

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mark Bradley, a prisoner at HMP Stafford, on 17 August 2022

A report by the Prisons and Probation Ombudsman

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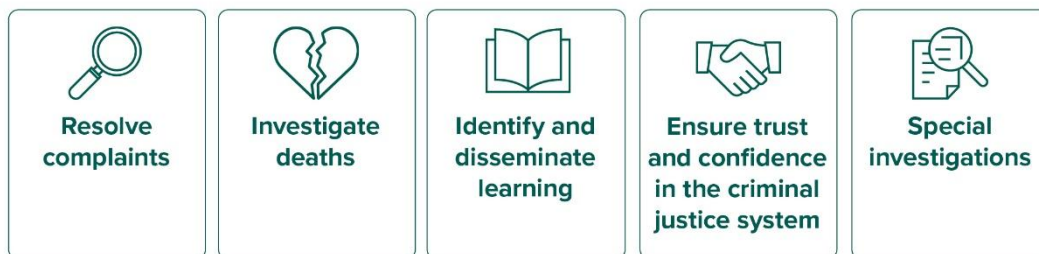
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OUR VISION

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 best to assist HMPPS in ensuring the standard of care received by those within service remit is appropriate, then our recommendations should be focussed evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Mark Bradley was found hanged in his cell on 17 August 2022 at HMP Stafford. He was years 53 old. I offer my condolences to Mr Bradley's family and friends.

Mr Bradley was serving an indeterminate sentence for public protection (IPP). He was first released in 2013, three years and three months past his minimum tariff of 578 days. He was recalled to prison in 2016 and then released and recalled a further four times, the last time on 4 August 2021. In September 2022, the Justice Committee found that IPP sentences cause acute harm to those subject to them, with the prospect of serving a sentence without an end date causing higher levels of self-harm as well as a lack of trust in the system that is meant to rehabilitate them. The Committee also highlighted the "recall merry go round" with almost half of IPP prisoners having been released previously. Mr Bradley's story serves to illustrate these concerns.

Mr Bradley's was the first self-inflicted death at Stafford since 2012. In his most recent report, His Majesty's Inspector of Prisons (HMIP) found that the integrated psychosocial substance misuse and mental health team provided effective care coordination for prisoners with complex needs. Mr Bradley's care at Stafford illustrated this and demonstrated effective partnership working with operational staff. Overall, he was well-managed by Prison Service suicide and self-harm monitoring procedures (ACCT) during periods of crisis, and I did not find evidence that he was at imminent or heightened risk of suicide in the period leading to his death.

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

June 2026

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Summary

Events

1. Mr Bradley had a history of attempted suicide and self-harm, anxiety and depression. In 2008 he was given an indeterminate sentence for public protection (IPP) with a minimum time to serve of 578 days. He was released in 2013 but recalled to prison in 2016. He was then released and recalled a further four times, the last time on 4 August 2021 to HMP Hewell.
2. On 8 December 2021, the Parole Board directed Mr Bradley attend an oral parole hearing in June 2022. On 21 December 2021, he transferred to HMP Stafford.
3. In February 2022, Mr Bradley agreed to work with Midlands Integrated Therapy Service (MITS) to try to break the cycle of his release and recall to prison. The nature of this service meant that work could not start until after his parole hearing in June 2022.
4. Mr Bradley worked regularly with a mental health nurse and psychosocial recovery worker from the prison's Inclusion team. He also worked closely with his prison offender manager (POM).
5. Mr Bradley was managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) between 17 May and 9 June 2022 and 17 June and 6 July 2022 after he said he felt suicidal.
6. On 16 June, he attended his oral parole hearing. He was aware that none of the reports requested by the Parole Board supported his release and all those involved with his care shared the view that he should complete therapy with MITS before being considered for re-release.
7. On 30 June, Mr Bradley was informed that the Parole Board had decided he should remain in prison to complete further risk reduction work.
8. In July 2022, Mr Bradley began working in the prison's Restart workshop. He enjoyed the work and was saving money to buy new clothes. On 10 August, he was able to reflect positively on the progress he had made.
9. On 17 August, Mr Bradley was found hanged in his cell. Rigor mortis was present, and he was not given cardio-pulmonary resuscitation. Paramedics attended and confirmed that he had died.

Findings

10. Mr Bradley had a significant number of risk factors that indicated that he was at high risk of suicide and self-harm and his mental health meant that his risk fluctuated according to context but was never absent.
11. Mr Bradley received a high standard of care at Stafford from a multi-disciplinary team showing effective partnership working.

12. Overall, he was well-managed by Prison Service suicide and self-harm monitoring procedures (ACCT) during periods of crisis. ACCT monitoring should have continued on 9 June until after Mr Bradley's parole hearing on 16 June. This did not affect the outcome for him but is a learning point for the prison. An ACCT post-closure review did not take place on 13 July as it should have done.
13. We did not find any evidence that Mr Bradley was at imminent or heightened risk of suicide in the days leading to his death.
14. During the night he died, Mr Bradley obscured his observation panel. CCTV indicated that the night patrol officer was unable to see through the observation panel to satisfy himself that Mr Bradley was alive and well during his roll check.
15. Mr Bradley had signs unequivocally associated with death when he was found, and prison nurses were correct not to begin cardio-pulmonary resuscitation.
16. The nature of the emergency was not effectively communicated to the Ambulance Service, and this resulted in the call being wrongly triaged. This did not affect the outcome for Mr Bradley.
17. The clinical care received by Mr Bradley was at least equivalent to that he could have expected in the community.

Recommendations

18. We make no recommendations. However, the Governor should note the following learning points for the prison:
 - ACCT documents should not be closed in the run up to events associated with an identified trigger.
 - The nature of the emergency was not effectively communicated to the Ambulance Service, and this resulted in inappropriate triage of the call.

The Investigation Process

19. We were notified of Mr Bradley's death on 17 August. The investigator issued notices to staff and prisoners at HMP Stafford informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
20. The investigator obtained copies of relevant extracts from Mr Bradley's prison and medical records. She requested CCTV of the week leading to Mr Bradley's death was in August. CCTV from between 4.00am and 7.15am on the morning Mr Bradley was found was received in November. Further information was provided by West Midlands Ambulance Service, the Deputy Governor of Stafford and the personal assistant to the West Midlands Prison Group Director.
21. NHS England and NHS Improvement (NHSE&I) commissioned a clinical reviewer to review Mr Bradley's clinical care at the prison. The interviewer and clinical reviewer interviewed eight members of staff at Stafford in November 2022. The investigator spoke to three staff by telephone.
22. We informed HM Coroner for Staffordshire of the investigation. The coroner did not request a post-mortem examination. We have sent the coroner a copy of this report.
23. The Ombudsman's family liaison officer contacted Mr Bradley's brother to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Bradley's brother said he had received letters from Mr Bradley that were angry in tone and in which he spoke about killing himself. He asked:
 - Why was Mr Bradley recalled to prison, and why was he transferred to Stafford?
 - Was Mr Bradley on suicide watch (and if not, why not)?
 - Did Mr Bradley have difficulty with any staff or prisoners at Stafford?
24. We have answered the first two questions in the body of the report. We did not find any evidence that Mr Bradley had difficulty with any staff or prisoners during his time at Stafford.

Background Information

HMP Stafford

25. HMP Stafford is a medium security training prison for adult male prisoners convicted of sexual offences. It holds about 750 prisoners, over half of whom are aged over 50. Healthcare is provided by Practice Plus Group (PPG). Mental healthcare and psychosocial substance misuse services are sub-contracted to Inclusion.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Stafford was in 2020. Inspectors reported a safe, calm and well-ordered prison. Levels of self-harm were lower than most similar prisons. The weekly safety intervention meeting (SIM) provided a good forum to monitor individual prisoners. The quality of suicide and self-harm monitoring delivered through the ACCT process was mostly good. There was easy access to psychosocial substance misuse support and integrated working with the mental health team resulted in effective care coordination for prisoners with complex needs. The mental health team was well integrated into the prison, attended the SIM and contributed consistently to ACCT reviews. Over 90% of staff had received mental health awareness training.

Independent Monitoring Board

27. 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 April 2022, the IMB reported that their main concern was inefficient medicines management. Despite that most comments the IMB received about mental and physical healthcare were positive.

Previous deaths at HMP Stafford

28. Mr Bradley's was the first self-inflicted death at HMP Stafford since 2012. In that investigation we also found that the ACCT post-closure review was not held, although the circumstances were slightly different.

IPP

29. Indeterminate public protection (IPP) sentences were abolished in 2012. They were intended to protect the public against offenders whose crimes were not serious enough to merit a normal life sentence, but who could only be released once they had served their minimum tariff and had demonstrated to the satisfaction of the Parole Board that they had sufficiently reduced their risk.
30. As of June 2022, there were 2,926 IPP prisoners, of which 1,492 have never been released and 1,434 have been recalled to custody.

Parole Board

31. The Parole Board for England and Wales is an independent public body. Its role is to make risk assessments about prisoners to decide whether they can safely be released into the community once they have served the minimum term imposed by the courts.

Assessment, Care in Custody and Teamwork

32. 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. 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.
33. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

34. Mr Mark Bradley had a history of alcohol misuse, anxiety and depression. On 18 June 2008, Mr Bradley was sentenced to an indeterminate sentence for public protection (IPP). He was given a tariff of 578 days (the minimum he would have to spend in prison before he could be released).
35. Mr Bradley was managed under Prison service suicide and self-harm monitoring procedures (known as ACCT) on several occasions. He reported frequent suicidal thoughts and attempts to kill himself. He also self-harmed by making superficial cuts.
36. Mr Bradley was released from prison and recalled five times between April 2013 and 4 August 2021, when he was returned to HMP Hewell. On each occasion he was recalled for failing to comply with the conditions of his release by drinking alcohol and not maintaining contact with the Probation Service. He did not re-offend.
37. On 8 December 2021, the Parole Board requested an addendum report from Midlands Psychology Service and directed Mr Bradley attend an oral parole hearing in June 2022. On 21 December 2021, Mr Bradley transferred from Hewell to HMP Stafford as part of standard sentence progression from a local prison to a training prison where he would have greater access to programmes designed to help him to work towards release and rehabilitation.

HMP Stafford

38. A nurse identified at an initial health assessment that Mr Bradley had a history of anxiety, depression, self-harm and suicidal thoughts. Mr Bradley said he had been working on his alcohol misuse with the substance misuse team at Hewell. He said he was prescribed mirtazapine (an anti-depressant) but had stopped taking it a couple of weeks previously as he thought it was not working anymore. He referred Mr Bradley to the Inclusion team for assessment and to the GP for a medication review.
39. Mr Bradley was assessed on 24 December and allocated him to a psychosocial recovery worker.
40. On 4 January 2022, the psychosocial recovery worker held a 1:1 session with Mr Bradley on his wing. Mr Bradley was angry and frustrated at his recall to prison. He said he felt persecuted by his IPP sentence, badly managed in the community and overwhelmed by the injustice of his situation. They discussed his alcohol misuse and possible coping strategies. Mr Bradley agreed to a referral to the psychiatrist to discuss medication to help support him.
41. The next day Mr Bradley told the psychosocial recovery worker that he was worried that seeing the psychiatrist would be used as a reason to keep him in prison and that he would rather see the GP. She reassured him that he did not have to see the psychiatrist if he did not want to and that he was on the list for a medication review with the GP service.

42. On 6 January, a prison GP reviewed Mr Bradley's medication with him. Mr Bradley said he had anxiety and depression and was very frustrated with his IPP sentence. He said he had been on mirtazapine for years and thought it had stopped working for him. He was willing to re-try sertraline (another anti-depressant) and the GP prescribed it for him.
43. The same day, the psychosocial recovery worker contacted Mr Bradley's prison offender manager (POM) for more information about him. She said she had received two applications from Mr Bradley one asking for contact and one saying he did not.
44. The POM replied on 12 January and included email correspondence from Mr Bradley's community offender manager (COM). The COM said he was due to have a personality disorder consultation about Mr Bradley as he wanted to try to break the "persistent cycle of recalls" that Mr Bradley had fallen into through non-compliance with the terms of his licence.
45. The next day the psychosocial recovery worker saw Mr Bradley together with a mental health nurse. The recovery worker said she had asked for support from a mental health nurse because she was concerned about Mr Bradley's mental state and thought he might have a personality disorder (he was never diagnosed with a personality disorder and his medical records showed a previous assessment by a psychiatrist had found he did not have one). Mr Bradley was again very angry and frustrated about his IPP sentence and recalls to prison. The recovery worker and the nurse agreed to have four structured sessions with him starting in mid-February, focussed on anxiety and emotional regulation.
46. The psychosocial recovery worker saw Mr Bradley again on 27 January. He said the sertraline was helping with his over-thinking, but he was sleeping badly and still felt depressed and unmotivated. Mr Bradley scored 20 on the generalised anxiety disorder assessment (GAD-7 – showing severe anxiety) and 21 on patient health questionnaire nine (PHQ9 – showing severe depression).
47. On 9 February, a nurse prescriber reviewed Mr Bradley's sertraline and increased the dose from 50mg to 100mg.
48. On 11 February, a trainee psychologist completed the psychological risk-assessment requested by the Parole Board. She said Mr Bradley engaged well and was open to the idea of working with Midlands Integrated Therapy Service (MITS) on managing his feelings about his sentence. (One of the eligibility criteria for this service is that the prisoner must not be due for release, therefore Mr Bradley's therapy could not start until after his parole hearing in June 2022.)
49. In her report, the trainee psychologist said she thought Mr Bradley's thoughts of suicide had increased to 'strongly present' in the previous 12 months because of his history of self-harm when recalled to prison. She said he had unresolved trauma from his prison experience and problems accepting his IPP sentence. She said Mr Bradley would benefit from therapy with MITS to reduce his risk of relapsing and being recalled to prison. As an IPP prisoner he would be prioritised for treatment, but she was unable to say when this was likely to start. She said in her opinion it was essential for the work with MITS to be completed before Mr Bradley was released again.

50. On 15 February, Mr Bradley's sertraline was reduced back to 50mg after he complained the increase had made him unwell. The next day he attended the first of the four planned sessions with the psychosocial recovery worker and mental health nurse. Mr Bradley's anxiety score had reduced to 14 and he said the sertraline was helping him. He was visibly calmer and more able to focus. He said he felt less angry and that his sense of humour was returning. He showed good reflection on what he could have done better in the lead up to his most recent recall. Mr Bradley said he was enjoying distraction materials provided to him and asked if it was possible to have in-cell education.
51. The trainee psychologist disclosed her report to Mr Bradley on 17 February. She said he remained polite but appeared upset with his experience of professionals throughout his sentence. He was frustrated with probation services and said he felt there was no hope for successful parole and did not want to engage with his oral parole hearing. She walked back with Mr Bradley to his wing and said he seemed in better spirits. She wrote an entry in the wing observation book to let staff know he had been upset.
52. On 22 February, Mr Bradley wrote a wing application saying he did not want any further contact with the Inclusion team, offender management, probation services and the Parole Board and that the prison could "throw away the key". He also wrote two letters to the prison psychology department accusing them of conspiring with the probation service to exploit the IPP sentence.
53. The senior prison psychologist visited him the same day in response. Mr Bradley said he had written the letters when he thought that his parole hearing would not go ahead until the completion of his MITS therapy. His solicitor had since told him this was not the case. He asked her to disregard his letter and rejected her offer to arrange for the trainee psychologist to see him. He said his IPP sentence was "horrendous", but he was not losing hope. She said he was calm and polite and denied feeling suicidal.
54. On 23 February, Mr Bradley attended his second session with the psychosocial recovery worker and the mental health nurse. Mr Bradley was tense and "inappropriately challenging" to the nurse. He complained that another prisoner had been playing loud music and this had triggered traumatic memories from a previous prison. The nurse added him to the nurse triage list for investigation of his sensitivity to noise.
55. The next day Mr Bradley asked to have no further contact with the mental health nurse. On 8 March, he was discharged from her caseload. The next day he saw the psychosocial recovery worker and talked at length about the Russian invasion of Ukraine. Eventually he agreed to resume work on his anxiety with her and another nurse. The same day he was allocated to another nurse.
56. The trainee psychologist visited Mr Bradley on 11 March after he wrote her a number of letters. They discussed his letter writing and she explained the benefits of working with MITS to improve his chances of a successful release from prison.
57. On 22 March, Mr Bradley had his first session with the psychosocial recovery worker and a nurse. They discussed his several recalls to prison and his dependence on alcohol. He agreed to continue working with them.

58. On 30 March, Mr Bradley stopped taking his sertraline. The next day he told a Senior Officer (SO) that he was keen to engage with MITS and was thinking of deferring his parole hearing. In correspondence with MITS, the SO said he was pleased Mr Bradley fitted their criteria as he thought he would clearly benefit from therapy.
59. On 4 April, Mr Bradley wrote another letter to the trainee psychologist asking for no further contact from psychology, the SO or the Parole Board. She rang his wing and told officers she was worried about him. They told her he was interacting with other prisoners during social time and appeared fine. She also emailed Mr Bradley's keyworker and asked him to check on him, but he was on a late shift. She then told the SO, and he arranged for a welfare check on Mr Bradley.
60. On 8 April, Mr Bradley wrote to the Inclusion team and told them he wanted no further contact with them. A nurse and the psychosocial recovery worker went to see him in response, and he changed his mind. A further appointment was planned for 20 April.
61. On 19 April, Mr Bradley completed a wing application to the Inclusion team saying he had made cuts to his stomach with a razor. The psychosocial recovery worker contacted the wing and an officer later confirmed that Mr Bradley admitted to making the cuts three days previously. He said he decided not to start Prison Service suicide and self-harm monitoring procedures (known as ACCT) because Mr Bradley told him he was not currently at risk of harming himself. The psychosocial recovery worker arranged for a nurse to check Mr Bradley's cuts and told the wing that she and a nurse were due to see him the next day on 20 April.
62. Mr Bradley was agitated and distressed when they met. He continued to talk about his sentence and the agencies involved with his recall to prison. He became tearful about feeling a lack of control and was reluctant to discuss his risk of suicide or self-harm. He asked about in-cell education. The psychosocial recovery worker and the nurse discussed ACCT monitoring. Mr Bradley said this would 'push him over the edge' and be detrimental to his mental health. They decided ACCT monitoring was inappropriate on this occasion.
63. The next day, staff told the psychosocial recovery worker that the prison no longer ran in-cell education, but she would check Mr Bradley's literacy levels and see if he was suitable for one of their out-reach courses.
64. On 22 April, a prison GP spoke to Mr Bradley and agreed to change his anti-depressant to venlafaxine.
65. On 27 April, the psychosocial recovery worker and a nurse saw Mr Bradley in his cell. He agreed to complete week one of the Managing Emotions workbook.
66. On 5 May, an officer held a keyworker session with Mr Bradley. Mr Bradley told him about his frustrations with his multiple recalls to prison due to his alcohol misuse and said he would like some paid in-cell work. The officer said he would speak to the activities department and also see if Mr Bradley could attend alcoholics anonymous (AA) meetings. Mr Bradley was subsequently allocated to Workshop 1 but refused to attend his first day of work on 9 May.

67. On 10 May, Mr Bradley told a prison GP that he wanted to stop taking venlafaxine because of side-effects and did not want an alternative.
68. On 11 May, the officer discussed Mr Bradley's options for employment with a SO. They decided to ask another officer to assess Mr Bradley for the Restart workshop. (The Restart workshop is a local initiative in Stafford that aims to provide a constructive working environment for prisoners in crisis or those with disciplinary problems.) Mr Bradley agreed to talk to the officer Adamson and a SO excused him from his job in Workshop 1 pending his assessment for Restart.
69. On 17 May, a SO began ACCT monitoring after Mr Bradley told him that he could not cope with loud music being played in the cell above him. The SO said Mr Bradley appeared distressed and asked to see someone from the mental health team. He asked the psychosocial recovery worker and a nurse to come to the wing urgently and when they arrived Mr Bradley disclosed that he had made cuts to his torso and had tied a ligature with the intention of taking his life the night before. The psychosocial recovery worker said Mr Bradley was tearful and irate. He said loud music on the wing had triggered a severe trauma response. The SO agreed to move Mr Bradley to a safer cell (a cell with minimal ligature points). The psychosocial recovery worker and the nurse briefed the wing staff on how best to respond to Mr Bradley during a crisis.
70. Mr Bradley told a SO at his ACCT assessment that he had given up hope of ever leaving prison and had nothing to live for. He said he had made numerous attempts to kill himself during the course of his sentence and his attempts were getting more serious. He did not want to be monitored and would rather be left alone to end his life.
71. The same day, an officer spoke to Mr Bradley about the Restart workshop. He said Mr Bradley was obviously in crisis. Mr Bradley talked at length about his mental health and alcohol misuse. The officer explained that the Restart group was for prisoners in crisis, numbers were limited to 12 and there were currently no spaces. Mr Bradley said he was not in a fit state to work at that time but agreed to him adding his name to the Restart referral list.
72. A nurse attended an ACCT review with a SO and Mr Bradley the next day on 18 May. Mr Bradley reiterated his issues with his sentence and recall to prison. He was worried about his June parole hearing. He said he was triggered by loud music and was worried about attending the Restart workshop as music was usually played there. The SO said he would try to move Mr Bradley to a quieter cell on a different wing. The nurse collected two books for Mr Bradley from the prison library. Mr Bradley remained in the safer cell and was checked four times every hour.
73. The psychosocial recovery worker attended an ACCT review on 20 May. She said Mr Bradley was much calmer. She suggested he attend an AA meeting the following day and he agreed to go. He spoke about his problem with loud music and agreed to a hearing test. He remained in the safer cell and observations were reduced to once every hour.
74. On 24 May, Mr Bradley wrote letters to the psychology department and MITS referring to his IPP sentence and his belief that he was being exploited and was a victim of 'sentence plan obstruction'. A trainee psychologist attended the Safety

Intervention Meeting (SIM) to discuss Mr Bradley. A nurse told her Mr Bradley was being managed under ACCT procedures.

75. Mr Bradley attended another ACCT review on 25 May with the psychosocial recovery worker, a SO and wing staff. Mr Bradley was subdued but eventually began talking about his parole hearing. The SO offered to set up a video call with his COM, so Mr Bradley could address some of the things he was worried about.
76. On 31 May, Mr Bradley was offered in-cell English classes but declined as they did not pay him enough. He said he preferred to continue with the outreach programme.
77. The next day, on 1 June, a SO held an ACCT review with Mr Bradley and the psychosocial recovery worker. Mr Bradley was still located in the safer cell on E Wing. He said he was worried he would not be released by the Parole Board in June, and this would send him into crisis. He asked if he could move to a cell on the ground floor of E Wing because loud noise caused him to think about killing himself and he started to look for ligature points in his cell. The SO scheduled the next review for 9 June, which was the next day a cell on E Wing ground floor might become available.
78. Mr Bradley attended another ACCT review with a SO and the psychosocial recovery worker on 9 June. Mr Bradley talked at length about his upcoming parole hearing, his previous licence conditions and recall to prison. Everyone agreed that ACCT monitoring should stop because Mr Bradley was no longer in crisis. He was to remain in the safer cell pending a move to a quiet location on E Wing. A post-closure review was scheduled for 17 June, the day after his parole hearing. Later the same day Mr Bradley moved to a cell on E2 landing, close to the wing office.
79. On 14 June, a trainee psychologist went to see Mr Bradley to see how he was feeling about his parole hearing and to tell him she would be there. Mr Bradley was not very talkative, so she spoke to the wing staff about him. They told her he had been OK over the past few days but written a wing application offering to check the locks and bolts on the wing by hanging himself from them. When they had spoken to him about this, he had said he "didn't mean it like that".
80. On 16 June, Mr Bradley attended his parole hearing by videolink with a SO and a nurse. The Parole Board had requested reports from prison psychology, Inclusion, the SO and Mr Bradley's COM. The nurse and the trainee psychologist were among those called to give evidence. No one supported Mr Bradley's re-release on licence, and all shared the view that he should complete therapeutic work to address his trauma over his IPP sentence and repeated recalls to prison.
81. The next day Mr Bradley attended his ACCT post-closure review with a SO. Mr Bradley said he felt hopeless and suicidal. The SO asked a nurse to attend because he was concerned about Mr Bradley's state of mind. ACCT monitoring was restarted with hourly checks. Mr Bradley was moved to a safer cell.
82. The SO and nurse reviewed Mr Bradley again on 20 June. Mr Bradley said he had possibly been through the worst weekend of his life musing on his situation. He said he had no hope and detailed how he might kill himself. He said he had considered a

number of potential ligature points but concluded it was not possible to attach a ligature in the safer cell.

83. The SO and another nurse reviewed Mr Bradley on 24 June, as the original nurse was not available. He said he had thought constantly about how to kill himself but had again concluded that the safer cell was too safe. He said he had tried to attach a ligature to the corner of the door at about 3.45am but it had not worked. The SO escorted Mr Bradley to his cell and removed two blades that he had been given to sharpen his pencil. He consulted the orderly officer who did not think Mr Bradley needed to be put on constant observations. The SO agreed with the safer custody team to increase observation of Mr Bradley to three times every hour.
84. The same day, the senior prison psychologist received a note from Mr Bradley saying that he wanted no further contact with psychology. She noted Mr Bradley had sent similar notes in the past. She decided against visiting him as he was in crisis, and she did not want to trigger him any further about his sentence and planned treatment.
85. On 27 June, at the SIM, an officer was asked to explore whether Mr Bradley felt up to visiting the Restart workshop. Mr Bradley agreed and managed to walk through the workshop to the office and sit and have a long conversation. He agreed to visit again in a couple of days.
86. Mr Bradley was discussed in the SIM on 29 June. The meeting agreed it was not the appropriate time for the senior prison psychologist to visit Mr Bradley to discuss his issues with psychology.
87. Later the same day, Mr Bradley visited the Restart workshop with a nurse and an officer. Mr Bradley's mood was much brighter, and he appeared to enjoy the visit.
88. On 30 June, a SO told Mr Bradley that the Parole Board had not recommended him for release because they thought he needed to complete further risk reduction work. Mr Bradley said he had been expecting the decision and did not want to see the official paperwork. He said he still wanted to engage with MITS to undertake the planned therapy. He said loud noise posed more of a risk to his wellbeing than his parole decision. The SO said he thought Mr Bradley understood that the proposed therapy with MITS was a good idea and had not been expecting to be released.
89. Also on 30 June, Mr Bradley attended an ACCT review with a nurse, a SO and an officer from Safer Custody. The SO briefed another SO before the review. Mr Bradley said he felt that he had no future but had no current plans to kill himself. He was looking forward to working in the Restart workshop and still intended to start therapy with MITS. He said he realised it was not possible to stay in the safer cell long term but was worried about noise if he moved out of it. The SO said he had arranged for Mr Bradley to move to cell E2-26 because this had no cell below or on one side and wing cleaner's cells above and to the other side. Observations were reduced to one every hour.
90. A trainee psychologist updated MITS on Mr Bradley's situation. They decided that Mr Bradley's planned therapy would be put on hold until he stabilised with the support of Inclusion and the ACCT process.

91. On 4 July, Mr Bradley told his keyworker that he had started working in the Restart workshop and it was going well. His mood changed when he began talking about his parole hearing and his recall to prison. Mr Bradley attended an AA meeting the same day.
92. On 6 July, Mr Bradley attended an ACCT review with a SO and a nurse. Mr Bradley was in a positive mood and said the move to his new cell was a success. An officer had briefed the SO that Mr Bradley was doing well in the Restart workshop. The nurse said Mr Bradley appeared very positive. He told her he wanted to move on from the Parole Board decision and concentrate on the services open to him at Stafford. The review concluded ACCT monitoring was no longer necessary. A post-closure review was scheduled for 13 July but did not take place as it should have done.
93. On 17 July, Mr Bradley submitted a complaint to the prison psychology department. He said he believed a trainee psychologist was unsupportive and said she had not challenged his COM's attempts to mislead the Parole Board at his hearing. He asked for a change of psychologist. Mr Bradley submitted a covering letter about his IPP sentence, his belief that he should not have received one and how it had affected him. He praised the Inclusion team and the care he had received from them.
94. On 20 July, Mr Bradley took part in an in-depth learning skills assessment in the education department. He subsequently attended English classes three times a week.
95. On 22 July, the senior prison psychologist replied to Mr Bradley's complaint about her colleague. In a long and detailed letter, she said she had examined Mr Bradley's psychology records and spoken to her colleague. She went through each of the meetings Mr Bradley had with her colleague and explained why she thought they were appropriate. She explained that Mr Bradley did not currently have an allocated psychologist because there was no planned work with him. She noted that her colleague was no longer based at Stafford asked him to stop writing to her.
96. Psychology records showed that the senior prison psychologist arranged for her reply to be delivered in person to Mr Bradley because she wanted him to have someone to express himself to and ACCT could be started if necessary. Her reply was not delivered as planned, but there are no records to indicate why.
97. On 25 July, a SO exchanged emails with MITS and confirmed that he thought Mr Bradley was now stable enough to begin therapy with them. On 28 July, the senior prison psychologist attended a MITS referral meeting. It was decided that Mr Bradley should have sessions with two therapists due to the complexity of his trauma and how this affected his interactions with staff. A further meeting was planned for 16 August.
98. On 5 August, Mr Bradley told a SO that he had read an article in the prison newspaper Inside Time and was worried about parole changes and the impact on IPP prisoners. The SO offered to contact Inclusion or another SO, but Mr Bradley said it was not a matter for Inclusion. The SO offered to contact the psychology department and Mr Bradley said he would like to speak to them. The senior prison psychologist was off-site that day, but spoke to another SO on the telephone.

99. The senior prison psychologist said she explained to the SO that Mr Bradley was not on the psychology caseload and their involvement in his parole hearing had finished some months before. She said that, given Mr Bradley's history of projecting his frustration about his sentence on to the psychology department and that previous visits had not alleviated his distress, she thought it was unhelpful for psychology to visit him as it might confuse matters. Parole was a matter for his POM and COM and the psychology department could not answer his questions.
100. The psychosocial recovery worker said she received a telephone call from a SO the same day asking her to come and see Mr Bradley because he appeared to be distressed and was asking for psychology. When she arrived on the wing, Mr Bradley said he did not want to offload to her. She said Mr Bradley appeared to have questions about his sentence and his parole hearing that he wanted to discuss with psychology. They talked about his attendance at AA meetings, and she reminded him that he was due to meet a nurse and an officer for the six week review of his placement in the Restart workshop.
101. The officer and nurse met Mr Bradley on 10 August. During their meeting a Custodial Manager (CM) delivered the senior prison psychologist's response to Mr Bradley's complaint about psychology. The nurse said the CM entered the meeting unannounced and left the reply with them. She said Mr Bradley's demeanour changed immediately and he became anxious and angry. He said he did not want to read the response because it would probably cause him to self-harm by cutting. The nurse and officer agreed to return the complaint answer to the CM.
102. The nurse said she and the officer considered whether ACCT monitoring was necessary but decided against it. She said Mr Bradley was clear that reading the letter would be a trigger for self-harm and wanted it removed so he could be safe. She managed to calm Mr Bradley down using mindfulness techniques. Mr Bradley was able to reflect on the progress he had made by attending Restart and they discussed his plans to spend the money he was earning. By the end of their session, she was satisfied that Mr Bradley was not at risk of harming himself in response to the letter.

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103. Officer A answered Mr Bradley's cell bell at 9.00am. She said Mr Bradley appeared quite angry. He tried to explain to her what his issue was but was "going round in circles". Eventually she managed to understand that he was fed up, frustrated and angry with the parole licence and recall system. He said his solicitor had sent him a letter containing a psychology report and he wanted to speak to someone from psychology about it. Mr Bradley told her a SO knew about the issue.
104. Officer A raised the matter with the SO, and he told her he would bring it up at the SIM meeting that morning. When she relayed this to Mr Bradley, she said he was calmly watching TV in his cell.
105. The SO said he had not spoken to Mr Bradley, but he understood from Officer A that he wanted someone to go through a psychology report with him.
106. The minutes of the SIM and Mr Bradley's psychology records showed that the SO told the meeting that Mr Bradley had received a psychological assessment from his

solicitor and wanted to discuss it. A trainee psychologist said this was likely to be an independent assessment as prison psychology reports were disclosed in person and this had happened some time before. She said she would look into the matter after the meeting. She said that during the meeting, a nurse said she would visit Mr Bradley. The nurse was not on the attendance list that day and could not remember attending the meeting. She said she had suffered a family bereavement that week and had taken some days off.

107. Officer A said the SO told her after the SIM that she could tell Mr Bradley that someone from psychology would come and see him. She told Mr Bradley that Officer B was on duty on his landing that afternoon and that if no one had come to see him by 3.00pm he should press his cell bell.
108. The trainee psychologist read Mr Bradley's notes and discussed what to do with a senior psychologist. She said they decided that, given her previous decision not to see Mr Bradley and that a nurse would be providing support to him that day, they should not visit Mr Bradley. She emailed the nurse and said Mr Bradley could contact the department if he had specific questions regarding the assessment he had received from his solicitor.
109. During the morning Mr Bradley attended an AA meeting as usual. After lunch he came out of his cell for exercise. He did not attend the medication hatch to take his anti-histamine and other medication for allergies.
110. At 2.47pm, Officer B answered Mr Bradley's cell bell, and Mr Bradley asked him if someone was still coming to see him. The officer said he called the psychology department, but the person he spoke to was not aware they were supposed to be going to see Mr Bradley. They told him they would chase it up and call him back. When someone called back, they asked him for more information about why Mr Bradley wanted to see them.
111. When Officer B asked Mr Bradley for more information, he told him to "forget it". He said he asked Mr Bradley if he was sure, and Mr Bradley told him not to worry about it and that he had only asked about it because he had been told someone was coming. He said he was familiar with Mr Bradley and nothing about his demeanour that afternoon gave him cause for concern.
112. Psychology records showed that a trainee psychologist answered Officer B's call. She was unaware of what had happened that morning, so she discussed Mr Bradley's request with the senior psychologist. Again, in the light of her previous decisions not to go to see Mr Bradley, they decided to ask for more information about what Mr Bradley wanted before deciding whether it was appropriate to visit him. No further information was received and so they did not visit him.
113. Officer B said Mr Bradley came to collect his dinner that evening and did not mention anything to him about the psychology department or raise any other issues.
114. The investigator wrote to Mr Bradley's solicitor to try to identify the report that Mr Bradley had received, but she did not receive a reply.

Events of 17 August

115. Using the ambulance records and control room log, we have calculated that the time on the CCTV clock is about 12 minutes behind the correct time. The times below refer to the CCTV clock.
116. The prison provided CCTV from 4.00am – 7.15am on 17 August. The camera is positioned almost directly opposite Mr Bradley's cell door. CCTV showed that at 4.00am, Mr Bradley's cell light was on (visible through the gap at the top of his cell door) and his observation panel was closed. The recording jumps between 4.06am and 4.08am. By 4.08am, something dark has appeared in the middle of the lighted gap in the door, immediately above the observation panel.
117. At 5.00am, an Officer Support Grade (OSG) checked Mr Bradley's cell during the early morning roll check. He opened Mr Bradley's observation panel and simultaneously reached up to turn the cell night light on. The panel remained completely dark even though the cell light and the night light were on. He took out his torch and shone it at the observation panel before shutting the panel and moving on. It is not possible to see whether the torch illuminated the cell, but the observation panel remained black.
118. The OSG wrote a handover note in the E wing observation book before he left the prison that morning. He confirmed that he had checked and counted all 152 prisoners. He also signed the E wing night patrol pegging record and the residential unit diary to confirm that he had completed the roll check. He was suspended from duties during the investigation, and we have not spoken to him.
119. CCTV showed that Mr Bradley's light remained on with the same object in the gap above the observation panel. At 6.54am, Officer C, the early start officer on E wing, looked through Mr Bradley's observation panel for the morning roll check. In her contemporaneous statement she said she noticed the main cell light was on as she approached the cell and that there was "something dark and unusual" wedged between the door and the doorframe. She opened the observation panel and noticed it had been covered.
120. Officer C shut Mr Bradley's observation panel and looked through the lefthand side of Mr Bradley's door. She then checked the prisoner next door using the cell night light and moved down the landing. She returned to Mr Bradley's cell at 6.55am. She opened the observation panel which again was dark. She looked through the lefthand side of the door again and then reached up to the top of the door. She said she tried to get hold of the dark material at the top of the door but could not move it. While she was trying to see into the cell, she called Mr Bradley's name and knocked on the door. She looked through the observation point into Mr Bradley's cell toilet. At 6.56am, she radioed for assistance and called out to Officer D, who was on duty on F wing. While she was waiting for him, she said she switched on the cell night light but still could not see into the cell through the observation panel.
121. Officer D joined her at the cell at 6.57am. He also tried unsuccessfully to get a response from Mr Bradley, and then radioed for permission to enter the cell. He opened Mr Bradley's door at 6.58am and he and Officer C went in. CCTV showed that as Officer D opened the door, whatever was wedged in the top of the door fell down and the cell light shone through the observation panel. Officer C said she

thought the obstruction on the door was an article of black clothing and a sheet because she noticed both on the floor by the door.

122. Officer C said Mr Bradley was hanging from the window bars at the back of the cell. He was wearing trousers but no top. One of his legs was hanging off the bed and one was bent into an unnatural position underneath him resting on the bed. There was a significant amount of dried blood on the walls and on Mr Bradley's face and torso, but she did not know where this had come from. Officer D radioed a code red and a code blue emergency. Officer E arrived in response to the radio calls. Officer D held Mr Bradley up while Officer E cut the ligature and they laid Mr Bradley on his bed.
123. Officer C said Mr Bradley was stiff and as they moved him to the bed his bent leg remained in the same unnatural position. The bottom of his legs and his arms were blue, but his torso was very white. As soon as they had laid him down a nurse and a nurse associate arrived.
124. CCTV showed the nurse and nurse associate arrived within two minutes of the emergency radio call. They both checked for a pulse but could not find one. They said there were obvious signs that Mr Bradley had died, including rigor mortis (stiffening of the limbs) and post-mortem pooling of the blood. They agreed not to give Mr Bradley cardio-pulmonary resuscitation (CPR) in line with Resuscitation Council guidelines.
125. The control room log recorded the emergency code at 7.10am and the ambulance records showed that the communications officer rang 999 immediately. He did not know any details of the emergency and the call-handler prioritised the incident C2 indicating a response time target of within 40 minutes.
126. We requested the radio traffic from the prison, but the system at Stafford does not allow it to be saved, so we do not know what information was passed from the officers at the scene to the control room and when.
127. Ambulance records showed that another communications officer rang 999 at 7.31am and said Mr Bradley was not breathing. The incident was upgraded to priority C1 with a response time target of within 15 minutes.
128. Paramedics arrived at 7.37am and confirmed that Mr Bradley had died.

Contact with Mr Bradley's family

129. The prison appointed a family liaison officer (FLO), and she and a custodial manager drove to Mr Bradley's brother's house that morning to break the news of his death in person. The family liaison officer remained in contact with Mr Bradley's brother and returned his property to them.
130. Mr Bradley's brother subsequently visited the prison to see his cell and speak to staff that had known him. The prison held a service of remembrance for Mr Bradley in the prison chapel. The prison contributed to the cost of Mr Bradley's funeral in line with national guidance.

Support for prisoners and staff

131. After Mr Bradley's death, the Head of Residence & Services 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, Trauma Risk Management (TRiM) team and POA also offered support.
132. The prison posted notices informing other prisoners of Mr Bradley'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 his death.

Post-mortem report

133. The coroner gave the cause of death as hanging.

Investigation of the OSG's roll check

134. After viewing the CCTV from 16/17 August, the Governor commissioned an investigation into the actions of the OSG that night. The investigation was led by the deputy governor of HMP Brinsford. During his interview with the deputy governor, the OSG said he could not remember Mr Bradley's cell, but that he had checked all 152 cells on the wing and had not seen anything untoward. He said it was not unusual for him to use his torch as well as putting the night light on because sometimes he used the torch to get a response from the prisoner. He said if he had seen anything untoward, he would have contacted the night orderly officer.
135. The deputy governor found that the CCTV evidence showed the OSG's conduct merited testing at a disciplinary hearing on charges of failing to conduct a roll check in line with local instructions.
136. The disciplinary hearing took place on 29 November in front of the Governor of Stafford. The OSG said that he had seen Mr Bradley in his cell during his roll count, that he was in bed with his face turned away from him and that he had used his torch to get a response from him.
137. The Governor reviewed the CCTV and concluded that Mr Bradley had obscured his observation panel before the OSG's roll check, by hanging some material from the top of his door. There was no evidence that he had subsequently moved or adjusted the material. Therefore, as Officer C was unable to see Mr Bradley through the observation panel when she checked the cell, on the balance of evidence, the OSG must not have been able to see him either. The Governor found the charges proved and dismissed the OSG from his employment for gross misconduct.
138. The OSG appealed the Governor's decision on the grounds that it was an unduly severe penalty and that the disciplinary findings were unfair and breached the rules of natural justice. The West Midlands Prison Group Director heard the appeal on 16 January 2023. She concluded that it was not possible for her to form a clear view either about whether the OSG had carried out his roll check properly or whether he could have seen Mr Bradley or not. As the Governor had concluded that any failing on the OSG's part had not caused Mr Bradley's death, she concluded that the

OSG's actions had not amounted to gross misconduct. She reduced the penalty to a final written warning for two years to reflect the seriousness of the charge.

139. The OSG has since moved to a different prison.

Coroner's Inquest

140. At a Coroner's Inquest held between 16 and 19 March 2026, the jury gave the medical cause of death as hanging and found that Mr Bradley died by suicide.

Findings

Care at HMP Stafford

141. Mr Bradley was a complex individual and we consider that, overall, he received a high standard of care at Stafford. We found evidence of strong multi-disciplinary input from the Inclusion team, a SO and an officer. It was also evident that wing staff were aware of his issues and tried hard to support him, including giving some thought to his location and summoning help from Inclusion and others when he appeared distressed. Mr Bradley tended to isolate himself in his cell and it is a credit to the officer and a nurse in particular, that he was able to start work and earn money in the Restart workshop. The generally very good standard of record keeping across all departments allowed us to build a detailed picture of the care offered to Mr Bradley.

Assessment of Mr Bradley's risk on 16 August

142. Mr Bradley had a significant number of risk factors that indicated that he was at high risk of suicide and self-harm and his mental health meant that his risk fluctuated according to context but was never absent. It is clear from this investigation that Mr Bradley was left traumatised and ultimately hopeless by the number of times he had been released and recalled to prison between 2013 and 2021 and his apparently endless sentence.
143. The day before he died, apparently prompted by a report sent to him by his solicitor, Mr Bradley was angry and upset about the parole licence and recall system. A SO appropriately raised Mr Bradley's request to speak to the psychology department in the SIM that morning. We consider the psychology department's decision not to visit Mr Bradley in response was reasonable in the circumstances. They were reassured by the belief that a nurse would see him that day and were prepared to reconsider their decision if further information justified it.
144. Although Mr Bradley followed up his request to see psychology that afternoon, he told Officer B that he had only asked because he had been told someone would be coming. He declined to give the officer more information and told him not to worry about it. The officer said later that Mr Bradley collected his evening meal and appeared to be fine. There is considerable evidence that Mr Bradley was able to communicate to staff when he was in crisis. We consider that there was little to indicate that he was at imminent or heightened risk of suicide that day.

The OSG's roll check on 17 August

145. Stafford's local instructions on roll checks at night, issued in April 2021, include the following instructions to staff:

"Roll checks are conducted to ensure that:

- Prisoners are in the cell and are alive and well.
- The roll is correct.

- Every prisoner is in the correct cell, by obtaining a clear view of their face – if necessary, by waking them.

“If any of these cannot be achieved the Night Orderly Officer must be contacted immediately for advice.

“The Night Orderly Officer must be informed immediately if any observation panels are blocked. The Night Orderly Officer must arrange for them to be cleared immediately.”

146. CCTV showed that Mr Bradley placed something in the gap above his door directly above the observation panel almost an hour before the OSG completed his roll check. It does not appear that Mr Bradley subsequently moved or adjusted the article. When the OSG opened the observation panel, no light was visible despite the cell light still being on.
147. The cell light was still on, but no light was visible through the observation panel when Officer C made her early morning check about an hour and 54 minutes later. When Officer D opened the door, the cell light immediately became visible through the panel. Officer C said an item of black clothing fell to the floor as the door was opened and she also saw a sheet on the floor.
148. The evidence indicates that the observation panel was blocked when the OSG completed his roll check and that it was not possible for him to see into the cell past it and satisfy himself that Mr Bradley was alive and well.
149. We cannot say whether the outcome would have been different had the OSG raised the alarm, but it is unlikely. In cases of hanging, CPR must be administered extremely swiftly to ensure preservation of life. Rigor mortis normally sets in between two and six hours after death, and evidence indicated that Mr Bradley had been dead for some time when he was found.
150. Had the prison not commissioned an investigation of the OSG’s roll check, we would have recommended that they do so. This process was completed in January 2023 and therefore we make no recommendation.

Emergency response

Resuscitation

151. In September 2016, the National Medical Director at NHS England wrote to Heads of Healthcare for prisons to introduce new guidance to help staff understand when not to perform cardiopulmonary resuscitation (CPR). This guidance was designed to address concerns about inappropriate resuscitation following a sudden death in prison. It was taken from the European Resuscitation Council Guidelines which states, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile”. The European Guidelines were updated in May 2021, but the same principles apply.
152. A nurse and a nurse associate were both trained in intermediate life support (ILS), which also includes guidance on when CPR is inappropriate. Evidence from both indicated clear signs of death were present including rigor mortis and post-mortem

blood pooling. The decision not to give Mr Bradley CPR was appropriate and in-line with national guidance and ILS training.

Clinical care

153. The clinical reviewer concluded that Mr Bradley had received appropriate care for his physical health and effective multi-disciplinary input from the Inclusion team for his mental health and substance misuse issues. Overall, his clinical care was equivalent to that expected in the community.

Learning points for the prison

154. This section contains learning identified during the investigation that did not affect the outcome for Mr Bradley which the Governor should note and consider taking appropriate action.

ACCT documents should not be closed in the run up to events associated with an identified trigger.

155. The ACCT process focuses on identifying risks and triggers that might increase a person's risk of suicide and self-harm and providing extra support around these events. On 17 May, staff correctly identified that his IPP sentence and recalls to prison were significant issues that increased Mr Bradley's risk of self-harm and recorded it on his ACCT document. His parole hearing, due less than a month later, provided a focus for these issues and was therefore a time when Mr Bradley might be at heightened risk of harming himself. The ACCT reviews on 18 May, 25 May, 1 June and 9 June demonstrated Mr Bradley's concern about his hearing. He knew that no one called to provide evidence to the Parole Board supported his re-release on licence and that the plan was for him to complete therapeutic work first. His hearing was therefore likely to reinforce to him that his IPP sentence meant he would remain in prison for the foreseeable future. ACCT monitoring was then stopped on 9 June, one week before his parole hearing.
156. The post-closure review was set for the day after the hearing, on 17 June, in recognition that it was a significant event for him, however this left the possibility that he would ruminate that week and overnight on 16 June and attempt to harm himself when he was not subject to extra checks. Mr Bradley said he felt hopeless and suicidal at his post-closure review and ACCT monitoring was re-started, which indicated that the hearing did indeed prompt a period of heightened risk. We consider that ACCT monitoring should not have stopped on 9 June but should have continued until after his parole hearing.
157. We also note that ACCT monitoring was stopped on 6 July, but we have not seen any evidence that a post-closure review took place on 13 July as it should have done.

The nature of the emergency was not effectively communicated to the Ambulance Service, and this resulted in inappropriate triage of the call.

158. In line with Prison Service Instruction 03/2013, Stafford use an emergency code system to indicate the seriousness of an incident to staff. Calling an emergency code should automatically trigger the control room to call an ambulance. The PSI makes clear that these codes are for use within the prison only and should not be used when communicating with ambulance service staff, because they are unlikely to be familiar with them and this could lead to confusion and delays to ambulance attendance. The PSI also instructs the member of staff that called the code to provide relevant information about the condition of the prisoner to the control room for use in the ambulance triage process.
159. The control room officer immediately called an ambulance on receipt of the emergency code, however the 999 call showed he did not know any details of the incident apart from the fact that it had been designated a code blue. The call handler did not appear to understand the nature of the emergency and did not ask any of the standard triage questions including whether the patient was breathing. She triaged the emergency as priority two.
160. The prison's local instructions to staff direct the communications officer to call an ambulance and wait for updates from the scene. The ambulance call indicated this did not happen. The delay in the ambulance arriving did not affect the outcome for Mr Bradley, but cases of hanging it is crucial that the nature of the emergency is communicated to allow paramedic help to arrive as soon as possible. Paramedics are experts in resuscitation, have more sophisticated equipment such as Lucas machines and are able to administer adrenaline.
161. Communications staff would benefit from guidance on what information is required by the 999 call-handler and both they and the orderly officer should be instructed to remain in radio contact in order to provide updates on the condition of the prisoner.



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