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Mr D.D.W. Reid
HM Senior Coroner for Worcestershire
Worcestershire Coroner's Court
The Civic
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DY13 8UN

17 June 2021

Dear Mr Reid

Regulation 28: Prevention of Future Deaths report, Richard James Ormond (Deceased)

Thank you for your Regulation 28 Prevention of Future Deaths Report issued to Practice Plus Group following the inquest touching upon the death of Richard James Ormond at HMP Long Lartin. Practice Plus Group would like to express its condolences to Mr Ormond's family and friends.

Below you will find each of the matters of concern addressed in turn:

Matter of Concern 1. During the course of the inquest I heard evidence that:

(a) Pursuant to an agreement between HM Prison Service and West Midlands Ambulance Service (WMAS):

(i) When a Code Blue or Code Red emergency is phoned through to WMAS by a prison, and no answer can be given by the prison control room to the questions "is the patient conscious?" and "is the patient breathing?", then without further information a Category 2 response will be generated (i.e. average attendance time of c.18 minutes);

(ii) Should further information be relayed to WMAS by the prison control room that the patient is either in cardiac arrest or peri-arrest, or not breathing, or fitting, or

choking, or that CPR is being administered, WMAS will upgrade the response to Category 1 (i.e. average attendance time of 7 minutes).

(b) In Mr Ormond's case:

(i) It was immediately apparent to prison officers who found Mr Ormond in his cell that he was unresponsive and required CPR. When healthcare staff responded to the Code Blue call which went out over the radio, and attended the cell a short time later, they found those officers already giving Mr Ormond CPR;

(ii) (The prison control room initially informed WMAS that this was a Code Blue emergency, but were unable to say whether Mr Ormond was conscious or breathing. The call was therefore given Category 2 status;

(iii) There was then a delay of at least 9 minutes before the prison control room provided WMAS with information that Mr. Ormond was not breathing and was requiring CPR, at which point WMAS upgraded the response to Category 1;

(iv) In a Safer Custody Learning Bulletin issued in December 2016 to all prison staff, entitled "The Importance of Immediate Emergency Response", the instruction was given to *"Ensure that information on the condition of the patient is passed to the control room as soon as possible so that the ambulance service can be updated."*

(v) The 9 minute delay referred to at (iii) above occurred despite the prison officers and healthcare staff who first attended the scene having radios, and therefore being in a position to the control room the information that Mr Ormond was not breathing and required CPR.

Response: We understand that a process was put in place at HMP Long Lartin, which had been agreed between the West Midlands Ambulance Service (WMAS) and HMP Long Lartin. This had been circulated to prison staff in a Safer Custody Bulletin in 2016, prior to the implementation of the new ambulance response categories and before Practice Plus Group held the contract for healthcare provision at Long Lartin. Unfortunately Practice Plus were not made aware of this agreement and it has not been revisited with WMAS since the original process was agreed. We have contacted WMAS to jointly review the process and we will:

- work together to understand the information they require in order to despatch an ambulance appropriate to the patient's needs
- use this information to write a new process to call for ambulances in a manner that is appropriate to the patient's needs.

- provide prison staff with guidance to enable them to provide the relevant information to the ambulance despatch team.

Matter of Concern 2. The failure to provide WMAS with critical information about Mr Ormond's condition, which would have resulted in the call being given the highest category of emergency response did not appear to have been recognised by either HM Prison Service or Practice Plus Group until this inquest hearing. In the circumstances, there is concern that members of the prison and healthcare staff at HMP Long Lartin may still not recognise the need to update WMAS with critical information about a patient's condition in similar circumstances.

Response: Practice Plus Group has a robust process (our Purple Alert system) for sharing important patient safety information across all prison sites within which we provide healthcare services. We can confirm that in April 2021, as soon as we became aware of this issue, a Purple Alert was disseminated across all sites to request that immediate action be taken to ensure that systems are in place to escalate deteriorating patients, particularly those who require CPR, to enable an appropriate ambulance response time.

Following the receipt of a Purple Alert, sites will inform their staff of the information via daily handover or 'buzz' meetings, clinical supervision and training events (including emergency scenario training), to ensure all staff are aware of the detail. They will also liaise with the prison if actions need to be taken by HMIP. All sites are required to provide a description of the actions taken in response to the purple alert. At HMP Long Lartin the purple alert was shared via a buzz meeting and the daily handover on 4th and 5th May. Staff were also emailed via a global alert on 7th May. This was further reiterated as a mop up on 19th May.

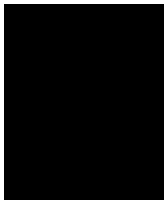
In addition, Practice Plus Group have become aware that ambulance response arrangements to secure establishments vary between regions, and therefore have initiated conversations with several Ambulance Trusts that serve our sites to seek wider collaboration and solutions to this issue across the country. An initial meeting was held with WMAS in March 2021 to review arrangements for calling ambulances in prisons; further meetings are planned. Any outcomes will be shared nationally in order to share learning across all our sites.

Furthermore, our Resuscitation Council-accredited immediate life support (ILS) trainers have been asked to include the importance of upgrading calls to category one where CPR is in progress in their ILS training materials for Practice Plus Group staff and this has been in place since 13th May 2021.

Practice Plus Group is committed to providing a high quality healthcare service at HMP Long Lartin and to patient safety across all our sites. We are deeply sorry that Mr Ormond died while receiving care from our service and we will ensure that the lessons learnt are not just implemented at HMP Long Lartin but across Practice Plus Group's services.

We trust that the above responses provide the information that you require but please do not hesitate to contact me if Practice Plus Group can be of any further assistance.

Yours sincerely



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National Medical Director, Health in Justice Practice Plus Group

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