



HCRG Care Group
The Heath Business & Technical Park
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9th March 2026

For the attention of His Majesty's Senior Coroner for Chelmsford Mr Horstead

Regulation 28 Report issued following the inquest into the death of Stuart Berry

We would like to express our sincere condolences to the family of Stuart Berry. We recognise the seriousness of the matters raised by the Coroner and have carefully considered the concerns identified in the Regulation 28 report. We are committed to learning from this Mr Berry's death and to taking proportionate, meaningful action to reduce the risk of similar incidents occurring in the future.

Understanding of the Coroner's Concerns

It is our understanding that the coroner's concerns relate to the following areas:

- **Information Sharing:** A failure to share the Prisoner Warning Notice with custodial colleagues.
- **Documentation:** A failure to document the risk of self-harm and suicide in SystemOne by the reception Nurse.
- **Conduct Assessment:** A failure to recognise the level of risk of self-harm and suicide, raising concerns regarding the adequacy of staff training and the monitoring of standards, supervision, and quality assurance processes.
- **Escalation / Referral:** A failure to refer for an urgent review by the mental health team.

We are focusing on strengthening the interfaces between healthcare and custodial services, retraining reception nurses, and introducing a dedicated Early Days in Custody (EDiC) Nurse role.

The EDiC Nurse is leading an action plan to improve standards in early days in custody care. We are currently working to a 3-month turnaround for the action plan, with completion targeted for 26 May 2026. The EDiC Nurse will provide clinical supervision, oversee quality assurance, and monitor delivery against the action plan. Progress and performance against the plan will be reported through the Clinical Governance structure, with oversight from the Clinical Governance Lead.

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Actions Already Taken

Since Mr Berry's death, the following actions have been completed or initiated:

- **Quality Assurance and Oversight of Early Days in Custody (EDiC):**

A dedicated EDiC Nurse role has been created to manage and oversee risks during the early days in custody, in close partnership with the custodial and safer custody teams. Reception has been identified as a key risk point for those new in Custody. The EDiC Nurse role provides leadership and quality assurance for reception screening, mental health risk assessment, information sharing, and escalation pathways. This role commenced in January 2026 and has been temporarily filled by a long-standing dual qualified nurse pending the onboarding of a substantive post holder.

- **Prisoner Warning Notices (PWN):**

The PWN is received into the prison via secure email and it is the responsibility of the Reception Nurse to review this notification on receiving a patient into custody, consider it in their assessment of patient risk and take immediate appropriate action, including sharing with Custodial Managers and Officers covering reception.

A formal communication logbook has been implemented to provide clear assurance of PWN sharing. The logbook records the date and time of receipt, the staff member with whom the PWN was shared, and confirmation that risks were communicated and acknowledged. All relevant staff have been trained on this new process.

The EDiC Nurse reviews the logbook to ensure compliance, timeliness, and effective two-way communication of risk information alongside providing supervision and training to all Reception Nurses.

The Safeguarding Administration and Patient Experience lead (appointed September 2025) reviews all PWN alerts on a daily basis, ensuring the information is recorded within the patient's records, and alerting all health care professionals, particularly Mental Health, to risk information concerning suicide and self-harm.

- **Improving SystemOne Documentation and Clinical Recording**

Targeted SystemOne (the Clinical Computer System we use) training has been introduced to reinforce expected standards. North of England Care System Support (NECS) have been commissioned by NHS England to provide support for SystemOne and have arranged for all staff to have access to their training portal which has a suite of training packages. Our induction paperwork has been adapted to ensure that all new staff are provided with access and are required to attend SystemOne basic training. Existing members of staff have been provided with refresher training.

In addition, the EDiC Nurse role provides structured supervision and coaching to reception nurses, including regular review of SystmOne entries, case-based feedback, and support to improve clinical reasoning and documentation. This approach provides ongoing assurance that mental health risks are clearly recorded, appropriately escalated, and visible to all relevant professionals.

Documentation quality is monitored by the EDiC Nurse through monthly audits and review of supervision records, with learning and themes fed back to the wider team to support continuous improvement. This is a key agenda item on the monthly Clinical Governance Meeting and team meetings. A daily staff handover meeting has also been commenced to ensure staff are aware of current issues and any patient or safety concerns. These quality assurance processes are undertaken by the EDiC Nurse with the support of the local Quality Lead.

Our Quality Lead attends monthly induction meeting with new starters and provides further bespoke training. Help sheets are circulated to all staff giving hints and tips on appropriate clinical documentation and guidance on incident reporting process.

- **Referral to the NMC**

HCRG reflected on the Coroner's recommendation to reconsider referring the Reception Nurse to the Nursing and Midwifery Council. Given the Nurse is currently on maternity leave, HCRG sought advice from the NMC as to the timing of the referral. In line with advice from the NMC, the referral was made on 18 December 2025 in accordance with our professional regulatory requirements. Our internal HR processes are also being followed to ensure concerns are addressed in parallel with the NMC referral directly with the individual. This action sits alongside internal clinical governance review and system learning to reduce the risk of recurrence.

Further Actions Planned

We continue to make changes to improve the service and embed learning, including:

- **Strengthening Mental Health Awareness and Screening at Reception**

Targeted 1-1 training was introduced on 27 January 2026 to enhance staff understanding of suicide and self-harm risk factors, acute mental distress, and the impact of early custody on mental wellbeing. The newly established EDiC Nurse role provides clinical leadership and quality assurance through supervision, coaching, and review of reception assessments, supporting nurses to move beyond checklist-based screening and to apply professional judgement when identifying and escalating mental health risk. This approach supports earlier identification of risk and timely referral for mental health assessment. The Edic Nurse also supports and supervises staff in identifying the appropriate ACCT observation levels and carries out reviews of ongoing ACCT observation levels to check their appropriateness.

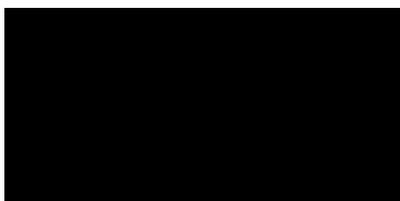
- **Improving Identification and Escalation of Urgent Mental Health Referrals**

The Mental Health Operational Standard Operating Procedures and referral processes are being reviewed, clarifying thresholds for urgent mental health referrals, escalation routes, and agreeing expected response times as within 24 hours. This is audited by the EDiC Nurse. This review will be completed by 30 April 2026. Reception nurses are being supported to identify and escalate urgent presentations through targeted training on assessing the risk of suicide and self-harm alongside ongoing supervision.

The newly established EDiC Nurse role provides quality assurance by reviewing referrals, supporting timely escalation, and monitoring referral times to ensure that urgent mental health needs are prioritised and responded to within the set 24-hour timescale. Referral timeliness and escalation decisions are monitored through case review and audit, with learning fed back through supervision to support sustained improvement.

We would like to thank the Coroner for the opportunity to respond. While we are confident that this response addresses the points raised in your Report, if the Coroner has any ongoing concerns or queries in respect of the actions we have taken, we would welcome the opportunity to provide further information.

Yours sincerely,



Regional Director