Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Keith Gadd, a prisoner at HMP Bristol, on 9 March 2023

A report by the Prisons and Probation Ombudsman

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

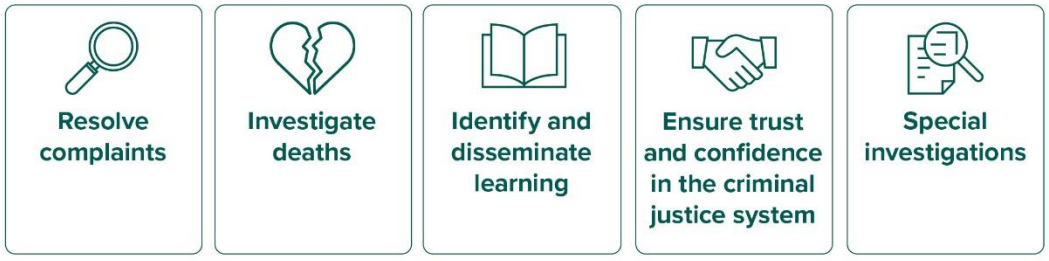
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 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

© Crown copyright, 2025

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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

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

Mr Keith Gadd died on 9 March 2023 after being found hanged in his cell at HMP Bristol. He was 60 years old. I offer my condolences to Mr Gadd's family and friends.

Mr Gadd was serving a sentence of Imprisonment for Public Protection (IPP). His tariff (minimum time to be served in prison) expired more than thirteen years before he died, and he had never been released on licence. In September 2022, the Justice Select Committee found that IPP sentences cause acute harm to those subject to them, with the prospect of serving a sentence without an end date causing higher levels of self-harm as well as a lack of trust in the system that is meant to rehabilitate them.

In September 2023, following a worrying increase in the self-inflicted deaths of IPP prisoners in 2022, I issued a Learning Lessons bulletin on the subject. Mr Gadd had most of the risk factors I identified in that bulletin as increasing the risk of suicide and self-harm of IPP prisoners. I conclude that insufficient weight was given to those risk factors when Mr Gadd's behaviour changed in the days before he died. As a result of some commendable local innovation, support for IPP prisoners has improved at Bristol since Mr Gadd died. However, as a reception prison, it remains an inappropriate location for them and HMPPS must deliver on its plans to ensure IPP prisoners' needs can be met in more suitable prisons.

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 **August 2025**

Contents

Summary

Events

1. In 2006, Mr Keith Gadd was sentenced to a sentence of Imprisonment for Public Protection (IPP) for wounding with intent. In 2009, he successfully appealed the minimum time he had to serve before he could be considered for release (tariff) from over seven years to three years five months. His tariff expired in January 2010. Despite this, Mr Gadd had not been released on licence.

2. In March 2021, Mr Gadd transferred to HMP Leyhill (an open prison). On 11 July 2022, staff started Prison Service suicide and self-harm monitoring procedures (known as ACCT) after Mr Gadd said he felt depressed and helpless and had suicidal thoughts. He had withdrawn from work, been rude to other prisoners and stayed in his room.

3. On 19 July, Mr Gadd refused to comply with the terms of his escorted release on temporary licence (RoTL). Another prisoner said he had overheard Mr Gadd threaten to stab someone. A case conference on 25 July decided that Mr Gadd could no longer be safely managed in an open prison, and he was transferred to HMP Bristol the same day. Mr Gadd was frustrated and upset by his return to a closed prison, which he felt was unjustified. He could no longer access risk reduction groups or the same level of mental health support he had been able to at Leyhill and must have felt that his release was even more of a distant prospect.

4. On 2 August, staff closed Mr Gadd's ACCT as they no longer assessed him as a risk to himself. On 20 December, the Parole Board recommended Mr Gadd be returned to an open prison. The decision was sent to the Secretary of State for Justice for approval. Mr Gadd did not receive a response before he died.

5. In early March, Mr Gadd stopped attending work, did not collect his meals and stayed in his cell more. On 9 March 2023, an officer found Mr Gadd hanged in his cell. Cardio-pulmonary resuscitation (CPR) was started but quickly stopped because there were clear signs Mr Gadd had died.

Findings

6. Overall, more needs to be done to recognise a prisoner's IPP status as a potential risk factor for suicide and to identify the triggers for suicide and self-harm that are associated with this status.

7. Mr Gadd had a number of risk factors that meant he was at risk of suicide or self-harm including previous suicide attempts, personality disorder, anxiety and depression. In the days leading to his death, Mr Gadd did not go to work, spent more time in his cell and his behaviour to his friends was out of character. Prisoners raised concerns about Mr Gadd, but staff did not give sufficient weight to them in light of Mr Gadd's IPP status.

8. As a reception prison, Bristol was an inappropriate location for Mr Gadd and was unable to offer him risk-reduction work and the level of support he had at Leyhill.

9. The decision to return any IPP prisoner to a reception prison must only be taken in the most exceptional circumstances due to the difficulty of onward transfer, the particular risks associated with that sentence and the lack of prison places generally.

10. Leyhill did not provide Mr Gadd with a move-on plan or make sufficient effort to ensure his return to a more appropriate prison. This remains an issue for transfers of IPP and life-sentence prisoners to Bristol.

11. Mr Gadd had a single key work session at Bristol in over seven months. We consider that IPP prisoners should be treated as a vulnerable group and be prioritised for key work. This now happens at Bristol.

12. The clinical reviewer concluded that Mr Gadd's healthcare was partially equivalent to that he could have expected in the community. There was a lack of continuity and equity in Mr Gadd's mental health care between Leyhill and Bristol.

Recommendations

- The Governor and Head of the Offender Management Unit at HMP Bristol should ensure that all staff are aware of the risks associated with IPP prisoners and actively consider these when an IPP prisoner's behaviour changes or they are assessing their risk of suicide and self-harm.

- The Governor at HMP Leyhill should ensure that if they return prisoners to closed conditions, they must provide a move-on plan and make determined, documented efforts to return the prisoner to the sending prison.

The Investigation Process

13. HMMPS notified us of Mr Gadd's death on 13 March 2023. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

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

15. The investigator interviewed nine members of staff and three prisoners between June and August 2023.

16. NHS England commissioned a clinical reviewer to review Mr Gadd's clinical care at the prison. She joined the investigator for the interviews with healthcare staff.

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

18. We were informed by the prison that Mr Gadd had no next of kin. He was not in contact with his family and had no friends listed on his prison telephone account.

Background Information

HMP Bristol

19. HMP Bristol is a local prison serving the courts and holds up to 580 adult men. Healthcare is provided by Oxleas NHS Foundation Trust.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Bristol was in July 2023. Following the inspection, the Chief Inspector of Prisons invoked the Urgent Notification (UN) process because he was so concerned about conditions there. He noted that the UN process had been invoked after the last inspection in 2019 and many of the failings highlighted then were also observed during the 2023 inspection. Despite this, there were many excellent, dedicated staff in the prison who were doing their best to support the men in their care. The issues highlighted included:

    - Staffing across the prison was insufficient to ensure the delivery of a safe and purposeful regime.
    - The number of self-inflicted deaths and reported levels of self-harm were much too high.
    - Most prisoners spent 22 hours a day locked up, with half of them sharing cramped cells designed for one.
    - Wing staff did not develop effective relationships with prisoners. The prison was not delivering key work, wing staff had little time to advocate for prisoners who needed their help, and they lacked the capability and confidence to manage behaviour more effectively.

    The poor regime, ineffective relationships with wing staff and lack of support contributed to a sense of hopelessness and despondency among many prisoners.

21. Inspectors reported that there were staff shortages on the mental health team, which was struggling to meet increased demand. Referrals to the team had doubled in the previous six months with patients in crisis prioritised.

Independent Monitoring Board

22. 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 31 July 2023, the IMB reported that there had been an increase in deaths, self-harm and violence and more prisoners than the previous year were on ACCT and constant supervision. There had been high levels of overcrowding (over 50% all year) with two prisoners in cells built for one person. Staffing was below the required levels, which affected the consistent delivery of a full daily regime, resulting in more prisoners spending time in their cells. Activities were often cancelled on the day and key working had not yet been re-established after the Covid-19 pandemic. The Board reported that there

were insufficient staff in the mental health team to support the mental health needs of all prisoners. Priority was given to the most unwell.

Previous deaths at HMP Bristol

23. Mr Gadd's was the fifth self-inflicted death at Bristol since March 2020. There were also two deaths from natural causes and one drug related death during that period. Up to the end of 2023, there have been a further five self-inflicted deaths since, including that of an IPP prisoner on the same wing as Mr Gadd. As a result of these self-inflicted deaths and the Urgent Notification issued by HMIP, Bristol is receiving additional support and monitoring from regional and national safety teams. One prisoner has died from natural causes and there has also been a homicide. Apart from the other IPP prisoner there were no similar issues between Mr Gadd's death and the other self-inflicted deaths.

Imprisonment for Public Protection (IPP) sentences

24. Imprisonment for Public Protection (IPP) sentences were introduced in 2005 and abolished in 2012. They were intended to protect the public against offenders whose crimes were not serious enough to merit a normal life sentence, but who could only be released once they had served their minimum tariff and had demonstrated to the satisfaction of the Parole Board that they had sufficiently reduced their risk. The abolition was not applied retrospectively. There are about 3,000 IPP prisoners, of which half have never been released.

25. Since June 2022, the Secretary of State for Justice must approve all Parole Board recommendations for the release or return to open conditions of prisoners serving indeterminate sentences.

26. In September 2022, the Justice Select Committee (JSC) published a report of its review of IPP sentences. The JSC found that the indefinite nature of the sentence contributed to feelings of hopelessness and despair that had resulted in high levels of self-harm and some suicides within the IPP population. They recommended that all IPP prisoners be re-sentenced.

27. In February 2023, the Government announced that it would not re-sentence IPP prisoners. In response to the JSC report, the Ministry of Justice (MOJ) and HMPPS published a new IPP action plan in April 2023. The aim of the plan is to focus on ensuring that HMPPS processes support IPP prisoners to "maximise their prospects of achieving a safe and sustainable release".

28. In September 2023, we issued a Learning Lessons Bulletin on the self-inflicted deaths of IPP prisoners after 2022 saw the highest number of these deaths since the sentence was introduced. We concluded that an IPP sentence should be considered as a potential risk factor for suicide and self-harm. We also identified a number of risk triggers associated with IPP prisoners including parole hearings, prison transfers and change in security categorisation.

The key worker scheme

29. The key worker scheme was introduced in the men's prison estate in 2018. It provides prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address. Improving safety is a key aim of the scheme. All adult male prisoners should have around 45 minutes of key work each week, including a meaningful conversation with their allocated officer.

30. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

31. At Bristol key worker duties are not allocated to specific prison officers due to staff shortages.

Psychologically informed planned environment (PIPE)

32. PIPE units are designed to provide a supportive environment for high-risk prisoners with personality disorders.

Returning prisoners from open to closed conditions

33. If a prisoner is deemed no longer suitable for an open prison (a prison with minimum security that aims to reintegrate prisoners into the community) they should be returned to their original sending establishment. However, if the move is deemed urgent they will be sent to the nearest local prison as an interim measure. The open prison retains responsibility for ensuring the prisoner then either goes back to their original prison or moves to a lower category training prison. Prisoners that are returned from open conditions should travel with a 'move on plan'.

Key Events

34. On 4 August 2006, Mr Keith Gadd was sentenced to a sentence of Imprisonment for Public Protection (IPP) for wounding with intent. On 6 August 2009, he successfully appealed his tariff (the minimum time he had to serve before he could be considered for release) from over seven years to three years five months. His tariff expired on 14 January 2010, but he had never been released on licence.

35. Mr Gadd was diagnosed with anti-social and avoidant personality disorders which meant he had excessive social anxiety. He attempted suicide twice by overdose, in 1999 and 2013. His overdose in 2013 coincided with his removal from therapy. Mr Gadd's probation assessment showed he had spoken of "ending it all" in 2015 and had told a previous Community Offender Manager (COM - probation officer) that he could feel suicidal if he felt things were "not going right".

36. In December 2018, he moved to the PIPE unit (psychologically informed planned environment) at HMP Hull where he completed a number of offence-focused interventions. On 17 September 2020, the Parole Board recommended his transfer to an open prison to allow him to apply the skills he had learned there.

HMP Leyhill, March 2021 - July 2022

37. Mr Gadd transferred to HMP Leyhill open prison (a prison with minimum security that aims to help prisoners reintegrate into the community) on 24 March 2021. His Probation Service risk assessment from 2021 noted that Mr Gadd's thoughts of suicide and self-harm would need on-going monitoring, especially if he became stressed about his situation.

38. Mr Gadd had regular appointments with the mental health in-reach team at Leyhill and, as an IPP prisoner, came under the care of the prison psychology team. In August 2021, he started escorted release on temporary licence (RoTL) visits to Bristol. Mr Gadd completed several risk-reduction courses at Leyhill.

39. A senior probation officer said Mr Gadd always appeared quite frustrated although he was polite and appreciative of her time. She thought that he felt 'stuck' which, in her experience, was common among IPP prisoners. She said Mr Gadd liked being able to discuss his situation and she felt that he needed an outlet to share his frustrations.

40. In June 2022, Mr Gadd's COM noted in a report to the Parole Board that Mr Gadd withdrew from professionals and became socially avoidant when feeling stressed and emotionally affected.

41. On 8 July, a Supervising Officer (SO) spoke to Mr Gadd after one of the Prison Offender Managers (POMs) raised concerns about Mr Gadd's state of mind. Mr Gadd said he was fine but was obviously agitated. The same day another prisoner told the SO that they were worried about Mr Gadd as for the previous two days he had not gone to work and been alone in his room shouting and arguing with himself.

42. On 11 July, a member of the prison Wellbeing Team started Prison Service suicide and self-harm monitoring procedures (known as ACCT) after Mr Gadd told her he

felt “depressed and helpless”. He said nothing was going right for him and he had spent the last three days in his room. He said he was having suicidal thoughts, his appetite was poor and he was struggling to sleep.

43. At his first ACCT case review the same day, Mr Gadd said that he felt anxious about his progression towards release. He said he had been unable to talk through his concerns and everything had become too much, to the point that he felt depressed and suicidal. He was not taking his antidepressants or eating properly and had been using laxatives to control his weight.

44. The review agreed an ACCT care plan to support Mr Gadd which included attending the prison’s weekly anxiety group, advice on healthy weight management, an appointment with his new POM to discuss sentence progression and returning to his prison job in the DHL workshop.

45. On 19 July, Mr Gadd refused to go on an escorted half-day release because he wanted to get a passport photo for a driving licence application but was not allowed to take cash to do so.

46. Mr Gadd attended a second ACCT review on 20 July. He had not yet attended healthcare for weight management advice, or the anxiety group and it was agreed these referrals would be followed up. He had returned to his prison job and had an appointment with his POM for the following week.

47. On 25 July, the POM and prison managers held a case conference about Mr Gadd. They noted that there had been an escalation in concern about his behaviour from staff and prisoners. A prisoner had reported hearing Mr Gadd threaten to stab someone. He had been verbally hostile to other prisoners, withdrawn from his support networks and refused to engage with his temporary release programme. The case conference panel concluded that Mr Gadd was no longer manageable in open conditions and should return immediately to closed conditions in a category C prison. Given the immediacy of their concerns they decided Mr Gadd should urgently transfer to HMP Bristol, a category B local prison, as an interim measure.

HMP Bristol, 25 July 2022 – 8 March 2023

July and August 2022

48. Mr Gadd transferred to HMP Bristol the same day, 25 July. He attended an ACCT review in reception with an SO and Mr Gadd’s new POM at Bristol. Mr Gadd said he was not expecting to be moved from open conditions and was surprised to be in Bristol. He said he was confused and felt he had been treated unfairly.

49. Mr Gadd wrote in the resident contribution section of his ACCT plan that he was in a bad place, did not know what he had done to end up in closed conditions and wanted to know why he was there.

50. The next day, a SO held an ACCT review with Mr Gadd, a duty POM, and a mental health support worker. Mr Gadd said he was frustrated about his return to closed conditions and still did not know the reasons behind it. He said he had no thoughts of suicide or self-harm but was having a bad time due to his transfer. He said he intended to work to pass the time and was focused on a Parole Board review of the

decision to return him to a closed prison. The review team agreed Mr Gadd's observations could be reduced and decided to review him again a week later once the reasons for his transfer had been explained to him.

51. A SO held another ACCT review on 2 August with Mr Gadd and a wing officer. A nurse told the SO that the mental health team had no concerns about Mr Gadd and would not be attending his review (even though they had not formally assessed his mental health). The SO also spoke to the POM, who explained that he had re-issued the reasons for his recall to closed conditions to Mr Gadd.

52. Mr Gadd said he had no current thoughts of suicide or self-harm. He had been receiving support from his cellmate who was in a similar position having been recalled to closed conditions. Mr Gadd said he would like to transfer to a prison where he could receive help with his personality disorders and, ideally, wanted to transfer to a PIPE unit that specialised in prisoners that had been returned from open conditions. The review team concluded that ACCT monitoring could be stopped.

53. On 3 August, a nurse reviewed Mr Gadd's medication with him. She said Mr Gadd was initially guarded and said he was frustrated about his transfer. He denied acting aggressively at Leyhill and said he had been overheard venting his frustration in his room. He said he felt stable in mood and was eating and sleeping well but was worried about paranoia and rumination since being taken off chlorpromazine (an anti-psychotic) at Leyhill. He was happy with his current dose of fluoxetine (an antidepressant). Mr Gadd was keen to attend an anxiety support group as he had done in Leyhill, but the nurse told him these were not currently running at Bristol.

54. On 5 August, the POM met Mr Gadd to properly introduce himself. They discussed the possibility of Mr Gadd transferring to a lower security closed prison (a category C prison). Mr Gadd asked if he could be considered for transfer to HMP Warren Hill as it had a progressive regime and the POM said he would contact them. He said Mr Gadd was polite and receptive throughout their conversation.

55. At his ACCT post-closure review on 9 August, Mr Gadd said he was feeling better and had discussed his options for transfer with his POM.

September 2022

56. There were no entries on Mr Gadd's electronic prison record (NOMIS) in September 2022. On 12 September, Mr Gadd applied to see someone from the mental health team because of how he was feeling. Mr Gadd's clinical record indicated that a task had been sent to the mental health team but there is no record of Mr Gadd being seen in response.

57. On 27 September, the POM met Mr Gadd to discuss his potential transfer to Warren Hill. The POM said he had no news despite an initial exchange and a chasing email. Mr Gadd said he did not belong in Bristol and should be somewhere more suitable. The POM said he agreed with Mr Gadd but told him that arranging a transfer was not as simple as he might think.

58. The POM told the investigator that Mr Gadd had not arrived with a move-on plan from Leyhill as he should have. He said at the time there was an influx of

indeterminate sentence prisoners being returned from open conditions due to measures introduced by the then Secretary of State for Justice in June 2022. The increase in numbers made it harder to move these prisoners out to lower category closed prisons (category C prisons) that offered risk-reduction work and more specialised support for indeterminate sentence prisoners. He said category C prisons were often unwilling to take IPP prisoners because of the complexity of their cases and the fact that they were often in a 'parole window'. He said there was a lot of kickback from these prisons at the time.

October 2022

59. On 3 October, the POM and Mr Gadd again discussed his transfer from Bristol. The POM said he had chased a reply from Warren Hill but had not had a response. He said Mr Gadd again appeared confused about the reason he was in Bristol, and he reminded him of the reasons for his transfer from Leyhill and directed him to the form he had previously provided to him which explained the reasons.

60. On 5 October, Mr Gadd began work in the prison's print workshop and moved to a cell on B wing.

61. On 23 October, Mr Gadd told an officer that two prisoners had called him a "nonce" (prison slang for a sex offender). He said he did not want to move wings but wanted to know why they had done that. The officer completed a challenge support and intervention plan (CSIP – the process in prisons used to support perpetrators and victims of bullying and/or violence) referral. The CSIP referrals meeting subsequently decided that Mr Gadd could be supported outside the CSIP process. There is no evidence that Mr Gadd received any additional support.

62. On 24 October, the POM spoke to Mr Gadd about a potential transfer to HMP Erlestoke, a category C prison. He explained that he had still not heard back from Warren Hill and that Erlestoke offered more opportunities to complete risk-reduction work than Bristol did. Mr Gadd refused the transfer and said his solicitor had told him that he had an oral Parole Board hearing on 20 December. The POM said he had not been made aware that Mr Gadd had a hearing date. This meant that Mr Gadd was in a 'parole window' and any potential transfers would be put on hold until the outcome of the hearing was known. This hearing was to review the decision to move Mr Gadd back to closed conditions and also review his potential for a move back to open conditions or release.

63. On 25 October, an officer had a key worker session with Mr Gadd. Mr Gadd said he was generally okay because he was busy in the print shop but sometimes got frustrated with his situation and wanted time on his own. This was the only key worker session Mr Gadd had during his time at Bristol.

November 2022

64. On 7 November, the Parole Board formally notified both POMs of Mr Gadd's oral parole hearing via video-link on 20 December. They requested a report from the first POM, with details of why Mr Gadd had been returned to a closed prison and a report from the second POM on Mr Gadd's conduct and progress at Bristol.

65. There was only one entry on Mr Gadd's NOMIS record in November – on 8 November his workshop instructor recorded that he had handed in a Stanley knife blade and always worked hard and "keeps busy with cleaning".

66. On 29 November, the first POM spoke to Mr Gadd via video-link for his report to the Parole Board. Mr Gadd told him he had settled at Bristol but that he resented being back in a closed prison and the rationale for the decision. He denied threatening to stab someone and said this was a malicious accusation made by another prisoner who he suggested had bullied him. He said he had talked out loud in his room to work through his negative emotions and this had been overheard and spread about by prisoners. He said prisoners had spread rumours about his offending history which had resulted in some hostility towards him. He had therefore distanced himself and focused on his work while at Leyhill.

67. The POM said that during their conversation, Mr Gadd told him that he had "looked at some ceiling pipework and considered that he could hang himself". He added this to a minute on Mr Gadd's case notes but did not directly bring it to the attention of the other POM or suggest that that POM begin ACCT procedures. The second POM said he had not noticed this reference in the case notes. He said at the time he had an extremely high case load due to staff shortages.

December 2022

68. There are three entries on Mr Gadd's NOMIS record in December. Two alerts indicating he was on parole hold and unable to transfer and a negative entry for refusing to work in the kitchens on 12 December. The alert on 30 December 2022 was the last entry on Mr Gadd's NOMIS before he died.

69. On 12 December, the POM assessed Mr Gadd for his report to the Parole Board. They discussed Mr Gadd's transfer from Leyhill and Mr Gadd said he remained upset over his treatment there.

70. In his report, the POM noted Mr Gadd had positive reports from wing staff however, he tended to isolate and not engage with others. Mr Gadd said he deliberately kept his distance from some prisoners as he thought they were curious about his offending history. He noted that Mr Gadd had been unable to undertake any core risk-reduction work at Bristol because the prison did not offer any accredited programmes or group work and he had not had capacity due to his high workload to undertake one to one offending behaviour work with him. Mr Gadd had been unable to continue with his programme of temporary release into the community because Bristol did not facilitate temporary release.

71. On 13 December, Mr Gadd applied to see the mental health team because he was low in mood. A healthcare assistant noted on his clinical record that she had attempted to see Mr Gadd three times during the day but that there had been too few officers to facilitate the appointment.

72. The next day, a mental health practitioner saw Mr Gadd on B wing. He showed her a diary he had kept of how he was feeling. He said he spent a lot of time in his cell and used the diary as a coping mechanism. He said he ruminated on everything and was very low in mood. Mr Gadd said he had been in prison for 17 years and was worried about the outcome of his upcoming parole hearing. He asked her

whether it was possible for someone from the mental health team to support him during his video-link hearing. She told him this was unlikely but said it might be possible for someone to see him afterwards to check how he was. Mr Gadd said he would be very grateful if that was possible.

73. Mr Gadd told the mental health practitioner that it had helped to offload how he was feeling to someone as he had a lot of things bottled up in his head. She noted in his clinical record that his mood was very low and booked a crisis visit for him on 21 December, the day after his parole hearing.

74. On 20 December, Mr Gadd attended his oral parole hearing via video-link. His POM had annual leave booked before he learned of the date of the hearing.

75. On 21 December, a member of the mental health crisis team saw Mr Gadd briefly for his pre-booked visit. She said she had been unable to see him for longer as she had been assigned to escort another prisoner to hospital that day. Mr Gadd said he had had a bad night as he had been ruminating on his parole hearing. They agreed she would come and see him at 8.30am the next morning.

76. The member of the mental health crisis team visited Mr Gadd the next day as planned. Mr Gadd said his parole hearing had lasted about four hours. He told her about his POM not having accepted his explanation for his behaviour at Leyhill and his transfer to Bristol. He said he tended to ruminate due to his personality disorder but had learned some "avoidance and distraction techniques" that helped him cope. Mr Gadd said his mental health was currently stable and he had no thoughts of harming himself or others.

77. The member of the mental health crisis team said that the mental health team was not able to offer Mr Gadd a regular appointment. She said he would have benefitted from attending an anxiety management group, but none were running. She said she would make another appointment for Mr Gadd once he had received his parole decision and Mr Gadd agreed to let clinical staff know when this had happened. The mental health team leader told the investigator that Mr Gadd did not require crisis support. Due to staff shortages as a result of the change of healthcare provider in October, there was no capacity to offer primary mental health support and none of the groups such as anxiety management were running.

78. Mr Gadd received the Parole Board's decision letter on 23 December. The panel decided that the evidence put before it did not indicate that Mr Gadd's risk had increased. They agreed with the psychologist's assessment that Mr Gadd should be tested in the community via a gradual and staged process of escorted releases on temporary licence. They therefore recommended to the Secretary of State for Justice that Mr Gadd should be returned to an open prison to allow this to happen. There is no evidence that staff spoke to him about this decision, nor that Mr Gadd asked to see the mental health team, as he had agreed with the member of the mental health crisis team before the hearing.

January 2023

79. There is very little information in Mr Gadd's records during this period. There are no entries on his NOMIS record. The mental health team leader said she had moved from Leyhill to Bristol in October 2022 to take up a role as manager in the offender

management unit (OMU). She had started a monthly forum for IPP and life sentence prisoners, but this had been slow to get off the ground as staff shortages meant there was no one to escort the prisoners to the group. As a result, in January 2023, she decided to hold the group on B wing as this was the wing with the most IPP and life sentence prisoners. She said Mr Gadd attended the group and was very open about his frustration at having to wait for Secretary of State approval of his return to an open prison. Mr Gadd said he was struggling and at times wondered what was the point. She said other prisoners in the group would try to cheer him up, but she thought it was harder for Mr Gadd because he had no family or friends supporting him outside prison.

80. She told us that the team at Bristol responsible for organising transfers stopped looking for a category C prison for Mr Gadd because he was waiting for the Secretary of State's approval of his return to open conditions. Mr Gadd did not receive the Secretary of State's response before he died.

February – March 2023

81. On 9 February, the POM told Mr Gadd that the Government had rejected the Justice Committee's recommendation that all IPP prisoners be resentenced. He also gave Mr Gadd a copy of a letter to all IPP prisoners from the Governor explaining what the decision meant and offering support. He said Mr Gadd was aware of the decision and had not been expecting the recommendation to be accepted. He said Mr Gadd did not appear disappointed and showed insight into the issue.

82. The POM also explained to Mr Gadd that it might take some time for the Secretary of State's approval of the Parole Board's recommendation that he return to an open prison to be received. Mr Gadd said he was aware of the process and, although he was keen to receive an answer, he knew he had to be patient. He said Mr Gadd was calm and polite throughout their conversation and he was not concerned about Mr Gadd's well-being.

83. Mr Gadd's Probation Service record showed he telephoned his community offender manager on 1 March, but she was not there, and he declined to leave a message. He was advised to ring back on 10 March.

84. Three prisoners who all lived in cells on Mr Gadd's landing, told the investigator that Mr Gadd's behaviour changed in the days before he died. They said he did not go to work, and they were worried that he was not eating. He stayed in his room and was verbally abusive to Mr Walker when he brought him some food. All three prisoners said this was out of character for Mr Gadd. One prisoner said he remembered that the prison newspaper Inside Time had a lot of articles about IPP prisoners and delays in returning them to open prisons at about this time. All three prisoners said they told wing staff that they had been worried about Mr Gadd.

85. During the HMPPS Early Learning Review after Mr Gadd's death, catering staff confirmed to the Area Safety Lead that Mr Gadd had not attended his job in the kitchens for three or four days before 9 March. The Lead said an officer told him that concerns had been raised at the wing briefing on 7 March that Mr Gadd was behaving out of character. The officer was tasked with completing a welfare check.

86. The officer told the investigator that Mr Gadd's behaviour had not changed at all in the days leading to his death. He thought Mr Gadd had an arrangement with the kitchen that he did not have to work every day, so he was not concerned when Mr Gadd did not go to work. He said he was not aware Mr Gadd was not eating but he did remember completing a welfare check on Mr Gadd after he had been rude to a prisoner who had taken him some food. He said Mr Gadd told him he was fine and seemed to be his usual self.

87. A SO said she did not remember a wing briefing in which concerns for Mr Gadd's behaviour were raised. She said she had been on duty on 8 March, and no one had raised any concerns about him with her. An officer said he regularly worked on Mr Gadd's landing. He had been away for a few days, returning to work on 8 March but no one had raised any concerns about Mr Gadd's behaviour.

Events of 9 March 2023

88. Unknown to staff, a prisoner had smeared a clear substance on to the lens of the CCTV camera on Mr Gadd's landing obscuring the view from it. It is especially difficult to see exactly what happened before the landing light is turned on. (The prison investigated and identified the prisoner responsible – it was not Mr Gadd.)

89. At 5.35am, an Operational Support Grade (OSG) checked the prisoners on Mr Gadd's landing for the morning routine check. CCTV showed the OSG used his torch to look through the observation panels on the cell doors. The substance on the camera lens and the angle due to the location of Mr Gadd's cell meant it was not possible to see how long he remained outside Mr Gadd's cell.

90. The OSG said that he could not remember checking Mr Gadd that morning. He said prisoners on B Wing often obscured their observation panels and this was a regular issue that had been raised with prison managers. He said that when he came across a covered observation panel, he knocked on the door until the prisoner responded. If he failed to get a response, he would radio the orderly officer for assistance. He said the fact that he had not used his radio that morning indicated he had either seen Mr Gadd in his cell alive and well or had obtained a verbal response from him.

91. Just before 8.00am, Officer A opened Mr Gadd's cell door to give him his breakfast pack. He saw Mr Gadd suspended from the window frame by a belt. He radioed a code blue emergency (indicating a prisoner is not breathing or having difficulty breathing), cut the belt from the window frame and released the buckle from Mr Gadd's neck. The control room log recorded the code blue at 7.58am. Ambulance records showed the control room officer called an ambulance at 8.00am and an ambulance was dispatched with the highest priority.

92. Officer B helped Officer A lay Mr Gadd on the floor and Officer B started cardio-pulmonary resuscitation (CPR). A SO attached a defibrillator. The defibrillator did not detect a shockable heart rhythm and advised CPR to continue. A nurse arrived and asked for Mr Gadd to be moved to the landing where there was more space to work on him.

93. The nurse said she was unable to insert an airway into Mr Gadd's mouth because his jaw was too stiff. She inserted an airway into Mr Gadd's nostril instead. She said

there was evidence of blood pooling in Mr Gadd's lower abdomen (hypostasis - indicating a lack of circulation), his lips were blue, and his pupils were fixed with no reaction to light. She told the investigator that she had not received any guidance or undertaken any training about the circumstances in which CPR should not be given.

94. The Head of Healthcare arrived two minutes after Mr Gadd was moved to the landing and told the nurse to stop resuscitation, as there were clear signs that Mr Gadd had died. At 8.14am, paramedics confirmed Mr Gadd had died.

Contact with Mr Gadd's family

95. The prison was unable to identify a next of kin. Mr Gadd was estranged from his family and his previous partner had died.

Support for prisoners and staff

96. After Mr Gadd's death, the Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team and also offered support.

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

Post-mortem report

98. The Coroner gave the cause of death as suspension by ligature around the neck (hanging).

Inquest

99. On 28 July 2025, a Coroner's inquest found Mr Gadd had died by suicide.

Findings

Assessment of risk

100. In our Learning Lessons Bulletin issued in September 2023, we concluded that more needs to be done to recognise a prisoner's IPP status as a potential risk factor for suicide and to identify the triggers for suicide and self-harm that are associated with this status. These include parole hearings, prison transfers and change in security categorisation. The regularity with which IPP prisoners are subject to parole review means that these triggers are often relevant. We also concluded that insufficient opportunities to participate in offending behaviour programmes can increase frustration and create a sense of hopelessness. Additionally, 2022-2023 was a significant year for IPP prisoners. In June 2022, the Secretary of State for Justice tightened the criteria for transfer to open prisons and introduced ministerial approval of Parole Board recommendations for these transfers. In February 2023, the Government announced they would not accept the JSC recommendation to re-sentence IPP prisoners.

101. Mr Gadd had a number of risk factors that meant he was at risk of suicide or self-harm including previous suicide attempts, personality disorder, anxiety and depression. A risk assessment in 2021 noted Mr Gadd's thoughts of suicide and self-harm would need on-going monitoring, especially if he became stressed about his situation. His records showed that he experienced suicidal thoughts when he felt things were not going right for him and withdrew from professionals and became socially avoidant when feeling stressed and emotionally affected.

102. There is evidence that in the days leading to his death Mr Gadd displayed many of the signs noted above. He did not go to work, spent more time in his cell and his behaviour to his friends was out of character. It is clear from the HMPPS Early Learning Review that concerns were raised to staff about Mr Gadd in this period. We consider that staff should have given more weight to these concerns in the light of Mr Gadd's IPP status.

103. Mr Gadd had been waiting for Secretary of State approval of his return to an open prison for the best part of three months and this would have been a source of anxiety and frustration. The stricter criteria introduced in June 2022 meant approval was by no means guaranteed. He was in a reception prison that was not set up to support and manage IPP prisoners. He did not have the outlet of group work and regular mental health support as he had at Leyhill. He was unable to complete risk reduction work and his transfer to a category C prison had been put on hold pending the Secretary of State's decision. We consider that all these factors should have been considered when determining Mr Gadd's risk of suicide and self-harm. We recommend that:

The Governor and Head of the Offender Management Unit at HMP Bristol should ensure that all staff are aware of the risks associated with IPP prisoners and actively consider these when an IPP prisoner's behaviour changes or they are assessing their risk of suicide and self-harm.

Transfer to HMP Bristol

104. Mr Gadd's transfer to Bristol was intended to be a temporary measure pending a return to his original sending establishment or to a category C prison that could offer him risk-reduction work and more specialist support. The Secretary of State's tightening of the criteria for open conditions in June 2022 was in response to the high profile abscondence of a sex offender from Leyhill. It was perhaps natural that this would result in Leyhill being more cautious when assessing prisoners' risk.

105. We note that Mr Gadd was transferred on the hearsay evidence of a fellow prisoner and after he refused to engage with his programme of release on temporary licence. We have not seen any evidence that Mr Gadd's explanations were explored, or alternatives considered. His new POM had not met him at this point and did not speak to him personally. Additionally, Mr Gadd was subject to ACCT monitoring and the actions on his care plan deemed necessary to reduce his risk had not been completed and one of them, that he attend an anxiety management group, could not be completed at Bristol.

106. A senior probation officer told the investigator that she was frustrated to see so many IPP and life sentence prisoners at Bristol that she remembered from Leyhill. She said Bristol was not a suitable environment for these prisoners. She provided the investigator with email correspondence from 11 January 2023 that showed there were 26 prisoners at Bristol who had been returned from Leyhill since October 2020. Of these, 22 were IPP or life sentence prisoners and 18 had been returned after the Secretary of State for Justice brought in the new measures in June 2022.

107. The manager in charge of the Offender Management Unit subsequently had a meeting with his counterpart at Leyhill, after which the senior probation officer said the situation improved.

108. We consider that the decision to return any IPP prisoner to a reception prison must only be taken in the most exceptional circumstances due to the particular difficulty of onward transfer, the risks associated with that sentence and the lack of prison places generally. As a minimum, the returning prison must provide a move-on plan and make proper efforts to return the prisoner to their original sending prison. Clearly there was an influx of IPP and other indeterminate sentence prisoners to Bristol from Leyhill after June 2022 and this was sufficient for Bristol to initiate a meeting to try to resolve the issue.

The Governor at HMP Leyhill should ensure that if they return prisoners to closed conditions, they must provide a move-on plan and make determined, documented efforts to return the prisoner to the sending prison.

109. We understand that the lack of move-on plan and the exploration of alternatives continues to be a problem for Bristol, albeit there is now more national scrutiny of the location of IPP prisoners and Bristol is now receiving more help moving IPP prisoners on. We think that this investigation very clearly demonstrates both the particular vulnerabilities of IPP prisoners and the lack of wider staff understanding of them. We recommend that:

110. In its report on IPP sentences published in September 2022, the Justice Select Committee (JSC) found that "the psychological harm caused by IPP sentences is a

considerable barrier to progression for some IPP prisoners. The indefinite nature of the sentence has contributed to feelings of hopelessness and despair that has resulted in high levels of self-harm and some suicides within the IPP population. In addition to this, IPP prisoners distrust the people and services that are necessary to support their progression."

111. The Government responded to the review in February 2023, when they announced that they would not be resentencing those currently subject to an IPP sentence. In response to the JSC report, the Ministry of Justice (MOJ) and HMPPS published a new IPP Action Plan in April 2023. The aim of the plan is to focus on ensuring that HMPPS processes support IPP prisoners to "maximise their prospects of achieving a safe and sustainable release". It includes measures to support those serving IPP sentences and to reduce the risk of suicide and self-harm.

112. The IPP Action Plan includes a requirement for Executive Directors to introduce IPP Delivery Plans for the prisons in their regions by the end of April 2024. It is important that these plans contain meaningful actions to support IPP prisoners through to release and that staff have an awareness of the specific risks that IPP prisoners present in regard to self-harm and suicide if we are to stop seeing more IPP prisoners from taking their own lives.

Key work at Bristol

113. In common with some other prisons, the key work scheme has not been operating as it should at Bristol due to staff shortages. One of HMIP's key concerns during their recent inspection was that wing staff did not develop effective relationships with prisoners. Mr Gadd had just a single key work session in over seven months. Mr Gadd's records showed he welcomed the opportunity to talk about his situation. Regular key work sessions might have allowed staff to build a more accurate picture of his risk to himself and others.

114. Some prisons prioritise the most vulnerable prisoners for key work. Our Learning Lessons Bulletin concluded that IPP prisoners should be considered vulnerable and prioritised for key work. Since Mr Gadd's death and the death of another IPP prisoner at Bristol, all IPP prisoners are prioritised for fortnightly key work sessions. We therefore make no recommendation.

Clinical care

115. The clinical reviewer concluded that Mr Gadd's healthcare was partially equivalent to that he could have expected in the community. There was a lack of continuity and equity in Mr Gadd's mental health care between Leyhill and Bristol. In particular, Mr Gadd was well supported by the mental health team at Leyhill but there was no capacity to offer him individual support or group work at Bristol. The clinical reviewer has made several recommendations which the Head of Healthcare will wish to consider.

Emergency Response

116. We note that prison staff and the emergency response nurse initially gave Mr Gadd CPR despite signs unequivocally associated with death. Once the Head of

Healthcare arrived, he directed that CPR should stop. The nurse concerned said she had not received guidance on this and was unaware that she did not need to perform CPR when someone had clearly died. We note that this training need was recognised by the Head of Healthcare who subsequently issued a Learning Lessons Bulletin to all staff with appropriate guidance. Simulation training to improve staff competence and confidence on when to perform CPR is planned for February 2024. We make no recommendation.

Good practice

117. The senior probation officer's introduction of an IPP/Lifer forum to support these prisoners at Bristol is an example of good practice. We consider that this initiative should be fully recognised and supported by senior managers at Bristol.

Prisons & Probation Ombudsman
Independent Investigations

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

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

T I 020 7633 4100