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Mr Nigel Meadows
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HM Coroner's Office
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6th March 2020

Dear Mr Meadows

Re: Letter of Concern written under Paragraph 37 of the Chief Coroners Guidance number 5 on Prevention of Future Deaths – Mr Tomasz NOWOSAD, Date of Death 2 February 2017.

Thank you for your letter dated 20 December 2019 (hereinafter the 'letter') concerning the death of Tomasz Nowosad on 2 February 2017. At the very outset I would like to express my deep condolences to Mr Nowosad's family.

Following the conclusion of the inquest you raised concerns regarding the skills and knowledge of the Clinical Reviewer whose report was used as part of the evidence provided to the inquest.

Your letter mentions that you are aware of the NHS England Guideline for Health and Justice Clinical Reviewers[1], published on 21 September 2018. Alongside this document, NHS England also published a suite of supporting documents and templates for Clinical Reviewers and commissioners. These can be found at: https://www.england.nhs.uk/publication/guidelines-for-health-and-justice-clinical-reviewer/

In addition to the above guidelines NHS England also published, on 21 September 2018, Guidelines for the provision of Clinical Reviewers to support Health and Justice deaths in custody investigations[2]. On 12 June 2017 [redacted] Deputy Prison and Probation Ombudsman and [redacted] National Clinical Quality Lead for Health and Justice at NHS England, met with you in order to inform and shape the development of these guidelines. NHS England has sought to implement and develop a robust framework based upon your comments and feedback arising from that meeting. It is deeply regretted that the sad circumstances of this case have prompted further concerns. I hope that the

[1] https://www.england.nhs.uk/wp-content/uploads/2018/10/guidelines-for-health-and-justice-clinical-reviewer.pdf
[2] https://www.england.nhs.uk/wp-content/uploads/2018/10/guidelines-for-the-provision-of-clinical-reviewers-to-support-health-justice-deaths-in-custody-investigations.pdf

following information will help to assuage those further concerns in relation to Clinical Reviewers and Clinical Reviews.

After considering feedback relating to the provision of clinical reviews across the North region NHS England resolved to procure a more robust and secure contractual arrangement in order to address concerns and act upon that feedback. A revised procurement exercise for the Death in Custody Clinical Review service across the North of England was undertaken during 2018/19 with a contract start date of April 1st 2019. The procurement included the incorporation of the newly approved guidance from NHSE (the links of which are provided on the previous page and in '1' and '2') into the service specification, including sections regarding compliance with governance and quality aspects of service delivery along with confirmation of appropriate payments. Robust processes around quality assurance, approval pathways and relevant performance monitoring were included in the contract and compliance with the guidance was mandated. The compliance is monitored through the quarterly contract performance meeting, against the clinical service provider data in the quality schedule return (see template in Annex 1).

As part of the new arrangements NHSEI Health and Justice Quality Leads are required to approve the identification and selection of appropriately skilled and suitable individuals by the service provider. This involves ensuring the clinical reviewer has the appropriate skill set through review of qualifications. There is a recognition that there may be gaps in knowledge, in some instances, however these are mitigated by the clinical reviewer accessing support from other professional advisors and subject matter experts as required. All appointments must be agreed by NHSEI and an up to date register is kept of all reviewer's professional registration, either as a nurse or doctor. In addition data regarding qualifications and training and evidence of ongoing mentorship and supervision by experienced professionals, within the service is also documented. Reviewers are assessed for their suitability to carry out specific reviews through discussion between the service provider and NHSEI. For example, only reviewers who have experience within mental health services will be considered suitable for reviews with a mental health component and likewise with physical health. The final draft clinical review produced after each investigation must now be quality checked and approved by NHSEI Health and Justice Quality Leads before being passed to the Prison and Probation Ombudsman for their approval. It is explicit in the contract for the service and in the guidance that clinical reviewers should not be expected to act as an expert witness but are expected only to review the service provided to the deceased and map against the service they could have expected to receive in the community.

Contract meetings are held quarterly between the commissioner of the services, the quality leads from the North West, Yorkshire and Humber, and Cumbria and the North East regions, and provider representatives from the service. There is a performance and quality data set for the service which is provided at the meeting and for which the service is held accountable (See Annex 1). Current progress with this contract demonstrates good practice in maintaining an accurate record of professional registration and qualifications, clinical reviewer supervision and appraisal. There are some process issues with some clinical reviews regarding a range of reasons e.g. access to information and clinical records, some of which are outside of the providers control. All processes throughout the period of an

investigation are jointly agreed between NHSEI, the service provider and the PPO and any issues or problems are dealt with in the contract meetings with action plans for service improvement being formulated.

It is hoped that such additions to the procurement and oversight of Clinical Reviews will ensure the robustness of future Clinical Reviews.

In relation to the review concerning Mr Nowosad, I recognise the concerns you have outlined in your letter.

NHSE were informed of the tragic death of Mr Nowosad on 3rd February 2017 by Health Care Provider Staff. NHSE were contacted on 23rd March 2017 to inform them that there would be a delay to the publication of the first draft of the clinical review due to delays in the reviewer interviewing staff. The PPO therefore granted an extension. The first draft of the clinical review was sent to NHSE on 10th April 2017, which was quality checked by NHSE. The Quality lead made a range of comments on the report and a revised version was produced on 5th May 2017. The comments were largely asking for further clarification regarding observations made by the clinical reviewer such as why a particular action wasn't followed up and the reason why certain actions had not been undertaken in Mr Nowosad's care. There were two references made to use of outdated guidance suggesting the reviewer re look at the more recent guidance.

On 14th July 2017 the first draft of the PPO report was submitted for factual accuracy checking by the prison and health services. On 19th July 2017 concerns were raised by [redacted] consultant forensic psychiatrist, regarding potential "misinterpretation" of comments which he had made and which he felt may not have been fairly reflected in the report. Further suggested factual accuracy changes were submitted to NHSE by the prison health provider, along with an action plan to address recommendations made in the report. These suggested changes were submitted by the NHSE quality lead on 24th July 2017 for comment by the clinical reviewer and PPO. The clinical reviewer responded to these suggestions on 25th July 2017 by stating that, over the course of several email discussions with [redacted] they had reached an understanding of the position. The reviewer acknowledged that the purpose of the report was to identify opportunities to learn lessons. She felt, however, that good mental health care was provided to Mr Nowosad. The final report was published by the PPO in October 2017 after additional suggested changes to the report were received from the prison service.

Since the very sad death of Mr Nowosad in 2017, and in recognition of the scope for improvement that had been identified, NHSE has published an amended specification for the provision of mental health services in prison (see Annex 2) and all providers must comply with the scope of the specification. HMP Manchester audited its services against the requirements of the specification and, as a result, additional resource was provided by NHSE to enhance the service accordingly. This resulted in additional investment into HMP Manchester which provided for additional mental health, nursing, psychology and well-being staff.

Additionally, I am aware that HMPPS are currently rolling out revisions and amendments to the ACCT process which will include enhancements to the multi-disciplinary contribution of the clinical team within the prison.

I trust that the steps outlined above relating to the framework for clinical reviews and reviewers will reassure you that NHS England has taken steps to ensure the robustness of such reviews in the future.

I am deeply saddened by Mr Nowosad's death and the fact that you have identified concerns in the area of clinical reviews. I am however grateful for the opportunity to highlight in this letter the work that has been carried out to ensure that such concerns do not arise in the future.

Yours sincerely,

Professor Stephen Powis
National Medical Director
NHS England and NHS Improvement