HM Prison & Probation Service

[redacted]
Director General of Operations
HM Prison and Probation Service
8th Floor Ministry of Justice
102 Petty France
London
SW1H 9AJ

[redacted]

Ms Alexandra Pountney
Assistant Coroner for Nottingham
and Nottinghamshire
The Council House
Old Market Square
Nottingham NG1 2DT

1 June 2026

Dear Ms Pountney

**REGULATION 28 REPORT TO PREVENT FUTURE DEATHS: MR JONATHAN THORNTON**

Thank you for your Regulation 28 report of 10 March 2026 addressed to the Ministry of Justice and the Governor of HMP Nottingham following the inquest into the death of Jonathan Thornton on 12 July 2024. I am responding on behalf of His Majesty's Prison and Probation Service (HMPPS) and the aforementioned recipients.

I know that you will share a copy of this response with the family of Mr Thornton, and I would first like to express my condolences for their loss. Every death in custody is a tragedy and the safety of those in our care is my absolute priority.

You have raised concerns regarding information sharing between healthcare and prison staff and the categorisation and visibility of alerts on NOMIS/DPS.

Although your concerns about the sharing of information between healthcare and prison staff have been referred to Nottinghamshire Healthcare NHS Foundation Trust and Northampton Healthcare NHS Foundation Trust for their separate consideration and response, HMPPS has also considered whether there is any supportive action that it can take.

A national Information Sharing Advisory Group (ISAG) is in place, which aims to improve information sharing between health and prisons. In order to improve practice, HMPPS Health and Care Information Sharing guidance was issued to prisons in July 2022 in two formats (A5 booklet and wallet size) and is available on the HMPPS intranet. The guidance aims to improve and achieve a more consistent approach to the sharing of information between all

partner agencies and to give staff confidence in decision making, to reduce risk to self and others, and to achieve better outcomes for all staff, people in prison and people under probation supervision. We will ask the ISAG to consider the circumstances of Mr Thornton's death to identify learning and whether there is a need for additional or updated guidance.

We have considered the points you have raised regarding the categorisation, visibility and accessibility of alerts within NOMIS/DPS. We recognise the seriousness of the issues identified and acknowledge the importance of ensuring that operational and healthcare staff have clear, relevant and actionable information to manage risk effectively within custodial settings.

The current system already contains more granularity than a single "violent" categorisation. However, we recognise that improvements are needed in consistency, clarity and visibility. A dedicated programme of work is scheduled to review alerts later this calendar year, subject to prioritisation, and will be undertaken in collaboration with safety experts, digital and policy colleagues. This work will strengthen both the quality and usability of alerts in order to reduce risk and support safer decision-making. We will ensure that the findings from this review inform future enhancements and address the matters you have raised.

Thank you again for bringing your concerns to my attention. I trust that this response provides assurance that action is being taken to address the matters raised.

Yours sincerely,

Director General of Operations