Practice Plus Group
Hawker House
5-6 Napier Court
Napier Road
Reading
Berkshire
RG1 8BW

practiceplusgroup.com

Senior Coroner ME Hassell
Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

6 November 2023

Dear Madam

The Inquest touching upon the death of Mr Amarjit Singh

Thank you for your Report to Prevent Future Deaths issued pursuant to Regulation 28 Coroners (Investigations) Regulations 2013 dated 18th September 2023 and following the inquest touching upon the death of Mr Amarjit Singh, who sadly passed away on 21st November 2021 whilst residing at HMP Pentonville.

I would like to take the opportunity on behalf of Practice Plus Group to offer my sincere condolences to Mr Singh'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. The completion of the cell sharing risk assessment was described by the extremely experienced nurse who completed it, as careless.

2. Though I was told that training for prison staff in how to deal with fits is to be given at HMP Pentonville in October 2023, I heard that there is only a hope that prisoners will also receive some guidance in what to do if their cellmate suffers a fit. Apparently, this has already been implemented in HMP Brixton.

3. Whilst the fact that not all prison officers receive ongoing first aid training is a national resourcing issue, the level of first aid understanding of some prison officers at HMP Pentonville seemed surprisingly low.
   One officer told me that it did not cross his mind to start CPR in the three minutes it took nurses to arrive after Mr Singh was found not breathing. (Mr Singh had been assessed by a custodial manager as having died, but the other officer did not know this at the time.)

A different officer told me he did not know that there is a difference between a person who is unconscious and a person who is dead.

Response

Only number 1 above relates to healthcare, and therefore PPG, so we do not propose to respond to points 2 and 3, which no doubt will be addressed by the Prison.

This letter is to be read in conjunction with the written submissions made by PPG during the inquest dated 6 September 2023.

Under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 Act, and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, where an investigation gives rise to concern that future deaths will occur, and the investigating coroner is of the opinion that action should be taken to reduce the risk of death, the coroner must make a report to the person that they believe may have the power to take such action.

Chief Coroner's Guidance 5 at [7] outlines that in considering their duty to make a PFD report, the coroner should focus on the current position, including any relevant changes made since death. It is a fact sensitive decision and relevant factors include:

a. The nature of the commitment to take action;
b. Any evidence in support of it;
c. The coroner's assessment of the organisation's understanding of, and commitment to addressing, the area of concern.

During the course of the inquest, His Majesty's Senior Coroner ("HMSC") heard evidence from the Head of Healthcare for HMP Pentonville about a number of healthcare processes in place at HMP Pentonville to address any deficiencies or inaccuracies in completing cell sharing risk assessment forms for patients who suffer from epilepsy. That evidence is summarised below.

<u>The reception screening process</u>

The Inquest heard evidence about the process of performing an initial healthcare screening at reception for a patient arriving at HMP Pentonville.

The evidence from both [redacted] and [redacted] was that [redacted] made an error in completing a form without having conducted the assessment screening. The correct procedure, described by [redacted], was that the initial reception screening should have been completed by [redacted] who should only have completed the form on completion of that screening.

This is an extract from counsel's note of the inquest, recording Ms Barratt's responses to questions from HMSC.

Q: Part of initial process heard for every prisoner cell sharing risk assessment. The reverse page wasn't completed by the person who saw Mr Singh ("AS"), instead completed by [redacted]. He describes completing those assessments for most of the time at Pentonville but ticked the box for no increased risk, wrote the words 'single cell', and did not specify AS needed a lower bunk. [redacted] said that he hadn't read the first page, then said that he had skim read it. When it was put to him that that was careless, he agreed. In the healthcare system, how can that happen?

A: The form absolutely should be completed by the person seeing the patient and if a thorough assessment by the nurse is done, they can fill it out. Reception nurses undergo specially

designed training specifically just for the reception process, which is a two day training. Which Antonio has been on recently.

On the basis of that evidence we make the following submissions:

- We appreciate HMSC's concern that if ██████████ could have completed the assessment in the manner that he did in 2019, the same might be said for 2023. We respectfully draw HMSC's attention to the fact that the nursing staff undergo specialised training on the correct reception process, and the nurse in question, ██████████████, has revisited the risk assessment form training.

- There is no evidence from any other witness that they would have completed the form carelessly or incorrectly in the same manner. ██████████ evidence supported this.

- The nurse completing the initial assessment should have completed the risk assessment form: this is the correct procedure. Evidence was heard from a number of witnesses that the initial reception screening completed by nursing staff is designed to be a thorough, comprehensive survey of a patient's healthcare needs. The completion of the risk assessment form during or following the initial reception screening should ensure that the forms are completed in an accurate and considered manner.

All new nurses shadow reception screenings and other EDIC (Early Days in Custody) processes comprehensively before starting out themselves. The two day reception training also runs periodically for staff to attend and get refreshers. The risk assessment part of the process is also explained clearly as part of their induction period and shadowing.

The Early Days process

The second process in place to ensure an accurate risk assessment form for patients is the Early Day Passport and Early Days process.

██████████ evidence on this process is set out below.

Q: What strikes me is if that happened on that day, what is happening with all the other prisoners?
A: Since then [AS's death] changes have been made to the reception process, on each side. There has been a big focus on early days in custody, recognising that the first 14 days and particularly the first couple of days are the most important period in someone's stay in prison. <u>One of things that would identify poor completion of cell sharing risk assessment is early day passport. This is overseen by custodial managers and nursing staff. There is a checklist to ensure that everything mandatory within the process has been completed and completed to a good standard. Certainly if not completed to good standard would expect that to be flagged to me.</u>
Q: Who is doing this?
A: Custodial managers. And nurses, with oversight, are required to complete healthcare sections
Q: Do you think that such a poor standard would not exist today?
A: I do
Q: This was only two years ago?
A: That's one element of the changes that we have made. The other side to that is in the past year we have re-modelled healthcare across London. We have moved to new models of care. The sole purpose of new model and reason why it has been redesigned is to reduce deaths in custody. There is very much a heavy focus on early days in custody team. What is happening now is as follows. If someone comes to Pentonville this evening, they are the subject of a

meeting the next day. A group of staff will look through every patient that came through the previous night. People in that meeting have dedicated roles. There is a chair, someone writing notes on standardised template, someone checking medical records. Someone from pharmacy looking out for medications and checking reconciliation. We have someone from mental health and substance misuse teams looking at notes to ascertain anything important to be picked up. Out of that meeting a care plan is generated for that patient. That is for every patient now. There was a referral meeting but that is based on referrals only. The key difference now is that everyone is screened in this meeting.

[…]

Q: What's the reason staff didn't [complete a F35 form]? Is it about culture?
A: It's about thoroughness, conducting a thorough assessment of the patient and ensuring factors are covered off. It is something I expected them to have asked.
Q: Has that culture changed?
A: Yes.
Q: How do you know?
A: There are more opportunities now to safety net patients and catch patients. This is the purpose of the Early Days process. Part of that process in the meeting is looking at the Prison Escort Record […] and also looking at the cell sharing risk assessment to make sure that it was filled out correctly and make any recommendations if not yet done at this stage. I can confidently say that if Mr Singh came in this evening then everything would be picked up at meeting tomorrow morning.

On cross-examination by counsel, [redacted] described how a list would be created within the Early Days meeting of tasks to be completed for the patient. These patients and any associated tasks would appear on an Early Days ledger. At the end of a patient's first 14 days in prison, they cannot be transferred out of the Early Days system until each of their required actions is marked as complete by a member of the healthcare staff. Outstanding tasks would reappear on the ledger every day until the tasks were complete.

By way of summary of the Early Days process and its role in quality assuring a patient's risk assessment form:

- Every patient has an Early Days passport as part of the Early Days process, which requires custodial managers and nurses to check off that items like the risk assessment form had been completed and completed to a sufficient standard. This requires a nurse to ensure that the risk assessment has been correctly completed, and sign off the passport.

- Care for every new arrival is transferred to a multi-disciplinary team. That team meet the next day and discuss a patient holistically. This occurs for every patient. Holding the Early Days meeting ensures that if a reception screening form is absent, incomplete or completed incorrectly for a patient with a medical history of epilepsy or seizures, it would be addressed in the Early Days meeting by the multi-disciplinary team and correctly completed. These meetings are conducted 5 days a week and are started earlier on a Monday to account for the weekend admissions.

- If a patient had not had the risk assessment form completed during the initial reception screen or the Early Days meeting, that patient would not be able to transfer out of the Early Days patient ledger until all outstanding tasks (e.g. completing or reviewing a cell sharing risk assessment form) had been marked as complete.

- There is an EDIC checklist of tasks/ procedures that must be carried out in the first two days of a patient's admission which is ticked and signed off by the EDIC Lead to ensure completion. The risk assessment forms part of this checklist.

Other checks in the system

There are several other aspects of Ms Barratt's evidence that, we submit, substantiate her assertion that a deficient risk assessment would be identified earlier and corrected. This is again taken from Counsel's note.

Q: We know that by time of death he was sharing cell and on upper bunk. Is it the case that because this was missed in the risk assessment that is it? Nobody ever looks back and checks? A: The risk assessment form is the initial *way of communicating that to discipline staff. Any senior clinician or GP when they see a patient with needs can commission an F35. This is a special recommendation form which we hand over to operational staff to say 'this man on bottom bunk', 'single cell', 'allowed two showers a day'. That's us giving that notice to operational staff. The clinicians that saw Mr Singh subsequently to his reception screening should have checked as part of their assessment if he was sleeping on bottom bunk. If the risk assessment form said 'no' then they should have issued the F35 which was in place at time*.

[redacted] also described the process in place for managing long term conditions.

On the basis of that evidence provided, we make the following assurances:

- A patient like AS would qualify for long terms conditions monitoring through the long term condition ("LTC") ledger and clinic appointments.

- This would result in AS having more frequent contact with clinical staff, each equating to an additional opportunity for staff to consider cell sharing risk issues and issue a F35 form if required.

Finally, we provide the HMP Pentonville prison team with a list of patients with epilepsy/seizures to ensure that custodial staff are also able to identify cell-sharing issues. This list is provided to all governors and custodial managers working in the establishment. We also have the Safety Intervention Meeting (SIM) and prison safety meeting where these issues can be discussed. If we wish to have an impromptu MDT (Multi-Disciplinary Team meeting) with the prison in regards to a patient then we will arrange this directly with wing managers and governors and any other relevant stakeholders.

I hope that the above information provides you with reassurance that action has been taken and cell sharing risk assessments would not be completed as it was in this case.

Practice Plus Group is committed to ensuring the high quality provision of healthcare services to all prisoners at HMP Pentonville. We will also ensure that the lessons learnt as a result of this inquest are shared across all of Practice Plus Group's services.

I do hope that this letter provided the necessary reassurance sought and if I can be of any further assistance you should not hesitate to contact me directly.

Yours sincerely

[redacted]
National Medical Director, Health in Justice, Practice Plus Group
[redacted] [redacted]