Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Bryant, a prisoner at HMP Stocken, on 19 April 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit, is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Paul Bryant died from a catastrophic haemorrhage after he made a deep cut to his carotid artery on 19 April 2023 at HMP Stocken. He was 38 years old. I offer my condolences to Mr Bryant's family and friends.

Mr Bryant had been in prison since July 2021 and was due for release in May 2023. He had been supported through the Prison Service suicide and self-harm prevention procedures for a month in April and May 2022, but had then settled.

Mr Bryant experienced difficulties in his personal life in 2023 but was dismissive when staff tried to help him and he insisted that he had no thoughts of suicide or self-harm. We are satisfied that there was little indication that Mr Bryant was at imminent risk of suicide at the time of his death.

Staff who responded when Mr Bryant was found on 19 April, tried hard to save him despite the extremely distressing circumstances.

We have not made any recommendations but have identified an area of learning that the Governor will want to consider.

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

Adrian Usher
Prisons and Probation Ombudsman **April 2024**

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Summary

Events

1. Mr Paul Bryant was recalled to custody in July 2021 after he was arrested for burglary. He moved to HMP Stocken in January 2022 and had a conditional release date of 14 May 2023.

2. In early January 2023, Mr Bryant damaged his cell furniture to engineer a move to the segregation unit. He said that he had problems in his personal life and needed some time alone. He would not tell staff about his problems but said that he had no thoughts of suicide or self-harm. Mr Bryant's mother died later that month after a period of ill health.

3. In early April, Mr Bryant's partner told the prison that she was concerned about his welfare. Staff spoke to him, and he told a nurse that he was upset with one of his sisters. He said he believed his partner was having an affair. He told the nurse that he had no thoughts of suicide or self-harm, and he declined an offer of counselling.

4. At 2.35am on 19 April, a prisoner rang his cell bell after hearing a strange noise from Mr Bryant's cell. The night officer saw Mr Bryant lying on the cell floor, partly obscured by his bed. The night officer saw a lot of blood and he radioed a medical emergency code. The night officer went into the cell and when he pulled Mr Bryant away from his bed, he saw he had a gaping wound to his throat. The night officer pressed a towel to Mr Bryant's neck and gave chest compressions with his other hand. Other officers arrived at the cell and took turns in giving chest compressions.

5. Ambulance paramedics arrived at 3.10am and took charge of Mr Bryant's treatment. At 3.23am, they confirmed that Mr Bryant had died.

Findings

6. While Mr Bryant had concerns about his personal life, he declined offers of support and he gave no clear indications that he was at risk of suicide or in need of additional monitoring.

The Investigation Process

7. HMPPS notified us of Mr Bryant's death on 19 April 2023. The investigator issued notices to staff and prisoners at HMP Stocken informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

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

9. The investigator interviewed ten members of staff at Stocken on 6 and 7 June 2023. He subsequently interviewed two further staff and one prisoner by video-link and telephone.

10. NHS England commissioned a clinical reviewer to review Mr Bryant's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with healthcare staff and with the officers who responded to Mr Bryant's discovery.

11. We informed HM Coroner for Rutland and North Leicestershire of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

12. The Ombudsman's family liaison officer contacted Mr Bryant's partner to explain the investigation and to ask if she had any matters she wanted us to consider. It would appear however that she did not receive the letter.

13. Separately, Mr Bryant's sister forwarded us an email she sent to the prison which referred to two emails she had sent the previous year in which she raised concerns about her brother's mental health at the time of their mother's death. She wrote that despite raising these concerns, her brother was nevertheless able to take his life. Mr Bryant's sister also complained that it took almost seven hours for the family to be told of her brother's death. We have tried to address these concerns in this report.

14. We shared our initial report with Mr Bryant's family via their solicitors and with HM Prison and Probation Service (HMPPS).

15. Mr Bryant's sisters commented on part of the evidence given by Officer A about their mother's funeral. They said that they both approached their brother at the funeral and that he interacted with one of them.

16. Mr Bryant's partner said that in their final telephone conversations, Mr Bryant made a number of comments to suggest that he intended to harm himself. She also said that she reported her concerns a number of times to his community offender manager.

17. HMPPS pointed out two factual inaccuracies on the background information about Stocken and these have been corrected.

Background Information

HMP Stocken

18. HMP Stocken is a category C training prison in Rutland which holds up to around 1,070 men. Practice Plus Group provides all healthcare services. Healthcare is provided from 7.30am to 6.30pm during the week and from 8.30am to 5.30pm at weekends.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Stocken was in January 2023. Inspectors found that staff were knowledgeable about prisoners receiving support through ACCT (Prison Service suicide and self-harm reduction procedures) and the quality of ACCT documentation had improved since the previous inspection. Inspectors found that mental health staff contributed effectively to ACCT reviews. However, inspectors noted that there remained some deficiencies, including inconsistent case managers. Inspectors noted that 63% of prisoners said that most staff treated them with respect although many prisoners said that staff were detached and kept their distance.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to April 2022, the IMB found that Stocken was a safe environment and that in general, prisoners were treated fairly and humanely. The IMB noted that the Governor prioritised safety and violence reduction, supported by a well-resourced and enthusiastic safer custody team. The IMB noted that quality assurance checks showed improvements in ACCT documentation but identified some areas of concern.

Previous deaths at HMP Stocken

21. Mr Bryant was the seventh prisoner to die at Stocken since January 2019. Of the previous deaths, two were self-inflicted, three were from natural causes, one was drug-related and in one case, no cause of death was established. We have found no similarities between Mr Bryant's death and the previous deaths.

Assessment, Care in Custody and Teamwork

22. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Checks made on prisoners 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 care plan to identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

23. In July 2021, Mr Paul Bryant was arrested for burglary and was later sentenced to 12 months in prison. He was also subject to a life sentence recall so received an additional 18-month sentence to run concurrently with his new sentence. His conditional release date was 14 May 2023.

24. On 18 January 2022, Mr Bryant was moved to HMP Stocken.

25. Mr Bryant saw a nurse for a first reception health screen on arrival at Stocken. The nurse noted that Mr Bryant engaged well, reported that he had no history of mental health problems and had no thoughts of suicide or self-harm.

26. When Mr Bryant's cell was unlocked on the morning of 3 April, an officer noted that he was covered in blood. He told the officer that he had used a razor blade to cut his neck. A nurse was called who noted that Mr Bryant had numerous cuts to his throat, although they were not deep cuts. The nurse cleaned and dressed the cuts.

27. Staff started Prison Service suicide and self-harm monitoring procedures (known as ACCT) and a supervising officer (SO) chaired an ACCT review later that morning. Mr Bryant, an officer and a mental health nurse attended. Mr Bryant said that he had not been getting much sleep recently due to the noise from a neighbouring cell and he also believed people were pumping gas into his cell. He said that he thought he could hear his brother's voice outside his cell window, although he knew his brother was not there and he accepted he was becoming paranoid. Mr Bryant said that when he cut himself, he had done it before he realised what he was doing. He said that he had not harmed himself in the past and had no intention of doing so in the future. He said that he had good support from his family and had made some friends in prison. Mr Bryant's observations were set at two an hour.

28. The nurse who attended the ACCT review noted that while Mr Bryant said that he had no past mental health issues, it was possible that he had a potentially undiagnosed mental health condition. He referred him to the prison psychiatrist.

29. Mr Bryant's next ACCT review was on 6 April. The SO asked Mr Bryant about his report of hearing voices, the other thoughts that had prevented him sleeping and whether he had any history of anxiety, paranoia or depression. Mr Bryant said that he had no such history and he denied taking illicit drugs. Mr Bryant again said that he had no intentions of suicide or further acts of self-harm. The SO reduced Mr Bryant's observations to one an hour. A mental health nurse who attended the review told Mr Bryant that he had an appointment with the prison psychiatrist later that morning. She encouraged him to be open about his situation.

30. Mr Bryant did not attend his appointment with the psychiatrist. The mental health team sent Mr Bryant a letter to ask why he did not attend and whether he wanted a new appointment.

31. On 8 April, two officers and a chaplain separately spoke to Mr Bryant in response to concerns that had been raised by his family. Mr Bryant told one of the officers that he was fine, but he complained to the chaplain and the other officer about the men in the cell above his, including that they were talking about him. Mr Bryant declined an offer of support from the safer custody team.

32. Mr Bryant's next ACCT review was on 13 April. He said that he was doing very well and was enjoying his prison job which kept him distracted. He also said that he was no longer hearing voices, although the SO noted that he was not necessarily convinced by Mr Bryant's answer. A mental health nurse at the review asked Mr Bryant about his missed psychiatric appointment and he said that he was alright and did not need to see anyone. The nurse noted that Mr Bryant appeared well-kempt, he maintained good eye contact, his speech was normal in rate and rhythm, and he was showing no overt signs of psychotic illness. Mr Bryant again said that he had no thoughts of suicide or self-harm, and his observations were reduced to one every three hours.

33. At his next ACCT review on 20 April, Mr Bryant appeared dismissive of the process. The SO noted that he did not consider that Mr Bryant's risk was raised compared to the previous review, but he decided to keep the ACCT open due to his poor interaction with the review. The SO maintained Mr Bryant's observations at the same level.

34. Nothing of concern arose during Mr Bryant's next two ACCT reviews and on 4 May, the ACCT was closed.

35. On 7 January 2023, Mr Bryant damaged his television and cell furniture. He told staff that he had difficulties with his personal life outside prison, which he did not want to discuss. He said that he did not have any problems in the prison, he was not having thoughts of suicide or self-harm, but he wanted some time alone in the segregation unit.

36. Mr Bryant was moved to the segregation unit pending an adjudication hearing. He pleaded guilty at a hearing later that day and was told he would remain in segregation for seven days.

37. All of the entries made by prison staff, healthcare staff and chaplaincy visitors over the following days show that Mr Bryant was polite, behaved well and engaged in conversation. There were no entries to suggest that he might be at risk of suicide or self-harm. A mental health nurse noted that she asked him why he damaged his cell, but he only said that he "wanted some time out". The nurse told him that someone from the healthcare team would see him each day while he was in segregation, and he could speak to them if he wanted.

38. On 14 January, Mr Bryant left segregation and returned to his usual wing. He told one of the wing SOs that his "head [was] in a better place" and that he had learned from his "negative behaviour".

39. Officer A told the investigator that she had always had a good relationship with Mr Bryant, and he spoke about his children and others in his family. She said that she tried to speak to Mr Bryant about the problem that led to him moving to segregation, but he would not explain. She said that after his return to the wing, he seemed his normal self again.

40. On 23 January, Mr Bryant learned from his family that his mother had died suddenly. Stocken's managing chaplain told the investigator that he gave Mr Bryant some literature about bereavement, and he was involved in the arrangements for Mr Bryant to attend his mother's funeral.

41. On 2 February, a mental health nurse saw Mr Bryant for a welfare check. Mr Bryant said that his mother had been unwell for a while and that had affected his mood and behaviour. He said that he felt he was processing the news of her death better than how he had dealt with her illness. He said that his partner and children were strong protective factors for him, and he was receiving good support from the chaplaincy team. He said that he did not have any thoughts of suicide or self-harm.

42. Mr Bryant attended his mother's funeral on 17 March. Officer A told the investigator that she was one of two officers who escorted him to the funeral, and she made an entry in his records to say that he had behaved impeccably and had been polite and respectful at all times.

43. On 4 April, Mr Bryant's prison offender manager emailed various staff to say that Mr Bryant's partner had contacted his community offender manager as she was concerned about comments he had made on the telephone about never seeing her or their children again, His partner said that she did not want him to know that she had reported this to the prison. We understand from Mr Bryant's partner that she contacted the community offender manager a number of times expressing her concerns following telephone conversation with Mr Bryant.

44. An SO told the investigator that she was copied into the email from Mr Bryant's offender manager, and she went to see him. She said that Mr Bryant was standing at a friend's cell, and they were preparing a meal. She asked him if all was well and if he had had any recent contact with his family. He said that all was good, and he had no problems. She told the investigator that Mr Bryant did not tend to seek help from staff and his response that day was typical for him: he was polite, he smiled, and he did not present as being in crisis.

45. On 5 April, a mental health nurse also saw Mr Bryant in follow-up to the email. She noted that Mr Bryant was surprised that she had come to see him, and he was initially defensive. However, after prompting, Mr Bryant spoke about some of his feelings about his biological family, including that he did not consider that they had done enough for his mother during the final stages of her life. He also said that he believed that his partner was having an affair and he considered that he was entitled to be angry with her about that. She asked Mr Bryant if he had made statements implying that he wanted to die, but he said that that was a misinterpretation and he had said instead that he was angry and he had told his family that he did not want to see them again. She noted that Mr Bryant engaged well, that his tone and rate of speech was good, that he had no thoughts of suicide or self-harm and that he declined the offer of counselling.

Mr Bryant's telephone calls

46. Most of Mr Bryant's calls were to his partner. A lot of their conversation was about domestic issues, including their children. From the end of March onwards, the majority of their conversations were about Mr Bryant's belief that his partner had been unfaithful to him, which included events that had occurred 15 years previously. Mr Bryant's partner became increasingly annoyed by his repeated accusations and his failure to accept her denials. On a number of occasions, she told him that he was mentally unwell and needed to see a doctor. Their final conversation was an 18-second call at 8.58am on 18 April when Mr Bryant made the same accusations

and his partner responded by saying, “I’m done with this now, I’m done with being accused”. Mr Bryant did not make any comment in any of the conversations to indicate that he intended to take his life, although he made a number of comments to say that he considered their relationship to be over and he also threatened to take her to court to fight for custody of their children.

Events of 18 and 19 April

47. At just after 10.00am on 18 April, an officer noted that she spoke to Mr Bryant about failing to carry out his work as a wing cleaner: he had previously been warned about this. She told him that he would receive no pay for that day, and he promised to try harder the next day.

48. At around 8.30pm on 18 April, an Operational Support Grade (OSG) completed a routine check on H wing. He told the investigator that he could not recall any previous contact with Mr Bryant, and he had not recorded any concerns following his check on Mr Bryant that evening.

49. At 2.35am on 19 April, the prisoner in the cell next door to Mr Bryant rang his cell bell and the OSG answered the bell nine seconds later. The prisoner said that he had heard a strange noise from Mr Bryant’s cell. When the OSG looked into the cell, he saw Mr Bryant on the cell floor but could only see him from the waist down as he was slumped to one side and obscured by the bed. He could see a lot of blood and he radioed a medical emergency code red (to indicate a prisoner with blood loss). Communications staff noted that the code red call was made at 2.36am and that an emergency ambulance was called immediately.

50. A Custodial Manager (CM) was the senior officer on duty and was in the centre office when the code red call was made. He went to H wing with three night support officers, and he took emergency equipment. He said that he and his colleagues walked quickly as the distance to H wing was at least a five-minute walk away.

51. After around two minutes of looking into Mr Bryant’s cell, the OSG decided that he needed to go into the cell without waiting for his colleagues. Although he could not see any injuries to Mr Bryant’s body, he considered that he needed assistance based on the amount of blood on the floor and on the bed. He said that while he had been looking at Mr Bryant, he had seen some movement in his hand, which had wobbled slightly before dropping again. He said that after making a risk assessment, he radioed the CM to say he was going into the cell.

52. The CM said that when the OSG radioed to say he was going into the cell, he and his colleagues began running.

53. The OSG said that when he went into the cell, he pulled Mr Bryant away from his bed and saw that he had a gaping wound to his throat. Mr Bryant did not have a pulse. He pressed a towel to Mr Bryant’s neck and, with his other hand, began giving chest compressions.

54. The CM and the support officers arrived around 90 seconds later. The OSG continued to press the towel to Mr Bryant’s neck while the response officers took turns in giving cardiopulmonary resuscitation (CPR).

55. Ambulance paramedics arrived at 3.10am and they took over Mr Bryant's care. All efforts to try to resuscitate Mr Bryant proved unsuccessful and he was declared dead at 3.23am.

56. Following Mr Bryant's death, a broken prison issue disposable razor was found in his cell. Two blades were found, which were not blood stained. The third blade from the razor was not discovered.

Contact with Mr Bryant's Family

57. An officer was appointed as the family liaison officer (FLO). Due to the distance from Stocken to Mr Bryant's partner's home in London, the FLO contacted HMP Pentonville to ask them to deliver the news. Stocken's Governor then decided that the local police should break the news instead. The police visited the family home and broke the news at 10.00am. The FLO then telephoned Mr Bryant's partner and arranged to visit her the following day. When he visited, he also met Mr Bryant's father and one of his sisters.

58. Stocken contributed to the cost of Mr Bryant's funeral in line with national instructions.

Support for prisoners and staff

59. Stocken's Governor spoke to the staff involved in the emergency response. The staff care team also spoke to staff and offered support. The TRiM team also offered specific trauma support to each member of staff on duty when the incident occurred.

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

Post-mortem report

61. The pathologist found that Mr Bryant had a deep cut to his neck that extended into the carotid sheath and carotid artery. The pathologist gave the cause of death as a catastrophic haemorrhage. Toxicological examination had no significant findings.

Findings

Assessment of risk

62. Mr Bryant was serving a relatively brief sentence, with a release date of 14 May 2023. He had been supported through ACCT in April and May 2022 after he had a period of apparent psychotic thinking and made superficial cuts to his neck, but his condition settled, and he declined an assessment with the prison psychiatrist.

63. In early January 2023, Mr Bryant deliberately damaged his cell furniture to engineer a move to the segregation unit for a period of time alone. He said that he had problems in his private life, but he would not say more. Nothing occurred during his time in segregation to suggest he was at risk of suicide or self-harm.

64. Mr Bryant's mother died later on in January, and he seemed to take comfort from the pastoral support provided to him by the chaplaincy staff.

65. When Mr Bryant's partner reported concern about his mental wellbeing, he was seen on 5 April by a nurse and spoke openly about being upset with one of his sisters about events leading up to his mother's death. He also said that he believed that his partner was having an affair. However, he again declined the offer of further help and said that he had no thoughts of suicide or self-harm.

66. It was clear from his final conversation with his partner that Mr Bryant had concerns about their relationship, but he said nothing to her to suggest he had thoughts about taking his life.

67. An SO told the investigator that Mr Bryant was not someone who tended to seek help from officers. Other officers gave similar evidence.

68. While it is clear that there were issues causing Mr Bryant concern at the time of his death, he did not speak to staff about them, and we do not consider that they could reasonably have anticipated that he was at immediate risk of suicide or of significant self-harm. Nor do we consider that there was any reason for staff to have recommenced suicide and self-harm monitoring procedures (ACCT).

Governor to Note

69. We understand that all custodial managers at Stocken have up-to-date first aid training as they provide 24-hour cover at the prison. It is positive that in addition to custodial managers, there is a further cohort of staff with up-to-date training. The OSG told us that he had voluntarily attended a first aid training course outside the prison but had not received first aid training from Stocken. In view of the large footprint of Stocken and the distance and time it can take for the custodial manager to reach an emergency, the Governor may want to encourage more of his other regular night staff to volunteer for first aid training.

Good practice

70. We commend the OSG in particular, as well as the other staff involved in the response, for their concerted efforts to try to save Mr Bryant's life in what were highly unusual and extremely harrowing circumstances.

Clinical care

71. The clinical reviewer concluded that Mr Bryant's care at Stocken was good and was of a standard equivalent to that which he could have expected to receive in the community. He found that the mental health team responded promptly to referrals made by prison staff and was given good support.

Inquest

72. An inquest into Mr Bryant's death held from 15 to 22 May 2025 concluded that his cause of death was catastrophic haemorrhage following self-inflicted laceration to the neck.

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