Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Armstrong, a prisoner at HMP Holme House, on 23 April 2024

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, 2026

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

Mr George Armstrong was found hanging in his cell at HMP Holme House on 23 April 2024. Staff and paramedics tried to resuscitate him but were unsuccessful. He was 56 years old. I offer my condolences to Mr Armstrong's family and friends.

Mr Armstrong's was the third self-inflicted death at Holme House in three years.

Mr Armstrong was supported using suicide and self-harm prevention procedures (known as ACCT) for three weeks up to 11 April, after he told staff he had taken an overdose of painkillers. I am satisfied that the decision to stop ACCT monitoring on 11 April was reasonable based on the information available at the time.

The clinical reviewer found that the care Mr Armstrong received for his mental health was not equivalent to that which he could have expected to receive in the community. Despite having been referred to the secondary mental health team when the ACCT was opened, and again a few days later, Mr Armstrong was never fully assessed. This was a missed opportunity.

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 **January 2025**

Contents

Summary 1

The Investigation Process.....3

Background Information.....4

Key Events.....6

Findings 11

Summary

Events

1. On 19 January 2022, Mr George Armstrong was recalled to prison. On 1 February, he was moved to HMP Holme House.

2. In December 2023, Mr Armstrong submitted a self-referral form to the mental health team which said that he was having racing thoughts, feelings of panic and could not sleep. A nurse diagnosed Mr Armstrong with anxiety and depression and put him on the waiting list for cognitive behavioural therapy (CBT). A GP subsequently prescribed Mr Armstrong an antidepressant.

3. On 13 March 2024, a nurse saw Mr Armstrong for his first CBT session and recorded that he had severe anxiety and depression.

4. On 19 and 20 March, an officer gave Mr Armstrong two negative entries for his behaviour. The officer recorded that Mr Armstrong displayed petulant and dictatory behaviour and refused to go to his cell when told to do so.

5. On 21 March, Mr Armstrong's partner called the prison and said that she was worried about Mr Armstrong because he had not called her. An officer from the safer custody team went to Mr Armstrong's cell to carry out a welfare check. Mr Armstrong told her that he had taken an overdose of painkillers. The officer called a nurse, but Mr Armstrong refused treatment as he said he had vomited all the tablets. The officer started suicide and self-harm monitoring (known as ACCT).

6. At an ACCT review that afternoon, Mr Armstrong said he had no further thoughts of self-harm or suicide and that he had taken the tablets because he was being bullied by the officer who had given him the negative entries. A nurse attended the ACCT review and recorded that Mr Armstrong had no thoughts of suicide or self-harm and there was no evidence of anxiety or psychosis. The nurse decided that there was no further action for the mental health team. No one from the mental health team attended subsequent case reviews.

7. On 11 April, staff stopped ACCT monitoring as Mr Armstrong had not self-harmed again and they considered he no longer needed the support of the ACCT process.

8. On 23 April, a custodial manager and senior officer held a meeting with Mr Armstrong to discuss complaints he had submitted about being bullied by an officer. They offered Mr Armstrong mediation or a move to another wing. Mr Armstrong declined both options and said that he would rather keep away from the officer and that he would like to speak to his offender manager.

9. At 11.40am, Mr Armstrong's offender manager went to see Mr Armstrong but because it was lunchtime, he said that he would return after lunch. At around 1.25pm, Mr Armstrong's offender manager returned to continue their meeting. When he looked through the cell observation panel, he could see Mr Armstrong hanging. He immediately radioed a medical emergency code.

10. Officers immediately started CPR and continued CPR with healthcare staff until paramedics arrived and took over. At 1.46pm, paramedics declared that Mr Armstrong had died.

Findings

11. We found that the ACCT process was, overall, well managed, and we consider that the decision to stop ACCT monitoring on 11 April, was reasonable given the information available. However, we consider that a member of the mental health team should have attended all the ACCT reviews.

12. We are satisfied that staff handled Mr Armstrong's complaints appropriately. We found no evidence of bullying.

13. The clinical reviewer found that the care Mr Armstrong received for his mental health was not equivalent to that which he could have expected to receive in the community. He found that the mental health nurse that attended the ACCT review completed only the first of three stages for referrals to the team via the ACCT process and that, had she completed the other two stages, Mr Armstrong may have met the criteria for the secondary mental health team. He also found that a referral to the secondary mental health team on 25 March was not actioned.

Recommendations

- The Head of Healthcare, in conjunction with the mental health lead, should ensure that mental health staff attending ACCT reviews are aware of their clinical responsibilities in these reviews and complete all three stages of the process: an initial assessment, a risk assessment and formulation.

- The Head of Healthcare, in conjunction with the mental health lead, should review the referral process to the secondary mental health service and implement a more robust process that ensures prisoners referred to the service are assessed.

The Investigation Process

14. HMPPS notified us of Mr Armstrong's death on 24 April 2024.

15. 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. One prisoner responded and asked to speak to the investigator.

16. The investigator visited Holme House on 30 April. She obtained copies of relevant extracts from Mr Armstrong's prison and medical records. She spoke to the prisoner who had contacted her. He told her that he thought Mr Armstrong was being bullied by an officer and that is why he took his own life.

17. NHS England commissioned an independent clinical reviewer to review Mr Armstrong's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with 12 members of staff.

18. We informed HM Coroner for Teesside and Hartlepool of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The Ombudsman's office contacted Mr Armstrong's partner to explain the investigation and to ask if she had any matters she wanted us to consider. She said she was concerned that Mr Armstrong was being bullied by an officer. This issue has been addressed in the report.

20. We shared our initial report with HMPPS. They found no factual inaccuracies.

21. We sent a copy of our initial report to Mr Armstrong's next of kin. They did not notify us of any factual inaccuracies.

Background Information

HMP Holme House

22. HMP Holme House is a category C training prison. Spectrum Community Health CIC provides primary care health services at the prison. Tees, Esk and Wear Valleys NHS Foundation Trust provides mental health services and Rethink Mental Illness (a mental health charity) provides psychological well-being services.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Holme House was in March 2023. Inspectors reported that incidents of self-harm had increased since the last inspection and were above average for the type of prison. Care for prisoners at risk of self-harm who were managed through ACCT was generally good, with appropriate care plans and multidisciplinary cooperation. Most prisoners who were or had recently been on an ACCT said that they felt well supported within the process.

24. Inspectors also reported that a seven-day mental health care service was delivered, offering a stepped-care approach, including assessment, low intensity psychological interventions and trauma-informed care. The service had a clear referral pathway, referrals were clinically triaged daily and seen within the required timescales. The team consisted of nurses, including a learning disability nurse, psychiatry, psychology, speech and language therapy staff, and talking therapy for anxiety and depression practitioners. The team was well led, and staff felt supported in their roles.

Independent Monitoring Board

25. 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 December 2023, the IMB reported that the incidence of self-harm by prisoners in 2023 was similar to that in 2022 – an average of 50 each month. The most common means of self-harm were cutting, ligature and overdose. The Board had observed ACCT reviews and was pleased to see clear action and support plans being put in place to help prisoners at risk.

26. The IMB also reported that the primary care team had no staffing vacancies and there were 297 patients on the caseload. Mental health representatives attend initial ACCT reviews and attend follow-up reviews when necessary.

Previous deaths at HMP Holme House

27. Mr Armstrong was the 22nd prisoner at Holme House to die since April 2021. Of the previous deaths 19 were from natural causes and two were self-inflicted. There are no similarities between the findings from our investigation into Mr Armstrong's death and the findings from our investigations into the previous deaths.

Assessment, Care in Custody and Teamwork (ACCT)

28. 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.

29. 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 carried out at irregular intervals 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 care plan (plan of care, support and intervention) is put in place. The ACCT should not be closed until all the actions on the care plan have been completed.

30. 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 (PSI) 64/2011.

Key Events

31. On 19 January 2022, Mr George Armstrong was recalled to prison for being found in possession of a large quantity of drugs. He was sent to HMP Durham. On 1 February, he was moved to HMP Holme House.

32. Mr Armstrong had a history of low mood and anxiety. During 2022, Mr Armstrong was seen by the GP for various minor ailments, including back and knee pain for which he was prescribed painkillers.

33. In 2023, Mr Armstrong had regular key work sessions, His allocated key worker recorded that Mr Armstrong engaged well in key work sessions, was polite and had a job working with the prison animals.

34. On 22 November, a drone was seen flying in the prison gardens where Mr Armstrong worked. Prison security staff reviewed CCTV footage of the drone and saw that Mr Armstrong was standing nearby. Security staff investigated and concluded that Mr Armstrong had no reason to have been outside at that time and that he was no longer suitable to work outside. He was sacked from his job.

35. On 12 December, Mr Armstrong told his key worker that he had not done anything wrong and that it was unfair that he had been sacked. Mr Armstrong submitted a complaint which was not upheld.

36. On 18 December, Mr Armstrong submitted a self-referral form to the mental health team. He said that he was having racing thoughts, feelings of panic and was not sleeping.

37. On 20 December, a nurse assessed Mr Armstrong following his self-referral. She recorded that Mr Armstrong was suffering with severe anxiety and moderate depression. She put him on the waiting list for Cognitive Behavioural Therapy (CBT).

2024

38. On 18 January 2024, a GP at Holme House saw Mr Armstrong to discuss his mental health and medication. Mr Armstrong told the GP that he was feeling anxious. He said that he was reluctant to take medication but did agree to try fluoxetine, an antidepressant.

39. On 30 January, the primary mental health service sent a letter to Mr Armstrong to tell him that he was on the waiting list for CBT and that there was around a six week wait.

40. On 6 March, Nurse A saw Mr Armstrong for an assessment of needs before he started his CBT. Mr Armstrong told her that he had been experiencing anxiety for around a year following a relationship breakdown and the murder of his nephew. She diagnosed anxiety and recorded that Mr Armstrong would benefit from developing coping skills before having counselling. After a discussion at the primary health team meeting, staff agreed that Mr Armstrong would be placed on Nurse A's caseload for CBT.

41. On 13 March, Nurse A saw Mr Armstrong for his first CBT session. She assessed that Mr Armstrong had severe anxiety and moderate depression. She recorded that she would discuss with her team whether Mr Armstrong was suitable for a counselling referral.

42. On 19 March, Officer A gave Mr Armstrong a negative entry for poor behaviour. He recorded that Mr Armstrong was challenging staff and displaying petulant and dictatory behaviour. The next day, the officer gave Mr Armstrong another negative entry for refusing to go into his cell when he was told to do so and for ripping up his prisoner compact (an agreement that all prisoners have to sign and agree that they will follow the rules on the wing) and throwing it on the floor. This incident was witnessed by another officer.

43. That afternoon, a supervising officer (SO) spoke to Mr Armstrong about his recent poor behaviour and the negative entries that he had received. Mr Armstrong did not want to engage in conversation with the SO and said that he only wanted to speak to a custodial manager (CM).

44. On 21 March, Mr Armstrong's partner called the prison and said that she was worried about Mr Armstrong because she had not heard from him the previous day, and he usually called her every evening.

45. An officer from the safer custody team went to Mr Armstrong's cell to carry out a welfare check. Mr Armstrong told her that he had taken an overdose of paracetamol and ibuprofen. He said that he did not know how many he had taken and that it did not matter because he had vomited them all up. A nurse attended and tried to take Mr Armstrong's clinical observations, but he refused to engage. Healthcare staff removed Mr Armstrong's remaining medication from his cell.

46. The officer started suicide and self-harm monitoring (known as ACCT). A SO completed the immediate action plan and set observations at two an hour.

47. Nurse A went to see Mr Armstrong to review his coping techniques. She recorded that he was in a low mood and said that he had had enough and could not see a way out. She assessed that CBT was not enough for Mr Armstrong and told him that she would refer him to the secondary mental health team for counselling, and that he would be seen by the secondary mental health team at his ACCT review.

48. Later that day, a SO held a multidisciplinary ACCT review. A nurse from the mental health team attended. The SO recorded that Mr Armstrong engaged well in the review. Mr Armstrong told staff that he had no current thoughts of self-harm or suicide and had acted on impulse the previous night because he thought that Officer A 'had it in for him'. The case review panel decided that Mr Armstrong should remain on ACCT monitoring with reduced observations of one an hour. They scheduled the next review for 24 March.

49. Following the case review, a nurse recorded in Mr Armstrong's medical record that he showed no signs of anxiety or psychosis, had no thoughts of suicide or self-harm and that no further interventions were needed. She removed Mr Armstrong from the mental health team's caseload. On 24 March, a SO held an ACCT case review. An officer from the safer custody team and another SO attended. During the review, Mr Armstrong said that he was still having issues with Officer A and that was why he

felt anxious and down. Mr Armstrong also said that he sometimes had thoughts of self-harm. The case review team decided that Mr Armstrong should remain on ACCT monitoring and observations should remain at one an hour.

50. On 25 March, a nurse saw Mr Armstrong for a medication review. Mr Armstrong told her that he had previously been prescribed fluoxetine but had not taken it because he was wary of the side effects. After a long conversation, Mr Armstrong agreed that he would try taking fluoxetine. He also said he was being bullied by an officer. She recorded that Mr Armstrong was extremely anxious and that he had agreed to start taking his medication.

51. The nurse referred Mr Armstrong to the secondary mental health team. Administrative staff did not process the referral and Mr Armstrong was not seen by the secondary mental health team.

52. Over the next two weeks, Mr Armstrong had several case reviews. On 11 April, a CM held a case review. Mr Armstrong's prison offender manager (POM) and an officer from the safer custody team attended. The CM noted that Mr Armstrong had not self-harmed since being supported by the ACCT process and had a job working on the wing. The case review team agreed that Mr Armstrong no longer needed to be supported by the ACCT process and closed the ACCT.

53. The CM recorded that Mr Armstrong said that he was still having issues with Officer A. The CM decided that Mr Armstrong should be supported with a Challenge Support and Intervention Plan (CSIP – a case management approach to managing prisoners who pose a risk of violence which can also be used to support victims of violence and bullying).

54. On 18 April, a SO completed a seven-day post closure review. The SO recorded that Mr Armstrong said he was feeling slightly better and that no further support was needed.

55. On 20 April, the SO and an officer held a CSIP case review. Mr Armstrong told the SO that he thought Officer A had a vendetta against him and that he had cancelled a visit with his partner because he did not want her to see him like this. The SO asked Mr Armstrong if he would consider mediation with Officer A or if he would like to be moved to another wing. Mr Armstrong said that he would think about it over the weekend. The attending officer said that he would speak to Mr Armstrong again on Monday. The SO recorded that Mr Armstrong was irate and frustrated throughout the case review. Mr Armstrong subsequently submitted a complaint to the PPO. In the complaint Mr Armstrong said that he was being bullied by an officer and that he wanted the officer to be disciplined for the negative entries that he had been given, and the negative entries to be rescinded. The complaint was not received until after Mr Armstrong's death.

Events of 23 April

56. On 23 April, at around 11.00am, a CM and a SO held a meeting with Mr Armstrong to discuss several complaints that he had submitted in March and April, about being bullied by Officer A. (This was not the first time that wing managers had responded to Mr Armstrong's complaints, as Mr Armstrong had also received written replies.) The CM asked Mr Armstrong why he felt that he was being bullied. Mr Armstrong

said that he had recently had negative entries about his behaviour (Officer A had not made any negative entries since 31 March). The CM asked Mr Armstrong if he would consider mediation with Officer A and if he would like to move to another wing. Mr Armstrong said that he had thought about it and did not want mediation and did not want to move off the wing. He said that he would rather just keep away from Officer A. Mr Armstrong said that he would like to speak to his POM.

57. At around 11.40am, the POM went to see Mr Armstrong. Mr Armstrong said that Officer A was bullying him. It was lunchtime on the wing, so he told Mr Armstrong that he would return after lunch. He walked Mr Armstrong back to his cell. In interview, he said that Mr Armstrong was making general conversation as they walked back to his cell and that he had no concerns about his wellbeing.

58. At around 1.25pm, the POM went to Mr Armstrong's cell to continue their meeting. When he looked through the cell observation panel, he saw Mr Armstrong hanging from a bed sheet attached to the medication locker. He radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately).

59. An officer responded quickly to the code blue. The POM supported Mr Armstrong's body while the officer cut the ligature from Mr Armstrong's neck. The officer checked for signs of life and found Mr Armstrong had no pulse and was not breathing. Another officer also responded and started CPR. The first officer took over CPR when the second officer became tired. Prison staff and healthcare staff continued resuscitation efforts until paramedics arrived and took over.

60. At 1.46pm, paramedics declared that Mr Armstrong had died.

Contact with Mr Armstrong's family

61. At around 2.00pm, a prison manager appointed two officers as family liaison officers (FLOs). Both FLOs went to Mr Armstrong's partner's address to break the news of his death.

62. When they arrived there was no one at home, but then a man arrived, who said he was Mr Armstrong's partner's son. He said that his mother was at work, and he was not prepared to give them any more information. When the FLOs said they were from the prison and had important information, he invited them in, and they told him about Mr Armstrong's death.

63. After they left, the FLOs called Mr Armstrong's partner to break the news, and she said that her son had already called and told her.

64. The Prison Service contributed to Mr Armstrong's funeral expenses in line with national instructions.

Support for prisoners and staff

65. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in

custody. Postvention procedures should be initiated immediately after every self-inflicted death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer support) to identify prisoners most affected by the death.

66. After Mr Armstrong's death, a prison manager 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 also offered support.

67. The prison posted notices informing other prisoners of Mr Armstrong's death and offered support. A prison manager went to every prisoner's cell on the wing and told each prisoner in person of Mr Armstrong's death. The prison also deployed Listeners to the wing to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Armstrong's death.

Post-mortem report

68. The post-mortem report concluded that Mr Armstrong died from hanging.

Findings

Assessment and management of risk

69. 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 processes (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm.

70. Staff started ACCT monitoring for Mr Armstrong on 21 March after he told them he had taken an overdose of his medication. Staff continued monitoring until 11 April. We found that the ACCT process was generally managed well. Staff held frequent case reviews, the care plan was of a reasonable standard and officers recorded good daily interactions with Mr Armstrong. We consider that the decision to stop ACCT monitoring on 11 April was reasonable based on the information available. However, the mental health team attended only the first case review and decided they did not need to attend any further reviews. Other members of the mental health team saw Mr Armstrong before and after that ACCT review and recorded that he had high levels of anxiety and moderate levels of depression. We consider that a member of the mental health team should have attended Mr Armstrong's case reviews.

71. When the ACCT was closed, a CM decided to use CSIP to support Mr Armstrong. We found that the CSIP document lacked detail, did not contain an action plan, and did not seem to serve any purpose in supporting Mr Armstrong. While we are satisfied that staff did all they could to support Mr Armstrong and the poor quality CSIP document was of no detriment to him, we bring this issue to the Governor's attention.

Allegations of staff bullying

72. In March 2024, Mr Armstrong took an overdose of painkillers and said that he did this because he was being bullied by Officer A. Mr Armstrong repeatedly told prison and healthcare staff that he was being bullied by Officer A. Mr Armstrong said that he did not feel that the three negative entries that he received were justified. When Mr Armstrong complained to the prison and to the PPO, the only issue that he raised related to the three negative entries that he had received.

73. The investigator interviewed Officer A. He said that he had no issues with Mr Armstrong, but on several occasions Mr Armstrong's behaviour had been unacceptable, so he had given him a negative entry on each occasion. He told the investigator that Mr Armstrong had been rude and abusive, had ripped up prison paperwork and had refused to go to his cell when he was told to do so. We found that these incidents had all been clearly documented and we consider that the negative entries were justified. We found no evidence of bullying.

74. The investigator found that Mr Armstrong's key worker, offender manager and wing managers regularly saw Mr Armstrong to discuss his concerns and address the complaints that he made. We also found that after Mr Armstrong died, a prison manager commissioned an internal investigation into Mr Armstrong's allegations of being bullied. The investigation concluded that the negative entries that Officer A

had issued were justifiable. We conclude that prison managers investigated and responded appropriately to Mr Armstrong's allegations of being bullied including offering reasonable solutions that Mr Armstrong declined to pursue.

Clinical care

75. The clinical reviewer concluded that the secondary mental health care that Mr Armstrong received was not equivalent to that which he could have received in the community. He found that the mental health nurse that attended the ACCT review on 21 March completed only the first of three stages for referrals to the team via the ACCT process. The second and third stages, risk assessment and formulation, were not completed. Had they been completed, Mr Armstrong may have met the criteria for the secondary mental health team. This was a missed opportunity. (The nurse was on sick leave for the duration of our investigation, so we were unable to ask why they did not complete the referral.)

76. The clinical reviewer also found that the referral to the secondary mental health team made on 25 March was not processed so Mr Armstrong was not assessed. Had he been assessed, and a formulation completed, then a treatment plan could have been put in place to support him. The clinical reviewer considered that the secondary mental health team referral process was not sufficiently robust. We recommend:

    The Head of Healthcare, in conjunction with the mental health lead, should ensure that mental health staff attending ACCT reviews are aware of their clinical responsibilities in these reviews and complete all three stages of the process: an initial assessment, a risk assessment and formulation.

    The Head of Healthcare, in conjunction with the mental health lead, should review the referral process to the secondary mental health service and implement a more robust process that ensures prisoners referred to the service are assessed.

77. The clinical reviewer found the primary physical and mental health care that Mr Armstrong received was equivalent to that which he could have expected to receive in the community. The clinical reviewer made three other recommendations which the Head of Healthcare will wish to address.

Inquest

78. At the inquest, held from 19 to 27 October 2026, the jury reached a narrative conclusion:

    "George's death was self-inflicted, his deteriorating mental health and feelings of being bullied leave the question of his specific intent unresolved.

    Possible contribution the failure to complete a full assessment including risk by secondary mental health team nurse at the ACCT review on 21.03.24 possibly but not probably contributed to George dying when he did.

Withdrawing secondary mental health support or ACCT review on 21.03.24 and not completing the ACCT process possibly but not probably contributed to George dying when he did.

There was a failure to reassess George on 25.03.24 by the secondary mental health team, this possibly, but not probably contributed to George dying when he did.

The secondary mental health team failed to remain involved/engaged with George after the ACCT was closed on 11.04.24. This possibly, but not probably contributed to George dying when he did.

The inadequate communication between secondary mental health team to share concerns with prison discipline staff resulted in missed opportunities to recognise the decline in George's mental health and subsequent increase in his risk, this possibly, but not probably contributed to George dying when he did."

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