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HM Senior Coroner for Worcestershire
David Reid

BY EMAIL

14 November 2022

Dear Sir

The Inquest touching upon the death of Mr Gary McDonald

Thank you for your Report to Prevent Future Deaths issued pursuant to Regulation 28 Coroners (Investigations) Regulations 2013 dated 20 September 2022 and following the inquest touching upon the death of Mr Gary McDonald, who sadly passed away on 21 July 2021 whilst residing at HMP Hewell.

I would like to take the opportunity on behalf of Practice Plus Group to offer my sincere condolences to Mr McDonald's family and friends for their loss.

This letter addresses the matters of concern insofar as they relate to Practice Plus Group.

Matter of Concern

Below are the concerns quoted in the PFD report:

1) During his initial healthcare screening appointment on the evening he arrived at HMP Hewell (25 March.2021) and his secondary healthcare screening appointment the following day, Mr. McDonald denied any mental health issues, and denied any current thoughts of suicide or self-harm. His community GP records were requested and were received by the prison on 30 March 2021; these showed a previous history of depression, and two previous drug overdoses, the most recent of which had been only 7 months earlier;

2) Despite this history, no appointment was made with Mr. McDonald by the healthcare or mental healthcare teams to follow this up with him, and discuss his mental health in more depth;

3) In his evidence to the inquest, the current Head of Healthcare at the prison conceded that it might have been appropriate for someone to have visited Mr. McDonald, raised with him what the GP summary had shown, and asked him if he would like any help, but

that he would only have expected any such follow up if there had been any current concerns about his mental health. He further confirmed that there would have been no automatic follow-up about this, even if staff believed that Mr. McDonald may have deliberately misled them about his mental health history during his healthcare screening appointments;

4) In subsequent correspondence to my office, the Head of Healthcare has suggested that it might be appropriate to delay a prisoner's secondary healthcare screening appointment until his GP records have been obtained and scrutinised, so that concerns about any history set out in those records can be raised with the prisoner. That proposal is due to be raised at the prison's next Local Quality Assurance Meeting;

5) I am concerned that there is currently no system in place at HMP Hewell to follow up with a prisoner any discrepancy between the mental health history which he has disclosed on arrival at the prison, and that revealed in his community GP records. Experience suggests that a prisoner with a recorded history of mental health issues, particularly one which includes a recent episode of attempted suicide or self-harm through overdose, may be at his most vulnerable during his first days and weeks at a prison, and having been reluctant to disclose such issues for any number of reasons (e.g. fear, embarrassment), may be reassured to be told that healthcare staff at the prison are aware of that history and can provide confidential support. In my view, without routine follow-up in such cases, there remains a significant risk that a prisoner's recent significant history of suicide or self-harm may be overlooked in those important early days and weeks in prison, and that such prisoners will therefore be at an increased risk of further episodes of attempted suicide during that period.

Response

In providing a detailed response to the concern raised we consider that it is important to outline the current process in place for new prisoners coming into HMP Hewell. This is important because the arrangements and processes have changed since Mr McDonald's death.

Changes since July 2021

When a patient is received into the prison he is immediately located onto the Early Days in Custody (EDiC) unit. This EDiC unit was opened by HMPPS colleagues and has been in operation since November 2021 and is based on House Block (HB)2. What this provides is a comprehensive induction period for up to 14 days for all new arrivals. Healthcare services form a part of this induction programme and are also based on HB2. As part of this ongoing development since its launch, the current pathway means that the patient undergoes a number of key assessments. As well as the assessments, day-to-day interventions are provided in accordance with any identified healthcare need and subsequent care planning.

As part of a national NHS England rollout programme since April 2022, the Healthcare team and patients alike at HMP Hewell have benefitted from the introduction of the SystmOne upgrades commonly referred to as GP2GP. GP2GP is a process whereby the entire patient's record from the community GP is transferred into HMP Hewell, where in effect the Healthcare team becomes the patient's registered GP practice. The GP2GP functionality supports a number of benefits including:

- Improved quality of care
- Access to the full GP records
- Continuity of care; past medical history available including drugs, allergies, immunisations and vaccinations

- Improved clinical safety
- Clinical time saving
- Administrative time saving
- Reduced time to summarise
- QOF information readily available
- Reduced risk of transcription errors

The GP2GP no longer requires the need for a GP summary of the patient's previous GP healthcare record. GP2GP *is* the patient's healthcare record which includes all read coded entries for reporting and key word search functionality. There is no longer the need for trained back-office staff to enter the read codes from the GP summary into SystmOne, it is an automatic process.

Following the Inquest of Mr McDonald

Since the Inquest, the Head of Healthcare has consulted with other stakeholders within the team about the concern raised and have considered ways this concern can be alleviated. The healthcare team have introduced an updated version (V4) of the EDiC pathway and passport. This "passport" is a document that serves as a checklist to be completed by the healthcare induction team. By working through such a checklist in a systematic way, assurance is gained that all identified needs are being met for all patients, and to a consistent standard.

The key change between the previous version and Version 4 of this EDiC pathway is the timing of the Initial Management Review. It has been moved from Day 3 to Day 5 and now includes key word searches for suicide/self-harm references and will be undertaken *after* the GP2GP transition process has been completed. This key word search of the GP records has been implemented to identify any discrepancies in the information the patient has disclosed during the reception screenings. If a patient was to deny a history of mental health illness during the reception screenings, the key word search would pick this history up in his GP records.

The adoption of version 4 of this pathway continues to provide management reviews of every patient's GP record during the first 2 weeks in custody. These management reviews are undertaken by a Senior Nurse, who provides a quality and assurance check that all actions have been completed. In summary, the new pathway within v4 means that the patient will now undergo the following key assessments:

- Day 1 – Initial Reception Healthcare Screen completed, including appropriate referrals and actions.
- Day 2 – Medication Reconciliation completed (including face-to-face consultation with the patient)
- Day 2 to 3 - Second Screen completed, including a holistic Wellbeing Assessment.
- Day 2 to 3 – Substance Misuse Assessment (ISMS)
- Day 3 to 4 – GP2GP record transition completed (assuming patient consent).
- Day 5 – Initial Management Review and key word search undertaken by a Senior Nurse
- Day 10 – Final Management Review undertaken by a Senior Nurse

In addition to these key assessments, day-to-day interventions are provided in accordance with those identified healthcare needs and subsequent care planning.

At the point where the Day 5 management check has been completed, we have introduced new measures such as the key word search that address those specific concerns raised by the Coroner. These measures enable identification of previously undisclosed information and discrepancies about previous suicidal ideation and/or self-harm (irrespective of when). If any discrepancy is identified a member of the EDiC team (either a nurse or HCA) will return to meet the patient, informing him of our findings and then proceed to ask him 2 specific questions:

- Question 1: “Does the patient have any current thoughts of suicide or self-harm?”
  If **Yes**, we will then open an ACCT and complete a TAG referral to the MH team.
  If **No**, we then proceed to Q2.

- Question 2: “Does the patient currently require any input or support from the MH team?”
- If **Yes**, we complete a TAG referral to MH.
- If **No**, then no further action is taken.

These questions serve as a prompt for further discussion and for nursing staff to then evaluate and assess a patient where any disclosure is made/discovered. For both questions, the EDiC passport is then updated accordingly and a corresponding entry is made onto the patients SystmOne record, along with any further action taken.

These improvements have been developed as a result of a systematic process of consultation and engagement with those key stakeholders, particularly the EDiC and MH teams. The changes now ensure that any discrepancies are identified and the patient is provided with another opportunity to discuss their current position with a member of the healthcare team. It also ensures that healthcare are aware of the patient’s history and can factor this into any subsequent assessments.

We have also recently undertaken a pilot exercise for mental health triage screening of every new reception, and that typically was being undertaken on day 2. This pilot exercise took place during May - July 2022. The results of this pilot exercise were positive from both the patients and team/clinicians perspectives. On this basis, the introduction of the MH triage on a permanent basis is now subject to contractual discussions between Practice Plus Group and Midlands Partnership Foundation Trust (MPFT) as our sub-contracted mental health provider.

As always, we continue to receive large numbers of new prisoners each week and therefore regular reviews of our EDiC pathway and processes are important to us and our service. Whilst we are happy that the clinical review found good and equivalence of care in this case, we are always looking for ways to improve and thank the Coroner for raising his concern with us.

I hope that the above information provides you with reassurance that the concerns expressed have been addressed. Practice Plus Group is committed to ensuring the high quality provision of healthcare services to all prisoners at HMP Hewell and Early Days in Custody is something that is regularly reviewed for improvement and a formal review of the EDiC Passport v4 will take place by end of December 2022. We will also ensure that any lessons learnt as a result of this inquest are shared across all of Practice Plus Group’s services.

If I can be of any further assistance you should not hesitate to contact me directly.

Yours sincerely

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National Medical Director, Health in Justice, Practice Plus Group

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