positive
about integrated healthcare

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Strictly Private and Confidential

Ms Mundy
Coroner's Court and Office
Crown Court
College Road
Doncaster
DN1 3HS

Dear Ms Mundy

Report to prevent future deaths following the inquest into the death of Mr Anthony Fraser

I write in response to your Prevention of Future Deaths (PFD) report dated 8th June 2016 in order to provide you with the information you have requested. This report was issued subsequent to the inquest into the death of Mr Fraser who died whilst a Prisoner at HMP Lindholme, where this Trust provides healthcare services.

The Trust welcomes any chance to improve the quality of its services 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 (PPO). If there has been any healthcare involvement, 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.

An external investigation was conducted regarding Mr Fraser's death. The Trust took action in response to the recommendation made by the PPO report prior to the inquest taking place. The actions taken by the Trust in response to the recommendation was set out in the Head of Healthcare, [redacted] oral evidence at the inquest.

Coroner's Concerns

Absence of a robust system for conveying summary medical information to receiving A&E departments when inmates are transferred with an acute illness.

Following the receipt of the Regulation 28 Report, a collaborative meeting took place with the Governor of HMP Lindholme, [redacted], and the Associate Director for Offender Health, [redacted] and the Head of Healthcare at HMP Lindholme, [redacted] and the Head of Security at HMP Lindholme, [redacted] The purpose of the meeting was to develop a shared system to address the concerns you have raised in the Preventing Future Deaths report.

A procedure was co-authored by the group, clearly identifying the roles and responsibilities of both Custodial and Healthcare staff. A copy of the procedure has been included with this letter. The procedure has been issued to staff and is now in operation. A review of compliance will be undertaken by the Head of Healthcare within the coming month, to ensure we have achieved full implementation for a robust system of conveying summary medical information to A&E depts.

A copy of the procedure will be shared at the Offender Health Learning the Lessons Forum on the 9th of September 2016, to ensure colleagues in other establishments also have a system in place for the transfer of medical information, thereby avoiding future deaths.

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

Yours sincerely

Ruth Hawkins
Chief Executive

[redacted]