Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Allan Waddup, a prisoner at HMP Northumberland, on 13 December 2019

## A report by the Prisons and Probation Ombudsman

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## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO


## WHAT WE VALUE

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 Allan Waddup was found hanged in his cell at HMP Northumberland on 13 December 2019. He was 33 years old. I offer my condolences to Mr Waddup's family and friends.

Mr Waddup had no history of self-harm or attempted suicide. Mr Waddup's partner ended their relationship in a phone call on the evening of 12 December. Staff were not aware of this and we do not think that the prison could have foreseen Mr Waddup's death.

However, he should have had a mental health assessment, which might have led to supportive measures being put in place.

I am very concerned that staff did not consider going into Mr Waddup's cell immediately after they discovered that he was hanging. The delay did not affect the outcome for him, but in other circumstances, could be crucial. This is not the first time that I have found staff at Northumberland do not understand national guidelines about going into a cell at night when there is a potential risk to a prisoner's life. The Director needs to take immediate action to address this.

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** **September 2025**

# Contents

# Summary

## Events

1. On 5 January 2015, Mr Waddup was sentenced to eight years in prison for sexual offences against a child. On 9 October 2018, he was released on licence.

2. On 29 October 2019, Mr Waddup's licence was revoked and he was sent to HMP Durham, where healthcare staff referred him for a mental health assessment.

3. On 1 November 2019, Mr Waddup transferred to HMP Northumberland. The nurse who screened him when he first arrived did not review his medical records or pick up on the outstanding mental health referral. After prompting from Durham, Mr Waddup was referred for a mental health assessment 12 days later. The mental health team were not able to contact Mr Waddup by phone or letter, so they discharged him from their caseload without assessing him.

4. On 5 December, Mr Waddup self-referred to the mental health team, but the mental health team did not see him before he died.

5. On the evening of 12 December, Mr Waddup's partner told him that she wanted to finish their relationship. Mr Waddup was very distressed by the call. Staff were not aware of this conversation.

6. At around 5.48am the next morning, an Operational Support Officer (OSO) saw Mr Waddup hanging from the light fitting in his cell. The OSO called an emergency code over the radio and another OSO attended to assist. The OSOs asked for permission to go into the cell, but were initially refused because there were not enough staff. Eventually they were allowed to open Mr Waddup's cell and go in. The OSOs cut the ligature and placed Mr Waddup on his bed. They saw that Mr Waddup had signs of rigor mortis and did not try to resuscitate him.

7. At 5.50am, the ambulance service received the phone call from the prison and an ambulance got to the prison gate eight minutes later. Paramedics pronounced Mr Waddup dead at 6.07am. They recorded that Mr Waddup showed signs of rigor mortis.

## Findings

8. We consider that staff could not have known that Mr Waddup was at risk of suicide or self-harm or having relationship difficulties. We do not consider that staff could have foreseen his death.

### Clinical care

9. The clinical reviewer found that the healthcare provided to Mr Waddup was of a mixed standard, so not equivalent to that he would have received in the community.

10. We share the clinical reviewer's concern that it took 12 days before Mr Waddup was referred to the mental health team at Northumberland. An insufficiently thorough

initial health screen contributed to the delay. Mr Waddup did not respond to calls or letters to engage and was never assessed.

11. We found that after Mr Waddup self-referral to the mental health team on 5 December, healthcare staff did not assess him within their expected timeframes. The mental health team did not see Mr Waddup before he died, and this was a significant missed opportunity to offer support to him.

### Emergency response

12. We are concerned that staff did not go into Mr Waddup's cell when he was found hanging, and permission to do so was initially refused. This led to a delay before anyone went into his cell. In this case, it is unlikely that it would have affected the outcome as Mr Waddup had been dead for some time when he was found, but such a delay could be crucial in future emergencies.

13. This is not the first time that we have found that staff at Northumberland do not understand national and local policy that they should go into a cell in a life-threatening emergency.

## Recommendations

- The Head of Healthcare should review the mental health referral management process at HMP Northumberland to ensure that:
    - initial health screens are thorough so that outstanding mental health assessments are actioned immediately; and
    - the triage and assessment of prisoners after referrals are carried out within expected timescales.
- The Director should write to the Ombudsman within 28 days setting out the actions that have been taken to ensure that staff are aware of the need to enter a cell at night when there is potentially a risk to life, in line with PSI 24/2011.
- The HMPPS Head of Custodial Contracts should satisfy himself that the Director of HMP 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 Investigation Process

14. 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. The investigator spoke to a prisoner as a result of these notices.

15. The investigator obtained copies of relevant extracts from Mr Waddup's prison and medical records.

16. The investigator interviewed ten members of staff and a prisoner at HMP Northumberland on 12 and 13 February 2020.

17. NHS England commissioned a clinical reviewer to review Mr Waddup's clinical care at the prison. The clinical reviewer interviewed four members of staff jointly with the investigator.

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

19. One of the Ombudsman's family liaison officers contacted Mr Waddup's partner, his nominated next of kin, and his grandparents, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They wanted to know how Mr Waddup killed himself.

20. We shared the initial report with HMPPS. They identified some factual inaccuracies, which we have amended in this report.

21. We also shared the initial report with Mr Waddup's family. They did not identify any factual inaccuracies.

# Background Information

## HMP Northumberland

22. HMP Northumberland holds up to 1,368 men. Sodexo Justice Services manage the prison and, at the time of Mr Waddup's death, G4S provided 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 Friday. At weekends and on bank holidays, healthcare staff are on duty from 8.00am to 6.00pm. Northern Doctors Urgent Care provide an out of hours service at other times. Tees, Esk and Wear Valley Mental Health NHS Foundation Trust provided mental health services.

23. Spectrum Community Health now provides health services at Northumberland.

## HM Inspectorate of Prisons

24. The most recent inspection of HMP Northumberland was carried out in August 2017. Inspectors found that mental health services were provided effectively at the prison but the management of prisoners subject to suicide and self-harm prevention procedures (known as ACCT) was weak, reviews were poorly attended and caremaps were incomplete. Handover arrangements were also poor and 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 prisoner unit.

## Independent Monitoring Board

25. 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 2018, the IMB reported that the introduction of the key worker scheme was managed well and prisoners have benefitted from it. They reported that the quality of support for prisoners subject to ACCT monitoring had improved.

## Previous deaths at HMP Northumberland

26. Mr Waddup's was the second self-inflicted death at Northumberland since November 2017. In our previous investigation, we found that staff could not have foreseen the prisoner's death, although we highlighted missed opportunities to refer the prisoner to mental health services. We also identified a delay in the emergency response, caused by technical issues with the radio system.

## Recall to prison

27. When someone is released from prison on licence or parole, they can be recalled to prison if:

    - they commit another crime or are charged with another crime, or

- they are behaving in a way that leads their Offender Manager to think they might be about to commit another crime, or

- they break the conditions of their licence.

28. The length of time a prisoner who has been recalled will have to serve in prison depends on the type of recall they are subject to:

- Fixed-term recalls: with a fixed-term recall, the individual is recalled to prison but will be released automatically after 28 days. He will be on licence in the community until the end of his sentence.

- Standard recalls: with a standard recall, the individual is recalled to prison and remains there until the end of his sentence unless the Parole Board decides otherwise. The case will be sent to the Parole Board automatically after 28 days. If they decide release is appropriate, they can either authorise immediate release or set a date (within one year) for release on licence.

# Key Events

## 2015 to 2018

29. On 5 January 2015, Mr Waddup was sentenced to eight years in prison for sexual offences against a child. Four months later, Mr Waddup transferred to HMP Northumberland from HMP Holme House. Mr Waddup took psychoactive substances (PS) on several occasions and had disciplinary hearings as a result. Mr Waddup was supported by mental health services and was prescribed antidepressants. He did not have a history of attempted suicide or self-harm.

30. On 9 October 2018, Mr Waddup was released on licence. One of the conditions of his licence was that he had to notify his offender manager if he formed a relationship with someone who lived with children. His licence was due to expire on 9 October 2022.

## Recall to prison

31. On 24 October 2019, the police found evidence that Mr Waddup was in a relationship with a pregnant woman who was living with her two children, in breach of the conditions of his licence. Mr Waddup had not told his offender manager about the relationship.

32. On 29 October, the offender manager revoked Mr Waddup's licence and he was taken to HMP Durham. On his Person Escort Record (PER a document that accompany prisoners when they travel from police stations, to court or prisons), a police officer recorded that Mr Waddup had mental health issues, but no risk factors for suicide or self-harm.

33. When he first arrived at the prison on 29 October, Nurse A recorded that Mr Waddup did not have any thoughts of suicide or self-harm, but said that he suffered from anxiety and depression. Nurse A referred Mr Waddup to the mental health team and he went on the waiting list for a mental health assessment.

## HMP Northumberland

34. On 1 November, Mr Waddup transferred to HMP Northumberland. He was located in the vulnerable prisoners' unit (VPU) because of the nature of his offence.

35. At his initial health screen, Nurse B did not record any health issues, and did not pick up that Mr Waddup had an outstanding mental health assessment. She assessed that Mr Waddup was mentally stable and did not have thoughts of suicide. The same day, the substance misuse team reviewed Mr Waddup, but he said that he did not want to engage with them. There is no evidence that Mr Waddup took any illicit drugs while he was in the prison.

36. On 9 November, Prison Custody Officer (PCO) A, introduced herself to Mr Waddup as his key worker while he was in the induction wing of the VPU. Mr Waddup told her that his main concern was that he could not look after his pregnant partner. Mr Waddup said that he was aware that the recall process was slow, and he knew that

it could take months for his hearing to take place. (His hearing was not scheduled before he died.) Mr Waddup said that he was pleased to be at Northumberland. He had already started to work as a tailor. Mr Waddup told PCO A that he felt safe and that he did not have any thoughts of suicide or self-harm.

37. On 12 November, Ms A, a mental health administrator at Durham, noted that Mr Waddup had been referred to the mental health team, but had not been assessed before he transferred to Northumberland. She telephoned Ms B, a mental health administrator at Northumberland, to notify her. The next day, Ms B added Mr Waddup to the mental health team's waiting list for review.

38. On 14 and 19 November, Ms B went to Mr Waddup's cell to arrange a mental health review, but Mr Waddup was not in his cell. Ms B followed up the missed appointments with a phone call to his in-cell phone, but Mr Waddup did not answer. On 21 November, Ms B tried to contact Mr Waddup over the phone again. Mr Waddup did not answer the phone. As a result, Ms B sent Mr Waddup a letter in the internal post asking him whether he wanted to engage with the mental health team (known as an "opt-in letter"). The letter stated that Mr Waddup had to respond by 29 November.

39. On 23 November, PCO B had a key worker session with Mr Waddup on behalf of PCO A. Mr Waddup repeated that he felt safe at Northumberland and was happy working as a tailor in the prison. Mr Waddup said that when he was not at work, he played pool and talked to other prisoners.

40. On 2 December, Ms B recorded that Mr Waddup had failed to respond to the "opt-in" letter, so she discharged him from the mental health team's caseload.

41. On 5 December, Mr Waddup self-referred to the mental health team using the wing's self-reporting kiosk. Four days later, Ms C, a mental health administrator, acknowledged his application and put him on the waiting list for a mental health assessment.

42. On 6 December, Mr Waddup moved to another cell (on the same wing but different corridor) in the VPU. The next day, PCO A spoke to Mr Waddup to explain that he would be allocated a new key worker as he had moved cells. Mr Waddup said that he felt safe and was happy at work. Mr Waddup told PCO A that he did not have any thoughts of self-harm or suicide. Mr Waddup did not have any further key worker sessions before he died.

43. On 8 and 9 December, Mr Waddup spoke to his partner on his in-cell telephone. The investigator listened to these calls. On 9 December, Mr Waddup's partner told him that she had met social services who were concerned about her relationship with Mr Waddup, as he was considered to be a risk to her children. She told Mr Waddup that she loved him but "if she had to choose between him and her kids, she had to choose them". Mr Waddup was very upset by their conversation. Prison staff were not aware of this conversation.

44. Over the next three days, staff did not record any conversations with Mr Waddup in his prison or medical record. Mr B, a prisoner, told the investigator that he spoke to Mr Waddup a lot, but he did not mention any concerns and seemed well.

## 12 and 13 December 2019

45. On 12 December, Ms B, Head of Mental Health, and Ms B discussed Mr Waddup's case. They confirmed that Mr Waddup had not returned the opt-in letter, but Ms B agreed to try to call Mr Waddup's in-cell telephone to check that he wanted support for his mental health. (Mr Waddup died before she called him.)

46. Between 7.47pm and 8.11pm, Mr Waddup spoke to his partner on the telephone in his cell. Mr Waddup's partner said that she had to finish their relationship or social services would take her children away. She said that he had lied to her as he had never mentioned his previous offence or licence condition. Mr Waddup was very distressed by the call, which ended when he ran out of credit. Just before they were cut off, he arranged to call her the following Monday. Prison staff were not aware of this conversation.

47. At around 8.20pm, OSO A went to Mr Waddup's cell during a routine roll check. She told the investigator that she opened the observation panel to check Mr Waddup. Although she could not remember seeing him, she said she had no concerns. OSO A then monitored the prisoners who were subject to ACCT procedures and responded to cell bells throughout the night. Mr Waddup did not press his cell bell.

48. At around 5.45am the next morning, OSO A started a routine roll check. Mr Waddup's cell was on the last corridor she checked. OSO A said she noticed that Mr Waddup's cell light was on. She opened the observation panel and saw that Mr Waddup was hanging from a ligature made of bed sheets attached to the light fitting in the middle of his cell.

49. At around 5.48am, OSO A radioed a code blue (a code blue emergency indicates that a prisoner is unconscious or having difficulty breathing) from the wing office. She told the investigator that she did not want to use her radio outside the cell in case other prisoners overheard. OSO A then collected the emergency bag, the defibrillator and the first aid kit.

50. OSO B arrived at the office and they ran back to the cell together. At the same time, the ambulance service received the phone call from the prison requesting an ambulance. OSO B said that he saw Mr Waddup hanging, so he immediately radioed for permission to go into the cell. Senior PCO (SPCO) A, the night orderly officer, refused permission because there were only two members of staff present. He said they needed one more member of staff before they could go into the cell safely.

51. OSO A said that as "back up did not arrive", OSO B asked SPCO A for permission to enter the cell again and he granted permission. OSO B said that he went into the cell with OSO A, "took the weight off Mr Waddup" and OSO A cut the ligature. They placed Mr Waddup on his bed on his back. OSO B checked for a pulse, but found none. He said that Mr Waddup was very stiff.

52. At around 5.50am, as the staff placed Mr Waddup on the bed, other officers arrived including PCO C. PCO C told the investigator that it took him around two minutes from hearing the code blue to get to the cell and that, on arrival, OSO A and OSO B were already in the cell. PCO C checked Mr Waddup and remembered that his skin

was “very blue - purple coloured”. All the officers agreed not to try to resuscitate Mr Waddup as there were signs of rigor mortis.

53. At 5.58am, the ambulance arrived at the prison’s gate. At 6.03am, paramedics arrived at Mr Waddup’s cell and pronounced him dead at 6.07am. They recorded that there were signs of rigor mortis.

## Contact with Mr Waddup’s family

54. At 10.40am, PCO D and PCO E, the prison’s family liaison officers, went to the house of Mr Waddup’s partner (his nominated next of kin) and broke the news of his death to her.

55. On 30 December, Mr Waddup’s funeral took place. The prison contributed to the costs of the funeral, in line with national policy.

## Support for prisoners and staff

56. After Mr Waddup’s death, Mr B, Head of Residence, 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.

57. The prison posted notices informing other prisoners of Mr Waddup’s death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Waddup’s death.

## Post-mortem report

58. A post-mortem examination established the cause of death as pressure on the neck due to hanging. The toxicology analysis found no drugs or alcohol in Mr Waddup’s body when he died.

# Findings

## Assessment of risk

59. Prison Service Instruction (PSI) 64/2011, governing safer custody, requires all staff in contact with prisoners to be aware of the triggers and risk factors that might increase a prisoner's risk of suicide and self-harm, and to take appropriate action, including starting ACCT procedures, if necessary. Mr Waddup's key risk factors included his relationship issues, his recall and his mental health concerns.

60. PCO A said that Mr Waddup was well regarded by staff and prisoners and knew the prison system well. Mr A told the investigator that Mr Waddup was very reserved, but appeared to be happy and well.

61. While we will never know what was on Mr Waddup's mind at the time he took his life, his conversation with his partner on 12 December was deeply upsetting and could have triggered his decision to take his life. We are satisfied that Mr Waddup did not give any indication to staff or prisoners that he was at risk of suicide or self-harm or having relationship difficulties. We do not consider that staff could have foreseen his death.

## Mental Health

62. The clinical reviewer found that the healthcare provided to Mr Waddup was of a mixed standard and therefore not equivalent to that he could have expected to receive in the community.

63. We are concerned that there was a significant delay of 12 days before Mr Waddup was referred to the mental health team at Northumberland. Nurse B should have noted that Mr Waddup had an outstanding mental health assessment from Durham at his initial health screen and referred him immediately. She did not check Mr Waddup's medical records and we agree with the clinical reviewer that her initial health screen was not sufficiently thorough, which contributed to the oversight. The mental health team therefore only attempted to contact Mr Waddup from 12 November. They eventually discharged him from the mental health team caseload, as he did not respond to their telephone calls or letter.

64. Ms E, a psychological wellbeing practitioner and Ms D told the investigator that all mental health referrals at Northumberland should be triaged within 24 hours of receipt and then an assessment should be completed five working days after that. Mr Waddup self-referred to the mental health team on 5 December. His application however was not added to the triage list until four days later and he was not triaged for a further three days on 12 December, exceeding the expected timeframes.

65. The clinical reviewer was concerned that triage mental health assessments were made without seeing prisoners at Northumberland. Ms E and Ms D told the investigator that they have revisited this process and the mental health team will triage all referrals by seeing prisoners in person in future.

66. We consider that Mr Waddup should have had a mental health assessment at Northumberland and there were missed opportunities to do so. We understand that

the mental health referral system is now under review, but make the following recommendations:

**The Head of Healthcare should review the mental health referral process at HMP Northumberland to ensure that:**

- **outstanding mental health assessments are picked up by initial health screens and actioned immediately; and**
- **the triage and assessments after referrals are carried out within expected timescales.**

## Emergency Response

67. PSI 24/2011 on management and security at nights stipulates that in normal circumstances, the night orderly officer must give authority to unlock a cell during night state and no cell should be opened unless at least two or three members of staff are present. However, the PSI, and Northumberland's own security strategy, state that the preservation of life must take precedence over security. The PSI says that where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff may go into the cell on their own, following an on-the-spot risk assessment.

68. OSO A and OSO B said that they understood that they could not go into a cell on their own under any circumstances. PCO C also said that more than two members of staff should "always" be present to go into a cell during the night state. This is contrary to national policy. We consider that OSO A should have gone into Mr Waddup's cell immediately. SPCO A wrongly refused permission to enter the cell after OSO B' first request, compounding the delay.

69. As a result, there was an avoidable delay before staff went into Mr Waddup's cell. Although the delay would not have affected the outcome for Mr Waddup (who had been dead for some time when he was found), in other emergencies such delay could be crucial.

70. We are concerned that this is not the first time that we have found that staff at Northumberland do not understand national and local policy on entering a cell at night. In a previous 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 from that report, the issue remains. We make the following recommendations:

**The Director should write to the Ombudsman within 28 days setting out the actions that have been taken to ensure that staff are aware of the need to enter a cell at night when there is potentially a risk to life, in line with PSI 24/2011.**

**The HMPPS Head of Custodial Contracts should satisfy himself that the Director of HMP 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.**

## Inquest

71. The inquest into Mr Waddup's death concluded on 10 August 2022 and recorded a verdict of suicide.

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