FINAL REPORT

ARTICLE 2 COMPLIANT INVESTIGATION

IN THE CASE OF 'MT'

FEBRUARY 2026

COMMISSION AND TERMS OF REFERENCE

This report is about the care and management of a young man, at HMP Bristol, where he engaged in an act of serious self-harm, causing severe physical and cognitive impairments, and ultimately his death. To preserve his anonymity, the young man is referred to as MT.

I was commissioned by the Secretary of State for Justice to conduct an independent investigation with the following terms of reference:

- to examine the circumstances of the incident on 15 January 2018 in which MT sustained a life-threatening injury, and, in so far as it is relevant, his management by HMP Bristol from the date of his reception on 11 September 2017 until that date, and in light of the policies and procedures applicable at the relevant time;

- to examine relevant health issues during the period spent in custody at HMP Bristol from 11 September 2017 until 15 January 2018, including mental health assessments and MT's clinical care up to the point of his life-threatening injury on 15 January 2018;

- to consider, within the operational context of His Majesty's Prison and Probation Service (HMPPS), what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved;

- to provide a draft and final report of my findings including the relevant supporting documents as annexes;

- to provide my views, as part of my draft report, on what I consider to be an appropriate element of public scrutiny in all the circumstances of this case. The Secretary of State will take my views into account and consider any recommendation made on this point when deciding what steps will be necessary to satisfy this aspect

of the investigative obligation under Article 2 of the European Convention on Human Rights (ECHR).

I have no authority to consider any question of civil or criminal liability.

The Interested Parties to the investigation are:

- MT's mother, to whom we extend our condolences, and our thanks for her contribution to the investigation.
- His Majesty's Prison and Probation Service (HMPPS)
- NHS England, who commissioned healthcare at HMP Bristol
- Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) who were contracted to provide mental health services at HMP Bristol from 2016 until October 2022
- Oxleas NHS Foundation Trust who have been contracted to provide healthcare at HMP Bristol since October 2022

The Interested Parties were offered the opportunity to comment on a draft of this report and to see the documentary and witness evidence on which we have relied.

The investigators are:

Barbara Stow, Lead Investigator
Andy Barber, Assistant Investigator

The clinical adviser to the investigation is:

Jackie Craissati, PhD, MBE, Consultant Clinical and Forensic Psychologist

Barbara Stow
BA (Hons), MSt (Cantab) Applied Criminology and Management

February 2026

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Part Three is about the events in detail: about MT, his time in prison and what happened. Each chapter ends with some observations about the events and our conclusions.

Part Four is the clinical review conducted by Dr Craissati.

Part Five says more about the context, about conditions in Bristol at the time and since, and policies, at the time and since, intended to keep prisoners safe.

PART ONE: ABOUT THE INVESTIGATION

The reason for the investigation

MT was arrested in May 2017 and remanded in custody. He was convicted and sentenced on multiple charges in November and December 2017. Between August and October 2017, MT made several attempts, sometimes tentative, sometimes more serious, to hang himself. For most of his time in prison, MT was supported through an ACCT plan. ACCT stands for Assessment, Care in Custody and Teamwork and is the Prison Service's case management system to protect prisoners identified as being at risk of suicide or self-harm.

MT's ACCT plan was closed on 10 January 2018. A post-closure review was scheduled for 17 January. On 15 January, MT barricaded his cell door and ligatured, with bed sheets suspended from the frame of a bunk bed. When they were able to open the cell door, prison staff cut the ligature and administered CPR. MT survived, but suffered brain injury and significant cognitive impairment. From an acute hospital, MT was moved in March 2018 to a Brain Injury Centre, then in October 2018 to a secure hospital. On 26 February 2022 MT died. The immediate cause was aspiration pneumonia but a Coroner's Inquest on 1 February 2023 found that this was a consequence of the hypoxic brain injury from the earlier hanging attempt.

This report examines the circumstances in which these events occurred, and whether there are lessons to be learned that might help to prevent something similar happening in future.

How we investigated

Our investigation was commissioned in August 2024. We obtained records from the Prison Service and healthcare agencies about MT's time in custody, at both Bristol and Birmingham prisons. We have also seen the Serious Incident Review completed for the NHS in July 2018. MT's defence solicitors have provided information about events at court, their dealings with the prison, and their unsuccessful attempt to arrange an assessment by a psychiatrist.

We met MT's mother, who told us something of MT's history, and what MT said to her when he was in prison. We interviewed members of the prison staff and healthcare staff about their knowledge of events concerning MT at the time, about conditions in Bristol prison, and about changes in policy and practice since MT was there.

Everyone we approached cooperated willingly, but several of the people we met asked why the investigation was happening so long after the event. It meant that their memories of what happened some six or seven years ago were inevitably hazy, and also for some it meant recalling distressing events, because of the traumatic nature of their involvement when MT ligatured, or because efforts they had made to support MT before then had seemingly come to naught.

Another consequence of the lapse of time since the events we were investigating is that circumstances change, so that lessons we might draw from what happened to MT may now be superfluous, or new issues may have emerged.

Several people involved at the time had moved on. We were able to interview staff who were still working in the Prison Service, some at other prisons. Others had left the service altogether and, after careful consideration, we did not think it necessary to try to contact them.

The requirement for public scrutiny: Article 2 of the European Convention on Human Rights

Article 2 of the European Convention on Human Rights says that everyone has an absolute right to life. The European Convention has been incorporated into UK law through the Human Rights Act 1998. Case law has established that when someone who is in the custody of the State dies, or suffers life-threatening self-harm, there must be an investigation that is impartial, independent and open to public scrutiny.
The purpose of an investigation of this kind is to ensure as far as possible:

- that the full facts are brought to light
- that any culpable and discreditable conduct is brought to light

- that suspicion of deliberate wrongdoing is allayed if it is unjustified
- that dangerous practices and procedures are changed
- and that those whose relative has been harmed may at least have the satisfaction that lessons learned may save others.

We consider that our investigation does provide the element of public scrutiny required under the European Convention and that no useful purpose would be served by further enquiry now. However, if Article 2 investigations of serious incidents in prisons are to achieve their purpose, we would urge the Ministry of Justice to endeavour to commission them as soon as it is evident that the Article 2 obligation applies.

PART TWO: SUMMARY, FINDINGS AND RECOMMENDATIONS

Part Two contains a summary of the investigation report followed by a summary of findings and recommendations, drawn from the detailed accounts that follow in Parts Three, Four and Five.

SUMMARY OF THE INVESTIGATION REPORT

The sequence of events

1. MT ligatured in his cell in Bristol prison on 15 January 2018. He survived, but with significant impairments which led to his death in February 2022. MT had made previous attempts to ligature, some tentative, some more serious, during the eight months he was in prison. From September 2017, MT was supported through an ACCT care plan which was closed on 10 January 2018.

2. In 1997, at the age of 14, MT was cautioned for indecent assault on a minor. He was removed from the family home, and lived variously in institutions or with relatives. He served 12 months in youth custody at the age of 17 and had convictions for public order and property offences dating from 1999 to 2007. He had no further criminal justice record until 2017, when, at the age of 34, he was remanded in custody charged with sexual offences and violence against a former partner, to which he pleaded guilty; and a single charge, which he denied but of which he was convicted in December 2017, of sexual assault of a daughter from a previous relationship.

3. In about 2014 MT was diagnosed with multiple sclerosis, which seems not to have had any major disabling effect at the time he was in prison, but may have had some bearing on his physical and mental condition. He complained of impaired vision in one eye, and also from time to time of migraines.

4. MT was in Birmingham prison from May 2017 until 11 September 2017. He was then in Bristol prison until 8 November 2017, but returned to Birmingham prison to attend court in Birmingham, where he was convicted and sentenced to five years on the single charge. On 6 December, in Bristol court, he was sentenced to 11 years on the multiple charges and returned to Bristol prison.

5. MT's first weeks in Birmingham prison were unremarkable until he assaulted a prisoner in July. After that he was reluctant to leave his cell. Two weeks later he

ligatured, and his cellmate raised the alarm. He was briefly in hospital then returned to the prison. An ACCT plan was opened, then closed within a week, but reopened when MT disclosed further attempts to ligature on the eve of appearing in Bristol Crown Court.

6. From court, MT transferred to Bristol prison, where he ligatured again and his cellmate raised the alarm. MT was placed under constant supervision in a gated cell in the Brunel Unit, where a few days later he attempted to ligature with a plastic bag. He remained in the unit for 15 days. Thereafter he moved with some hesitation to the vulnerable prisoners wing, where on 2 October he again placed a ligature round his neck and rang the cell bell.

7. At Birmingham after the assault, and especially after the ligaturing, then at Bristol, MT was adamant that he could hear other prisoners and sometimes staff talking about the charges against him and conspiring to harm him. He often showed visible distress and said he would prefer to kill himself than to be harmed by others. Inspection reports indicate that fear and violence were not uncommon at Bristol at the time, with one-third of the prisoners reporting in 2017 that they felt unsafe, but we found no evidence indicating specific threats directed at MT, and we understood that the vulnerable prisoners wing was considered the safest of the residential units.

8. MT's ACCT plan remained open from 10 September 2017 until 10 January 2018. At Bristol, case reviews were usually held daily while he was under constant supervision, then each week. Mental health staff attended reviews until 26 September when MT was discharged from the mental health caseload on the basis that mental health assessments found no evidence of a severe and enduring mental illness. This was confirmed by a further mental health assessment a few days later after MT tied a ligature again.

9. The investigation's clinical review considers the contribution of the mental health team and notes in particular that practitioners who assessed MT were apparently

not aware of his serious suicide attempt at Birmingham, that MT's clinical records contained no indication of escalation to the prison's psychiatrist for advice on MT's seeming continuing distress, no records from the weekly multi-disciplinary mental health team meeting to which MT's case was said to have been referred more than once, that the quality of the recorded information was not of the standard expected, sometimes containing subjective judgements that were not evidenced or explained, and that having discharged MT from the mental health caseload, mental health staff were unable to offer custodial staff any advice or support about how best MT's difficulties could be managed. Moreover, the deployment of mental health resources did not take into account the heightened risk of suicide among men with convictions for sexual offences.

10. The clinical review also notes that little attention appears to have been paid to MT's diagnosis of multiple sclerosis and that Sertraline prescribed in September seems to have been overlooked when he returned to Bristol from Birmingham in December.

11. Apart from initial input from the mental health team, with the exception of one review in January 2018 when MT was briefly placed under constant supervision again, ACCT case reviews were attended only by MT and various custodial staff, who sought to encourage him gradually to come out of his self-imposed isolation. MT declined proposals to engage with Samaritans, or Listeners, or a psychology group, but broadening the representation in the case review teams to bring in other perspectives might have been an opportunity to build trust.

12. More particularly, we note that there was no attempt to draw on MT's family to reinforce the support available to him. There are references in records that MT valued contact with his mother, but his mother told us that between the initial incident at Birmingham and the final occasion on 15 January she was not aware that MT had repeatedly tied ligatures and spoken to staff about harming himself. Although somewhat mistrustful of the prisons, she regretted that she had not been approached and thought she might have been able to help. We are aware that current prison safety policy emphasises the importance of engaging family support

for prisoners at risk of self-harm, where this is possible. We wholeheartedly endorse that view.

13. Case review summaries, and informative entries in the ACCT log of observations and conversations, indicate that the custodial staff's efforts were succeeding in reducing MT's isolation, especially in his second period at Bristol. After the initial impact of his sentencing, MT seemed to be progressing and looking forward. He began working as a painter and increasingly engaged with certain other prisoners and a cellmate he found supportive.

14. On 3 January 2018 there was a brief setback when a case manager was sufficiently concerned to restore constant supervision. Within hours, MT claimed the manager had misunderstood, and at his own request he returned to the wing. A further case review two days later noted MT's seeming progress, his more outgoing behaviour on the wing, that he was not unhappy about the prison where he would serve his sentence, and that he was looking to the future. On 10 January the ACCT plan was closed at a review led by the wing supervising officer with a wing officer from another landing and with unspecified reported input from the mental health team.

15. At the time, there was no requirement for further monitoring after a decision to close an ACCT plan, except for a post-closure meeting one week later. MT had received copious attention from staff while the plan was in force but there was no requirement for gradual change. Closure of the plan was a cliff-edge. There are no records indicating what interaction if any MT had with the wing staff in the following days. Current policy now requires completion of a monitoring sheet, recording at least one interaction each day in the period before the post-closure review. We welcome this change.

16. Five days after the ACCT plan was closed, when his cellmate was not in the cell, MT ligatured again. The regime was disrupted that morning because of the natural death of an elderly prisoner on the same landing as MT. MT had barricaded his cell door. There were brief difficulties in obtaining keys for the inundation point and the

anti-barricade device and in removing the anti-barricade device where bolt heads were rounded and painted over. This delayed staff by a few minutes gaining access to the cell. Once they did so, staff acted with urgency and efficiency which was commended by the ambulance staff.

17. The ligature, which was made of bed sheets, had to be untied, being too thick for the standard issue fish knife. Officers supported MT's weight and administered cardio-pulmonary respiration. Ambulance staff arrived and MT was taken to hospital. He suffered significant physical and cognitive impairments and in February 2022 he died as a result of hypoxic pneumonia which the coroner attributed to brain injury dating from the hanging attempt in January 2018.

A missed appointment with a psychiatrist

18. In September 2017, MT's trial on multiple charges in Bristol Crown Court was adjourned at the request of his barrister for the defence to obtain a psychiatrist's report on MT's fitness for trial. MT was aware of this and mentioned it to a member of the prison staff. However, he did not know when the psychiatrist would see him. On 31 October an officer came to MT's cell to collect him, along with a group of prisoners, to attend the legal visits area. MT did not know the reason and refused to leave his cell. At the time he was known to be fearful of contact with other prisoners. The psychiatrist left the prison and no psychiatric assessment was conducted.

19. Current staff told us that in similar circumstances their judgment would have been to find out more about the visit and why MT was refusing, to escalate to managers if necessary, and to find a way to enable the assessment to take place, possibly in the healthcare unit. MT's solicitors told us that in their experience it was usual for prisons to notify a prisoner the night before through a slip under the door of the time and nature of any official visit scheduled for the following day.

Conditions at HMP Bristol in 2017-18

20. Inspection reports about HMP Bristol over the last decade indicate that the prison has been struggling, with a challenging environment, low staffing levels and high turnover among a largely inexperienced staff. Levels of violence, fear and self-harm have been high. These problems are self-reinforcing: for example, bedwatches and sick leave deplete the numbers of staff available on the wings; high numbers of ACCT plans, with 1157 opened in the year 2017-18, militated against consistent and considered membership of review teams. Too often, for case reviews, it was a matter of simply enlisting who could be available on the day.

21. Despite the tragic outcome of MT's distress we consider that in the circumstances of Bristol prison at the time it was to the credit of the custodial staff that they cared for MT as much as they did. But that is not to say that at an institutional level these circumstances are a humane or useful way of managing the prison population.

22. Current staff at Bristol told us of changes made or in progress since 2018. Staffing levels had improved and the number of ACCTs substantially reduced. Trained case coordinators assigned by the safety team endeavour to secure consistent multi-disciplinary review panels relevant to the nature of risk and support required. The key worker scheme is being introduced gradually, with priority given to a cohort of prisoners likely to present high risk. Peer support helps to support new prisoners. The weekly Safety Action and Safety Intervention Meetings provide for multi-disciplinary perspectives and actions on prisoners or areas of the prison presenting high risk.

23. The problems faced by Bristol are not unique. The Prison Service faces pressures on multiple fronts which cannot be solved by Bristol prison alone or even by the Prison Service. In the case of MT, our overall conclusion is that within the constraints in which the custodial staff operated there was much concern and care to support and help MT, and that leaders, the safety team and the operational staff are working hard in difficult circumstances to support the prisoners in their custody.

KEY FINDINGS AND RECOMMENDATIONS FOR HMPPS

(Key findings and recommendations for the healthcare agencies are reported separately in the next section.)

Case Notes from Birmingham prison

1. The time that MT spent at Birmingham is outside the scope of our investigation, but we were surprised that there was no entry in his NOMIS case notes recording MT's serious self-harm on 8 August nor that he was admitted to outside hospital in a serious condition. Entries in his case notes for 8, 16, and 29 August, and 10 September record the opening and closing of ACCT plans, but with no explanation of the circumstances.

Engaging with families of prisoners at risk as a source of support

2. The nature of MT's offences indicated the need for sensitivity, and consideration of safeguarding, but review teams had sufficient evidence of the value of MT's links with his mother to suggest that consideration could have been given to building on those links as part of the ACCT plan. The latest guidance on prisoner safety, which was not in place at the time, requires case coordinators expressly to record that they have considered engaging with family members.

Recommendation – R1 (see paragraph 3.71)

We ask the Governor of HMP Bristol to explain how ACCT practice there now complies with the current requirements about engaging with family members of prisoners identified as being at risk of suicide or self-harm.

Consistent relationships in ACCT and the key worker scheme

3. Building trusted relationships is a significant protective factor for prisoners at risk. The high number of open ACCT plans at Bristol at the time, coupled with staffing levels that

were often critically low, militated against consistent case management and membership of review teams, as mandated by the now current Prison Safety Framework. Case reviews did not draw on staff from other disciplines, such as the chaplaincy or psychology, and once MT was discharged by the mental health team, responsibility rested solely on the custodial staff. Interactions with MT and some case review records, show a commendable level of care and concern by wing staff.

4. At the time, the key worker scheme, in which officers are allocated time for regular one-to-one sessions with particular prisoners, was not in place. Currently Bristol is rolling out the scheme in phases, with priority to a cohort of prisoners identified as most likely to be at risk.

ACCT paperwork

5. The voluminous ACCT documents in this case were often hard to follow and some members of staff told us they did not find them efficient. Some staff typed their review summaries and reproduced them in case notes. Others did not. We are aware that HMPPS has endeavoured to refine the ACCT system over time and there have been various versions of the paperwork. Though well intended, these have sometimes seemed to make the system more not less cumbersome. Time spent completing records is time spent not engaging with prisoners. Some members of staff suggested that it should be possible with the aid of technology to streamline the system. Specific proposals are outside our scope or competence but we tend to agree.

Recommendation – R2 (see paragraph 9.27)

We invite HMPPS to comment, and to tell us whether they have in train any plans to streamline the ACCT system with greater use of technological solutions.

MT's fears

6. We have seen no evidence to substantiate the fears that MT repeatedly expressed that others were conspiring to harm him.

The meeting with the psychiatrist

7. It was deeply regrettable that MT missed the meeting with the psychiatrist. It is easy to see how this happened given the arrangements described to us as in place at the time. But in our view the prison should not simply have accepted MT's refusal without further enquiry.

Recommendation – R3 (see paragraph 3.80)

We ask the Governor and HMPPS to take note of what happened in this case and to say what systems are in place to prevent this happening again. If, despite the prison's best efforts, a prisoner insists on refusing an official visit there should be an auditable record of the circumstances.

Closure of the ACCT

8. In our judgment, the decisions taken by staff in case reviews in January 2018 at Bristol were understandable, competent and taken in good faith. Conditions and availability of staff at Bristol at the time compromised the staff's ability to meet best practice, with consistency of ACCT case management, and multi-disciplinary participation, but we have no reason to believe that this would have affected the decisions.

9. At the time, there was no provision in ACCT policy for post-closure monitoring – a daily check-in with the individual concerned, and completion of a daily monitoring sheet, in the week between the decision to close an ACCT plan and the post-closure review. This is now a requirement and we think it a welcome development.

Recommendation – R4 (see paragraph 5.38)

We ask the Governor of HMP Bristol to confirm that post-closure monitoring is in place and to comment on any evaluation of how it works in practice.

15 January

10. Staff responded swiftly to the discovery that MT had barricaded his cell. Once they were able to enter, they acted professionally to preserve life. There were problems in accessing the cell – staff could not immediately locate an inundation point key, or the key to the tool cupboard, and the heads of the bolts on the anti-barricade device were said to be eroded and painted over. The debrief identified these issues and assigned remedial actions.

Recommendation – R5 (see paragraph 6.26)

We remind the Governor of the problems accessing the cell and would like to be assured that these lessons have been learned and are the subject of regular checks.

The prison's investigation

11. The investigation conducted by the prison at the time omitted certain information, in particular, when the cellmate was unlocked that morning and whether he was able to give any information about MT's seeming mood that morning and in the days immediately before.

Support for staff

12. Conscientious efforts were made by the prison safety team to support staff involved, through the immediate debriefing and by offering the independent employee support services the Prison Service makes available to staff. Nonetheless, some staff still felt scarred by the events of the day and that they were insufficiently supported at the time.

Empathy and care for staff subject to traumatic events need also to be part of daily practice and the management culture.

Prison conditions

13. It is clear from the inspection reports that Bristol Prison continues to have problems and remains a challenging environment for both prisoners and staff. Many of the problems reported are not unique to Bristol. It is common knowledge today that the prison service faces crises on several fronts. Longer sentences and delays in the courts have led to a relentless demand for prison places that is unprecedentedly high. Britain is an outlier among European countries in the number of people we lock up. This in turn makes for an impoverished regime, compromising prospects of rehabilitation and reduction in reoffending; and work for staff which is unsatisfying, and sometimes worse, many of whom understandably vote with their feet and seek safer, more rewarding employment.

14. The scourge of debt and drugs, fuelling violence, fear and self-harm, requires smart solutions, to counter the various methods by which contraband enters establishments, and to focus on reducing demand through active regimes and therapeutic services.

15. The inspectorate will continue to monitor conditions at Bristol prison, but many of the problems there are national issues which cannot be solved at Bristol, or even by the Prison Service, without political leadership, and public understanding of what works to reduce reoffending. Meanwhile we wish Bristol well. Despite the tragic outcome for MT in this case, our overall conclusion is that within the constraints in which they operated there was much concern and care to support and help MT to overcome his demons, and that leaders, the safety team and the operational staff whom we met are working hard in difficult circumstances to support the prisoners in their custody.

Delay in commissioning the Article 2 investigation

16. Our investigation of the events of 2017-18 was commissioned in August 2024. Delays of this kind compromise the quality and value of investigations. Once it is clear that an

Article 2 investigation is required, we would urge HMPPS to set this in train as soon as possible after the events.

KEY FINDINGS AND RECOMMENDATIONS FOR THE HEALTHCARE AGENCIES

Readers are referred to the clinical review in Part Four of the main report for further elaboration of the points presented in summary here.

Summary of findings

H1. It is not appropriate to attempt to determine in retrospect whether or not MT was suffering from a severe mental illness at the time that he attempted to take his life. There is little detailed and objective information available to determine this. However:

- The quality of the recorded information in the healthcare record was not to the standard expected. Some of the entries contain potentially derogatory or irrelevant comments, and there was a lack of factual objectivity to a number of the entries.

- There appeared to be too narrow a focus on determining whether there was the presence of a delusional paranoid belief (that is, a false belief without evidence to support it), with little exploration of alternative possibilities. For example, assessors did not appear to take steps to determine whether there was some specific reality to Mr T's fears of being attacked Assessors did not appear to take a wider history from Mr T that might have assisted with considering personality problems or other background vulnerability factors.

- Repeated referrals back to the mental health team appeared to be associated with intermittent periods of intense distress in Mr T. There was no evidence in the healthcare record that these ongoing concerns expressed by others led to any attempt by the mental health team to re-assess the situation, or to escalate the case to another professional for a second opinion. In the clinical reviewer's opinion, this was a case where ultimately it would have been helpful to gather a full history of Mr T's background and to ask for a psychiatric assessment.

H2. Improvements to the quality of clinical record keeping in the prison healthcare record need to be made; this should include details of MDT discussions, appropriate language, and a greater emphasis on objective and observable commentary in relation to mental health statements.

H3. If an individual is repeatedly referred back to mental health services due to concerns – particularly those that relate to a risk of harm – then there should be a consistent mechanism for escalation and/or gathering a second opinion. That is, a culture of curious enquiry should promote a more challenging multi-disciplinary team discussion and a greater willingness to revise opinions.

H4. The deployment of limited mental health resources in the prison does not fully take into account the significantly heightened risk of suicide posed by men with sexual convictions, particularly at times of acute anxiety in relation to the criminal justice process. There is scope for an improved collaboration between healthcare and HMPPS in relation to care and support provided to the vulnerable prisoners' wing.

H5. This clinical review raised questions about the confidence with which it can be assumed that reception screening, and timely secondary mental health screening could identify a history of serious self-harm (or indeed, a diagnosis of multiple sclerosis) if it were not self-reported by the prisoner. There were also omissions in terms of appropriate medicines management as MT moved between prisons.

H6. The current healthcare provider explained the following changes to practice at Bristol prison:

- Referral scoring system
  A referral scoring system now highlights risk and complexity in cases, in order to assist with prioritisation. Managers can pull referral information from the healthcare record and can identify patterns of referrals.

- Records management audits

  The current practice is for healthcare managers to pull ten records randomly every month and audit the quality of record keeping.

- Reception screening

  Over the past year, a checklist has been developed in relation to suicide and self-harm, which references any previous records of relevance. Staff are regularly encouraged to go back into historical records once the initial screening process has concluded, and to use professional curiosity.

  Secondary screening is now conducted by a registered mental health professional (rather than a support worker) and it is expected that this results in care planning and a needs assessment.

- Integrated working

  Teams previously worked in silos, but now everyone participates in safety intervention meetings and safety action meetings. All MDT meetings are minuted, and individual prisoner discussions entered into their clinical record.

- Medicines management

  A new medicines management policy (2022) now embeds a rigorous process to check continuity between prison transfers and between the prison and community services.

- General improvements

  Managers confirmed that supervision of staff now regularly achieves the target of 80% of staff having supervision within four weeks. Vacancies in healthcare – which were 50% previously – are now considerably improved; currently there were only two vacancies in the team.

Action plan/recommendations

H7. Prison healthcare will need to evidence the above improvements, insofar as they are relevant to the learning points identified in this report. Demonstrating adherence to new policies and positive audit results will achieve this.

H8. There will be some residual actions required, particularly in relation to developing the care and support to the vulnerable prisoners' wing.

PART THREE: THE EVENTS IN DETAIL

This part of the investigation report provides some information about MT's history before he was in prison and then relates what happened when he was there.

For most of the time he was in prison, MT was known to be at risk of harming himself and, accordingly, for much of the time he was given special attention under the 'ACCT' scheme.

ACCT stands for Assessment, Care in Custody and Teamwork and it is the process used to support prisoners at risk of suicide or self-harm. The history of events makes frequent reference to ACCT, which provided special monitoring and frequent reviews of MT's welfare.

In Part Five of the report we say more about the ACCT scheme and how policies have changed since MT was in prison.

Chapter 1: MT'S HISTORY BEFORE PRISON

What MT's mother told us

1.1 MT was born in 1983 and was the oldest of four children. MT's mother and a family friend told us he was a good child with a wicked sense of humour but who would happily do what he was asked, and who loved gardening. MT came to the attention of the authorities when he was about 14. He was being taunted at school about a close relative, who unbeknownst to MT was in prison for a serious offence. MT started playing truant, then one of his sisters told their mother that MT had interfered with her sexually. MT's mother asked her doctor for help. The doctor felt obliged to tell Social Services. MT was cautioned and because of the other children in the family he was required to leave the family home. MT's mother said that at the time MT was still a child, it was traumatic for him, and everything went downhill from then. She felt that counselling and support could have helped MT but to the best of her knowledge none was provided.

1.2 MT lived with various family members, then in a children's home. His mother told us he started running away, and hanging about with the wrong type of people. He began to take drugs, and started stealing. In 2000 he served 12 months in custody under a detention and training order for shoplifting. When he was released, local criminals tried to coerce him into more offences and MT's mother sent him to live elsewhere with her mother. In about 2014, MT was diagnosed with multiple sclerosis.

1.3 For about two years from the age of 16, MT lived with a girlfriend, who gave birth to a daughter. Later MT had a relationship for 11 years with another partner and they had two children. In 2016, the partner reported to the police that MT had consistently abused her. When she was about 14, the daughter from his previous relationship resumed contact with MT and in 2017 she reported that MT had molested her, which MT denied. The allegations by MT's current partner were still under investigation but the daughter's complaint prompted his arrest in May 2017.

MT's criminal justice history

1.4 MT's first recorded offence was in 1997 at the age of 14 when he was warned for indecent assault on a minor. Multiple other convictions between 1999 and 2007 were for disorderly or threatening behaviour and property related offences, for some of which MT was given probation orders. The only custodial sentence before 2017 was a detention and training order of 12 months for conspiracy and theft in 2000.

1.5 In May and June 2017, MT was charged with offences under the Sexual Offences Act that were alleged to have occurred between 2007 and May 2017, and two charges of assault occasioning actual bodily harm alleged to have occurred between 2011 and 2015. He was remanded unconvicted to Birmingham prison on a single charge under the Sexual Offences Act, then transferred to Bristol prison, as the remaining charges were to be heard in Bristol Crown Court.

1.6 On 14 November 2017, at Birmingham Crown Court, MT was convicted and sentenced on the single charge to five years in prison. On 6 December 2017, at Bristol Crown Court, he pleaded guilty to four charges and was sentenced to a total of an additional 11 years. The remaining charges were to 'lie on the file', which meant they would not be pursued without permission from a court.

Chapter 2: BIRMINGHAM PRISON MAY 2017 TO SEPTEMBER 2017

2.1 MT was 34 years old in May 2017 when he was remanded to Birmingham prison. The reception records say MT said he had no history of mental health problems or psychiatric treatment, that he had never self-harmed, nor had any current thoughts of harming himself. He said he had not seen a doctor in recent months but that he had 'MS' (multiple sclerosis). Subsequently, on 14 August at a consultation with a GP at the prison, MT said he had a history of MS and had been under the care of a specialist in Bristol but was not currently receiving any treatment. In late August MT reported impaired vision and the prison GP prescribed Prednisolone.

2.2 On 29 July 2017 MT assaulted his cellmate. MT was placed on Basic regime, so deprived of some facilities. On 6 August he barricaded his cell and would not release the door for a nurse to conduct a health check. On 8 August, MT ligatured from a bedrail and his then cellmate raised the alarm. He was briefly in hospital, at first in an induced coma, then returned to the hospital wing at Birmingham prison, where he remained until transfer to Bristol prison via Bristol Crown Court on 11 September. An ACCT plan was opened immediately after the incident, but MT's mood seemed to improve, he was in touch with his family, and the plan was closed on 16 August. The plan named MT's mother as his next of kin.

2.3 MT's mother told us that when he was arrested in May 2017, she was shocked by the charges against him, and had no contact with him until Birmingham prison told her he had ligatured. She went to the hospital, where he was in intensive care. She was surprised he was discharged to the prison hospital so soon after regaining consciousness. She said there was no chance to talk with him about why he had ligatured as there was always somebody there when she saw him in hospital. When he was back in prison and able to do so they talked regularly on the phone.

2.4 MT's mother said that after the ligaturing MT complained of being unable to see out of one eye. He also started to say that everyone was against him, and staff and prisoners were going to harm him. He was paranoid, and scared to do anything. She recalled that

while he was still at Birmingham MT told her he heard from a cellmate that someone said all the others were against him and were going to attack him. She wondered whether his condition and perception had possibly been affected by a brain injury from the ligaturing, or by his MS.

2.5 On 10 September, the day before he was due to attend Bristol Brown Court, MT disclosed to prison staff further tentative attempts to ligature. He presented as distressed and tearful, and expressed fears that people intended to harm him. A new ACCT plan was opened. MT's mother was again recorded as his next of kin.

OBSERVATIONS

2.6 The time that MT spent at Birmingham is outside the scope of our investigation, but we were surprised that there was no entry in his NOMIS case notes recording MT's serious self-harm on 8 August nor that he was admitted to outside hospital in a serious condition. Entries in his case notes for 8, 16, and 29 August, and 10 September record the opening and closing of ACCT plans, but with no explanation of the circumstances.

Chapter 3: MT'S FIRST PERIOD AT HMP BRISTOL 11 SEPTEMBER TO 8 NOVEMBER 2017

Accommodation at Bristol prison: 'A' wing and the Brunel Unit

3.1 At Bristol prison MT was located either on 'A' wing or in the Brunel Unit.

3.2 'A' wing was a conventional Victorian prison wing housing 126 prisoners on three landings. The cells were designed for single occupancy but most were shared. It was a dedicated wing for prisoners considered vulnerable, either because of the nature of their alleged or proven offences, or because they were victims of bullying elsewhere in the prison, or in other ways likely to be at risk from prisoners on the main wings.

3.3 In 2017-18, the Brunel Unit was a small unit housing up to 18 prisoners with complex mental health or physical needs, in single cells, and with its own association and exercise areas. MT was located there under constant supervision in a gated cell when he was thought to be at extreme risk of imminent self-harm. The unit was managed by the prison staff and at that time a member of the mental healthcare team would be allocated to the unit during the day. Some staff told us that there was sometimes a tendency among prison staff, and even the courts, to see the Brunel Unit as a hospital wing for which healthcare were responsible. We were told, emphatically, by healthcare managers that this was not the case and that the unit was always managed by the prison.

Attending court and admission to Bristol prison

3.4 At Bristol Crown court on Monday 11 September, MT's barrister found him lucid but *'paranoid'* about people wanting to kill him and prison officers being complicit. From the court, MT was taken to Bristol prison. He was to return to court the next day.

3.5 On reception at Bristol prison, a supervising officer and the reception nurse noted that MT was on an open ACCT plan. They found MT insistent that he was not safe at Bristol, though he had no evidence to support this. He was said to be shaking and crying and claimed everyone was talking about him. His risk of self-harm was assessed as high and

he was to be observed four times an hour. He was assessed by a mental health nurse, who found MT's presentation as described by the reception staff but saw no evidence of a severe and enduring mental illness. MT was moved to a shared cell on A wing,

3.6 At court the next day, Tuesday 12 September, MT was seen by a mental health nurse from the Liaison and Diversion Service (LIDS) provided by the Avon and Wiltshire Mental Health Partnership NHS Trust. The nurse sent a screening report to Healthcare at the prison and told them that MT's solicitor would be requesting an adjournment for a psychiatric assessment. The report says MT presented as anxious and nervous, consistently referring to others wanting to harm him and hearing them talk of him in a derogatory manner. He presented as low in mood and tearful at times, with ongoing ideation of self-harm so as not to be harmed by others. He referred to a recent attempt to hang himself at Birmingham prison. On occasion, he portrayed what he perceived others to be saying about him. He did not feel himself to be mentally unwell and had no history of contact with community mental health services.

3.7 The LIDS report says it was not clear whether MT's self-reported experiences of hearing and believing that others in the prison were attempting to cause him harm were part of his personality or a response to stressors. Psychotic phenomena were considered, but, aside from self-reported auditory hallucinations, his objective presentation was said not to be congruent with any psychotic disorder.

3.8 At the request of MT's barrister, the judge granted an adjournment for MT's defence to obtain a psychiatric report about his fitness for trial. MT's solicitors telephoned Healthcare at the prison and left a voicemail message asking for an assessment. Healthcare left a message with the solicitors' receptionist saying that the solicitors would need to commission an independent report.

Constant supervision in the Brunel Unit

3.9 Back at Bristol prison that afternoon, MT ligatured from the bed rail in his shared cell on A wing and his cellmate raised the alarm. Officers supported MT and cut the ligature. MT

remained conscious. Healthcare staff attended. MT was moved to the Brunel Unit where he was placed under constant supervision.

3.10 An ACCT review the next day, Wednesday 13 September, confirmed that MT remained at high risk and constant supervision should continue. The duty governor requested a further mental health assessment. 'Practitioner 1', who was a Registered Mental Health Nurse, made a detailed entry in SystmOne (the clinical record) about the review, describing MT's insistence that prisoners and officers were laughing at him and that he would kill himself rather than be murdered. The nurse was sceptical of MT's claims that he had not slept and would not eat, and stated that he was *'convinced that his paranoia is clinically pseudo.'*

3.11 On Thursday 14 September, staff intervened when MT tried to ligature with a plastic bag while he was under constant watch. An ACCT review later that day agreed to obtain a PIN number for MT to phone his mother, to obtain e-cigarettes, and night medication for sleep, and confirmed the referral for a mental health assessment. MT was encouraged to use the exercise yard on the Brunel Unit and to look at puzzles and books to try to occupy his mind.

3.12 The mental health assessment requested by the duty governor was conducted the same afternoon by Practitioner 1 and the mental health team leader. The findings were similar to the assessment in reception. The assessors concluded they could see no evidence of any psychosis or elevated mood apart from MT being frustrated when the team did not agree with what he believed. He expressed himself calmly and clearly. His speech content appeared grounded in reality and was delivered normally. The conclusion was that MT would be discussed at the weekly multi-disciplinary meeting (the SPEM – single point of entry meeting) and a second opinion might be needed. MT's SystmOne medical record contains no reference to consideration at the SPEM meeting.

3.13 Seven ACCT case reviews are recorded between 13 and 21 September, whilst MT was under constant supervision. Constant supervision required authorisation by a governor. Reviews were led by the duty governor for the day, or by Custodial Manager 1 (CM1),

who was the manager of the Brunel Unit, and they were attended by constant supervision officers and a member of the mental health team. MT always attended and took part. He repeatedly presented as very frightened, insisting that he heard prisoners and staff talking about him, that they were determined to harm him and he would kill himself to avoid being murdered.

3.14 Case reviews held on Friday 15 and Sunday 17 September found little change and agreed that constant supervision should continue. The medical record says MT was not eating or taking medication for fear he would be poisoned. He declined a shower and exercise and was unwilling to engage. He had phoned his mother on the official phone as he did not yet have a PIN. He was unwilling to engage with any partner agencies, such as Samaritans or Listeners, and declined a referral to psychology. Staff were to encourage MT to consider associating for periods on 'A' wing, in preparation for leaving the Brunel Unit.

3.15 An ACCT review on Monday 18 September was led by Governor A as the duty governor for the day, with MT, Practitioner 1, and two prison officers. It was intended as a constant supervision review with a view to discharge from the Brunel Unit, but although MT engaged, he continued to say he felt in fear for his safety and would kill himself before others could kill him. Throughout the review he could not be distracted from this topic. Governor A concluded that he had concerns about removing MT from constant supervision. He noted that the mental health team said they did not believe MT was suffering from any acute mental illness and the GP had confirmed he was receiving the medication he was receiving in the community. MT had not been in custody for many years; Governor A considered he might be finding it hard to come to terms with being in prison and with the charges against him and might have strong feelings of guilt. Actions agreed were:

- Mental Health to reassess again
- referral to psychology
- to continue to be supported though ACCT.

- Brunel unit staff and the constant supervision officer to engage with MT about moving to a residential unit
- ongoing discussion to be held with MT about associating for periods on A wing, with a scheduled plan to locate full-time there.

3.16 Practitioner 1's entry about the review on SystmOne says that MT was adamant that if removed from constant supervision he would kill himself, and that he had shared his assessment that MT was not suffering from any enduring mental illness. The Review Team's view was said to be that MT was finding it hard to be in prison, having not been in custody for some 20 years and that he was finding it hard to come to terms with strong feelings of guilt.

3.17 An entry in SystmOne by the mental health team leader agrees that there was no sign of any mental health issue. MT is said to be future-focused and mentioned his mother and grandmother.

3.18 A case review the next day was led by CM1, recorded as Case Manager, with MT, Governor B, as duty governor, a mental health nurse and an officer. MT was said to still feel the same but was considering a move to A wing. He wanted a single cell and to self-isolate. He reluctantly agreed to go to A wing next day for short periods to collect meals and possibly for a period of association the following day. He was to remain under constant supervision.

3.19 On Wednesday 20 September, MT saw the GP about reduced vision in his left eye which was also painful to move. The doctor noted that MT had been treated with steroids for optic neuritis for three weeks but with no response, so he made an urgent referral to an ophthalmology service. MT was said to remain fixated on paranoid thoughts, with depressed mood. He spoke of hearing other prisoners shouting his name between cells. The doctor wondered if the steroids (Prednisolone) were contributing to his paranoia symptoms. He was said to feel slightly better now because of his contact with family. The GP prescribed a low dose of Sertraline, which is an anti-depressant, for two weeks and

asked for a review by mental health as soon as possible about possible anti-psychotic medication.

3.20 An entry by Practitioner 1 notes the referral by the GP but says that there are no new concerns not previously addressed and MT had been discharged from the mental health service. In a further entry that afternoon Practitioner 1 says MT continued with his delusions that people were talking about him and said that if he was required to go to A wing he would self-segregate. However, he had come out of his cell to collect meals, was eating and drinking well, was pleased to have his PIN to make phone calls, had watched television in the association room in the Brunel Unit, and visited A wing with an officer. Practitioner 1 disagreed with the GP that anti-psychotic medication might help, as there was no clinical evidence of psychotic phenomena.

3.21 On Thursday 21 September, SystmOne records that MT's mental healthcare at Step 1 of the stepped care model was ended. He was discharged from the caseload of the mental health team.

3.22 The same day MT attended an eye hospital. He returned with a handwritten note from the hospital instructing the phasing out of Prednisolone over the next three days.

3.23 A case review was led by duty governor, Governor C, with an officer and a nurse from the mental health team. This was intended to be a review before discharge from healthcare but in view of the fears MT still expressed about being bullied on the wing, a compromise was agreed of withdrawing constant supervision but MT remaining in the Brunel Unit for a period and visiting A wing. MT is said to have been willing to work with that, to seem more settled and to be smiling and engaging with staff. Risk level was assessed as low, with three observations required per hour.

3.24 According to case notes, the next morning MT packed his bags to move to A wing but then refused to go. He was given a direct order to move and when he refused, he was placed on report.

3.25 At an adjudication on Monday morning 25 September, MT was given a suspended penalty of loss of certain benefits for refusing to obey an order. He returned to the Brunel Unit, where Supervising Officer 1 (SO1), as Acting Case Manager led a review, with MT and an officer. MT is said to have engaged well but remained insistent that officers and prisoners were talking about his case and, that whilst he felt safe on the Brunel Unit, he had been threatened he would be stabbed if he was on a wing. He maintained that the threats had followed him from Birmingham.

3.26 Practitioner 1 did not attend the review but had advised that there were no apparent mental health issues other than MT's seeming paranoia about being in danger. The review reduced the risk assessment to low on the basis of MT's good presentation and own statements about his risk, and reduced the level of observations and conversations required, but advised that there would need to be a reassessment if MT was moved to a wing.

On 'A' wing

3.27 On Tuesday 26 September, MT refused a further order to move from the Brunel Unit to A wing and was moved there under restraint.

3.28 Supervising Officer 2 (SO2) was one of three supervising officers who were responsible for A and G wings. Only one of the SOs would be on duty at any one time. When MT was moved to the wing, SO2 led an ACCT review as acting case manager, with MT, a mental health nurse and a prison officer. MT repeated that he did not feel safe and said he would have strong thoughts of self-harm. He believed officers would conspire to speak about him openly, and prisoners would harm him because of his offences. He said that prisoners were shouting out of the windows at him when he was on the Brunel Unit. SO2 thought this unlikely, as MT was on A wing only briefly when he arrived at Bristol, and he tried to reassure him, saying that although he was the wing supervisor he was not aware of MT's circumstances, and that MT was in a good cell to feel secure as it was close to the office.

3.29 The SO assessed that risk had increased due to the restraint, specified two observations per hour, and a further review the next day.

3.30 The next day, Wednesday 27 September, SO3, one of the other supervising officers responsible for A and G wings and said to be acting case manager, met MT. There were apparently no others at the review. The note records that MT was quite talkative about wing induction and getting a job and trying to come out on the wing more and to integrate. He said he was not having thoughts of self-harm but he was still fearful. Risk was assessed as low, with observations reduced to one every two hours. The next case review was set for Monday 2 October.

3.31 Entries in the ACCT log for Saturday and Sunday include several conversations with officers. On Saturday 30 September, MT complained of a migraine and said he wanted to stay locked up to try to sleep it off. Officers visited him regularly and brought his meals. The next day he seemed better, and approached an officer on the landing who helped with his canteen order. Later in the day he rang his cell bell and asked for a chat. He told Prison Officer 1 (Officer 1) he was constantly hearing other prisoners plotting to stab him. He said he knew he had been paranoid before through lack of sleep but he now slept well yet still heard it. He was insistent that he needed to stay locked up, and said that if he changed his mind he would ring the cell bell. Officer 1 took his meal to his cell.

3.32 Later in the evening MT rang the cell bell. When a staff member responded, MT was sitting on the floor at the end of his bed with a ligature round his neck which was tight but not fatal. According to case notes, staff entered within a minute, a Code Blue alarm was raised, nurses attended but there was no risk to life. MT explained his action by saying he wanted staff to listen to him as he was convinced prisoners on the wing were out to get him and that prisoners had been shouting abuse from the windows.

3.33 An immediate case review was held, led by Custodial Manager 2 (CM2 - who was the night orderly officer, the responsible manager overnight), with MT, SO 4 and Officer 1. Risk was considered low but observations increased to one per hour. Officer 1 had been

outside, but heard none of the shouting MT claimed to have heard. The note says it became apparent that MT did not want to be required to share a cell and that his actions were intended to get staff to listen to him.

3.34 Following the events of Saturday night, on Monday 2 October, SO1, as case manager and wing supervising officer on the day, led a case review with MT. A mental health nurse provided information in advance but did not attend. SO1's notes say MT still seemed quite low in mood but appeared to be having a better day. He was still self-isolating because of perceived threats. He had been urged to come out and had gone to the gym a couple of days previously but at present he was unwilling to leave his cell even to collect meals. The notes say MT openly admitted he ligatured with the intention of forcing a single cell for himself. He expressed concerns about sharing, as he was self-isolating and did not want his door to be opened regularly. The SO explained that staff would keep MT in a single cell if possible, but operational needs might mean he had to share.

3.35 Risk was assessed as low and observations set at one per two hours and one conversation in each of the morning, afternoon and evening, but it was noted that the risk would need to be reconsidered if MT was required to share a cell, as this could act as a trigger. Meanwhile, staff would encourage MT to come out of his cell, to collect meals and to try to build up his confidence gradually. It was noted that the mental health team found no evidence to indicate a mental health condition but had suggested MT could be experiencing *'stress-induced paranoia'*.

3.36 A case note in the evening of 4 October summarises the events of the day. It says that MT had been self-segregating and ringing the cell bell regularly, claiming he could hear prisoners and staff talking about him and threatening to stab him. He was made temporarily 'high risk'. He had asked to speak to mental health and safer custody staff; a member of the mental health team had come to speak to him and safer custody staff were to assess his cell sharing risk.

Emergency mental health assessment

3.37 An emergency mental health assessment was conducted by Practitioner 2, who was a mental health social worker, and reported in SystmOne as follows:

'MT maintained good eye contact, he was kempt in appearance, his speech was normal, and he was well orientated in time, place and person. He appeared to have genuine worries about being attacked and was hard to reassure. There were some signs of low mood, and some signs of paranoid thinking. It was hard to know if MT was exaggerating what he believed he had heard officers say in order to obtain move to the Brunel Unit. MT did not appear hypervigilant when moving through the busy wing to the assessment. It was possible that feelings of guilt and stress about his impending court date were perpetuating fears. This was his first time in prison as an adult.'

3.38 The report says that, according to A wing officers, MT was constantly on his bell and crying and he was convinced people were out to get him. He had been assessed several times while in the Brunel unit but was not thought to be suffering a specific mental illness though it was hard to reassure him he would be safe on A wing. He said officers and prisoners were out to get him and were telling him through the cell door he would be stabbed and required to share a cell with a boxer who would kill him. He believed he was targeted because of the nature of his offence. He was not susceptible to reassurance that there were many people charged with similar offences on the wing.

3.39 At present MT was coming out of his cell only with an officer to collect medication. He said he was awaiting a psychiatric report and that he was not worried about court but about getting killed. He wanted to move to the Brunel unit or segregation or at least to be in a single cell. Practitioner 2 reassured him that ACCT had rated him high risk until the next review. MT acknowledged that it was likely he was safer on A wing than other wings. He said he didn't think he was unwell, and said that when he had put a noose round his neck and rung the cell bell he didn't want to die and it was for attention. He

said he had never self-harmed by cutting and had no current feelings of suicide or self-harm.

3.40 The note concludes that the result of the assessment was recorded in the ACCT record and fed back to officers; the assessment would be discussed at a multi-disciplinary team meeting with a view to discharge back to primary care. As before, we have seen no record of a discussion at a multi-disciplinary team meeting.

MT continues to self-segregate

3.41 A case note on Monday 9 October says MT was continuing to self-segregate. He was unwilling to come out of his cell under any circumstances, and continued to say he was hearing threats that other prisoners would stab him. He remained temporarily rated as at high risk and was increasingly paranoid about the prospect of having a cellmate.

3.42 On 13 October, MT was said not to be taking his medication as he was unwilling to leave his cell. Healthcare staff asked wing staff to bring MT to collect his medication and to record in handover instructions that the medication should be taken to the cell if MT was not brought out to collect it.

3.43 An ACCT review on Monday 16 October was again led by Custodial Manager 1, with MT, and a prison officer who was designated an ACCT officer, and with input beforehand from a mental health nurse. Healthcare did not attend the review and no healthcare staff attended or contributed to subsequent reviews at Bristol until 3 January 2018. The review summary says that verbal input from the mental health team was that there was no diagnosis of a specific mental health condition; MT needed to address his 'paranoia' before the mental health team could help him; and he was scheduled to see a GP.

3.44 MT is said to have talked freely in the review but was still adamant that people wanted to harm him and were talking about him all the time. He declined support from the chaplaincy, and Prison Visitor scheme and said that he did not trust the Listeners or the Samaritans. He said he had not and would not harm himself as he believed that if he did

he would be forced to share a cell. He was eating food delivered to his cell by staff but he believed it had been tampered with. He took prescribed medications when they were brought to him at the cell door. He was unlocked twice a week to telephone his mother when staff were able to unlock him on his own. His mother was unable to visit as she did not live locally. The prison's telephone records were no longer available at the time of our investigation so we do not know how frequently MT was in fact able to phone his mother, and other family members with whom he was also apparently in touch. MT was unable to suggest any way the review team could help him. It was decided to refer MT to the complex case team as ACCT was not achieving any progress. The case manager's note says she felt she had run out of options. Observations were to remain at three conversations each day, with one observation every two hours overnight. There is no record of MT being considered by a complex case team. So long after the event, staff were unable to explain this to us but possible explanations were thought to be that there was an informal conversation with the safety team that was not recorded, and that MT's demeanour soon began to improve, before he was then transferred temporarily back to Birmingham.

3.45 A clinical record for Tuesday 17 October says MT refused to leave his cell for various healthcare screenings.

3.46 CM1 led a further ACCT review the following Monday, 23 October, with MT and Prison Officer 2 (Officer 2). The note identified significant change. MT engaged well. He had been coming out of his cell with a few of the prisoners employed as wing cleaners and seemed to be getting on well with one in particular, who was encouraging MT to collect his meals and engage with others. He had also been out to use the showers alongside other prisoners. He was working closely with Officer 2 and appeared to have developed a positive working relationship. Officer 2 had arranged for MT to move to a cell on the quieter side of the wing which might help to relieve some of his anxiety about prisoners shouting out of the windows, and MT was in contact with his mother, with whom he had a positive relationship. He remained extremely anxious and unable to associate in full but there were positive steps from his previous self-segregation, and he expressed no thoughts of self-harm. Observations and conversations were to remain as before.

3.47 The next review, on Monday 30 October, was led by Supervising Officer 5 (SO5), as stand-in case manager, and attended by MT and an officer. The summary and entry in case notes say MT was happy to engage even though he had not met SO5 previously. MT explained the background and why he felt as he did. Wing staff reported that MT had become much more positive in outlook and conversation. He was continuing to come out of his cell to shower and exercise with the wing cleaners. It seemed that good social interaction was having a beneficial effect. MT was concerned about his impending court date and about the possibility of having to share a cell, but was said to be in a positive mood.

3.48 The next review, on Wednesday 1 November, was again led by CM1, with MT and Officer 2, who was working closely with MT on the wing. The summary, which was also recorded in case notes, reports little change. MT was still self-isolating to a degree but coming out of his cell with a small number of particular prisoners for parts of the day. He was not leaving the wing to engage with any support agencies. He still believed unidentified prisoners wanted to harm him but he had no evidence to support this. He seemed brighter in mood. He was maintaining contact with his mother and talking freely with staff about his court case. The risk of self-harm was considered low, so long as MT felt safe, but this might change if he felt under threat. Observations and conversations were to remain the same.

3.49 The case note says MT ate sporadically during the week as he thought his food had been tampered with. He had no specific thoughts of self-harm but maintained he was at risk from others and would kill himself before others could harm him. The case note also says that

'the previous week MT missed an important meeting with an external doctor for his defence as he was too afraid to go to the visiting area.'

MT returns to court then to Birmingham prison.

3.50 The next ACCT review was scheduled for Thursday 9 November but MT was to appear in Birmingham Crown Court on 8 November and was transferred back to HMP Birmingham. On 14 November he was sentenced to five years on one of the charges against him.

The meeting that MT missed with the psychiatrist

3.51 This reference in case notes is one of only two records we have seen at the prison about MT missing a meeting with the psychiatrist commissioned by his solicitors. MT was aware that his solicitors were arranging an assessment. During the mental health assessment on 4 October, he mentioned that that he was waiting for a psychiatric report. The solicitors say that, as recommended by the barrister, they instructed a consultant psychiatrist to prepare a report about MT's fitness for trial. They wrote to MT about this on 2 October but they had no date for the assessment at that time. The solicitors had a note from the psychiatrist's office saying that they had asked the prison for a 'legal visit' appointment for 0900 on 31 October but the solicitors had no record from the psychiatrist confirming that the visit had been arranged as requested or that MT was informed of the appointment. The solicitors say that when the psychiatrist attended the prison he

'was advised by the prison that MT had refused to see him. Accordingly, a psychiatric report was not prepared on MT.

3.52 An entry in the ACCT log by Officer 2 at 1135 on 31 October says that

'MT has been behind his door this morning and asked to check who visited this morning as he refused to go.'

3.53 None of the members of prison staff we interviewed recalled any knowledge of this occasion. Officer 2 left the prison service some years ago and we have not spoken to him. We asked members of prison and healthcare staff what they would expect to happen in

these circumstances. We also asked MT's solicitors for any further information they could give us about how the visit was arranged, how the prison and MT were notified, and what happened when the psychiatrist visited the prison.

3.54 Prison staff told us it was likely that the psychiatrist visit was booked as a legal visit. At the time, members of staff allocated as 'runners' would go round the wings once at the start of the morning and once in the afternoon collecting the prisoners due for legal or social visits in that session. They would be taken in groups to the visits area. Prisoners from A wing would be taken separately from prisoners on the main wings and there was a separate waiting area for the A wing prisoners, but the 'runners' were unlikely to know the prisoners, and if someone said they did not want to go that would probably have been accepted. We were told that the system is different now and that prisoners are taken in smaller numbers shortly before the time of their allotted appointment.

3.55 Prison managers told us that if a prisoner refused to attend an official visit of this kind, they would expect the officer to notify senior staff on the wing, who would probably go to see the individual concerned, to try to understand the issues, and to give assurances about his safety. If the individual still refused, they would expect escalation to the duty governor, and they would probably make some sort of provision for the psychiatrist to see him somewhere in a safe space, possibly in the Brunel unit.

3.56 The current Head of Healthcare said that if they were aware of an appointment for a psychiatric assessment, they would do their best to facilitate it, and could, for example, offer a private venue in the healthcare area, just as they would if they were aware that an assessment had been commissioned by a court.

3.57 However, healthcare staff described tensions in the system. Where a prisoner's defence commissioned a medical report, the report was private to them. It might or might not be helpful to the prisoner's case and the defence were under no obligation to consult prison healthcare or to share either the fact that an assessment would take place, or its content.

3.58 MT's solicitors told us that in their experience, when a prison legal visit is booked, the prison makes a note in the visitor's diary that the booking has been agreed. Then the night before the visit, prison staff

'will post a slip under the prisoner's door to notify them that they have a visit the next day. The notification slip normally states that it is a legal visit or, in the case of a clinical visit, I would expect it to say doctor or psychiatrist. This is to ensure that the client is aware that the visit is taking place and also so they can notify the prison officers, should they be in a different part of the prison, that they need to get to the prison visits area at a certain time.'

OBSERVATIONS AND CONCLUSIONS

What resources did the prison use to reduce MT's risk of self-harm during his first period at Bristol.

3.59 MT was on an ACCT plan from 10 September throughout the period. He was under constant supervision until 21 September. Risk assessments and the requirement for mandatory observations and conversations were reviewed thereafter in regular case reviews.

3.60 The voluminous ACCT documents were not always easy to understand. The summaries of case reviews were clear but the records of actions agreed were less so. The ACCT document at the time required actions to be recorded in a Caremap with responsibility, timescale, and completion, recorded and monitored. That was less evident to us from the documents, but overall the principal resource seems to have been engagement with custodial staff, who spoke with MT, who tried to demonstrate that his fears were groundless, and who encouraged him gradually, and seemingly with some success, to come out of his self-imposed isolation. In Chapter 9 we say more about the ACCT paperwork and make a recommendation (see paragraphs 9.26-9.27 – Recommendation R2)

3.61 The ACCT record for the period while MT was under constant supervision contains detailed accounts of MT's demeanour and of conversations with officers. Often, he was said to be distressed and fearful, saying he could hear people threatening his life, sometimes refusing food and drink in the belief they were contaminated, but sometimes seemingly in better spirits, engaging with officers, talking about his circumstances, his life before prison, and his future. Officers tried to reassure him that he would be safe on A wing, which was a unit for vulnerable prisoners, but MT claimed that his cellmate there when he arrived at Bristol had not been a vulnerable prisoner. We do not know whether that was true, but we note that not all the A wing prisoners were vulnerable by virtue of the nature of their offence. MT was encouraged to visit A wing accompanied by officers and began to do so.

3.62 MT consistently expressed fears that other prisoners, and possibly staff, were conspiring to harm him. A Victorian prison like Bristol is not a tranquil environment. The physical conditions, the hard, reverberating acoustic, the clanging of gates, shouting, between cells and out of the windows, can be alarming, and inspection reports at the time report a high incidence of fear among prisoners and of actual violent incidents. We say more about this in Chapter 8. The nature of the prison environment should be understood, but we have found no evidence that MT was subjected to particular threats or harm by others. SO2, who was responsible for both A and G wings told us he was not aware of any significant bullying on A wing at the time, and that A wing, the wing for vulnerable prisoners, was very different in character from G wing where there were violent incidents almost every day.

3.63 MT was assessed by members of the mental health team when he was admitted to Bristol on 11 September then, at the request of ACCT case managers, he was assessed again on 14 September and on 4 October, both times after he ligatured. There are references that MT would be considered by the team's weekly team meeting, but there is no note of this in MT's clinical record. Mental health team members attended most ACCT reviews until 4 October but when repeated assessments identified no severe and enduring mental illness MT was discharged by the mental health team and mental health staff no longer attended reviews. There is no indication that mental health staff were able to advise or support

the custodial staff in how to keep MT safe. The clinical review conducted by Dr Craissati says more about the role of the mental health team in Part 3 of our report.

3.64 The ACCT documents indicated that MT was aware of the Samaritans, the Listeners, and opportunities to engage with psychology, the chaplains, and prison visitors, but declined all these services. None of these services took part in case reviews. That might have been a missed opportunity to build trust, and current policy on ACCT emphasises the value of multi-disciplinary case review teams.

3.65 On A wing in October, in a single cell, MT initially was unwilling to come out to collect food, and medication or to engage with others. When necessary, staff would take medication and meals to his cell and accompany him to make phone calls. Progress was uneven but, encouraged by staff, he gradually emerged from isolation, first mixing with the prisoners who worked as wing cleaners. Some officers in particular recorded detailed engagement with MT, helping to reduce his anxiety and mistrust. One arranged for him to move to a quieter cell where he would be less disturbed by other prisoners shouting at night.

3.66 There are gaps in some of the records. Mental health assessments say that MT will be considered at the weekly multi-disciplinary meetings but there is no record of any such discussion in his medical record. An ACCT review on 16 October says MT will be referred for a complex case review but we have not seen any indication that this happened.

3.67 There are references in the ACCT documents to the value of MT talking with his mother on the telephone. There is no indication, however, that consideration was given to the staff engaging with MT's mother to help to support MT. When he arrived at Bristol, his solicitors were listed in place of next of kin, but the ACCT plan opened at Birmingham on 10 September and continued at Bristol clearly named MT's mother as his next of kin.

3.68 MT's mother told us that, on the telephone, he spoke to her of his fears he would be attacked. She said it was torturing for her at the time. She felt powerless, but would send him money to buy food so he didn't have to leave his cell. She told us she knew

nothing about a helpline for family and friends to report concerns to the prison, but she thought it unlikely she would have used it. When MT was at Birmingham, she told an officer of MT's fears but the officer's response was not consistent with what her son was saying and it deepened her mistrust of the prisons. Staff had never talked to her about MT's fears and neither MT nor the prison had told her that MT had tied ligatures at Bristol on other occasions before January 2018. She thought she should have been made aware of this and might have been able to help. We say more in Chapter 9 about family contact in keeping prisoners safe.

3.69 Case reviews were not always conducted by the same members of staff, but there was some consistency both at the case reviews, and, we saw from the observation logs, among some particular members of staff who made efforts to engage with MT. Consistency of relationships with case managers and other members of staff can only be helpful to the ACCT process. Several of the staff we spoke to during the investigation emphasised the value of this. The numbers of ACCT documents the prison was managing in 2017 made this difficult but we were told that it is now easier to achieve. We say more about this in Part Four of this report.

Engaging with families of prisoners at risk as a source of support

3.70 The nature of MT's offences indicated the need for sensitivity, and consideration of safeguarding, but review teams had sufficient evidence of the value of MT's links with his mother to suggest that consideration could have been given to building on those links as part of the ACCT plan. The latest guidance on prisoner safety, which was not in place at the time, requires case coordinators expressly to record that they have considered engaging with family members.

Recommendation - R1

3.71 **We ask the Governor of HMP Bristol to explain how ACCT practice there now complies with the current requirements about engaging with family members of prisoners identified as being at risk of suicide or self-harm.**

Consistent relationships in ACCT and the key worker scheme

3.72 Building trusted relationships is a significant protective factor for prisoners at risk. At the time, the key worker scheme, in which officers are allocated to particular prisoners, and time for regular one-to one sessions, was not in place. Currently Bristol is rolling out the scheme in phases, with priority to prisoners identified as at risk (see Chapter 9).

3.73 In Chapters 8 and 9 we examine the context of Bristol prison at the time and since. The high number of open ACCT plans at Bristol at the time, coupled with staffing levels that were often critically low, militated against consistent case management and membership of review teams, as mandated by the now current Prison Safety Framework. In spite of this, the evidence, in particular, of some records of interactions with MT and some case review records, show a commendable level of care and concern by wing staff. However, case reviews did not draw on staff from other disciplines, such as the chaplaincy or psychology, and once MT was discharged by the mental health team, responsibility rested solely on the custodial staff.

3.74 We are drawing attention to the importance of building trusted relationships, and of consistent multi-disciplinary input to ACCT case reviews, but we are making no specific recommendation, in the belief that staff at Bristol are aware of these objectives and are making strenuous efforts to achieve them.

MT's fears

3.75 We have seen no evidence to substantiate the fears that MT repeatedly expressed that others were conspiring to harm him.

The meeting with the psychiatrist

3.76 None of the staff members we spoke to remembered the occasion when MT missed the meeting with the psychiatrist, but it is easy to understand, from the system in place at the time how this might have happened. There must be some onus on defence teams to

ensure that their client is aware of the arrangements and to make the prison aware of the sensitivity and importance of the appointment, but when the solicitors had asked healthcare about obtaining a psychiatric report, there is no indication they were given any advice other than that it was for them to obtain the assessment. Their enquiry could have been an opportunity for the prison to explain the best way for them to liaise with the prison about a psychiatrist's appointment.

3.77 MT had told a member of staff early in October that he was expecting a psychiatric assessment but it seems he was not notified either by the psychiatrist's office or by his solicitors of the date the psychiatrist would visit. Suddenly confronted with an unexpected visit, and given MT's frequently expressed fears at the time, it is unsurprising that he declined to accompany a group of prisoners collected at the same time just twice a day to wait for their visitors. It is regrettable that apparently no one explained the nature of the visit to MT, or considered how he could be helped to attend. The absence of any record of his refusal at the time is concerning. Where a prisoner declines an official visit it would be appropriate to have signed confirmation of this from the prisoner and for a record to be kept, ensuring that the prisoner had been fully informed of the nature and importance of the visit

3.78 We note the information from MT's solicitors about the systems they understood to be in place in prisons with whom they have had dealings.

3.79 MT's mother will be left with distressing doubts about whether there might have been a different outcome if the psychiatric assessment had gone ahead. We cannot know the answer, but we know from the barrister's advice that, having found MT capable of giving instructions and seeming to understand that he was likely to be convicted, she thought it unlikely he would be found unfit for trial.

Recommendation – R3

3.80 It was deeply regrettable that MT missed the meeting with the psychiatrist. It is easy to see how this happened given the arrangements described to us as in place at the time.

But in our view the prison should not simply have accepted MT's refusal without further enquiry.

We ask the Governor and HMPPS to take note of what happened in this case and to say what systems are in place to prevent this happening again. If despite the prison's best efforts, a prisoner insists on refusing an official visit there should be an auditable record of the circumstances.

Chapter 4: 'MT' APPEARS IN COURT IN BIRMINGHAM AND MOVES BACK TO BIRMINGHAM PRISON

4.1 The next ACCT review was scheduled for 9 November but MT was to appear in Birmingham Crown Court on 8 November and was transferred back to HMP Birmingham. On 14 November he was sentenced to five years on one of the charges against him.

4.2 On reception at Birmingham prison, MT was seen by a nurse on 8 November then on 9 November when he again returned from the court. The records say he was referred for mental health triage, but there is no indication that this took place in the month he remained at Birmingham. The Liaison and Diversion Service at Bristol court was told on 23 November that he was on a waiting list for further assessment.

4.3 The ACCT plan remained open, with observations and conversations as before. MT requested a single cell but staff explained to him why that was not possible. Brief case reviews were held on 19, 20 and 21 November. A safer custody officer visited on 1 December. At a further case review on 5 December MT is said to have engaged well but to have been very emotional and upset about attending court the next day in Bristol.

4.4 On 14 November, at Birmingham Crown Court, MT was sentenced to five years. He remained in Birmingham prison until 6 December when he would return to Bristol for trial for other offences. An ACCT review on 19 November recorded that MT made good eye contact and engaged well. He reluctantly accepted that he could not have a single cell. He said he had no thought of self-harm and *'would not put his Mum through it.'*

4.5 Records on 21 November and 1 December indicate that MT was again expressing fears for his safety on the wing and asking for a single cell.

4.6 On 6 December MT left Birmingham prison for Bristol Crown Court where he was sentenced to 11 years for multiple offences, to run consecutively to the five year sentence from Birmingham. From the court MT returned to Bristol prison.

Chapter 5: BRISTOL PRISON FROM 6 DECEMBER

6 December to 3 January

5.1 MT returned to Bristol prison on 6 December after sentencing. The ACCT remained open. The clinical record notes that MT was on an ACCT plan and states that he was very quiet but reported no thoughts of self-harm. Sertraline last prescribed at Birmingham on 8 November for 28 days does not appear to have been continued.

5.2 In reception a supervising officer met MT and recorded ACCT review 24, though only the SO and MT attended. The note says MT seemed in a state of shock, though he said the sentence of 11 years was not unexpected. He said he had no thoughts of self-harm, though he had ligatured in the past. They discussed that he would have to share a cell. MT is said to have been *'not keen'* but to have understood the necessity.

5.3 On Thursday 7 December, Supervising Officer 6 (SO6) met MT on A wing. The note says the case manager was not available. SO6 found MT reluctant to engage and saying little at first. MT said he could not get his head round the length of his sentence. He had no interest in doing anything and just wanted to self-isolate. SO6 encouraged MT to think about getting some structure into his day but, currently, he was unwilling to work, he declined in-cell work and had no interest in the gym. He wanted to know who his offender supervisor would be for his sentence plan. He said he had no current thoughts of self-harm, but SO6 retained the current level of vigilance. Wing staff would be asked to encourage MT to engage in the wing regime and to seek some employment. MT was said to be aware of the Listeners and Samaritans.

5.4 On Tuesday 12 December, SO6 led a further review, with MT and Officer 2. The summary says MT was negative and uninterested and annoyed that he was not in a single cell. MT is said to have declined wing work as a painter, also the library, in-cell education, the multi-faith centre, and the gym, saying he just wanted to self-isolate, and that ACCT was pointless as he did not get what he wanted. The SO explained that MT's input was required. MT was said to engage with staff at unlock but not otherwise. He said he had

no current thoughts of self-harm but given his lack of engagement the review maintained observations and interactions as before. SO6 notes that he had spoken with wing staff to encourage MT to leave his cell. He had also offered a weekly psychology group for anxiety and explained Samaritans and Listeners again. MT refused all these suggestions. SO6 asked him to give it some thought and they could discuss again.

5.5 On Monday 18 December SO6, as case manager, led an ACCT review with MT and Officer 1. The summary says that MT was now coming out of his cell, mixing with other prisoners, and he had started work as a wing cleaner. He had accepted cell-sharing and said he got on with his cellmate. He said he occasionally thought of self-harm but not frequently. The review discussed MT's length of sentence and how it would progress. SO6 would find out who MT's offender supervisor would be. Observations were reduced to one conversation twice a day and two-hourly observations at night.

5.6 The ACCT log of observations and conversations with officers for 18 December says that MT asked about a painting job and spent the afternoon painting on the landing. Next day, he was said to be very happy when an officer confirmed he was arranging for him to have a job as a painter. In the following days MT began to collect his own meals from the servery, he was said to be pleasant and positive with officers, used the showers, and was seen laughing and chatting with other prisoners. On 25 December, he was playing board games in his cell with other prisoners. He was said to be smiley and engaging and seemed relaxed.

5.7 An ACCT review on 26 December was led by Custodial Manager 3 (CM3) with MT and SO2. MT is said to have said he had no thoughts of self-harm. He was working hard on the wing. Officer 2 would make sure he got paid and would find out from his offender supervisor which prison he would go to. MT said he wanted to keep the ACCT open. CM3 explained that it could not be kept open indefinitely if MT's issues had been resolved, but they would keep it open for the time being while they found out from the offender management unit where MT would serve his sentence.

5.8 Conversations with MT noted in the ACCT log in the following days indicate that for the most part MT appeared to be in a positive mood, collecting his food, mixing with other prisoners and eager to work as a painter. On 29 December, he complained of a migraine overnight but said he now felt better. On 30 December, Officer 2 noted:

'MT has been playing cards in his cell with several other prisoners this afternoon. Collected his lunch and engaged well with others. MT's attitude has improved vastly and his confidence has begun to grow – no concerns.'

5.9 On Tuesday 2 January Officer 1 made a note about a chat with MT during lunch. MT

'said he was feeling good. Asked me about applying for enhanced IEP [the highest level of incentives and earned privileges]*. I told him to apply as his behaviour is good. No issues or concerns raised.'*

5.10 Later that day MT is said to have been in his cell most of the afternoon chatting with other prisoners, and to have been *'very chatty and engaging when I spoke with him. No concerns.'*

5.11 The indications that MT was feeling more positive during this period were consistent with his mother's impression. She told us that the last conversation she had with her son while he was in prison was after Christmas, about the end of December. She said he had really picked himself up. The guards had given them chocolate and she had sent him some money to get a Christmas present. He seemed happier.

Wednesday 3 January

5.12 The next ACCT review was scheduled for Tuesday 2 January but did not take place that day. The next morning, an officer spoke with MT about getting a paid job as a painter, and found him in good spirits chatting with other prisoners, but later that morning, MT's mood appeared to changed and his demeanour at an ACCT review gave cause for concern.

5.13 The review, at 1106, was conducted by Custodial Manager 4 (CM4), who was custodial manager for A and G wings. This was the first review of MT's plan attended by CM4. He consulted the officer who had spoken with MT that morning and with the mental health nurse, Practitioner 1, but they did not attend the review. CM4's note of the review says MT was low in mood, and reluctant to engage, with minimal eye contact and short answers. He gradually spoke more, saying that other prisoners were talking about him, saying things that were not true. He said he could not handle this: it was 'the end' and he would kill himself when he got the opportunity. Asked what had stopped him doing so, he said that his cellmate had not been out of the cell long enough for him to be sure to do it properly. They discussed possible protective factors. MT spoke of family but gave no assurance family support would dissuade him.

5.14 In view of MT's history, which included seemingly significant attempts on his life, CM4 spoke with the duty governor, and MT was moved to the Brunel unit and placed under constant supervision. The risk of self-harm was rated as high. CM4's case note says that, on moving to Brunel, MT was unhappy with the decision and asked why he had been moved. CM4 explained that MT's comments had led him to believe that if his cellmate was out for a long period he would try to kill himself. Although MT then backtracked slightly, CM4's note says that he thought this '*was to try to avoid supervision rather than evidence contrary to his original findings*.'

5.15 CM4 told us that he did not recall having any specific previous knowledge of MT. He suspected he might have been designated as case manager on some ACCT documents simply because he was custodial manager for A and G wings. His focus at the time was more often on the more volatile G wing, where there were violent incidents almost every day. He became concerned when MT said that other prisoners were spreading false rumours about his offences, that he was not prepared to deal with this, and that he would kill himself if his cellmate was away for long enough. Constant supervision had to be approved by a governor. Now, as a governor, himself, CM4 said there would be a presumption for the governor to agree and review later. It was always with regret that you would put someone on constant supervision. It placed a heavy restriction on

someone's decency and well-being and they tried to use it only when absolutely necessary.

5.16 At 1445 that afternoon, a further review was held, led by Governor D as duty governor and attended by a constant supervision officer, mental health nurse Practitioner 1, and MT. The note says CM4, who had arranged the constant supervision, could not attend. We do not know why. It is possible he was no longer on duty that day. Governor D's note says that MT maintained he had spoken to CM4 in general terms about the last six months and he had no current thoughts of harming himself. From what MT said in the meeting, Governor D understood he was about to start a full-time painting job in the prison and he had a good cellmate. MT had recently been sentenced to 16 years but said he had been expecting longer. The governor notes that she had spoken with SO5, who would email MT's newly appointed offender supervisor, and that she was able to assure MT that his sentence plan would be carefully considered and he would see his offender supervisor several times before he was moved to another prison . From the discussion, Governor D noted that MT was looking forward to returning to A wing, he had a supportive cellmate, a television, and a painting job. He was thinking about the future, anticipating his transfer and was willing to engage in offending behaviour programmes. Accordingly, she rated the risk of self-harm as low, constant supervision was discontinued, and MT was moved back to A wing.

5.17 When we interviewed Governor D in 2025, she told us she had no active recollection of what happened that day but having reviewed the documents she suspected that MT's conversation with CM4 might have been prompted by the fact that his ACCT review was overdue. CM4 had consulted her because constant supervision could only be authorised by a governor and as duty governor she reviewed the decision in the afternoon.

5.18 In MT's clinical record, under the heading assessment by multi-disciplinary team, Practitioner 1 entered a summary of the issues discussed and the outcome of the review meeting.

5.19 Entries in the ACCT log later that day say that MT said he was regretting having said what he said to CM4 and was silly to have done so. He was said to be looking forward to his painting job, he was chatty when receiving his canteen, and he gave a thumbs up while watching television in the evening.

4 January to 14 January

5.20 On 4 January MT was seen by the national careers service. He started painting, first his cell, then on the landing, and he would start his full-time painting job next day. He is said to have appeared happy, collecting his tea meal then chatting with his cellmate, and still painting his cell during the evening.

5.21 In the morning of Friday 5 January, MT was said to be working well on the wing and engaging with others. An ACCT review in the afternoon was led by SO2, who was the supervising officer on duty on A wing, with MT and Prison Officer 3 (Officer 3). SO2 is said to be standing in for the case manager but it is not clear who was nominated manager at that time. Previously, SO2 had led a review of MT's ACCT plan on 26 September as acting case manager after MT was moved to A wing under restraint, and he attended the review led by Custodial Manager 3 on 26 December. Officer 3 usually worked on a different landing on A wing and told us she did not know MT well.

5.22 The summary notes that MT had been working well and painting on the wing but his demeanour changed in the review. SO2 said this was the second time he had seen this. MT stated that he still felt other prisoners were making threats and would harm him at HMP Woodhill although it was not known whether he would go there. SO2 assured MT that most prisoners on A wing were convicted of sexual offences. MT said he had no current thoughts of self-harm and was feeling better than he had two days before. SO2 noted positive factors, that MT was working well, getting on with his cellmate, talking to fellow prisoners and talking about his sentence in future terms. SO2 felt able to maintain the risk assessment as low, and to reduce observations, but concluded that he had insufficient knowledge of MT personally to close such a complex ACCT at that time.

5.23 On Saturday 6 January, Officer 1's entry in the ACCT log says MT spoke with him about how he went on a constant watch earlier that week. The note says MT

'told me what he said but said it was taken out of context as he always had these thoughts and feelings but manages them. He didn't get his lunch but said he was feeling fine.'

5.24 Entries in the following days indicate that at times MT seemed quiet and stayed in his cell but said he was OK. On Monday 8 January he said he was struggling with a migraine, but later felt better and resumed painting and seemingly mixing with other prisoners.

5.25 SO2, now designated case manager, led a further review on Wednesday 10 January, attended by MT, and an officer. The note says there was 'verbal input' (not attendance) from OCA (concerned with allocating prisoners to particular prisons), another wing officer, and a nurse from mental health. The information from OCA was about the prison MT would move to. He was said to be happy with that and pleased not to be going to another prison where he had feared he would be unsafe. There is no record of the content of the input from mental health.

5.26 Again, SO2 observed a difference between MT's positive presentation on the wing, where he seemed jovial and to be mixing well with prisoners and staff, and the 'sad figure' he presented in the review. The note says SO2 asked MT about this but MT did not comment.

5.27 The summary of the review says MT asked for a GP appointment to review his medication and this was booked for the end of January. He said he was feeling better and had no thoughts of self-harm but he would not guarantee to tell staff if that changed. He was observed to be mixing well on the wing, he was passionate about his painting job, and he was talking about his sentence in future terms. In light of these factors, the ACCT was closed. The record of observations in the ACCT document ends at 0930 on 10 January. A post-closure interview was set for 17 January.

5.28 The clinical record says that, on 13 January, MT declined a secondary health screen appointment.

OBSERVATIONS AND CONCLUSIONS

5.29 In this second period at Bristol, after the initial shock of his 16-year sentence, evidence from the ACCT files indicate a progressive improvement in MT's mood and outlook. He came out of his cell, engaged with others, apparently had a good relationship with his cellmate and worked enthusiastically as a painter.

5.30 The ACCT reviews from December onwards do not represent best practice. The reviews were not multi-disciplinary, though in January SO2 obtained information from Offender Management about MT's likely progression from Bristol and consulted Mental Health. We say more in Chapter 8 about conditions at Bristol at the time, where among other things, very high numbers of ACCT plans meant that staff were struggling, and allocation of case responsibilities was often a matter of who could be made available. Various members of staff acted as case manager, and various prison officers attended along with MT.

5.31 However, the entries in observation logs, by certain officers in particular, were conscientious, and informative. They showed active engagement and concern for MT. When the ACCT plan was closed on 10 January, there had been none of the suicidal behaviour that occurred during MT's first period at Bristol.

5.32 There were some setbacks. MT twice complained of suffering migraines. On 3 January, he briefly reverted to behaviour more familiar from his first period at Bristol. He was understood to be stating an intention to kill himself because of what other prisoners were allegedly saying about his offences.

5.33 The decisions taken during 3 January are understandable. CM4 was cautious, but Governor D explained her rationale for returning MT swiftly to the wing. She explained her reasoning but it is also worth noting that the constant supervision environment is not

a pleasant or healthy experience and an extended stay there would have been a retrograde step for MT, tending to undermine the progress that his demeanour at that time generally indicated.

5.34 Likewise on 5 and 10 January, SO2's notes show care and concern and explain his thinking, though we note that only SO2, and wing officers who do not figure in other records as knowing MT well, attended each of these reviews with MT, with only 'verbal input', not specified, from the mental health team and another officer, and information from Offender Management about the prison to which MT would be transferred. This would not meet the standard required for ACCT reviews required by the Prison Safety Policy Framework in place since January 2025, which requires that the decision to close an ACCT must be taken by a multi-disciplinary case review team – see Chapter 9.

5.35 In our judgment, the decisions taken by staff in case reviews in this second period that MT was at Bristol were understandable, competent and taken in good faith. Conditions and availability of staff at Bristol at the time compromised the staff's ability to meet best practice, with consistency of ACCT case management, and multi-disciplinary participation, but we have no reason to believe that this would necessarily have affected the outcomes.

5.36 What is striking, however, is the cliff-edge once the ACCT plan is closed on 10 January. Correctly, a post-closure review was scheduled for a week later, but we know nothing of MT's behaviour or state of mind during that week, save that he declined a secondary health screen on 13 January. MT had been accustomed to a good deal of attention from officers through the whole of his period at Bristol - a remarkable degree of attention in view of what the records show about the numbers of ACCT plans the prison was managing at the time. Possibly MT's initial suicidal behaviour was at times so overt that he stood out as on the more extreme end of the spectrum of prisoners at risk of self-harm.

5.37 We do not know to what extent staff continued to engage with MT after the decision to close the ACCT on 10 January. There are no records, and the staff we were able to speak

to barely remembered MT after such a long time. But the withdrawal of the attention conferred by ACCT is likely to have been a significant change of circumstances for MT.

Post-closure monitoring

5.38 At the time, there was no provision in ACCT policy for post-closure monitoring – a daily check-in with the individual concerned, and completion of a daily monitoring sheet, in the week between the decision to close an ACCT plan and the post-closure review. This is now a requirement and we think it a significant development.

Recommendation – R4

We ask the Governor of HMP Bristol to confirm that post-closure monitoring is in place and to comment on any evaluation of how it works in practice.

5.39 In Chapters 8 and 9 we say more about conditions at Bristol at the time, and the changes in ACCT policies and practice that have taken place since then.

Chapter 6: EVENTS ON 'A' WING ON 15 JANUARY

SUMMARY

6.1 On Monday morning 15 January 2018, when his cellmate was not in the cell, MT was found to have ligatured. He had barricaded the cell door and staff had difficulty entering. When they did, they found MT unconscious. They cut the ligature, moved him to the floor, and prison and healthcare staff tried to resuscitate him. An emergency ambulance attended and MT was taken to hospital, still unconscious. He was placed in an induced coma. He subsequently regained consciousness but suffered significant brain injury. On 12 March 2018 he was moved to a specialist brain injury unit, then on 8 October 2018 he was discharged from prison custody and moved to a psychiatric hospital where he was detained under Section 47 of the Mental Health Act 1983. Until 8 October, Bristol prison remained responsible for MT's custody and he was always accompanied by bedwatch officers from the prison.

6.2 MT died on 26 February 2022. The immediate cause was aspiration pneumonia but a Coroner's Inquest on 1 February 2023 found that this was a consequence of the hypoxic brain injury from the earlier hanging attempt.

The events on 15 January

6.3 Shortly after MT was taken to hospital by the Ambulance Service, the deputy governor convened a hot debrief for staff who had been involved, to examine the sequence of events and any urgent issues. In the days following 15 January, HMP Bristol prepared various reports, as required by the Prison Service. The account of events below is based on the notes of the debrief, the healthcare records, and those reports and we have also had the opportunity to question prison staff about what happened.

6.4 At 0545 on Wednesday 15 January, the prison control room was alerted by the staff member patrolling A wing that a prisoner (not MT) was unconscious in his cell. Healthcare and an ambulance were called. The prisoner was pronounced dead at the

scene. This was not a self-inflicted death. The cause of death was cancer and the Prisons and Probation Ombudsman commended the quality of care the prisoner had received during his illness. The police attended, as is routine when a prisoner dies in a cell occupied by two prisoners. According to the note of the 'hot debrief' held that morning the wing *'was secured due to the police presence'*.

6.5 We were told that, ordinarily, prisoners would have been unlocked from about 0845 for breakfast and domestic requirements, then those who were employed would go to work at 0900. Because the wing regime that morning was disrupted by the police presence, most prisoners remained locked in their cells. We have not been able to discover when or why MT's cellmate was unlocked and left the cell. Nor is there any record of the cellmate being asked about MT's mood that day or any detail about what support he was offered after the event, save that he is said to have been seen by a chaplain. The cellmate was discharged from prison some years ago. We do not know his whereabouts and the chaplain is also no longer at the prison.

6.6 According to the incident report, at about 1020 Officer 3 was unlocking the wing cleaners and, as MT was now a painter, she also went to his cell to unlock it. She observed that the observation glass was covered and she shouted to MT but there was no response. Officer 3 and Officer 2 tried to open the cell door but it was blocked. Officer 2 went to get a key to unlock the 'inundation point' (which covers a small space in the door through which a hose can be inserted in the event of fire), while Officer 3 and two wing cleaners tried to force the door. There was no inundation key on the nearest hydrant so Officer 2 obtained one from the office. He undid the inundation point and saw that MT had ligatured at the back of the cell.

6.7 Officer 3 called a 'Code Blue' alarm on her radio twice. This did not immediately register in the control room, apparently because of other radio traffic, but staff and nurses heard it and hurried to the cell. Healthcare staff brought their emergency response bag and oxygen. A GP, a paramedic, nurses, and a healthcare assistant attended. Having heard the alarm, a supervising officer made a further Code Blue call, which was received by the control room. Staff continued to try to force entry to the cell

but were unable to force the barricade. An officer went to get an anti-barricade key, which allows the cell door to be removed outwards, and staff removed the barricade and entered the cell. MT was unconscious. The clinical record estimates there was a delay of three to five minutes from the Code Blue alarm while attempts were made to open the cell, and that officers gained access at 1025.

6.8 Members of staff supported MT's weight and the ligature, which was a thick green cloth, too thick to be cut by the officer's anti-ligature knife. A supervising officer climbed on to the top bunk to remove the ligature. MT was lifted on to the landing outside the cell. Officers performed chest compressions while healthcare staff inserted a laryngeal airway to assist MT's breathing and gave intravenous injection of adrenaline.

6.9 Meanwhile the control room had called an ambulance. The Command Suite incident log says the ambulance arrived at 1028 and an emergency car at 1030. The clinical record says that paramedics arrived (at the cell) at 1035.

6.10 The medical staff commended the first aid provided by the prison staff.

6.11 At 1035 MT was said to be unconscious and fighting to take breaths on his own but his pulse was solid. The ambulance left the prison at 1101. MT was taken to hospital.

6.12 MT's solicitors had been listed as his emergency contact. At 1310 on 15 January, then again the next day, a member of staff telephoned the solicitors, who simply noted the information. The prison obtained further information from the police and in the morning of 16 January a governor telephoned MT'S mother, and a family liaison officer was named for further contact. MT's mother said she understood that before calling her the prison had called another more distant member of the family because that was the person whom MT had phoned most recently. She said this caused some problems for her and she thought the prison ought to have made a point of calling her first.

Issues identified in the debriefing meeting

6.13 Officer 3 called Code Blue twice with no acknowledgement. No alarm or follow-up transmission was made to activate the Code Bue protocol. Staff noted a 60-90 second delay before the control room acknowledged the Code Blue call.

6.14 The inundation key was not located immediately.

6.15 Staff attempting to retrieve the anti-barricade Allen key were unable to locate the appropriate key for the tool cabinet on the wing. CM4 attempted to smash the tool cabinet case. An officer left to collect D wing's Allen key but meanwhile the G wing cabinet key was located.

6.16 CM4 described difficulty removing the anti-barricade device and felt the bolts did not 'bite' correctly. He was concerned about rounding of the heads and noted they had been painted over. Once the bolts were removed, the back plate would not move easily. An officer used his baton to aid in removing the back plate.

6.17 The ligature was too thick to be cut with the 'fish knife' issued to staff for that purpose. A supervising officer climbed on to the top bunk and untied the ligature, but with difficulty.

6.18 The following actions were identified in response to these concerns:

- to review control room transmissions regarding the delayed response
- to review the accessibility of Allen keys
- to consider further the concerns about the anti-barricade devices and missing inundation keys.

6.19 The prison Safety Team wrote on 17 January to staff identified as possibly affected by what happened, inviting them to attend a confidential meeting facilitated by the Employment Assistance service contracted by the prison service for staff support.

OBSERVATIONS

6.20 There are gaps in our knowledge of what happened that morning. First and foremost, we do not know what prompted MT's actions, whether it was an impulsive or deliberated decision, whether his multiple sclerosis played any part in his motivation or mindset, to what extent disruption to the regime that morning may have affected the course of events. We do know that this was unlike the previous occasions when MT seemed to contemplate suicide. This time he barricaded his cell, which delayed by a few minutes staff entering the cell.

6.21 When they did so, prison and healthcare staff acted appropriately, supporting MT, removing the ligature, laying him on the floor and administering CPR until the ambulance staff were able to take over. The actions of all the staff concerned should be commended.

6.22 The hot debrief and follow-up examined immediate lessons to be learned about the need for keys to be readily accessible and the procedures to be followed in the case of a barricade. We do not know whether those lessons have been incorporated into regular checks, but we remind the Governor of the problems that occurred, and ask for confirmation that there are processes in place to ensure that the necessary keys are accessible, that staff know where to find them, and that anti-barricade devices are in working order.

6.23 We do not know when MT's cellmate was unlocked, or whether he could have helped in understanding MT's demeanour that morning, or in the days preceding. That information was not included in the incident reports prepared by the prison. We do know that the cellmate saw a chaplain, and we would hope that was with the intention of providing support, for what we can only assume would have been a shocking and upsetting situation for him.

6.24 Support for the staff involved after events of this kind is essential. It was clear to us that staff were significantly affected by what happened in this case. Some had made

strenuous efforts to support MT during the months he was at Bristol, others were involved in ACCT decision-making, others were physically involved in his earlier and final ligaturing. Sadly, experience of traumatic events is not an exceptional occurrence for prison staff. The Prison Service recognises this and there is much information and various services available to staff to help support those who experience traumatic events during their work, if they feel able to access them.

6.25 We noted particularly emphatic comments by two members of staff of their abiding memories, even after such a long time, of their experience of the aftermath of MT's ligaturing. One member of staff told us how he had to go directly from giving critical CPR to MT to another wing to prepare for control and restraint to assist in forcibly removing a prisoner who was unwilling to leave his cell for transfer to another prison. Another member of staff, who had been closely involved in ACCT decision-making, had been away on a course in the week of 15 January. When he returned to the prison he was shocked to learn casually, by accident, what MT had done. In addition to the various support services available to staff, line managers' vigilance and appreciation, valuing and recognising the responsibilities their colleagues carry is the bedrock of staff welfare.

CONCLUSIONS

Accessing the cell

6.26 Staff responded swiftly to the discovery that MT had barricaded his cell. Once they were able to enter, they acted professionally to preserve life. There were problems in accessing the cell – staff could not immediately locate an inundation point key, or the key to the tool cupboard, and the heads of the bolts on the anti-barricade device were said to be eroded and painted over. The debrief identified these issues and assigned remedial actions.

Recommendation – R5

We remind the Governor of the problems accessing MT's cell and would like to be assured that these lessons have been learned and are the subject of regular checks.

The local investigation

6.27 The investigation conducted by the prison at the time omitted certain information, in particular, when the cellmate was unlocked that morning and whether he was able to give any information about MT's seeming mood that morning and in the days before.

Supporting the staff

6.28 Conscientious efforts were made by the prison safety team to support staff involved, through the immediate debriefing and by offering the independent employee support services the Prison Service makes available to staff, but empathy and care for staff subject to traumatic events need also to be part of daily practice and the management culture.

PART FOUR:

THE CLINICAL REVIEW

Chapter 7

This chapter contains Dr Craissatti's examination of relevant health issues, including mental health assessments and MT's clinical care up to the point of his leg-threatening injury on 15 January 2018.

Dr Craissatti was commissioned by HMPPS at my request and I am grateful for her expertise and advice.

Introduction

7.1 This clinical review was commissioned by His Majesty's Prison and Probation Service (HMPPS). The scope of the review was from 11 September 2017 when MT arrived at HMP Bristol to 15 January 2018 when the serious incident occurred. However, there was an important event at HMP Birmingham one month earlier, when MT made a serious attempt on his life, and this is relevant to the matters considered in this review. I am also aware that MT's mother has expressed concerns that the self-harm incident in HMP Birmingham may have had more serious consequences on MT's health than had been appreciated by healthcare staff thereafter. I have therefore included in my considerations the period 15 May 2017 when MT arrived at HMP Birmingham to 11 September 2017 when MT arrived at HMP Bristol.

7.2 MT made a very serious attempt on his life on 15 January 2018. He was transferred to hospital and thereafter required 24/7 care in a secure hospital environment until his death from asphyxiation pneumonia on 24 February 2022. An inquest was held before a jury at Bristol Coroner's Court on 1st February 2023, and a verdict of death by suicide was returned[1].

7.3 As clinical reviewer I would like to express my sincere condolences to MT's family for this tragic loss of their loved one.

Methodology

7.4 In compiling this clinical review of the care and support provided by health services to MT during the period he was resident in prison, the clinical reviewer worked alongside the Independent Investigator but the opinions expressed in this report are solely those of the clinical reviewer, and independent of the wider investigation team.

7.5 I have drawn on the following documentation:

- MT prison health records (SystmOne) between 15.5.17 and 12.9.18.
- The independent clinical review, dated 21 July 2018, which was commissioned by the Health and Justice Commissioner to examine MT's healthcare in prison custody

[1] The asphyxiation pneumonia having arisen as a consequence of the hypoxic brain injury resulting from the earlier hanging attempt.

- Assessment, Care in Custody and Teamwork (ACCT) documentation for two periods (8.8.17-16.8.17; 10.9.17-10.1.18;)
- HMP Bristol post incident review, and associated email correspondence and documentation relating to the serious incident.
- Family Liaison Officer log of contacts.
- Typed notes of Independent Investigators' interview with MT's mother.
- Bristol Community Health Grade 2 Serious Incident 72 Hour Report (dated 2.2.18).

7.6 Interviews were conducted with the following:

- Practitioner 1 – Registered Mental Health Nurse
- Practitioner 2 – Mental Health Practitioner with a Social Work registration
- Head of Healthcare – from 2022 to the present
- Portfolio Manager for Offender Health Services (Avon & Wiltshire Mental Health Partnership NHS Trust, AWP) – previously Service Manager overseeing mental health care in five prisons including HMP Bristol.
- Deputy Head of Healthcare – from 2022 to the present; previously Mental Health Team Lead at HMP Bristol.

7.7 This review was somewhat hampered by the serious incident having taken place over seven years ago. Those interviewed varied in their ability to recall any details about their role in MT's care. Nevertheless, I am grateful to interviewees for their constructive participation in the review.

THE CONTEXT

7.8 **HMP Bristol** is a Category B men's prison taking individuals on remand from the local courts as well as convicted prisoners. The prison had been placed in special measures by HMPPS since a 2017 inspection. In May – June 2019, following a further unannounced inspection, HM Inspectorate of Prisons issued an urgent notification for HMP Bristol. The inspection found problems similar to those identified in 2017, including concerns regarding prisoner safety, high levels of violence, use of segregation, and adjudications;

there were increasing rates of self-harm with recommendations from the Prisons & Probation Ombudsman not having been implemented and poor care observed.

7.9 The **Brunel Unit** is a located within HMP Bristol, with 20 cells, one of which can be used for constant supervision. At the time that MT was in the prison, the unit had been used for prisoners who were vulnerable due to mental health or physical needs, and a registered mental health nurse was located on the unit for both a morning and afternoon shift. However, the unit was not a healthcare wing and was always prison-led.

7.10 The **commissioned provider of healthcare** has changed over time. When MT was at HMP Bristol, the lead provider for healthcare was Bristol Community Health CIC, who then subcontracted the provision of mental health services to Avon & Wiltshire Mental Health Partnership NHS Trust and subcontracted the provision of GP services to Hanham Health. The situation changed in 2022, and currently Oxleas NHS Foundation Trust are the lead provider of healthcare at the prison, and deliver the mental health services, subcontracting GP services to Doctor PA.

7.11 It may be relevant to this investigation that in August 2017, there was a **restructuring of healthcare services** in HMP Bristol due to financial constraints arising from the transfer of costs for escorts and bed watches from the prison service to prison healthcare contracts. We were told that this led to a reduction in the number of GPs within the service and an associated increase in responsibilities for the mental health teams as a result.

7.12 It was clear from our interviews that there have been considerable changes to the delivery of healthcare in HMP Bristol, with positive developments in terms of quality and clinical governance. Where it has been possible, I present evidence of improvements that are relevant to the findings of this review.

BACKGROUND DETAILS RELEVANT TO MT'S HEALTH

7.13 I am grateful to MT's mother who, in discussion with the Independent Investigation team, provided extremely helpful background information. A summary of the elements directly relevant to MT's physical and mental health are provided here.

7.14 MT was born on 16 February 1983 and was aged 34 when the serious incident occurred.

7.15 MT was described by his mother as having been a good child with a wicked sense of humour. It was only when he was aged about 14 – following an allegation against him by his younger sister, and subsequent caution from the police for indecent assault – that MT's situation and behaviour changed. Social Services became involved, and MT was placed in care, first with family members, and then a children's home. He truanted and commenced offending.

7.16 MT's mother confirmed that he had been diagnosed with multiple sclerosis in about 2014, after having symptoms of numbness and tingling pain in his legs. She thought he might have been prescribed medication for the condition, but this was not clear.

7.17 The charges against MT, as well as the trial and sentencing for them are relevant to this clinical review. MT was charged with multiple sexual and violent offences against his ex-partner (to which MT pleaded guilty), and one sexual offence against his daughter from a previous relationship[2] (charge which MT denied). He was found guilty of a number of the charges against his ex-partner, with others left on file, and received in total a sentence of 16 years. Impending court attendance was a clear stressor for MT as was his belief that people were speculating about him abusing his children; it is important to note that his final suicide attempt took place five weeks after he received his final and longest prison sentence.

[2] Whose age at the time of the alleged sexual assault was unclear from the documentation, but it seems she may have been over the age of 16 at the time.

CHRONOLOGY

7.18 A full chronology can be found in the wider Independent Investigation report. All the matters relevant to the key health concerns have been detailed below, based mainly on the prison clinical record, although I have extracted information from the Independent Investigators' review chronology where appropriate.

Date	Details
15/5/17	Arrives at HMP Birmingham. The reception screen is negative for mental health concerns. MT states he has multiple sclerosis (MS).
29-30/7/17	MT was alleged to have assaulted his cell mate. A subsequent security report described that MT said he was under threat from prisoners on the wing, who were being paid by MT's cell mate to do this. The security report refers to no supporting intelligence for this.
8/8/17	MT was found hanging by his bed sheets from the cell bars. He was transferred to an acute hospital, to the Intensive Care Unit. He was returned to HMP Birmingham on 11/8/17. The discharge summary confirmed that although he complained of some neurological symptoms (new onset expressive dysphasia), no immediate investigations were advised for this, and they recommended that prison healthcare refer back to neurology outpatients for any further investigations or problems regarding MS or otherwise. They also recommended review by the prison mental health team for depression/post event amnesia. MT was reviewed by a mental health nurse and said he could not recall the incident. Leading up to it he said he had punched somebody and that all other prisoners were out to get him and to harm him. An ACCT was opened, and observations were

	four hourly. Thereafter, healthcare notes reported settled behaviour and no thoughts of self harm. ACCT opened (then closed on 16/8/17).
29/8/17	MT reported to the GP a visual impairment to his left eye, where he can see big but not small objects. He reported that he was suffering from MS and this was the first occurrence of visual impairment. He was reviewed by the GP the same day who diagnosed 'classical optic neuritis' and prescribed Prednisolone (5mg tablets, six daily for seven days).
7/9/17	MT was reviewed by the GP, as his optic neuritis was not improving. A further one week prescription of Prednisolone was provided. Throughout, MT had been noted to be compliant with medication.
10/9/17	MT reported that he had attempted to hang himself during the night, he was tearful and upset. No injury identified. He overheard the word 'paedo' and was annoyed at others knowing his offences; he felt unsafe. He was not hearing voices but heard others talking about him. The mental health practitioner queried in the notes whether MT wanted to draw attention to himself and gain special treatment. Speaking to a charge nurse, MT stated he did not want to die but 'cannot take things anymore'. The charge nurse considered that he was understandably anxious about his court attendance the next day. He did not want to return to HMP Birmingham. He was warned about the risks of using ligatures and offered opportunities to talk to staff if concerned. ACCT opened.

11/9/17	MT asked the practitioner to walk him to reception (to go to court from HMP Birmingham) as he did not trust officers. The mental health practitioner considers that this was '*bizarre*' and that MT was '*making it up'*. **Arrival at HMP Bristol** When transferred from court to HMP Bristol, the MH screen at reception resulted in the triage nurse making an urgent referral for a medical review as she was concerned about MT's mental health. Concerns included that all the prisoners were out to get him, the whole prison was '*in uproar'* because he was there, and that the officers have been discussing this via computer; he said he 'has not stopped shaking or crying.' The ACCT was still open from HMP Birmingham. The practitioner (a mental health nurse) asked the nurse from the Brunel Unit to see MT the same day. The notes regarding MT's self harm at HMP Birmingham were copied into the SystmOne notes. MT did not declare a diagnosis of MS at reception on this occasion. MT was reviewed by the mental health nurse (Practitioner 1) in reception. MT repeated his concerns regarding other prisoners being likely to stab him. He spoke of the current charges, when asked about them. The nurse concluded that he 'appears to exhibit Crocodile tears with no eye contact with me'. '(He) appears to be preoccupied with paranoid themes although in the brief discussion we had, there was no evidence of delusional misinterpretation of events. No suicidal thinking. No suffering from a severe and enduring mental illness. He appears to be vulnerable, no expressing of feeling guilt of what he did and ? personality disorder'.

12/9/17	A practitioner in the Liaison & Diversion team at court reported to the prison that MT appeared to be hyper-vigilant at court. The same paranoid ideas had been expressed. MT was subsequently seen by a GP at the prison and was prescribed three days of sleeping tablets to help stabilise him. Later that afternoon MT attempted to hang himself. He was found on the floor, conscious. There were no marks on his neck, and he stood up, sat on his bed and explained why he had harmed himself. The plan was to move him to the Brunel Unit.
13/9/17	MT was reviewed by the mental health nurse (Practitioner 1) in the ACCT review meeting. The governor led the conversation. MT explained that he was scared, he said prisoners were after him, officers were laughing at him, talking about his alleged offences against his daughter. He said he preferred to kill himself rather than be killed. He said he would not eat but was observed to have done so; similarly said he had not slept but had been observed to the contrary. Practitioner 1 concluded that MT had good insight, 'knew his problem in relation to the sexual offences but now appears to put the blame on other people'. Practitioner 1 stated MT did not hear voices, and the nurse was confident that his paranoia was 'clinically pseudo'. However, the governor was asking for a mental health assessment. 20 mins later, MT tried to harm himself by putting a bag over his head, but this was reported immediately by another prisoner. He was alert but very upset.
14/9/17	Practitioner 1 reviewed MT at the governor's request (who was concerned about extreme paranoia), accompanied by another

	practitioner. The same concerns were expressed by MT, including that he has been set up. He explained all the charges against him, and 'stated people are coming to get him with a long Blade shoving in his rectum' which Practitioner 1 noted he found 'very rude'. He remained on constant observations. The plan was that 1. MT would be discussed at SPEM (single point of entry meeting) 2. A second opinion might be needed.
16/9/17	MT was said not to be eating as he believed that people were poisoning his food. He refused his medication.
18/9/17	The practice nurse questioned the prescription of Prednisolone, initiated at HMP Birmingham but not re-prescribed at HMP Bristol. MT was unable to explain the need for it. Two days later (20/9/17), MT was reviewed by the GP who considered that an urgent attendance at eye hospital (within 48 hours) was required. In terms of mental health, the GP identified poor sleep, weight loss, and a fixation on paranoid thoughts (as previously described). Specifically, MT reported hearing shouting between cells as if it was about him, and that he would hang himself before being stabbed by others. The GP commenced MT on a low dose of Sertraline (an anti-depressant medication), warned him of possible side effects, and aimed to review him in two weeks. The GP also asked for a mental health review with consideration of whether anti-psychotic medication may be helpful, although the GP also wondered whether the symptoms were steroid related. Note: first mention of his family by MT whilst at HMP Bristol; he said that previously his mother and grandmother were not speaking to him

	(because of the nature of his offences) but he was now in contact with them which makes him feel better. A referral to ophthalmology service was made, and to the prison mental health service.
20-21/9/17	Reviewed again by Practitioner 1. MT was observed to eat and drink well, watched television and appeared relaxed. The nurse disagreed with the doctor's suggestion regarding anti-psychotic medication. He then reviewed MT the following day and concluded by closing the referral and discharging MT from mental health care. MT returned from an outpatient appointment at the eye hospital, with written recommendation as to how to reduce and stop the current Prednisolone prescription.
25/9/17	MT was adjudicated for refusing to move from the Brunel Unit to A wing (the vulnerable prisoners wing), due to fears that he would be stabbed on the wing. He reported to the safer custody officer that he felt there would be a high probability of another suicide attempt if he were moved to A wing.
1/10/17	MT attempted to hang himself by placing bedding around his neck in his cell (on A wing). No physical trauma was evident, he was conscious, alert and orientated. The ACCT was already open, but observations were increased to two hourly. A review the following day noted that MT acknowledged the self-harm attempt was to force a single cell for himself, due to his fears.
4/10/17	A request for an urgent mental health assessment was made due to MT being very distressed, refusing to come out of his cell, and expressing

	paranoid ideas as before. He was seen by Practitioner 2 and thought to have genuine worries about being attacked on A wing and could not be reassured. It was thought possible that feelings of guilt and stress of the impending court date were perpetuating fears about his own safety. He stated he did not want to die and that this (his self-harm attempt) had been for attention; he wanted to be transferred to the segregation unit or to the Brunel Unit. The plan was to discuss MT at the multi-disciplinary meeting with a view to discharging him back to primary care.
16/10/17	Safer custody note from the ACCT review. MT refused the offer of a prison visitor or the chaplaincy team as said he would not feel safe enough to do this. He expresses a view that staff are involved in tampering with his food. It was agreed to refer MT for a complex case review. Daily support was being offered by officers.
23/10/17 – 1/11/17	NOMIS entries report that MT is allocated a single cell, and gradually his mood brightens with the support of officers. He stopped believing his food was contaminated, although was still cautious about leaving his cell and did not attend his legally instructed psychiatric assessment due to a fear of attending the visiting area.
8/11/17	MT returned from court to HMP Birmingham and completed the reception screen. He denied, when asked, that he had tried to harm himself previously in prison. However, this was subsequently picked up and MT was reviewed the next day before going to court, with a recommendation that he be followed up for a mental health triage. This was not followed up.
6/12/17	MT returned to HMP Bristol and was screened. He reported no thoughts of self harm.

	His prescription of Sertraline (28 days supply) – last prescribed on 8/11/17, did not appear to have been continued.
3/1/18	MT was reviewed by Practitioner 1 having been brought to the Brunel Unit on constant supervision. MT told the custodial manager that he felt suicidal. He said that there were rumours he '*touched his own kids'*; he said he would '*kill myself when I get the chance*' and that the only reason he had not done so was because his cell mate had not been out of the cell for a long enough period. He had been sentenced at court to 16 years. The custodial manager later felt that MT then backtracked on his comments a little probably due to not wanting to be on constant supervision in the Brunel Unit, rather than because there were no concerns. The manager tried to assess protective factors but was not assured that the support of MT's family would discourage a suicide attempt. He assessed the risk as high and MT requiring constant supervision. Later that day, MT said to the nurse that he wanted to return to A Wing and start his painting job, despite not feeling safe there, but said he had a good cell mate. The plan was to discontinue constant supervision and to relocate him on A wing.
10/1/18	The ACCT review concluded that MT denied any thoughts of self harm, he appeared to get on very well with his cell mate. However, he was a little low in mood. He asked for an appointment with his doctor as he thought he should be on certain medication (not specified).
13/1/18	MT was seen by the triage nurse in his cell and a secondary screen was offered which MT declined.
15/1/18	Suicide incident described:

	Healthcare staff responded to a code blue alert, MT having been found to have tied a ligature around his neck. Access to the cell was delayed three to five minutes as the door had been barricaded by MT. Once access was achieved, officers supported MT's weight, and he was then carried out of the cell (due to the door not opening properly) and resuscitation commenced on the floor outside. The subsequent procedures were all described in the clinical record and were administered promptly and appropriately.

KEY LINES OF INQUIRY ARISING FROM THE INVESTIGATION

Was MT's mental health assessed to a good standard?

7.19 At HMP Bristol, MT was first assessed by a mental health professional – Practitioner 1 – on the day of his arrival. The next day, a member of the mental health team at court reported their brief assessment to the prison. MT was again reviewed by Practitioner 1 at an ACCT review the following day; over the following six days (September 2017), MT was reviewed on two further occasions by Practitioner 1, at the request of a governor, and at the request of the GP. He was then discharged from the mental health team.

7.20 In October 2017, after an attempt to hang himself, MT was again referred to mental health services and was seen by Practitioner 2. He was subsequently discharged from mental health. MT was in HMP Birmingham for much of November but returned to HMP Bristol on 6th December 2017; MT had not declared a mental health history or self-harming behaviour at reception. There was no follow up by the mental health team at that point and a secondary screen by the registered mental health triage nurse was only offered on 13th January 2018, five weeks later. It is not clear whether his previous SystmOne notes were reviewed by any staff. However, there were renewed concerns regarding MT's mental health in early January 2018, and he was seen again by

Practitioner 1 whose clinical note does not document any details of a mental health assessment[3].

7.21 MT's healthcare record indicates that he was assessed or reviewed on seven occasions at HMP Bristol by mental health staff, following concerns raised by prison staff and, on one occasion, by a GP. In interview, Practitioner 1 said he had no recall - and Practitioner 2 was uncertain in this regard – as to whether he knew of MT's serious suicide attempt in HMP Birmingham a few months earlier, even though it had resulted in a three day stay in Intensive Care in an acute hospital. The notes of the incident had been copied into HMP Bristol's SystmOne record for ease of access.

7.22 The mental health concerns raised over this period of a few months can be summarised as follows:

- Persistent beliefs that prisoners were going to attack him; these were largely non-specific, although on one occasion he said he knew he was going to be given a boxer for a cell mate who was going to kill him.
- Believing that others were talking about him being a paedophile and hearing this being said.
- Suspicions about the trustworthiness of officers (refusing to walk to Reception with them) and believing them to have tampered with his food and to be laughing at him, talking about offences against his daughter.
- Believing the prison was 'in uproar' because he was there, and that officers had been discussing this via computer.
- Shaking and crying in distress, repeatedly ringing the cell bell.
- He was considered to be hypervigilant at court
- Reporting poor sleep and weight loss.
- Repeatedly declaring he would kill himself rather than be killed.

[3] Note NICE guidance: Mental health of adults in contact with the criminal justice system (NG66, March 2017, revised August 2024) provides detail on what constitutes good practice when assessing mental health in prison.

7.23 These concerns were not consistently reported, and it was also observed that there were times when MT was laughing and interacting with other prisoners, eating and sleeping well. He was offered support from a prison visitor or the chaplaincy and refused this. He denied previous incidents of self-harm at reception. More than one health practitioner recorded their views that he might be faking or exaggerating his symptoms.

7.24 In interview, Practitioner 1 could not recall MT, but his entries in the healthcare record suggest he dismissed the possibility of the presence of severe mental illness[4] with confidence and seemed to imply that MT may be presenting with exaggerated or fake symptoms in order to get his needs (unspecified) met. Practitioner 1 also raised the possibility that MT may be suffering from paranoid personality disorder[5], although he did not explore this further in his assessment, and it was not raised at future reviews. This opinion did not appear to change as a result of subsequent reviews. Practitioner 2 had some recollection of MT, and his entry in the healthcare record evidences a more detailed assessment: he concluded that there was no evidence of severe mental illness and hypothesised that MT's fears for his own safety were not unreasonable but were aggravated by his impending court date.

7.25 Both practitioners were confident that MT would have been discussed at their weekly multi-disciplinary team (MDT) meeting, but it was not practice at that time to record the meeting discussion in the healthcare record.

7.26 MT was prescribed Sertraline (an anti-depressant medication) by the GP on 18 September 2017. He appears to have been compliant with this until 13 October 2017 when he did not attend the medication hatch on the wing for his medication as he said he was too scared. Arrangements were made for the prison staff to escort MT to the medication hatch. Although a little unclear from the healthcare record, it seems that MT continued to be prescribed the medication until his return from HMP Birmingham in early December 2017.

[4] Severe mental illness is used as a term to include conditions that are chronic and have a significant impact on a person's life, such as schizophrenia, bipolar disorder and major depression with psychotic features.
[5] Paranoid personality disorder is a diagnosis that is characterised by a pervasive and persistent suspiciousness of others who are felt to be malevolent in their intentions.

7.27 All interviewees were of the same view, that the sudden cessation of Sertraline after two months of use would not have had a significant impact on MT's well-being. However, it does highlight a failure of effective medicines management in a situation where a prisoner is transferring between prisons.

7.28 The mental health team were involved – as per the policy – in the first review of any ACCT. Practitioner 1 attended MT's first ACCT review at HMP Bristol in September 2017 and then again after his return from HMP Birmingham in early January 2018. ***A full review of the ACCT process and any associated recommendations is detailed in the wider report*.**

Learning

7.29 It is not appropriate to attempt to determine in retrospect whether or not MT was suffering from a severe mental illness at the time that he attempted to take his life. There is very little detailed and objective information available for us to determine this. However, the following observations can be made:

- The quality of the recorded information in the healthcare record was not to the standard expected. Not only did some of the entries contain potentially derogatory or irrelevant comments, but there was a lack of factual objectivity to a number of the entries. For example, the word 'paranoid' was used without example or explanation, and 'poor sleep' was not detailed.

- There appeared to be too narrow a focus on determining whether there was the presence of a delusional paranoid belief (that is, a false belief without evidence to support it), with little exploration of alternative possibilities. For example, assessors did not appear to take steps to determine whether there was some specific reality to MT's fears of being attacked (that is, evidence for his fears being true rather than false); assessors did not appear to consider severe depression as an option or that MT's beliefs might represent overvalued ideas that could be preoccupying and resistant to reason. Assessors did not appear to take a wider history from MT that

might have assisted with considering personality problems or other background vulnerability factors.

- Repeated referrals back to the mental health team appeared to be associated with intermittent periods of intense distress in MT. There was no evidence in the healthcare record that these ongoing concerns expressed by others led to any attempt by the mental health team to re-assess the situation, or to escalate the case to another professional for a second opinion. In the clinical reviewer's opinion, this was a case where ultimately it would have been helpful to gather a full history of MT's background and to ask for a psychiatric assessment.

The assessment and management of enhanced suicide risks associated with those prisoners who are subject to criminal justice processes for sexual offences.

7.30 The risk of suicide is significantly elevated in men who are arrested/convicted/sentenced for sexual offences (see the systematic review summarised in the Appendix to this report). This risk has been found to be greater than that posed by prisoners in general and more than the risk posed by those individuals with a mental disorder.

7.31 MT's first and serious attempt to take his life at HMP Birmingham took place two months after his remand into custody and appeared, from the healthcare record, to be related to his perception that he was under threat from other prisoners on the wing. A subsequent attempt to hang himself a month later, the day before appearing in court, did not result in any injury, but appeared to be linked to MT overhearing other prisoners use the word '*paedo*' (paedophile). The day after his arrival at HMP Bristol – having appeared in court the previous day – MT attempted to hang himself but was found quickly and had suffered no physical harm. In explaining his actions, he referred to a belief that officers and prisoners were talking about alleged offences against his daughter. A month later, MT was very distressed and referred to mental health services due to fears of being attacked. It was thought that the stress of the impending court date was a contributory factor. In early January 2018, four weeks after having been sentenced, MT reported feeling suicidal as there were rumours that he had '*touched his own kids*'. It was clearly documented that

he said it was only his cell mate not having been out of the cell long enough that had stopped him taking his life thus far.

7.32 ***Overall, MT made four attempts to take his life between August 2017 and January 2018, only the first of which resulted in significant harm, prior to the serious incident that ultimately led to his death.***

7.33 All interviewees understood that men with sexual convictions posed a higher risk of suicide than the general population. However, both practitioners 1 and 2 highlighted that there were many vulnerable prisoners with sexual convictions placed on A wing, and that fears of being attacked by other prisoners were common and not entirely unreasonable. As far as they were able to recall the case (having re-read their notes), they acknowledged that MT may have posed a risk of self-harm, but as this was not, in their view, associated with any mental illness (see above), they considered MT best managed under the ACCT process with no direct input from mental health services. There was however no evidence in the healthcare record that issues of shame and anxiety in relation to sexual offences was explored in any depth with MT by the mental health team.

7.34 It is important to note that neither practitioner could recall whether they were aware, at the time, of MT's previous serious suicide attempt in HMP Birmingham; however, there is no indication in the clinical record that this first serious self-harm incident was taken into account by mental health practitioners when assessing MT's risk or mental state. Knowledge of the first attempt may have raised more concerns.

NOTE: a wider review of the HMPPS response to MT's suicide risk is discussed in the wider report. In discussion with the investigation team, the clinical reviewer accepts that there was evidence for good quality support being provided by officers to MT.

Learning

7.35 Perhaps with the benefit of hindsight, one can see that MT was most distressed at times when he was due to appear in court, returning from court having been sentenced, and

when transferring between wings. That he believed others thought him to be a paedophile was a key triggering belief[6].

7.36 The clinical reviewer appreciates that mental health teams in prisons have limited resources which are required to provide care to a large number of prisoners with significant mental health difficulties, many of whom may pose a risk of self-harm and suicide. However, on this occasion, when under pressure of time, it seems that assumptions were made that MT's anxieties were no different to those of others, without fully exploring the details and depths of those anxieties.

7.37 The clinical reviewer is in agreement with the current Head of Healthcare who suggested in interview that more could be done regarding the role of healthcare with those who have sexual convictions. Although actions need to be proportionate, in light of the need to deploy resources carefully, a greater presence on the vulnerable prisoners wing, and closer relationships with HMPPS staff to deliver support jointly, might be important in keeping suicide risk as low as possible.

How should a self-reported diagnosis of multiple sclerosis be managed in custody

7.38 MT self-reported a diagnosis of multiple sclerosis (MS) when he first arrived at HMP Birmingham, but no further action was taken. Three months later, following a serious suicide attempt and a three day stay in Intensive Care in the local acute hospital, the discharge letter contained a recommendation for neurological outpatient follow up. Two weeks later, he was diagnosed by the GP with optic neuritis - a condition where inflammation damages the optic nerve and associated with MS – and prescribed Prednisolone (a steroid medication that decreases inflammation). He was followed up a week later, and the prescription continued.

[6] In their systematic review, Key and colleagues conclude that the high suicide risk associated with men with sexual convictions warrants the involvement of mental health services. They recommend that clinicians should target the shame and feelings of burdensomeness that offenders commonly experience, as well as identifying a clear pathway for those experiencing a crisis in adjusting to their situation who are not already known to public services.

7.39 When MT transferred to HMP Bristol on 11 September 2017, he did not mention MS at the health screening in reception, and although the HMP Birmingham healthcare notes were copied into SystmOne, no action was taken in relation to MS. However, a week later, the practice nurse questioned the prescription for Prednisolone and MT was reviewed by a GP two days later. The GP recommended urgent attendance at an eye hospital, a referral to community ophthalmology was made and MT was seen by this service a few days later. He returned to prison with written advice as to how to reduce and stop the Prednisolone. No referral to neurology was made, and no further reference to MS can be found in the healthcare record.

7.40 It was clear that none of those that we interviewed and who were working in healthcare at the time knew of MT's diagnosis of MS. There were differing views as to how relevant this diagnosis was to the assessment and management of MT's mental health, but all agreed that at the very least, GP and physical health nurses should have followed up MT.

Learning

7.41 It is clear that there was a missed opportunity at reception screening, to follow up on MT's self-reported diagnosis – subsequently confirmed by the hospital discharge letter – and request a review by the prison GP service, with a subsequent care plan developed. This missed opportunity was then compounded by HMP Bristol staff not noticing the diagnosis in the clinical record. Interviewees confirmed that they would have expected MS to be picked up at a secondary screening by healthcare staff within a week of arriving at the prison. It was also not clear that healthcare staff intended to check for the side effects of steroids (such as raised blood pressure or blood glucose). Although correct to refer MT to ophthalmology first, this should have been followed up by a prompt review by neurology, which did not take place.

7.42 There is no indication from the clinical record that MT's mental health was directly affected by his neurological condition. However, as healthcare managers in interview agreed, there could in principle have been implications for any mental health assessment,

in terms of the psychological consequences of the diagnosis, managing pain or impaired mobility.

Was the healthcare response to the serious incident in line with policy and best practice?

7.43 The management of the serious incident is discussed in detail by the wider report, including delays arising as a result of difficulties accessing the anti-barricade keys and accessing MT's cell. Healthcare staff were present and gained access to MT's cell and assisted officers in untying the ligature before taking control of the situation once MT was laid down on the landing. The healthcare record (SystmOne) provides details of the ventilation and resuscitation process until the ambulance crew arrived (within 15 minutes of Code Blue having been called. All actions taken by healthcare were timely and appropriate[7].

POST INCIDENT REVIEWS

7.44 The **72 hour review** carried out by Bristol Community Health provided incomplete details of MT's contact with health services, and did not recommend any actions. Bristol Community Health no longer provide healthcare in HMP Bristol.

The independent clinical review commissioned by NHS England

7.45 An independent clinician was commissioned by the Health & Justice team at NHS England to provide a review of this serious incident (final report dated 21/7/18). Although not entirely clear from the report, it seems likely that this report was a desk top review of MT's SystmOne record.

7.46 The independent review concluded that MT developed a persistent paranoid thought at some point during his prison stay and that these pervasive thoughts that others were out

[7] This was also the view expressed in the independent clinical review commissioned by NHS England

to harm him led MT to attempt to end his life on multiple occasions. independent clinician's view was that MT probably should have been formally assessed by a consultant psychiatrist and an evidence-based plan put in place that was agreed by all parties involved. The review went on to recommend that prison mental health services ought to consider asking the prison psychiatrist for an opinion when other measures to reduce prisoner risk do not appear to be working.

7.47 The current investigation was not able to identify any action plans developed as a result of the two reviews. However, positive developments have taken place, and the relevant details are provided in the section below.

SUMMARY AND RECOMMENDATIONS

7.48 MT was remanded to HMP Bristol at a time when the prison was facing considerable challenges, and this included challenges in the mental health team being able to meet the needs of a large number of vulnerable prisoners with mental health needs. There appears to be good evidence that MT was extremely troubled by the sexual nature of the charges he faced at court, and most particularly by the alleged offence against his daughter. He made a number of self-harm attempts prior to the serious incident that tragically resulted in his later death and was repeatedly referred to mental health services due to concerns about his well-being.

7.49 This clinical review has focused on the care and support provided by healthcare staff and is only one part of a wider review by the Independent Investigation team. The clinical review has found that there were a number of learning points arising as a result of our investigation which lead to our recommendations:

- Improvements to the quality of clinical record keeping in the prison healthcare record need to be made; this should include details of MDT discussions, appropriate language, and a greater emphasis on objective and observable commentary in relation to mental health statements.

- If an individual is repeatedly referred back to mental health services due to concerns – particularly those that relate to a risk of harm – then there should be a consistent mechanism for escalation and/or gathering a second opinion. That is, a culture of curious enquiry should promote a more challenging multi-disciplinary team discussion and a greater willingness to revise opinions.

- The deployment of limited mental health resources in the prison does not fully take into account the significantly heightened risk of suicide posed by men with sexual convictions, particularly at times of acute anxiety in relation to the criminal justice process. There is scope for an improved collaboration between healthcare and HMPPS in relation to care and support provided to the vulnerable prisoners' wing.

- This clinical review raised questions about the confidence with which it can be assumed that reception screening, and timely secondary mental health screening could identify a history of serious self-harm (or indeed, a diagnosis of multiple sclerosis) if it were not self-reported by the prisoner. There were also omissions in terms of appropriate medicines management as IT moved between prisons.

UPDATED ACTIONS FROM THE HEALTHCARE PROVIDER

Referral scoring system

7.50 The current healthcare provider has introduced a referral scoring system that highlights risk and complexity in cases, in order to assist with prioritisation. Managers can pull referral information from the healthcare record and can identify patterns of referrals.

Records management audits

7.51 The current practice is for healthcare managers to pull 10 records randomly every month and audit the quality of record keeping.

Reception screening

7.52 Over the past year, a checklist has been developed in relation to suicide and self-harm, which references any previous records of relevance. Staff are regularly encouraged to go back into historical records once the initial screening process has concluded, and to use professional curiosity.

7.53 Secondary screening is now conducted by a registered mental health professional (rather than a support worker) and it is expected that this results in care planning and a needs assessment.

Integrated working

7.54 Teams previously worked in silos, but now everyone participates in safety intervention meetings and safety action meetings. All MDT meetings are minuted, and individual prisoner discussions entered into their clinical record.

Medicines management

7.55 A new medicines management policy (2022) now embeds a rigorous process to check continuity between prison transfers and between the prison and community services.

General improvements

7.56 Managers confirmed that supervision of staff now regularly achieves the target of 80% of staff having supervision within four weeks. Vacancies in healthcare – which were 50% previously – are now considerably improved; currently there were only two vacancies in the team.

ACTION PLAN

7.57 Prison healthcare will need to evidence the above improvements, insofar as they are relevant to the learning points identified in this report. Demonstrating adherence to new policies and positive audit results will achieve this.

7.58 There will be some residual actions required, particularly in relation to developing the care and support to the vulnerable prisoners' wing.

APPENDIX

KEY EVIDENCE-BASED GUIDANCE

The risk of suicide in men with sexual convictions

Key R, Underwood A, Farnham F, Marzano L, Hawton K. Suicidal behavior in individuals accused or convicted of child sex abuse or indecent image offenses: Systematic review of prevalence and risk factors. Suicide and Life Threatening Behavior. 2021;51:715–728. https://doi.org/10.1111/sltb.12749.

Key and colleagues (2021) reviewed all the published research on suicidal behaviour in individuals with an arrest or conviction for sexual offending, excluding articles where the method of research was unclear or limited. In examining the remaining 18 research publications, the authors drew the following conclusions:

- Although the rates of suicide vary from study to study, there is a very clear and major excess of suicides in child sexual abusers as compared to the general population (perhaps around 100 times the rate). This excess rate is greatest for those who download illegal images but remains very high for those with contact sexual offences. The suicide rate in male child sexual offenders has been found to be three times higher than in men identified as having a mental disorder.

- The rate of suicide in individuals convicted of sexual offences against adults also appears to be high, with a suggestion that it is highest in those with both adult and child victims.

- The risk of suicide is at its highest within 24 hours of being arrested for a sexual offence, and over the following month. However, the risk remains elevated at key moments during the criminal justice process, including shortly after conviction and sentencing. In a number of studies, having no or limited history of contact with the criminal justice system was an important factor in elevating risk.

- There was no clear picture regarding the role of a mental disorder contributing to the suicide in this group of individuals. Depression was commonly diagnosed after a person was convicted, but this rarely resulted in a specific mental health intervention; suicides appeared to be a response to acute stress factors relating to the criminal justice process, and feelings of shame and stigma were key to understanding this response. This was thought to be particularly so when individuals were no longer able to use strategies such as denial and minimisation to avoid facing up to their offending behaviour.

- The authors recommend that despite the lack of major mental health difficulties, the extremely high suicide risk in these individuals does warrant mental health involvement in their care. They suggest that clinicians should target the shame and feelings of burdensomeness that offenders commonly experience, as well as identifying a clear pathway for those experiencing a crisis in adjusting to their situation who are not already known to public services.

NICE guidelines for suicide

Self-harm: assessment, management and preventing recurrence (NG225, September 2022, reviewed August 2024)

Subsection 1.8.8-1.8.12: assessment and care in the criminal justice system and other secure settings

Staff should be aware that those in their care have higher rates of self-harm and suicide.

Staff should be aware of support services available to them to support their own wellbeing.

Staff should be aware of arrangements for:

Transferring people to a healthcare setting when necessary

In-reach or onsite support

Their responsibilities for information sharing

How to access health services

Staff should follow local guidance on assessing people who have self-harmed and should also follow the NICE guideline on mental health of adults in contact with the criminal justice system.

Staff should ensure that people who have self-harmed have a safe location to await assessment or treatment following an episode of self-harm.

The guidance specifically states that staff should not use diagnosis, age, substance misuse or coexisting conditions as reasons to withhold psychological interventions for self-harm (1.11.9).

PART FIVE:

THE CONTEXT – CONDITIONS AT HMP BRISTOL AND THE POLICIES INTENDED TO KEEP PRISONERS SAFE

Chapter 8: HMP BRISTOL

8.1 Bristol prison is a Category B local and resettlement prison holding male adult and young adult prisoners. In 2017 it had a population of about 550 prisoners across five main wings. One wing has single cells. Elsewhere most cells are shared. There is a high turnover of prisoners, many of whom are on remand awaiting trial, others, following sentence, are waiting for transfer to a training prison. Most of the buildings date from the 19th century. They are of traditional prison design and not easy to maintain. When we visited, we found the accommodation clean and reasonably well-maintained but we found the residential units we visited unavoidably dingy and cheerless.

8.2 The prison has had a troubled history in the last decade, due in part to a challenging environment, but also to the difficulty of attracting and retaining sufficient staff. A high proportion of the staff, whilst not lacking in motivation, are young in years and experience. Permitted staffing levels are not generous and provide little margin for staff diverted from the wings through bedwatches, training or sick leave. Note, for example, that from 15 January until 8 October 2018, while MT he was in hospital, Bristol prison remained responsible for his custody and he was always accompanied by bedwatch officers from the prison – see paragraph 6.1 above.

His Majesty's Inspector of Prisons (HMIP) inspection of Bristol prison in March 2017

8.3 In 2013 HMIP reported serious concerns about the prison. A follow-up inspection in 2014 found some improvement, but then in March 2017 the inspectorate reported that standards had declined. The prison was found to be less safe than before, and purposeful activity was at its lowest level ever. The report makes shocking reading, with a catalogue of dirty and dilapidated conditions, cockroach

infestations, restrictions to the regime caused mainly by low staffing levels, violence fuelled particularly by drugs and debt.

8.4 In the inspection in 2017, more than half the prisoners reported problems with emotional well-being or mental health. One-third said they currently felt unsafe – this was twice the number in the previous inspection, and much higher than in similar prisons. Violence towards prisoners and staff was high. Self-harm had increased dramatically and there had been seven self-inflicted deaths since the 2014 previous inspection and five in the previous 12 months alone. Prison leaders had some credible plans for improvement but progress was fragile.

8.5 As self-harm incidents increased, so also did the number of ACCT plans for prisoners identified as at risk. In the six months before the 2014 inspection, 58 self-harm incidents were recorded compared with 230 in the six months before the 2017 inspection. In the six months before the 2014 inspection, 266 ACCT plans were opened compared with 486 in the six months before the 2017 inspection.

Independent Monitoring Board (IMB) report 2017-18, published in January 2019

8.6 The IMB report for 2017-18 noted the staffing challenges the prison faced. The prison's 'benchmark' figure was 154 staff. On paper, they had achieved 165 staff but this was constantly reduced by authorised absences for various reasons, notably by staff required for bedwatch and constant supervision. Staff turnover was high, with an average of six or seven leavers each month. The IMB found that in practice there was a deficit of up to 1310 officer hours per week. In their previous report the IMB had noted that over 60% of staff were recent recruits with less than two years' experience.

8.7 On the 'traffic light' scale there were usually only enough staff for an amber/red regime, with fewer than 50 Band 3 staff (prison officer grade) on duty during the day. On at least 29 days of the reporting year the prison had operated on a 'red' regime, with 40 or fewer staff, but there had been some improvement, with the

number of ‘green’ days increased from five to 100. One consequence of the shortage of staff was that the key worker scheme had not been rolled out. It was planned to introduce this in 2019.

8.8 The IMB described the physical environment as run-down, unhygienic, dated and shabby, affecting prisoners and staff alike. There had been 414 violent incidents in the reporting year 2017-18 compared with 371 in the previous year. Moreover, unreported violence was a cause for concern.

8.9 1157 ACCTS were opened in the reporting year compared with 886 the previous year. Some 10% of the population were on ACCTs. Some improvements were noted in the care of vulnerable and complex prisoners. A Safety Intervention Meeting was held every week for complex case reviews. There were improved communications between the prison and healthcare, and mental health staff now attended most ACCT reviews. There had been three deaths in the prison compared with seven in the previous year.

8.10 The problems described by the IMB are illustrated in the minutes of a Stability Assessment for the period 5 to 12 January 2018 (attached to the minutes of the Security meeting of 5 January). There had been multiple assaults on staff in the weekend of 6-7 January 2018. The assessments says that recent reporting suggested a lack of respect for officers, with threats routinely levelled against them by prisoners across several wings. The level of operational staff absence along with bed and constant watches had impacted regime delivery and contributed towards tensions between prisoners and staff. Moreover, the high proportion of new, inexperienced and largely young staff increased the risk that relatively small incidents might become difficult to manage if residents were unwilling to comply with staff managing them.

Managing ACCTs

8.11 In MT's case, with some exceptions, case managers and membership of the review varied from one meeting to another. Several of the staff we met spoke of the relatively chaotic way in which case reviews were often allocated in 2017-18. The Night Orderly Officer would allocate personnel for the following day's reviews. It was a matter of who was available. People spoke to us of attending five or more reviews in a day. This was not surprising given the numbers of ACCTs open at the time, as reported by the IMB and HMIP, and the numbers of staff available.

OBSERVATIONS AND CONCLUSIONS

8.12 This, then, was the context in which MT was living at Bristol in 2017-18, and in which staff were enjoined to keep him safe. Our focus so far in this report has been solely on MT, his fears, his vulnerabilities and the processes followed by staff to support him. The inspection and IMB reports indicate that among all the prisoners at Bristol at the time, many were subject to violence or the fear of violence, and to distress, and were identified as being at risk of self-harm.

8.13 We do not know what was the root cause of MT's intense fear that he would be harmed by other prisoners. We have not seen any evidence of threats or physical violence made against him, other than by his own account of what he believed other prisoners were saying. We note too that he was housed on the vulnerable prisoners wing, which staff told us was the safest part of the prison and in sharp contrast to neighbouring G wing where the threat of violence was much greater.

8.14 The reports remind us that prison is a challenging environment that can be frightening for both prisoners and staff. MT would not have been alone in his fears and vulnerability. We examine in Chapter 9 some aspects of how the ACCT process worked and how it has changed, but in our view, despite the tragic outcome of MT's distress, it is to the credit of the custodial staff that they cared for him as much as

they did. But that is not to say that at an institutional level the circumstances at Bristol at the time are a humane or useful way of managing the prison population.

Chapter 9: HAS BRISTOL PRISON CHANGED?

17. Our investigation concerns events that occurred in 2017 and 2018. Unfortunately, despite the efforts of some of the highly motivated staff whom we met, Bristol's troubles continued.

Further inspections

HMIP report 2019

18. Following the 2017 inspection, HMPPS placed the prison in 'special measures'. Staffing levels were increased; some refurbishment was instigated; there was some capital investment to support education. but HMIP inspecting again in June 2019 found the regime still unreliable and fragile. They reported that despite improved staff levels and some new investment, there had been no tangible improvement in delivery and consequently issued an Urgent Notification to the Secretary of State.

HMIP report 2023

19. Then again, in 2023, HMIP found no significant improvement and issued a further Urgent Notification. HMIP's inspections cover all aspects of the prison. Their 'healthy prison' tests examine respect, purposeful activity, safety and rehabilitation, and release planning. All were found unsatisfactory.

20. In 2023, HMIP rated work on prisoner safety as poor. Levels of recorded violence including serious assaults on both staff and prisoners were higher than in most other adult prisons. The prison was understaffed, so most prisoners were locked up for almost 22 hours a day, contributing to a sense of hopelessness among many. The incidence of self-harm was high and there had been eight self-inflicted deaths and one murder of a man by his cellmate since the previous inspection. The total environment of the prison – the physical conditions, the regime and prisoner/staff

relationships - all had a bearing on the well-being of prisoners and hence on the proclivity to self-harm.

21. A high number of prisoners were supported by ACCT case management, reflecting the high levels of self-harm and reported mental health issues in the population. HMIP found that care plans were reasonably good, and informed by sufficient exploration of the risks and triggers for each individual. Each individual at risk of self-harm was discussed at the weekly Safety Intervention Meeting (SIM). Staff made efforts to engage them in purposeful activity, and some had involved families where appropriate. They also sought input from other relevant departments, including mental health and substance misuse services. Oversight of ACCT case management had improved, and robust quality assurance and a programme of staff training were driving improvements. However, the demands on residential staff risked compromising the quality of care for those most at risk. Where there were multiple prisoners supported by ACCTs, staff struggled to conduct all the well-being observations required.

HMIP June 2024

22. In June 2024, HMIP reviewed progress. The report found that some substantial improvements had been made and commended the work of the governor and her team to stabilise the prison. But progress was still said to be fragile and levels of self-harm had not reduced. Staff shortfalls had been addressed, enabling a consistent daily routine, with many more prisoners employed. This reduced prisoners' frustration, and levels of violence had reduced, but it remained almost double the average rate at similar prisons. In the previous 12 months there had been 986 incidents of self-harm, with 32 requiring hospital treatment and two investigated as near fatal incidents. A poor regime, ineffective relationships with wing staff and a lack of support – for example to help and rebuild family ties - contributed to a sense of hopelessness and despondency among prisoners. The inspector urged HMPPS to continue significant support for the prison.

23. ACCT reviews were found to be mostly on time and mostly thorough, but day-to-day oversight from case managers for those requiring most support was not robust enough. They took too long to carry out welfare checks prompted by the safety team, and were not always available to react to prisoners' needs promptly. Prisoners on ACCT reported infrequent interactions with their case manager, and case reviews were not always conducted by the same staff member, which prisoners found unhelpful.

24. Improvement at Bristol is clearly still a 'work in progress'. But with particular reference to some of the issues that have struck us in relation to MT, we note some changes – some national, some local - to practice, and to policies, strategies and structures to support good practice, that we think are helpful.

The ACCT process

25. There have been changes to the national policies on ACCT since MT was at Bristol. In Chapter 3 we noted that the prison did not try to engage with MT's mother as a source of support, and the cliff-edge when monitoring of his well-being ended abruptly in the days following the decision to close the ACCT. Current policy addresses both those issues.

Involving families

26. MT's mother told us she was not aware that MT had used ligatures during his first period in Bristol prison. She was not aware of how he had been supported through the ACCT process, or that at times he was under constant supervision. She was not aware of a helpline for prisoners' families. She was mistrustful of the prison but felt helpless.

27. Staff told us that, given MT's particular offences, contact with family might present difficulties, and they noted that on admission to Bristol, MT apparently gave his solicitors as next of kin. But the ACCT form passed on from Birmingham gave MT's

mother as next of kin. Some reviews mention MT referring to contact with his mother as helping, and valuing his phone calls with her, but there is no indication of any attempt to collaborate with her in supporting MT.

28. The current Prison Safety Policy Framework emphasises the value of family engagement in keeping prisoners safe. It places on Governors various positive duties, including:

- Providing information to families about how the prison keeps prisoners safe and explain the benefits of sharing information with prison staff about any safety concerns or risks

- Asking prisoners being supported on ACCT whether they would like a family member to be involved in their care

- Advertising the process for contacting the prison to share safety concerns

- During case reviews, to make reasonable efforts to contact family when a prisoner has consented to involving them. (Where a contact is not appropriate for safeguarding reasons, the decision should be recorded in the case review.)

29. One member of staff told us about family members taking part in reviews through a telephone link or in visits. Custodial Manager 4, who is now Head of Reducing Reoffending, stressed the value of family engagement, within case reviews or alongside, not only as a protective factor for prisoners at risk of self-harm, but also a key element in reducing reoffending. There were obvious sensitivities regarding safeguarding and consent, but staff recognised the value of family engagement.

Post-closure monitoring

30. When MT was in prison the process for closing an ACCT provided for a post-closure case review seven days after the decision that the ACCT could be closed, but there

was no requirement for the prisoner's welfare or behaviour to be monitored during those seven days. Under the current Prison Safety Policy Framework there is a requirement for a post-closure monitoring form to be completed on each of the seven days before the post-closure review team meets to decide whether further reviews are required or whether the ACCT needs to be re-opened. This tapering of vigilance and support seems to us a positive measure.

Consistency of case management

31. Several of the staff we met, spoke of the relatively chaotic way in which case reviews were often allocated in 2017-18. The Night Orderly Officer would allocate personnel for the following day's reviews. It was a matter of who was available. People spoke to us of attending five or more reviews in a day. This was not surprising given the numbers of ACCTs open at the time, as reported by the IMB and HMIP. When we invited witnesses to tell us what changes would help protect prisoners at risk, several, without prompting, identified consistency of case management, but also that time should be allocated for case coordinators to be properly trained.

32. There have been national policy changes in the remit of case review teams, with specified responsibilities for what are now called case coordinators. Para 4.179 of the Prison Safety Policy Framework provides that all case reviews must be multi-disciplinary and chaired by a trained ACCT case coordinator. Para 4.182 provides that a case co-ordinator must be allocated to a prisoner for the duration of their ACCT support to conduct all ACCT case reviews, unless in exceptional circumstances the allocated case coordinator is not available. A case review that decides to close an ACCT must be multi-disciplinary.

Key working

33. The IMB report for 2017-18 says that Bristol was unable to introduce key working at that time. We understand that it has now been partially rolled out at Bristol and staff

told us that this helps to build relationships with prisoners and sometimes to nip problems in the bud.

34. The current key working model was introduced in 2018-19. A March 2021 document HMPPS Offender Management in Custody Model, says that the role of the key worker is to develop constructive motivational relationships with people in prison, supporting them to make appropriate choices and giving them hope and responsibility for their own development through one to one key work sessions. Governors in the male secure estate are asked to ensure that time is made available for key workers to spend an average of 45 minutes per week to provide one-to-one support to each of five or six prisoners.

The direction of travel in Safer Custody at Bristol prison – what the Head of Safety told us

35. Governor E, who was the head of safety at Bristol until recently, took over the role in 2022. He was aware of the difficulties Bristol experienced: limited staffing, a high number of ACCTs, sometimes as many as 45 reviews each day, and limited resources to manage prisoners' risks. In 2017-18 allocation of case management was by the Night Orderly Officer and often depended on who was available on the day who was qualified.

36. Since 2022, staffing levels had improved and there were more staff members who were case co-ordinator trained. ACCTs had reduced by 60-70% and case coordination was assigned by the Safety Team, where possible according to location, to promote continuity. The shift from case manager to case coordinator emphasised the shared responsibility of a multi-disciplinary panel to decide levels of support. The coordinator would consider the nature of the risk, the kind of support needed, and would try to obtain a consistent panel. If a member was not available for a particular review, they would try to obtain a representative from the appropriate discipline.

37. At the time of our investigation the prison had been working for about 18 months on introducing the Offender Management in Custody Key Worker model. There had been positive feedback from prisoners and prison staff believe it may have had a positive impact on safer custody metrics. But they were not able to comply with it fully so through a Key Worker strategy meeting they had identified a high risk cohort for priority for key work, based on evidence about the factors that tend to increase risk – for example, young adults, isolation, IPP prisoners that is those who remain on the now obsolete indefinite life terms for public protection.

38. The Key Worker strategy meeting is co-chaired by the Head of Residence and Head of Offender Management and there are referral pathways through the Safety Intervention Meeting and the Safety Action Meeting. The approach of both meetings was said to be focussing on quick, smart, actions to mitigate risk.

39. The weekly Safety Intervention Meeting (SIM) is led by the Head of Safety with other heads of function and other members of the Safety Team. It focusses on managing individuals who present increased risk, who may be perpetrators of violence, or victims, or vulnerable in other ways. It considers prisoners on ACCT requiring enhanced case management, complex case referrals, and individuals on Challenge, Support and Intervention Plans (CSIPs). Challenge Support and Intervention Plans are used for prisoners who present special problems as perpetrators or victims. CSIP plans are reviewed at the SIM meeting. The CSIP scheme provides a more flexible structure than ACCT for lower level monitoring of the progress of prisoners causing concern.

40. The Safety Action Meeting (SAM) focusses on increased risk to the establishment as a whole, for example, where there was evidence of increased violence, use of force, or safeguarding referrals. They try to look at causes and allocate resources accordingly

Peer support

41. Peer support by trusted prisoners helps to support new prisoners on their first night at Bristol, making sure prisoners have what they need in their cells, and checking on prisoners at risk to counter isolation. In addition, trusted prisoners are allocated to check on prisoners who have been identified as at risk of self-harm who are being supported on ACCT or CSIP plans.

The ACCT paperwork

42. Some members of staff spoke to us about how inefficient and *'clunky'* they found the present ACCT paperwork. Some had devised ways to type review summaries on to a template that they could also paste into case notes, but this was a 'workaround' and for the most part the system relied on handwritten loose sheets of paper, which seemed extraordinary given the digital tools that enable easy record keeping and communications in most other administrative processes

43. The voluminous ACCT documents in this case were often hard to follow. We are aware that HMPPS has endeavoured to refine the ACCT system over time and there have been various versions of the paperwork. Though well intended these have sometimes seemed to make the system more not less cumbersome. Time spent completing records is time spent not engaging with prisoners. Some members of staff suggested that it should be possible with the aid of technology to streamline the system. Specific proposals are outside our scope or competence but we tend to agree.

Recommendation – R2

We invite HMPPS to comment, and to tell us whether they have in train any plans to streamline the ACCT system with greater use of technological solutions.

OBSERVATIONS AND CONCLUSIONS

44. It is clear from the inspection reports that Bristol continues to have problems and remains a challenging environment for both prisoners and staff. Many of the problems reported are not unique to Bristol. It is common knowledge today that the prison service faces crises on several fronts.

45. Longer sentences and delays in the courts have led to a relentless demand for prison places that is unprecedentedly high. Britain is an outlier among European countries in the number of prisoners we lock up.

46. This in turn makes for an impoverished regime, compromising prospects of rehabilitation and reduction in reoffending; and work for staff which is unsatisfying, and sometimes worse, many of whom understandably vote with their feet and seek safer, more rewarding employment.

47. The scourge of debt and drugs, fuelling violence, fear and self-harm, requires smart solutions, to counter the various methods by which contraband enters establishments, and to focus on reducing demand for drugs through active regimes and therapeutic services.

48. The inspectorate will continue to monitor conditions at Bristol prison, but many of the problems there are national issues which cannot be solved at Bristol, or even by the Prison Service, without political leadership, and public understanding about what works to reduce reoffending. Meanwhile we wish Bristol well. Despite the tragic outcome for MT in this case, our overall conclusion is that within the constraints in which they operated there was much concern and care to support and help MT to overcome his demons, and that leaders, the safety team and the operational staff whom we met are working hard in difficult circumstances to support the prisoners in their custody.