NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

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Private and Confidential
Ms Emma Brown
Area Coroner, Birmingham and Solihull
50 Newton Street
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4 February 2019

Dear Ms Brown

Response to PFD/regulation 28 in relation to the death of Mr Delahaye

Thank you for your Regulation 28 report relating to the death of Mr John Delahaye which we received from your office on 31 December 2018. Please do be assured that we have taken your concerns and findings very seriously. We note that actions are required to be delivered by a number of agencies. This response relates to the actions to be delivered by Birmingham and Solihull Mental Health NHS Trust and Birmingham Community Healthcare NHS Trust.

The concerns that you raised pertinent to BSMHFT and BCHT were:-
"Matter 2. During the inquest it emerged that the mental health nurse who assessed Mr. Delahaye on the 2nd January 2018 and the GP who assessed him for in possession medication on the 29th January 2018, had not identified from his notes all relevant past medical conditions. It emerged that whilst the System One records (a case management system used across the prison estate) has the facility to provide a summary of significant past and current medical conditions, it is not reliable at HMP Birmingham because conditions are not consistently given the correct 'read code'. Evidence from the NHS England clinical reviewer [redacted] was that this problem is not unique to HMP Birmingham and is found in other prison healthcare teams and requires a change of culture and practice to bring the system for read coding into line with that in the community. The absence of a reliable source for quickly identifying relevant past and current medical conditions puts lives at risk from misinformed decision making."

HMP Birmingham healthcare, both BCHC and BSMHFT identify past medical conditions from System1 using both read codes and a 'search' facility on System1. If a clinician (in any prison healthcare setting) has identified a medical condition and used a read code when documenting this, it will then flag the patient has a medical condition within the

summary and family history. However there are multiple read codes for conditions and they are not used consistently across the prison healthcare system nationally. System1 is a national system and is out of the local control of Birmingham and Solihull Mental Health NHS Foundation Trust. It is therefore recommended that this issue is highlighted by HM Coroner to NHS England for national resolution indeed we can see that this has been raised with NHSE as part of the same regulation 28 report. BSMHFT does however recognise that it could put some additional local controls in place to mitigate the risk associated with SystemOne and Read Codes and we are therefore implementing the following action as a provider of Healthcare in HMP Birmingham.

The Head of Healthcare at HMP Birmingham will remind all clinical staff (including those working within BCHT) that when reviewing a patient's records for previous medical conditions that the following most be followed:

1. The clinician will check the 'summary and family history' section of System1
2. The clinician will check the 'quick glance' section of System1
3. The clinician will use the 'search function' to check for the medical conditions relevant to the clinical intervention they are undertaking

This reminder will be sent out to all staff in writing on the 1st February 2019.
We will of course also work in collaboration with NHSE in terms of any national resolution to SystemOne.

We would like to thank you for drawing this matter to our attention and sincerely hope that the controls outlined above will help to prevent future deaths of this nature.

Yours sincerely

John Short

John Short
CEO, Birmingham and Solihull Mental Health NHS Trust

Cc: BCHC, Legalservices (BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST)

Dawn Clift, Associate Director of Governance, Birmingham and Solihull Mental Health NHS Trust

[redacted] Senior Solicitor, Birmingham and Solihull Mental Health NHS Trust

HM Prison &
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13 February 2019

Dear Ms Brown,

Inquest into the death of John Delahaye

Thank you for your Regulation 28 Report of 18 December 2018, issued following the inquest into the death of John Delahaye and addressed to NHS England, Birmingham and Solihull Mental Health Foundation Trust, Birmingham Community Healthcare NHS Trust, G4S and the Ministry of Justice. As Chief Executive Officer of Her Majesty's Prison and Probation Service (HMPPS), I am responding on behalf of the MOJ. I understand that the NHS Trust, Healthcare Trusts and G4S will be responding to you separately.

I know that you will share a copy of this response with Mr Delahaye's family and I would first like to express my sincere condolences for their loss. Every death in custody is a tragedy and the safety of those in our care is my absolute priority.

I am grateful to you for bringing to my attention your concerns. You have raised the issue of healthcare attendance at all first ACCT case reviews, and said that the

checklist of actions within the ACCT booklet does not include a requirement to make staff aware of the first review.

PSI 24/2011 Safer Custody chapter 5 states that healthcare must be informed when an ACCT is opened, and should attend the first case review which must be held within 24 hours of opening an ACCT.

In July 2018, HMPPS issued a Learning Bulletin (ACCT - Case Reviews, CAREMAPs and Levels of Conversations and Observations) to all prisons. The Bulletin reminded staff that ACCT review meetings must be multi-disciplinary and must take place within the specified timescales. It further stated that that where any individual involved in the prisoner's management cannot attend the review, they must submit written contributions

Following a review of ACCT, we are currently in the process of piloting an updated ACCT document and revised guidance, which is clear that healthcare must attend the first case review, and is expected also to attend every subsequent review (and where this is not possible to provide a written contribution) in cases in which issues of physical or mental health have been identified as relevant. The pilot will run for a 4 month period from mid-February. It will be evaluated, and we hope to roll out the new procedure nationally in the autumn.

In June 2018 all HMP Birmingham ACCT case managers and members of healthcare staff including those from the mental health team and integrated drug services, were reminded by way of a written staff briefing that they must attend all first ACCT case reviews, and any subsequent reviews where necessary. Since Mr Delahaye's death, staff are now alerted at the Governing Governor's daily staff meetings of the first ACCT case reviews which are scheduled for the day, and reminded of such by the communications room staff In September 2018, the establishment set up a new quality assurance process by which members of the Safer Custody team check that all ACCT documents are completed in accordance with instructions and that all necessary actions have been taken. Since December 2018, a member of the senior leadership team has carried out a daily check of all ACCT documents, including verifying that healthcare staff did attend the first case review.

Your second concern is that whilst you were told at the inquest that senior staff had been advised that unlocking prisoners should include a welfare check, it was not clear how this had been communicated to the staff who were actually unlocking prisoners, or how compliance would be monitored.

PSI 75/2011 Residential Services, states that there must be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock. Since October 2018, HMP Birmingham has met this requirement by the introduction of a new compliance process known as Residential Activities, Basics and Cleanliness (ABC). Since January this year, senior managers carry out weekly checks to ensure that staff are following the correct procedures. All staff were made aware of the process by way of a staff briefing.

Thank you again for bringing these matters of concern to my attention. Please be assured that learning from the circumstances of John's tragic death will be shared more widely with colleagues across the prison estate.

Yours sincerely

Michael Spurr

Michael Spurr

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Ms Emma Brown
Area Coroner
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The Coroner's Court,
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By email: coroner@birmingham.gov.uk and first class post.

Tuesday 12th February 2019

Dear Mrs Brown,

Inquest into the death of John Delahaye

Thank you for your Regulation Report dated 18 December 2018 addressed to NHS England, Birmingham and Solihull Mental Health Foundation Trust, Birmingham Community Healthcare Trust, G4S and the MOJ. Your report was written concerning the recent death of Mr John Delahaye at HMP Birmingham on 5th March 2018. This response is sent on behalf of G4S Care and Justice Services (UK) Ltd ("G4S").

The report raises four concerns but it is noted that only the fourth concern is highlighted by you as being capable of being addressed by G4S and so we respond below to that concern only. You have indicated that your fourth concern is:-

"On the morning of the 5th March 2018 Mr. Delahaye's cell had been unlocked at approximately 07:50. It is likely that he was already dead at this time (and had been so for some hours) but he was not found because the prison custody officer who unlocked his cell did not look into the cell or seek any kind of acknowledgement from Mr. Delahaye. It was acknowledged by the relevant PCO and by the Safer Custody Manager that unlock ought to have involved a welfare check. The Safer Custody Manager's evidence is that the need for a welfare check on unlock has been emphasised to senior managers and leads through a bilateral document covered at formal briefings. However, it was not clear how this is then communicated down to the individual custody officers and how they are being audited to make sure they are conducting a welfare check on unlock. The absence of a welfare check creates a risk that a prisoner in need of life saving assistance at the time of unlock is not identified."

It is acknowledged that the Inquest heard that the PCO who unlocked Mr Delahaye on 5th March did not carry out a welfare check on him at that time and that further, that PCO conceded that he knew he ought to have done, a position reiterated by the Head of Safer Custody. When officers first enter the employ of G4S at HMP Birmingham, they do as part of their induction training receive instruction on the process of unlocking prisoners. It is explained to them that as well as unlocking prisoners, they should assure themselves that each prisoner is alive and well at that time. New recruits also undergo a period of shadowing experienced officers who will also demonstrate to them how the unlocking process is carried out and how a welfare check should be conducted.

You will recall that the Inquest heard that on 20th August 2018, HMPPS took over the day to day running and management of HMP Birmingham for a period of six months, subject to further extension by the MOJ. Any instruction to staff does therefore come direct from HMPPS and not G4S at this point in time. However, we can confirm that since October 2018, HMP Birmingham has met this requirement by the introduction of a new compliance process known as Residential Activities, Basics and Cleanliness (ABC). Since January this year, senior managers have been carrying out weekly checks to ensure that staff are following the correct procedures. All staff were made aware of the process by way of a staff briefings during October 2018.

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We can further confirm that when the time comes for HMPPS to 'step out' of HMP Birmingham. The system in place as described in the paragraph above will continue with G4S Senior Residential Managers continuing to audit that welfare checks are being carried out correctly by conducting weekly checks of staff.

Yours sincerely,

[redacted]
Managing Director
Custodial & Detention Services
G4S Care & Justice Services (UK) Limited

NHS England

Professor Stephen Powis
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Ms Emma Brown
Area Coroner, Birmingham and Solihull
Coroner's Court
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8th February 2019

Dear Ms Brown

Re: Report to Prevent Future Deaths (Regulation 28) concerning the death of Mr John Anthony Delahaye who died whilst remanded into the care of HMP Birmingham on 5 March 2018.

Thank you for your letter and Regulation 28 Report ("Report") issued on Tuesday 18 December 2018 following the inquest into the death of John Delahaye. I would like to express my deep sympathy to Mr Delahaye's family.

In your report you raised two concerns for NHS England;

1. There is confusion surrounding the meaning of the following question from NHS England's national clinical template for In-Possession Risk Assessments in the Secure Estate: "Have you had problems in the last 6 months with not taking, or not remembering to take your medicines as prescribed?"
2. The read coding in SystmOne is not consistent across the prison estate to provide a reliable summary of significant past and current medical conditions to ensure consistency in care due to incorrect read codes being applied.

I will answer both your concerns below taking each one in turn.

1. In-Possession Risk Assessment Template

In 2018 NHS England developed and rolled out a national clinical template to support the completion of in-possession (IP) risk assessments in prisons. This supports the implementation of the provider's local in-possession medication policies. The assessment template was developed by a multidisciplinary group of stakeholders who were experienced in using local in-possession risk assessments. The template aligns with national guidance on in-possession medication in prisons[1,2]. The template was piloted successfully before it was implemented and training for all providers was commissioned by NHS England and delivered as part of the roll out process. It is the responsibility of the provider to ensure that clinicians using the assessment template understand how to use it effectively and that it is used in line with their local in-

[1] National Prescribing Centre 2004 "In-possession medication" link
[2] RPS 2017 "Professional Standards for Medicines Optimisation in Secure Environments 2nd Edition" link

possession medication policy.

The full assessment is designed to be used on initial admission into a prison. This assessment outcome is then accessed by clinicians such as GPs who wish to review and update the status of an individuals in-possession medicines during their time in prison. Clinicians have the option of completing the full assessment again thus replacing the previous assessment in full or viewing the previous assessment information as an IP review. This means they can adjust the possession status during a consultation, documenting the rationale for any change.

The national in-possession risk assessment has 10 questions included with weighted scoring for each question. The overall score informs the assessor about whether it is safe for the person to have their medication in-possession. The score is a guide and the suggested outcome can be over-ridden by the assessor based on their clinical judgement about the person and their ability to manage their medicines independently.

The question detailed in your Report (question 5 in the assessment) is focussed on unintentional non-adherence rather than intentional non-adherence/overdose with prescribed medicines. There is an additional question 6 in IP risk assessment (see the attached- user guide) that asks about specifically medicines overdoses:

In the last 12 months have you:
a) Self-harmed or attempted suicide?
b) Overdosed with medicines?

The assessor is prompted to pause the assessment to check clinical notes for information about this and the reception screen outcome which may also have information included about risks of self-harm.

It is not clear from your Report whether the GP who reviewed the in-possession status for Mr Delahaye used the previous assessment information to inform the changes to his in-possession or whether there was a clear record of Mr Delahaye's previous overdose of insulin that would alert clinicians to this specific risk. It is the healthcare provider's responsibility to ensure that the in-possession risk assessment us used effectively and that their in-possession policy aligns with the RPS standards[2] and guidance about how in-possession policies should be developed[1].

On this basis NHS England does not feel that the assessment tool needs to be revised. The provider at HMP Birmingham can take local action to reduce the risk of future harm by using local audits of in-possession risk assessments and ensuring that clinicians using the template do so in line with the User Guide, national guidance and the provider's local in-possession medication policy.

In relation to this case NHS England Regional Health and Justice Commissioners (North Midlands) will monitor the in-possession process including use of the In-Possession Risk Assessment Template through the Death in Custody and Her Majesty's Inspectorate of Prison action plans that have been produced at HMP Birmingham. The monitoring and oversight of the action plans and learning will also be included for review at the 2019 clinical quality visit, scheduled for the 6th June 2019, undertaken as part of the quality assurance of healthcare at HMP Birmingham. Any

further concerns relating to the use and implementation of the In-Possession Risk Assessment template will be escalated to the NHS England central team for support and review.

2. SystmOne Read Codes

By way of background this concern is not limited to prison healthcare and exists across all primary care general practice settings. Historically there have been two clinical coding systems in use in general practice, with not all general practice systems using the same coding system causing inconsistency in coding. NHS Digital began rolling out a new mandated coding system called SNOMED CT coding from April 2018 to replace all other coding systems. The rollout schedule varies depending on the clinical system provider but will be complete by April 2020. SNOMED CT will provide a single clinical terminology, enabling clinical data to be exchanged accurately and consistently across all care settings. This will allow better patient care and improve how clinical data can be analysed and reported on.

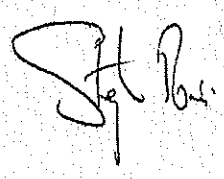
SNOMED CT will be subject to an update and management processes whereby coding can be added *if* it is deemed necessary but only by a central system; UK Terminology Centre. There will be no ability to update or change coding at a local level.

SNOMED CT has been introduced as an alternative coding system into the prison general practice electronic medical records, SystmOne since 14 January 2019. In May 2019 SNOMED CT will be the default coding system for all health and justice SystmOne.

In terms of transition to SNOMED CT, all historic data will have a Read and SNOMED code applied via the mapping tables, the dual coding approach will support users in ensuring they can revise their clinical searches as necessary. NHS England are working with NHS Digital and regional commissioners to support HJIS users during the transition phase.

I hope the information above addresses the concerns you have raised within your Report and provide you with assurances that you requested. If you require any further information please do not hesitate to contact me.

Yours sincerely



Professor Stephen Powis
National Medical Director
NHS England