positive
about integrated healthcare

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Chief Executive Office
The Resource [Trust HQ]
Duncan Macmillan House
Porchester Road
Nottingham
NG3 6AA

E-mail: [redacted]

Tel: [redacted]

Our ref:RH/JH/AP
Your ref:

13 April 2016

Mr McNamara
HM Coroner Nottinghamshire office
The Council House
Old Market Square
Nottingham
NG1 2DT

Dear Mr McNamara

Report to prevent future deaths following inquest into the death of Steven James May

I write in response to your Prevention of Future Deaths report dated of 16 March 2016 in order to provide you with the information you have requested. This report was issued subsequent to the inquest into the death of Steven May, who died whilst a prisoner at HMP Ranby, where this Trust provides healthcare services.

The Trust welcomes any chance to improve the quality of its service and we have considered the concerns you raise in your report with care. As you will be aware, the Trust commissions internal investigations whenever Serious Incidents (SIs) occur. The purpose of these SI reports is to look at the whole circumstances of the incident, set against best practice, and to identify opportunities for learning and improvement. In the context of any death in a prison setting, the circumstances are always investigated by the Prisons and Probation Ombudsman. If there has been any healthcare involvement with a prison, the Ombudsman is assisted by a clinician, appointed by NHS England, who carries out an independent clinical review. This ensures that whenever there is a fatality involving a patient of the Trust who is held in a prison setting, there is both an internal and an external investigation.

Where considered appropriate by the investigators, each of those investigations can make formal recommendations for changes in, or reviews of, clinical practice and management.

Both an internal and an external investigation were conducted regarding Mr May's death. A copy of the Trust's internal SI report was shared with your office. The Trust took action in response to recommendations made in both its own SI report, and the PPO report, prior to the inquest taking place. The actions taken by the Trust in response to these recommendations were set out in Head of Healthcare, [redacted] written and oral evidence at the inquest.

Continued

Coroner's Concerns

Of the 10 concerns listed in the PFD report, (1), (2) and (10) relate to healthcare. I will address each of these in turn.

(1) The failure of reception nursing staff, by reason of lack of training and/or instruction or lack of staff and/or time, to consult the deceased's historical medical notes prior to or during the reception interview.

As I have noted above the Trust's Serious Incident report made a number of recommendations. One of the recommendations was as follows:
"In order to ensure there is a good knowledge of the patient before they are located into the prison it is essential that previous records are reviewed to determine any immediate risk issues. Whilst patient self-report is essential and vital it should not be relied on in isolation of clinical records."

Prior to Mr May's death, staff were aware of the requirement to review a patient's SystmOne notes to check for any relevant history during the first reception screen. Although this should have been done when Mr May was being reviewed during his first reception screen, it did not.

In response to this recommendation all staff were reminded via primary care team meetings (minutes of the meetings have been emailed to all staff members) and during one to one sessions with their line manager of the importance of reviewing patient notes for key information during the reception health screen.

In evidence at the inquest, [redacted] confirmed that she was, at that time, both aware of the need to check for relevant medical history (in particular, any history of self harm/ suicide attempts) and routinely did so.

As set out in [redacted] statement and oral evidence, in recognition of the fact that there is a limited time a nurse on reception can spend with each individual prisoner, the Trust introduced a key word search facility (i.e. nurses can search key words, such as 'mental health' or 'self-harm'). This enables nurses to identify key entries in a patient's SystmOne medical history (which can be extensive if an individual is serving a long sentence) very quickly.

In addition to this, I understand that [redacted] gave evidence at the inquest that in November 2015 the Trust submitted a business case to NHS England (the Trust's commissioner) seeking recurrent funding for further healthcare staff. This document was provided to you by the Trust's solicitors after the conclusion of the inquest. The funding requested was secured, with the exception of that for a paramedic post, which the Trust may bid for again in future. As a result, the Trust is now able to provide a designated reception nurse, so that nurses on reception do not experience the time constraints that [redacted] would have experienced in May 2015 due to her other duties.

(2) The lack of experience and/or training of reception nursing staff in the field of mental health.

Individuals arriving into HMP Ranby can have a history of physical illness, mental illness, substance misuse or a combination of these. All healthcare needs must be considered, not purely mental health in isolation. Reception nurses are generally primary health nurses.

When an individual arrives into reception, the nurse reviews any relevant documentation and medication that is brought in with the patient and then completes general physical healthcare observations. After this, the nurse will complete a very detailed template of questions with the patient relating to their physical health, mental health and any history of substance misuse. Further, as set out above, reception nurses are trained to look back through a patient's medical history and to search for key areas of concern such as a history of self harm/suicide. If an individual has a history of mental illness then the reception nurse will refer the individual to the Primary Mental Health Team. The Primary Mental Health Team will aim to have a triage appointment with that patient within 48 hours (and must see the patient within 5 working days). As confirmed in evidence by [redacted] the Trust was compliant with this target in 2015.

If a reception nurse has significant concerns about a patient, they can seek immediate assistance from a member of the Primary or Secondary Mental Health Teams.

(10) The accessibility of health and/or mental health care to inmates at weekends and during Bank Holidays.

The Trust's resources are of course limited in accordance with its contract with NHS England. In May 2015, the Trust was not commissioned to provide mental health services at HMP Ranby at a weekend. Despite this service not being commissioned, the Trust had identified a need for weekend mental health cover and was providing limited cover by transferring resources from elsewhere (which is why [redacted] was available on Sunday 24 May 2015).

The Trust was in discussion with NHS England about securing extra resource for HMP Ranby around one year ago. NHS England requested that evidence needed to be gathered to feed into its assessment of healthcare needs in connection with those aspects of healthcare which it commissions.

This led to the Trust instructing an independent company to complete a Healthcare Needs Assessment ("**HNA**"). The HNA identified that there was a particularly high level of healthcare need at HMP Ranby and the demand for services was not fully met by the level of service commissioned by NHS England. It was identified that part of the added demand was fuelled by health problems caused by New Psychoactive Substances ("legal highs").

The business case set out, among other things, the demand that the Primary Mental Health Team was facing. In particular, it highlighted that the team had tried to deliver an out of hours service at weekends, however this had caused the commissioned Monday- Friday service to be stretched. The business case set out that if NHS England provided funding for a Band 6 Primary Mental Health Nurse, increased the existing Band 5 post to a Band 6 post and met

additional costs associated with unsocial hours, it would enable the Trust to provide a safe an effective service 7 days per week.

I understand that at the inquest, during her evidence, [redacted] explained that following the submission of the attached business case to NHS England in November 2015, NHS England acceded to all of the requested funding (save for the paramedic post), which amounts to just under £143,000.

As is clear from the business case, the Trust has already taken action to address this concern. The Trust has been recruiting to fill the new posts at HMP Ranby for which funding has been agreed. From the Trust's perspective, and also we understand from that of NHS England, this has been an effective example of partnership working that has also involved the prison service, who were supportive of the Trust's efforts to obtain the extra funding.

The Trust cannot respond to the other 7 concerns highlighted in the Prevent Future Death report as they are matters for HM Prison Service and/or other parties.

Please do not hesitate to contact me should you require any further information.

Yours sincerely

Ruth Hawkins

Ruth Hawkins
Chief Executive
Nottinghamshire Healthcare NHS Foundation Trust