Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Governing Governor [redacted], HMP Nottingham** **2 [redacted], Executive Medical Director and Executive Director of Forensic Services, Nottinghamshire Healthcare NHS Foundation Trust** **3 [redacted] Founder and CEO, TPP-UK**
1	**CORONER** I am Laurinda Bower HM Area Coroner for the coroner area of Nottingham and Nottinghamshire.
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	**INVESTIGATION and INQUEST** On 06 April 2020, I commenced an investigation into the death of Alexander Michael BRAUND, aged 25. The investigation concluded at the end of an inquest, conducted before a Jury, on 30 November 2022. Alex was a remand prisoner at HMP Nottingham, when he became acutely unwell on 6 March 2020, with symptoms of a productive cough (brown sputum) and feeling generally unwell. He deteriorated such that by the 8 March 2020 he was coughing, vomiting, wheezing, wasn't eating and had a headache. Alex and/or his cell mate pressed the emergency buzzer inside their cell at 22.22 hours on 9 March 2020 because Alex had deteriorated further. He had a burning sensation in his chest and difficulty breathing. The nurse attended but did not perform a complete NEWS2 assessment, take a sputum sample, nor listen to his chest. A plan was made to refer Alex to the prison GP the next day. There was no agreed plan between healthcare and discipline staff as to whether or how frequently Alex ought to be checked in his cell, what constituted a deterioration of his condition, and what to do in such circumstances. At 05.35 hours on 10 March 2020 the emergency cell bell was activated again. Alex's cell mate explained to the PCO that he was increasingly concerned about Alex's condition and that he wanted to see healthcare. Sometime later the nurse attended the wing but did not see Alex. She told the PCO nothing more could be done at this time of night. Alex was noted to be collapsed on the floor of his cell at 06.55 hours, and his cell mate raised the alarm by pressing the emergency cell bell for the third time. The PCO in charge of the wing failed to clearly establish whether Alex was breathing. There was a delay in entering his cell for the provision of basic life support, and there was a delay in calling a code blue, which in turn delayed the dispatch of an ambulance. These delays probably more than minimally contributed to Alex's death.

	Alex was declared deceased at 11.44 hours on 10 March 2020 in the Intensive Care Unit at Queens Medical Centre, Nottingham, following the withdrawal of life support. He had been suffering from an atypical pneumonitis that was not detected. The continuous failures to provide adequate healthcare to Alex probably more than minimally contributed to his death.
4	**CIRCUMSTANCES OF THE DEATH** The conclusion of the Jury was that Alex died on 10 March 2020 as a result of a hypoxic-ischaemic brain injury, caused by cardiac arrest with prolonged downtime, caused by an atypical pneumonitis, to which neglect had probably contributed.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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.**(HEALTHCARE) Lack of safe system, supported by training, guidance, and compliance auditing, for the provision of physical healthcare assessment and monitoring by NEWS2 for acutely unwell patients in a secure setting.** The Jury found shortcomings in the healthcare afforded to Alex at HMP Nottingham in the form of "*continuous failures to provide adequate healthcare, which probably more than minimally contributed to his death*". I heard evidence that staff were not consistently assessing acutely unwell patients using the NEWS2 system, despite the scoring system having been adopted across the NHS over the past decade and having been adopted by this Trust many years prior. In 2017, when relaunching the NEWS system, the Royal College of Physicians noted, "*Every so often, someone comes up with an idea that is so obvious, no one can understand why it wasn't thought of before. I am proud that the RCP's National Early Warning Score (NEWS) is one of those initiatives – not just a chart (or iPad) at the end of the bed to record the patient's physical signs and symptoms, but the chart at the end of the bed – a single point of truth to unify recording of symptoms across the NHS, consolidate training for doctors and nurses in the recording of symptoms, and thereby improve patient safety. When the RCP launched the NEWS in 2012, we hoped to see the score adopted across the NHS. What has been more astonishing is the adoption of the score internationally, with requests to use NEWS coming from health services across the world from Europe to India and the USA, including the US Naval Air Forces!*" I heard evidence of an inconsistent application of NEWS2 by staff, an inconsistent awareness of NEWS2 across the staff body, and an absence of clear and robust training supported by guidance, ensuring staff were aware of the expectations of their employer with regards to the use of NEWS2 in monitoring acutely unwell patients. Sadly, Alex's is not an isolated case. I have been repeatedly assured at a senior level from Nottinghamshire Healthcare NHS Foundation Trust that they are seeking to embed NEWS2 across their Directorates, yet successive inquests have heard of patients failed by the lack of use of the system by the clinical staff responsible for their medical care. If this issue is not addressed across the Trust, with sufficient urgency, patients will continue to die in Trust settings due to a failure to recognise the deteriorating patient, and to arrange for timely healthcare intervention.

Further, I heard evidence that the newly implemented compliance audit plans for NEWS2 are not safe or robust because the audit is limited to monitoring the emergency review template on Systmone, which staff are routinely failing to utilise, instead preferring to add free text entries to the running record, which cannot be audited with ease. If the Trust is incapable of monitoring compliance with the initiative, there will be repeated missed opportunities to provide support and guidance to Directorates, wards or individual staff who are deviating from expected practice with regards to NEWS2.

2. **(HEALTHCARE AND HMP) The absence of a safe joint system of care (between discipline and healthcare staff) for supporting and managing acutely unwell patients who remain in the prison setting, rather than being transferred to a dedicated healthcare facility.**

The very nature of incarceration curtails the prisoner's free movement and ready access to healthcare. Instead, their incarceration places them wholly reliant on the communication between discipline staff on the wing, and healthcare staff available elsewhere within the setting, to obtain timely healthcare assessment and monitoring.

I heard evidence that Alex had been told to "press his cell bell" if he "felt worse". Both Alex and his cell mate did so repeatedly between 9 and 10 March 2020, with varying degrees of success regarding healthcare attendance at his cell.

Despite discipline and healthcare staff knowing that Alex was suffering with an acute illness, and in the knowledge that there was no plan for him to be transferred to a hospital, there was an absence of agreed joint plan between health and discipline staff as to how often Alex would be seen by each profession, what constitutes a deterioration for him, and what to do in the event of such a deterioration, to seek to detect and manage his risk of physical healthcare deterioration.

In contrast, in circumstances whereby a prisoner is thought to be at risk of self-harm or suicide, there is an agreed joint care planning system (ACCT Version 6) which sets out the clear expectations placed on each profession to seek to keep the prisoner safe (enshrined in Prison Service Instruction). There is no such equivalent system in operation nationally with regards to the risk of physical healthcare deterioration, but that does not absolve each service from ensuring acutely unwell patients are kept safe by way of robust joint local care planning.

If acutely unwell patients continue to be managed in the prison setting without an agreed joint plan of care between health and discipline staff, deaths will continue to occur in these circumstances.

3. (**HM PRISON SERVICE) There continues to be a misunderstanding across discipline staff as to what constitutes a CODE BLUE/CODE RED situation, and in what circumstances a cell can be entered by a prison officer for the purpose of preserving life, despite this having been enshrined in Prison Service Instruction for many years.**

I heard evidence from the PCO that he erroneously believed it was necessary for 3 discipline staff to be present before a cell door could be opened during night state even in circumstances where Alex was collapsed and unresponsive on the floor.

This is not the first-time issues of this nature have been identified at HMP Nottingham. Indeed, successive Prison and Probation Ombudsman reports have recommended that the Governor take action to address these issues since the cluster of deaths in 2017/2018, and while the prison has been subject to Urgent Notification procedures.

I heard evidence from a medical expert that post-cardiac arrest, every minute which elapses without appropriate CPR and defibrillator use reduces the patient’s chances of survival. Timely life support is critical, and staff must be clear on when to call a medical emergency code, and when to enter the cell, subject to their dynamic risk assessment.

4. **(TPP-UK) Amendment of Medical Records without clear evidence of such amendment on the face of the SystmOne patient summary**

The vast majority of primary care health services across the community and secure settings, such as prisons, utilise an electronic patient health record known as SystmOne.

I heard evidence that the system automatically records the date, time, and user, shown along the left-hand side of each entry in the printed patient summary, as below.

17 Apr 2019 08:11	Surgery: Health Professional Access Role)

I was assured by health staff that any retrospective entry or amendment to a previous entry in the patient record would be flagged by a new date and time stamp towards the right-hand side of the entry, as below.

24 Apr 2019 15:55	Surgery: (Health Professional Access Role)	Entered: 25 Apr 2019 11:55

However, in this case, I discovered from scrutinising an audit record, that an entry made in Alex's patient record at 06.46 hours on 10 March 2020, had been amended by way of the deletion of some words, and the addition of others, at 09.30 hours on the same date, without any such time stamp being generated on the right-hand side of the entry. This made it look as if the entire text visible in the record would have been visible from around 06.46 hours that date.

The Head of Healthcare was unable to explain how the health professional who made the entry had been able to amend her previous entry, without it being obvious on the face of the record, after it became apparent Alex was critically unwell

This potentially raises serious safety issues about the integrity of the patient record, and at the very least, if the record is not as robust as first thought by its users, this ought to be made clear. I shall share this report with TPP-UK, the creators of SystmOne, to see if they can explain the safety features in place to ensure amended records are clearly marked as such, especially as in this case, the witness was not forthcoming about her amendment of Alex's patient record. Accurate record keeping is integral to learning from incidents and seeking to prevent future deaths.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 February 14, 2023. 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** and to the **Interested Persons**.

I have also sent it to

- **Ministry of Justice, Minister for Prisons, Parole and Probation, The Rt. Hon. Damian Hinds**
- **Care Quality Commission**

	• **Independent Monitoring Board, HMP Nottingham** • **Prison and Probation Ombudsman** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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:** 20th December 2022 **Miss Laurinda Bower** **HM Area Coroner** **Nottingham and Nottinghamshire Coroner's Service**