Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Callum Stephenson a prisoner at HMP Northumberland on 8 January 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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 Callum Stephenson was found hanged in his cell at HMP Northumberland on 8 January 2016. He was 24 years old. I offer my condolences to Mr Stephenson's family and friends.

The investigation found that the prison did not respond effectively to bullying and threats made against Mr Stephenson, which left him feeling increasingly vulnerable. The day before he died, prison staff had considered whether Mr Stephenson should be monitored as at risk of suicide, after his relationship had broken down, but decided that this was not necessary. We cannot know whether monitoring would have prevented Mr Stephenson's death and this was a difficult judgement.

I do not criticise the decision, but a more holistic assessment of Mr Stephenson's risks and triggers during his time at HMP Northumberland, including the impact of bullying and threats, might have led to a different conclusion. However, I recognise it would have been difficult to predict that Mr Stephenson was at high and imminent risk of suicide.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2016**

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Summary

Events

1. On 3 June 2015, Mr Callum Stephenson was remanded to HMP Durham charged with assaulting his partner. He had tried to kill himself after the assault. Prison staff began suicide and self-harm prevention procedures, known as ACCT, but ended monitoring the next day. On 7 August, he was sentenced to three years and two months in prison.

2. On 14 August, he was moved to HMP Holme House. On 18 August, other prisoners allegedly assaulted him at knife point, searching for a mobile phone they believed he had concealed internally. Mr Stephenson was distressed and frightened, but the police and the prison took no action, as he would not name the people who had attacked him and said he did not want the matter pursued.

3. On 26 August, Mr Stephenson was moved to HMP Northumberland. In September, staff monitored him under ACCT procedures for two periods, the first time for two weeks, after he cut his ear lobe following an argument with his partner and because he said he needed mental health support. The second time, he was monitored for just one day, after an officer found a noose in his cell.

4. Between September and December, Mr Stephenson and his partner reported a number of incidents of being bullied and intimidated by other prisoners at Northumberland, including Mr Stephenson being assaulted and his partner threatened.

5. At a visit on 7 January 2016, Mr Stephenson and his partner ended their relationship. Mr Stephenson told an officer that he was worried that his partner was being pressured to bring drugs into the prison to clear his debts. Three members of staff spoke to Mr Stephenson, who said he was angry that his partner might smuggle drugs into the prison for another prisoner. Another prisoner told staff he was concerned Mr Stephenson intended to harm himself. The staff accepted Mr Stephenson's assurances that he had no thoughts of suicide or self-harm and did not begin ACCT monitoring. On the evening of 7 January, the other prisoner told the night patrol officer that he was worried about Mr Stephenson, who had received bad news that day. The officer checked Mr Stephenson by observing him through the door but did not speak to him.

6. Around 6.30am on 8 January, the night patrol officer found the observation panel in Mr Stephenson's cell door covered. He immediately called the night manager, who sent two officers to the cell. At 6.36am, the officers went into the cell and found him hanged by a ligature made from a sheet. The night patrol officer immediately radioed an emergency. It was evident that Mr Stephenson had been dead for some time. Paramedics arrived and recorded his death.

Findings

7. Mr Stephenson and his partner had reported bullying and intimidation from other prisoners a number of times and we are concerned that the prison did not do enough to investigate this or challenge the alleged perpetrators. There is little to indicate that staff recognised and considered the links between bullying and the

risk of suicide. We were not satisfied that when Mr Stephenson was monitored under ACCT procedures, the process operated effectively.

8. Staff appropriately considered whether to begin ACCT procedures on 7 January, as they recognised that Mr Stephenson might have been at increased risk of suicide and self-harm when his relationship ended, but were satisfied by his assurances that he did not intend to harm himself. We recognise that this was a judgement call, which in hindsight was incorrect. While we do not criticise the decision, it is not clear that the staff took into account all his risk factors and triggers. Mr Stephenson had previously cut himself and made a noose when he and his partner were having relationship difficulties. These problems were exacerbated by pressures and threats Mr Stephenson and his partner had received from other prisoners.

9. However, we cannot say that beginning ACCT monitoring on 7 January would have prevented his death, as monitoring is unlikely to have been set at a very high frequency. There was little to indicate that Mr Stephenson was at high and imminent risk of suicide and it would have been very difficult for staff to have anticipated and prevent his actions. Nevertheless, we consider that when a prisoner told the night patrol officer that he was concerned about Mr Stephenson, the officer should have spoken to Mr Stephenson to assess the situation, rather than just observing him through the cell door.

10. Managers should have debriefed staff involved in the emergency response immediately after the death before they went home after their shift.

Recommendations

- The Director should ensure that all information about bullying and intimidation is fully coordinated and investigated; that those suspected of involvement are appropriately challenged and monitored; that staff consider whether victims are at increased risk of suicide or self-harm; and that apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.

- The Director should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidance, including that:

    - Staff appropriately assess, identify, consider and record all relevant risk factors when determining a prisoner's risk of suicide or self-harm, and begin ACCT procedures when indicated.
    - ACCT case reviews are multidisciplinary where possible and include all relevant people involved in the prisoner's care, with healthcare staff attending all first case reviews.
    - ACCT case reviews fully consider and record the implications for managing the risks of prisoners suspected of being bullied and intimidated.
    - ACCT caremap actions are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary and that all actions are completed before an ACCT is closed.

- The Head of Healthcare should ensure that all important information about prisoners' health and appointments is entered in SystmOne and that nurses

adequately review newly arrived prisoners' SystmOne records to ensure appropriate continuity of care.

- The Director should ensure, in line with PSI 64/2011, that a manager debriefs all the staff involved in a death at the prison immediately after the emergency response, and offers appropriate support.

The Investigation Process

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

12. NHS England commissioned a clinical reviewer to review Mr Stephenson's clinical care at the prison.

13. The investigator visited HMP Northumberland and obtained copies of relevant extracts from Mr Stephenson's prison and medical records. She interviewed members of staff at the prison on 22 and 23 March 2016. The clinical reviewer joined her for some of the interviews.

14. We informed HM Coroner for Northumberland of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Stephenson's father to explain the investigation and ask if he had any matters he wanted the investigation to consider. He had a number of concerns, some of which we have addressed in separate correspondence, but he wanted to know why prison staff had not monitored his son more closely; why a doctor or nurse had not checked him in the days before his death; and whether drugs were involved in his death.

16. Mr Stephenson's father received a copy of the draft report. He raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Northumberland

17. HMP Northumberland is a private sector training prison operated by Sodexo, predominantly holding prisoners from the North East. The prison holds up to 1,300 men. Care UK provides healthcare services.

HM Inspectorate of Prisons

18. In the report of the most recent inspection of Northumberland in September 2014, inspectors noted that there had been three self-inflicted deaths since their last inspection in 2012. Previous monitoring of the implementation of the Prisons and Probation Ombudsman's recommendations into deaths at the prison had lapsed. The number of prisoners assessed as at risk of suicide or self-harm and being monitored under ACCT procedures was relatively low. Inspectors found the quality of care they received and mental health services were good. There was a high number of violent incidents and many prisoners felt unsafe. Inspectors noted that the management and monitoring of bullying and violence reduction had received little attention in the months before their inspection. Prisoners were not confident about giving staff full details of bullying. Investigations into alleged bullying were limited and did not always address the matters raised.

Independent Monitoring Board

19. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to 31 December 2015, the IMB found that the prison had settled down after major change in 2014, but the level of self-harm remained a concern. Incidents of self-harm had increased by 20 per cent since 2014. The number of closed visits, banned visitors and drugs finds had increased, which showed tighter control of drugs entering the prison. The IMB reported that violence, disruptive behaviour and self-harm levels fluctuated, and safety remained an important focus.

Previous deaths at HMP Northumberland

20. We have investigated 13 deaths at Northumberland since 2014. Of these, Mr Stephenson's' death was the second self-inflicted death. We have previously identified the need for effective assessments of prisoners at risk of suicide and self-harm and the need for effective continuity of healthcare.

Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of

the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Violence reduction strategy at HMP Northumberland

22. The prison's violence reduction strategy document issued in October 2015 sets out an aim to provide a safe and secure environment for prisoners, staff and visitors by challenging anti-social behaviour and/or violence. The strategy outlines a six-step process for staff to follow. They must understand the information received; use equipment to influence attitudes, behaviour and decisions; manage prisoners using a multidisciplinary approach; deter prisoners from committing violent or anti-social acts; support victims, perpetrators and those at risk; and develop and embed a culture of safety and moral legitimacy. Examples in the strategy of anti-social behaviour include verbal threats and trafficking drugs or forcing others to do so. The strategy includes a range of sanctions for staff to consider, and sets out some ways to support victims and perpetrators. It notes that all serious incidents should be formally investigated in line with Prison Service Instruction 15/2014.

Key Events

HMP Durham

23. On 3 June 2015, Mr Callum Stephenson was remanded to HMP Durham charged with assaulting his partner. He had tried to hang himself after assaulting her.

24. At an initial health screen, Mr Stephenson said he did not take any medication, did not drink alcohol and did not want to be referred to the drug and alcohol team. He said he had no current thoughts of suicide or self-harm but felt depressed. A nurse noted he had a history of alcohol, cannabis and cocaine misuse. He declined to see a GP, but the nurse referred Mr Stephenson to the mental health team. Mr Stephenson had arrived with a suicide and self-harm warning form from the court and staff began ACCT suicide and self-harm prevention procedures, as his offence was against his partner and he had tried to hang himself the previous week.

25. On 4 June, at an ACCT assessment interview, Mr Stephenson talked about his feelings of shame and his relationship difficulties. Family and relationship issues were identified as a trigger for suicide and self-harm. At a case review that day, Mr Stephenson said he had no current thoughts of suicide or self-harm and the review ended ACCT procedures.

26. On 5 June, a mental health nurse assessed Mr Stephenson and he talked about his recent attempt to hang himself. At an ACCT post-closure review on 15 June, Mr Stephenson asked for mental health support. The nurse saw him again on 19 June, and he said he was anxious, slept poorly and had nightmares. He said he found it difficult being in prison, was worried about his forthcoming court appearance, but had no thoughts of suicide or self-harm. On 23 June, the nurse reviewed his mental health again and referred him for cognitive behavioural therapy after he said his mental state was deteriorating. He said that he always masked his feelings and “put on a front” but he was struggling.

27. On 30 June, a security intelligence report noted that he had threatened to kill himself during a telephone conversation with his partner.

28. On 1 July, Mr Stephenson was convicted of assaulting his partner. It was not his first offence. He had a history of domestic violence and had two restraining orders against him (not in relation to his current partner).

29. On 6 July, Mr Stephenson started cognitive behavioural therapy and was noted to be motivated and bright in mood. His partner had visited him, and it had gone well. He said he was due in court for sentencing on 7 August, and was pleased that a more serious charge had been dropped. He denied thoughts of suicide or self-harm but said when he could not sleep in the previous fortnight, he had had fleeting thoughts of not wanting to be alive. He was anxious about the future and not being able to get a job. He said he had considered not speaking to his partner, as this sometimes triggered negative thoughts and jealousy.

30. On 15 July, at a cognitive behavioural therapy session, Mr Stephenson again denied any thoughts of suicide or self-harm. He said he had had a tough week

but had been trying to think positively and focus on the future. He said he had spoken to his partner about his negative thoughts and had told an officer that he would press his cell bell if he needed urgent support.

31. On 18 July, Mr Stephenson tried to harm himself while he was speaking to his partner on the phone. He said this had been in the heat of the moment because his partner had stressed him and he did not have thoughts of suicide or self-harm.

32. Mr Stephenson missed a therapy session on 21 July but attended for the next three weeks. Each time, he completed a questionnaire, which indicated his anxiety levels were increasing. On 30 July, he indicated he had thoughts that it would be easier if he was not alive, but consistently denied any thoughts of suicide. He said the therapy helped him and he wanted to do work to address his domestic violence issues.

33. On 7 August, Mr Stephenson was sentenced to three years and two months in prison for assault. He told a nurse that he was upset about this but it would do him good because he "needed to sort [his] head out". He asked for counselling and the nurse agreed to contact the mental health team. Mr Stephenson did not attend his next two cognitive behavioural therapy sessions.

HMP Holme House

34. On 14 August, Mr Stephenson was transferred to HMP Holme House. At an initial health screen, he said he had no thoughts of suicide or self-harm and that he had only harmed himself once, a long time earlier. He said he had a history of cannabis and cocaine misuse but had not used drugs in the last month and had not tried to harm himself in prison. A nurse referred Mr Stephenson to the mental health team.

35. On 18 August, two psychological wellbeing practitioners in the mental health team assessed Mr Stephenson, who told them that he felt okay and did not need mental health support. However, he asked to move wings because he did not know anyone on the wing and he was "only little". (Mr Stephenson was five foot five inches.) They agreed that Mr Stephenson did not need to see the mental health team but could ask for help in the future if he needed it.

36. That evening, Mr Stephenson told staff that he had been assaulted. He said that other prisoners had forced him to put his fingers in his anus to show them that he did not have a hidden mobile phone. A nurse noted he was in pain and distress and admitted him to the prison's inpatient unit. Another nurse examined him and noted soreness but no bleeding.

37. That night, Mr Stephenson told a nurse that he felt lonely. Initially, he did not want to speak to a Listener (a prisoner trained by the Samaritans to support other prisoners), so the nurse and a custodial manager spent some time with him to help ease his distress. The nurse gave him paracetamol. His medical record indicated that he had a restless night and nightmares.

38. On 19 August 2015, Mr Stephenson told the custodial manager that he was finding it very difficult to deal with what had happened. He said that the prisoners had held him down for 45 minutes at knifepoint. He had since spoken to Listeners and felt a little better, but was worried about being assaulted again. He

was reluctant to provide further information about the alleged perpetrators and the police and the prison took no further action, as Mr Stephenson said he did not want to pursue the matter.

HMP Northumberland

39. On 26 August, because of the alleged assault, Mr Stephenson was moved to HMP Northumberland. There is no record that Holme House informed Northumberland of the reasons for the move. At an initial health screen, Mr Stephenson said he had been depressed, but had no thoughts of suicide or self-harm and had not received any mental health treatment. He does not appear to have told the nurse about the recent alleged assault, although the details were recorded in his medical record, as was his previous contact with mental health services.

40. On 5 September, Mr Stephenson told an officer that two prisoners had threatened him and wanted him to put pressure on his partner to bring drugs into the prison. Mr Stephenson said that the two prisoners had let him use their (illicit) mobile phone to call his partner. Once he had dialled her number, they took the phone from him and told her that if she did not do as they said, they would find out where she lived. They told Mr Stephenson that they would call his partner and tell her that they would "slice up his face" if she did not bring in drugs.

41. Mr Stephenson told the officer that he would tell him where the mobile phone was, and who the perpetrators were, if he was moved from the unit. He was moved to Houseblock Three. Mr Stephenson named the other prisoners but when officers searched their cells, they did not find a phone. Officers submitted a security intelligence report but no one investigated further, or challenged the other prisoners. A member of security staff said they had completed a violence reduction information report but the prison could find no record of this.

42. On the night of 14 September, Mr Stephenson cut his earlobe. Initially he said this was because his request for mental health support had been ignored. (There is no record that he had asked to see anyone from the mental health team.) His ear bled steadily but he refused any treatment. The night patrol officer, an operational support grade, started ACCT procedures. The night manager initially set hourly observations.

43. At 10.30am on 15 September, an officer assessed Mr Stephenson as part of ACCT procedures. He said Mr Stephenson was tearful and paranoid, and thought everyone was talking about and laughing at him. Mr Stephenson told him about the assault at Holme House. The officer noted that he seemed "emotional" about it.

44. At 3.00pm that day, a Supervising Officer (SO) chaired the first ACCT case review with an officer and a mental health nurse. (The ACCT record does not indicate that the nurse was present, but she made a detailed entry about the review in his medical record.) Mr Stephenson said he was sorry about cutting his ear. The SO noted that Mr Stephenson had a history of anxiety and bipolar disorder and that he had seen community mental health teams for five years. The case review assessed him as at low risk of suicide and self-harm. Officers were expected to have a meaningful conversation with him in the morning,

afternoon and evening and check him twice during the night. The SO noted three actions in Mr Stephenson's caremap. (The caremap should identify actions to reduce risk.) The only action added on 15 September was for Mr Stephenson to apply for a job. Two further actions were added subsequently. One was for a referral to the mental health team (it said an appointment was made for 24 September). The other was to check how he was after a prisoner died at the prison on 18 September.

45. After the ACCT case review, the mental health nurse noted in Mr Stephenson's medical record that the mental health team had not received any earlier referrals for him. He had said he was anxious and in a low mood. He had mentioned to the assault in August and said he wanted to go back to the healthcare unit at Holme House. She advised him to work on coping strategies. She noted that she would speak to the GP about prescribing an antidepressant and submitted a security intelligence report about the alleged assault at Holme House.

46. On 17 September, the mental health nurse saw Mr Stephenson again and he said he felt much better. He explained that the night he had cut his ear, he had had an argument with his partner but they had since resolved matters. The nurse spoke to the prison psychologist about the possibility of trauma therapy and referred him for cognitive behavioural therapy. The mental health team decided to monitor Mr Stephenson's mood over the next week, before deciding whether he needed antidepressants.

47. On 18 September, a SO and an officer held an ACCT case review with Mr Stephenson to check how he was after a prisoner at Northumberland had hanged himself that day. There was no member of healthcare staff present. Mr Stephenson said the death had not affected him. He said he did not want to be monitored under ACCT procedures and wanted the level of observations reduced. The SO said this would be considered at his next ACCT case review.

48. On 22 September, a SO and an officer held the next case review. No member of healthcare staff was present. The SO noted that Mr Stephenson was smiling, said he had no thoughts of harming himself and had started a job in waste management. He had not yet had a mental health assessment, which was one of the caremap actions, but the SO and officer agreed to stop ACCT monitoring.

49. On 23 September, a psychologist from the mental health team saw Mr Stephenson, who said he was angry, violent and controlling and wanted help to control this. Mr Stephenson said he became angry when he felt let down and lied to. They planned to work on his anger and trauma.

50. At the ACCT post closure case review on 29 September, Mr Stephenson said he had no thoughts of suicide or self-harm. Although he had seen a mental health nurse and the psychologist, Mr Stephenson said he was still waiting to be seen by the mental health team.

51. On 30 September, a worker from the mental health team, assessed Mr Stephenson for the Rethink programme, a coping skills programme. She told the investigator that Mr Stephenson seemed angry. He said that his head was bursting", but he had no thoughts of suicide or self-harm. While she was with Mr

Stephenson, an officer found a noose in his cell. The officer informed her, who started ACCT procedures at 2.30pm.

52. A SO spoke to Mr Stephenson at 3.15pm that afternoon and assessed his risk of suicide and self-harm as low. Staff were required to have a meaningful conversation with him in the morning, afternoon and evening and check him four times during the night. There was no new ACCT assessment. The SO said that as Mr Stephenson had been assessed on 15 September, he had used the previous ACCT assessment.

53. On 1 October, the worker from the mental health team saw Mr Stephenson again. He apologised about his angry behaviour the day before and agreed to have a few cognitive behavioural therapy sessions to recap on the skills he had learnt at Durham. He said he had no thoughts of suicide or self-harm and said that his partner's two children were protective factors. He said he would never act on such thoughts even if he had them.

54. At 5pm that day, a SO and an officer held the first ACCT case. There was no member of healthcare staff present. Mr Stephenson said that he had made the ligature earlier in September, when he was feeling down at the time he was previously being monitored under ACCT procedures. He said that he did not have any issues on the wing, had a full time job, was in touch with the mental health team and was aware of the available support. The SO noted that Mr Stephenson was cheerful and ended ACCT monitoring.

55. On 6 October, a SO spoke to Mr Stephenson after he had passed a note to staff, saying he was in debt to some Traveller prisoners for £200 because he had smashed a phone belonging to them. He said that he had "done a few jobs for them" because he felt scared and intimidated and they had also contacted his partner. The SO recorded detailed information about this in the prison records and in a security information report. He told Mr Stephenson to tell his partner to contact the police or the prison if she had any further calls and not to pay the perpetrators any money.

56. Mr Stephenson asked to move to the segregation unit. He also asked to be regarded as a vulnerable prisoner and kept apart from the general population, as he did not feel safe in the prison. He agreed to move temporarily to Houseblock One. He said he had no thoughts of suicide or self-harm and said that he would stay in his cell. The SO told him to speak to staff if he felt he needed help.

57. The SO completed an application for Mr Stephenson to be regarded as a vulnerable prisoner. (There is no record of the outcome, although Mr Stephenson was subsequently moved to a houseblock for vulnerable prisoners when he got back from a short stay at Durham.) The security manager told us that they investigated the incident and produced a violence reduction information report, which they passed to the police intelligence officer, who was seconded to the prison from Northumbria Police. However, the prison was unable to give us the report or any other evidence of the investigation.

58. On 7 October, the worker from the mental health team saw Mr Stephenson for cognitive behavioural therapy. He said he was happier in Houseblock One, because he was locked in his cell 23 hours a day. (The safer custody manager

told us that this was because he chose not to come out of his cell during association periods and was not attending work or education.) He said that his anxiety symptoms had reduced and he felt stronger mentally. Although things were difficult, he felt more able to deal with them. She advised him to consider the cognitive behavioural therapy techniques he had already learned and make sure he was occupied. She agreed that Mr Stephenson should have one more therapy session and then be discharged from the mental health team's caseload.

59. On 8 October, a SO held an ACCT post-closure review. Mr Stephenson told him that the issues that made him think about harming himself were still ongoing, but he had received good support from staff.

60. On 26 October, Mr Stephenson transferred briefly to Durham for a court appearance where he was found guilty of a charge of assault (against his brother) and criminal damage. On 29 October, he returned to Northumberland. At a reception health screen, he said that he had never received mental health treatment in the community and did not refer to his recent contact with the mental health team at Northumberland. (It does not appear that the nurse reviewed his medical record where this information was recorded.) He told the nurse that he had no thoughts of suicide or self-harm and had never harmed himself in prison. Mr Stephenson went to Houseblock 11 on the vulnerable prisoners' side of the prison. He asked to transfer to a prison where he could complete the Healthy Relationships Programme, for prisoners involved in domestic violence. (His offender supervisor subsequently applied for him to move to Holme House or HMP Erlestoke.)

61. The worker from the mental health team told the investigator that when a prisoner moved to another prison, his name would be removed from the mental healthcare team's caseload. She said that she would not have been told when Mr Stephenson returned to the prison and would not have seen him again unless someone made a further referral to the mental health team again. This never happened.

62. On 4 November, Mr Stephenson told an officer that some prisoners had assaulted him in his cell the night before, because of something that had happened outside prison. The officer submitted a security intelligence report, which said that Mr Stephenson was frightened for his safety.

63. That day, Mr Stephenson's partner phoned the prison and said some prisoners had phoned her and told her they had given Mr Stephenson "a good hiding" the evening before. She was worried about him and wanted to know what to do. In response, staff moved Mr Stephenson to Houseblock 12, also for vulnerable prisoners. As before, the security manager said that the prison investigated the incident and passed a report to the police intelligence officer. Again, there is no evidence of this investigation. There was no record of the assault in their log of violent incidents or in the daily operational report.

64. A security intelligence report was completed. A SO told the investigator that reports were sent to the national security hub, where staff analysed them for connections with other reports. He said they did not always interview the alleged perpetrators because of the risk of putting victims in a more dangerous position.

He said that the usual response was to complete a violence reduction report and move the victim to another houseblock.

65. There was an undated security intelligence report, which said that Mr Stephenson's partner told the prison that Mr Stephenson was calling her from a mobile phone at night and "hassling" her. Two further undated security reports said that Mr Stephenson was using a mobile telephone to call an ex-partner, in breach of a restraining order. In another security report, Mr Stephenson's partner said that she had received an anonymous telephone call and was told that if she did not pay £500 into a bank account, her partner would be hurt again and would not be able to use his legs.

66. On 6 December, Mr Stephenson told his personal officer that prisoners in his houseblock believed he had a mobile phone and were "constantly on his case" to use it, even though he said he did not have one. He asked the officer if he would pretend to put him on the basic regime of the Incentives and Earned Privileges Scheme for two weeks to make it appear he had been found with a phone so that the other prisoners would leave him alone. (The scheme is to encourage good behaviour and compliance with sentence plan targets. Prisoners on the basic level lose privileges such as extra time out of cell, additional visits and a television.)

67. The officer searched Mr Stephenson's cell in case he was trying to manipulate him. When he did not find a mobile telephone, the officer agreed to pretend he was on the basic level because Mr Stephenson had already been moved between other houseblocks and the options were limited. He said that this seemed to work and the prisoners left Mr Stephenson alone.

68. However, during a cell search on 14 December, officers found that Mr Stephenson had a mobile phone. He was charged with a disciplinary offence and genuinely downgraded to the basic regime level. An officer noted at the time that Mr Stephenson had had a poor reporting period and received "a lot of abuse from other prisoners as he [was] a weak character". He noted that Mr Stephenson had previously told staff that other prisoners had his partner's contact details and used this to manipulate him into doing what they wanted. After a week on the basic regime, Mr Stephenson told an officer that he found it difficult to cope without a television in his cell. (He returned to the standard regime on 29 December.)

69. On 21 December 2015, an Offender Assessment System (OASys) risk management plan completed for Mr Stephenson identified that his partner, family members, former partners and the public were at risk of violence, psychological and emotional harm. It noted that factors which might increase his risk to others included anger, stress, the breakdown of relationships with his partner or family and jealousy, especially when separated from his partner.

70. On 5 January 2016, Mr Stephenson's partner visited him. During the visit, he and his partner argued and his partner slapped him. On 6 January, his personal officer had a long discussion with him about the visit. Mr Stephenson said that he had planned to end his relationship with his partner at the visit the previous day but did not say why. He told him that his partner had got angry with him and had attacked him. She had thrown a coffee cup at him, which had nearly hit an

officer. He said that his partner had been very upset. The officer said that relationship issues were the same issues that Mr Stephenson had had during his time in Houseblock 12. As Mr Stephenson had no phone credit, he allowed him to use the office telephone to call his partner and check whether she still intended to visit him on 7 January, as they had arranged.

71. The officer said the phone call became heated, as Mr Stephenson tried to convince his partner to visit him because they needed to sort things out. His partner agreed, but, after the call, Mr Stephenson seemed angry. Mr Stephenson asked him to leave his cell unlocked that morning, so he could talk to his friends, and he agreed. He asked him to check whether his partner had been banned from visiting because of the incident on 5 January, but he reassured him that she had not been banned. He said that Mr Stephenson appeared fine for the rest of the day. He collected his meals as usual and mixed with other prisoners during the association period.

72. On 7 January, the officer saw Mr Stephenson throughout the morning. He said he seemed happy. He was talking to other prisoners and following his daily routine.

73. At the visit with his partner that day, they ended their relationship. After the visit, a SO and another officer talked to Mr Stephenson to make sure he was okay. The SO said that he had considered starting ACCT procedures but after he had spoken to Mr Stephenson, he did not think it was necessary. Based on how Mr Stephenson spoke and made eye contact, he was not concerned about him. The SO said that he was experienced in dealing with ACCT procedures and had dealt with some complex cases. He said he was aware that prisoners could say they were fine when they were not. However, he considered that Mr Stephenson came across well and he reminded him of the available support. Mr Stephenson said he had no thoughts of suicide or self-harm and said he would not harm himself because he had “two kids to think about". (His partner had two young children from a previous relationship.)

74. The personal officer noted that Mr Stephenson spent some time talking to other prisoners, including a close friend. Afterwards, he asked him if he could speak to him in private. They went to the office. Mr Stephenson said his partner had sent texts to and phoned another prisoner, who he named. He said he was worried that his partner had already brought in, or intended to bring in, drugs for that prisoner. He said that he had debts outside prison, and money had been put into their joint bank account, which he could not account for. He said he was giving the prison this information so that his partner would be banned from visiting the prison and this would protect her and her children.

75. The officer submitted a security intelligence report about what Mr Stephenson had said. He said that Mr Stephenson did not give him any indication he intended to harm himself. He did not think that ACCT monitoring was necessary, as Mr Stephenson did not seem particularly upset or worried, and he had denied having any negative thoughts. The Head of Security told the investigator that Mr Stephenson’s partner had been approved as a visitor for another prisoner, who Mr Stephenson had known in the community, but she had never visited him. He said that the prison had not taken action about Mr Stephenson’s allegation, as he

made it after their relationship had ended, and there was no evidence to corroborate it.

76. At 5.10pm, Mr Stephenson phoned his partner and confronted her about whether she was visiting another prisoner and whether she intended to smuggle in drugs to clear his debt. He called her at 5.22pm and 5.35pm, and asked her not to do anything stupid.

77. Later, a prisoner told the personal officer that he was concerned that Mr Stephenson intended to harm himself. He took the prisoner and Mr Stephenson to a quiet area of the social room and Mr Stephenson told them he had no thoughts of suicide or self-harm. He said that Mr Stephenson was calm and composed and said that he was just angry with his partner. He made sure that other officers on the wing were aware of the situation.

78. After the personal officer had locked up the prisoners for the evening roll check, he opened Mr Stephenson's cell again and asked him in private if he was okay, after such a stressful day. Mr Stephenson repeated that he was fine, told him not to be "daft" and thanked him for asking. He said he reminded Mr Stephenson that he could ask to call the Samaritans or speak to a Listener anytime if he needed support.

79. Around 9.05pm, the night patrol officer started a routine roll count. A prisoner told him that he was worried about him, as he had had some bad news that afternoon. (The records do not show whether or not this was the same prisoner who had earlier told the personal officer that he was concerned that Mr Stephenson might harm himself.) The officer said that he would check on him and carried on with his roll check. When he came to Mr Stephenson's cell, he did not talk to him but said he was moving around his cell at the time and he had no reason to think there was anything out of the ordinary. The officer said he checked Mr Stephenson again a couple of times before midnight and said everything appeared normal, but again he did not speak to him to ask him how he was feeling. He did not check him again until the next morning.

80. At 5.45am, the night patrol officer started the morning roll count. At around 6.30am, he found that Mr Stephenson had covered the observation panel in his cell door. He radioed the night manager and told him that he could not see into Mr Stephenson's cell to check him.

81. The night manager sent two officers to the houseblock. The officers opened Mr Stephenson's cell at 6.36am and found Mr Stephenson hanged from a torn sheet tied to the television bracket. The night patrol officer immediately radioed an emergency medical code to alert the control room to call an ambulance. One officer cut the ligature and checked for a pulse but found none. As there were clear signs of rigor mortis, the officers did not attempt resuscitation. Paramedics arrived at the prison at 6.49am and assessed Mr Stephenson. At 6.59am, they recorded that Mr Stephenson had died.

82. Mr Stephenson had left three notes in his cell, indicating his intention to kill himself because he could not live in the same place where his partner intended to visit another man. In one of the notes, Mr Stephenson said that his personal

officer had been very good to him and should not be blamed for not starting ACCT procedures, as he had told him he was fine.

Contact with Mr Stephenson's family

83. The prison appointed a SO and an officer to liaise with Mr Stephenson's family. The SO and another prison family liaison officer left the prison at 9.30am to inform Mr Stephenson's father that he had died. When they got to the address Mr Stephenson had given, they found he no longer lived there. The SO phoned him and he gave then his current address. The family liaison officers then went to see him and broke the news of his son's death. That afternoon, the SO visited Mr Stephenson's partner and informed her what had happened. The prison contributed to funeral expenses in line with national instructions. Mr Stephenson's father had some concerns about family liaison and support, which we have raised with the prison and dealt with in separate correspondence.

Support for prisoners and staff

84. At 12.30pm on 8 January, the duty manager held a debrief, to which he invited the staff involved in the emergency response, but this was after most had gone home. The night patrol officer and one officer did not attend. The night patrol officer said that it was an inconvenient time, as he worked night shifts and slept at that time of day. The officer said that staff had gone off duty after Mr Stephenson's death without senior managers debriefing them or offering them any support, which he thought was poor practice. The staff care team offered support.

85. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Stephenson's death. Staff offered prisoners on Mr Stephenson's wing the support of the chaplaincy team and held a memorial service for Mr Stephenson on 19 January. Three members of Mr Stephenson's family attended.

Post-mortem report

86. A post-mortem examination found that the cause of Mr Stephenson's death was hanging. Toxicology tests did not test specifically for new psychoactive substances, but did not detect the presence of any other drugs.

Findings

Bullying and intimidation

87. Northumberland's violence reduction strategy says that it aims to "communicate zero tolerance towards violence", understand the causes and triggers for violence, manage and reduce the risk of violent behaviour, report and challenge all incidents of violence, identify and support violent offenders and intervene early to prevent further incidents. The policy says that, "All serious incidents will be formally investigated in line with PSI 15/2014". It says that it aims to "ensure appropriate support…for perpetrators and victims". It does not identify that victims of bullying, violence, intimidation or threats, might be at increased risk of suicide or self-harm.

88. There is a lot of information that throughout his time at Northumberland, other prisoners bullied, intimidated and threatened Mr Stephenson and his partner. The threats appear to have been because other prisoners wanted Mr Stephenson's partner to bring drugs into the prison and because Mr Stephenson got into debt over problems with a mobile phone. The problems started shortly after Mr Stephenson arrived at Northumberland and he first reported them to staff on 5 September. At the beginning of November, it appears that other prisoners assaulted him in his cell. An officer said that other prisoners abused him because he was a "weak character".

89. We are concerned that the violence reduction team and other staff responsible for managing Mr Stephenson do not seem to have recognised or considered that the assaults, bullying and intimidation Mr Stephenson experienced might have increased his risk of suicide and self-harm. Yet the PPO has published a range of publications identifying the links between bullying and suicide.

90. In a review of self-inflicted deaths, published in June 2011, we found evidence of bullying and intimidation in 20 per cent of the cases we reviewed. In a follow-up report of October 2011, 'Violence reduction, bullying and safety', we identified the importance of implementing local violence reduction strategies, investigating all allegations of bullying and recognising that individuals who have been the victim of bullying are potentially at greater risk of suicide and self-harm. We repeated similar messages in our review of all self-inflicted deaths in prisons in 2013/14 and pointed to the need for all reports or suspicions that a prisoner is being threatened or bullied to be recorded and thoroughly investigated and for the potential impact on the victim's risk of suicide to be considered.

91. Mr Stephenson made it clear that he felt unsafe in the prison and there is evidence to indicate that his concerns were genuine and well-founded. The prison's response to Mr Stephenson and his partner reporting that he was under threat from other prisoners was always to move him to another part of the prison. Mr Stephenson moved five times in five months. This was an inadequate response and did not address the underlying reasons for the bullying or intimidation Mr Stephenson and his partner experienced.

92. The prison should have done more to investigate the allegations Mr Stephenson and his partner made and challenge the alleged perpetrators, who Mr Stephenson named. While staff completed security intelligence reports, these

did not result in meaningful action other than moves within the prison. Staff appeared to have considered each report in isolation rather than as part of a bigger problem. The prison said that they had investigated when Mr Stephenson reported being intimidated and threatened for a debt at the beginning of October 2015, and when he had reported being assaulted in November. However, they were unable to give us the investigation reports and we have seen no evidence that anyone challenged the alleged bullies, monitored the incidents or adequately supported Mr Stephenson. We make the following recommendation:

The Director should ensure that all information about bullying and intimidation is fully coordinated and investigated; that those suspected of involvement are appropriately challenged and monitored; that staff consider whether victims are at increased risk of suicide or self-harm; and that apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.

Assessing and managing the risk of suicide and self-harm

93. PSI 64/2011 lists a number of risk factors and potential triggers for suicide and self-harm. Mr Stephenson had a number of these risks, including a history of violent offences against his partner, ex-partners, and members of his family; previous attempted suicide and self-harm; a history of mental health issues, particularly anxiety; and a loss of contact with his family (although his father visited him). Records indicate that his relationship with his partner was turbulent. He had been bullied and threatened, and prisoners had also threatened his partner.

94. Mr Stephenson was managed under ACCT procedures three times during his time in prison. The first time was when he arrived at Durham, as he had tried to hang himself after assaulting his partner. He was then managed under ACCT procedures at Northumberland twice in September.

95. We had some concerns about the management of the ACCT procedures and the assessment of Mr Stephenson's risk. Staff correctly started ACCT monitoring on 14 September, after Mr Stephenson cut his ear. (This was ostensibly to get mental health support, but he later admitted he had cut himself after arguing with his partner.) An assessment the next day, found he was paranoid and tearful yet the subsequent first case review that day assessed his risk as low. We consider that this was an under-assessment of his risk, so shortly after he had self-harmed. No one referred to the fact that he had recently reported being threatened by other prisoners.

96. PSI 64/2011 says that ACCTs should not be closed until all identified actions in caremaps have been completed. Staff ended ACCT monitoring on 22 September, before Mr Stephenson had had a mental health assessment. A SO noted that a nurse was due to assess Mr Stephenson on 24 September. We consider that the ACCT should not have been closed until after this planned appointment had taken place. There was no member of healthcare staff present and the case review was not multidisciplinary.

97. Mr Stephenson was monitored under ACCT procedures again on 30 September, after an officer found a noose in his cell. There was no ACCT assessment to

help identify his concerns as should have happened. Although it is a mandatory requirement of PSI 64/2011, no member of healthcare staff was present at the first case review. Again, there was no examination of whether Mr Stephenson was being bullied. (A few days later, he said he was being threatened for a debt of £200.) Staff closed the ACCT at this first case review just over 24 hours after it had been opened. We consider this was too early and relied simply on what Mr Stephenson had said, without a proper assessment of his risks and concerns.

98. The main trigger for Mr Stephenson harming himself appeared to be his relationship with his partner, which staff at Durham had identified. Although they had some recognition of his risk in relation to his partner, staff at Northumberland do not seem to have formally recorded that Mr Stephenson had a pattern of harming himself after a problem in his relationship or that his risk was also linked to the fact that he and his partner were being bullied and intimidated by other prisoners.

99. On the 7 January, three members of staff (a supervising officer and two officers) talked to him after his relationship with his partner had ended. They recognised the possibility that this might have increased his risk of suicide or self-harm and considered whether to start ACCT monitoring, but they were persuaded by his reassurances that he did not intend to harm himself. The personal officer spoke to Mr Stephenson about his risk twice on the evening of 7 January, after another prisoner said he was worried about him, but still considered that he did not need ACCT monitoring.

100. A prisoner told the night patrol officer that he was worried about Mr Stephenson. (We do not know whether this was the same prisoner who had told the personal officer he was concerned about him, but this appears likely.) We consider that the night patrol officer should have spoken to Mr Stephenson to satisfy himself that he was all right, but we recognise that it is likely that Mr Stephenson would have given the night officer the same assurances he had given the other staff.

101. Prison Service suicide and self-harm prevention procedures rely on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. While we are concerned that there appeared to a systemic underestimation of Mr Stephenson's risk factors at Northumberland, we recognise that the staff who spoke to him on 7 January, had identified that the break up with his partner had increased his risk of suicide and self-harm. They considered whether to begin ACCT monitoring, but had all concluded that this was not necessary. A SO said he was fully aware that he should not just to rely on what prisoners told him about their risk. He took this into account when he spoke to Mr Stephenson and was satisfied that he did not need ACCT monitoring. The personal officer had taken into account that Mr Stephenson's friend was concerned about him and had spoken to him subsequently.

102. It is apparent that prison staff made the wrong judgement when they assessed Mr Stephenson on 7 January. With hindsight, we consider it would have been prudent to begin ACCT procedures. However, we accept that this was a judgement call, which the staff had considered and discounted, knowing that Mr Stephenson might have been vulnerable after his relationship difficulty. Other

than the fact of the relationship breakup, Mr Stephenson does not appear to have given any signs that he was at heightened or imminent risk of suicide that evening. It appears that he had deliberately aimed to mislead staff about his intentions, and we consider it would have been difficult for them to have predicted or prevented his actions.

103. A more holistic assessment of Mr Stephenson's risk factors might have reached a different conclusion. However, we recognise that even if staff had decided to begin ACCT monitoring on 7 January, it us unlikely that they would have assessed him as at high risk, and that the level of observations would have been set at such a level at to prevent his death. While we do not criticise the individual decisions taken by staff on 7 January, we are concerned that Mr Stephenson's overall and ongoing risk was not effectively managed at Northumberland. We make the following recommendation:

The Director should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidance, including that:

- **Staff appropriately assess, identify, consider and record all relevant risk factors when determining a prisoner's risk of suicide or self-harm, and begin ACCT procedures when indicated.**
- **ACCT case reviews are multidisciplinary where possible and include all relevant people involved in the prisoner's care, with healthcare staff attending all first case reviews.**
- **ACCT case reviews fully consider and record the implications for managing the risks of prisoners suspected of being bullied and intimidated.**
- **ACCT caremap actions are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary and that all actions are completed before an ACCT is closed.**

Clinical care

104. The clinical reviewer concluded that the overall standard of healthcare Mr Stephenson received in Northumberland was equivalent to the care he would have received in the community, but has made some detailed recommendations about record keeping, reception health screens and other matters, which the Head of Healthcare will need to address.

105. When Mr Stephenson arrived at Northumberland, he said he had not received treatment for mental health issues and did not mention that he had recently been assaulted at Holme House. The reception nurse relied entirely on Mr Stephenson's account and was not aware that he had been under the care of the mental health team at previous prisons, in the community and at Northumberland until three days previously. This was not identified until after Mr Stephenson self-harmed on 14 September.

106. We consider that healthcare staff should have identified this from his SystmOne medical records to ensure appropriate continuity of care. While prisoners have a responsibility to inform healthcare staff of ongoing health problems and relevant medical history, this cannot always be relied on.

107. We are concerned that, when Mr Stephenson returned to Northumberland on 29 October after just three days in Durham for a court appearance, the mental health team had removed him from their records and caseload, although he had a further outstanding appointment for CBT and had never formally been discharged from the mental health team's caseload. The worker from the mental health team said that Mr Stephenson would have had to be referred again to see them and this never happened. Since Mr Stephenson's death, the mental health team have changed their practice and write patients' names on a whiteboard so there remains a record, even after their formal records have been deleted. While this might be helpful, we consider that all outstanding treatment needs should be recorded and identified on the SystmOne, computerised medical record. We make the following recommendation.

The Head of Healthcare should ensure that all important information about prisoners' health and appointments is entered in SystmOne and that nurses adequately review newly arrived prisoners' SystmOne records to ensure appropriate continuity of care.

Staff support

108. PSI 64/2011 says that a senior member of staff must debrief staff involved in the emergency response immediately after a death at the prison. A manager did not hold a debrief until 12.30pm in the afternoon of 8 January, which was an inappropriate time for staff who had been working all night. We make the following recommendation:

The Governor should ensure, in line with PSI 64/2011, that a manager debriefs all the staff involved in a death at the prison immediately after the emergency response, and offers appropriate support.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141