



30th June 2026

PRIVATE AND CONFIDENTIAL

Mr MJ Pemberton
HM Area Coroner for Manchester West
First Floor
Paderborn House
Howell Croft North
Bolton
BL1 1QY

Dear Mr Pemberton

Re: Mr Jake O'Brien (deceased) Regulation 28 Preventing Future Deaths Response

Thank you for highlighting your concerns following Mr O'Brien inquest which concluded on 6th May 2026. On behalf of Greater Manchester Mental Health NHS Trust (GMMH), I would like to offer Mr O'Brien's family our sincere condolences for their loss.

As highlighted to you in email correspondence GMMH do not have the ability to provide a response or power to address lesson learning relating to the Matter of Concern Points 1, 2 and 3 as outlined in the PFD as these relate to prison staff and Prison Service Orders, which are the remit of Sodexo, the Ministry Of Justice (MoJ) and the Health and Safety Executive (HSE).

Further in relation to Matter of Concern 3, the decision not to place Mr O'Brien on medical hold took place at HMP Liverpool where GMMH is not a healthcare provider.

In respect of Matter of Concern point 4, please find the Matter of Concern highlighted in bold and the Trust's response to this concern.

Evidence was heard that no mental health nurses from primary mental health care charge with completing a segregation algorithm form for segregated prisoners to determine medical suitability, had received training on how this should be done, definitions to be applied or necessary escalation to healthcare for a Multi-Disciplinary Team meeting to occur. On the evidence a question of whether a prisoner had self-harmed during this period of custody was viewed as meaning since arrival at the establishment, meaning

that any acts of self-harm at a former establishment were not included in the risk assessment matrix. Alongside the confusion of when to refer to healthcare for advice (given a view healthcare were attending to do this assessment), there was an apparent missed opportunity to escalate to secondary mental health care ongoing bizarre behaviour being witnessed on Jake's part.

The Trust has clarified with the MoJ that there is no national or formal guidance for the completion of the segregation algorithm form currently available. It is therefore unknown what the expectation is with regards completion of the segregation algorithm or whether practice is consistent and standardised nationally throughout the prison healthcare setting.

However, to address this concern on a local level the Operational Manager from HMP Forest Bank is coordinating the development of guidance for health care staff to go alongside the algorithm explaining the parameters of each question, e.g. that this period of custody includes the whole period of custody where prisoners have been transferred from another prison. The guidance will also include when to escalate any concerns and who to.

This guidance will be approved at the Trust's Health & Justice Senior Leadership Team Meeting on 6th August 2026. Once approved the guidance will be shared with all current GMMH health care staff by way of a learning event led by the Operational Manager from HMP Forest Bank and held by 18th September 2026 where the learning from Jake's death will be shared along with the guidance for completing the algorithm. This learning event will be held on Teams so it can be recorded and the link to the recording will be shared with all health care staff.

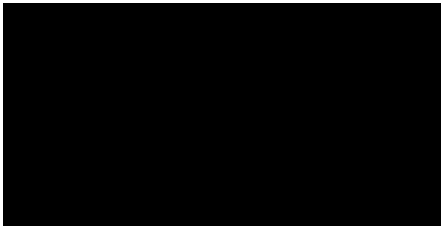
The guidance will be added into the induction programme for all health care staff who work in prisons across the Trust footprint. Once in place the Trust will share the guidance with partners who provide health care service in prisons across the GMMH footprint. We will also share with the Royal College of Nursing (RCN) UK Professional Lead for Justice and Forensic Nursing who leads a Nursing in Justice and Health Care Forum. This forum promotes guidance and best evidence for forensic nursing practice and supports in the development of guidance and competency for nurses.

The identified missed opportunity to escalate ongoing bizarre behaviour witnessed on Jake's part to the secondary mental health care team has been addressed through the implementation of weekly single point of access (SPOA) meetings. These meetings are attended by all mental health care staff and give the opportunity to discuss cases and escalate any concerns. Joint staff meetings have been implemented with all mental healthcare staff meeting together to enable any issues in how the teams work with each other to be raised and addressed. Learning from Jake's death has been shared with staff through these meetings and in individual supervision sessions.

There is a weekly allocation meeting in place where all prisoners referred into the secondary mental health team are reviewed by the healthcare senior leads. Anyone who has an active open referral to a mental health hospital are identified on admission or transfer. This case is reviewed by the duty worker, and a secondary care mental health nurse is allocated immediately. All other referrals are prioritised based on clinical presentation and need.

I thank you again for bringing these matters of concern to the Trust's attention. If you have any further questions in relation to the Trust's response, please do let me know.

Yours Sincerely



Chief Nursing Officer

Please contact us if you require support with this information including other language, audiotape, Braille or larger print.