Keele University Teaching Trust
NHS North Staffordshire Combined Healthcare NHS Trust

[redacted]
Chief Executive Officer
Trust Headquarters
Lawton House
Bellringer Road
Trentham
ST4 8HH

Date: 22nd March 2024

[redacted]

Mr J P Ellery
Senior Coroner
Shropshire, Telford and Wrekin Area
HM Coroner's Service
The Shirehall
Abbey Foregate
Shrewsbury
Shropshire
SY2 6ND

[redacted]

Dear Mr Ellery

Regulation 28 Report – Prevent Future Deaths – Martin Samuel Willis

I am writing in response to your correspondence dated 19th December 2023 regarding the regulation 28 of the Coroners (Investigations) Regulations 2013 following the inquest regarding the death of Martin Samuel WILLIS which concluded on the 17th November 2023.

At the time of Mr Willis' death the Mental Health Services in HMP YOI Stoke Heath were provided by the North Staffordshire Combined Healthcare NHS Trust and Substance Misuse Services were provided by Forward Trust, however from 1st November 2023 Mental Health Services have been provided by the Midlands Partnership University NHS Foundation Trust. The services are delivered by the Health in Justice Team within the Trust. The Shropshire Community Health NHS Trust continue to provide the Prison Healthcare services within HMP YOI Stoke Heath.

Colleagues from HMP YOI Stoke Heath, the Midlands Partnership University NHS Foundation Trust, Shropshire Community Health NHS Trust and the North Staffordshire Combined Healthcare NHS Trust met on 29th January 2024 to conduct an inter-agency review as directed in the Regulation 28 correspondence.

The MATTERS OF CONCERN described in the Regulation 28 correspondence have informed the development of the Health in Justice Suicide Prevention Plan including the development of a multi-agency Suicide Prevention Forum for the Midlands Partnership University NHS Foundation Trust Health in Justice Services and partners as is referenced in the response/s below.

The agreed actions from our inter-agency review in response to the MATTERS OF CONCERN outlined in your correspondence are as follows:

1. **The ACCT procedure was not properly implemented, complied with or supervised. A scheduled observation at 8 am did not take place and a false entry was entered at 7:30 am and later deleted. The last correct entry was at 7 am with earlier omissions.**

2. **The prison service has taken action to address the issues relating to the ACCT procedure and will be kept under review.**

   Action 1. HMMPS YOI Stoke Heath, the Shropshire Community NHS Trust and the Midlands Partnership University NHS Foundation Trust have reviewed the ACCT processes and procedures and have communicated regarding this directly, as outlined in the HMMPS response to you dated 28th February 2024. The multi-agency review received assurances from HMP YOI Stoke Heath that the new processes are being kept under review.

   Action 2. All Midlands Partnership University NHS Foundation Trust staff working in HMP YOI Stoke Heath are required to complete the Trust's mandatory suicide prevention training and the ACCT training provided by HMP YOI Stoke Heath. As part of the Suicide Prevention plan for Health in Justice Services the Midlands Partnership University NHS Foundation Trust will continue to seek opportunities for joint / shared training initiatives regarding best practice regarding suicide prevention in His Majesty's Prison Services in line with the national strategies referenced above and in support of a personalised / person centred multi-agency approach to suicide prevention in Health in Justice Services. **Completion timescale September 2024.**

3. **Overriding issues remain as to whether or not the late Mr Willis was on the correct levels of observation up to constant watch and whether he should have been transferred out on psychiatric grounds for treatment at another prison establishment with a hospital wing**

   Action 3. In addition to the above actions the Midlands Partnership University NHS Foundation Trust will request a review of the NHS England procedures and processes regarding the referral of and transfer to patients to prison establishments with a hospital wing to ensure clarity of criteria for admission and referral and escalation and appeal processes taking into consideration some perceived challenges in terms of criteria and escalation highlighted during the inter-agency review. **Completion timescale September 2024.**

4. **Whilst the prison service and the mental health providers have reviewed the circumstances of Mr Willis's death, I am concerned that there should be a collective and not individual response to ensure that all lessons can be learned. I therefore recommend that there be an inter-agency review between the prison service and mental health services as to the mental health care provided to the late Mr Willis including the evidence at the inquest and the jury's findings. In so doing, I do not purport to suggest what the outcome of the review should be.**

Action 4. The interagency review was conducted on 29th January 2024 as referenced above. The required actions / next steps of the inter-agency review and subsequent progress will be shared with staff and partners via the Midlands Partnership University NHS Foundation Trust Multi-Agency Health in Justice Suicide Prevention Forum which will support delivery of the Health in Justice Suicide Prevention Plan and facilitate continued shared learning across partner agencies. **Completion timescale September 2024.**

I hope the above information meets with your approval and satisfaction and that the actions outlined suitably address your MATTERS OF CONCERN. I would also like to express my condolences to the family for their loss of Mr Willis.

Please do not hesitate to contact me if you require any further information.

Yours sincerely

[redacted]

[redacted]
Chief Executive Officer
North Staffordshire Combined Healthcare NHS Trust

CC'd

- The Rt Hon Edward Argar MP Minister of State for Prisons, Parole and Probation [redacted]
- [redacted] – Chief Executive Midlands Partnership NHS Foundation Trust (if appropriate) [redacted]