Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Matthew Manning at Bristol Magistrates Court on 6 November 2023

## A report by the Prisons and Probation Ombudsman

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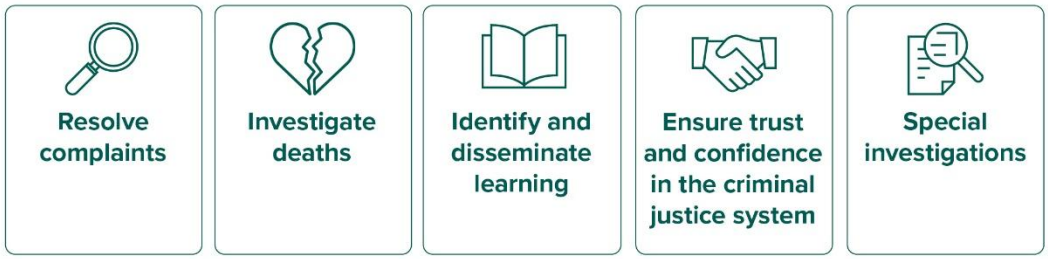
## OUR VISION

**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 Matthew Manning died on 6 November 2023 at Bristol Magistrates' Court after compressing his neck with a ligature. He was 55 years old. I offer my condolences to Mr Manning's family and friends.

Mr Manning spent three days in police custody during which there were no concerns about his mental health. He arrived at Bristol Magistrates' Court on the morning of 6 November. His offences included violence against his partner, and he had not been in prison before. However, once Mr Manning arrived at court, he was subject to standard half-hourly welfare checks.

Mr Manning was calm and complied with the court's processes and staff had no concerns about him during their welfare checks. At lunchtime, Mr Manning met his solicitor who warned him to expect to be remanded to prison. When staff came to collect Mr Manning for his hearing, they found him unresponsive with a ligature around his neck. They quickly started life-saving techniques and alerted emergency services.

Although he had some risk factors for suicide and self-harm, my investigation found that there was nothing in Mr Manning's behaviour while he was at court to indicate that he would take his life.

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 2026**

# Contents

# Summary

## Events

1. On 3 November, police arrested Mr Matthew Manning for violent offences against his partner and other persons. He was intoxicated and the police detained him at Patchway Police Station in Bristol over the weekend. The medical staff gave him pain relief for a trapped nerve. Neither the police nor medical staff had any concerns about his mental state while he was in police custody.

2. On 6 November, the police completed the PER (Person Escort Record) ready for the PCOs (Prisoner Custody Officers) who would collect Mr Manning for court. Mr Manning was an increased suicide and self-harm risk because his offence was against his partner and he had not been in prison before, but the police had not highlighted this in the PER.

3. Two PCOs collected Mr Manning and took him to Bristol Magistrates' Court. PCO's at the court had no concerns about him and carried out standard, half-hourly welfare checks.

4. That morning, a distressed detainee and a malfunctioning court alarm disrupted staffs' duties and they were confused about which welfare checks had been carried out. One of Mr Manning's welfare checks was missed earlier in the day.

5. At lunchtime, Mr Manning met his solicitor and was told to expect to be remanded to prison. A PCO spoke to Mr Manning shortly after this as he was worried the court might close before he was dealt with. She assured him it would not and gave him some water.

6. At 2.12pm, the PCOs went to collect Mr Manning for his hearing but were unable to open the cell door. When they pushed their way in, they found he was slumped against the door with a ligature around his neck. PCOs and the court paramedic started cardiopulmonary resuscitation and called emergency services. Mr Manning did not regain consciousness and at 2.55pm, paramedics pronounced his death.

## Findings

7. Mr Manning's period in police custody is not within our remit, but violent offences against a family member and not having been in custody before are recognised risk factors for suicide and self-harm and these were not detailed on the PER. However we consider that the court's standard half-hourly welfare checks were proportionate. While Mr Manning had some risk factors that indicated he might be at risk of suicide and self-harm we found no evidence that staff should have considered his risk to be raised.

8. Deaths in court custody are uncommon, but staff acted quickly and professionally to help Mr Manning.

# The Investigation Process

9. Serco notified us of Mr Manning's death on 6 November 2023.

10. The investigator issued notices to staff at Bristol Magistrates' Court informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Manning's police custody record and court documentation. The investigator spoke to the Court Custodial Manager in March 2024 and formally interviewed both the contract and delivery, and the operations manager in April 2024.

12. We informed HM Coroner for Avon of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

13. The Ombudsman's office contacted Mr Manning's family to explain the investigation and to ask if they wished to raise any issues. They asked the following questions:

    - What was the content of the conversation between Mr Manning and his solicitor at court?
    - What happened to Mr Manning's Apple watch?
    - Why was the family originally told Mr Manning had hanged himself but later told he was found on the floor?
    - We have answered these questions in this report.

14. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. They pointed out that SERCO have now contributed to Mr Manning's funeral costs and we have amended the report.

15. We also shared the report with Mr Manning's family. They pointed out one factual inaccuracy. We have amended this report accordingly.

# Background Information

## Bristol Magistrates Court

16. Bristol Magistrates' Court is in Bristol city centre. The court is run by His Majesty's Courts and Tribunal Service (HMCTS). The Prisoner Escort and Custody Services (PECS) arm of HM Prison and Probation Service (HMPPS) contract Serco to provide court custody and escort services. There are 29 cells in the custody suite on the ground floor of the court. Aeromed provide healthcare services at the court from 8:00am to 5.00pm Monday to Saturday.

## HM Inspectorate of Prisons

17. In March 2020, HMIP inspected court custody facilities in Avon.

18. The inspectors' findings were positive, particularly regarding how custody staff dealt with and managed detainees, and how these relationships mitigated other shortcomings (such as the time spent in cells and condition of some cells). Custody staff engaged well with detainees during their time in court custody facilities and detainees were complimentary about their treatment.

19. Custody staff were skilled at noticing signs of risk and responded appropriately. Most individual person escort records were completed reasonably well, but some still lacked risk information. The reception checklists were not always completed thoroughly but because staff were good at identifying behavioural signs of risk, these shortcomings were mitigated.

20. Police custody suites had well-embedded liaison and diversion services which reduced the need for them in court custody. Some courts received an inconsistent service from mental health professionals, but staff had access to contact details if they were required.

# Key Events

21. On 3 November 2023, Mr Matthew Manning was arrested for violent offences against his partner and other persons. He was taken to Patchway Police Station in Bristol.

22. Between 8.40pm on 3 November and 11.01pm on 5 November, different police custody staff made a total of 19 entries on Mr Manning's record. He initially presented as intoxicated but reported no thoughts of suicide or self-harm. He said he had a trapped nerve in his leg, and he was given his prescribed pain relief every day.

23. Mr Manning's property consisted of some medication, tobacco and a lighter. No watch was listed. The investigator was told that the police would normally remove a detainee's smart watch but there is no record of it in his police property log.

24. On 6 November, the police completed Mr Manning's PER (Person Escort Record). They recorded that he had been arrested and charged with assault offences, that he had a trapped nerve and was on medications Omeprazole, Naproxen and Amitriptyline. The PER said Mr Manning was at no risk of self-harm and had no mental health needs. Hourly observations were set which is the standard level for police custody.

25. On the morning of 6 November, two Prisoner Custody Officer (PCO) and went to Patchway Police station to collect Mr Manning and other detainees and take them to court. They were not told of any mental health concerns about Mr Manning.

26. A PCO noted Mr Manning had a trapped nerve and told him she would be careful when searching him. She asked Mr Manning if he was okay, and Mr Manning said he was, but he was worried about his mother who was 79 and had dementia. The PCO asked Mr Manning if he had a solicitor and he said that he did and he was meeting him at the court.

27. Mr Manning got into the escort van at 8.07am and the vehicle left the station at 8.22am. Mr Manning accepted some water for the journey and sat quietly in cell 5 of the van. Mr Manning did not display any concerning behaviour or say anything to raise alarm. The CCTV footage shows he was not wearing a watch.

28. At 9.31am, A PCO completed the Prisoner Arrival sheet. He allocated Mr Manning to cell M11 and noted he had medical needs. He explained his prisoner rights and the complaints procedure and checked if Mr Manning had any religious needs (which he did not). The welfare check included asking Mr Manning whether he required a conversation with a liaison and diversion worker (a mental health specialist usually based within a court). He said he did not.

29. A Court Custody Manager completed the Risk Profile Chart. She added a marker for violence (red) and medical health (amber). The risk mitigation section said Mr Manning should be on standard watch (which at the court is a welfare check every 30 minutes). A PCO gave Mr Manning some water.

30. At 10.08am, a PCO observed Mr Manning sitting down in his cell. At 10.35am, an officer observed the same. There was then a 55 minute gap until Mr Manning was

seen again. Another detainee was very disruptive and on increased observations. Staff said that this contributed to one of Mr Manning's morning checks being missed.

31. At 11.40am, an officer checked Mr Manning and he was still sat in his cell. The officer had no concerns.

32. At 12.12pm, a member of staff accidentally activated an alarm outside one of the courts and it could not be turned off. (The affray alarm alerts staff to the fact their assistance is urgently required.) Maintenance staff tried to fix it but were unable, so the alarm continued to go off randomly over the next few hours, with staff having to respond each time in case it was a genuine alarm.

33. In the meantime, at 12.23pm, the officer checked Mr Manning again and he had no concerns.

34. At 12.34pm, Mr Manning saw his solicitor. The meeting lasted 11 minutes. After the meeting, a PCO escorted Mr Manning back to his cell. He asked Mr Manning how the meeting had gone, and Mr Manning said, "Not sure, mate."

35. The police have informed us that his solicitor told them he had advised Mr Manning that the prosecution would be putting forward a strong case for remand (meaning he would remain in prison until his sentence). The solicitor told Mr Manning he would appeal against the remand, but not until 7 November, therefore he was very likely to spend the night at HMP Bristol. He described Mr Manning as 'low' as a result.

36. At 12.53pm, a PCO went to Mr Manning's cell to offer him some food, but he did not want any. He was sat on the cell bench and the PCO had no concerns about him.

37. During and after this time, the affray alarm continued to go off randomly, and staff had to respond.

38. At 1.36pm, a PCO spoke to Mr Manning and gave him some water. She told him that the court would stay open until everyone had been seen.

39. At approximately 2.00pm, a PCO noticed Mr Manning's cell check was due and asked colleagues in the control room if it had been done and they believed it had. The PCO described the control room as chaotic at that time, likely due to the affray alarm, and he does not know who confirmed that the check had been completed. The PCO entered a completed check on the computer system at 2.04pm.

## The emergency response

40. At 2.12pm, a PCO went to Mr Manning's cell to collect him for court. She was unable to open the door and thought he was leant against it. She looked through the observation panel and saw his legs on the floor (because he was sat on the ground with his back against the door). She pushed herself into the cell and saw Mr Manning had tied a ligature around his neck using his shoelaces and the cord from his hooded top attached to his shoe. She shouted to colleagues who were right behind her, and she and another PCO removed the ligature between them. (A PCO used an anti-ligature knife).

41. At 2.13pm, a PCO called an ambulance and another PCO shouted for the nurse. A PCO r started cardiopulmonary resuscitation (CPR). The Court paramedic arrived and a PCO went to get a defibrillator. Two other PCO's took over CPR. The Court paramedic inserted an airway into Mr Manning's mouth and monitored staff doing compressions. A PCO cut Mr Manning's top off and applied the defibrillator pads. The defibrillator advised 'no shock'.

42. At 2.21pm, paramedics arrived. They could not resuscitate Mr Manning and pronounced his death at 2.55pm.

## Contact with Mr Manning's family

43. The police decided they would inform Mr Manning's family of his death. Mr Manning's family have asked why they were told he had hanged himself when in fact he was on the floor, leaning against the door. We can only presume that the term was used because Mr Manning had used a ligature.

44. Serco contributed to the cost of Mr Manning's funeral.

## Support for staff

45. On 6 November, the Serco Area Operations Manager, carried out an immediate debrief with the staff involved and offered staff support. He visited the court again the next day to ensure all staff were aware that Trauma Risk Management (a support model) was available should they need it.

## Post-mortem report

46. The post-mortem concluded that Mr Manning died of compression of the neck by a ligature. Toxicology tests revealed therapeutic levels of prescribed medication and no illicit substances.

# Findings

## Assessment of risk

47. Mr Manning had been charged with an offence against his partner and, as far as we are aware, had not been to prison before, both are known risk factors for suicide and self-harm. The police did not add this information to the PER (which is intended to record any risks to self or others). However, there was nothing about Mr Manning's presentation which suggested he was at risk, and the CCM's decision that staff should carry out standard half-hourly welfare checks at court was proportionate.

48. We do not know in detail what took place between Mr Manning and his solicitor. His solicitor gave the police a brief account of what had happened but did not wish to say anymore, citing client confidentiality. We know that he told Mr Manning to expect to be remanded to HMP Bristol. Solicitors can draw court staff's attention to any clients they are concerned about, he did not mention Mr Manning to anyone in the custody suite.

49. The investigator asked the Serco Area Operations Manager and the HMPPS Contract Delivery Manager, about mental health provision at Bristol Magistrates' Court. There is none, and staff are expected to contact Bristol Crown Court if they have concerns about an individual, as they have a team.

50. The managers told us that no mental health provision in magistrates' courts is normal because the resources are generally concentrated in the crown courts. Mr Manning did not present as someone who obviously required mental health support. However, we feel this point is worthy of note, particularly as custody suite staff told the investigator they had tried to contact Bristol Crown Court for assistance in the past but had found it impossible to get hold of anyone.

## Welfare checks

51. There was a 55-minute gap between two of the morning checks. We are aware that another detainee was on enhanced checks and their behaviour was taking a lot of staff time which may have contributed to this error. We do not consider that it had any impact on Mr Manning at that time.

52. In the afternoon, the affray alarm malfunctioned causing confusion, and a PCO recorded that a check had been completed which had not taken place. We are satisfied that the PCO made this entry as a result of confusion and nothing more. However, we would suggest that PCOs only enter checks on the system that they themselves have completed. We do not make a recommendation.

53. The malfunctioning affray alarm caused considerable distraction that afternoon and it continued after the engineer's initial efforts to fix it. The HMPPS Contract Delivery Manager, told the investigator that HMCTS would be carrying out a review of how the issue had been managed.

## Good practice

54. Deaths in courts are uncommon, but staff acted quickly and professionally. The CCM has been particularly helpful during this investigation at a time which has clearly been difficult for her and her staff.

## Inquest

55. At the inquest, held on 5 August 2025, the medical cause of death was determined to be compression of the neck by a ligature, with a conclusion of suicide.

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