

**Prisons &
Probation**

Ombudsman
Independent Investigations

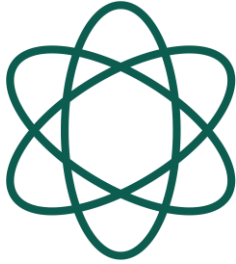
Independent investigation into the death of Mr Justin McLelland, a prisoner at HMP Northumberland, on 15 October 2021

A report by the Prisons and Probation Ombudsman



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

OGL

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

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 Justin McLelland was found hanged in his cell at HMP Northumberland on 15 October 2021. He was 29 years old. I offer my condolences to his family and friends.

Mr McLelland had spent six months at Northumberland before he took his life. He was being treated for depression and was prescribed medication but declined to take part in cognitive therapy to support his mental health. However, Mr McLelland generally sought minimal support from staff and there were no clear signs to indicate to staff that he intended to take his life.

I am satisfied that prison staff could not reasonably have prevented Mr McLelland's death. I make no recommendations.

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

June 2022

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Summary

Events

1. On 17 March 2021, Mr Justin McLelland was recalled and remanded to HMP Durham. On 14 April, he was convicted and sentenced to two years and two months in prison for assault, criminal damage and breaching a restraining order.
2. On 21 April, Mr McLelland was transferred to HMP Northumberland. He had depression, arthritis and perthes disease (a rare childhood disorder which causes the deterioration of the hip joint). While the mental health team identified that Mr McLelland would benefit from low intensity cognitive behavioural therapy, he declined to engage with the treatment offered.
3. During his six months at Northumberland, Mr McLelland's key worker met with him regularly but raised no concerns about his wellbeing.
4. On the morning of 15 October, a prison custody officer checked on Mr McLelland during the roll check and found him hanged in his cell. A medical emergency code blue was radioed promptly, and staff went into Mr McLelland's cell and cut the ligature from around his neck. Mr McLelland showed no signs of life and rigor mortis was present. Paramedics arrived soon after and pronounced that he had died.

Findings

5. Prison and healthcare staff appropriately reviewed Mr McLelland's risk information and assessed his risk of suicide and self-harm at Northumberland. We do not consider that they could reasonably have prevented his death.
6. The clinical reviewer concluded that the clinical care that Mr McLelland received at Northumberland was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community.

The Investigation Process

7. 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.
8. The investigator obtained copies of relevant extracts from Mr McLelland's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr McLelland's clinical care at the prison. They jointly interviewed five members of prison staff by telephone due to the COVID-19 restrictions. The investigator also interviewed a prisoner.
10. We informed HM Coroner for Northumberland of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.
11. One of the Ombudsman's family liaison officers contacted Mr McLelland's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She asked whether Mr McLelland was being monitored under suicide and self-harm procedures and what mental health support he received. We have covered these issues in this report.
12. Mr McLelland's mother received a copy of the initial report. She did not make any comments.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). They identified two factual inaccuracies in the report, which have been amended.

Background Information

HMP Northumberland

14. HMP Northumberland is a Category C prison which holds up to 1,368 prisoners. Sodexo Justice Services manage the prison and Spectrum provides healthcare services. Healthcare staff are on duty from 7.30am to 7.30pm from Monday to Thursday and from 7.30am to 6.00pm on Fridays. At weekends and on Bank Holidays, healthcare staff are on duty from 8.00am to 6.00pm. Spectrum provide an out-of-hours doctor advice and support service at other times. Tees, Esk and Wear Valley Mental Health NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

15. The last full inspection of HMP Northumberland was in August 2017. Inspectors found that mental health provision was effective but the management of prisoners monitored under suicide and self-harm prevention procedures, known as ACCT, was weak, reviews were poorly attended and caremaps were incomplete. They found that handover arrangements were also poor and the required observations did not always take place. Access to Listeners (prisoners trained by the Samaritans to provide support to other prisoners) was inadequate, although it was better for prisoners on the Vulnerable Prisoners' Unit.
16. Inspectors carried out a scrutiny visit at Northumberland in September 2020 to review the treatment of prisoners during the COVID-19 pandemic. In its survey, 60% of those who had been monitored under ACCT procedures reported feeling cared for by staff. Inspectors reported that from their review of ACCT documentation, initial assessments were generally good, and case reviews were mostly multidisciplinary, with input from the mental health team. Inspectors reported that mental health services were responsive and provided face-to-face support, including access to psychological therapies. They found that the team attended all initial ACCT reviews and prisoners had direct access to them, using their in-cell telephones.

Independent Monitoring Board

17. 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 31 December 2020, the IMB reported that in most cases, prisoners' health and wellbeing needs were being met. It noted that the inevitability of restrictions had meant a significant reduction in opportunities for prisoners to engage in education, work and appropriate training and meant opportunities were extremely limited, if available at all.

Previous deaths at HMP Northumberland

18. Mr McLelland was the fourth prisoner to take his life at Northumberland since October 2019. There are no similarities between our findings in this report and those of the previous deaths.

Key Events

19. On 17 March 2021, Mr Justin McLelland was recalled to HMP Durham because he had breached a restraining order against his ex-partner and had been charged with assault and criminal damage. It was not his first time in prison. He had last been released from prison in July 2020.
20. Mr McLelland had depression, arthritis and perthes disease which resulted in joint pain. He also had a history of alcohol and cannabis misuse.
21. After his reception screen, Mr McLelland was referred to the mental health team and the prison GP continued to prescribe him mirtazapine (an antidepressant) and pain relief medication. Mr McLelland told staff that he had no thoughts of suicide or self-harm. He said that he had tried to hang himself a number of years earlier but regretted his actions. He denied substance misuse issues and declined substance misuse support.
22. Mr McLelland had a harassment order in place not to contact his ex-partner, and staff explained the public protection rules that applied to him. He told staff that he was fully aware of its requirements and had the support of his family and friends.
23. On 5 April, a mental health nurse assessed Mr McLelland and noted his history of attempted suicide and depression. The nurse noted that Mr McLelland engaged well. He said that he had poor emotional regulation. He said that he was concerned about his partner and children but was able to see his children. He denied thoughts of self-harm. The nurse referred Mr McLelland to the primary care mental health team and added him to a waiting list for psychoeducational sessions to manage his stress.
24. On 14 April, Mr McLelland was convicted and sentenced to two years and two months in prison. He told staff that he was not happy about his sentence but that he was okay.
25. On 21 April, a nurse from Durham telephoned a psychological wellbeing practitioner in the mental health team at HMP Northumberland, to tell him that Mr McLelland was due to be transferred to Northumberland that day and to brief him about Mr McLelland's medical records so that Northumberland could plan for his arrival. (The psychological wellbeing practitioner no longer works at Northumberland.)
26. A nurse examined Mr McLelland before he left Durham but noted no concerns. Mr McLelland was transferred to HMP Northumberland shortly afterwards.

HMP Northumberland

27. When Mr McLelland arrived at Northumberland on 21 April, staff completed his reception screen. He told staff that he had last been released from Northumberland in July 2020.

28. The psychological wellbeing practitioner noted that Mr McLelland had been added to the waiting list for cognitive behavioural therapy (the first line psychological treatment offered for anxiety and depression).
29. The next day, a nurse completed Mr McLelland's secondary health screen. Mr McLelland said that he had a history of substance misuse (alcohol and drugs) but declined support. He talked about his hip pain resulting from perthes disease and surgery, for which he took pain relief medication. The nurse noted that Mr McLelland denied thoughts of suicide or self-harm but referred him to the mental health team.
30. The prison GP continued Mr McLelland's prescription of mirtazapine and codeine.
31. On 29 April, a PCO completed a key work session with Mr McLelland. He raised no concerns. She noted that Mr McLelland had settled on the wing, engaged positively with staff and had no thoughts of suicide or self-harm.
32. On 5 May, Mr McLelland moved to Houseblock 9.
33. On 13 May, a Prison Custody Officer (PCO) saw Mr McLelland and introduced herself as his new key worker. Mr McLelland said that he felt settled and safe on his new wing and had no thoughts of suicide or self-harm. The PCO had known Mr McLelland from a previous prison sentence. She noted that he had asked for a telephone PIN phone application form as he had not yet had his phone numbers approved.
34. On 19 May, a prison GP noted in Mr McLelland's medical record that he was concerned about his ongoing codeine prescriptions. The prison GP emailed the hospital's orthopaedic service to ask for further information so that he could consider whether an alternative pain relief medication was appropriate. (Mr McLelland remained on codeine and doctors decided not to change his medication.)
35. On 7 June, a trainee nurse wrote to Mr McLelland about his cognitive behavioural therapy. She noted the delay in him starting treatment due to a long waiting list. She gave Mr McLelland information about other forms of support.
36. An entry in Mr McLelland's medical records on 9 June noted that he would be issued his weekly medication to keep and administer himself.
37. On 17 June, a PCO completed a key work session with Mr McLelland. She recorded that he was polite and kept his cell clean. Mr McLelland said that he felt safe on the wing and had no thoughts of suicide or self-harm. He talked about his sentence and release date.
38. On 18 and 23 June, a senior psychological wellbeing practitioner, tried to review him by phone. On 18 June, Mr McLelland did not want to engage with her and told her that he was about to leave his cell to mix with the other prisoners. On 23 June, the call was disconnected after ringing.

39. On 19 July, the psychological wellbeing practitioner saw Mr McLelland and completed a detailed assessment. He identified Mr McLelland's historic self-harm attempts but noted that he had no thoughts of self-harm. Mr McLelland was concerned that he had a limited number of telephone numbers on his PIN account, complained that he was unable to concentrate and lacked motivation to exercise or attend to his personal care. The psychological wellbeing practitioner completed a Generalised Anxiety Disorder scale (GAD-7) assessment and Patient Health Questionnaire (PHQ-9), both of which are standard assessment tools. Mr McLelland's scores indicated moderate/severe depression and anxiety. He noted that this was consistent with Mr McLelland's presentation. He made an appointment for Mr McLelland to start cognitive behavioural therapy on 2 August.
40. Prison records indicate that on 26 July, Mr McLelland tried to make a phone call from his in-cell PIN phone. The telephone number he dialled was not on his permitted list, and the call did not connect.
41. On 30 July, a PCO tried to conduct a key work session with Mr McLelland but he did not want to engage with him.
42. On 2 August, the psychological wellbeing practitioner went to Houseblock 9 to collect Mr McLelland for his cognitive behavioural therapy. Mr McLelland told wing staff that he could not be bothered to attend. The psychological wellbeing practitioner rebooked the session for 9 August.
43. On 6 August, the psychological wellbeing practitioner discussed Mr McLelland's care, GAD-7 and PHQ-9 results and self-harm history with a senior psychological wellbeing practitioner.
44. When the psychological wellbeing practitioner tried to see Mr McLelland on 9 August, he again refused to participate. McLelland told wing staff to tell the psychological wellbeing practitioner that he wanted to be discharged from the service.
45. A mental health multidisciplinary team meeting took place on 10 August, and clinicians discussed Mr McLelland's decision not to engage with the services proposed. The team (which included mental health nurses, psychiatrists, psychology and support workers), agreed to discharge Mr McLelland from the mental health team's caseload, in line with his request. This decision was confirmed during the psychological wellbeing practitioner's supervision meeting with his senior psychological wellbeing practitioner on 13 August.
46. On 20 August, a PCO completed a key work session with Mr McLelland. The only question Mr McLelland raised was why his PIN phone numbers had not been added to his account. The PCO said that she would look into this. Mr McLelland had asked for a number of telephone numbers to be added to his PIN account, but the security team had not authorised them.
47. On 23 August, a PCO phoned Mr McLelland in his cell and completed an education/work assessment. Mr McLelland said that his work history included joinery, bricklaying, plastering and fabricating. He said that he was unsure what he wanted to do when released from prison but was keen to complete courses in

- prison. On 31 August, Mr McLelland asked at the wing kiosk why he had still not been allocated a job. The PCO reminded him that he had had been placed on the waiting list and would be informed once a space became available.
48. At a key work session on 14 September, Mr McLelland said that he felt safe and had no thoughts of self-harm. He was still waiting to be allocated a job. A PCO told Mr McLelland to consider working in the paints or engineers' workshops and noted that this would help to get Mr McLelland out of his cell, where he tended to spend most of his time. She offered to put his name forward for these workshops. Mr McLelland said he would think about it and let her know.
 49. On 27 September, Mr McLelland again asked prison staff why he had still not been allocated a job. A PCO reminded him that he was on the waiting list and would be contacted once a space became available. She directed him to the wing kiosk to consider other job options.
 50. A PCO noted that on 5 October, when she unlocked Mr McLelland to collect his evening meal, he tried to get into the servery which was not allowed. The PCO explained this to Mr McLelland who responded that he did not "give a fuck". He proceeded to use the microwave in the servery and was told to remove his food as he was not allowed to use it. Mr McLelland retreated and called the PCO a "bitch". She noted his negative behaviour in his prison records.
 51. The next day, Mr McLelland was allocated a space on a woodwork course.
 52. On 8 October, the security intelligence team noted that money had been sent into the prison for Mr McLelland. A compliance check deemed that this appeared to be a suspicious activity and the payment was rejected. The intelligence noted that the payment had come from the mother of another prisoner.
 53. At his key worker session on 9 October, Mr McLelland told a PCO that nothing had changed since their last meeting. He had no issues, felt safe on the wing and had been allocated a course so he was likely to get a job through this.
 54. The investigator was not able to listen to PIN phone data as it was unusable. However, prison records on 10 October indicate that Mr McLelland made one phone call to a male friend and two phone calls to his mother. (The prison reported that they had listened to these calls after Mr McLelland's death and the contents contained no issues of concern.)
 55. On the morning of 14 October, when unlocking Mr McLelland's cell, a PCO noticed that he had smashed his television. Mr McLelland was in bed and the television lay on the cell floor in multiple parts. When the PCO asked Mr McLelland what happened and why the television was broken, he replied "Nothing" and pulled the blanket over his head. The PCO submitted an intelligence report. Staff reported no further concerns about Mr McLelland that day.
 56. A Night Operational Support Officer (NOSO) completed the wing roll check at 7.45pm. He looked through each prisoner's cell door observation panel. The NOSO told us that he had no concerns about Mr McLelland when he checked on

him. During the night, the NOSO and a PCO patrolled the wing landings intermittently. Both told us that they heard nothing when they passed Mr McLelland's cell.

15 October

57. At around 5.35am, the PCO and the NOSO started the morning roll check on Houseblock 9. The PCO used a torch to shine through the cell door observation panels to check on prisoners. He said that when he arrived at Mr McLelland's cell, he saw him hanging from a ligature, made from a bed sheet, wedged between the cell window frame at the back of the cell. He shouted to the NOSO and radioed a medical emergency code blue (used when a prisoner is unconscious or having difficulty breathing). The control room log recorded that this was at 5.40am. Staff in the control room called an ambulance and the prison healthcare team immediately.
58. As he was only across the landing from Mr McLelland's cell, the NOSO arrived in seconds. He broke his sealed key pouch, unlocked the cell door and entered the cell, followed by the PCO. The PCO cut the ligature, and with the NOSO, placed Mr McLelland on the bed and checked him for signs of life. The PCO said that it was immediately obvious that rigor mortis (stiffening of the body after death) was present. The NOSO confirmed that Mr McLelland had no pulse, was extremely pale, blood was pooling in his legs and he was cold and stiff. The NOSO said that Mr McLelland's body did not bend when he was placed on his bed and they were unable to place him in the recovery position. They agreed that it was not appropriate to resuscitate him.
59. A Senior Prison Custody Officer (SPCO) arrived at Mr McLelland's cell within five minutes of the emergency code being radioed. He checked Mr McLelland, found no signs of life and confirmed the presence of rigor mortis. No healthcare staff are available at Northumberland overnight and no prison healthcare staff were therefore involved in the emergency response. At 6.00am, ambulance paramedic staff arrived, agreed with the PCO and the NOSO's assessment and pronounced Mr McLelland's death at 6.15am.

Post-mortem report

60. The post-mortem examination established that Mr McLelland had died from hanging. No illicit substances were detected in his body.

Contact with Mr McLelland's family

61. Mr McLelland's mother was identified as his next of kin. A PCO was appointed as the prison's family liaison officer (FLO). Due to the COVID-19 restrictions, The FLO spoke to Mr McLelland's mother at 8.30am am and offered her condolences and support. Northumberland offered to contribute to the cost of Mr McLelland's funeral in line with national instructions.

Support for prisoners and staff

62. After Mr McLelland's death, a prison manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
63. The prison posted notices informing other prisoners of Mr McLelland's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr McLelland's death.

Findings

Identifying risk of suicide and self-harm

64. Prison Service Instruction (PSI) 64/2011 on safer custody sets out the procedures (known as ACCT) that should be followed when a prisoner is identified as at risk of suicide and self-harm.
65. Mr McLelland had a number of risk factors for suicide and self-harm: he had been recalled to prison after eight months, he had a history of depression and physical pain, a history of substance misuse and he had tried to take his life a number of years earlier. With the benefit of hindsight, there were a few indications that Mr McLelland might have been struggling in prison. He was not happy about the length of time it took for him to get a job, there were a couple of instances of poor behaviour (including being rude to prison staff and smashing his television), he was not consistent in engaging with the mental health team, he declined cognitive behavioural therapy (despite being identified as having moderate to severe depression) and the prison was subject to COVID-19 restrictions, with a limited regime in place and reduced time out of cell.
66. However, it was not the first time that he had been in prison or recalled to custody, he had no known recent history of self-harm, he consistently denied thoughts of suicide or self-harm and said that he felt safe, he was prescribed antidepressants to manage his depression, he had regular key work (despite the COVID-19 restrictions), he gave staff no indication that he was distressed, at imminent risk of suicide or that he was in debt or feared for his safety.
67. The day before Mr McLelland took his life, he had smashed his television but did not tell staff why he had done this. With hindsight and while we note that an intelligence report was submitted about this incident, this might have been an indication that he was at risk of suicide or self-harm and might have been a missed opportunity to identify that he was struggling to cope. However, in the absence of any other signs or evidence that he had thoughts of suicide or self-harm, prison staff could not reasonably have known that Mr McLelland was at imminent risk of suicide or prevented his death.

Clinical care

68. The clinical reviewer concluded that overall, the healthcare that Mr McLelland received at Northumberland was of a reasonable standard and was equivalent to that which he could have expected to receive in the wider community.
69. When Mr McLelland was discovered hanged in his cell, the emergency response from staff was immediate and swift. Rigor mortis was present, and staff appropriately decided not to start CPR.
70. While Mr McLelland had a history of substance misuse, there was no evidence that he misused illicit substances in custody, and he declined substance misuse support.

Mental health

71. Mr McLelland had had depression for several years and had been prescribed antidepressants. When he arrived at Durham and subsequently Northumberland, he was offered cognitive behavioural therapy.
72. Although the mental health team was generally responsive to Mr McLelland's mental health needs, he failed to engage consistently with their services. The clinical reviewer noted that cognitive behavioural therapy used in combination with antidepressants might have been effective in treating depression. While we note that a prison GP was concerned about Mr McLelland's continued use of codeine (which is linked to depression), they decided not to change his pain relief medication. The clinical reviewer considered that overall, mental health services responded appropriately to Mr McLelland's identified needs.

Inquest

73. The inquest into Mr McLelland's death was held in March 2023. The conclusion was that Mr McLelland's death was due to suicide

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