

**RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS
REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

THIS RESPONSE IS BEING SENT TO:

The Senior Coroner, Mr David Reid for the Coroner Area of Worcestershire in response to a **REPORT TO PREVENT FUTURE DEATH REGULATION 28'** following an inquest into the death of **Adam Eaton CLARK** that concluded on **23 July 2026**.

1.	RESPONDENT In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, Practice Plus Group provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths.
2.	DATE OF RESPONSE 21/09/2026
3.	CONFIRMATION OF CORONER'S MATTERS OF CONCERN The MATTERS OF CONCERN were identified in the report are as follows: Mr Clark's background medical and mental health history was notable for long-standing mental health, alcohol and drug issues, and a number of attempts at suicide and/or self-harm in the community. The most recent attempt at self-harm was a drug overdose only 6 weeks before his arrival at HMP Hewell. His Person Escort Record (PER) which accompanied him to HMP Hewell summarized this history, and marked him as a risk of suicide/self-harm. During the inquest, I heard evidence that the agency nurse who conducted the deceased's initial healthcare screening appointment on his arrival at HMP Hewell may not have looked at his PER, either because he did not have access to a copy of it, or because he had not been trained to ensure that he looked at it. I heard evidence from the Head of Healthcare at HMP Hewell that agency nurses working in prisons throughout England and Wales are provided to Practice Plus Group (PPG) by one agency, and that whilst PPG can request the agency to ensure that all nurses provided understand the need to look at the PER when conducting the initial healthcare screening appointment, they cannot

	mandate it. I also heard evidence during the inquest that, whilst it may be possible to amend the template for the healthcare screening appointment by including a mandatory question for the nurse to complete indicating that they have read the PER, any changes to the template can only be made nationally, and not locally.
4.	DETAILS OF ACTION TAKEN, how has the concern been addressed. Practice Plus Group would like to express its condolences to Ms Clark's family and friends. The matters of concern to you are highlighted in bold with the response set out below each concern. This response addresses the matters of concern insofar as they relate to Practice Plus Group only.
	1. Agency nurses provided to Practice Plus Group to work in prisons, may not understand the need to consult a prisoner's Person Escort Record (PER) when completing the initial healthcare screening appointment Extensive evidence was given at the Inquest to explain the work conducted by Practice Plus Group to the early days in custody process which incorporate the first reception screen and the opportunity to review the PER By the reception nurse. Discussion of the above concern should therefore be considered alongside these developments undertaken not only at HMP Hewell but across all prisons in which Practice Plus Group provides a primary healthcare service. Examples of the steps that have been undertaken by the Head of Healthcare at HMP Hewell to ensure the PER reports are reviewed include obtaining written confirmation from the agency who provides agency nurses to HMP Hewell that they are aware of the need to review the PER form if working in the reception area. In addition, there are posters in every reception room reminding all healthcare staff that the PER report should be reviewed. The administration staff review all new admissions daily to check that the PER record is reviewed during the reception screening. If review of PER form has not taken place (and this can sometimes be as there is not a form in existence), this observation is brought to the daily lunchtime meeting by the administration staff to ensure that the PER is reviewed. In addition to the above steps, there is a daily multidisciplinary team meeting that takes place every morning in which all new prisoners who have entered the prison are reviewed again. This multidisciplinary team meeting includes review of the PER report. This reflects a national practice and is not limited to HMP Hewell only. Over recent years, and particularly with the implementation of the Early Days in Custody process, the reception screening pathway has developed beyond a single, stand-alone screen. A full and detailed reception screen, including review of the PER, remains an essential first step. However, this now forms part of a wider process of ongoing review during the early days of custody, providing

further opportunities to identify and act upon important clinical or risk information that may not have been identified at the initial reception screen. This allows further information that becomes available during the early days of custody to inform a more complete assessment of the individual's clinical needs and risks. This provides additional safeguards and reduces the risk of important information contained within the PER being overlooked.

The use of agency nurses in the reception area at HMP Hewell has significantly reduced. Where agency nurses continue to be used, these are predominantly established, long-term agency staff who are familiar with HMP Hewell and its reception processes. Agency nurses who have not previously worked at the establishment are only used by exception, when there is no other alternative and as short-term cover due to unplanned absence.

To support consistent quality and assurance standards, Practice Plus Group now contracts a single agency for the provision of temporary healthcare staff across its prison healthcare services. The agency is required to ensure that staff supplied to Practice Plus Group have the appropriate professional registration, training, experience and competencies for the role in which they are deployed.

Over the last year the agency has given assurance that they have strengthened its induction and assurance arrangements, implementing an induction and competency framework for staff deployed to Practice Plus Group services. This includes specific requirements relating to working within reception, the reception health screening process and the role and responsibilities of the healthcare professional undertaking this activity. The framework specifically includes the requirement to review the DPER and to identify and act upon relevant information contained within it.

Alongside these arrangements and the actions outlined above, Practice Plus Group has been undertaking a wider organisational programme of work with the agency to further strengthen and standardise agency workforce induction and assurance across its prison healthcare services. This work was already underway prior to receipt of the PFD and is now nearing completion.

The wider work builds upon the agency's existing framework and Practice Plus Group's current induction and assurance processes, bringing these together within a jointly agreed Agency Workforce Induction and Assurance Framework. This will provide greater clarity and consistency regarding the respective responsibilities of the agency and Practice Plus Group throughout the induction and deployment process, including pre-deployment assurance, mandatory training, role-specific knowledge and competencies, Practice Plus Group induction requirements, and local site induction, orientation and supervision.

As part of the wider arrangements, agency staff new to prisons healthcare are also now expected to attend Practice Plus Group's recently introduced national induction programme, which provides face-to-face learning relevant to working within prison healthcare. This includes reception and early days in custody, the

	role of the healthcare professional within the reception process and the importance of reviewing and acting upon information contained within the PER. Practice Plus Group is working with the agency and operational teams to ensure that this requirement is consistently implemented. The learning arising from this case has been incorporated into this wider programme of work and has provided a further opportunity to review and reinforce these existing requirements, particularly the importance of reviewing all available information during reception health screening and appropriately identifying, escalating and acting upon any identified risks. 2. Any changes to the template for the initial healthcare screening appointment in prison, designed to ensure that the nurse completing it has consulted the PER, can only be made nationally, and not locally. As outlined at the inquest, the reception screening template is a national NHS England clinical template used across the adult prison estate in England and is not owned or controlled by Practice Plus Group. Consequently, Practice Plus Group is unable to make local amendments to the template itself. However, the concern identified in relation to the recording and review of the PER has been actively escalated. Practice Plus Group has raised this through NHS England commissioning and quality routes, including again recently in May and July 2026 through the national NHS England template assurance process. This is intended to ensure that the issue is considered at the appropriate national level and that any amendment, if agreed, can be applied consistently across the secure estate. In the meantime, Practice Plus Group has introduced additional safeguards within its own reception process. Since September 2025, an additional prompt before commencing the reception screen, requires the clinician to review the available medical record, including the PER, before progressing with the reception screen. This does not alter the nationally controlled template itself, but provides an additional local control while the national escalation is progressed. As mentioned above, the completion of the PER form is also checked daily by the administration staff so any missed PERs may be picked up promptly. Practice Plus Group will continue to work with NHS England and the relevant national template governance arrangements to support consideration of a more definitive national solution. In conclusion, we remain committed to providing high-quality healthcare service at HMP Hewell and across all our services, and to ensuring those detained in our care are as safe as possible and receive the best quality care. We are deeply sorry that Mr Clark died while receiving 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.
6.	SIGNATURE



**Medical Director Health in Justice
Practice Plus Group**

DATE 21/09/2026