NHS
Nottinghamshire Healthcare
NHS Foundation Trust

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Chief Executive Office
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4 April 2025

Private and Confidential
HMC Bower

Dear HMC Bower

Further to the Joinder Inquest into the death of Anthony Binfield, David William Richards and Rolandas Karbauskas, I write on behalf of Nottinghamshire Healthcare NHS Foundation Trust in response to the Prevention of Future Deaths Report issued on 7 February 2025.
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All three men died as a result of self-inflicted injuries in March 2023 while in state detention at HMP Lowdham Grange, within a 19-day period of one another.

We accept the inquest conclusion and would like to assure you that we take the findings very seriously. Please see the following, in which we detail the actions we have taken to improve patient care and experience subsequently to the inquest.

The Inquest conclusion identified that there was a complete failure to identify and share risk pertinent information between prison and healthcare staff, and within those teams:
More specifically, there was a concern in relation to risk identification and information sharing, Prison and Healthcare staff did not routinely consider information captured within the electronic systems, nor did they update the systems with risk pertinent information gathered during interactions with the prisoners. The Trust is committed to being compliant with PSI 64/2011 *"All staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence, and take appropriate action*."

Improvement oversight for Offender Health and HMP Lowdham Grange **-** The Trust has established enhanced Executive led oversight and assurance reviews for Offender Health. This comprises a weekly meeting where progress against the Transformation Plan is reviewed with individuals held to account.

The update against the required actions for this PFD will be reviewed as part of this process.

Reception screening: A new national template for prison reception screening for the male prison estate was launched on the 1 April 2025. Staff are in the process of receiving the Nationally delivered

training for this and the benefits include a standardised and simplified model of screening which enable the understanding and recording of previously documented clinical risk which needs to be further considered as part of the reception and induction process.

Part of the reception screening is the ability to access a digital Person Escort Record (PER). This is a prison document which follows the prisoner journey through their custodial sentence and contains risk pertinent information. There is no ability to audit this access however, the supervision proforma for the clinical staff in reception will be amended to ensure it forms part of the supervision record.

The Head of Safer Custody has introduced a new Early Days in Custody (EDIC) booklet along with colleagues from Reception and the Induction wing. This booklet has now been in place for one month and contains a section for healthcare staff to complete, identifying any immediate risks that the individual may present with and including any historical information. Ideally the document is completed in reception and follows the patient to the induction unit. The Officer in charge of the induction unit will meet with the Head of Healthcare to audit the use of the EDIC forms on a monthly basis to enable ongoing quality improvement as required.

Safety Interventions Meeting (SIM): We have worked with Prison colleagues to ensure that SIMs are attended on a weekly basis by a member of the Mental Health Team. This meeting is to discuss any patients of concern and highlight any specific issues relating to that individual. A Prison safeguarding referral form (Annex Q) is now in use and concerns can also be raised online via the DPS system. A random spot check of attendance and the quality of information shared will be randomly reviewed by the Head of Healthcare at HMP Lowdham Grange.

CSIP: Patients can also be referred to CSIP (Challenge, Support and Intervention Plan). This is a prison risk management system and process that will enable information sharing on risk in the prison estate and also support the development of cross professional relationships. Healthcare staff are currently accessing the training for this, and full compliance is aimed to have been achieved by June 2025.

Training - Healthcare staff have arranged to attend the Prison staff induction programme so that they can deliver health training to the Prison Officers. Initially this will be focused on emergency response but will later include Mental Health awareness training. This was agreed at the Local Delivery Board and the first session was provided on 23 January 2025. Feedback from staff was very positive. Healthcare staff will continue to receive clinical risk, self-harm and suicide training, which is an inhouse training programme. Compliance will be achieved by July 2025.

Discussions have taken place with the Head of Residential Services to discuss how appropriate risk pertinent information can be shared on the wings as part of effective information sharing with prison colleagues. Systems such as identifying clinical risk by adding a coloured dot to their name on the wing prisoner list are being scoped. Healthcare staff have been informed that they must document in the wing observation book any relevant risk pertinent information to alert staff to any potential issues. Again, this will be audited and reviewed for quality by the Head of Healthcare and Safer Custody Officer.

ACCT: Assessment, Care in Custody and Teamwork processes are being managed through a booking process with advance notification. All first ACCT reviews are attended by a registered nurse in line with the ACCT process. Subsequent follow up reviews are attended where possible or prioritised based on clinical risk and need. Phone and email contributions are also supported if required. The process of our ACCT attendance and contribution will be reviewed as part of the safer custody process to ensure the quality is as desired and required. As part of the ACCT process

safety plans should be shared with the Patient and with prison colleagues with escalation routes identified. This will be reviewed and audited by the Head of Healthcare as part of local quality assurance processes.

Healthcare daily handover: Daily attendance at the prison morning meeting handover should provide any risk information at the start of the day that may have occurred overnight. This information is then cascaded for action to the Healthcare Team as required.

The healthcare team have a daily lunch time handover which is designed to capture any matters of concern, risk or escalation. Where appropriate, this should be recorded in the S1 record. A brief note of the risk should be recorded in the meeting record along with person responsible for management.

Email: Healthcare has generic email inboxes which are monitored daily by administrative staff which have been provided to the wings as a first point of contact for non-urgent issues. This includes a mailbox for each clinical pathway. A reminder has also been sent to Prison staff via the Governors secretary, to the wings, of the mailbox addresses and call signs on the radio for contacting healthcare. No personal emails should be used for patient related queries.
I hope this information provides assurance that we have and continue to consider the points identified very seriously, and that we are actively seeking to improve the services we provide by implementing the actions outlined

Yours sincerely

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Chief Executive Officer