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15 October 2013

Mr G U Williams LLB
HM Senior Coroner for the County of Worcestershire
The Court House
Bewdley Road
STOURPORT ON SEVERN
Worcestershire
DY13 8XE

RECEIVED
1st OCT 2013
H.M. CORONER

Dear Mr Williams

Re: Reggie Johns (deceased)
Regulation 28 Coroners and Justice Act 2009

Thank you for your letter dated 16 September 2013 and the enclosed Regulation 28 report. I have read your report with great care and in particular the concerns you have raised as a result of your investigation into Mr Johns' death. I have also discussed this report with the lead for Offender Health [REDACTED] and the Head of Healthcare, HMP Hewell [REDACTED]

I do not intend to comment on your report in terms of the circumstances of Mr Johns' death. I have read this section of your report and have discussed it with [REDACTED] who confirms that it is an entirely fair reflection of the evidence given during the course of the inquest.

With regard to your Matters of Concern I propose to consider each of these in turn.

1. Communication

Whilst this concern largely focuses on the issue of communication between HMP Bristol and HMP Hewell I think it is appropriate to seek to reassure you about communication between the healthcare team at HMP Hewell and other HM Prisons. There is continuous dialogue within HMP Hewell between the healthcare and the discipline teams. Some of this is formalised through various meetings and forums and some is informal and reflects a relatively constant ebb and flow of communication on patient specific issues, task related discussion, operational issues and joint working. If prisoners are transferring to other prisons the prisoner's healthcare record is transferred to the receiving prison. In some cases the Nurse in Reception at HMP Hewell will contact the receiving prison to raise specific issues or concerns. Messrs [REDACTED] and [REDACTED] will ensure that appropriate information is communicated to receiving prisons

when prisoners are transferred from the prisons in which the Trust provides healthcare services, namely HMPs Hewell, Long Lartin and Oakwood.

2. Prison Service Order 2700

Healthcare provides representation into Assessment, Care in Custody and Teamwork (ACCT) reviews as follows:

- prisoners in the Inpatient Unit (Lower Medical)
- prisoners in the segregation unit
- prisoners actively managed by the mental health team / part of Multi-Disciplinary Team discussion
- any other prisoner if requested by the prison (this may be telephone advice or attendance at the review).

3. ACCT Document

At the time of Mr Johns' inquest when this issue was discussed [REDACTED] wrote to all staff within the healthcare team at HMP Hewell to set out his expectations in respect of prisoners arriving in Reception at HMP Hewell on an ACCT. These are as follows:


- The ACCT document is made available to the Nurse in Reception. This has been discussed with the Reception Governor to ensure that Prison Officers undertake to do this
- The ACCT document must be reviewed while the prisoner is in Reception
- A note must be entered into the ACCT document regardless of the level of risk presented by the prisoner
- A note must be made in the reception screen or subsequent healthcare record that the ACCT has been seen and reviewed and any actions/plans are recorded.

Subsequently these requirements have been re-iterated to all staff.

I can also confirm that following the inquest into Mr Johns' death [REDACTED] and [REDACTED] Prison Governor, HMP Hewell have reviewed Prison Service Instruction 64/2011 (updated) – in order to identify any areas of non-compliance and to address these.

I trust that the foregoing has adequately addressed the Regulation 28 report issued subsequent to the inquest into Mr Johns' death.

Yours sincerely



Sarah Dugan
Chief Executive