

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Bull, while a prisoner at HMP Stafford, on 29 May 2023

A report by the Prisons and Probation Ombudsman

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

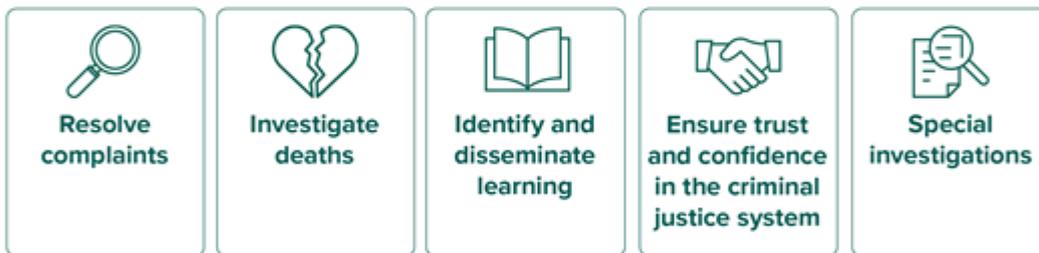
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 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



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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 Bull died in hospital on 29 May 2023, of a large subdural bleed, while a prisoner at HMP Stafford. He was 73 years old. I offer my condolences to Mr Bull's friends.

On 27 May, Mr Bull was found semi-conscious on the floor of a toilet at HMP Stafford. It became apparent that he had attempted suicide by hanging, but the ligature had broken, which caused him to fall to the ground and hit his head.

Mr Bull had been at Stafford for almost seven years and during this time he was subject to suicide and self-harm monitoring (ACCT) on two occasions. My investigation found that this was managed well, and Mr Bull was well supported both by prison and clinical staff.

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

November 2023

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Summary

Events

1. On 26 February 2012, Mr George Bull was remanded to HMP Birmingham, charged with sexual offences. He was 61 years old. On 2 June 2012, Mr Bull was sentenced to 18 years imprisonment. On 8 June 2016, Mr Bull was transferred to HMP Stafford.
2. Mr Bull had several chronic health conditions which affected his mobility, and he used a wheelchair and a walking frame to get around. His mobility issues also resulted in him having a number of falls in his cell. Suitable adjustments were made to his cell and a social care package was put in place to support him. Mr Bull was assigned a cellmate who also functioned as his carer, to assist with day to day living. In 2019, Mr Bull was diagnosed with Alzheimer's type dementia. His keyworker, nursing staff, social care staff and dementia nurses saw Mr Bull regularly.
3. On 9 January 2023, a mental health nurse started suicide and self-harm prevention measures, known as ACCT, after Mr Bull said that he was going to kill himself. Mr Bull was frustrated by his deteriorating health and was in a lot of pain. He wanted to see a GP and attend hospital. The ACCT remained open until 16 January when staff considered he was more settled.
4. In the afternoon on 26 May, Mr Bull attended a Senior Support Group (SSG) and went to use the toilet. A prisoner waiting outside the toilet heard a bang, and knowing that Mr Bull was in there, alerted staff. Staff attended and found Mr Bull on the floor and semi-conscious. They placed Mr Bull into the recovery position and radioed a medical emergency code. It became apparent that Mr Bull had tried to attempt suicide at the time of his fall.
5. Nursing staff arrived and cared for Mr Bull until paramedics arrived at 3.40pm. Mr Bull was taken to hospital.
6. At hospital, it was confirmed that Mr Bull had a bleed on the brain, but there were no plans to operate.
7. Mr Bull's condition deteriorated over the weekend, and hospital staff provided palliative care to make him more comfortable. At 11.00am on 29 May, it was confirmed that Mr Bull had died.

Findings

8. Mr Bull had previously been identified as being at risk of suicide and self-harm. The ACCT procedures provided good support to Mr Bull. Case reviews were multi-disciplinary and involved all those who were caring for him, and care map actions reflected his concerns about his on-going pain, and his GP and hospital appointments. ACCT procedures ended when staff considered his risk had sufficiently decreased and they had no particular concerns about him in the days and weeks before he died.

9. The clinical reviewer concluded that the clinical care Mr Bull received at Stafford was of a good standard and equivalent to what he could have expected to receive in the community.

The Investigation Process

10. On 29 May 2023, HMPPS notified us of Mr Bull's death.
11. The investigator issued notices to staff and prisoners at HMP Stafford informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded and was interviewed as part of the investigation.
12. The investigator obtained copies of relevant extracts from Mr Bull's prison and medical records.
13. The investigator interviewed one member of staff, and one prisoner at Stafford on 20 July.
14. NHS England commissioned two clinical reviewers to review Mr Bull's clinical care at the prison. The investigator completed two interviews with healthcare staff with the clinical reviewers using Microsoft Teams on 28 July.
15. We informed HM Coroner for Staffordshire South of the investigation. The Coroner informed us that no post-mortem was completed and gave us the cause of death. We have sent the Coroner a copy of this report.
16. Mr Bull had no identified next of kin.
17. An inquest was concluded on 25 November 2025. A jury found that Mr Bull died as a result of a large subdural bleed which was the result of a suspected ligature injury with unknown intent.

Background Information

HMP Stafford

18. HMP Stafford is a medium security training prison for adult male prisoners convicted of sexual offences. It holds about 750 prisoners, over half of whom are aged over 50. Practice Plus Group (PPG) provide healthcare services. Mental healthcare and psychosocial substance misuse services are sub-contracted to Inclusion.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Stafford was in 2020. Inspectors reported a safe, calm and well-ordered prison. Levels of self-harm were lower than most similar prisons. The weekly safety intervention meeting (SIM) provided a good forum to monitor individual prisoners. The quality of suicide and self-harm monitoring delivered through the ACCT process was mostly good. The mental health team was well integrated into the prison, attended the SIM and contributed consistently to ACCT reviews. Over 90% of staff had received mental health awareness training.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to April 2022, the IMB reported that their main concern was inefficient medicines management. Despite this, most comments the IMB received about mental and physical healthcare were positive.

Previous deaths at HMP Stafford

21. Mr Bull's death was the third self-inflicted death at HMP Stafford since 2012. There are no similarities between our findings in the investigation into Mr Bull's death and our investigation findings for the previous deaths.

Assessment, Care in Custody and Teamwork

22. 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. 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.
23. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. 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 worker scheme

24. The key worker scheme 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.
25. 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.

Parole Board

26. The Parole Board for England and Wales is an independent public body. Its role is to make risk assessments about prisoners to decide whether they can safely be released into the community once they have served the minimum term imposed by the courts.

Key Events

27. On 28 February 2012, Mr George Bull was remanded to HMP Birmingham, charged with sexual offences. He was 61 years old. On 2 June, Mr Bull was sentenced to 18 years imprisonment. He remained at Birmingham until 8 June 2016, when he was transferred to HMP Stafford.
28. Mr Bull had long-term health conditions including type 2 diabetes, chronic obstructive pulmonary disorder (COPD), asthma and hypertension. He also had mobility issues and used a wheelchair and walking frame to move around. In 2019, Mr Bull was diagnosed with Alzheimer's type dementia and in 2022, he had a stroke.
29. Mr Bull settled in well at Stafford and attended work despite his mobility issues. He experienced a series of falls and was supported by social care who provided him with aids to help with his mobilisation, and guards to prevent him falling from his bed. He was also allocated a carer who shared a cell with him. HMP Stafford has a group of prisoners who volunteer to function as carers for those prisoners with reduced mobility and other long term health conditions. Their role is to assist with day-to-day routines.
30. On 16 May 2022, Mr Bull's keyworker conducted a keywork session. He spoke to Mr Bull about his upcoming Parole Board review. He recorded that Mr Bull was happy with what they had discussed and understood the parole process. Mr Bull raised no other issues.
31. On 14 June, another officer took over the keyworker role. He recorded that he had spoken to Mr Bull about his parole review, but he felt that Mr Bull had shown some confusion. Mr Bull's carer talked to the keyworker and reminded him that his prison offender manager (POM) had recently seen him and explained the process to him.
32. The keyworker recorded that Mr Bull was in receipt of a social care package and had begun attending the Senior Support Group (SSG) again, following its suspension during the COVID-19 pandemic. (The SSG provides a space for elderly prisoners to get together and socialise and participate in arts and crafts and other activities.) Mr Bull confirmed that he had no family contact and that he was not interested in seeing an official prison visitor, as he was happy with the interaction he had with his peers.
33. Between 14 June and 29 December, the keyworker completed keyworker sessions with Mr Bull on twelve occasions. During these sessions, he discussed Mr Bull's parole and noted that he was anxious about his possible release. Mr Bull raised no other concerns and said that he was attending the SSG as often as he was able.

2023

34. On 9 January 2023, Mr Bull submitted an application to see someone from the mental health team and he was triaged that morning. During the appointment, he talked about his physical health conditions and said that he had had enough. He talked of his intention to attempt suicide by hanging, although he had no plans. Staff started suicide and self-harm prevention procedures known as ACCT. A senior

officer met with Mr Bull to complete an ACCT assessment later that morning. She recorded that Mr Bull presented as low, he felt suicidal, and said that he would hang himself if he were able. Mr Bull said that he had been unable to go to the toilet for weeks and was in an incredible amount of pain.

35. After the assessment, a Supervising Officer (SO) chaired an ACCT review. The Deputy Head of Healthcare, a nurse, a worker from the mental health team and a senior officer also attended. The Deputy Head advised Mr Bull to drink water regularly to assist with the movement of his bowels, but Mr Bull said that he was drinking water, but had not been taking his medication, despite being advised that this would benefit him. The review asked Mr Bull whether he had any plans to harm himself and he replied, 'I don't know'. Mr Bull said that he had regular thoughts about self-harming due to the pain he was in, and that he wanted a hospital and GP appointment.
36. The review considered whether Mr Bull needed to be moved to another cell for closer observation, but due to his mobility issues and the adjustments that had been made to his cell, they decided that he would be better to remain in his own cell with his carer, but on a high level of observations. The nurse also confirmed that a GP appointment had been arranged and that he was due a hospital appointment in the next two weeks. Mr Bull said that he felt better and relieved that he was going to be seen by the GP and the hospital. The review completed a care plan which included the scheduled GP and hospital appointments. Observations were set at three per hour and three conversations per day. The next ACCT review was set for 13 January.
37. On 10 January, the SO completed an ACCT review, three days earlier than planned because Mr Bull needed a higher level of care due to his physical and mental health issues and because of the comments he had made the previous day. Members of the mental health team and a nurse also attended. Mr Bull told the review that his only issue was that he had not slept well due to the night officer checking on him three times per hour. Nursing staff told him that he needed to start taking his medication prior to his hospital appointment, otherwise the examination might not be able to go ahead. Mr Bull agreed.
38. Mr Bull told the review that he would not harm himself, and staff reminded him that they had his best interests in mind and that they had a duty of care towards him, which he accepted. Mr Bull said that he was looking forward to his hospital and GP appointments and eventually being released from prison. The review considered his level of observations, and they agreed that due to his brighter outlook and the fact that he was sharing a cell with his carer, observations would be reduced to two per hour, day and night. A further review was set for 16 January.
39. Another SO chaired an ACCT review on 16 January. The keyworker and a member of the chaplaincy team attended. It was recorded that Mr Bull displayed a good sense of humour during the review. He said that he was due to go out to hospital, was attending the SSG regularly, and was being supported by his cellmate. Mr Bull denied any thoughts of self-harm and told the review that he had been angry when he had initially made the comments about harming himself, but that he was positive about the future, his forthcoming hospital appointment, and that he was approaching the last year before his release. Mr Bull said that he got on well with the wing staff and that he would speak with them or his carer if he had suicidal

thoughts in the future. The review agreed to stop ACCT monitoring and a post closure review was arranged for 23 January.

40. The first SO completed the post closure review on 23 January. He recorded that Mr Bull was positive about the future and felt things were moving forward with his hospital appointments. He also spoke about his release from prison and not returning to prison. The SO reminded Mr Bull that staff were available if he needed to talk about how he was feeling.
41. On 28 January, the keyworker completed a keywork session with Mr Bull. Mr Bull said that he was currently on a limited diet due to attending hospital on the Monday for an endoscopy and colonoscopy. He said that he had been waiting for the appointment for a while, but now it was close, he was worried about what the results might show. Mr Bull had the procedures at the hospital and the results showed nothing abnormal and no signs of cancer.
42. Between 11 February and 1 May, the keyworker had six keywork sessions with Mr Bull. During these sessions, Mr Bull talked about feeling better since his hospital appointment and said that he was eating normally again. Mr Bull's parole hearing had been set for 9 May, and he was feeling anxious about his release due to his age. The keyworker reassured Mr Bull that when he was released, a support package would be in place for him, and he would be cared for. Mr Bull said that he was being supported by his carer and seeing healthcare staff regularly and had recently been seen by the dementia nurse. The keyworker recorded that Mr Bull remained positive.
43. A Parole Board directions hearing took place on 9 May by video link. The hearing was adjourned for further assessments and was to reconvene on 14 November 2023.
44. On 22 May, the keyworker met with Mr Bull for a keywork session. The keyworker spoke to a senior officer before seeing Mr Bull and she updated him about the adjourned parole hearing. The keyworker recorded that Mr Bull had suffered another fall the previous day and had attended hospital due to a cut to his eye. He noted that the cut to Mr Bull's eye did not appear that bad and that he was in good spirits.
45. Mr Bull said that he had been attending the medication hatch daily with the aid of his walking frame but said that his feet were hurting, and that nursing staff saw him daily. Mr Bull spoke about attending the SSG and said that he enjoyed sitting outside talking to his peers. The keyworker recorded that Mr Bull continued to be supported by his carer, staff from the social care team and a dementia nurse. He said that he had no concerns about Mr Bull's well-being and there was no indication that he was feeling low or harbouring thoughts of suicide or self-harm.

Events of 26 to 29 May

46. On the afternoon of 26 May, Mr Bull went to the SSG. He was taken across by his cellmate, who stayed with him initially, but then had to leave. The cellmate said that he had no concerns about Mr Bull and that he had never been concerned about Mr Bull harming himself.

47. At around 3.20pm, Mr Bull went to use the toilet. A prisoner had been waiting outside and heard a bang. Knowing that Mr Bull was in the toilet, the prisoner alerted staff. An officer attended and found the door locked, so he unlocked it from the outside. When he entered, he found Mr Bull on the floor, semi-conscious. The officer, with the help of the prisoner, placed Mr Bull into the recovery position. He then radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties).
48. The prisoner handed a piece of torn sheet to the officer and indicated to him that Mr Bull had attempted to hang himself. Nursing staff arrived within a few minutes and took over Mr Bull's care. The officer said that at this point he noticed another piece of green sheet hanging down from the toilet window.
49. At approximately 3.40pm, paramedics arrived and took Mr Bull to hospital.
50. On arrival at hospital, hospital staff noted that Mr Bull was not in respiratory distress and there were no signs of suffocation. There were no obvious injuries, other than what was described as a superficial mark on his neck, but Mr Bull complained of a headache. Mr Bull was stable and was eating and drinking.
51. A CT scan later showed that Mr Bull had a large subdural bleed in his brain. Nursing staff informed prison staff that there were no plans to operate, but that they would admit Mr Bull to hospital as an inpatient and observe him over the weekend.
52. On 27 May, prison staff started ACCT monitoring and conducted an assessment with Mr Bull at the hospital. Mr Bull told staff that he could not recall why he had attempted suicide. Observations were considered adequate as Mr Bull had two escort officers with him. An ACCT review was scheduled for 2 June, as hospital staff had indicated that Mr Bull might be discharged then.
53. While in hospital, Mr Bull's levels of consciousness declined. A further CT scan showed that the subdural bleed had expanded. A hospital consultant told prison staff that Mr Bull's prognosis was poor. Mr Bull continued to receive palliative care to make him more comfortable.
54. At 11.00am on 29 May, it was confirmed that Mr Bull had died in hospital.

Contact with Mr Bull's family

55. Mr Bull had no family. Following his death, the prison paid for his funeral in line with national policy. A memorial service was also held at Stafford, attended by prisoners and staff.

Support for prisoners and staff

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

Cause of death

58. The Coroner accepted the cause of death provided by the hospital doctor and no post-mortem examination was carried out. The hospital doctor gave Mr Bull's cause of death as a large subdural bleed (a collection of blood between the skull and the brain).

Findings

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

59. Prison Service Instruction (PSI) 64/2011 on safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. Mr Bull had been at Stafford for almost seven years and was subject to ACCT monitoring on two occasions, from 9 to 16 January and again on 27 May 2023, after he had been admitted to hospital following his suicide attempt. Mr Bull had poor physical and mental health, was anxious about the parole process and being released from prison due to his age.
60. We consider that the ACCT procedures provided good support to Mr Bull. Staff held supportive multi-disciplinary case reviews which appropriately assessed his risk. Observations were set based on the perceived risk Mr Bull presented but took into consideration the support he would receive from his carer, with whom he shared a cell. Staff added actions to his caremap which reflected his concerns about his on-going pain and medical appointments. Mr Bull also talked about his anxiety around being released due to his age, but staff reassured him that a support package would be in place for him in the community. The ACCT was closed when staff were satisfied that Mr Bull was no longer thinking of suicide.
61. There were no indications that Mr Bull's risk of suicide had noticeably risen in the days or weeks leading to his death.

Clinical care

62. The clinical reviewer concluded that the care Mr Bull received at HMP Stafford was good and was equivalent to what he could have expected to receive in the community.
63. She noted that while Mr Bull had a number of physical health conditions and mental health concerns, his erratic compliance with care plans, medication and health advice made it particularly challenging for staff to help him maintain good physical and mental health. The clinical reviewer found no issues of concern with the care staff at Stafford provided.

Good practice

64. We consider the provision of the Senior Support Group at Stafford to be good practice. It offers an outlet to older prisoners who are often isolated due to age, to socialise and engage in a range of activities. It was clearly an important source of support for Mr Bull.
65. We consider the keyworker's interactions with Mr Bull was an example of good practice. It is clear that he delivered consistent and supportive keywork to Mr Bull and sought to address his immediate needs on each occasion.

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