REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **[redacted] (Head of Healthcare) and Dr [redacted] (Regional Medical Lead) Practice Plus Group HMP Pentonville** **(via [redacted])**
1	**CORONER** I am R Brittain, Assistant Coroner for Inner London North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATIONS and INQUESTS** Mr Khairul Rahman, an inmate at HMP Pentonville, died on 22 January 2021 at University College Hospital from COVID-19. I concluded, at an inquest into his death on 21 May 2021, that he died from natural causes. In box 3, I set out as follows: *Mr Rahman died from COVID-19 after treatment in hospital. There were intervals to reviewing his clinical condition, whilst he was detained in prison. However, it is not possible to state that this caused or contributed to his death.*
4	**CIRCUMSTANCES OF THE DEATH** In January of 2021 there was an outbreak of COVID-19 in the prison. Mr Rahman had been previously coded as a 'moderate risk' in May 2020, owing to his asthma diagnosis. I heard evidence that he became unwell on the 4th of January 2021. However, he did not report this to prison staff, who first recognised that he was unwell at 10am on the 7th of January. Attendance of nursing staff was requested at approximately 10.30am. It is unclear when the nurse subsequently attended to Mr Rahman, owing to non-contemporaneous recording of the consultation, documented at approximately 5pm. The entry states: *Pulse rate 129 bpm* *O/E – tympanic temperature 38.8 C* *Pulse oximetry 97%* *148 94 mmHg* *Examination: Had a covid19 swab taken* I heard evidence that once-daily observations were planned to be undertaken. In oral evidence, Dr [redacted], Regional Medical Lead of Practice Plus Group in

	London, stated that a NEWS2 early warning score system was used by prison healthcare staff, in order to establish what next steps should be taken, based on clinical observations (along with clinical judgement). It was established that the above observations would score '3' on the NEWS2 system which, according to score calculators would prompt consideration of repeat observations to be taken every 4-6 hours. When asked to account for the disparity between the planned daily observations and the NEWS3 prompted 4-6 hourly observations, Dr [redacted] stated in oral evidence: *I think that the honest answer is that, at the time, that we were struggling across all prisons to be able to monitor people…on a regular basis, i.e. specifically between 4-6 hours but we were relying on the prisoners working with us to self-report any changes in their symptoms. I can't explain why we didn't do a further observation before that point actually.* In a statement provided after the conclusion of the inquest, provided in order to address concerns I had raised regarding this point, Dr [redacted] set out: *When Mr Rahmun was initially seen on 7/1/21 he had observations taken which were abnormal and were somewhat suggestive of Covid-19, and a swab was taken. The positive result was entered into Mr Rahmun's records on 11/1/21. It is expected that when the result was known to be positive the protocol would be activated, which means covid age would be worked out which would then guide us on our future observations. It is these subsequent observations which would include the NEWS2 and not necessarily the original observations taken on 7/1/21… Covid age is what Practice Plus Group were using to guide us on the frequency of observations and had to be calculated after a positive result… Mr Rahmun was due to undergo once daily observations, which was appropriate given the known risk at that time…* *Despite NEWS2 being a hospital based scoring system and it not being ideal for the prison estate it was the best we had at the time… Throughout the pandemic healthcare staff have been reminded regularly at daily handover meetings to use NEWS2 when carrying out observations and this is a message that has continued.* No further treatment or care was provided to Mr Rahman prior to concerns being raised to prison staff at approximately 1pm on 8 January, regarding a deterioration in his condition. Emergency services were called, with the details of the request given as 'sats 46'. The ambulance service attended and, despite 15 litres per minute of oxygen being administered, were not able to get Mr Rahman's oxygen saturations above 78%. He was transported to University College London Hospital where, despite intensive care treatment, he died on 22 January from the consequences of COVID-19.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: 1. There does not seem to be a robust system in place in the prison healthcare setting for contemporaneous or accurate retrospective documentation of the timing of clinical interactions. I heard evidence and received a further statement, following the conclusion of the inquest, which set out the difficulties that the prison environment causes, in terms of being able to document accurately. However, I remain concerned that the lack of accurate documentation means that subsequent review of the appropriateness of clinical care, in particular, response times is hampered;

	2. The interval to further observations being undertaken were not inline with the NEWS2 scoring system and, in oral evidence, it was set out that prisoners were expected to self-report deterioration. This differs from latter information, provided after the conclusion of the inquest. However, it remains a concern. The use of the NEWS2 scoring system remains unclear; the post-inquest information seemingly sets out both that this system was only to used after a positive COVID-19 result but also at daily handover. Whilst recognising that the prison environment differs from a hospital setting, I remain concerned that the care provided was not as guided by the NEWS2 scoring system and that no alternative system appears to be in place that can be used effectively in the prison healthcare setting.
6	**ACTION COULD BE TAKEN** In my opinion action could be taken to prevent future deaths and I believe that the addressees have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 27 August 2021. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner, Mr Rahman's family, the Prison and Probation Ombudsman, HMP Pentonville and the CQC. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated: 2 July 2021  **Assistant Coroner R Brittain**