Worcestershire Health and Care NHS
NHS Trust

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Our Ref: [redacted]

Date: 16 March 2015

Mr G U Williams
HM Senior Coroner for the County of Worcestershire
The Court Office
Bewdley Road
STOURPORT ON SEVERN
Worcestershire
DY13 8XE

Dear Mr Williams

Re: the late James Paul Colton
Regulation 28: Report to Prevent Future Deaths

I write further to your letter sent pursuant to Regulation 28 of the Coroner's Rules to Prevent Future Deaths dated 5 February 2015.

Prior to addressing paragraph 6 of your PFD report I thought it was important to identify some of the learning that had taken place following the tragic death of Mr Colton. I know that you will already be aware of the action plan that had been brought together taking account of the issues identified in the Prison and Probation Ombudsman report, Clinical Review and internal root cause analysis review. I understand that the action plan was submitted as part of the evidence at the inquest and you will therefore already be aware of how several processes have changed since Mr Colton's tragic death and how we have embedded such changes. I have identified below some of the most significant changes that have taken place which will all improve care provided at HMP Long Lartin.

Importantly, a couple of study sessions were held in which staff were taken through the case notes of Mr Colton and had an opportunity to discuss learning identified and how they may act in future situations. Whilst there are a number of learning objectives for the day, principally, staff were asked to be open and to be curious in clinical situations. I understand from my Deputy Head of Healthcare at HMP Long Lartin that staff still talk about the learning generated from this case and in the last week there has been an example of staff raising an issue and being encouraged to consider alternative options.

Additionally, the daily lunchtime meeting at HMP Long Lartin is now properly minuted with actions being allocated and recorded in patient records. This meeting is attended by a range of staff and encourages greater discussion about the care of particular individuals. As a result of some of the issues raised in Mr Colton's case, there have been changes to practices such as nurses undertaking pain scores. I am aware that individual nursing staff are more frequently recording pain scores in order to allow a judgment to be made as to whether a problem is persisting or becoming increasingly painful or resolving itself.

I am aware that in Mr Colton's case there were issues about his medication although I do now feel that as a result of work between healthcare and discipline staff, there are improved relationships between these different groups which enables staff to feel more confident when challenging, such as asking for patients to be unlocked during a period of lockdown.

I recognise that in Mr Colton's case there was a lack of continuity of care and I am able to notify you that now every patient who is on the inpatient facility has a named nurse and this is identified on each cell door so that the discipline officers are also aware of the identity of the named nurse. For those individuals who are on normal location, there are two nurses assigned to each wing so that there is a greater continuity of care for all prisoners. There are also now regular nursing meetings to discuss individual patients that take place both in respect of physical and mental health patients.

I understand that you have been made aware as part of the action plan of an audit that took place in respect of care planning in January 2014 which showed an improvement in previous performance. However, I am not complacent about the need to ensure effective care planning and would confirm that the Trust has now appointed a quality and safety lead for offender healthcare as well as a new lead for SystmOne, our prison patient record, both of whom will work across the three prisons that this Trust provides healthcare in respect of and ensure best practice in areas such as care planning audits, improving our functionality and training on the patient records system. Discussions are taking place in the Trust as to introducing some further training on care planning and how SystmOne may be adapted to support improved practice in this area.

As part of our continuing efforts to provide safe, high quality care in all of our services, I was keen to share with you some recent initiatives. A new standard operating system for inpatient prisoners is being conducted, at which time a review of previous entries is conducted. This is an additional review aimed at ensuring that no significant issues or tests are missed, as well as reviewing patient care. Further, the Deputy Head of Healthcare has identified an opportunity to accompany the Prison's Disability Liaison Officer when undertaking her activities, to raise awareness of the healthcare function, especially for hard to reach groups, as well as identifying any issues being raised about the healthcare provision.

In respect of the workload of clinicians at the prisons, there is no national guidance as to staffing levels within prison environments. You may be aware that for other inpatient areas there is a NICE accredited tool entitled Safer Nurse Care Tool (SNCT) which provides a framework for assessing the number of qualified and unqualified staff on a particular ward. As a result of having no national guidance for identifying the establishment, the Trust is undertaking an assessment of nursing numbers in offender healthcare based upon the range of task undertaken and the headcount. The Trust is also having discussions about the assessment of our other medical inputs involving our commissioners.

The Trust has been involved in discussions for some time with the South Worcestershire Federation to seek agreement for having dedicated GPs in place in the prison and I am pleased to report that this agreement has been concluded and we are now just awaiting the security clearances for the staff to be physically working at HMP Long Lartin. Discussions are underway with the senior GP from the Federation to arrange for clinical supervision for the general practitioners at the prison to be provided through this mechanism. However, I do need to also raise the issue as to whether it is appropriate for a consultant psychiatrist to be the responsible individual to monitor the standard of work for GPs at the health centre. The Trust has a management structure in which there are clinical directors for a number of different areas of specialism including a clinical director for offender healthcare. The role of the clinical director is to provide assurance and clinical leadership for the care delivered within that service delivery unit. Whilst I note that there may be concerns about appropriate clinical supervision of an individual clinician, I do not agree that it is not appropriate for management supervision to be provided by either a different professional or a professional of the same nature but of a different specialism. Whilst I agree that clinical supervision should be provided by somebody appropriate skills and experience I do not think it is necessary for there to be management supervision similarly so provided.

At HMP Long Lartin, the GPs who provide sessional cover do have a weekly opportunity when they are both in the prison at the same time to discuss individual cases and share good practice. I consider that this is a positive move and as well as formalising the new process for the obtaining of clinical supervision, which I anticipate will be through the South Worcestershire Federation, I consider that this provides adequate support for any individual clinician. Overall, I do consider that it is entirely appropriate for a clinical director from a different specialism (psychiatry) to manage other doctors from other specialties. If this was not appropriate we would inevitably have a position where we had to have lead clinicians for every type of professional within the organisation and I think that this would neither be desirable nor an appropriate use of scarce public funds.

I do hope that you feel that the Trust has taken seriously the issues raised in respect of Mr Colton's tragic death and I confirm that I had already, prior to the inquest, written to [redacted] to express my apologies in respect of the standards of care provided to her brother. I confirm that I have sent to her a copy of my response to your letter.

If you have any further queries do not hesitate to contact me.

Yours sincerely

[redacted]

Sarah Dugan
Chief Executive