

**Mr Michael James Pemberton**  
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**National Medical Director**  
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7 July 2026

Dear Mr Pemberton,

**Re: Regulation 28 Report to Prevent Future Deaths – Jake Anthony O'Brien who died on 12<sup>th</sup> November 2024.**

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 18<sup>th</sup> May 2026 concerning the death of Jake Anthony O'Brien on 12<sup>th</sup> November 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Jake's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Jake's care have been listened to and reflected upon.

Your Report raises the following concerns:

1. There is no ongoing training provided to prison officers after their initial training on basic life support or first aid.
2. Evidence was provided to you that the national standard is one trained first aider to 50 prisoners, set by the Health & Safety Executive. You would like clarification as to whether this includes life preserving response.
3. The Prison Service Order (3050) which relates to clinical holds and consistency of healthcare for prisoners is 20 years old and makes no reference to mental health or neurodiversity.
4. Mental Health Nurses who complete the segregation algorithm for segregated prisoners had not received training for how to do this or when to escalate to healthcare for a Multi-Disciplinary Team meeting. There appeared to be confusion over which period the question on the form about self-harm related to.

**Ongoing Basic Life Support and First Aid Training for Prison Officers**

The provision of initial and refresher first aid and basic life support training for prison officers is an operational responsibility of HM Prison and Probation Service (HMPPS). NHS England recognises the concern raised regarding the absence of ongoing refresher training following initial officer training and agrees that maintaining competence in emergency response is important in supporting patient safety. As the training requirements for prison officers are determined and delivered by HMPPS, and your Report has also been addressed to the Ministry of Justice, they are best placed to provide detail regarding current training arrangements, refresher requirements and any planned improvements. NHS England will continue to work collaboratively with

prison partners to support safe emergency healthcare responses within custodial settings.

In addition, the learning arising from this inquest will be raised through the regional Prison Partnership Board to ensure consideration is given to any opportunities to strengthen joint working and emergency response arrangements across health and custodial services.

### **National Standard**

As this is set by the Health & Safety Executive who you have also addressed your Report to, they are best placed to answer this concern.

### **Prison Service Order**

The Prison Service Order (3050) is written by HM Prison and Probation Service (HMPPS), within the Ministry of Justice. As you have also addressed your Report to the Ministry of Justice, they are best placed to answer this concern.

### **Segregation Algorithm and Training**

The North West Region Health & Justice (H&J) Quality Lead has escalated the lack of clarity regarding the algorithm to the regional Prison Partnership Board and feedback will be provided on progress against actions.

The H&J Quality Lead and Senior Commissioning Manager have worked closely with the healthcare provider(s) in HMP Forest Bank to address the concerns raised in your Report. The following actions have been taken as a result:

1. **Development of Local Clinical Segregation Unit (CSU) Safety Guidance** – The mental health provider, Greater Manchester Mental Health (GMMH) has led on the creation of a local CSU safety guidance document, with input from other providers and NHS England, to address the lack of written procedures within HMPPS and to provide assurance to the Trust and Coroner. This draft guidance is expected by the end of July 2026.

The CSU self-assessment/algorithm is designed as a template for local teams to define their own process, which is now understood and being progressed. The document will include an algorithm for clinical decision-making, guidance on gathering information around assessment of risk and clear escalation processes. This requires provider and HMPPS governance approval.

2. **Patient Flow and Transfer Data Management** - A new patient flow and transfer data workbook, to track and manage prisoner transfers, delays, and related clinical information is in development and to be shared regionally.
3. **Escalation, Audit, and Implementation Planning:** An audit process will be developed to monitor the use of the new CSU safety guidance. This audit process

will be developed alongside the CSU safety guidance, with governance and implementation planning expected during August 2026. Planning for governance approval is underway, and scheduled follow-up meetings are planned to review progress and implementation.

4. **Training aligned with the guidance** – training will be delivered to current staff and incorporated into the induction for new staff. Training materials will be developed following approval of the guidance, with rollout to existing staff and incorporation into induction processes targeted for Autumn 2026.

Each provider is responsible for developing and delivering the training and ensuring staff competence. [Integrated Care Boards](#) (ICBs) who commission the services are responsible for assuring themselves that appropriate actions, including training, have been implemented and are effective.

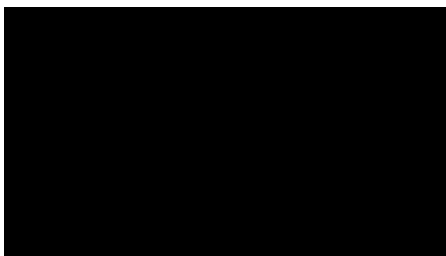
Local commissioners can facilitate sharing of good practice across the system, but this is not mandatory and responsibility for that would sit locally across other ICBs and providers.

The guidance and training for staff in this case have been led by GMMH as the provider locally, as such we cannot comment on this. However, we are aware that you have also addressed your Report to the provider, who will provide more detail on this specific concerns.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Jake, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



National Medical Director  
NHS England