Midlands Partnership University
NHS Foundation Trust

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Mr David Reid
HM Senior Coroner for Worcestershire
Worcestershire Coroner's Court,
The Civic,
Martins Way,
Stourport-on-Severn,
Worcestershire
DY13 8UN

06 December 2024

Dear Sir,

Regulation 28 Report to Prevent Future Deaths regarding the death of Mr Oliver Davies

I am writing to you on behalf of Midlands Partnership University Foundation NHS Trust (MPFT) in response to your Prevention of Future Deaths report dated 11 October 2024, following the inquest touching the death of Mr Oliver Davies.

At the outset I would like to express my sincere condolences on behalf of MPFT to Mr Davies' family and friends.

This letter is MPFT's formal response to your PFD report.

1) Oliver had been at HMP Hewell since 20.10.22. He was a man with longstanding mental health issues, for whom this was a first experience of custody. After a steady deterioration in his mental state, a mental health referral on 17.11.22 led to a belated mental health examination conducted by a registered learning disability nurse on 6.12.22. In the week leading up to the nurse's assessment:
(a) A prison officer had made an urgent TAG mental health referral on 30.11.22, citing concerns that Oliver was experiencing active thoughts of self-harm or suicide, and that he (the officer) had "mild concerns" about intentional self-harm, and there were "definite indicators" of unintentional self-harm; and
(b) Oliver himself had submitted a healthcare application form asking to see a doctor, saying that he was "extremely depressed", his anxiety was "really high", and he was "not coping at all, please help";

These important events were not highlighted on Oliver's SystmOne medical record, and so the nurse conducting the assessment 6.12.22 was not aware of either of these important recent events and did not take them into account when assessing Oliver.

Since the time of Mr Davies' death, MPFT has implemented a process for managing referrals and patient-related communications at HMP Hewell, centred around the EDiC (Early Days in Custody) model. MPFT staff working within the prison, have been thoroughly briefed on the EDiC model and are provided with a good practice guide, ensuring consistent and efficient handling of referrals and patient communications across services. This process has been circulated to staff by email, discussed in team business meetings and included in staff inductions.

There is also now, a clear process for the management of TAG referrals and Healthcare applications ensuring that they are added to and visible in SystmOne.

The importance of staff familiarising themselves with recent clinical activity from the electronic patient record has been highlighted to all Inclusion staff as part of the key messages that arise from our monthly Health in Justice Serious Incident Meeting.

In addition, this learning was shared with all our Prison services at our monthly Health in Justice clinical governance meeting, and a reminder given to all team managers of the importance in reminding staff of this practice in their regular supervision.

2) Oliver was allocated a care coordinator on 6.12.12 following the nurse's assessment. An appointment was fixed for Oliver to meet the care coordinator for the first time on 14.12.22. Due to workload pressures, the care coordinator was unable to fulfil that appointment before he went on leave from 16-28.12.22. Shortly before he went on leave, the care coordinator conducted a "RAG rating" exercise to determine whether he should prioritise seeing Oliver, and determined that Oliver's case merited the lowest priority RAG rating (green). When conducting that RAG rating exercise, the care coordinator did not take into account:

(a) The prison officer's urgent TAG mental health referral of 30.11.22 (above);

and

(b) A further TAG mental health referral made by a prison paramedic which cited "mild concerns" about both deliberate and unintentional self-harm on Oliver's part, the details of which had been entered onto Oliver's SystmOne medical record.

In addition, the care coordinator did not raise in the mental health team's daily forum the fact that he was unlikely to have time to see Oliver before he went on leave. Had the care coordinator taken into account the referrals at (a)-(b) above, and raised at the daily forum his difficulty in being able to see Oliver, it may well have been that Oliver's case would have merited a more urgent response from the care coordinator or someone else in his stead

As per the response above, staff have been reminded in a variety of forums as to the importance of familiarising themselves with recent clinical activity in the patient's SystmOne notes prior to any assessment or clinical intervention.

Following Mr Davies death, all MPFT colleagues at HMP Hewell have participated in specific clinical supervision focused on the importance of listening to and responding to prisoner concerns. To further support this, the team holds daily team meetings, monthly business meetings, weekly healthcare huddles, and weekly Safety Intervention Meetings (SIM) meetings; all of which have recorded minutes where prisoners' concerns are addressed. Information from the SIM meetings is disseminated to care coordinators via email, ensuring that tasks arising from these discussions can be actioned promptly. All patient concerns are documented on SystmOne by the person who is notified of the concern so that anyone looking at the

SystmOne record can see that a concern has been raised. One focus of clinical supervision is to manage patient concerns by mitigating risk and ensuring any care and treatment is planned in accordance with this.

There is now also a process embedded within the service to ensure continuity of care during planned and unplanned staff absence. This is set out in the MPFT guidance called “Reallocation when staff are leaving and when absent for 2 weeks or more”. Patients of concern are also discussed within our multidisciplinary forums, both internally within our service, and at joint daily huddles that are now in place led by Practice Plus Group.

A standing agenda item of “Provision of Care to Patients in the Absence of Care Coordinator” was added to the Daily Meeting standing agenda. This ensures continuous care for all patients, regardless of staff availability. When a patient concern is raised during these meetings and the assigned care coordinator is absent, the issue is thoroughly discussed among the present team members. A specific worker is then designated to address the concern and assume temporary responsibility for the patient's care. This handover of responsibility is formally documented in the meeting minutes and the patient’s SystmOne record along with rationale. New staff members are introduced to this process during their induction, with details available in the induction folder, and all team members are required to attend these daily meetings.

We wish to assure you and Mr Davies’ family that the actions described above are being taken forward with considerate attention.

Yours sincerely,

Chief Executive
Midlands Partnership University NHS Foundation Trust