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24 July 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Frazer Charlie Williams who died on 7 March 2022

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 31 May 2024 concerning the death of Frazer Charlie Williams on 7 March 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Frazer's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Frazer's care have been listened to and reflected upon.

I have responded to your matters of concern which are relevant to NHS England below.

1. **There is inequity within the system of the treatment of a person with mental illness in the prison setting, compared to an individual in the community, since in the community a person would be placed in a hospital setting on the day they were deemed to require hospital admission. In prison however, there are delays in transferring a prisoner in the same situation to hospital.**

I would like to reassure you that NHS England consistently strives for equality in mental health healthcare provision. To address the specific concerns about Frazer's care, there are several cross party workstreams underway.

In February 2024, His Majesty's Inspectorate of Prisons (HMIP) published "The Long Wait", a thematic review of delays in the transfer of mentally unwell prisoners, which identified several concerns. The concerns include areas such as length of time to transfer, hospital availability, information sharing and early identification of needs. NHS England's Health and Justice, Specialist Commissioning and Adult Mental Health Teams, the Department of Health and Social Care (DHSC) and His Majesty's Prison and Probation Service (HMPPS) are in the process of directly responding to the concerns highlighted in this review. This response is due to be with our National Director of Health & Justice, Armed Forces and Sexual Assault Referral Centres imminently, for approval to meet the timeframe for submission.

A new clinical template for improving data collection and monitoring has been developed and is now in place, to record the referral, assessment and transfer process for prisoners and detainees, under sections 47 and 48 of the Mental Health Act (MHA)

1983. This template is for use within the health and justice information system (HJIS) in prisons (currently SystmOne). NHS England is working to use the information generated to gather data on the timeliness of transfers, whilst also proactively working with Health and Justice commissioners to improve data quality and completeness of existing manual collection.

A review of processes, communication and information sharing around mental health concerns is also underway and will be completed by February 2025. This review is calling "Health and Justice Mental Health Pathway". Work on the development of a Mental Health Pathway aims to:

- Ensure from a patient perspective the pathway is robust, seamless, individualised, and responsive to a person's needs and requirements.
- Provide people with mental health concerns consistent, high-quality advice/treatment/support across all Health and Justice services.
- Reduce reoffending and improve health outcomes by addressing the underlying mental health and associated vulnerability issues.

To achieve this, NHS England will:

- Clarify the current mental health provision within each Health and Justice service.
- Identify and build on best practice.
- Identify and understand dependencies between Health and Justice services and other parts of the pathway.
- Understand where we are now and develop a proposed pathway for engagement.
- Develop a pathway programme plan based on identified gaps and key priorities.

To support this work, a series of online workshops are planned throughout August 2024 for subject matter experts to come together and share knowledge and experience in areas such as governance, transfer and remission, and information sharing.

2. There is a lack of NHS guidance, and joint guidance with HMPPS, on the identification, management, and treatment of someone with self-neglect in the prison setting.

It is clear in this case that information sharing, and general communication, could have been stronger. NHS England is committed to improving information sharing between agencies and promoting better joint working, to improve outcomes for people with mental health needs, and the Prison Mental Health Service Specification (March 2018) covers these elements: service-specification-mental-health-for-prisons-in-england-2.pdf.

This service specification links directly the Royal College of Psychiatrists' (RCPsych) guidance on Standards for Prison Mental Health Services (September 2023) which provides clear guidance for mental healthcare provision. The regional NHS England Health and Justice commissioners include these specifications as a link into the Prison Mental Health Service Specification. The commissioners monitor the providers'

progress against the agreed specification. Regular NHS England national meetings are held with the regional commissioners, and this will be raised this at the national meetings.

3. There are two parts to this next concern, which I have separated as follows:

i. **There is a lack of a national directory detailing the facilities and provision of healthcare at individual prisons across England and Wales, and associated guidance on the transfer of individuals between prison establishments when they are under the care of the healthcare teams and are not placed on medical hold.**

NHS England suggests that this would be for HMPPS to respond to, however we will continue to work with HMPPS on any proposed actions requiring healthcare input.

ii. **There is a lack of guidance on consultation with prison doctors where a prisoner is receiving medical care, whether that be for physical or mental health, when there is consideration by the prison to transfer the prisoner who is not placed on medical hold. Further there is a lack of consultation with the healthcare team at the proposed receiving prison to ensure they can provide the appropriate care for the person.**

It is clear that communication between clinicians in Frazer's case fell below the expected standard. It is also a concern whether a receiving prison can manage and support significant mental health concerns such as those experienced by Frazer.

As explained above, the pathway work currently underway will review issues around consistency of clinical care, information sharing and communication, not only within NHS England but across the dependent and aligned services. The output from this work should address the concerns highlighted.

4. There is a lack of national guidance for healthcare teams working in prisons around the handover of healthcare of a prisoner to the receiving prison when they are transferred to another prison.

NHS England is continually striving to improve communication, information sharing and handover of information between the custodial services. In addition to the Mental Health Pathway work, each Health & Justice regional commissioner manages the contract and monitors the services against the agreed specification.

There is a National Partnership Agreement (NPA) in place which sets the agreement between DHSC, HMPPS, the Ministry of Justice (MOJ), NHS England and the United Kingdom Health Security Agency (UKHSA), which supports and strengthens partnership working across agencies.

The NPA sets out the basis of shared understanding of, and commitment to, the way in which partners will work together across prison and people - National Partnership Agreement for Health and Social Care (publishing.service.gov.uk). This is a regional

commissioner responsibility, to ensure from a health perspective that the providers are fully engaged with the partnership agreement.

HMPPS can provide a response regarding the NPA from their perspective to also commit to this.

5. There is a lack of national specification in respect of prison healthcare units.

The Prison Mental Health Service Specification (March 2018), referred to above, provides clear guidance for mental healthcare provision within prisons. This will be updated and reviewed by quarter one of 2025. In the meantime, following the sad death of Frazer, NHS England will work with our commissioning teams to ensure the specifications are being followed and measures are put in place to monitor their progress.

In addition to the concerns highlighted above, I note that there are also concerns at paragraphs 7 (vii), 8 (viii) and 9 (ix) of your Report around:

7. **The lack of Assessment Care in Custody and Teamwork (ACCT) quality assurance or audit between day 7 of the ACCT and post closure review.**
8. **The lack of automatic flagging of a missed ACCT review at HMP Guys Marsh, which may be a national issue.**
9. **Relevant individuals such as key workers not being invited to attend ACCT reviews at HMP Guys Marsh, in line with ACCT 6 guidance.**

The points above relating to the ACCT process (annex-to-psi-64-2011-acct .docx (live.com) will be shared with NHS England's regional Health and Justice commissioners, with a request that they monitor this in contract review meetings and feedback via the Health and Justice Oversight Delivery Group (HJDOG).

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.

Overall, HMPPS is responsible for, and oversees, the ACCT process, including delivery of effective training that is carried out at establishment level for all staff, including healthcare, and I note that HMPPS is responding independently to the concerns about ACCT in Frazer's case.

I understand that in September 2022, the Safer Custody Team provided refresher training to healthcare staff at HMP Guys Marsh, to ensure they understand their responsibilities to identify prisoners at risk of suicide and self-harm. Further guidance supporting this was issued to ensure staff awareness of the need to notify relevant departments where concerns about a prisoner's risk of self-harm or suicide are identified. Relevant training highlighting the importance of sharing, recording, and considering all relevant risk information has also been provided to induction and

reception staff who conduct first night interviews. HMP Guys Marsh confirms this will continue at regular intervals throughout the year.

NHS England will continue to work in partnership with HMPPS nationally and regionally to support the ACCT process.

Additionally, HMP Guys Marsh sit as a member on the Dorset Local Safeguarding Board and are therefore subject to Bournemouth and Poole and Dorset Safeguarding Boards' guidance on self-neglect. NHS England's South West region also supported the development of the e-learning training for healthcare staff on safeguarding in secure and detained settings: Adult Safeguarding in a Secure and Detained Setting - elearning for healthcare (e-lfh.org.uk).

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 that key learnings and insights around preventable 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 patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

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National Medical Director