Regulation 28 Report
Regarding the death of Mr Carl David Roy Smith on 22 November 2012

1. Introduction

1.1. The Trust commenced the provision of services within the Devon Prisons on 1 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 Ron Shields, Chief Executive on behalf of Dorset HealthCare on 29 July 2015.

1.3. As at the 25 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 The term Rule 43 has been replaced by 'Report on Action To Prevent Future Deaths (PFDs).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 (29 July 2015) no later than 18 September 2015.

1.5. Devon Partnership Trust were the Commissioned Healthcare Provider at the time of the patient death.

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 Fiona Haughey 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 Carl Smith 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. Coroner's Concerns

3.1. The regulation 28 letter related to concerns that arose out of the inquest held into the death of Mr Carl Smith, concluding on the 21 July 2015. These concerns were:

It is noted that Mr Smith was at HMP Exeter on remand having arrived there approximately 1 week before his death. He was due his court appearance on 22 November 2012. He was at risk of self-harm so was on 30-60 minutes observations and in a cell fitted with a camera.

On the evening of 21 November 2012, he was given medication for seizures and detox. On 22 November at 07.15 hours a Prison Officer called to him through the cell hatch but got no response so she entered the cell with another Prison Officer to find him unconscious with no signs of life. CPR was commenced whilst paramedics were called who found that his airway was blocked by vomit, resus attempted but unsuccessful and his death confirmed at 0805 hrs.

The Matter of Concern is as follows:

The quality of custodial and welfare check were insufficient for a prisoner on an ACCT and methadone stabilisation programme and information sharing in relation to checks made, appear to be deficient.

4. Prison and Probation Ombudsman (PPO) Report Including Clinical Review

4.1. The Trust received the Draft PPO report relating to Mr Norton in August 2013 (see appendix 1) which provides a chronology of events following which an action plan was drafted to address the recommendations. The PPO noted:

While the investigation has not concluded that Mr Smith's death was foreseeable, it has nonetheless identified a number of significant concerns about his short time at Exeter.

The clinical reviewer makes a number of criticisms, including of dispensing arrangements and of substance misuse staff. It is of particular concern that the substance misuse team lacked clinical leadership. The investigation also identifies weaknesses in suicide and self-harm procedures, searching arrangements and the conduct of observations by night-time staff on someone on a methadone maintenance programme.

PPO Nigel Newcome CBE

4.2. The following recommendations were made by the PPO:

- The Head of Healthcare should ensure that all healthcare staff take and record prisoners' basic observations after a reported seizure.
- The Head of Healthcare should ensure that opiate dependent prisoners are treated and monitored safely, within clinical guidelines and to the standards set out in PSI 45/2010.
- The Head of Healthcare should ensure that a clinical lead doctor in substance misuse is appointed urgently.
- The Head of Healthcare should ensure that appropriately trained nurses are used to dispense controlled drugs.

- The Head of Healthcare should ensure that healthcare staff take appropriate lifesaving equipment to incidents when responding to an emergency code indicating a life-threatening situation.

- The Governor should ensure that appropriate searches are conducted to help support prisoners' safety when they move cells.

- The Governor should ensure that ACCTs are managed in accordance with Prison Service Instruction 64/2011 and that observations and documentation are completed appropriately.

- The Governor should ensure that ACCT checks are recorded accurately and that staff responsible for conducting observations do so thoroughly and are alert to any concerns.

- The Governor should ensure that staff are trained to recognise the common symptoms of drug-induced unconsciousness and methadone toxicity and know how to respond.

- The Governor and the Head of Healthcare should ensure that there are adequate security measures including when dispensing methadone to prevent its illicit use in the prison.

5. Trust response to the Regulation 28 Ruling

5.1. The Trust recognises that there were failings in relation to Mr Smith'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 receipt of the PPO report into Mr Smith's death, as the Trust was not the provider at the time of Mr Smith's death. This action plan assured the Trust that actions taken by the provider at the time of Mr Smith's death addressed the issues outlined.

5.2. The action plan is provided at Appendix 2, however it should be noted that this Trust did not take over the ownership of the draft report findings, final publication and the action plan until April 2013. The Trust did however comment and update its findings within 6 months of taking over the contract.

5.3. The Trust is committed to ensuring provision of high quality responsive services.

5.4. The following is a summary of the action taken to address the findings of this review.

5.5. Concern 1 - To review the systems for Information Sharing reference those on drug treatments stabilisation programmes for Substance Misuse IDTS with Prison Officers so that all Prison Officers are aware of Prisoners concerned.

5.5.1. All patients at HMP Exeter on drug treatment programmes are reviewed jointly by DHC substance misuse staff and prison service staff to ensure their location and observation levels are jointly agreed with clear decision regarding who/when monitoring will take place. Details of all patients on the caseload are held in a shared drive to which both Prison and DHC staff have access. Decisions to increase or decrease observation levels are taken by clinical staff and clearly communicated to the prison service staff.

5.6. Concern 2 - To review training of Prison Officers as to when they ought to involve healthcare when Prisoner's behaviour could be construed as erratic/ odd, needs assessment by healthcare BEFORE deleterious consequences occur.

5.6.1. There is now an education package in place for all staff (prison and DHC) regarding substance misuse awareness. It contains information around the structure of the team, the different types of substances that are used, the complex nature of withdrawal, and signs and symptoms (including potential fatal consequences) of withdrawal. Training packages can be adapted and reshaped according to any new legislation or guidance that is produced in the future. This is provided at Appendix 3. The substance misuse service provides further update packages as appropriate for example following identified use of 'spice' or other New Psychoactive Substances (NPS).

5.7. Concern 3- To review training and audit the operation of the ACCT document system so that it is made as robust as possible.

5.7.1. This is the responsibility of NOMs at HMP Exeter- Appendix 4 details the response.

5.8 Concern 4 –To ensure that there is a clear directive on the operation and retention of all CCTV footage which is not just a "live Camera"- the coroner received information that the footage outside the cell had been seen but was not available to the Police when called to investigate.

5.8.1 This is the responsibility of NOMs at HMP Exeter- Appendix 4 details the response.

6. Summary

6.1. In addition to the Coroners Ruling noted in this report the Trust has introduced a robust system for the monitoring of patients arriving at HMP Exeter and requiring Night Welfare Checks (see appendix 5). This guidance was developed jointly with Public Health England (NTA), HMP Exeter National Offender Management Service and will be approved by NHS England at the Devon Prison Partnership Board in October 2015.

6.2. 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.

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