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Oxleas NHS
NHS Foundation Trust

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12 September 2024

Case [redacted]

Private & Confidential

Patricia Harding
HM Senior Coroner Mid Kent and Medway
Mid Kent and Medway Coroners' Service
Oakwood House
Oakwood Park
Maidstone
Kent
ME16 8AE

Dear Madam,

Regulation 28 Report to Prevent Future Deaths – Inquest touching the death of Mr Benjamin Harrison

Thank you for your regulation 28 report to prevent future deaths dated 19th July 2024 following the inquest into the death of Mr Benjamin Harrison which concluded on 3rd June 2024.

In advance of responding to the specific concerns raised in your report, I would like to express my deep condolences to Mr Harrison's family and loved ones. Oxleas NHS Trust is keen to assure the family and the coroner that the concerns raised about Mr Harrison's care have been listened to and acted upon. I appreciate that responses to Coroner Reports may constitute an important part of process through which family and friends come to terms with the passing of their loved one, and that this will have been an incredibly difficult time for them.

In your paragraph 7 letter you raised concerns in relation to the care provided to Mr Harrison whilst at HMP Rochester, namely:

1. Evidence was given by prison staff that it was not uncommon for prisoners to be under the influence of substances, particularly spice at HMP Rochester.

During the day when it was suspected that someone was under the influence, healthcare would attend to assess whether medical attention or monitoring was required, there was however no access to in house health care during the night state.
OSG officers without medical training or knowledge of the prisoner's medical history had to use their own judgement whether to monitor a prisoner or to escalate the matter.
The prison orderly was not notified immediately when someone appeared to be under the influence and that the individual was thought to be under the influence was not documented.
Prison staff did not have any guidance or policy to assist them as to when to escalate matters or what monitoring should be undertaken and staff did not routinely use the GP on call service for advice.

2. Prison staff did not receive a briefing about prisoners with medication in possession in accordance with PS24/2011.

3. In evidence there were discrepancies between the policies in place and the understanding of healthcare staff as to what information could be shared with prison staff and when it should be shared.
Some healthcare staff in evidence indicated they would not share information about medication in any circumstances.
The healthcare policy and practice of healthcare staff in relation to information sharing does not align with PSI64/2011 that *information can be shared without a prisoner's consent if it is considered necessary to protect the individual or anyone else from the risk of death or serious harm.*
There was no clear process as to how or where the information would be shared and recorded either where a prisoner had consented to information sharing or where consent had not been given but it was nevertheless necessary to share the information.

In addition to the above concerns, you have also clarified in your email dated 29th August the following:

> In many inquests including this it is apparent that witnesses either do not know of or do not follow policy and in some instances, there are no policies/mechanisms in place. In relation to this inquest in particular one of the concerns was that there was no in house healthcare in this prison after 9pm whereas there is in many but not all other prisons. Whilst there are mechanisms for seeking external help in the context of the evidence in this case that was significant.

Following the inquest senior leaders from Oxleas NHS Foundation Trust have considered these helpful observations and have responded to each of your concerns as follows:

1. HMPPS colleagues have responsibility for reducing demand and supply of drugs in prisons, and there is a Governor responsible for Drug Strategy at the prison. The Drug Strategy meeting is attended by healthcare and issues including trends of use of drugs

such as psychoactive substances 'spice' are explored. Change, Grow, Live (CGL) are subcontracted by Oxleas to provide psychosocial substance misuse and they have a large caseload at HMP Rochester who undertake group and 1:1 work to address substance misuse issues including the use of psychoactive substances, and encourage harm minimisation and ultimately recovery. Healthcare attend those suspected to be under the influence of substances during the day until 21:00 as contracted by NHS England. As a Category C Prison, Rochester, in accordance with most Category C prisons does not have 24-hour healthcare provision. The contracts for Category C prisons do not normally make provision for healthcare services at night if there is no Inpatient department, and therefore no prisoners requiring 24-hour healthcare provision. NHS England would need to be asked to account for their commissioning decision arrangements if it is felt that 24-hour healthcare is necessary in Category C Prisons due to patient safety risks emerging from increased use of drugs such as psychoactive substances, despite the fact that these substances should not be available in prisons.

OSG officers have undergone basic first aid training during their induction to the standard deemed by HMPPS appropriate for their roles, including being in service during night patrol without healthcare staff on site, and managing any situation which may occur. HMPPS colleagues will be able to give further details regarding this training. The OSGs work together with Orderly Officers who have additional training and experience, and they have operational procedures to follow in the event of prisoners who present as requiring medical support during night state. The agreed arrangements between the hours of 21:00 – 07:30 when there is no commissioned healthcare provision on site, is that all higher risk prisoners have an agreed personal management plan in accordance with the Personal Management Plan Local Operating Procedure, and that in the event that officers have any healthcare concerns regarding a prisoner the Custodial Manager in charge of the prison should call the On-Call GP for further advice and guidance, and in an emergency they should dial 999 for emergency services. A review of out of hours calls to the out of hours GP service will be carried out in Autumn 2024 to ascertain frequency and effectiveness of use. Any calls to out of hours GP are discussed in the Governor's morning briefing each day and followed up by the healthcare team.

2. The guidance states that "during the night state Prisoners who are 'at risk' are observed, managed, supported and information and actions are recorded. Night staff must receive a **clear verbal briefing** on any prisoners who are identified to require a higher level of individual observations than normally required (such as those on an open, or, post closure Assessment Care in Custody and Teamwork (ACCT) plan (check and be directed by individual plans), or other prisoners on a higher than normal observation level for other reasons such as E-List, high security risk, or medication purposes). The briefing should also include information about **any prisoner with medication in possession** or where healthcare staff will have to administer medicines dose by dose throughout the "Night State". Staff must record their actions on the Night Occurrence Sheet and other relevant documentation such as an open ACCT plan."

This guidance is that the clear verbal briefing should include all prisoners who are 'at risk', and not all prisoners. It would not be possible to include all prisoners who have medication in possession in a nightly verbal briefing when up to a third of the total population are prescribed In Possession medication. It would not be practical and could distract from the prisoners who are at risk, and who require inclusion in the clear verbal briefing to ensure safety. We have agreed with prison colleagues that healthcare will share relevant information within the weekly Safety Intervention Meeting and discuss men with in-possession medication who may be at risk, so that prison managers responsible for those individuals are aware of any prescribed medication that may inform any risk management decisions. Being in-possession of a fentanyl patch is included within this criteria, and I can confirm that there are no prisoners at Rochester prescribed a fentanyl patch.

3. To support addressing understanding of policies, we have a new Practice Development Nurse (PDN) joining the team in September 2024, to ensure that the healthcare team are up to date with all relevant training and guidance. The PDN will share the clear guidance set out in chapter 2 of PSI 64/2011 and ensure via teaching sessions, read-and-sign procedure and supervision that this guidance is understood and followed by the nursing and wider healthcare team. There are mechanisms in place to share relevant safety and risk information on NOMIS, and this would have included sharing information of the risks of misusing a Fentanyl patch.

   Our Quality Manager has very recently reviewed all policies, updated them to the latest versions and shared their location with all staff. Our PDN will have the responsibility of ensuring that the healthcare team are aware of all relevant policies, that they understand the policies and the importance of following them, and that these are shared and discussed in teaching sessions, handovers, and supervisions. Training records will be kept in order to evidence this.

   As stated, there is no in-house healthcare in HMP Rochester after 9pm. There are arrangements for GP on-call provision arranged by providers which we have in place at HMP Rochester. GPs on an on-call rota have access to SystmOne records and therefore access to past medical history, past and current medical problems and any future appointments is in place to provide medical advice to prison staff, prevent unnecessary transfers to hospital and ensure patient safety by providing guidance on next steps when hospital transfer is required. We will ensure that this guidance is updated and that it also includes the relevant information to manage the expectations of HMPPS colleagues – for example if any patient monitoring is required then this cannot be undertaken at HMP Rochester when there are no healthcare staff on site and in any circumstances where a patient requires monitoring then they would need to be transferred to hospital.

I hope that this letter reassures you that Oxleas has been highly attentive to the findings of your investigation, and that concerted remedial action has been taken on all the areas you identified to prevent any similar future deaths.

Please do not hesitate to contact me if any clarification or further assurance is required.

Yours sincerely,

[redacted]

[redacted]
Chief Executive Officer

CC:
Chief Operation Officer, [redacted]
Chief Nursing Officer, [redacted]