ANDREW HETHERINGTON
H M Senior Coroner for North Northumberland and
Acting Senior Coroner for South Northumberland

County Hall, Morpeth, Northumberland NE61 2EF

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Tees, Esk and Wear Valley, c/o Ward Hadaway LLP
1	**CORONER** I am Andrew Hetherington, Senior Coroner for North Northumberland and Acting Senior Coroner for South Northumberland.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 16 December 2019 I commenced an investigation into the death of Allan Michael WADDUP. The investigation concluded at the end of the inquest . The conclusion of the inquest was Suicide 1a Pressure on the Neck 1b Hanging 1c
4	**CIRCUMSTANCES OF THE DEATH** The inquest heard that in the North East cluster of prisons Tees Esk & Wear Valleys NHS Foundation Trust (TEWV) are subcontracted to provide secondary mental health services who in turn subcontract primary mental healthcare services to RETHINK. It was heard that once a referral is received into the mental health team those referrals are triaged within 24 hours. Further that based on contractual obligations, referrals must be triaged within 24 hours of receipt. The triage is undertaken by a qualified mental health or learning disability nurse. The outcome of the triage is that when assessment is deemed to be required the patient is referred to primary care (Rethink) or secondary care (TEWV). I heard

	that a routine assessment should be offered within 4 working days after triage. I did not hear any evidence that would suggest Mr Waddup's assessment was deemed to be urgent. I heard that an urgent referral would take place urgently and within 24 hours with the inmate being kept safe. Mr Waddup was referred to the mental health team at HMP Durham on 29th October 2019 following his recall to prison. His needs were identified as anxiety and depression. He was triaged by a mental health nurse on Thursday 30th October 2019 and was sent to RETHINK for assessment. An assessment should have been offered within 4 working days i.e. before Wednesday 6 November 2019. On 1st November 2019 Mr Waddup was transferred to HMP Northumberland On 4 November 2019 a HMP Durham a psychological well-being practitioner noted the triage had been received by RETHINK but the patient had been transferred. On 12th November 2019 a telephone call handover was provided from primary care in HMP Durham to primary care in HMP Northumberland. This was 13 days/7 working days after triage. I heard the delay in assessment was due to the absence of a staff member. On 14th, 19th and 21st November 2019 attempts were made to assess Mr Waddup in his cell by telephone. The system in place in 2019 was that the day before the appointment the wing are notified that an inmate has an appointment with healthcare. It is unclear as to whether Mr Waddup would have been personally aware of the appointment. He worked and would have left the wing at specific times. On 21st November 2019 on opt in letter and discharge letter was issued via internal post by RETHINK. The letter requested he make contact by 29 November 2019 other wise it was assumed he longer required input from the service. After three to four attempts to assess Mr Waddup via in cell telephone, he was not contacted in person. Mr Waddup was discharged without having been assessed on 2 December 2019. A letter was provided during the course of the inquest. The discharge letter was undated On 5th December 2019 Mr Waddup self referred via the prison kiosk system saying "I need to see someone from mental health as my head is gone and I'm really down and in a bad place right now pls asap". 5th December 2019 is a Thursday and the time that Mr Waddup made that referral is not clear. The referral was received by the prison administration team and added to the mental health teams triage waiting list on 9th December 2019 at 09.54 hours. The referral was triaged by a mental health nurse and by a RETHINK colleague on 12 December 2019, 7 days after Mr Waddup self-referred himself to mental health services. The mental health team do not triage cases on a Saturday and mental health services are not contracted to provide mental health services at weekends at HMP Northumberland. On 12 December 2019 a triage form was completed with the decision that the primary care (RETHINK) should attempt to re-engage with Mr Waddup. Mr Waddup was not assessed by primary mental healthcare prior to his death on 13 December 2019. Mr Waddup had a telephone call at 19.47 hours on 12 December 2019 where he received upsetting news. The contents of that telephone call and what was discussed were not available to anyone working in the prison until after his death
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Mr Waddup was referred to mental health on 29th October 2019 on triaged within 24 hours on 30th October 2019. Attempts were made to assess him by telephone on 14, 19 and 21 November 2019. It is not clear if Mr Waddup

	personally knew of the appointments. Appointment letters are currently not sent to inmates at HMP Northumberland to notify them of planned appointments. Prisoners could be notified on the day via the appointment 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 including four prisons in the North West. In some custodial facilities an appointment letter is sent. This system is not replicated in HMP Northumberland (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 2019 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. (3) Mr Waddup self-referred via the kiosk system. There is no triaging of referrals on a weekend. A disclaimer or warning directing inmates to how to seek urgent assistance is not currently displayed on the kiosk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Tees Esk & Wear Valleys NHS Foundation Trust . I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons The family of Mr Waddup, Sodexo Justice Services, G4S and Rethink. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	10th August 2022 Signed:  Andrew Hetherington HM Senior Coroner for North Northumberland and Acting Senior Coroner for South Northumberland