

**Prisons &
Probation**

Ombudsman
Independent Investigations

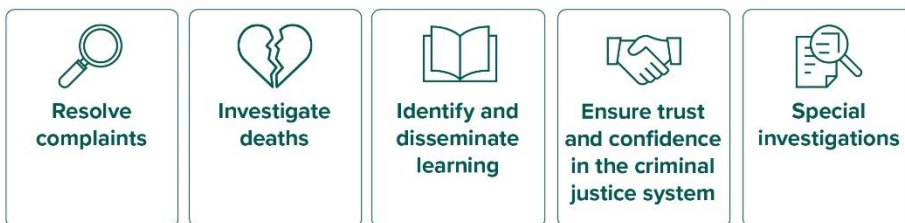
Independent investigation into the death of Mr Paul Feltham, a prisoner at HMP Northumberland, on 31 May 2022

A report by the Prisons and Probation Ombudsman

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



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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 Paul Feltham died after he was found hanged in his cell at HMP Northumberland on 31 May 2022. He was 37 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the clinical care that Mr Feltham received was of a mixed standard. His clinical substance misuse and mental health care was good and equivalent to that which he could have expected to receive in the community. However, the non-clinical substance misuse support and delay in GP care was not equivalent. The clinical reviewer noted that low staffing levels affected service delivery in these areas.

Mr Feltham was experiencing issues in his relationship and had difficult conversations with his partner during his time at Northumberland. His friends on the houseblock were aware of these issues but did not think that he was in crisis when he died. In the weeks before his death, Mr Feltham told staff that his anxiety had increased. He did not share any other information of concern and there was nothing unusual in his presentation to suggest that he needed additional support. We consider that prison staff could not reasonably have known that there was an imminent risk to Mr Feltham's safety.

We found that the key worker scheme at Northumberland was not implemented in line with Prison Service policy, which meant that Mr Feltham did not have regular contact with the same member of staff. We cannot measure the impact that this had on the outcome for Mr Feltham but consider that key work has the potential to improve safety and is an important source of support for prisoners, particularly those who may be vulnerable.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman

January 2023

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	6
Findings	111

Summary

Events

1. On 25 November 2021, Mr Paul Feltham was recalled to prison on licence, having committed further offences. On 2 December, he was transferred to HMP Northumberland.
2. Mr Feltham had experienced mental ill-health and had tried to take his own life by overdosing on drugs in 2019. He also had a long history of substance misuse. He engaged with prison substance misuse services, including a methadone maintenance programme. We found no evidence that he took illicit drugs while in prison.
3. During his five months at Northumberland, Mr Feltham was employed and got on well with staff and other prisoners. No concerns were raised about his wellbeing. Mr Feltham contacted the mental health team and was prescribed medication for anxiety. The mental health team gave him advice on how to manage stress, but he did not share the reason or extent of his stress with staff. The telephone calls that we have listened to since Mr Feltham's death suggest that he had relationship difficulties with his partner. Mr Feltham's friends on the houseblock knew about this but did not think that he was in crisis at the time of his death.
4. On the morning of 31 May, an operational support officer checked on Mr Feltham during the early morning roll check but could not see him in his cell. He asked for further support. Other officers responded and, when they entered, found Mr Feltham hanged in his cell. Mr Feltham showed no signs of life and rigor mortis was present, so officers did not try to resuscitate him. Paramedics arrived soon after and at 6.12.am, pronounced he had died.

Findings

5. Prison and healthcare staff appropriately reviewed Mr Feltham's risk information and assessed his risk of suicide and self-harm when he arrived at Northumberland.
6. The clinical reviewer concluded that the clinical care that Mr Feltham received at Northumberland was, overall, of a good standard and equivalent to that which he could have expected to receive in the community. However, the mental healthcare was not equivalent.
7. We found that the support and engagement provided through the key work model was satisfactory when it worked, but key work did not happen as often as it should have done and instead of a consistent point of contact, several officers met Mr Feltham during his time at Northumberland. It is possible that the development of a trusting relationship might have enabled Mr Feltham to share his anxieties.
8. The officer who could not see Mr Feltham in his cell during roll checks did not use his radio as he should have done. The Director of Northumberland has since issued a reminder of medical emergency procedures to staff, and all operational support officers have received additional training on how to respond when assistance is required.

9. Mr Feltham was found by an officer trained in first aid, who responded appropriately to the emergency. We noticed that although a first aider was always on duty during the night, an immediate response might not be possible at times due to security restrictions on the movement of certain officers. Northumberland has already responded to this learning and put first aid training in place for all operational support staff who work night shifts.

Recommendations

- **The Director should ensure that all prisoners are allocated a key worker in line with Prison Service policy and that staff are given adequate time to perform the key worker role.**
- **The Head of Healthcare should agree and implement appropriate timeframes for mental health follow-up appointments, in line with NICE guidelines.**
- **The Head of Healthcare should ensure that healthcare staff share relevant clinical information with HumanKind staff, where this is appropriate for care planning, to provide holistic support.**

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and asking anyone with relevant information to contact her. Nobody responded.
11. The investigator obtained copies of relevant extracts from Mr Feltham's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Feltham's clinical care at the prison. The investigator and clinical reviewer jointly interviewed eight members of prison staff in July. The investigator also interviewed a workshop instructor and three prisoners.
13. 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.
14. The Ombudsman's family liaison officer contacted Mr Feltham's stepfather, his next of kin, to explain the investigation and to ask if he had any matters he wanted us to consider. He asked whether Mr Feltham was prescribed medication, if there was any evidence that he had taken an overdose in the two weeks before he died, and whether the prison took any action to assess Mr Feltham's mental health. We have addressed these issues in this report.
15. Mr Feltham's next of kin received a copy of the initial report. They did not identify any factual inaccuracies.
16. The prison also received a copy of the report. We have amended the name of the night operational manager contacted when Mr Feltham was discovered.

Background Information

HMP Northumberland

17. HMP Northumberland is a private Category C prison which holds around 1,350 prisoners. Sodexo Justice Services manage the prison and Spectrum provides healthcare services. Healthcare staff are on duty from 7.30am to 7.30pm, Monday to Friday. At weekends and on Bank Holidays, healthcare staff are on duty from 7.30am to 5.30pm. Tees, Esk and Wear Valley Mental Health NHS Foundation Trust are contracted to provide mental health services.

HM Inspectorate of Prisons

18. 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.
19. Inspectors carried out a scrutiny visit at Northumberland in September 2020 to review the treatment of prisoners during the COVID-19 pandemic. In the inspectors' 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.

Independent Monitoring Board

20. 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 2021, the IMB reported that relationships between staff and prisoners were generally good, and that in November 2021, key work resumed in residential houseblocks, which would be monitored in the next reporting year. The IMB noted the number of healthcare vacancies but were satisfied that the temporary leadership had united staff and that they had a strong sense of purpose.

Previous deaths at HMP Northumberland

21. Mr Feltham was the fourth prisoner to take his life at Northumberland since May 2020. There have also been seven deaths from natural causes and two which are awaiting classification. There are no similarities between our findings in this report and those of the previous deaths.

Assessment, Care in Custody and Teamwork

22. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to

which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

23. Part of the ACCT process involves assessing immediate needs and drawing up support actions to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all support actions are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key worker scheme

24. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm, and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners, and helping people settle into life in prison. Details of how the system should work are set out in HMPPS's Manage the Custodial Sentence Policy Framework which says:
 - All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
 - Key workers must have completed the required training.
 - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
 - Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

During the pandemic, key working was suspended across the prison estate under the Exceptional Delivery Model, except for those prisoners considered most at risk.

Key Events

25. Mr Paul Feltham was recalled to custody on 25 November 2021, after committing further offences whilst on licence. He was serving two consecutive sentences for burglary and vehicle theft offences and his release date was 13 November 2022.
26. Mr Feltham had a history of drug misuse, including opioids. He had tried to take his own life in 2019, by overdosing on drugs. When he arrived at HMP Durham, staff created and implemented a five-day withdrawal care plan. This included continuity of Mr Feltham's methadone prescription. Mr Feltham also saw the substance misuse team. He was not assessed as presenting a risk of harm to himself and no additional monitoring was in place during his time at Durham.
27. On 2 December, Mr Feltham was transferred to HMP Northumberland. He told staff that he was motivated to continue to address his drug use and was referred to the drug and alcohol recovery team (DART). His methadone prescription continued.
28. At his reception screen, Mr Feltham told the reception nurse that he felt fine but at times, he felt anxious, and his mood dipped. He said that he regretted the overdose he took in 2019. He said he had been prescribed an antidepressant in the past but was coping without it. Staff assessed that no additional monitoring was needed. Mr Feltham moved on to the induction wing and staff regularly checked for any signs of withdrawal or changes in mood. No concerns were recorded. The next day, a nurse from the DART saw Mr Feltham, reviewed his methadone medication, and started to develop his care plan.
29. On 7 December, Mr Feltham's partner contacted the Safer Custody Team. She said that she had not heard from him and was concerned that he might not have her number. The information was shared with the wing manager, who added the number to Mr Feltham's PIN phone. Mr Feltham had four key work sessions during December.
30. On 25 January, Mr Feltham requested a methadone reduction programme and a nurse from the DART put one in place for him.
31. Over the next few weeks, Mr Feltham followed his methadone reduction and maintenance programme and prison staff noted that he was engaged with the wing regime. He got a job in a workshop.
32. On 2 March, Mr Feltham applied to see the mental health team. He wrote that he had asked to see them two months earlier but had not had a response. He wanted to be prescribed mirtazapine (used to treat anxiety and depression) and described his anxiety as 'through the roof'. That day, a mental health nurse tried to speak to Mr Feltham on several occasions by in-cell telephone, but he did not answer. She wrote to Mr Feltham and asked him to make a GP appointment.
33. On 9 March, a non-clinical DART worker (from HumanKind, an organisation which supports people with drug and alcohol issues) met Mr Feltham. She gave him some workbooks to complete, and they spoke about his wish to restart his antidepressants. She told Mr Feltham that he would be reviewed in two to three weeks. She booked four appointments between 9 March and 16 May, but there is

no record that they took place. There is no evidence that she contacted the mental health team to discuss Mr Feltham's request to restart his medication.

34. On 16 March, Mr Feltham asked to be assessed for the Thinking Skills Programme (TSP, which teaches skills to reduce the risk of reoffending). The next day, a programme facilitator completed the TSP assessment and she told Mr Feltham that he would be considered for the course. Mr Feltham said that he had asked to see the mental health team but had not had a response. She contacted the mental health team who said they had been trying to contact Mr Feltham on his in-cell phone. She asked them to contact Mr Feltham during lunchtime because he worked all day. A mental health nurse contacted Mr Feltham and said that he had been added to the urgent GP list but that there was a long wait. Mr Feltham was unhappy and said that he felt other prisoners were getting preferential treatment. A nurse met Mr Feltham to review his methadone programme.
35. Later that day, staff found an illicit mobile phone in Mr Feltham's cell. They put him on report and reduced his privileges for 7 days.
36. On 25 March, a prison GP saw Mr Feltham. The GP completed a physical health assessment and found that Mr Feltham's observations were all within normal ranges. He did not have time to check Mr Feltham's medical records during the appointment but after talking to him about his anxiety, prescribed mirtazapine tablets to help manage the symptoms. He told Mr Feltham that he would be reviewed again in four weeks, if necessary.
37. Between 18 January and 24 April, Mr Feltham had three key work sessions, with three different officers. He told the key workers that he had no issues. They each noted that he was engaged with the wing regime, mixing well with his peers, attending work, and maintaining contact with his family.
38. On 2 May, Mr Feltham's keyworker for a keywork session. He recorded that Mr Feltham was happy on Houseblock 5 and his behaviour had improved after a period of unsettled behaviour. At interview, the keyworker said that his entry reflected that Mr Feltham could be argumentative at times.
39. On 14 May, the keyworker saw Mr Feltham for a further key work session. He recorded that Mr Feltham continued to enjoy working in the workshop, had no issues and was happy on Houseblock 5. This was the last entry in Mr Feltham's prison record.
40. On 16 May, the non-clinical DART worker contacted Mr Feltham on his in-cell phone. She invited him to attend the opiate support group, which he declined. She told Mr Feltham that his next appointment would be in six to eight weeks' time, but if he needed to see someone sooner, he could make an application.
41. On 17 May, Mr Feltham sent a request to the mental health team, asking to see them. In his application, he said, 'My anxiety is through the roof, I feel like I'm having panic attacks all the time and it's stressing me out big time.' A mental health nurse tried to contact Mr Feltham on his in-cell telephone, but he did not answer because he was at work. She went to see Mr Feltham at his place of work, and they spoke privately in the workshop office. Mr Feltham said that he felt tense, and she gave him advice and information on relaxation techniques to help reduce his

anxiety. She suggested that Mr Feltham should be referred for cognitive behavioural therapy (a talking therapy that can help manage problems by changing thoughts and behaviours), but he declined. He explained that he was content to use the relaxation exercises and assured her that he did not have any thoughts of suicide or self-harm.

42. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to some of the calls Mr Feltham made in the week before he died, all of which were with his partner. As well as using his own PIN, Mr Feltham asked three friends on his houseblock to add his partner's telephone number to their PIN, which he also used to contact her. During May, Mr Feltham tried to contact his partner 5,878 times. 234 of the calls were answered and, in total, there was over 56 hours of conversation. Mr Feltham and his partner often argued and discussed ending their relationship, which Mr Feltham did not want. He told his partner that he was upset that at times, she did not answer his telephone calls or switched her phone off. On a number of occasions, he said that he would not cope if the relationship ended.
43. On 28 May at 4.59pm, Mr Feltham spoke to his partner for around 23 minutes. During the call, Mr Feltham told his partner that he would not let her down again, but if the relationship ended, he would take his own life by jumping off a bridge. The telephone call ended amicably. During the evening, Mr Feltham made several unanswered calls to his partner using his own and one of his friends' PIN phone. At 9.34pm, they spoke for around 34 seconds. During the call, Mr Feltham said that he would call her back at 11.00pm and made her promise to answer. At 11.16pm, they spoke for 25 seconds, before his phone credit ran out. This was the last time they spoke.
44. On 30 May, Mr Feltham did not attend work. A workshop instructor said that when she went to collect Mr Feltham at around 1.45pm, he said that he needed to make an important telephone call, but he did not give any further detail. She said that this was not unusual or a cause for concern and presumed that Mr Feltham had a legal call or needed to speak to his family. She described Mr Feltham as looking tired and as though he had lost a little weight since she last saw him, but there were no signs that he might be in crisis and she had no reason to question his request or alert anyone to her observations at that stage.
45. Between 5.29pm and 9.12pm, Mr Feltham tried to get through to his partner 83 times, using his friend's PIN. None of the calls connected.
46. An Operational Support Officer (OSO) started his shift early, at around 7.30pm, and completed the roll check (a count of prisoners) at 9.45pm. There were no concerns recorded.

Events of 31 May

47. CCTV footage shows that the OSO started the early morning roll check at around 5.36am and arrived at Mr Feltham's cell four minutes later. He could not see Mr Feltham and did not get a response when he kicked the door and switched the light on. He went to the wing office to double check if the cell was meant to be occupied, and then returned to the cell to try and obtain a response again. When he did not get one, he returned to the wing office and telephoned a Senior Officer, the

operational night manager, to ask for help. The OSO removed the inundation bung from Mr Feltham's cell door (a removable bung that allows a hose to be used to spray water into a cell without opening the door, in case of a fire), in an attempt to see into the cell, but was still unable to see Mr Feltham.

48. At 5.51am, Officer A arrived at Mr Feltham's cell to support the OSO. Two more officers also responded to the request for assistance. Officer A looked into the cell, but when he could not see Mr Feltham, the officers went in and found him behind his privacy screen. Mr Feltham had used a ligature made from bed sheets to hang himself, which he had attached to a screw placed in a vent above the toilet. Officers cut the ligature and laid Mr Feltham on the floor. At 5.56am, Officer B radioed a medical emergency code blue. Officer A described Mr Feltham as extremely cold, his skin was blue and rigor mortis was present. Staff decided not to start cardiopulmonary resuscitation (CPR) because they found clear signs that Mr Feltham had been dead for some time.
49. North East Ambulance Service confirmed that they had received a request for an emergency ambulance at 5.56am. Paramedics arrived at Mr Feltham's cell at 6.10am and confirmed his death at 6.12am. Paramedics noted that there were clear signs that Mr Feltham had been dead for some time.

Contact with Mr Feltham's family

50. The prison appointed a family liaison officer and a deputy. They both travelled to Mr Feltham's stepfather's house to tell him of Mr Feltham's death, and they offered ongoing support. The prison contributed towards the costs of Mr Feltham's funeral, which was held on 22 June, in line with national instructions.

Support for prisoners and staff

51. After Mr Feltham's death, prison managers debriefed staff involved in the emergency response. They provided staff with the opportunity to discuss any issues arising and offered support. The prison care team and the trauma risk for staff (TRiM) manager also made contact.
52. A nurse said that although she had worked closely with Mr Feltham on his methadone maintenance programme, she was not formally told about his death. She found out by chance and was upset not to have had the opportunity to discuss and reflect on what happened.
53. The prison posted notices informing other prisoners of Mr Feltham'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 Feltham's death. Several of Mr Feltham's friends said that they did not feel that they were sufficiently supported after his death. Although staff asked them immediately if they were managing, they said that Listeners (prisoners trained by Samaritans to support their peers) had not attended the houseblock. They said that after the initial contact, no further support was offered. The Deputy Head of Security and Safety said that there had been a shortage of trained Listeners due to the impact of the COVID-19 virus, but that Northumberland had since trained new Listeners.

Post-mortem report

54. The pathologist concluded that the cause of Mr Feltham's death was hanging. Toxicology results confirmed that he had not taken any illicit substances and toxicology results showed only therapeutic levels of his prescribed medication.

Findings

Assessment of risk of suicide and self-harm

55. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures that staff must follow when they identify that a prisoner is at risk of suicide and self-harm.
56. When Mr Feltham was arrested and recalled to prison in November 2021, staff considered information about his overdose in 2019 when they completed initial risk assessments. Prison and healthcare staff did not assess that it was necessary to start ACCT monitoring. We are satisfied that this was reasonable.
57. Mr Feltham had been living at Northumberland for just over five months when he took his own life. His friends on Houseblock 5 said that although he had been stressed and tired because of his relationship issues, they did not think that he was in crisis or that he would take his own life.
58. Wing staff said that they did not notice a change in Mr Feltham's appearance or behaviour in the period before his death, and he did not share anything with them that might have suggested that he was in crisis. The day before he died, Mr Feltham did not attend work. His workshop instructor had been on leave for over a week and she noticed that he looked tired and had lost weight, but she had no specific concerns and Mr Feltham did not share any concerns with her.
59. Staff were unaware of Mr Feltham's relationship difficulties which appear to have triggered his decision to take his life. We are satisfied that staff did not overlook any signs that he was at imminent risk of suicide.

Access to PIN phones

60. PSI 49/2011, *Prisoner Communication Services*, sets out the requirements for all prisoner communication, including telephone use. The PSI says that, 'The checking of social numbers must be proportionate to risk and checked as necessary in accordance with the NSF [National Security Framework] and as set out in the local security strategy.'
61. Northumberland allows prisoners to have up to £100 credit for phones calls at any one time and a maximum of 99 calls can be made each day, with a time limit of 30 minutes per call; they have to wait 10 minutes before their next call. Unless there are specific security restrictions, prisoners can have any number added to their PIN. All calls are recorded (except to legal advisors or confidential access organisations) but only five per cent of calls are randomly checked.
62. Mr Feltham signed a standard Communications Compact when he arrived at Northumberland. The first condition states that; 'The Personal Identity Number (PIN) allows you to use the telephone. Only you must use this PIN number. You must not let other prisoners use your PIN and must not use another prisoner's PIN.' The compact goes on to state that using another PIN may result in disciplinary action.

63. During his time at Northumberland, Mr Feltham made a significant number of telephone calls to his partner, using other prisoners' PINs, as well as his own. The majority of the calls were not answered and the conversations that took place were at times volatile. Staff were unaware of this pattern. The friends who allowed Mr Feltham to use their PINs and phone credit listed his partner as a friend, cousin and aunt. The Deputy Head of Security and Safety explained that any security checks on telephone numbers would be intelligence-led and that it was not unusual for prisoners and their families to know each other from the community so having the same number was not necessarily a concern. We are satisfied that there was no obvious reason for staff to check Mr Feltham's call records in the circumstances.

Staff engagement with Mr Feltham

64. Under the Offender Management in Custody (OMiC) model, every prisoner should have a dedicated key worker as their first point of contact. The purpose of the model is to improve safety by building better relationships between staff and prisoners.
65. During 2022, Mr Feltham had only had five key work sessions (18 January, 23 February, 24 April, 2 and 14 May). The sessions were held with four different officers. The keyworker who completed the last two key work sessions, said that officers were not allocated any specific time for key work duties during their shifts. They were expected to find time within their normal duties. He said although most prisoners did not wish to meet for 45 minutes, the expectation of the OMiC model, finding enough time to have a meaningful discussion with a prisoner was extremely difficult.
66. We found that the key worker scheme at Northumberland did not comply with the OMiC model. We are unable to measure the impact on Mr Feltham, but we know that regular key work sessions with a consistent officer help to improve wellbeing and therefore safety for prisoners. We make the following recommendation:

The Director should ensure that all prisoners are allocated a key worker in line with Prison Service policy, and staff are given adequate time to perform the key worker role.

Clinical care

67. The clinical reviewer concluded that overall, Mr Feltham's clinical care was of a good standard and equivalent to that which he could have expected to receive in the community. Some aspects of his care were not equivalent and need to be addressed.

Mental health

68. There was a significant delay in the prison GP making an appointment to see Mr Feltham when he asked to restart medication to treat his anxiety. When he was seen on 25 March, the GP did not review Mr Feltham's medical record, because he did not have time. He prescribed a sub-clinical dose of mirtazapine (which would have had a minimal effect) and said that he would have reviewed and increased the dosage at a later date, but a review did not take place before Mr Feltham died.

69. The interim Head of Healthcare said that waiting times for GP appointments were significant at the time due to the lack of a permanent GP in post. He told us that waiting times had since improved. The prison GP said that waiting lists had reduced and at the time our investigation, time was available to review medical records before consultations with a prisoners.
70. When Mr Feltham met the non-clinical DART worker from the DART team, he spoke about his anxiety and wish to re-start medication, but this was not reflected in his care plan. She did not contact the mental health team to follow up the request for medication. We found that DART workers at Northumberland did not have access to prisoner medical records because of limitations in the cabling infrastructure for the prison. She was also unaware that Mr Feltham was on a methadone reduction and maintenance programme, despite the significance of this in the context of her work. We found that this was the consequence of a lack of joint-working between the clinical and non-clinical substance misuse services at Northumberland, who did not appear to collaborate.
71. Mr Feltham saw a mental health nurse on 17 May. She had reviewed his records but was unaware that he had taken an overdose in 2019. The nurse told us that had she known about Mr Feltham's history, she would have referred him to the GP for a medication review.
72. Mr Feltham would have benefited from earlier involvement with the mental health team and there were several factors which meant that this did not happen in a timely manner. We therefore recommend:

The Head of Healthcare should agree and implement appropriate timeframes for mental health follow-up appointments, in line with NICE guidelines.

The Head of Healthcare should ensure that healthcare staff share relevant clinical information with HumanKind staff, where this is appropriate for care planning, to provide holistic support.

Substance misuse

73. There is no evidence that Mr Feltham took illicit substances while in prison and the clinical reviewer concluded that he was well supported by the clinical DART services.
74. The clinical reviewer has made some process-based recommendations, not directly related to Mr Feltham's death, about DART staff supervision, record-keeping, and appointment bookings. We have not included these in our report, but they should be actioned by the Head of Healthcare.

Emergency response

75. When the OSO discovered that he could not account for Mr Feltham during the morning roll check, he said that he did not know it was a medical emergency because he was unable to see him. He took steps to assure himself that the cell was occupied. He then returned to the cell but assessed that it was not safe to unlock alone for security reasons. We consider that this was reasonable, in the circumstances.

76. The OSO did not radio for assistance from other officers when he identified that there might be a problem. He went to the wing office and used the telephone to make the request. The office was a very short distance away and there was no significant delay caused. The delay did not impact on the outcome for Mr Feltham, who had been dead for some time, but we know that any delay may be critical in an emergency, and staff should radio for help at the earliest opportunity.
77. The Deputy Head of Security and Safety told us that in response to the learning from Mr Feltham's death, he had delivered training to all operational support officers throughout May 2022. The training was designed to remind staff of the protocols about requesting assistance in emergency situations. In addition, on 6 June 2022, the Director issued a Community Notice to staff, reiterating the need to use medical emergency codes when appropriate, in line with Prison Service instructions. As the prison has already addressed this issue, we do not make a recommendation.

Night staff trained in first aid

78. The healthcare service at Northumberland does not operate during the night. PSI 29/2015, *First Aid*, requires that there are suitably trained first aiders available to treat anyone who becomes ill in the prison. The PSI states that 'first aid provision must be adequate and appropriate in the circumstances'. This means that sufficient first aid equipment, facilities and personnel must be available at all times.
79. The Deputy Head of Security and Safety provided us with a copy of Sodexo's *First Aid at Work Policy* issued in February 2020, which mirrors the national requirements of PSI 29/2015. He also provided a copy of Northumberland's annual First Aid Provision Inspection Report, completed in November 2021 by the Safety and Risk Manager. It confirms that Northumberland has above the legal minimum number of staff trained in first aid.
80. An officer who responded to the emergency when Mr Feltham was found hanged, was trained in first aid. Although a member of staff trained in first aid was always available during nights, movement around the prison was often restricted for security reasons. In practice, this meant that an immediate response might not always be possible. While this did not impact on the emergency response when Mr Feltham was discovered, any delay in administering emergency first aid might be crucial in future emergencies.
81. In response, Northumberland have confirmed that from September 2022, all night operational support officers will receive annual first aid training. From November 2022, all night operational managers will be trained in first aid. Northumberland has already taken steps to address the issue and we do not make a recommendation.

Inquest

82. The inquest into Mr Feltham's death concluded in October 2023. Mr Feltham's death was suicide as a result of pressure on the neck caused by hanging.

**Prisons &
Probation**

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