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18 May 2016

Mr G U Williams LLB
HM Senior Coroner
Worcestershire Coroner's Court
The Civic
Martins Way
Stourport on Severn
Worcestershire
DY13 8UN

Dear Sir

Mathew Colin Sargent (deceased) - Regulation 28: Report to prevent future deaths.

I am writing in response to your letter of 7 April 2016 addressed to Worcester Health and Care NHS Trust. This has been passed to Care UK as the new provider of healthcare services at HMP Long Lartin with effect from 1 April 2016.

I have noted the Matters of Concern which you identified in section 5 of your report and respond as follows:

1) *The Personal Officer of Mr Sargent appeared to have had little to do with him. It was suggested that there should be regular meetings between Personal Officers and individual prisoners so that more in depth knowledge of individual prisoners could be obtained and shared.*

The role and responsibilities of Personal Officers fall within the remit of the Prison Service and not the Healthcare Provider. Care UK is therefore unable to comment on this but trusts that the Government Legal Department will respond on behalf of the MoJ.

2) *There was a concern that historical information which was available to Officers and Healthcare Staff was not reviewed when the prisoner first presented at the prison and it was suggested that it would be beneficial if there was an instruction that any member of staff dealing with a prisoner who had access to historical information should make some enquiry as to that historical information so as to inform them of both the present and past risks.*

As a provider of healthcare services within a custodial setting, Care UK is cognisant of the framework provided by relevant Prison Service Instructions. PSI 74/2011 First Days in Custody (a copy of which is attached for ease of reference) stipulates that key information on individual prisoners should be identified at the point of entry to the Prison and for that information to be recorded and shared with other departments and agencies, both internal and external. The PSI sets out the requirement for the Person Escort Record (PER) form that accompanies each new prisoner, and any other available documentation, to be examined in Reception by Prison staff to identify any immediate needs and risks already recorded.

Communication is key in all areas and Care UK staff are expected to develop close partnership working with the Prison to ensure that relevant information sharing occurs in the best interest of the prisoner to ensure their safety.

We recognise that early identification of risk factors and effective management of prisoners in relation to self-harm is imperative in addressing the rising incidence of suicide. The Care UK Suicide Prevention Strategy (a copy of which is attached) draws on national external and internal evidence relating to risk factors associated with suicide and provides a framework for local teams to address this vital area in their prison. A number of the measures identified in the Suicide Prevention Strategy have relevance to the concerns you have raised.

As stated above, Care UK was not the healthcare provider at HMP Long Lartin at the time of Mr Sargent's death. Going forward, the Care UK suicide prevention strategy will be shared and rolled out across all sites. In addition, since taking over healthcare responsibility on 1 April 2016, Care UK plans to review the reception screening process to introduce a standard template for first reception screening across its prison healthcare settings. We are also looking at the process of information gathering on reception and the culture around this. We will expect staff to ask 'Where is the information for this patient?' and the SystmOne template will reflect this, ensuring that staff cannot proceed without seeking out the information and recording reasons why, in instances where the information is not available. We will ensure our processes for obtaining information on reception are clear and effective and build relationships with local community providers to improve information flow. Furthermore, we will record lack of information at reception on our incident system so that we understand the extent of the issues and can monitor trends and share good practice. We recognise that we cannot rely solely on the first night reception and that on-going assessment over several days is essential in order to ensure we are aware of any changing clinical picture and to take account of any new information that arrives.

Since the death of Mr Sargent, discussions have been held with Prison colleagues to review communication pathways between the Prison and Healthcare Services. These discussions are on-going.

3) *There was a concern that Healthcare staff were not made aware of prisoners who arrive with an ACCT history and it was suggested that Healthcare should be informed in all cases where a prisoner arrives at Reception with an ACCT history so that there is a continued sharing of pertinent information.*

4) *There was a concern that the Prisoner Escort Record (highlighting concerns and risks) was not supplied to the Healthcare Department nurses at Reception. It was suggested that this should be an imperative requirement for the further sharing of relevant information.*

These two points raise similar issues and can be answered together. It is the responsibility of prison service staff to share information with other departments and agencies both internal and external. PSI 74/2011 (First Days in Custody) sets out the requirement for the Person Escort Record (PER) form to be examined in Reception by prison staff to identify any immediate needs and risks and for this information to be forwarded to other staff and agencies as necessary, including healthcare. PSI 74/2011 sets out the mandatory requirements for prison staff and healthcare in respect of a prisoner's ACCT status, ACCT alerts and risk assessments. Care UK thus expects PSI 74/2011 to be followed and that prison personnel will record a prisoner's ACCT status on their record and share this and any concerns with Healthcare.

In order to ensure robust communication and partnership working going forward we will continue to work closely with our prison partners on this and in particular, the Head of Healthcare is working to address the concern with the Safer Custody Governor. In addition, all (prison and healthcare) staff have been reminded that they must see the PER on every occasion and that non-access should be escalated within the prison via a datix incident report. If the staff member does not have access, an incident form should be completed as soon as it is apparent that a PER isn't available.

I hope this letter answers your concerns, however, please do not hesitate to contact me if you require any further information.

Yours faithfully

Lorraine McMullen
Regional Services Manager