NHS England

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26 January 2024

Dear Ms Griffin,

Re: Regulation 28 Report to Prevent Future Deaths – Samuel Lewis Jones who died on 30 April 2021.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 05 December 2023 concerning the death of Samuel Lewis Jones on 30 April 2021. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Samuel's family and loved ones. NHS England is keen to assure the family, and the coroner, that the concerns raised about Samuel's care have been listened to and reflected upon.

I respond to each of the matters of concern raised in your Report below.

1. **The lack of flagging of, and access to, key dates which may have an impact on prisoners' safety.**

Ownership of the Health and Justice Information Service (HJIS) lies with NHS England, which commissions the NHS North of England Commissioning Support Unit (NECS) to manage a programme of upgrades to the system.

NECS explains that there are two options available for flagging key dates on HJIS, which include a patient status marker or alert (PSA). This would appear on the patient home screen and use a report, set up to support the alert, to send a task to a specific user on a specified date. This would be a 'batch' run and would continue until the patient's discharge or, manual removal of the PSA.

NECS also confirms that most system administrators and regional performance leads know how to set up PSAs and batch reports, and training and guidance relating to this is distributed.

The second option is a scheduled task, which can be sent to a specific user or group, on a specified date. This method of flagging a key date is simpler to set up but requires a manual reset annually.

[1] Recommendations | Physical health of people in prison | Guidance | NICE

2. **The lack of national Prison Service or NHS guidance on how to manage key dates where risks to the safety of the prisoner may be increased. Such as bereavement or traumatic incident, or any other key dates.**

3. **The accessibility of key information recorded on NOMIS and the potential to miss key information which could impact on risk assessments.**

It is my understanding that [redacted], Director General for His Majesty's Prison and Probation Service (HMPPS) is intending to write to you directly in response to the matters highlighted in concerns two and three.

I note you reference in the report that in response to the learning from this incident, a local process has been put in place by HMP Portland to *'ensure prisoners will be asked about any significant or trigger dates at the initial and second healthcare screen when they arrive at prison'.* As you have identified this as good practice, NHS England will contact HMP Portland to obtain more information, and share this learning and subsequent action with regional health and justice commissioners, requesting they bring this to the attention of their own healthcare providers.

4. **The lack of national guidance around the operation of in possession medication in prisons either by HMPPS or NHS England to ensure prisoners do not stockpile or retain medication when they have stopped using it.**

The National Institute for Health and Care Excellence (NICE) guideline NG57 (1) published in November 2016, provides guidance for managing medicines, including those held in-possession. This guidance references review and repeat of a person's risk assessment for in-possession medication in certain circumstances. An example of this is where security concerns are raised which may include hoarding or stockpiling or, where prescription requesting or medicines information held by the healthcare team, suggests non-adherence to treatment.

As for people in the community, patients in prison are advised to return any unused medicines for disposal. This approach is underpinned by NICE guidance CG76 on medicines adherence published in January 2009 which can be found here and national professional standards for secure environments published by the Royal Pharmaceutical Society in 2017, available here.

Had any concerns been raised that Samuel may have been hoarding or stockpiling his medication (Sertraline), responsibility for a cell search lies with HMPPS. NHS England contacted HMPPS to discuss this matter of concern and it has been confirmed this will be addressed in the direct response from the HMPPS Director General.

I would also like to provide 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 learning and insights around events 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,

Medical Director for Professional Leadership and Clinical Effectiveness

NHS England