NHS
Nottinghamshire Healthcare
NHS Foundation Trust

Chief Executive
The Resource
Duncan Macmillan House
Mapperley
Nottingham
NG3 6AA

27 September 2023

Private and Confidential

Dear HMC Bower

Further to the Inquest into the death of Christopher Howard Smith I write in response to the Prevention of Future Deaths order Nottinghamshire Healthcare NHS Trust were issued on 1st August 2023.

Mr Smith died on 19th May 2019 at the Queens Medical Centre having been a serving Prisoner at HMP Lowdham Grange.

We accept the findings from the Inquest and would like to assure you that we take the findings and actions very seriously and will provide the updates below:

1. **An inability to provide Christopher with safe clinical care:**

Nottinghamshire Healthcare NHS Foundation Trust has undertaken a number of improvements which have been implemented by the Trust and Offender Health Care Group on NEWS 2. This includes the quality and delivery of the training (drill base) and expectations of the Trust of its attending GPs. The segreation pathway and clear escalation pathways have been implemented and are being reviewed to support safe patient care.

As a result of identifying a need to develop a training programme and approach that would ensure our staff have a greater understanding of NEWS 2 and the application of NEWS2 in a patient setting, a number of actions have been undertaken in order to address this:

- The Offender Health Care Unit brought in specific resource to support the rollout of NEWS2 training. This was in the form of the Trust's Resus Lead who is seconded into Offender Health for two days a week for six months initially (June-December), with a view to potentially securing this resource long term to ensure there is an all-year-round training programme providing support, training, and coaching to staff on Hospital Life Support and assessing, and managing deteriorating patients. This means Offender Health have dedicated support that will train staff on site and will shadow live situations within the prison and provide onsite support, training and guidance / debriefs as necessary.

- Additionally, training has been made available online to provide ease of access for staff members.
- NEWS2 training package was developed by the Clinical Leads (includes Sepsis and SBAR) which was delivered to all staff including GPs back in April 2023. Additionally, this now forms part of the local induction undertaken by the Clinical Leads for all new starters. This is delivered every month to capture any new starters during that period.
- As part of the onsite training delivered by the Trust Resus Lead, recognising deteriorating patient scenario drills are undertaken with staff. Weekly reports on the training such as any further identified training needs, are provided on a weekly basis into the Head of Nursing / Area Managers. Additionally, as an aide, a patient assessment form has been developed and put in place for staff to use in clinical situations. This now forms part of the core Emergency Response Kit and has been incorporated into the Emergency Response policy.
- The Resus Lead is attending code calls with staff on site so that he can shadow, assess competencies, and staff response, and provide feedback via a hot de-brief (one undertaken 19th July 2023).
- Escalation flow chart has been developed to assist staff and provide scenarios / context of when this might apply and what to do if unable to access an unwell patient. This has been ratified and disseminated to staff.
- There has been extensive work with the prison provider to develop relationships and clearer lines of communication. It is recognised that where there are issues around escalation or an emergency, this should be escalated to Victor 2 and / or Deputy Director or Prison Director.
- Incidents are being monitored weekly and shared with commissioners and prison provider to enable better sharing of concerns and development of joint responses to issues.
- Development of an audit programme relating to NEWS2, latest audit undertaken in August 2023, report and recommendations being compiled which will feed into internal governance infrastructures and be disseminated.
- Prison provider has changed its practice relating to the Segregation and will endeavour to ensure two staff members and a senior experienced member of staff are available in Segregation at all times. Where this is not happening, this is incident reported and / or escalated to the Prison Provider for action.
- Amendments have been made to the SystmOne Unit to ensure it is easier for staff to capture and record observations relating to NEWS2.
- A SOP describing the process of:
    - Admission to segregation
    - Healthcare review
    - Medication administration
    - Assessments from Neuro Diversion
    - Assessments from Substance Misuse
    - Assessment from Mental Health
    - Transfer to a secure Mental Health Unit
    - Assessment of access and patient risk
    - Management of food
    - ACCT
    - Access to GP
    - Complex cases and review

As of September 2023, all staff were 100% trained in NEWS 2 across Lowdham Grange. As a Care Unit, we have 223 staff trained out of 231 which translates as 97% compliant. The outstanding staff will be trained as a priority.

Segregation training is also being delivered as an ongoing programme by Clinical Leads, this has been done via specific, tailored sessions and forms part of the staff induction programme in both the face-to-face induction element and the physical induction pack. Additionally, Clinical Leads are also conducting spot checks on a recurring basis to ensure Segregation processes are being conducted in line with the SOP.

2. **An inability to record, retain and supply HM Coroner with material relevant to the inquest**

It is with deep regret that we were not able to supply you with the relevant materials to support the Coronial proces. We recognise the impact this had on your investigation but also the distress to the family, which is not acceptable. We are committed to improving this process across the Trust to ensure you and your team are provided with all relevant information to support your enquiries, and that there is support for Clinical Teams post serious incident, including where a death has occurred.

We recognise that post serious incident it can be difficult for the clinical areas to be clear on what information needs to be collected and stored to support both the investigation process and importantly, the HM Coronial process. We have therefore agreed a checklist of core information that must be collated. This will be supported by a weekly oversight group led by a senior team to both support the team but to oversee the Trust's process for collating and storing the correct information.

We recognise that across Nottinghamshire Healthcare NHS Foundation Trust, Care Groups and Units have developed numerous policies in isolation. We introduced a Trust wide Clinical Policy Group (CPPG) approximately 3 years ago to review and amend the oversight and governance of Policies. The CPPG continue to work towards reducing the quantity of clinical policies and procedures to support ease of access and clarity for staff and also to eliminate individual Care Group Policies. To date, reduction has been achieved by producing single combined Trustwide clinical policy/procedure documents via Topic Expert Groups relating to specific areas of clinical practice, and archiving all related local clinical procedures. The CPPG has also expanded its activities to include oversight of the processes governing the creation of any new local clinical procedures and now requires approval from the group before any new policy can be implemented. Further improvements include:

- Attendee to include Learning and Development Lead to join up the training requirements form each policy.
- Production of concise and accessible Clinical Policies Bulletins providing information regarding clinical policy/procedure activity.
- Explore possibility of the addition of QR codes to Trust clinical policies/procedures for increased colleague accessibility.
- To produce a one page brief per policy to support understanding the key information.

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- CPPG will ensure that the nominated writer has liaised with the Clinical Audit Team to determine how, when and by whom monitoring will take place to determine compliance and performance against the requirements of the policy.
- CPPG will determine that the nominated writer has identified any necessary training and agreed this with Learning and Organisational Development.

3. A complete lack of candour, openness and honesty when engaging in post death investigations

We recognise and regret that we did not undertake our duty of Candour with Mr Smith's family on this occission. We have reviewed the process of how we embed a meaningful culture of candour in the Offender Health Care Group. This includes access to support and training from the Family Liason Team specifically in relation to Duty of Candour.

You will be aware that we have undertaken a formal review of all Offender Health cases which are due to be heard as a Coronial process and this has idetifed a number of cases where further review is required. This review recognised that not all investigations unfortunately met the Trust's high standards of quality, candour and reflection. The further infomration provided as part of these reviews aims to strengthen our evidence and understand more about the required learning.

I can confirm that moving forward, I have bought in two indepndant investigators to support and work alongside Offender Health and they will also be allocated new Serious Incident Investigations with the aim of improving, supporting and providing leadership in this area of practice.

The Trust's Medico Legal Team have worked hard to review their processes in terms of preparing staff members for inquests, particularly those carried out in line with Article 2. As part of this review, the Trust witness statement template has been improved upon, with clear and specific guidance included in a number of areas, including relevant training and policies, reflections and duty of professional candour.

The Medico Legal Team and senior managers now hold a weekly Inquest Oversight Meeting whereby the specific requirements of each case are reviewed and updated to ensure documents and staff members required are identified and located at an earlier stage of the process. Discussions are held in terms of any witness conflict concerns, noting the important learning that came from Mr Smith's inquest in this regard. In addition, any staff members not engaging with the process are identified and this is escalated appropriately, with clear guidance that the Trust cannot represent staff members who do not engage with the Trust support in terms of statement provision and preparation for the inquest itself. During the pre-inquest preparation meetings with the Medico Legal Team, and where relevant any legal representative, provide a further opportunity for staff members to raise concerns as a group or individually in terms of their professional duty of candour, and addendum statements will be supported in any case whereby staff raise their concerns or reflections at a later date than their initial statements were made.

There have been four Inquest Training Days within the last 18 months, with another two planned, which have equipped attendees with the information required to fully understand and engage with the coronial process. In addition, the Medico Legal Team have been providing bespoke training sessions to smaller groups in person and via MS teams and will continue to do so in order to share the important message regarding inquest requirements. These have been with team groups in general upon request but also at a relatively early stage following a death with the care team(s) involved in order to introduce the coronial process and requirements, answer any immediate questions and importantly, to ensure the messages regarding being open and reflective within their statements for the inquest and during other processes such as the serious incident investigation are shared and staff are live to their obligations and the fact they will be supported by the Medico Legal Team and Trust management in doing so.

I hope that the information contained within this response provides assurance to you and Mr Smith's family that we, as a Trust have heard and understood the significant concerns raised throughout and as a consequence of this inquest, and that we are committed to continuing to make these important improvements to services and processes for future patient care.

Please do not hesitate to contact me should you require any further information.

Yours Sincerely

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Chief Executive