizarre behaviour and should be reviewed in two days' time. She noted that he showed some signs of self-harm but gave no further details in the medical record. At interview, she said that she saw cuts on Mr Ryan's arms, which she believed he had made during his transfer from court. She offered to treat his wounds, but he declined. This information was not recorded.

31. A supervising officer (SO) completed the Immediate Action Plan. She noted that Mr Ryan said he had lost his mind with his neighbour and gone mad with an axe. He thought he would get four years and that it would make or break him. He was struggling to come to terms with being in prison. She kept observations at three an hour and scheduled a case review for the next day.

32. An officer who was also working in reception that day had concerns about Mr Ryan's presentation, so he contacted the mental health team. He spoke to a crisis support worker, and said they had someone in reception behaving strangely. Once the SO confirmed that Mr Ryan was on an ACCT, the crisis support worker said that someone from the mental health team would attend the case review the next day.

33. The crisis support worker phoned the Bristol Crisis Team to find out if they had any information about Mr Ryan. They said he had a diagnosis of personality disorder and had had minimal engagement with the community team.

34. Mr Ryan was offered a phone call, but he refused. He was allocated a single cell on the induction wing.

35. During an ACCT check shortly after 8.00pm, Mr Ryan told an operational support grade (OSG) that he felt he had let his parents down. The OSG offered Mr Ryan the opportunity to speak to Listeners (prisoners trained by the Samaritans to offer support), which Mr Ryan accepted, and two Listeners were brought to his cell. Conversations with Listeners are confidential, so we do not know the contents of their discussion.

Events of 29 January

36. On 29 January, the OSG checked on Mr Ryan throughout the night and recorded that he had not slept.

37. The ACCT document shows that Mr Ryan was checked three times an hour until 7.43am. This was the last check recorded in the ACCT document.

38. Officers started the day shift at 8.30am. A SO said she briefed officers about the ACCTs on the wing, and at around 8.50am, staff began to unlock prisoners for the morning regime.

39. An officer started her ACCT checks shortly after 8.50am. Mr Ryan was the first person she checked. When she got to his cell, she looked through the observation panel but could not see him. The light in the cell was on, so she tried to get a response. When she got no response, she entered the cell.

40. The officer saw Mr Ryan slumped on the floor in the toilet area of the cell. He had a ligature tied around his neck and attached to the window. She left the cell to see if any other officers were nearby and called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties).

41. The officer said she tried to cut the ligature, but it was too thick. She was joined by a SO and another officer. The SO and officer cut the ligature and started CPR.

42. Paramedics arrived at around 9.05am and took over resuscitation attempts. However, these were unsuccessful. At 9.20am, they pronounced that Mr Ryan had died.

Contact with Mr Ryan's family

43. The prison appointed an officer as the family liaison officer on 29 January. At 12.30pm, she visited the home of Mr Ryan's parents and told them of their son's death.

44. The prison offered a contribution towards the funeral costs in line with national guidance.

Support for prisoners and staff

45. After Mr Ryan's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

46. The prison posted notices informing other prisoners of Mr Ryan's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Ryan's death.

Post-mortem report

47. The Coroner has told us that the final post-mortem report is not yet available. The toxicology report shows that Mr Ryan had no drugs or alcohol in his system when he died.

Findings

Management of Mr Ryan's risk of suicide and self-harm

48. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide or self-harm.

49. Staff correctly started ACCT procedures for Mr Ryan when he arrived at Bristol on the afternoon of 28 January. He died the next morning before the scheduled case review had taken place, so staff had not had the opportunity to put a care plan in place.

50. Staff had set ACCT observations at three an hour, which was reasonably high (the highest frequency is four times an hour and then constant supervision). We consider this was an appropriate frequency and in line with Mr Ryan's assessed risk.

51. Staff carried out the required observations until 7.43am on 29 January, but then they stopped. Mr Ryan was discovered at around 8.50am so there was a period of around an hour when he was not checked. The prison suspended the officer responsible and started an investigation, but he resigned from the Prison Service before a disciplinary hearing could take place.

52. In a previous investigation into a death at Bristol in May 2020, we found that ACCT checks were not being completed correctly. In response to our recommendation, we were told that daily assurance checks were now completed to ensure that observations were taking place in line with the agreed level set out in the ACCT document.

53. We found a similar issue in a subsequent investigation into a death at Bristol in December 2021. We were told that the custodial manager responsible for safety now quality assured 50% of all ACCT documents opened within a calendar month, which included checking that observations and conversations had been recorded as expected. We also made a recommendation to the Prison Group Director for Avon, South Dorset and Wiltshire asking him to write to the Ombudsman setting out what was being done to improve ACCT procedures at Bristol. He told us that Bristol carried out various quality assurance measures to improve the quality of ACCT delivery and that all the operational Senior Management Team were involved in the ACCT quality assurance process.

54. However, both our investigation into Mr Ryan's death and our investigation into another death at Bristol in November 2022, found that there continue to be issues with the management of ACCT procedures at Bristol. We recommend:

    The Prison Group Director for Avon, South Dorset and Wiltshire should satisfy himself that meaningful improvements have been made to the management of ACCT procedures at Bristol.

Clinical care

55. The clinical reviewer found the care Mr Ryan received at Bristol was of the standard reasonably expected and therefore equivalent to that which he could have expected to receive in the community.

56. However, she made several recommendations about record keeping, communication and safety planning, which the Head of Healthcare will need to address.

Inquest

57. At the inquest, held from 15 to 26 September 2025, the jury concluded that Mr Ryan died by suicide. They found that his death had been contributed to by neglect due to the failure to carry out ACCT observations between 7.43am and 8.50am on 29 January 2023.

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