NHS England

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3rd May 2024

Dear Ms Ainge,

Re: Regulation 28 Report to Prevent Future Deaths – Mr John Joseph Singleton who died on 10 September 2019 whilst in the custody of HMP Risley.

Thank you for your Report to Prevent Future Deaths (hereafter 'Report') dated 16 November 2023 concerning the death of John Joseph Singleton on 10 September 2019.

In advance of responding to the specific concerns raised in your report, I would like to express my deep condolences to Mr Singleton's family and loved ones. NHS England is keen to assure the family, and the coroner, that concerns raised about Mr Singleton's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused to John's family or friends. I realise that responses to Coroner Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones and appreciate this will have been an incredibly difficult time for them.

Your Report raised the concern that there is a lack of functionality on the Health and Justice Information Service (HJIS) known as SystmOne, to be able to flag a medication non-compliance warning for early identification and referral and that an automated flag alert via the system would be a more efficient and effective way to monitor non-compliance.

In prisons people are risk assessed to determine if they can have their medicines in their possession (for self-administration) or are supplied each dose of some or all of their medicines under direct supervision by a healthcare professional (not in possession).

HJIS is not able to report on omitted doses at a national level however, local reports can be produced that show failed collections for a specific date, which can inform follow up. National standards published by the Royal Pharmaceutical Society expect provider services to have mechanisms in place to identify and follow up if 3 consecutive doses, or to follow up if supplies are not collected. It is worth noting that:

- as in the community, once a person has their medicines in their possession, compliance is not checked by the healthcare team routinely. Checks are made as part of a medicines or clinical review by the GP.
- A person can collect in-possession medicine any time between when it's ready to collect and when they need to take the first dose from the supply. This means the date for collection shown in HJIS may not be the date the supply needs to be used.

In prisons this means that the HJIS reports are used to check and follow up missed collections for not in-possession medicines as these represent missed doses. For in-possession medicines, routine weekly or monthly checks of the medicines supply rooms for any uncollected medicines would trigger a follow up where there is a clinical concern such as mental health or epilepsy medicines.

It is our view that a flag in a record is not a solution that would improve safety, as the flag would not be seen until a clinician opens that patient record, whereas a HJIS generated report will detail every individual who missed doses, or supplies, in the timeframe reported on.

I can advise that work is underway now to investigate the reporting functions in HJIS to establish whether there is a suitable mechanism that can be used by provider services, to identify non-collections of in-possession medication. This would be used to prioritise medicines supply room checks and follow up. Once an effective way forward is identified and agreed, the national NHS England Health and Justice team will work to facilitate roll out across the estate.

In the interim, in response to the concerns noted, NHS England's National Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning, will write to Health and Justice regional teams sharing these concerns, and asking commissioners to work with prison healthcare provider organisations, to remind all staff of the requirement to monitor uncollected in-possession medicines and the current options available within HJIS and in local processes to support this.

The findings and information will also be taken to a future NHS England Health and Justice Delivery Oversight Group (HJDOG). The HJDOG is the senior leadership forum, which holds responsibility for the oversight of delivery and continuous improvement in Health and Justice commissioned services, through both the national and regional teams, with a focus on improving health outcomes and reducing variation across England. These matters will be discussed, and regional commissioners will be asked to give assurance at a subsequent HJDOG meeting that the proposed action has been taken.

I would also like to provide assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by

the Regulation 28 Working Group, comprising Regional Medical Directors and other clinical and quality colleagues from across the regions. This ensures key learning and insights around events, such as the sad death of Mr Jones, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely

National Medical Director