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[redacted]

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11 December 2023

Dear Dr van Dellen,

Re: Regulation 28 Report to Prevent Future Deaths – Jack Peter Zarrop who died on 20 March 2021.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 2nd October 2023 concerning the death of Jack Peter Zarrop on 20 March 2021. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Jack's family and loved ones. NHS England is keen to assure the family and the coroner that the concerns raised about Jack's care have been listened to and reflected upon.

Matter of concern

The training of agency staff in the Assessment, Care in Custody and Teamwork (ACCT) process and recognising the appropriate threshold to open an ACCT does not appear to be part of the commissioning process by NHS England and individual providers do not appear to provide training to agency staff in the ACCT process.

NHS England notes your concern relating to training of agency staff and the ACCT process, and the absence of training for agency staff amongst individual providers.

NHS England is the responsible organisation for the commissioning of healthcare into prisons, which is devolved to regional teams. Commissioning healthcare in prisons is done on a principle of equivalence, which has been defined by the Royal College of General Practitioners (RCGP) and has been adopted by the National Prison Partnership Board[1]. The definition broadly states the aim is to ensure people detained in prisons in England, are offered provision of and access to appropriate services and treatment, considered to be at least consistent in range and quality, with that available in the wider community.

ACCT is the care planning process for prisoners identified as being at risk of suicide or self-harm, and training is provided by His Majesty's Prisons and Probation Service (HMPPS). The ACCT process requires that certain actions are taken to ensure the risk of suicide and self-harm is reduced. The ACCT process is multi-disciplinary, involving

[1] PowerPoint Presentation (publishing.service.gov.uk)

staff from all departments with knowledge of the individual, and consideration of all interventions that may help to address their needs.

HMPPS is responsible for and oversees the delivery of effective training that is carried out at establishment level. This includes the roll-out of suicide and self-harm training, ACCT Case Manager, and ACCT Assessor training.

In response to the concerns noted, NHS England's National Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning, has written to Health & Justice regional teams sharing these concerns, asking commissioners to work with prison healthcare provider organisations and HMPPS locally, to ensure all staff, including agency and bank staff, have timely access to all joint training, including ACCT, that is necessary for them to undertake their role effectively within the prison environment. .

In addition, the findings in your report will be taken to the NHS England Health and Justice Delivery Oversight Group (HJDOG) in December 2023. The HJDOG is the senior leadership forum, which holds responsibility for the oversight of delivery and continuous improvement in Health and Justice commissioned services, through both the national and regional teams, with a focus on improving health outcomes and reducing variation across England. Regional teams will be asked to give assurance at the HJDOG meeting planned for June 2024, that the proposed action has been delivered and agency and bank staff have timely access to ACCT training.

Regarding the matter of concern around the use of Custodial Nurse Practitioners, this is for the Police Chief Council to respond to. NHS England does not hold responsibility for commissioning healthcare in police custody settings, therefore cannot comment.

I would also like to provide further assurances on the national NHS England 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 key learnings and insights around events raised in Reports to Prevent Future Deaths 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 issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]

National Medical Director