HMP Pentonville
Healthcare Department
Caledonian Road
London
N7 8TT

[redacted]

Dear Madam,

Regulation 28: Prevention of Future Deaths report
The inquest touching the death of John Williams Deceased
HMP Pentonville
Date of death: 26th June 2016

Thank you for your Regulation 28 Prevention of Future Deaths Report dated 28 March 2017 issued to Care UK following the inquest into the death of Mr John Williams Deceased.

Care UK is the provider of primary healthcare services at HMP Pentonville. I have addressed the issues you have directed to Care UK only which you have highlighted as paragraphs 5.1, 5.2, 5.3 and 5.5

The matters of concern to you in so far as they relate to Care UK is highlighted in bold with the response set out below each concern.

5.1. The first reception nurse who saw Mr Williams when he entered HMP Pentonville gave evidence that he had no thoughts of self-harm or suicide but she recorded that he had.

It appears she may benefit from additional training and/or supervision

The nurse who completed the First Reception Health Screen on 30 May 2016 recorded in the free text section in Systmone that Mr Williams had made a statement of intent to self-harm and that was a reason as to why Mr Williams was placed on an open ACCT. This was clearly recorded by the nurse at the time.

The nurse has been reminded of the process of giving evidence at an inquest and to listen carefully to the question that is being and to take time in considering her answer. Enquiries have been made by the Interim Head of Healthcare who is satisfied that the nurse in giving evidence at the inquest was confused and made a mistake in response to your question. Further reassurance, support and guidance has already been given to the nurse involved.

5.2. There was no second reception screen conducted. If Mr Williams was not brought to healthcare staff for his second reception screen then healthcare staff need to follow this up.

On this occasion no Second Reception/Wellman assessment was completed. An appointment was arranged for 1 June 2016 but was not completed as Mr Williams did not attend his appointment. This was marked as "DNA" in Mr William's Systm0ne record.

As you heard in evidence, it is the case now that a register is kept of any Second Reception/Wellman assessments that are not completed. It is then the responsibility of the Lead Nurse to arrange for the

patient to be contacted and an appointment for the assessment to be completed. In the event that the patient declines the Second Reception/Wellman assessment then they are asked to sign a disclaimer which is then scanned into Systm0ne. I have set out below a copy of the register for December 2016 and January 2017 as follows:

Snapshot for December 2016

388 receptions for the month (100%)

- 18 patients in prison less than 72 hours (5%)
- 100 patients refused (26%) disclaimer signed
- 12 patients transferred from a Care UK prison with a Valid Wellman Assessment (3 %)
- 88 missed assessments due to location other than First Night Centre (23%)
- 0 patients outstanding for assessment (0%)
- 170 completed assessments (44%)

Snapshot for January 2017

476 receptions for the month (100%)

- 23 patients in prison less than 72 hours (5%)
- 58 refused (12%) disclaimer signed
- 7 patients transferred from a Care UK prison with a Valid Wellman Assessment (2%)
- 128 missed assessments due to location other than First Night Centre (27%)
- 23 patients outstanding for assessment (5%)
- 231 completed assessments (49%)

5.3. This first reception nurse did not make the referral to the mental health team (although this took place in any event because the court diversion team had already made the referral).

I heard that it is now done automatically when that box is ticked on the system, and I wonder whether other prison healthcare providers would benefit from such a system

As you heard in evidence, we have investigated the process with regard to the templates and referrals to mental health as part of the First Reception Health Screen and whether it would be possible to not being able to pass onto a second page until the task has been completed.

The investigation has been completed and the template has been changed at HMP Pentonville with immediate effect. It is now a mandatory box to say if a Mental Health referral is required and that one has been made. The referral is then made electronically directly to the mental health in-reach team. As of Friday 24 March 2017, this revised template is being followed at HMP Pentonville.

Care UK are looking into implementation of this template at all the prisons where they undertake the First Reception Health Screen. In addition we will raise the revision with NHS England and ask them to inform other healthcare providers of the revision we have made.

5.5. Mr Williams also told the member of Phoenix Futures who saw him that he felt cannabis gave him what the mental health team did not. However, the staff member felt he did not have the training or experience to explore either of these issues in greater depth.

It may be that Phoenix Futures staff would benefit from additional training, perhaps alongside prison healthcare staff.

Again as you heard in evidence, this service is commissioned by NHS England. As you were also advised this service has also gone out to tender and we await details as to who has been awarded the procurement. It is our understanding that NHS England are making the service specification very much a joint, integrated and collaborative working model.

It was confirmed to you that at this stage there are daily handovers where we capture staff attendance and prisoners and the attendance of Phoenix Futures is requested at handover. However we are unable to compel their attendance.

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
HMP Pentonville