Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gary Bell, a prisoner at HMP Holme House, on 28 December 2019

A report by the Prisons and Probation Ombudsman

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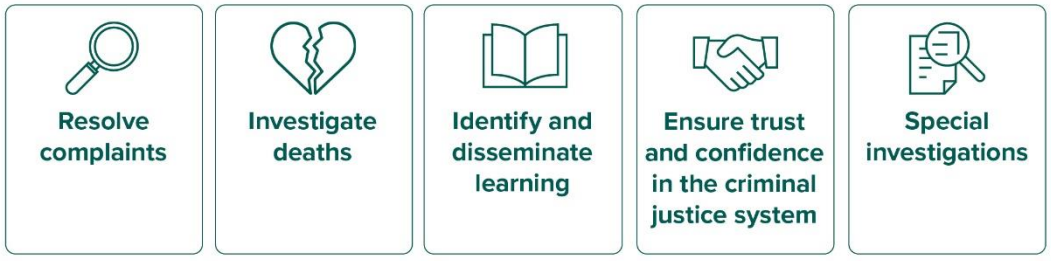
OUR VISION

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

WHAT WE DO



WHAT WE VALUE

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

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

Mr Gary Bell died in hospital on 28 December 2019, after being found hanging in his cell at HMP Holme House on 25 December. He was 44 years old. I offer my condolences to Mr Bell's family and friends.

Mr Bell was subject to suicide and self-harm prevention procedures (known as ACCT) on several occasions at Holme House. He suffered severe pain in his right leg, following an old knee injury, and after his leg was amputated in October 2019, he continued to complain that he was in pain, as well as struggling mentally with having lost his leg.

Staff started the last period of ACCT monitoring on 17 December, after Mr Bell cut his arm with a razor blade and told them that his pain was not being managed. On 21 December, staff found him hanging in his cell. Staff cut him down and he remained conscious. Staff increased his observations to four an hour. The next day, staff assessed that his risk had reduced and lowered his observations to two an hour. On 24 December, staff lowered his observations again, to hourly.

The investigation found that overall, staff managed the ACCT procedures well. While it may appear that staff reduced observations too soon, I am satisfied that they assessed Mr Bell appropriately and that it was not unreasonable for them to consider that his risk had reduced. However, as many prisoners find Christmas difficult, it may have been wiser to have continued observing him twice an hour until after Christmas Day.

I am concerned that the agreed frequency of observations was not always recorded on the ACCT paperwork and observations were not always carried out at the agreed frequency.

The clinical reviewer found that Mr Bell received good support from the mental health team when he was in crisis. She found that healthcare staff prescribed appropriate pain relief, but she considered that they should also have considered referral for specialist pain management advice. She also noted that Mr Bell did not receive any physiotherapy after his amputation as he should have done.

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

Sue McAllister CB
Prisons and Probation Ombudsman **November 2020**

Contents

Summary

Events

1. In January 2018, Mr Gary Bell was sentenced to five and a half years imprisonment for arson. He was moved to HMP Holme House on 1 February.

2. Mr Bell had recurrent leg infections because of an old knee injury and on 30 October 2019, he had his leg amputated above the knee. He returned to Holme House the next day.

3. On 25 November, staff started suicide and self-harm prevention procedures (known as ACCT) after Mr Bell cut his arm and told staff that his pain was not being managed and that he was struggling mentally with the loss of his leg. Staff stopped ACCT procedures on 6 December but restarted them when Mr Bell cut his arm again on 17 December.

4. On 21 December, Mr Bell was found hanging in his cell. He was still conscious and did not require hospital treatment. Staff increased observations to four an hour. However, during an ACCT case review on 22 December, it was agreed the observations should be reduced to two an hour. On 24 December, staff reduced observations again, to hourly.

5. At 12.30pm on 25 December, Mr Bell was found hanging in his cell. Staff cut him down and started cardiopulmonary resuscitation (CPR), which was continued by ambulance paramedics. The paramedics managed to restore a pulse and took Mr Bell to hospital where he was placed in an induced coma.

6. Mr Bell did not regain consciousness and died in hospital on 28 December.

Findings

7. We found that overall, staff managed the ACCT procedures well. Most ACCT reviews were multidisciplinary and appropriate caremap actions were identified. We note that observations were reduced from four an hour to one an hour between 21 and 24 December. We consider that staff assessed Mr Bell appropriately and that it was not unreasonable for them to consider that his risk had reduced. However, as many prisoners find Christmas difficult, we consider that it may have been wiser to have maintained Mr Bell on two observations an hour until after Christmas Day.

8. We are concerned that the agreed frequency of observations was not always recorded in the ACCT documentation and some observations were not carried out at the agreed frequency.

9. The clinical reviewer found that Mr Bell received a good and prompt response from the mental health team when he was in crisis. She concluded that overall, Mr Bell's health care needs were well managed. She found that there was effective prescribing of pain relief medication to Mr Bell. However, she considered that it would have been helpful for the prison to have considered referring Mr Bell for specialist pain management advice. Also, Mr Bell had no physiotherapy or occupational therapy input after his amputation, as he should have done.

10. We are concerned that not all staff felt adequately supported following Mr Bell's death.

Recommendations

- The Governor should ensure that staff:
  - record the agreed frequency of ACCT observations on the front of the ACCT document and in the case review notes;
  - carry out observations at the correct frequency; and
  - vary times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked.
- The Head of Healthcare should ensure that prisoners with complex pain management needs have access to a local specialist pain service.
- The Head of Healthcare should ensure that prisoners have access to appropriate therapy services, such as physiotherapy and occupational therapy, following major surgery.
- The Governor should ensure that local systems and arrangements are in place for effective post-incident care for staff who are exposed to distressing or traumatic events during their duties.

The Investigation Process

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

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

13. NHS England commissioned an independent clinical reviewer to review Mr Bell's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed 11 members of staff on 6 and 7 February 2020. The clinical reviewer also interviewed two prison GPs by telephone and spoke to the Mental Health Locality Manager again. The investigator asked a prison officer questions by email and made notes of her interview with a supervising officer.

14. We informed HM Coroner for Teesside of the investigation. Mr Bell's post-mortem examination and toxicology report were not available at the time of issuing this report. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Bell's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Bell's family asked:

    - Whether Mr Bell was being bullied.
    - How his mental health was managed after his leg was amputated.
    - When the prison started checking on Mr Bell, and how frequently.

    We have addressed these issues in the report.

16. We shared our initial report with HM Prison and Probation Service (HMPPS). They raised no factual inaccuracies.

17. We provided Mr Bell's next of kin with a copy of our initial report. They did not raise any issues or comment on the factual accuracy of the report. Other issues were addressed separately, via their solicitor.

Background Information

HMP Holme House

18. HMP Holme House is a category C training prison holding over 1200 men. G4S provides health services at the prison. There is a 24-hour healthcare unit with 16 beds.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Holme House was in February and March 2020. Inspectors reported that the safer custody team had undertaken some recent work to improve the quality of the ACCT case management process through stringent quality assurance, but it was too soon to judge its effectiveness. Inspectors found that in the sample of ACCTs they reviewed, case managers were not always consistent and reviews not always multidisciplinary. Some care maps lacked detail and observational entries were often limited. Prisoners they spoke to who were being monitored under ACCT had mixed views about the quality of staff care and support.

20. Inspectors found that all prisoners in the inpatient unit had a care plan and they saw caring interactions from nursing and prison staff on the unit. Mental health services operated seven days a week. Prisoners could be seen on the same day by the duty worker or within seven days for non-urgent referrals. Members of the team attended all initial ACCT reviews and were present in the segregation and inpatient units daily.

Independent Monitoring Board

21. 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 report, for the year ending 31 December 2018, the IMB found that the prison was less volatile and dangerous for both prisoners and staff, that the mental health team were fully staffed, and that they had observed excellent examples of a caring and consistent approach to ACCT reviews.

Previous deaths at HMP Holme House

22. Mr Bell was the 13th prisoner to die at Holme House since December 2017. Of the previous deaths, eight were from natural causes, one was self-inflicted, and three were drug-related. There are no similarities between our investigation findings in Mr Bell’s case and our investigation findings from the previous deaths.

ACCT

23. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

25. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction 64/2011, Management of prisoners at risk of harm, to self and from others (Safer Custody).

Key Events

26. Mr Gary Bell was remanded in custody on 27 May 2017, charged with arson, and sent to HMP Holme House. He showed mild withdrawal from opiates and was placed on a methadone (opiate substitute) programme. Mr Bell also said he had pain and mobility difficulties because of a deformed right knee. He was prescribed pain relief and anti-inflammatory medication.

27. Mr Bell was moved to HMP Durham on 9 August 2017. On 19 January 2018, he was sentenced to five years and six months imprisonment.

28. On 31 January, staff started Prison Service suicide and self-harm prevention procedures (known as ACCT) after Mr Bell told them that he had thoughts of taking his life and that he had taken an intentional overdose in the past.

HMP Holme House

29. Mr Bell was moved to Holme House on 1 February. He continued to be monitored under ACCT until 8 February.

30. Mr Bell had a history of leg infections, cellulitis, and knee pain due to an old injury and subsequent knee surgery. In April, he was told that his leg needed to be amputated due to recurring infection.

31. On 20 May, staff started ACCT procedures for Mr Bell who said he was feeling low because of the possible loss of his leg and because he was in constant pain. Staff stopped ACCT procedures on 22 June when Mr Bell appeared to accept that amputation was inevitable.

32. Over the next few months, Mr Bell remained on varying doses of gabapentin, dihydrocodeine and codeine (painkillers). He continued to have his methadone dose adjusted, with a view to being off it by the time of his release in February 2020. Staff put a personal care plan in place, to assist Mr Bell with tasks such as showering. He was allocated two 30-minute sessions each week which he accepted on occasions, while other times he said he could manage by himself.

33. On 18 June, Mr Bell received a letter from the hospital, which said his only option was for an above the knee amputation. Mr Bell agreed but was given a ‘cooling off’ period in which to decide.

34. Mr Bell met with a MIND counsellor on 12 September, but missed the next appointment and declined the service on 3 October. Mr Bell said he knew how to access the service should he need it.

2019

35. On 24 January 2019, Mr Bell requested a second opinion about his planned leg amputation. In February, he was told his leg could not be repaired. On 20 March, Mr Bell referred himself to the mental health team as he felt depressed as he was still waiting for his leg surgery. He was added to the mental health team’s waiting list.

Mr Bell had a mental health assessment on 24 June. He said he had no need to see them anymore, but he had just felt frustrated waiting for his operation.

36. Mr Bell's knee became ulcerated on 29 June, and prison healthcare staff managed his infection. He continued to complain of leg pain. A GP assessed him on 4 September. She prescribed him a two-week course of doxycycline. Mr Bell's methadone was also increased to help with pain relief.

37. On 30 October, Mr Bell had his leg amputated above the knee. He only remained in hospital for 24 hours, and then returned to Holme House. He was admitted to the prison's inpatient unit in the healthcare department and used crutches and a wheelchair, as he had done before the surgery. He was due to have amputation physiotherapy approximately six weeks after his surgery. This was to help him mobilise and possibly prepare for a prosthetic limb. (The Prosthetic Limb Service telephoned with an appointment for Mr Bell in January 2020.) Healthcare staff put a care plan in place to manage Mr Bell's wound, to dress it and keep it free from infection.

38. Mr Bell complained of pain during the early hours of 3 November and was given Oramorph (liquid morphine). He remained comfortable after that. Mr Bell remained in the inpatient unit. He was assisted with showering and his wound was dressed, and he appeared to be mobile. His wound appeared to be healing well and there were no signs of infection.

39. On 24 November, Mr Bell complained of phantom leg pain from his amputated leg. (Phantom pain happens after a limb amputation when the brain reacts as if the limb is still there and so reacts to the previous pain experience.) He was given pain relief and the next day was assessed by a GP. He noted that Mr Bell's leg pain was getting worse and the gabapentin pain relief did not seem effective. He was reluctant to prescribe dihydrocodeine, as it was made less effective by methadone, but agreed to prescribe it for the short term.

ACCT: 25 November to 6 December

40. On 25 November, Mr Bell made a cut to his left arm. He said he felt low as his pain was not being managed. Staff started ACCT procedures and put him on hourly observations until the first ACCT case review. During an assessment interview, Mr Bell told staff that following his leg amputation, he was not only in great pain, but he was also struggling mentally as he did not know how his life would be on release. Mr Bell said his actions were a distraction, and he had no intention of taking his life. Mr Bell said he felt anxious about moving out of the inpatient unit and returning to a standard cell on a houseblock in due course.

41. Staff held the first ACCT case review at 11.10am, the same day. Two mental health nurses attended with prison staff and Mr Bell. At the review, Mr Bell told them he now felt fine but was concerned about where he might live when he was released from prison in February. They discussed Mr Bell's pain relief and said an appointment to see a doctor had been made for later that day. Mr Bell said he did not want to end his life but could not promise he would not harm himself again. It was agreed that there would be no further input from the mental health team, but that Mr Bell could refer himself at any point. It was agreed that Mr Bell would remain

on hourly observations. A GP prescribed Oramorph that afternoon and Mr Bell said he experienced no pain that night.

42. Staff held the second ACCT review on 28 November, at 3.30pm. No healthcare staff attended, but they had telephone input beforehand. Staff assessed Mr Bell's level of risk as low, and reduced his observations to two each morning, afternoon and evening. Mr Bell seemed well during the review. He said he was on pain medication and had no thoughts of suicide or self-harm. Mr Bell spoke about his future and wanted to focus on getting a prosthetic leg and becoming mobile. Mr Bell said he was aware of the support networks available to him and would ask for help if he needed to.

43. On 2 December, Mr Bell's leg wound became infected. A GP prescribed him a course of antibiotics. She told the clinical reviewer that she had treated Mr Bell for pain management both before and after the amputation. She said she believed the prescribed pain relief had been appropriate and she noted a reduction in Mr Bell's reported level of pain once he was able to mobilise again.

44. Staff held the third ACCT case review on 4 December. There was no healthcare input. Mr Bell said his pain was under control, but he was still waiting to speak to someone from Through the Gate (TTG) about accommodation on his release. Mr Bell said he had no thoughts of suicide or self-harm. Staff reduced his observations to one in the morning, afternoon and evening, and three times during the night.

45. Staff held Mr Bell's fourth ACCT case review on 6 December. Mr Bell seemed well and said he was due to meet with TTG on 22 December who would assist him with his release. Staff noted that all the actions on Mr Bell's caremap had been completed and they agreed to stop ACCT procedures. They scheduled a post-closure review for 13 December, but there is no evidence that it took place.

ACCT: from 17 December onwards

46. On 17 December, an officer started ACCT procedures for Mr Bell, after he cut his arm with a razor blade. During the assessment interview, Mr Bell said prisoners in healthcare were talking about him and he would consider moving to a houseblock. Mr Bell said he felt his mental health was declining, he felt paranoid, and was worried about his release as he was not sure where he would live. Mr Bell said he would like to work with the prison's mental health team before he felt worse. The officer put Mr Bell on hourly observations until the first ACCT case review.

47. Later that morning, Mr Bell met with a worker from Links Care Path to discuss his substance use. They discussed the amputation, and Mr Bell said the operation had gone well and he was hoping for a prosthetic leg in the New Year. Mr Bell said he felt more positive. They then discussed his substance use care plan. Nothing had changed on the plan and Mr Bell was due to reduce his methadone dose once he felt stable. They agreed to review Mr Bell in six weeks, with a view to methadone reduction.

48. At 2.30pm, three managers and the mental health team leader met with Mr Bell for the ACCT case review. Mr Bell spoke about his anxiety about being released and his request to move out of healthcare. He was told that healthcare staff would need to complete a Social Care Needs Assessment before he could move. Staff added

the following actions to the caremap: that Mr Bell needed to meet someone from TTG, that he needed a Social Care Needs Assessment, that he should move to a houseblock when there was space, and to arrange a mental health appointment. Staff assessed Mr Bell's risk of suicide and self-harm as low. Staff did not record his level of observations in the ACCT review or on the front of the ACCT document, but the on-going record shows he was checked once in the morning, afternoon and evening, and four times during the night.

49. On 19 December at 1.30pm, staff found Mr Bell with a piece of torn bedsheet. Mr Bell said he intended to make it into a ligature. Mr Bell asked to see a member of the mental health team because he was stressed and thinking of killing himself.

50. Shortly afterwards, Mr Bell met with a mental health nurse. Mr Bell said he felt very low in mood, was anxious and nervous, had disturbed sleep and a lack of appetite. Mr Bell said he was hearing voices, but she noted he did not appear preoccupied or distracted. Mr Bell said he felt embarrassed about the loss of his leg and did not feel ready to return to a houseblock. Mr Bell said he enjoyed seeing his friends and playing cards on the inpatient unit. He spoke about support from his family. Mr Bell said he had no further thoughts of suicide or self-harm, and felt better by talking to her, but asked if she could chase up a follow up outpatient hospital appointment, which was overdue.

51. Staff held an ACCT review an hour later, with representatives from healthcare present. Mr Bell said he did not want to die, but was concerned about his medication and his mental health. Staff increased Mr Bell's observations to two an hour and made an appointment for him to see a member of the mental health team. They also arranged counselling.

52. From 8.00pm, on 19 December, until 6.00am the next morning, Mr Bell was checked hourly rather than twice an hour. No explanation was given.

21 December

53. Officer A was working in the inpatients unit on 21 December, and knew Mr Bell should be on two ACCT checks an hour. Another officer had checked him at 6.00am, and 6.30am, before handing over to Officer A.

54. At approximately 6.55am, Officer A looked through Mr Bell's observation panel and saw him hanging from his bed frame by a ligature made from a strip of pillow case. Officer A radioed a code blue call (a medical emergency code used to indicate a prisoner who is unconscious or having breathing difficulties) and went straight into Mr Bell's cell. A nurse responded to the call immediately, taking a bag of equipment with him. The nurse loosened the ligature by putting his fingers in-between the ligature and Mr Bell's neck. Officer A cut the ligature and Mr Bell fell to the floor and then got onto the bed. He was conscious throughout. The ligature had left a deep mark on his neck. Officer A left the nurse to assess Mr Bell.

55. The nurse assessed Mr Bell and found he was physically well, apart from red marks around his neck, but seemed "vacant" and did not say much about what had happened. The nurse requested an urgent mental health assessment. Officer A returned to speak to Mr Bell at approximately 7.20am. He told the investigator that

they had a good chat, although could not remember what they had spoken about. Mr Bell was checked every 15 minutes.

56. Staff held the second case review on 21 December at 8.25am. Mr Bell attended with a prison manager, Officer A and a nurse. He said he felt paranoid and was hearing voices. Mr Bell said people were calling him a “nonce “and he had thoughts of taking his life. Mr Bell said he had a visit booked with his father, but did not want to go. The prison manager suggested it might be a positive thing to do, and Mr Bell agreed. Officer A said he would arrange for TTG to visit Mr Bell. Staff assessed Mr Bell’s risk as raised. There is no record of the level of observations agreed, but the on-going record shows he was checked four times an hour.

57. Later that afternoon, a Mental Health Locality Manager, who was the on-call manager that day, met with Mr Bell. He had read Mr Bell’s ACCT and SystmOne record before speaking to him. Mr Bell told him he was adjusting to the loss of his leg, did not feel ready to leave the inpatient unit, and was anxious about his release and lack of hospital appointments. He spoke about his earlier self-harm and said he was pleased to be alive. The Mental Health Locality Manager noted that Mr Bell could concentrate and follow their conversation. Mr Bell said he had support available in the inpatient unit, in particular from Officer A. Mr Bell said he had no further thoughts of self-harm. They agreed his ACCT observations would remain at four an hour. The Mental Health Locality Manager told him he would be reviewed again the next day by a member of the mental health team.

58. The Mental Health Locality Manager told the investigator that Mr Bell did not appear to be flat in mood. He said that Mr Bell was pleased to have had a visit from his father that morning and had reflected on his actions the previous day and the impact it would have on his family. He said that Mr Bell had arranged to live with his father on release and seemed to have a long-term plan. The Mental Health Locality Manager said that Mr Bell did not present as someone who had plans to end his life.

22-24 December

59. A nurse met with Mr Bell on 22 December at 11.35am. On her way to see him, another prisoner mentioned to her that Mr Bell had said he was hearing voices. Mr Bell told the nurse he had recently had a visit from his father and did not want to let his family down any more. He said he would remain focused on his release and stay drug free. Mr Bell said he felt “all over the place”, had no appetite and was hearing voices. He said the voices were calling him a “nonce” and a “wrong ‘un”. Mr Bell said he used his television to distract him and drown out the voices. He said he wanted to be alive and felt happy that he could return to his father’s house on his release.

60. At 2.20pm, Mr Bell attended another ACCT review. A nurse attended with a member of the safer custody team and another manager. Mr Bell said that he felt better and more positive after seeing his father, who had said he could stay with him on release. He said he was thankful for the support he had received from healthcare staff and was looking forward to seeing someone from TTG. Staff agreed that Mr Bell would remain in the inpatient unit until a Social Care Needs assessment had been completed, that he would be referred for physiotherapy and

to the remedial gym, and to the dentist as Mr Bell was having difficulty eating because of problems with his teeth. Staff arranged a soft food diet for him. Staff assessed Mr Bell's risk as low, but they did not record the agreed level of observations, either on the case review paperwork or on the front of the ACCT. The on-going record shows he was checked twice an hour during the day, and hourly during the night.

61. A mental health manager met with Mr Bell on 23 December. Mr Bell said he thought people were talking about him. They discussed this and looked at ways for Mr Bell to challenge these thoughts. He admitted he only heard voices when he was standing at his cell door and agreed it might be linked to his anxiety about his release. She noted Mr Bell had an ACCT review the next day, so would see a member of the mental health team then.

62. In the afternoon, Mr Bell's key worker saw him. He recorded that Mr Bell said that "his head has gone again" but that he did not know why because his medication had been sorted and he had good contact with his family. Mr Bell said he was feeling better after speaking to the mental health manager, but he was worried because he did not know what was causing these feelings. He hoped he would feel better in time for his release in February 2020.

63. On 24 December, at 8,40am, Mr Bell stood at his cell door shouting that people were talking about him. Staff assured him this was not the case, but he did not believe them. This continued for about an hour, until Mr Bell was given some emergency credit to make a telephone call.

64. Staff held Mr Bell's last ACCT review on 24 December. A SO attended along with a nurse and Mr Bell. Mr Bell spoke about his plan to live with his father when he was released. He said he had no thoughts of suicide or self-harm. Staff noted that he was still waiting for a Social Care Needs Assessment before he could be moved to a houseblock. Staff assessed Mr Bell's risk of suicide and self-harm as low and reduced his observations to hourly. They scheduled the next review for 30 December.

65. The GP that was on duty on 24 December met Mr Bell for the first time on the inpatient rounds. Mr Bell asked for pain relief. The GP noted that Mr Bell was already taking methadone and gabapentin, both of which have sedative effects, and he was not willing to increase the dosage of gabapentin. The GP prescribed carbamazepine (used for neuropathic pain) instead.

66. That evening, at 9.28pm, pressed his cell bell and a nurse responded. He told her he felt as if he were having a heart attack and palpitations. She arranged to go into his cell to assess him further. Mr Bell's palpitations had subsided by then and he said he got them when he felt stressed. The nurse said she would continue to check him throughout the night and he agreed to press his cell bell if he felt unwell again. Two nurses checked on Mr Bell six times during the night and there were no issues.

25 December

67. At 9.16am on 25 December, Mr Bell telephoned his father (this was the last call he made) then played cards with other prisoners. He collected his lunch and was locked in his cell from approximately 11.30am. An officer had arranged to cover a

colleague over the lunch period and they met for a handover just before 12.30pm. The officer looked through all the ACCTs and noticed Mr Bell was due to be checked. At 12.30pm, the officer went to Mr Bell's cell and looked through the observation panel and saw Mr Bell was hanging from a ligature, made from a bedsheet, tied to his bed. The officer had not been designated to hold a radio that day, so he shouted for code blue assistance from healthcare staff before he went into the cell. A nurse called a code blue over her radio and went to Mr Bell's cell.

68. The officer cut the ligature and placed Mr Bell on the cell floor. The nurse started chest compressions. Three more nurses arrived at Mr Bell's cell. One was coming back into the prison when he was told about the emergency. He went straight to Mr Bell's cell and saw nurses carrying out cardiopulmonary resuscitation (CPR) while another nurse administered breaths via an ambu-bag. Mr Bell was given one shock of the defibrillator at 12.35pm.

69. One of the nurses took over chest compressions from another nurse until the paramedics arrived at the cell at 12.39pm. The paramedics took over CPR and after approximately two minutes they detected a carotid pulse and spontaneous circulation. The paramedics said they needed to have a "hands off" period before they could move Mr Bell. After ten minutes they put Mr Bell onto a stretcher and took him to hospital, leaving the prison at 1.07pm. At this point, paramedics reported Mr Bell's heart was beating and he was breathing by himself.

70. Mr Bell was taken to North Tees General Hospital, where he was placed in an induced coma. His father and brothers visited him on 27 December, when he also had a brain scan which detected no activity and it was agreed that his life support would be withdrawn. Mr Bell was pronounced dead at 2.33am on 28 December.

Contact with Mr Bell's family

71. Two family liaison officers visited Mr Bell's father at home at 3.30pm, on 25 December and arranged to meet him and Mr Bell's brothers at the hospital. Prison staff remained at the hospital throughout until Mr Bell died on 28 December. The prison contributed to Mr Bell's funeral, in line with national guidelines.

Support for prisoners and staff

72. A prison manager held a debrief on 25 December. Some staff told the investigator they had not felt supported after this incident and this was not the first time that they had felt this way.

73. The prison posted notices informing other prisoners of Mr Bell'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 Bell's death.

Post-mortem report

74. The post-mortem and toxicology reports were not available at the time of issuing this report.

Findings

Management of Mr Bell's risk of suicide and self-harm

75. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm.

76. Mr Bell was being monitored under ACCT when he was found hanging on 25 December. He was being checked once an hour. His level of observations had been four an hour on 21 December, after he was found hanging but conscious, but these were reduced to two an hour on 22 December, and then to one an hour on 24 December.

77. We consider that overall, the ACCT procedures were managed well. Healthcare staff were frequently part of the ACCT case reviews and staff identified appropriate caremap actions to help support Mr Bell.

78. We note that staff reduced the level of observations on Mr Bell on 22 December, and again on 24 December. While with hindsight this appears to have been ill-advised, we consider that staff's assessment of Mr Bell's risk, and the lowering of observations, was not unreasonable based on the evidence they had at the time. Mr Bell received a visit from his father on 22 December and had agreed to live with him on release, which appeared to make him much more positive about his future. Mental health staff noted that he engaged well, was remorseful about his suicide attempt on 21 December, and was making long-term plans. As Christmas is known to be a difficult time for many prisoners and Mr Bell had been found hanging only four days earlier, it may have been wiser to have maintained him on twice hourly observations until after Christmas Day. Nevertheless, we consider that there were reasonable grounds to assess that Mr Bell's risk had reduced and that the lowering of observations was not unreasonable.

79. However, we are concerned that Mr Bell was not always checked at the agreed frequency. From 8.00pm on 19 December to 6.00am on 20 December, Mr Bell was checked once an hour, rather than twice an hour as agreed at his ACCT review on 19 December. The frequency of observations required was never recorded on the front of the ACCT document, as it should have been. Mr Bell's on-going record also shows that there were times when he was checked at regular and, therefore, predictable intervals. We make the following recommendation:

    The Governor should ensure that staff:

    - **record the agreed frequency of ACCT observations on the front of the ACCT document and in the case review notes;**
    - **carry out observations at the correct frequency; and**
    - **vary times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked.**

Clinical care

Mental health

80. The mental health team saw Mr Bell on several occasions prior to his amputation. He was anxious about the life changing nature of his planned surgery and frustrated about waiting for his operation. He was discharged on 24 June 2019, after saying he no longer needed mental health support. After his surgery on 30 October, he refused a mental health referral.

81. Mr Bell had more frequent interaction with the mental health team following his self-harm on 25 November. After this, healthcare staff including mental health staff were involved in his ACCT reviews, and he was assessed by The Mental Health Locality Manager and a nurse in some depth.

82. The clinical reviewer concluded that Mr Bell received a good and prompt response from the mental health team when he was in crisis. Mr Bell's wider needs were identified and mental health practitioners acted appropriately to address or mitigate these.

Physical health

83. The clinical reviewer concluded that overall, Mr Bell's health care needs were well managed. She found, however, that there were some aspects of his care that were not equivalent to that which he could have expected to receive in the community.

84. Mr Bell had longstanding pain and mobility difficulties due to his deformed right knee. After his amputation, Mr Bell continued to complain of severe pain. On 25 November and 17 December, he self-harmed by cutting his arm and said that his pain was not being managed properly.

85. The clinical reviewer noted that Mr Bell was on a methadone programme, which influenced what pain relief medication he could be prescribed. (The management of pain for someone with opiate dependence is complex and requires a balance between ensuring the safe use of opiates and ensuring pain is controlled as well as possible. There is evidence to indicate that the sensitivity to pain experienced by someone with opiate dependence is greater than someone who is not dependent. In addition, many of the medicines usually prescribed for both chronic and acute pain will either contain opiates and/or be less effective in the presence of an opioid substitute such as methadone.) The clinical reviewer concluded that there was effective and informed prescribing of pain relief medication to Mr Bell. However, she considered that it would have been helpful for healthcare staff to have considered referring Mr Bell for specialist pain management advice.

86. Mr Bell should have had physiotherapy six weeks after his amputation. This was to help him mobilise with his stump and prepare him for a prosthetic limb. The prison did not follow this up and Mr Bell had no physiotherapy before he died. There is also no evidence of occupational therapy input to prepare Mr Bell for independent living after his release.

87. We make the following recommendations:

The Head of Healthcare should ensure that prisoners with complex pain management needs have access to a local specialist pain service.

The Head of Healthcare should ensure that prisoners have access to appropriate therapy services, such as physiotherapy and occupational therapy, following major surgery.

The family's concerns about possible bullying

88. Mr Bell's father asked us to look into whether Mr Bell was being bullied and to listen to Mr Bell's telephone calls. Unfortunately, the prison could only provide the investigator with the recording of Mr Bell's final telephone call that he made on the morning of 25 December. They said that they had deleted all the other recordings.

89. The investigator listened to Mr Bell's final telephone call. Mr Bell appeared anxious and said, 'I can't take much more of this', and, 'If anything happens to me, it's them that done it', but it is unclear who he was talking about. Later, when his father asked him if had told someone at the prison, Mr Bell said, 'There's nothing she can do…All the screws are saying it.' It is unclear what he meant.

90. There is nothing in the prison records to indicate that Mr Bell was in debt or being bullied. The Mental Health Locality Manager told the investigator that when he saw Mr Bell on 21 December, he asked him whether he had any debts or any other issues that would make him reluctant to move to a houseblock, but he said he had no issues.

91. We have found no evidence that Mr Bell was being bullied at Holme House. We note that Mr Bell had said he was feeling paranoid and had told staff he could hearing voices talking about him. It is possible that this explains his telephone call on 25 December.

Staff support

92. PSI 02/2018, Post Incident Care, says that effective post-incident care should be made available to staff who are exposed to potentially traumatising incidents during the course of their duties. It is disappointing that some staff did not feel they were supported after Mr Bell's death. We make the following recommendation:

The Governor should ensure that local systems and arrangements are in place for effective post-incident care for staff who are exposed to distressing or traumatic events during their duties.

Inquest

93. At the inquest, held from 7 to 10 October 2024, the jury concluded that Mr Bell died by suicide contributed to by Mr Bell's recent above the knee amputation and associated mental health. They also found that failure to implement safeguarding measures such as constant watch and/or safer cells and anti-ligature bedding/clothing were contributing factors.

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