virgincare

01 APR 2015

NHS

Virgin Care Services Limited
Lynton House
7-12 Tavistock Square
London
WC1H 9LT

t: [redacted]
f:
e: [redacted]
w: www.virgincare.co.uk

FAO: Jacqueline Lake
HM Senior Coroner
HM Coroner's Office
69-75 Thorpe Road
Norwich
Norfolk
NR1 1UA

27 March 2015

Dear Sirs

Inquest touching the death of Darren Wright

We are providing this letter in response to the Coroner's report issued pursuant to Regulation 28 of the Coroner's (Investigations) Regulations 2013 dated 2 February 2015.

At the conclusion of the inquest, the Coroner raised two concerns, one of which is directed to the healthcare department, which is currently provided by Virgin Care Services Limited ("Virgin Care"). We have set out below the steps Virgin Care has taken to address the concerns raised by the Coroner.

At the outset which the Coroner may already be aware of, at the time of Mr Wright's death, on 3 November 2013, Virgin Care was not the provider of healthcare services at HMP Norwich. The provider at the time was SERCO.

The Coroner's conclusions have been of considerable assistance in informing our review of the training and guidelines which are currently in place.

We now address the specific concern directed at healthcare which the Coroner has required Virgin Care's response to in his Rule 28 report.

(1) *On receiving Code Blue Notification the Staff Nurse did not know where to go and had to call on her radio to be found and then taken to the cell*

Mr Wright was transferred to HMP Norwich on 4 September 2013. Mr Wright was found dead in his cell on 3 November 2013. This was Mr Wright's first time in prison at HMP Norwich and no active risks were identified, although he was described as 'nervous and anxious'. The cause of death was hanging and the coroner heard that the contributory factor was due to inconsistencies with sharing and access to information across different departments within the prison system.

As stated previously, this incident occurred before 1 April 2014, and therefore pre-dates Virgin Care's management of the healthcare service at HMP Norwich. The provider at the time of the incident was SERCO.

We have instigated two specific measures as a result of our review but it is worth setting out a short summary of the background on these matters.

The specific issue in this matter was that the staff nurse did not know how to get to the cell. To address this, it is important to understand the building issues within HMP Norwich. HMP Norwich is split into two sites and the layout is not similar in a number of locations due to the differing ages of the building. As a result, the cell numbering is not straightforward and it can be confusing to know which cell numbers can be found where, and the sequence being followed in a specific part of the building. This is of particular note as healthcare services are provided in the F/G wing and does not usually require our nurses to attend to prisoners in their cells and hence their knowledge of the numbering of cells is limited.

In terms of training, all new nurses working in HMP Norwich are required to undergo a two week 'shadow' period where they are fully inducted to all areas of the prison. During this time, emergency response kits are highlighted to staff. This amended process for shadowing of new staff was already in place on 1 April 2014 when Virgin Care's contract to provide the service came into force. Unfortunately, whilst we did consider introducing maps of the prison to assist our staff in locating cell numbers, this is not permitted by the prison governor for security reasons in prisons.

During normal operational hours, prison officers would direct nurses to the medical emergency but this can be more challenging during 'patrol state' (when prisoners are locked in their cells) as the number of prison staff on duty is reduced.

In response to the concerns raised, we have undertaken the following:

- The induction process has been reviewed and revised to include 'shadowing' time for all new starters and agency staff. To further evidence this, a local induction process and checklist template is being developed and introduced to record an individual's completion of this process. This will therefore increase the knowledge of our staff in terms of the layout of cells when they are required to attend an emergency. This will be followed up with refresher training on an annual basis.

- A review of the response procedure – the Head of Healthcare at HMP Norwich has met with the Operations Governor within the prison and agreed where a medical emergency arises when the prison is in patrol state, a prison officer will wait for the nurse in the entrance corridor and direct the nurse to the medical emergency. This has already been put into place and a joint protocol will be ratified by both ourselves and HMP Norwich by 31 March 2015. This will ensure that our nurses can be directed to the correct cell to attend to medical emergencies.

As a result of these measures, Virgin Care is confident that it has in place a robust process for ensuring that staff members have completed the appropriate training when they commence work at HMP Norwich and that they complete the induction process. Virgin Care is also confident that the agreed process with the Prison Operations Governor will ensure that nurses are appropriately directed in a medical emergency.

For completeness, we enclose the following documents:

- Local Induction Process and Checklist template (to be in place by 31st March 2015);

- Guidance for Resuscitation - joint protocol with HM Prison Service (to be in place by 31st March 2015).

We also note the second concern raised by the Coroner as follows:

(2) *The Prison Officers attending Mr Wright had not had recent CPR training. It is understood that due to lack of resource, CPR training has to be allocated to certain members of staff only. This will result in gaps in CPR-trained Officers available and able to attend emergencies*

Unfortunately, this is a concern that Virgin Care is unable to respond to as it is not within our remit.

In conclusion, Virgin Care has welcomed the constructive comments which have been made by the Coroner in his Rule 28 report. The contents of the report have been considered carefully, and Virgin Care has instituted changes to its procedures to ensure robust processes are now in place to address the concerns raised by the Coroner.

Should the Coroner have any queries once she has had an opportunity to consider this letter and the attached documentation, she should not hesitate to contact us.

Yours faithfully

[redacted]

Karen Millen
General Counsel and Company Secretary
For and on behalf of Virgin Care Services Limited

Enc.