Coroner MS Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

[redacted]
Head of Healthcare Services
HMP Pentonville
Caledonian Road
London
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[redacted]

24 August 2016

Dear Madam,

Regulation 28: Prevention of Future Deaths report
The inquest touching the death of Terrence Darren Adams Deceased
HMP Pentonville
Date of death: 9th November 2015
Inquest: 18 – 20 July 2016
Venue: St Pancras Coroners Court

Thank you for your Regulation 28 Prevention of Future Deaths Report issued to Care UK following the inquest into the death of Mr Terence Adams Deceased.

Care UK would like to express its condolences to Mr Adams' family and friends.

Care UK is the main provider of healthcare services at HMP Pentonville. There is a sub-contracting arrangement in place with Barnet, Enfield and Haringey Mental Health Trust (BEH-MHT) in respect of the provision of mental health services.

This response addresses the matters of concern in so far as they relate to Care UK.

The matters of concern to you are highlighted in bold with the response set out below each concern

1. **I heard at inquest that the prison escort record (PER) that accompanies each prisoner to HMP Pentonville (and which in the future will be forwarded to healthcare staff), is not checked on arrival and thereafter to ensure that, as it progresses through the prison, it includes the attachments described within the document, for example the risk assessment conducted by the police. This seems an unhelpful omission.**

   Response: In so far as this concern relates to healthcare, in order to allow healthcare professionals to make the best possible assessment of a person's risk of serious self-harm and/or suicide, staff will be reminded to check they have had sight of the core record and

any accompanying information including the PER, relating to history, index offence, sentence status, clinical history and possible warnings.

We have allocated an extra member of healthcare staff (healthcare assistant) to the reception process who will be working alongside the reception front desk officer triaging prisoners and reviewing available information from the PER, warrant and any other documentation accompanying the prisoner. This way, all relevant information will be available for nurses and GPs when they conduct their assessment.

If the HCA encounters a prisoner with a medical issue (physical or mental health), the HCA will 'fast track' them for screening by the reception nurse and/or a doctor.

2. **The general practitioner (GP) who saw Mr Adams when he first arrived at HMP Pentonville did not have the key for the first night reception template when she considered the information contained therein. Mr Adams scored 8. The GP did not know that the advice on the template for scores of 6 and over was to admit the prisoner to inpatient healthcare.**

   Response: This information was available in SystmOne for the General Practitioner. As a result of it having been overlooked, we will be rolling out a program of refresher training to all staff

3. **Neither the nurse nor the GP conducting the first night reception interviews was clear about the status of the first night reception template. The nurse, particularly, talked about it being a document referring to historical matters, whereas the reality is that it encompasses both past and relevant current issues. The document did not give any indication on the face of it that its instructions are advisory rather than mandatory**.

   Response: There is an expectation that nurses undertaking reception duties within the prison complete an assessment of a person's current risk of self-harm and suicidality when they are initially received into custody. This is particularly relevant as it is known that, for some prisoners, the early days of custody prove particularly stressful and so increase their risk. You heard the evidence of the Deputy Head of Healthcare who explained that following another recent death in custody, we were already undertaking a review of the current risk assessment that is in use in reception in an attempt to improve its efficacy.

   The current risk assessment in use within the reception area is largely actuarial in nature which means that it does not sufficiently employ the use of clinical judgement but merely translates certain material to calculate a risk score which then directs which action the assessing nurse or doctor takes. Modern day thinking around risk assessment is that we should reflect theoretical, clinical and empirical knowledge about the issue that we are assessing by combining clinical and actuarial approaches (*Douglas & Kroop, 2002).*

   The risk assessment is another tool available to clinical staff for them to use alongside their own assessment and clinical decision of the presenting situation. Staff should be using the assessment as a guiding tool in conjunction with their face to face consultation with the patients as well as any other information available to them at the time of

assessment (such as prison information, warrant etc) in order for them to finalise the care pathway for the patient.

In order to allow healthcare professionals to make the best possible assessment of a person's risk of serious self-harm or suicidality we need to ensure that we focus on a number of key issues:

- That we have had sight of the core record and any accompanying information, relating to history, index offence, sentence status, clinical history and possible warnings. As highlighted in response to concern 1, we have allocated an extra member of staff to review this information prior to nurses and doctors assessing new receptions.
- That we ask in detail about a person's previous history of self-harm and suicide attempts – paying particular attention to the triggers.
- That we ask about previous mental health history including diagnosis.
- That we consider their current presentation in terms of distress, hopelessness, suicidal ideation and possible plans.
- That we document a basic risk formulation stating the factors we have considered, and actions taken and rationale.

The National Offender Management Service (NOMS) are currently undertaking a review of the current policy and processes that we nationally employ, including the ACCT process. The focus of the review relates to three pillars: Prevention, Intervention & Education built on a foundation of analysis. In line with NOMS project we are currently working with the mental health leads (BEH Mental Health NHS Trust) on reviewing our existing First Night Mental Health Assessment at HMP Pentonville.

We have currently presented the initial draft at the Clinical Governance Meeting and the next steps include final approval of the new procedure and the introduction of training and implementation of the new risk assessment to staff and on SystmOne. We are planning for a 'Go Live' date by end August 2016. In addition the risk state score will be accompanied by the text that the guidance is advisory and to be used in conjunction with staff's clinical judgment.

4. **Mr Adams told the GP that he had been suicidal on and off for twenty years, but she did not explore with him the potential triggers for this. In fact, one such trigger was incarceration.**

Response: As discussed above in Point 3, a key issue is asking in detail about a person's previous history of self-harm and suicide attempts paying particular attention to the triggers.

5. **On the morning he died, Mr Adams should have attended his second reception screen, also known as the well man clinic. When he did not arrive, the healthcare nurse did not attempt to find out why or to secure his attendance.**

Response: New prisoners should receive their healthcare screenings within 72 hours. Healthcare book new prisoners into the well man clinic and provide the prison officer with a

list of who is to be seen that morning. The clinic time is given but, in the same way that a hospital theatre list operates for example, the prisoners will all be listed for the same appointment time. For prisoners located in the first night centre, the prison officer will unlock everyone on the list and take them to the healthcare waiting area. The nurse will work through the list and return each prisoner to the waiting area. At the end of the clinic, the prison office will collect the prisoners from the waiting area and return them to the first night centre.

Where a prisoner is located elsewhere in the prison (as Mr Adams was), they will be able to move from one area of the prison to another area during set times known as free-flow (at 8.15 am, 11.30 am,2 pm and 4.15 pm) . If the prisoner misses that window for moving for whatever reason, the prisoner will not be allowed to move to healthcare (unless it is an emergency).

It is not unusual for prisoners, especially those located outside of the first night centre, to miss appointments. This can be for a number of reasons including the prisoner refusing to attend, an emergency in the prison, prison officer shortages, the prisoner attending a different appoint.

When a patient is booked for a clinic but does not attend (DNA), nurses will investigate and chase up that person once the clinic is over. It would not be possible, nor an efficient use of clinical time, for nurses to chase up prisoners during the course of a clinic. With 15-20 new receptions everyday (Pentonville being a remand prison and thus having a high population turnover), if nurses chased up DNA prisoners during the course of the clinic, they would spend their time doing nothing else.

After the clinic, nurses will re-book prisoner into the next clinic if they fail to attend. In addition, whenever a prisoner is booked into an appointment, an outcome must be recorded on SystmOne. This can be confirmation that the prisoner was seen, treatment was given or that the DNA. By default, SystmOne will also DNA everyone scheduled for an appointment (in the overnight system running) if an appointment outcome has not been manually entered by the nurse.

In this case, it is likely that the code blue for Mr Adams' death was recorded on SytmOne before a nurse could enter a DNA.

6. **The root cause analysis (RCA) conducted by Care UK after Mr Adams' death in November 2015, and finalised in February 2016, was not shared with HM Coroner until part way through the inquest, and then only following the accidental discovery of its existence by two of the inquest advocates. It had not been shared with HMP Pentonville's head of safer custody governor; nor even with the deputy head of healthcare of Care UK itself. Its existence had not been disclosed to HM Coroner.**

Response: At the inquest the learned Coroner commented that she had seen completed Root Cause Analysis ("RCA") before from ourselves and that they were robust documents.

This is always a document that is disclosable and it was not on this occasion. Advice was sought from our external legal advisors prior to the inquest and on this occasion the Root Cause Analysis was not forwarded to you by them. Your concern has been discussed with the relationship partner at the external firm.

The agreed position with NHS England as to when an RCA is conducted is as follows:

- Self-inflicted death – this always requires an RCA.
- Expected death (e.g. palliative care) – this would not normally require an RCA unless there are significant concerns.
- Unexpected death but not a surprise (e.g. heart attack in a high risk patient) – a judgement will be made as whether an RCA is undertaken.

RCAs are shared with NHS England as Commissioner (but staff names are redacted). We recognise that RCAs should be share in an open and transparent manner and the prison Governor will automatically receive (redacted) copies going forward. The findings of all RCA's should be shared, reviewed and discussed during individual site Quality Assurance Meetings. This is the forum where Action plans should be agreed on and progressed forward. The importance of this will be presented by the in-house legal team at our next divisional Quality Assurance meeting.

We trust that the above response provides the information that you require but please do not hesitate to contact us if Care UK can be of any further assistance.

Yours sincerely,

[redacted]

Head of Healthcare Services
HMP Pentonville

On behalf of Care UK