Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Joe Bartlett a prisoner at HMP Norwich on 5 April 2017

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Joe Bartlett was found hanged in his cell at HMP Norwich on 5 April 2017. He was 36 years old. I offer my condolences to Mr Bartlett's family and friends.

Mr Bartlett was subject to suicide and self-harm prevention monitoring when he died, but these procedures were managed poorly. Prison staff did not fully assess Mr Bartlett's risk of suicide and self-harm and failed to identify appropriate actions to reduce his risk. It is disappointing that we have made a similar finding at Norwich previously.

Mr Bartlett felt under threat because of debts he owed and was assaulted by another prisoner. While staff did take some steps to try to protect Mr Bartlett, they did not act quickly enough and they failed to follow the prison's violence reduction policy.

Shortly before Mr Bartlett's death, another prisoner took his life on the same wing at Norwich. Our investigation into that death also showed inadequacies in Norwich's management of violence reduction procedures. The Governor needs to address this as a priority.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **December 2017**

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Summary

Events

1. On 23 March, Mr Joe Bartlett was remanded to HMP Norwich for harassment offences against his ex-partner. When he arrived at Norwich, staff noted that Mr Bartlett had a history of attempted suicide and self-harm, and had anxiety, depression and a psychotic disorder. Staff referred him to the mental health team and to the substance misuse team due to his drug dependency. Mr Bartlett requested Vulnerable Prisoner (VP) status, as he had previously been in debt at the prison and was concerned prisoners would remember him. He was allocated a single cell on the VP wing.

2. On 25 March, Mr Bartlett told staff he was too frightened to leave his cell because he felt threatened by other prisoners on the wing. On 28 March, Mr Bartlett was assaulted by another prisoner because of an old debt and, despite being supported by violence reduction procedures, he was left in the cell next to the alleged perpetrator for a further five days.

3. On 28 and 29 March, Mr Bartlett received warnings because he refused to attend work. He told staff he did not want to leave his cell as he feared for his safety. On 30 March Mr Bartlett was dismissed from work because of non-attendance. He was put onto the basic regime, which meant his cell privileges, such as his television, were removed. His bail application was also refused.

4. On 31 March, Mr Bartlett said he might hang himself if he remained on the VP wing, so staff began suicide and self-harm prevention procedures (known as ACCT). On the same day, Mr Bartlett saw a nurse from the mental health team and told her he was considering self-harming because he felt at risk. The nurse noted on Mr Bartlett's medical record that he would have a full mental health assessment the following day, but there is no record that this took place.

5. On 5 April at 2.37pm, staff found Mr Bartlett hanged in his cell. They attempted to resuscitate him but he was pronounced dead at 3.19pm.

Findings

6. We found that the ACCT procedures, designed to support and monitor a prisoner at risk of suicide and self-harm, were not well managed. Staff failed to fully assess Mr Bartlett's risk and failed to identify and put in place appropriate actions to reduce his risk. We found that Mr Bartlett's risk was incorrectly assessed as low in spite of unresolved risk factors, and observations were reduced too quickly.

7. Mr Bartlett felt under threat at Norwich because of unpaid debts, and was assaulted by another prisoner. We found that despite Norwich having a violence reduction policy, staff did not follow it effectively and Mr Bartlett's situation was not well managed. Although staff started victim support procedures, Mr Bartlett remained in the cell next door to the man who he said had assaulted him for five days.

8. We found no evidence that Mr Bartlett had a mental health assessment on 1 April, despite a mental health nurse noting that he would be assessed after he had threatened to self-harm.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular:
    - Staff should set effective caremap objectives which are specific, time bound and meaningful, aimed at reducing risk.
    - Case reviews should take into account all known risk factors and triggers and set a level of observation which appropriately reflects that risk.
    - ACCT observations should be at irregular, unpredictable intervals.
- The Governor should ensure that all information about bullying and intimidation is fully coordinated and investigated, including that:
    - Apparent victims are effectively supported and protected with meaningful, long-term solutions that address their individual situations.
    - Staff consider whether victims are at increased risk of suicide or self-harm.
- The Head of Healthcare should ensure that where a follow up mental health review is scheduled, this is carried out as planned.

The Investigation Process

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

10. The investigator visited Norwich on 11 April. She obtained copies of relevant extracts from Mr Bartlett's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Bartlett's clinical care at the prison. The investigator and clinical reviewer interviewed nine members of staff at Norwich on 24 April 2017. The investigator interviewed a further three members of staff and one prisoner.

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

13. One of the Ombudsman's family liaison officers contacted Mr Bartlett's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Bartlett's mother asked:

    - whether her son was being treated for mental and physical health conditions, and drug issues;
    - whether staff knew about his history of self-harm; and
    - whether he was being bullied.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not identify any factual inaccuracies.

15. Mr Bartlett's mother and her solicitor received a copy of the initial report. The solicitor representing Mr Bartlett's mother pointed out some factual inaccuracies. The report has been amended accordingly. There were some questions that did not impact on the accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor. We have also written to the prison about not referring Mr Bartlett's assault to the police.

Background Information

HMP Norwich

16. HMP Norwich is a multi-function prison, which predominately serves the courts of Norfolk and Suffolk. The prison holds up to 769 men. Virgin Care provides healthcare services.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Norwich was in September 2016. Inspectors noted that a violence management strategy had been introduced in November 2014, but that the number of fights and assaults had increased, that investigations into these incidents needed to be improved and that drug and associated debt remained a significant problem. Inspectors recommended that staff should challenge perpetrators of violent and antisocial behaviour and support for victims should be improved.

18. Inspectors noted that support for prisoners being assessed under suicide and self-harm monitoring procedures was generally good, although there were some weaknesses in the management of the process itself and adult safeguarding arrangements needed to be stronger.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 29 February 2016, the IMB reported that they were concerned about prisoner (and staff) safety, as violent incidents had increased. Low staffing levels and a rise in prisoners using new psychoactive substances (NPS) exacerbated this.

20. The IMB noted that the small mental health team at Norwich had a considerable workload. This meant that care had become limited to those most in need.

21. The IMB also noted deficiencies in ACCT procedures, particularly a lack of engagement with mental health staff at case reviews, lack of evidence of meaningful interactions with prisoners, and inadequate caremaps. The personal officer scheme did not function well.

Previous deaths at HMP Norwich

22. Mr Bartlett was the fourth person to take his life at Norwich since March 2015. There has been a further self-inflicted death since Mr Bartlett's death.

23. A prisoner took his life on the same wing at Norwich shortly before Mr Bartlett's death. Our investigation into that death also showed inadequacies in Norwich's management of violence reduction procedures. We have also previously made a recommendation about the prison's management of the ACCT process.

Assessment, Care in Custody and Teamwork

24. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT until all the actions are completed.

Key Events

25. On 23 March 2017, Mr Joe Bartlett was remanded to HMP Norwich for charges of harassment and a breach of a non-molestation order against his ex-partner. During the journey from the court to Norwich, escorting staff checked Mr Bartlett every five minutes after he tied a jumper around his neck.

26. When he arrived at Norwich, staff reviewed Mr Bartlett's Person Escort Record (PER), which highlighted that he had a history of attempted suicide and self-harm, including an attempt to hang himself while in a police van in 2014. The PER also noted that Mr Bartlett had a history of anxiety and depression, along with a psychotic disorder. Staff completed a Cell Sharing Risk Assessment (CSRA), which concluded Mr Bartlett was a high risk of assaulting a cellmate and not suitable to share a cell until staff had carried out a mental health review.

27. A prison manager saw Mr Bartlett in reception and remembered him from his previous time at Norwich. Mr Bartlett told him he wanted to live on a Vulnerable Prisoners (VP) wing because he had previously been in debt at Norwich and was concerned prisoners would recognise him. Mr Bartlett also said he had been assaulted before because prisoners believed he had concealed illicit drugs internally. Mr Bartlett was allocated a single cell on a VP wing (C Wing).

28. The same day, Mr Bartlett saw a nurse for an initial health assessment. The nurse noted that Mr Bartlett had arrived at the prison with a suicide and self-harm warning form (SASH), that he had attempted suicide and had self-harmed before, had been subject to Prison Service suicide prevention procedures (known as ACCT) previously and that he had anxiety and depression. Mr Bartlett was on a number of medications, including antidepressants and pain relief. The nurse referred Mr Bartlett to the Integrated Drug Therapy Scheme (IDTS) because of his drug dependency, and to the mental health team. A prison GP saw Mr Bartlett later that evening, confirmed he should be on the substance misuse programme and re-prescribed his current medication.

29. During the morning of 24 March, a healthcare support worker assessed Mr Bartlett's opiate withdrawal as moderate. A prison GP prescribed him 60ml methadone daily. Mr Bartlett continued on this programme throughout his time at Norwich.

30. That afternoon, a nurse assessed Mr Bartlett's mental health. Mr Bartlett said he felt down because he was back in prison and they discussed his long history of mental health problems. Mr Bartlett said he had been diagnosed with thought disorder, paranoia and schizophrenia and had drug and alcohol issues. Mr Bartlett told her he had been sectioned under the Mental Health Act four or five times in the past, but was not currently under the care of any community health services. He said he had previously taken overdoses and attempted to set fire to himself. Mr Bartlett told her he had no thoughts of suicide or self-harm at that time. She noted that Mr Bartlett would have another mental health review the following week.

31. On 25 March, staff noticed that Mr Bartlett kept his cell door shut. He told them it was because he had accumulated debt when last in Norwich and felt threatened. No action was taken.

32. Mr Bartlett saw a prison GP on 27 March, as he wanted to change his antidepressants and spoke about a number of physical ailments. The GP thought Mr Bartlett displayed some drug seeking behaviour during their consultation. He increased Mr Bartlett's antidepressant dosage and prescribed other medication for his physical complaints.

33. On 28 March, Mr Bartlett's licence (granted from 30 November 2016) was revoked because of the alleged new offence. He was subject to a 14-day recall.

34. Also on 28 March, a prisoner assaulted Mr Bartlett. Mr Bartlett reported this to staff and told them the prisoner was trying to collect his debt on another prisoner's behalf. Staff checked the CCTV, which supported Mr Bartlett's allegation. The prison recorded that the matter was referred to the police and the prisoner was put on report (which meant he would be subject to an internal disciplinary hearing). However, following enquiries made with the police, the investigator discovered that the prison had not reported this assault to the police. Staff placed Mr Bartlett on victim support procedures and agreed to move him to a different landing on the wing when a space became available. Staff noted that this would be reviewed on 11 April.

35. An officer met Mr Bartlett the next day as part of the victim support procedures. Mr Bartlett told her that he had agreed to send a prisoner a twenty-pound postal order to cover a tobacco debt he had accumulated while at Norwich before, but had never done so. A prisoner had become involved and wanted Mr Bartlett to repay this debt. Mr Bartlett had also told staff that the prisoner had also been bullying him for his medication. Mr Bartlett had asked to move to a different landing as the prisoner was in the cell next door to him and he did not feel safe. The officer noted that Mr Bartlett had been placed on victim support procedures for two weeks, and had been set objectives to support him. They included telling staff immediately if he had any concerns, that a personal officer or safer custody officer should support him, staff should update his case notes daily, and Mr Bartlett should have access to Listeners and the Samaritans telephone.

36. The officer then spoke to the prisoner. She explained Norwich's violence reduction policy, and they discussed what had happened. The prisoner also had objectives set (including to refrain from any violent or anti-social behaviour, to receive support from safer custody staff and to refrain from encouraging other prisoners to bully or intimidate anyone) and was told that any further violent incidents would result in a reduction in his regime (from standard to basic) and further monitoring.

37. Mr Bartlett received warnings on 28 and 29 March because he refused to attend work in the market gardens. Mr Bartlett said he did not want to leave his cell as he feared for his safety. No action was taken, despite him telling staff he was too scared to leave his cell and the fact he was still located in the cell next to the prisoner. (The prisoner was transferred to HMP The Bure on 6 April, after Mr Bartlett had died.)

38. Mr Bartlett met a health support worker on 30 March to discuss his mental health. Mr Bartlett said that he was afraid to leave his cell and, as a result, was not getting his medication or food. He also said he was worried about his father who was ill, and that he was not sleeping well. He wanted to move to the healthcare

department or to E Wing, as he did not feel safe on C Wing. The health support worker noted that Mr Bartlett seemed in a low mood but he said he had no thoughts of suicide or self-harm. He arranged for Mr Bartlett to be unlocked after other prisoners to enable him to collect his medication; no further action was taken.

39. On the same day, 30 March, a nurse spoke to Mr Bartlett. Mr Bartlett said he was coping well with the methadone programme but was not coping very well mentally. He said he was being bullied on C Wing but was seeing the mental health team for support.

40. Mr Bartlett was dismissed from work that day because of non-attendance, despite telling staff he was too scared to leave his cell. He was put onto the basic regime, which meant his cell privileges, such as his television, were removed, he was confined to his cell for 14 days during prisoners' activity time, and he was only allowed to visit the gym for one session a week. Also, on 30 March, Mr Bartlett's application for bail was refused.

41. On 31 March, around 4.00pm, staff opened an ACCT for Mr Bartlett, because he said he felt like he was going to hang himself. He was put on hourly observations until his assessment interview. At 6.45pm, Mr Bartlett spoke to a nurse. He told her he wanted to self-harm so he could be monitored, as he felt under threat on the wing. She noted in Mr Bartlett's medical record that he would have a full mental health review the next day. There is no record that this happened.

42. Staff undertook Mr Bartlett's ACCT assessment interview and case review on 1 April. A nurse attended as part of the mental health team. Mr Bartlett said his father was dying, that he felt bullied on the wing and thought he should not be in prison. He said he was low in mood and had thoughts of dying but had not planned how to take his life. The nurse recalled that Mr Bartlett spoke about feeling stressed. Mr Bartlett asked to move to a different landing and for a medication review. The nurse said he would arrange the latter. Mr Bartlett was assessed as low risk and his level of observations were lowered to one in the morning, one in the afternoon, one in the evening, and five at night. Staff completed the caremap with only one action, for a doctor to review Mr Bartlett's medication. This action was not completed before Mr Bartlett died.

43. On 2 April, staff moved Mr Bartlett to a cell on a different landing within C Wing, so that he was now on a different landing to the prisoner. (The prisoner was subsequently moved to another prison on 6 April.)

44. The nurse saw Mr Bartlett at lunchtime on 3 April, and asked how he was. Mr Bartlett replied that he was considering moving off C Wing, as he felt he could now cope better on a standard wing.

45. On 4 April, Mr Bartlett wrote three emails to his mother, in which he requested trainers and clothing. He referred to another prisoner as a psychopath and said he avoided him, but did not name him.

46. The same day, Mr Bartlett met the health support worker again. He said he still felt at risk on C Wing and was not collecting his medication or meals (although

this was not the case). Mr Bartlett asked if he could move to the healthcare department or transfer to another prison. The health support worker told him he should discuss this with an officer or during an ACCT case review. He assessed Mr Bartlett's risk of self-harm as high while he was on C Wing, but noted that he was supported by ACCT procedures. There is no record of another planned ACCT review.

47. On 5 April, Mr Bartlett met a psychological therapist and part of the prison's Wellbeing Service, which offers support to prisoners with low level mental health needs such as anxiety and mild depression. A SO was present for part of this conversation. Mr Bartlett said he wanted to move from C Wing because he felt threatened there. He also said he was schizophrenic. The therapist quickly realised that the Wellbeing Service would not be able to meet Mr Bartlett's needs and discharged him from their caseload. She said she was not aware at that time that Mr Bartlett was on an ACCT.

48. Mr Bartlett collected his lunch at approximately 11.40am. CCTV shows he took his methadone at the nursing hatch at 12.08pm, and stopped at a prisoner's cell at 12.15pm. The prisoner told the investigator that he did not know Mr Bartlett particularly well, but he tended to have items to lend to prisoners. He said that Mr Bartlett appeared "high" and his eyes were glazed. Mr Bartlett requested some tea bags, which he provided, and then Mr Bartlett went to his cell. At 12.21pm, staff locked all cells for the lunchtime period.

49. At approximately 1.30pm, CCTV shows staff unlocking prisoners who were attending work, medical appointments and legal visits. Mr Bartlett was not among them. CCTV shows contractors from Carillion Support Service Company (responsible for all prison work programmes and stores) looking into every cell to determine whether they were double or single cells. They passed Mr Bartlett's cell at 2.28pm, but there is no indication they saw anything of concern.

50. At approximately 2.00pm, two officers began unlocking the wing. One officer opened Mr Bartlett's cell at 2.37pm and saw him suspended from the window bars by a bedsheet and slouched on the cell floor. He immediately radioed a code blue emergency call (indicating that a prisoner is not breathing and urgent support is required). He called his colleague, went into the cell and cut the ligature using his anti-ligature knife. Upon hearing the code blue emergency call, a member of staff in the communications room telephoned for an ambulance and passed the call to an officer on C Wing, who spoke to the 999 operator directly.

51. Two other officers heard the emergency code over their radios and immediately went to Mr Bartlett's cell. One officer was cutting the ligature, assisted by a colleague. They laid Mr Bartlett on the floor of the cell and an officer immediately noticed that his lips looked blue. He checked for breathing and for a pulse, but found neither. He began chest compressions and his colleague radioed for healthcare staff to attend Mr Bartlett's cell with a defibrillator.

52. A nurse was holding the healthcare department's radio for a colleague when she heard the emergency call and went to C Wing. On arrival at Mr Bartlett's cell, at approximately 2.38pm, she used a mask to administer two rescue breaths. She saw that two officers were already carrying out chest compressions competently. She attached the defibrillator to Mr Bartlett, and it advised that no shock should

be given. Two healthcare colleagues arrived to assist her, and she and another nurse attempted to use a suction machine to remove vomit from Mr Bartlett's nose and throat, with limited success.

53. At 2.49pm, paramedics arrived at the prison and were quickly escorted to Mr Bartlett's cell where they took over his care. Air ambulance paramedics arrived 12 minutes later. At 3.19pm, Mr Bartlett was pronounced dead.

54. Staff found a note on Mr Bartlett's bed, written on a page torn from a Gideon bible. It said, 'I give up'.

Contact with Mr Bartlett's family

55. The Governor and the prison's family liaison officer visited Mr Bartlett's mother on the afternoon of 5 April, to inform her that her son had died. The prison contributed to Mr Bartlett's funeral in line with national instructions.

Support for prisoners and staff

56. A prison manager carried out a debrief for staff that afternoon (5 April). Staff spoke of being tired and frustrated at the lack of staff on C Wing.

57. The Governor issued notices to staff and prisoners informing them of Mr Bartlett's death. Officers and members of the chaplaincy team supported prisoners. Staff reviewed all prisoners who had been assessed as at risk of suicide and self-harm, in case they were adversely affected by Mr Bartlett's death

Post-mortem report

58. A post-mortem report concluded that Mr Bartlett died from hanging. The toxicology report showed that Mr Bartlett tested positive for his prescribed medication: codeine and paracetamol (painkillers) and mirtazapine and trazadone (antidepressants). The report also showed that Mr Bartlett had taken his prescribed methadone.

Findings

Managing Mr Bartlett's risk of suicide and self-harm

ACCT management

59. We found deficiencies in the implementation of ACCT procedures. Prison Service Instruction (PSI) 64/2011, 'Safer Custody', requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide or self-harm, and take appropriate action. The risk factors were also listed in our thematic report published in 2014. Mr Bartlett had a number of risk factors for suicide and self-harm, including previous suicide attempts and episodes of self-harm, a history of depression and anxiety, and a history of substance misuse.

60. Although staff began ACCT procedures for Mr Bartlett on 31 March, which continued until he died, the procedures did not support him effectively. The overall management of the ACCT was poor and not in line with the policies and procedures set out in the PSI.

61. Caremaps should reflect the prisoner's needs, level of risk and the triggers of their distress. Each action should be tailored to meet the individual needs of the prisoner, be aimed at reducing the risk to themselves and be time-bound. Mr Bartlett raised a number of issues that were causing him distress: his health (mental and physical); he was being bullied and felt under threat on the wing; he felt he was in prison for an offence he had not committed; and his father was terminally ill and had weeks to live. Despite the range of issues that were troubling Mr Bartlett, his caremap had a single action, for a doctor to review his medication. This action had no deadline and was not completed before Mr Bartlett died. PSI 64/2011 says caremaps should aim to address issues identified in the ACCT assessment interview and consider a range of factors including health interventions, peer support, family contact and access to diversionary activities. We consider staff failed to identify appropriate actions aimed at reducing Mr Bartlett's risk.

62. We are concerned that Mr Bartlett's level of risk was not assessed fully and the frequency of observations was reduced too quickly. At Mr Bartlett's first and only case review on 1 April, his risk was assessed as low and his observations were reduced from one every hour to one observation in the morning, one in the afternoon, one in the evening and five times during the night. The case review took place less than 24 hours after Mr Bartlett had told staff that he felt that he was going to hang himself because he was scared on the wing, and this source of distress had not been resolved by the time of the case review. In fact, Mr Bartlett was still in a cell next to his alleged assailant and continued to feel threatened. He was also on the basic regime. It is unclear therefore, why staff assessed Mr Bartlett's risk of suicide and self-harm as low and reduced his observations. Furthermore, ACCT observations were usually carried out at regular and therefore predictable intervals, which is not in line with guidance.

63. We found that staff managed the ACCT process poorly and make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular:

- **Staff should set effective caremap objectives which are specific, time-bound and meaningful, aimed at reducing risk.**
- **Case reviews should take into account all known risk factors and triggers and set a level of observation which appropriately reflects that risk.**
- **ACCT observations should be at irregular, unpredictable intervals.**

Bullying

64. Norwich has a violence reduction policy, issued in July 2016, which sets out the process for raising and investigating any identified or suspected act of aggression, bullying, intimidation or violence. There are various mandatory actions that wing staff should complete if a prisoner is identified as a bully or is witnessed demonstrating violent or antisocial behaviour. This includes staff challenging the perpetrator giving clear guidance on expected improvements of behaviour, and activating bullying perpetrator alerts. The alert should remain in place for a minimum of 14 days, with a review to take place at the end of that period.

65. In this case an officer checked the prison's CCTV, which appeared to confirm that a prisoner had punched Mr Bartlett. He placed the prisoner on a disciplinary charge and the incident was referred to the police. The officer met both Mr Bartlett and the prisoner, explained the prison's violence reduction policy and what it meant for them, and set objectives for them both, in line with the violence reduction policy.

66. The prisoner remained in the cell next door to Mr Bartlett for five days, before Mr Bartlett was moved to another landing on the wing. Prior to the move, Mr Bartlett told staff he felt intimidated and threatened, and refused to leave his cell. Although the violence reduction policy does not explicitly say that staff should consider moving a prisoner to a different cell if they feel threatened, it says measures to modify a perpetrator's behaviour would include relocation in the prison. We have seen no evidence that anyone considered relocating the prisoner. Leaving Mr Bartlett in the cell next to him resulted in his non-attendance at work and his subsequent dismissal and reduction to the basic level of regime and privileges. There were no other entries in his case notes about any support or interactions with staff, as required by the violence reduction policy, apart from initially recording the incident.

67. A PPO publication in October 2011, Violence reduction, bullying and safety, noted the links between bullying and violence and self-inflicted deaths of prisoners of all ages. In our PPO thematic report into self-inflicted deaths in 2013-2014, we highlighted how important it is that reports or suspicions that a prisoner is being threatened or bullied are recorded, investigated and responded to robustly.

68. We consider that the prison made inadequate attempts to resolve Mr Bartlett's concerns about his safety. When violence reduction reports were submitted,

these did not result in meaningful action other than initial meetings with the officer and an eventual landing move, with Mr Bartlett and the prisoner remaining on the same wing. It is apparent that Mr Bartlett remained concerned for his safety during this time. We make the following recommendation:

The Governor should ensure that all information about bullying and intimidation is fully coordinated and investigated, including that:

- **Apparent victims are effectively supported and protected with meaningful, long-term solutions, which address their individual situations.**
- **Staff consider whether victims are at increased risk of suicide or self-harm.**

Mental health

69. Mr Bartlett had a history of mental health issues and was seen by the mental health team on a number of occasions. On 31 March 2017, after prison staff had started ACCT monitoring, Mr Bartlett saw a nurse and told her that he was thinking about self-harming because he felt at risk on the wing. She noted on his medical record that he would have a full mental health assessment the next day, but this never happened. A member of the mental health team was present at Mr Bartlett's case review on 1 April, but there is no evidence that a mental health assessment was discussed.

70. The clinical reviewer concluded that Mr Bartlett's physical and mental health needs were managed in accordance with National Institute for Health and Care Excellence (NICE) guidance, but she found that Mr Bartlett's mental health referral should have been followed up. We make the following recommendation:

The Head of Healthcare should ensure that where a follow up mental health review is scheduled, this is carried out as planned.

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