Dorset HealthCare
University NHS Foundation Trust

Regulation 28 Report
Regarding the death of Mr H Norton on 06.01.2014

1. Introduction

1.1. The Trust commenced the provision of services within the Devon Prisons on 1st April 2013. It was recognised that prior to this there were significant issues with the quality of the service being provided and the Trust has been working hard to improve service provision since taking over the service. Since the contract award, the Trust has implemented new policies and procedures which ensure a quality service is being delivered and these are closely monitored.

1.2. This report has been produced in response to the Regulation 28 report to prevent future deaths received by [redacted] Specialist Services Manager on behalf of Dorset HealthCare on 24th April 2015.

1.3. As at the 25th July 2013, Coroners Rule 43 reporting, which gave coroners the power to report at their discretion, has been replaced. Under Regulation 28 of The Coroners (Investigations) Regulation 2013, coroners now have a statutory duty to issue a report where, in their opinion, action should be taken to prevent future deaths. The term Rule 43 has been replaced by 'Report on Action To Prevent Future Deaths (PFDs).

1.4. The Regulation was issued by HM Senior Coroner for the County of Devon and Exeter and Greater Devon District Dr Elizabeth A Earland. The Trust is required to respond within 56 days of the date of the report (24th April 2015) no later than 8th June 2015.

1.5. The Trust was not made aware of the occurrence of the inquest, or invited or requested to attend or provide statements.

1.6. In response to the Regulation 28, a review of the case has been undertaken and this report outlines the process, findings and action arising out of this review.

2. Investigation team and terms of reference

2.1. The review was carried out by the Executive Quality and Clinical Risk Group, Chaired by the Medical Director [redacted], and Director of Nursing and Quality [redacted] who have not had previous involvement in this case.

2.2. The Terms of reference for the review were to consider the recommendations relating to Mr H Norton and review the actions taken by the team, and ensure that the Trust is assured that a robust change in practice has occurred.

2.3. This report constitutes the formal Regulation 28 report to HM Senior Coroner for the County of Devon and Exeter and Greater Devon District Dr Elizabeth A Earland.

3. Coroners Concerns

3.1. The regulation 28 letter related to concerns that arose out of the inquest held into the death of Mr H Norton, Concluding on the 11th March 2015. These concerns were:

It is noted that Mr Norton was medically assessed whilst an Inmate of HMP Albany (now part of HMP Isle of Wight) on 28th September 2006 and known to have extensive and well documented history of high cholesterol, ischaemic heart disease with episodic angina, two previous myocardial infarctions, blood pressure 220/100. After arrival at HMP Dartmoor on 15th March 2013 is noted that:

- There was no record that his blood pressure was monitored
- There was no record that he had been informed of screening test for aortic aneurysm
- There was a delay in calling an emergency ambulance because HMP Dartmoor did not have an emergency code (unlike HMP Exeter) protocol.

3.2. The Coroner noted that whilst there is insufficient evidence that these are causative of Mr Norton's death there would have been an awareness of possible problems to come had the monitoring been in place.

3.3. The third of the concerns relates to the HMP Dartmoor service, at the time of this report it is not clear whether the prison have been asked to respond separately or whether the Trust is expected to do so on their behalf. The Trust is awaiting a response from HM Coroner's office to determine this. For the purposes of this report the third recommendation has been left for HMP Dartmoor Governing Governor Bridie Oaks-Richards to respond to as this is a prison responsibility.

4. Prison and Probation Ombudsman (PPO) Report and Clinical Reviewers Investigation

4.1. The Trust received the PPO report relating to Mr Norton in October 2014 (see appendix 1) which provides a chronology of events (see PG 8 and 9) following which an action plan was drafted to address the recommendations. The PPO noted:

'I am concerned that there is no record that Mr Norton's blood pressure was monitored during his time at Dartmoor or that he had been informed of a screening test for aortic aneurysm. However, we do not know whether Mr Norton would have decided to be screened and, if so, whether this would have altered the outcome. I am also concerned that, because Dartmoor did not have an emergency code protocol, as national instructions require, there was a delay in calling an emergency ambulance. In future emergencies such a delay could be crucial'

PPO Nigel Newcome CBE

4.2. The following recommendations were made by the PPO:

- The Head of Healthcare should ensure that staff appropriately monitor and record blood pressure readings for prisoners with hypertension in line with national guidelines.
- The Head of Healthcare should ensure that information on national screening programmes is available for eligible prisoners as part of good health promotion in the prison.

- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Dartmoor has a medical emergency response code protocol based on the PSI which:
    - Provides guidance to staff on efficiently communicating the nature of an emergency;
    - Ensures staff called to the scene bring the relevant equipment;
    - Ensures there are no delays in calling, directing or discharging ambulances.

5. Trust response to the Regulation 28 Ruling

5.1. The Trust recognises that there were failings in relation to Mr Norton's care, and agrees with both the PPO and HM Coroners view that these issues are of concern. In order to ensure that these issues do not reoccur within the Trust services, an action plan was put into place at the time of Mr Norton's death, to address the issues outlined.

5.2. The action plan is provided at Appendix 2, however it should be noted that the Trust action plan did not reflect the recommendation relating to emergency protocols and the requirement for the Governor to ensure a protocol be in place as this was directed at the Prison Service by the PPO.

5.3. The Trust is committed to ensuring that it provides a high quality responsive service. The following is a summary of the action taken to address the findings of this review.

5.4. Concern 1 - There was no record that his blood pressure was monitored

5.4.1. National guidelines (NICE) are in place in the Prison healthcare service and form part of the Trusts prison healthcare clinical audit programme. In line with the PPO action plan following the death of Mr Norton, GP Clinical Lead Dr [redacted] undertook a baseline review of compliance against ***NICE QS28 Hypertension*** to ensure compliance. This is provided at Appendix 3 and at point of audit the Trust was fully complaint. A further audit is planned for July 2015 to ensure ongoing monitoring and compliance.

5.5. Concern 2 - There was no record that he had been informed of screening test for aortic aneurysm

5.5.1. The Trust now provides a AAA screening programme, which is available to all patients with the Devon prisons. Eligible patients (as defined by the National AAA Screening programme) are tracked to ensure all are offered and receive screening, or reasons for declining are clearly documented.

5.5.2. The review team noted that all eligible patients are invited for screening as per national guidance and are sent a letter by the NHS AAA Screening Programme. All patients over the age of 65 are invited to self-refer for AAA screening if they wish. As per guidance, a second offer of screening is made after a year. (see appendix 4)

5.5.3. The AAA screening is actively promoted in the prison, as noted in recent audit where of the 29 patients who attended for AAA screening, 18 were self-referrals. (See appendix 5)

5.5.4. Screening programmes are built into the monthly health promotion timetable with Health Promotion posters regarding national screening programmes displayed widely around the Prison. (See appendix 6)

5.6. Concern 3- There was a delay in calling an emergency ambulance because HMP Dartmoor did not have an emergency code (unlike HMP Exeter) protocol.

5.6.1. Bridie Oaks-Richards Governing Governor of HMP Dartmoor has confirmed that the prison are now compliant with Prison Service Instruction (PSI) and have an emergency code protocol in place.

6. Summary

6.1. Trust is assured through robust review at the Executive Quality and Clinical Risk Group that the recommendations made by the PPO and HM Coroner have been addressed and will continue to be monitored through compliance audit and review.

[redacted]