

Trust Headquarters  
West Park Hospital,  
Edward Pease Way,  
Darlington  
DL2 2TS

Dear HM Coroner,

**Re: REGULATION 28 REPORT TO PREVENT FUTURE DEATHS REPORT regarding HMP Northumberland following the Inquest into the death of Allan Waddup**

Following a review of the Regulation 28 Report 19<sup>th</sup> August 2022, we have reviewed the matters of concern to HM Coroner and wish to share the following feedback and actions.

Concern 1

*(1) Mr Waddup was referred to mental health team at HMP Durham on 29th October 2019 and triaged within 24 hours on 30<sup>th</sup> October 2019. Attempts were made to assess Mr Waddup in his cell by telephone on 14, 19 and 21 November 2019. It is not clear if Mr Waddup personally knew of the appointments. Appointment letters are not currently sent to inmates at HMP Northumberland to notify them of planned appointments. Prisoners could be notified on the day via the scheduling process within the prison whereby the wing is notified of who has appointments with various departments. I heard that TEWV provide mental health services across the North East cluster of prisons four prisons in the North West. In some custodial facilities an appointment letter is sent. This system is not replicated in HMP Northumberland.*

Appointment letter templates have been reviewed and updated and have now been introduced across all prison establishments, including HMP Northumberland where TEWV provide Mental Health care delivery. As part of this process of review, the letter content has been reviewed to ensure its content is succinct and clear, dated and provides the relevant information.

The Transfer of care telephone handover call has been audited between HMP Durham and HMP Northumberland to ensure patients are handed over in a timely manner. Audit results show this process is effective and patients are handed over within the required contractual timeframe of 24 hours or, the next working day if the transfer takes place at the weekend. Any urgent transfer information is handed over on the day of the expected transfer.

The standard process has been reviewed and updated to ensure all staff are clear regarding responsibilities of transferring patient care. The templates the sending and receiving clinicians fill out, to complete the handover, have been updated to improve

consistency and robust information sharing processes. Staff have received support in completing the documents to ensure full awareness.

In order to ensure compliance with the required contractual timeframe for carrying out assessments (4 working days if a non-urgent appointment), we have carried out an audit of this process in HMP Northumberland and can confirm that the audit result demonstrated 100% of offered assessments are undertaken within the 4 working days.

### Concern 2

*(2) Mr Waddup was referred to mental health on 30 October 2019. Attempts were made to assess him in his cell over the telephone on 14, 19 and 21 November 2019. He was discharged from mental health on 2 December without an assessment being undertaken. There was no in person contact to explore the reasons he did not attend those appointments prior to discharge. It could not be confirmed he was personally aware of those appointments. He self-referred on 5 December 2019 and was not triaged within 24 hours or assessed prior to his death. An immediate review of the Did Not Attend (DNA) policy for the mental health services to include an in person contact is being undertaken prior to discharge but has not been completed.*

Following the inquest, an immediate lessons learned bulletin was shared with all staff working across the service within the Trust, advising at the point of discharge, appointments must take place face to face. A service level meeting was also convened to share the information and requirements with Team Managers, to ensure information was filtered down to all staff. The Operational Policy for the service has been updated to reflect the updated discharge process and a request has been made to ensure upon review (in January 2023) this is also reflected in the trust wide discharge policy.

### Concern 3

*(3) Mr Waddup self-referred via the kiosk system. There is no triaging of referrals on a weekend. A disclaimer warning directing inmates how to seek urgent assistance is not currently displayed on the kiosk.*

The prison service provider at HMP Northumberland has granted the request to remove the ability to refer to mental health services via kiosk. Due to the restrictions on the prison kiosk system, men are unable to give any detailed rationale for the appointment request making triage processes difficult for the team upon receipt of the request. A request has been made to the prison provider at HMP Northumberland as to whether an electronic referral can be uploaded to the kiosk system, as well as a notification advising patients of timeframes for referrals to be processed and who to contact, and how, in an urgent situation.

In the interim, posters have been produced and displayed on the wings providing clear information to all prisoners about how to refer to the mental health team using a self-referral, or by speaking to any member of staff. Posters include what to do in urgent or crisis situations, specifically in relation to risk to self.

Self-referrals, including easy read versions, are available to all men on wing locations. The referral asks specific questions which allow the team to triage the referral appropriately in relation to service required, as well as urgency.

This is consistent with all other services within the NE cluster of prisons.

Yours sincerely

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Executive Director of Nursing and Governance