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[redacted]

22 December 2022

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Dear Ms Griffin,

Re: Regulation 28 Report to Prevent Future Deaths – Bradleigh Trevor Barnes who died on 28 December 2019

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 24 October 2022 concerning the death of Bradleigh Trevor Barnes on 28 December 2019. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Bradleigh's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Bradleigh's care have been listened to and reflected upon.

You raised several concerns in your Report at section 5 (Coroner's concerns), paragraphs 2 (i) to (iii). This letter has been prepared in response to the concern raised to NHS England at paragraph 2 (i), regarding the lack of national guidance to healthcare staff on the use of force in prison.

Firstly, I would like to clarify that the Prison Service Instructions (PSIs), Prison Service Orders (PSOs) and Policy Frameworks set out the framework for the operational running of a prison. NHS England and prison healthcare providers are required to ensure that all prison healthcare policies and service delivery are aligned to the appropriate PSI, PSO or policy framework. NHS England cannot deliver guidance that is not cognisant with these documents. In this case, as you have highlighted, PSO 1600 Use of Force is the operational instruction that includes the use of manual restraint, and section 6 outlines the roles of healthcare in the planned and unplanned use of force.

It may also be of assistance to mention that healthcare provision in a prison is commissioned using a principle of equivalence with what is provided in the community, such as primary care GP services, and community mental healthcare and nursing services. Prison healthcare is not always a 24/7 service, and even during hours where healthcare staff are present in the prison, there is no guarantee they would be asked, or available, to attend whilst prison officers are restraining a prisoner (where this is not a planned intervention). PSO 1600 sections 6.1 and 6.2 set out the circumstances in which healthcare staff are required to attend planned and unplanned control and restraint interventions. Specifically, for planned interventions, healthcare staff on duty

'MUST attend' and, for unplanned interventions, a member of healthcare must, whenever reasonably practicable, attend every incident.

On 28 May 2015, the National Institute for Health and Care Excellence (NICE) published 'Violence and aggression: short-term management in mental health, health and community settings' (NG10)[1]. This national guidance was published with the aim of safeguarding both staff and service users, by providing evidence based best practice to support the prevention of violent situations and guidance to manage them safely when they occur, including the requirement to observe the physical and psychological health of the person under restraint for as long as clinically necessary. The guidance was written for all healthcare staff and provides a range of factors that must be considered to minimise the risk of harm to patients during and following a period of manual restraint. Although this guidance was written for settings where healthcare may well undertake control and restraint, there are sections that provide principles for roles and responsibilities, observations during restraint and monitoring physical and psychological health following a restraint, which are applicable for adoption in prison settings.

NHS England's Patient Safety Team published a Patient Safety Alert (PSA) in December 2015, 'The importance of vital signs during and after restrictive intervention/manual restraint'[2]. This PSA was written for all organisations providing NHS funded care, where restrictive interventions or manual restraint are used, and this included healthcare provided in prisons. It built on the NICE guidelines and required all healthcare providers, including those in the secure estate, to undertake four actions. This was followed up with NHS England's regional health and justice commissioners.

Whilst the guidance and PSA referred to above were already in place around the time of Bradleigh's death, NHS England recognises there is learning to be taken from the sad events in this case, and will be writing to all prison healthcare providers, via our seven regional commissioning teams, requiring them to work with their prison governor and have an agreed local operating procedure in place that includes:

- An outline of healthcare roles and responsibilities during and following a control and restraint incident, as described in PSO 1600: Use of Force.
- A requirement to monitor, record and act on vital signs during and after all control and restraint incidents they attend as per NICE Guidelines 10 and NHS England's PSA from December 2015. This monitoring should use the National Early Warning Score (NEWS) 2 tool that is commonly used across the NHS to support clinical assessment and decision making in deteriorating patients.

NHS England's central team will request assurance from our regional Directors of Commissioning that the above actions have been implemented and evidenced by April 2023. We are happy to provide you with a further update at this time if you consider this would assist?

[1] Overview | Violence and aggression: short-term management in mental health, health and community settings | Guidance | NICE
[2] psa-vital-signs-restrictive-interventions-031115.pdf (england.nhs.uk)

In addition to the above, NHS England will be working with colleagues in the HM Prison and Probation Service (HMPPS) to assist with their planned review and revision of PSO 1600: Use of Force. We will be supporting this review through providing clinical leadership on the revision and enhancement of section 6 and the roles and responsibilities of healthcare.

I hope the information above addresses the concern you have raised at paragraph 2 (i) of your Report, and provides some assurances that NHS England recognises there is learning and is working to address this in an adequate and timely manner.

I would also like to provide further assurances on the national NHSE work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Bradleigh, are shared across the NHS at both a national and regional level, and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]
National Medical Director