Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jack Phillipson, a prisoner at HMP Northumberland, on 15 August 2021

A report by the Prisons and Probation Ombudsman

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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 Jack Phillipson was found hanged in his cell at HMP Northumberland on 15 August 2021. He was 27 years old. I offer my condolences to Mr Phillipson's family and friends.

Mr Phillipson had some risk factors for suicide and self-harm, and I am concerned that these were not properly considered at HMP Durham around two months before he died. In the time leading up to his death, following his transfer to Northumberland, I consider that there was little to indicate to staff that he was at imminent risk of suicide.

However, there are some lessons for Northumberland to learn from Mr Phillipson's death. There was little evidence of meaningful contact with wing staff following his transfer, which is particularly important for newly arrived prisoners who are isolating in line with COVID-19 requirements.

I am also concerned that staff did not immediately go into Mr Phillipson's cell when they identified that there was an emergency. I have expressed concerns to the Director of HMP Northumberland and the Head of Custodial Contracts at HM Prison and Probation Service (HMPPS) about similar deficiencies in previous investigations at Northumberland and it is troubling that I have had to raise these issues again in this report.

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

Sue McAllister CB
Prisons and Probation Ombudsman **May 2022**

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Summary

Events

1. On 15 January 2021, Mr Jack Phillipson was remanded in custody to HMP Durham. He had previously been diagnosed with anxiety and depression and was prescribed medication for this.

2. On 24 January, Mr Phillipson spoke aggressively to his partner on the telephone and threatened to commit serious offences against her and others. Prison staff randomly monitored this call and, as a result of the content, removed Mr Phillipson's partner's telephone number from his approved contacts list.

3. In April, Mr Phillipson moved wings, having been under threat "due to drugs" on his previous wing. He appeared to settle on his new wing and there were no recorded incidents of violence or drug use involving Mr Phillipson.

4. On 18 June, Mr Phillipson told a prison chaplain that he had not heard from his partner for four days and said that he would "take his life" if she did not answer the telephone. (It is not clear how Mr Phillipson was contacting his partner at the time.) The chaplain started Prison Service suicide and self-harm prevention procedures, known as ACCT. The next day, a supervising officer ended the ACCT procedures when Mr Phillipson said that he had now spoken to his partner.

5. Over the following days, prison staff recorded that Mr Phillipson had asked several times for his partner's telephone number to be added to his approved list. An officer telephoned his partner, who asked that her number was not added. This was not discussed at the ACCT post-closure review on 26 June. On 1 July, Mr Phillipson told an officer that he had now separated from his partner.

6. On 27 July, Mr Phillipson was sentenced to six years in prison.

7. On 9 August, Mr Phillipson was transferred to HMP Northumberland. A nurse began an initial health screen, but because Mr Phillipson arrived late in the afternoon, this was not completed until 12 August.

8. On 13 August, Mr Phillipson telephoned a number that was listed for a friend. When we later listened to the call, it was apparent that the number belonged to his ex-partner. Mr Phillipson repeatedly asked his ex-partner to restart the relationship, but she did not want to. Over the following two days, Mr Phillipson made 25 unanswered calls to his ex-partner.

9. At a count of prisoners on 15 August, an operational support officer found Mr Phillipson seemingly sitting on the heating pipe in his cell. He did not respond to her attempts to rouse him. The operational support officer telephoned for assistance. An officer attended and radioed a medical emergency code when he also could not rouse Mr Phillipson. When additional staff attended, they opened the cell and found Mr Phillipson hanged from a ligature. Prison staff began cardiopulmonary resuscitation, but paramedics later confirmed that Mr Phillipson had died.

Findings

Identifying the risk of suicide and self-harm

10. Mr Phillipson had some risk factors for suicide and self-harm, although not all were known to prison staff at the time. We consider that it would have been difficult for staff at Northumberland to have foreseen his death.

11. However, there is little evidence that wing staff had meaningful contact with Mr Phillipson following his transfer. This is always important when a prisoner is in their first days in a new prison, but particularly so during the COVID-19 pandemic when national guidelines require new prisoners to isolate for two weeks. We do not therefore consider that staff gave themselves the best opportunity to identify any issues that Mr Phillipson might have had.

12. We are also concerned that no one appeared to consider whether Mr Phillipson's risk might have increased at Durham in the week after ACCT procedures ended, when requests he made about contacting his partner were closely related to the reasons the ACCT procedures were started.

Clinical care

13. A full health screen was not completed when Mr Phillipson arrived at Northumberland, as national guidelines require.

Emergency response

14. We found that staff did not immediately go into Mr Phillipson's cell when they identified an emergency.

Family liaison

15. It took too long to inform Mr Phillipson's family of his death.

Recommendations

- The Director of Northumberland should ensure that staff have meaningful contact with prisoners on the Reverse Cohort Unit.

- The Governor of Durham should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

    - All relevant information about risk is recorded, shared and considered, and ACCT procedures are started when indicated.

    - Post-closure reviews consider all new information about risk, and re-start ACCT procedures when indicated.

- The Head of Healthcare at Northumberland should ensure that the reception health screen is completed on arrival for all prisoners, or at the earliest opportunity afterwards for those prisoners who arrive very close to or after the healthcare unit closes.

- The Head of Custodial Contracts for HMPPS should write to the Ombudsman within 28 days, setting out steps he has taken to satisfy himself that the Director of Northumberland has taken sufficient action to ensure that staff understand the need to enter a cell at night when there is a potential risk to life, in line with PSI 24/2011.

- The Director of Northumberland should ensure that the prisoner's family is informed as soon as possible after a death in custody, in line with national guidance, and that any discussions with the police about breaking the news of a death are contemporaneously recorded.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and asking anyone with relevant information to contact him. He obtained copies of relevant extracts from Mr Phillipson's prison and medical records.

17. The investigator interviewed five members of staff at Northumberland and two members of staff at Durham in October 2021. NHS England commissioned a clinical reviewer to review Mr Phillipson's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

18. We informed HM Coroner for Northumberland North of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The Ombudsman's family liaison officer contacted Mr Phillipson's partner to explain the investigation and to ask if she had any matters she wanted us to consider. She asked whether Mr Phillipson should have been identified as at risk of suicide, whether his mental health was assessed and what happened on the night of his death.

20. We shared the initial report with Mr Phillipson's partner and mother. Mr Phillipson's mother asked some additional questions which we have addressed in separate correspondence.

21. We also shared the initial report with HM Prison and Probation Service. They provided some additional information and we have amended this report accordingly.

Background Information

HMP Northumberland

22. HMP Northumberland is a Category C prison which holds up to 1,368 men. Sodexo Justice Services manages the prison and Spectrum provides healthcare services. Healthcare staff are on duty until 7.30pm from Monday to Thursday and until 6.00pm from Friday to Sunday.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Northumberland was in September 2020. Inspectors reported that recorded self-harm had reduced in the last year, although there was evidence that it was beginning to increase again. They found that mental health services were responsive to needs. Inspectors also reported that some prisoners on Reverse Cohort Units were not provided with enough time out of their cells.

Independent Monitoring Board

24. 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 2020, the IMB reported that there had been a steady and sustainable decline in self-harm during the reporting year.

Previous deaths at HMP Northumberland

25. Mr Phillipson is the seventh prisoner to die at Northumberland since August 2019, and the third man to take his own life. Our investigation into the death of a prisoner in December 2019 found that there was a delay before staff opened the cell when they found the man hanged. This is an issue that we have highlighted previously at Northumberland and, as a result, we recommended that the Head of Custodial Contracts satisfy himself that the Director had taken sufficient action to ensure that staff understand the need to enter a cell at night when there is a potential risk to life.

Assessment, Care in Custody and Teamwork

26. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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.

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

Reverse cohort units

28. During the COVID-19 pandemic, HMPPS took steps to help prisons to manage the threat of large numbers of prisoners and staff becoming infected and to reduce the likelihood of the infection spreading throughout the prison system. All prisons were required to establish designated areas for specific groups of prisoners. One of these areas, known as a Reverse Cohort Unit, provided for the temporary separation of newly arrived prisoners for up to 14 days to allow the prison to be sure that the individual did not have symptoms of COVID-19.

29. During their 14-day 'reverse cohorting' period, prisoners must receive a minimum of 30 minutes time in the open air every day, have access to a telephone, and access to a shower at least once a week. At the end of the reverse cohorting period, prisoners who are not symptomatic are allowed to mix with the general population.

Key Events

30. Mr Jack Phillipson was convicted of a number of offences from 2013 onwards and served several short prison sentences. As a child, he was diagnosed with attention deficit hyperactivity disorder (ADHD) for which he was prescribed medication for several years. As an adult, Mr Phillipson was diagnosed with anxiety and depression, and prescribed antidepressants. In 2015, he twice cut his arm while in prison.

31. Mr Phillipson was twice served with restraining orders to prevent contact with his mother. The most recent one, served in April 2020, expired on 19 April 2021.

HMP Durham

32. On 15 January 2021, Mr Phillipson was remanded in custody to HMP Durham, charged with arson and destroying property. On his arrival, Mr Phillipson told prison staff that he had no issues or concerns and no thoughts of suicide and self-harm. A nurse noted his mental health diagnoses and referred him to the mental health team. A prison doctor continued Mr Phillipson's community prescription of mirtazapine (an antidepressant).

33. On 24 January, Mr Phillipson made several telephone calls to his partner that prison staff monitored. (All prisoners telephone calls are recorded. Prison staff listen to some at random and others are listened to if security staff have intelligence that information about the safety of individuals or the prison might have been discussed.) They identified that Mr Phillipson spoke very aggressively to his partner and threatened to burn down her house and those of several other people. As a result, prison staff removed Mr Phillipson's partner's number from his telephone list in order to prevent contact.

34. On 4 February, Mr Phillipson's key worker recorded that he was settled on his wing and got on well with his cellmate. Mr Phillipson told her that he had not been in touch with his partner as he was waiting for her number to be cleared for his telephone list. He said that he was feeling anxious about this.

35. On 16 February, Mr Phillipson told his key worker that his partner's telephone number had been rejected and so he had not been able to speak to her. It is not recorded when or who told Mr Phillipson this.

36. On 3 March, a mental health nurse assessed Mr Phillipson. She recorded that Mr Phillipson said that he did not feel that he had any current mental health issues and that mirtazapine helped him. She recorded that he showed no symptoms of acute distress or psychosis and that he said he had no thoughts or history of self-harm. She concluded that Mr Phillipson no longer required ongoing support from the mental health team and discharged him from the service.

37. On 2 April, a mental health nurse spoke to Mr Phillipson, as he had referred himself to the mental health team. Mr Phillipson said that mirtazapine had limited effect on his anxiety and asked to be prescribed sertraline (which he had previously been prescribed in the community) instead. The nurse arranged for the change of prescription.

38. On 16 April, Mr Phillipson moved into a cell on C Wing, having moved from B Wing to A Wing shortly before. Mr Phillipson told staff on his new wing that he had been under threat on B Wing and that his issues had followed him to A Wing. In his first days on C Wing, and for his protection, Mr Phillipson lived under a separate regime to other prisoners. He later told his key worker that the threats were "due to drugs".

39. On 5 May, the key worker recorded that Mr Phillipson was now settled on C Wing and no longer lived under a separate regime.

40. On 30 May, the key worker recorded that Mr Phillipson had no problems or concerns and hoped to be released at his next court date. Mr Phillipson said that he was in contact with his partner by telephone when he had enough credit to call. It is unclear what number Mr Phillipson was using to contact his partner at the time and there is no record that she was now on his approved list of contacts.

41. On 7 June, the key worker recorded that Mr Phillipson was "stressed and anxious" before his sentencing hearing that afternoon. When she returned to check on him later, Mr Phillipson said that the hearing had been adjourned but that he had been told to expect a long sentence. Mr Phillipson said that he was "devastated" about this but was not suicidal.

42. On 18 June, Mr Phillipson asked to speak to a prison chaplain. A chaplain visited him and recorded that he said that he had not heard from his partner for four days, that he believed that the relationship had ended and that she was ignoring his calls. The chaplain told us that Mr Phillipson asked him to telephone his partner to check that she was well. He said that Mr Phillipson showed him some scratches on his arms.

43. The chaplain subsequently telephoned Mr Phillipson's partner. He told us that Mr Phillipson gave him the number to call. He told us that Mr Phillipson's partner said to tell him to call at a specified time that afternoon and that he passed this message to Mr Phillipson. The chaplain said that Mr Phillipson told him that he would "take his life" if his partner did not answer the telephone. He subsequently started ACCT procedures.

44. On 19 June, a Supervising Officer (SO) held the first ACCT case review. The ACCT document could not be found at Durham or HMP Northumberland, but the SO told us that his recollection of the assessment interview (which takes place before the first case review) was that Mr Phillipson's main issue was contact with his partner. He recorded that Mr Phillipson told him that he had made contact with his partner and that he had spoken impulsively and did not want to harm himself or end his life. He recorded that Mr Phillipson spoke of other protective factors such as his future employment plans and said that he wanted to focus on the future. He told us that Mr Phillipson said that it was a relief to have spoken to his partner. He said that his conclusion was that Mr Phillipson was at low risk of suicide and self-harm. He subsequently ended the ACCT procedures.

45. A mental health nurse also attended the case review. She recorded that there was no evidence of anxiety, low mood or mental health breakdown. She noted that Mr Phillipson did not want any further input from the mental health team. The nurse recorded that Mr Phillipson had no current mental health needs and discharged him from the service.

46. Over the following days, staff recorded that Mr Phillipson had asked several times to have his partner's telephone number added to his approved list. One officer recorded that she had contacted Mr Phillipson's partner, who said that he was not allowed to speak to her and asked that the number not be added.

47. On 23 June, the key worker recorded that Mr Phillipson was feeling anxious about not knowing what his sentence would be. He asked her to complete a referral to the mental health team, which she did that afternoon.

48. On 26 June, an SO completed an ACCT post-closure review. He recorded that Mr Phillipson had no thoughts of suicide or self-harm.

49. On 1 July, the key worker recorded that Mr Phillipson was feeling "a bit down" as he said that he had broken up with his partner. Three days later, he told another officer that his "head was in the shed" since the relationship ended.

50. On 8 July, Mr Phillipson's new key worker recorded that he was settled on the wing and appeared to get on well with other prisoners. He recorded that Mr Phillipson said that he had "no problems" coping in prison.

51. On 27 July, Mr Phillipson was sentenced to six years in prison. The key worker met him the next day and recorded that Mr Phillipson said that the sentence was longer than he expected. He recorded that Mr Phillipson said that he had no thoughts of suicide or self-harm and raised no issues or concerns.

HMP Northumberland

52. On 9 August, Mr Phillipson was transferred to Northumberland. A Prison Custody Officer (PCO) interviewed him on his arrival. She recorded that Mr Phillipson had been in the prison before and had no immediate concerns.

53. A nurse began an initial health screen. She told us that Mr Phillipson arrived near to the end of her shift and there was only time to complete a basic screen. (She said that her shift finished at 4.00pm or 4.30pm. She recorded the health screen at 4.18pm.) The reception nurse said that late arrivals were a weekly occurrence. She said that the basic screen covered immediate needs and the full screen was usually completed a few days later. The reception nurse recorded that Mr Phillipson said that he had not harmed himself in the past, had no suicidal thoughts and was not worried about being at Northumberland. She told us that Mr Phillipson's main concern was related to his chiropody needs.

54. Mr Phillipson moved into a cell on Houseblock 7 and began a period of isolation in line with national COVID-19 guidelines.

55. On 10 August, staff in the mental health team at Northumberland held a handover call for recently transferred prisoners with their counterparts at Durham. A trainee psychological wellbeing practitioner told us that Mr Phillipson was on the handover list, but it was not clear why as there was no record of a referral at Durham. She subsequently telephoned Mr Phillipson on his in-cell telephone to discuss the referral. She told us that Mr Phillipson said that he was not aware of a referral but that he struggled with anxiety. She subsequently added him to the list for a mental health assessment.

56. On 11 August, the trainee psychological wellbeing practitioner telephoned Mr Phillipson to assess him. She recorded that he spoke about his childhood diagnosis of ADHD and that he had also been diagnosed with a personality disorder. (There is no note in Mr Phillipson's medical records of this diagnosis.) The trainee psychological wellbeing practitioner recorded that Mr Phillipson said he had not previously harmed himself and that he had no current thoughts to do so. She completed anxiety and depression assessments and noted that Mr Phillipson showed moderate symptoms of both. She told us that Mr Phillipson said that he struggled with symptoms of anxiety and he said that this was worse when his cell door was open, which he related to witnessing an assault at Durham. The trainee psychological wellbeing practitioner added Mr Phillipson to the waiting list for Talking Therapies (treatments for anxiety, stress and depression which involve the patient speaking to a professional about their thoughts and feelings) and provided self-help material in the meantime.

57. On 12 August, the reception nurse completed the initial health screen. She recorded that Mr Phillipson had no suicidal thoughts. The reception nurse told us that Mr Phillipson's mood was normal and his only concern was again related to his chiropody needs.

58. On 13 August, Mr Phillipson telephoned an approved number that was listed for a friend. When we listened to this call, it was apparent that this was a false name and that the number belonged to his ex-partner. They spoke for 29 minutes. During the call, Mr Phillipson said that he was "struggling with being in jail". He repeatedly asked his ex-partner to restart the relationship, but she said that she did not want to. Mr Phillipson made a further nine unanswered calls to this number later in the day.

59. In the evening, Mr Phillipson made a short call to another number listed as a friend. This was another false name and the number belonged to his mother. Mr Phillipson told his mother that he had cut his wrist. He said that he had not told anyone about this.

60. On 14 August, Mr Phillipson made a further nine unanswered calls to another friend. He also made three calls to his mother.

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61. Mr Phillipson made seven unanswered telephone calls during the day. He also made three calls to his mother. During their last conversation at 6.02pm, Mr Phillipson's mother indicated that she had messaged his ex-partner and that she had not replied.

62. At around 8.50pm, an operational support officer (OSO) began a count of prisoners. When she arrived at Mr Phillipson's cell at 8.53pm, she spent around one minute and 25 seconds looking through the cell door observation panel. The OSO told us that she could see Mr Phillipson sitting on the heating pipe underneath the window. She said that she rattled and knocked on the door, but Mr Phillipson did not move. The OSO told us that she could not see a ligature or any other physical or visual sign that indicated a problem but that something "didn't feel right" about it.

63. The OSO went to the staff office to telephone the control room to ask for officers to attend. While waiting for them to arrive, she returned to the cell twice, again looking through the observation panel.

64. At 9.02pm, a PCO arrived on the Houseblock and went to Mr Phillipson's cell with Ms MacPhee. He spent around 35 seconds looking through the observation panel before they both left the cell door. The PCO told us that Mr Phillipson was sitting on the pipe and did not respond when he rattled the door. He therefore radioed a medical emergency code blue, indicating a life-threatening situation. The control room operator telephoned for an ambulance. (The control room recorded the emergency radio message at 9.00pm. We have quoted the times recorded in CCTV footage of Houseblock 7.)

65. The PCO told us that he did not immediately enter the cell as local protocols instruct that three officers are present before a cell is opened at night. He also said that as he could not see a ligature, he could not be certain that Mr Phillipson was not "faking" and he therefore had to consider the safety of the staff at the scene.

66. At 9.03pm, around 45 seconds after the PCO and the OSO had left the cell, two more PCOs arrived and went into the cell with the first PCO. They found Mr Phillipson hanged from a ligature, which he had made from a bedsheet and tied to the window bars. The officers cut the ligature and began cardiopulmonary resuscitation. The OSO collected a defibrillator, which advised to continue chest compressions.

67. At 9.23pm, paramedics arrived at Northumberland. At 9.48pm, they confirmed that Mr Phillipson had died.

Contact with Mr Phillipson's family

68. At around 10.45pm, the duty operational manager telephoned two numbers that the prison held for Mr Phillipson's ex-partner, his nominated next of kin. He recorded that there was no answer on either number. He told us that he left a message for Mr Phillipson's ex-partner to contact the prison.

69. At around 7.30am on 16 August, a family liaison officer (FLO) was appointed. The FLO recorded that Mr Phillipson's ex-partner was his next of kin. He noted that he was told that Northumbria Police had asked prison staff during the night not to break the news to her as she was the victim of Mr Phillipson's offence and had a restraining order against him. (We contacted local courts, none of which could identify that there was a restraining order in place, restricting contact between Mr Phillipson and his ex-partner. Mr Phillipson's prison offender manager also told us that there was no restraining order.) The duty operational manager initially told us that, as the duty operational manager, he briefed the Criminal Investigation Department and uniformed police who attended Northumberland during the night and could not recall them making this request. He later said that the police told him that Mr Phillipson's ex-partner was the victim of his offence and had a 'not to contact' marker and that they would therefore contact his mother. He said that, at 1.19am, the police said that they had visited Mr Phillipson's mother's address but received no response.

70. The FLO recorded that the police had said that they would contact Mr Phillipson's mother, but it was unclear whether they had done so yet.

71. At around 10.00am, Mr Phillipson's ex-partner telephoned Northumberland and spoke to the duty operational manager, who told her that Mr Phillipson had died. The FLO telephoned Mr Phillipson's ex-partner afterwards and, in the early afternoon, spoke to his mother by telephone about the circumstances of Mr Phillipson's death.

Support for prisoners and staff

72. After Mr Phillipson's death, an operational 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.

Post-mortem report

73. A post-mortem examination established that Mr Phillipson died from pressure on the neck caused by hanging. The post-mortem did not identify an injury on Mr Phillipson's wrist.

Findings

Identifying the risk of suicide and self-harm

HMP Northumberland

74. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Northumberland should have recognised Mr Phillipson as at risk and begun ACCT procedures to support him.

75. Mr Phillipson had some risk factors for suicide and self-harm. He had previously harmed himself in prison and had been monitored under ACCT procedures, albeit briefly. He was prescribed antidepressants and had been assessed for anxiety. Mr Phillipson had recently received a longer sentence than he had expected and longer than he had previously served. He was in his first days in a new prison following transfer and was isolating in line with COVID-19 protocols. Significantly, in the days before his death, Mr Phillipson had a difficult conversation with his ex-partner, although this was not known to prison staff at the time.

76. While Mr Phillipson had these risk factors, we are satisfied that there was little to indicate to staff that he was at immediate risk of suicide or self-harm at the time of his death.

77. However, we are concerned that there is no record that anyone from Houseblock 7 spoke to Mr Phillipson at any time following his transfer to see how he was settling in or whether he had any concerns. The Deputy Head of Residence told us that prisoners are allocated a key worker when their period of COVID-19 isolation ends, after which they receive either a weekly or fortnightly check depending on whether they are identified as 'high-risk'. He said that prisoners in isolation on a Reverse Cohort Unit should receive an introductory visit from an isolation officer. There is no record that this happened for Mr Phillipson.

78. While we appreciate the pressures that prisons are under, we consider it vital that prisoners have the opportunity to speak to staff on a one-to-one basis through key work or wellbeing checks. This is particularly important in the first days in a new prison or when a prisoner is in COVID-19 isolation. A meaningful one-to-one session might, for example, have identified that Mr Phillipson was having difficulties in his relationship. We make the following recommendation:

    The Director of Northumberland should ensure that staff have meaningful contact with prisoners on the Reverse Cohort Unit.

HMP Durham

79. The chaplain appropriately started ACCT procedures when Mr Phillipson told him he would "take his life" if he did not speak to his partner by telephone.

80. Guidance in the ACCT document says that staff can end ACCT procedures at the first case review if the case review team believe it is safe to do so and if all issues identified in the assessment interview are resolved. Mr Phillipson's ACCT document has been lost so we do not know exactly what issues were recorded at the assessment, but it is apparent that contacting his partner was Mr Phillipson's main concern. As he had since spoken to his partner, and also spoke of other protective factors, it might have been reasonable to end the ACCT procedures at the time.

81. However, we are concerned by the events of the following week, when Mr Phillipson asked several times for his partner's number to be added to his approved list. His partner was contacted and said that he was not permitted to call her. No one identified that this meant that Mr Phillipson's earlier calls to his partner either did not happen or, as seems more likely, were via illicit means. More significantly, no one identified how closely these events related to the reason for starting ACCT procedures or considered their potential impact on Mr Phillipson's risk of suicide and self-harm. There was also no recorded discussion of the events at the ACCT post-closure review. We make the following recommendation:

The Governor of Durham should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- **All relevant information about risk is recorded, shared and considered, and ACCT procedures are started when indicated.**
- **Post-closure reviews consider all new information about risk, and re-start ACCT procedures when indicated.**

Clinical care

82. National Institute for Health and Care Excellence (NICE) guidelines (NG57) instruct that continuity of care should be ensured for people transferring between prisons by, for example, accessing relevant information from the patient clinical record. When a prisoner arrives at a new prison, a full health assessment should be carried out and NICE guidelines identify questions that should be put to all new arrivals.

83. On arrival at Northumberland, Mr Philipson received a basic health screen, which was completed three days later. The reception nurse told us that prisoners often arrived too late for her to complete the screening. We note that the nurse finishes work at 4.30pm and that the healthcare department's opening hours are until 7.30pm from Monday to Thursday. (Mr Phillipson arrived at Northumberland on a Monday.)

84. We appreciate that healthcare staff cannot control the time that prisoners arrive at Northumberland, but it is important that they complete the full health screen on the first day, if possible. When this is not possible, the screen should be completed at the earliest opportunity and preferably on the day after arrival. We make the following recommendation:

The Head of Healthcare at Northumberland should ensure that the reception health screen is completed on arrival for all prisoners or at the earliest

opportunity afterwards for those prisoners who arrive very close to or after the healthcare unit closes.

Emergency response

85. PSI 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer manager and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

86. When she first went to Mr Phillipson's cell, the OSO told us that he did not respond when she rattled and knocked on the door and that something "didn't feel right". She went to the staff office to telephone for assistance, although it would have been quicker to use her radio.

87. Both the OSO and the PCO told us that Mr Phillipson was sitting on the heating pipe and did not respond when they tried to rouse him. The PCO said that he did not open the cell immediately as there were less than three officers present and, as he could not see a ligature, he could not be certain that there was a genuine emergency. We recognise that it can be difficult for staff in such situations to make instant decisions but when there is a potentially life-threatening situation, it is essential to act quickly. The PCO was sufficiently concerned to radio a code blue medical emergency, and, in these circumstances, we would normally expect prison staff to go into a cell as soon as possible, in case there is a chance of saving someone's life.

88. We have previously expressed concerns about delays to entering cells in an emergency at Northumberland. In a report issued in July 2019, we asked the Director to ensure that staff prioritise the potential or actual threat to the safety or life of prisoners. Although the Director accepted our recommendation, we found in a later investigation that the issue remained. As a result, in June 2020, we recommended that the Head of Custodial Contracts for HMPPS satisfy himself that the Director had taken sufficient action to ensure that staff understand the need to enter a cell at night when there is a potential risk to life. Despite issuing this recommendation over a year ago, we have yet to receive a final response. We make the following recommendation:

The Head of Custodial Contracts for HMPPS should write to the Ombudsman within 28 days setting out steps he has taken to satisfy himself that the Director of Northumberland has taken sufficient action to ensure that staff understand the need to enter a cell at night when there is a potential risk to life, in line with PSI 24/2011.

Family liaison

89. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner dies. PSI 64/2011 gives a mandatory instruction that, wherever possible, this must be done in person by a family liaison officer and another member of staff. During the COVID-19 pandemic, prisons have been permitted to break the news of a death by telephone rather than in person to reduce the risk of transmitting the virus.

90. Around an hour after Mr Phillipson died, the duty operational manager telephoned Mr Phillipson's ex-partner, his nominated next of kin. As she did not answer, he left a message asking her to contact the prison. No further attempt was made to contact her that night.

91. The duty operational manager initially told us that he could not recall a conversation with the police about breaking the news of Mr Phillipson's death. He later remembered that the police asked prison staff not to contact Mr Phillipson's ex-partner and that they would contact his mother. This was seemingly unsuccessful, with no evidence of any further attempt made. We note that there is no contemporaneous record of any such request. It was not until later that morning, over 12 hours after he died, that Mr Phillipson's next of kin was told of his death.

92. We appreciate that contacting the next of kin of a deceased prisoner can be difficult when a death occurs late at night, and prison staff might not always successfully make contact on their first attempt. However, we would usually expect staff to make several attempts to contact the next of kin during the night. We make the following recommendation:

    The Director of Northumberland should ensure that that the prisoner's family is informed as soon as possible after a death in custody, in line with national guidance, and that any discussions with the police about breaking the news of a death are contemporaneously recorded.

Inquest

93. The inquest into Mr Phillipson's death concluded on 23 February 2023, and concluded that he died of misadventure.

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