HMP Pentonville
Healthcare Department
Caledonian Road
London
N7 8TT

[redacted]

HM Assistant Coroner Heather Williams QC
Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

19 January 2018

Dear Madam,

Regulation 28: Prevention of Future Deaths report, Mark Anthony Doyle (died 28 March 2017)

Thank you for your Regulation 28 Prevention of Future Deaths Report issued to Care UK on 18 December 2017 following the inquest into the death of Mr Mark Anthony Doyle at HMP Pentonville. Care UK would like to express its condolences to Mr Doyle's family and friends.

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

The matters of concerns are highlighted in bold with the response set out below each concern.

Matter of Concern 1: Although, [redacted], Head of Healthcare, described how healthcare staff have received recent encouragement to make entries on a prisoner's ACCT in relation to matters that could bear on risk, I am concerned that this does not go far enough to change past practice and ensure that relevant information is shared, in light of the prison staff's lack of access to System One records and the infrequent occasions that Care UK staff made entries on Mr Doyle's ACCT daily record.

Response: Following the inquest I have reflected and reviewed healthcare processes and there have been discussions within the healthcare team. Going forward we will ensure that the Local Operating Procedures (LOPs) are embedded, with senior management undertaking audits, to ensure that where any relevant risks and triggers are identified, we will share information with the prison in the following ways:–

- Update on C nomis – entry to be made by allocated healthcare staff
- Update the ACCT document and highlight any trigger points
- Share with the Safer Custody team via their functional mailbox SafercustodyPentonville@hmps.gsi.gov.uk.

By sharing triggers with the Safer Custody team, healthcare can ensure that the senior managers on the landings and units are updated on what information has come through to their team.

Matter of Concern 2: Decisions that prisoners are fit to be transferred from F Wing are made and conveyed to prison staff by the charge nurse on duty that morning annotating by hand a list of the prisoners on the Wing. There appears to be no clear criteria for assessing when a prisoner is fit for transfer; the information that should be considered in making this determination is left to the discretion of the decision maker; and there is no process for recording the decision, the reasons for it or the identity of the decision maker in the prisoner's records or otherwise.

Response: We agree that the system described above requires improvement. We have therefore, with immediate effect, implemented a Patient Wing Movement Assessment. This is similar system to what we have in the in-patients unit as follows.

All prisoners who are deemed necessary to be admitted to the Substance Misuse Unit will remain on the unit for a period of stabilisation and until it is deemed safe for them to be moved off this unit and to be placed on normal location. By default, prisoners should not be discharged from the in-patients unit for two weeks as a minimum. If someone needs to be moved from the unit then the senior manager and clinical lead (either a GP or Care UK employed Nurse Medical Prescriber) must review the patient's notes and make a decision on whether or not they are fit to move. This decision and the reasons for it will be recorded in the new Assessment template in the patient's SystmOne medical notes.

"Ward rounds" and "review meetings" will be undertaken three times a week. All patients should be discussed in the review meeting and agreement reached and whether they are suitable or not to be moved from the unit and transferred to either E wing (an overspill wing for stable Substance Misuse Service clients) or to ordinary location. This ward round should always be attended by senior clinicians including either a GP or unit clinical lead.

The discussion and outcome of the meeting will be recorded in the patient's SystmOne notes and the decision shared with the wing officer so that they are aware of who can and cannot be moved from the unit.

We are committed to providing a high quality healthcare service at HMP Pentonville and are doing everything we can to ensure those detained there are as safe as possible and receive the best quality care. We are committed to ensuring that the lessons learnt following this inquest are not just implemented at HMP Pentonville but across Care UK's services.

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

Yours

[redacted]

[redacted]
Regional Service Manager
London & IOW prisons

On behalf of Care UK