

Ms. Caroline Topping
HM Assistant Coroner
HM Coroner's Court Surrey,
Station Approach,
Woking
GU22 7AP

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
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12 March 2025

Dear Ms Topping,

Re: Regulation 28 Report to Prevent Future Deaths – Haydar Jefferies who died on 5 March 2023 at Frimley Park Hospital whilst under detention at HMP Coldingley.

Thank you for your Report to Prevent Future Deaths (hereafter 'Report') dated 20 December 2024 concerning the death of Haydar Jefferies on 5 March 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Haydar's family and loved ones. NHS England is keen to assure the family, and the Coroner, that concerns raised about Haydar's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused Haydar's family or friends. I realise that responses to Coroners' Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones, and I appreciate this will have been an incredibly difficult time for them.

Your Report raises the concern that, outside of weekday office hours, there is no mental health clinical provision and that overnight staffing levels at HMP Coldingley make it difficult for prisoners in mental health crisis to be taken to hospital. As a result, you raised that:

- a) custodial staff take decisions about how to keep prisoners safe overnight without the necessary clinical knowledge to assess the risks presented by their mental health conditions; and
- b) it is not possible for medication to be obtained to alleviate any acute mental health symptoms between 6.30pm and 7.00am the following morning.

I note your concern around overnight staffing levels and the lack of clinical presence overnight, outside of weekday hours. For clarity, I can explain that not all prisons in England provide 24-hour healthcare so there is no overnight clinical presence. HMP Coldingley is a Category C establishment, which means it is considered as someone's 'usual residence', or home. There is therefore no provision for overnight healthcare.

In the event of there being serious concerns about an individual's health, it is expected that a 999 call is made to request an ambulance in the same way an ambulance would be called for a person in their own home. This falls under what is described as 'urgent referrals'.

I would also like to inform you that since Haydar's tragic death, the healthcare at HMP Coldingley, including mental health services, has been re-commissioned.

As of 1 April 2023, the new provider is contracted to provide the following:

- **Primary care services:** Delivered seven days per week between the hours of 07.00 and 19.00 Monday to Friday, and between 08.00 and 17.30 on weekends and public holidays.
- **Mental health services:** These services are delivered seven days a week at a minimum, Monday to Friday 08.00 until 20.00 and 'on call' from 10.00 until 16.00 on weekends and public holidays. There is also on-site attendance available seven days a week.

Within the new contract, if there is a requirement for any emergency treatment, such as medication to alleviate any mental health symptoms, for example, the following applies:

- **Emergency referrals:** Must be made within two hours when primary care services are on-site
- **Urgent referrals:** Must be made within twenty-four hours, with protocols in place with out of hours (OOH) service providers to manage any urgent cases that arise during the OOH period. These are provided through Integrated Care Board (ICB) commissioned services or specialised services. This also includes 999 calls where there are serious concerns as mentioned above.

Contract Management Processes are in place to ensure that emergency and urgent referrals are reviewed and monitored regularly. This is a quarterly process which is audited and recorded. With regards to any urgent issues identified, these are reported via Datix (a digital system for reporting incidents and risks used to support risk mitigation and regulatory compliance) and acted upon immediately.

The [Service Specification](#) for primary (medical and nursing) and dental care provision in prisons, published in 2020, and the [Service Specification](#) for integrated mental health service for prisons in England, published in 2018, both support the regional commissioning and contract management process for primary care and mental health service provision. These service specifications detail core service delivery and the standards that providers are expected to prioritise, including expected outcomes.

A review of the NHS England health and justice service specifications is being undertaken by NHS England through 2025 to 2026, and any learning from this case will be used to ensure that the primary care specification continues to support commissioners to be able to tailor services to meet the needs of their prison population.

In addition to this, NHS England and His Majesty's Prison and Probation Service (HMPPS) are working collaboratively to produce the Joint Care and Separation Unit Standards Framework. This will be rolled out later in 2025, along with a range of resources to support implementation, at establishment level, once the Segregation Policy Framework is published. This supports a multi-disciplinary approach to healthcare, including mental health, for people in segregation. There will be a planned implementation phase to support healthcare, and governors will adopt the standards over an agreed period, which will be determined by HMPPS.

I note your Report also directs a concern to both NHS England and HMP Coldingley, that the Assessment, Care in Custody and Teamwork (ACCT) process is not designed, nor effective, to protect prisoners in acute mental health crisis who do not appear to be suicidal.

Ownership of the ACCT process and policy lies with HMPPS. NHS England are therefore not able to comment on this point and would recommend that this is directed to HMPPS for a full response.

The findings, information and any learning from this case will be tabled at a future NHS England Health and Justice Delivery Oversight 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 national and regional teams. All health and justice related Reports to Prevent Future Deaths are shared and discussed at the HJDOG, and assurance is sought from regions where learning and action is identified.

NHS England's national health and justice team has also engaged with colleagues from the South East region on the concerns raised in your Report. For improvements to be made, a notice will be issued to healthcare staff that they should record a case note when they ask prisoners if they are having thoughts of self-harm, and they will be advised that negative responses should also be recorded. Good order and discipline reviews will now include questions around prisoners' thoughts on self-harm and responses will be recorded, and mental health teams will log all referrals on [SystemOne](#). A new template form for mental health referrals is also being designed, which will include prompts to include key information to aid triage and details on what to do with the referral. HMP Coldingley's Governor will ensure that the new template is circulated to all operational staff.

I would also like to provide assurance about 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 learning and insight around events, such as the sad death of Haydar, are shared across the NHS at both a national and regional level. This helps NHS England pay close attention to any emerging trends that may require further review and action.

I would like to 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



National Medical Director