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RG7 4SA

HM Assistant Coroner Mr James Puzey
Coroners Court
The Civic, Martins Way,
New St
Stourport-on-Severn,
DY13 8UN

28 April 2026

Dear Sir,

Regulation 28: Prevention of Future Deaths report, Mr Surendra Patel (Dec'd)

Thank you for your Regulation 28 Prevention of Future Deaths Report issued to Practice Plus Group following the Inquest into the death of Mr Surendra Patel (Dec'd). Practice Plus Group would like to express its condolences to Mr Patel's family and friends.

Practice Plus Group is the lead provider of healthcare services at HMP Hewell. There is a sub-contracting arrangement in place with Midlands Partnership NHS Trust ("MPFT") in respect of the provision of mental health services, whom have provided a separate response to the issues raised in the Prevention of Future death report as have the Ministry of Justice on behalf HMP Hewell.

This response addresses the matters of concern insofar as they relate to Practice Plus Group only.

Practice Plus Group welcomes the opportunity to respond to the concerns raised by HM Assistant Coroner. The circumstances of this case were complex. Mr Patel arrived in prison in a malnourished state which the Inquest learnt had been an ongoing chronic issue for him dating back at least one year. Further, and whilst Mr Patel was remanded at HMP Hewell, at no time was he found to lack capacity to refuse food and fluids and /or proposed medical assessments. This meant that, when assessments and food and fluid was offered and declined, the healthcare staff were required, pursuant to the Mental Capacity Act 2009, to respect the wishes of Mr Patel. This was reflected in the conclusion reached by the Jury that Surendra Patel died from natural causes contributed to by self-neglect by malnutrition.

The Inquest revealed that both the primary healthcare staff (Practice Plus Group) and mental health staff (MPFT) responded to Mr Patel with sensitivity, care and compassion following Mr Patel's decision to refuse food and fluid. It is also of note that the clinical reviewer commissioned by NHSE to assist with the investigation undertaken by the Prison & Probation Ombudsman's

investigations confirmed at the Inquest that the standard of care provided to Mr Patel whilst he was in prison was good.

The clinical reviewer did however identify areas where improvements could be made and some of these recommendations chime with the concerns listed below.

Matter of Concern 1

Amongst Healthcare staff, both MPFT and PPG, there was a general lack of awareness of the terms of the then current PPG food refusal policies. This took the form of:

- a. A failure to appreciate that once food refusal had begun. A mental capacity assessment should be undertaken as soon as practical:***

Response

Following notification of Mr Patel's refusal to eat and drink from 22 October 2024, a plan was already in place for Mr Patel to be reviewed by a GP on 23 October 2024. This had been arranged following a Multi Professionals Clinical Case Clinic ("MPCCC") It was not possible for the GP consultation to take place on that date and so [REDACTED] GP, was tasked with reviewing Mr Patel on 24 October 2024. He did this and would have gone on to complete a formal Mental Capacity Act Assessment, but Mr Patel refused to allow [REDACTED] to examine his neck wound and terminated the consultation before [REDACTED] could complete the planned assessment.

[REDACTED] explained when giving evidence at the Inquest that he had no reason to doubt that Mr Patel had capacity to refuse food and fluids. [REDACTED] was concerned however as he found it difficult to reconcile the reason Mr Patel was remanded into custody with the presentation of the man he met on 24 October 2024.

The following day, and at the next weekly MPCC, [REDACTED] spoke with the attending consultant psychiatrist employed by MPFT about Mr Patel. [REDACTED] asked the attending consultant psychiatrist to assess Mr Patel urgently. Arrangements were made for the psychiatrist to assess Mr Patel on 29 October 2024 which was the very next day the consultant psychiatrist was due to attend HMP Hewell. The standard expected time for a patient to be seen following an urgent referral to a consultant psychiatrist at HMP Hewell was 14 days at that time.

The arrangements made were for the psychiatric assessment to be undertaken within 7 days of the primary healthcare team being notified of Mr Patel's Unfortunately, Mr Patel was admitted to the local Acute Hospital on 27 October 2024. Therefore, the assessment never took place.

It is of note that the clinical reviewer commented when giving evidence at the Inquest that she did consider the referral had been made as soon as was practically possible and, in any event, even if a formal Mental Capacity Act assessment had taken place, she was not convinced it would have made any difference to the care provided.

- b. A failure to consider hospital transfer for patients in a physically weak state due to weight loss***

Response

Practice Plus Group accept with the benefit of hindsight that transfer to hospital may have been considered a couple of days earlier following the first time Mr Patel consented to having his weight checked on 25 October 2024. The case was complex in that, at no time during the period that Mr Patel refused food and fluid did his vital observations give any cause for concern. The jury heard

during the Inquest that, whilst Mr Patel was eating and drinking very little, Mr Patel was drinking small amounts of fluid during the period of food and fluid refusal and that by 25 October 2024 he had reversed his decision to refuse food and fluids such that Mr Patel had started to eat small amounts of food.

- c. A failure to expedite full medical assessment by a senior registered Healthcare professional: in particular assessment by psychiatrist of the reasons for food refusal in circumstances where a wear a prisoners physical health puts his long-term health or survival at risk.***

Response

This concern is in part addressed in response 1a above. However, MPFT did confirm during the Inquest that, since the death of Mr Patel, the number of consultant forensic psychiatrists available to attend HMP Hewell has increased. It is now anticipated that in urgent circumstances such as the scenario described above, it would now be possible for a psychiatric review to take place in 3 days. HM Assistant Coroner also heard during the Inquest about the current business case which has been sent to NHSE seeking to increase staffing levels across both primary care and mental health care which will also assist in ensuring the timeframe in referral to assessment may be expedited even further.

- d. A failure to consider an advocate for family contact***

Response

Healthcare staff do consider whether it is appropriate to contact family members to support the patient through a period of food and fluid refusal. In this case, the evidence heard at the Inquest was that whilst the family raised concerns that they were seeking to contact the prison, the prison was unable to find any evidence to confirm such contact was being sought. This was not something Practice Plus group had any knowledge about or was able to assist the Assistant Coroner with.

So far as Practice Plus Group is concerned, Mr Patel did not request any family support. Mr Patel told the nursing staff that his only external support had been his wife and that he was not in contact with his daughter at the time he entered HMP Hewell. Therefore, the need to act as an advocate for family contact did not arise in this specific case.

Had family contact been sought either by Mr Patel, or considered to be of benefit to Mr Patel, it would have been necessary to consult with the prison before any final decision was made to contact the family owing to the nature of the index offence which Mr Patel had been charged and remanded into prison for.

Action:

The factual matrix leading to Mr Patel's transfer to hospital on 27 October 2024 was complex. Mr Patel was not a typical prisoner who refuses food and fluid in that he was not refusing food and fluid to influence a decision or outcome to improve his incarceration at HMP Hewell. He arrived at HMP in a malnourished state owing to other physical health co-morbidities. At no time was there any clinical reason to believe that Mr Patel may lack capacity to refuse food and fluids and/or any other aspects of the care provided to him which, in the main, he consented to.

This does not mean that Practice Plus Group has not reflected on this case. The outcome of the Inquest follows a period whereupon the food and fluid refusal pathway has robustly been tested and, as a result, Practice Plus Group considers it to be robust and fit for purpose regardless of the

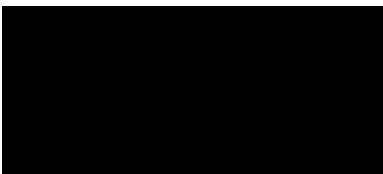



reason for the food and fluid refusal. In addition to local feedback to the primary healthcare staff at HMP Hewell following the outcome of the Inquest, Practice Plus Group has planned to roll out a series of talks nationally across the Group in July 2026 to feedback on the recent high profile food and fluid cases they have been involved in, and to reinforce the need to follow the food and fluid pathway in full.

In summary, Practice Plus Group is committed to providing a high-quality healthcare service at HMP Hewell and are doing everything we can to ensure those detained there are as safe as possible and receive the best quality care. We are deeply sorry that Mr Patel died following care from our service, and we will ensure that the lessons learnt are not just implemented at HMP Hewell but across Practice Plus Group's services.

We trust that the above responses provide the information that you require but please do not hesitate to contact us if Practice Plus Group can be of any further assistance.

Yours faithfully




Medical Director
Health in Justice
Practice Plus Group

On behalf of Practice Plus Group