HM Senior Coroner Mary Hassell
Inner North London
St Pancras Coroner's Court
Camley Street
London
NC1 4PP

HMP Pentonville
Healthcare Department
Caledonian Road
London
N7 8TT
[redacted]

14 March 2019

Dear Madam,

Tyrone Givans (Deceased)
Regulation 28: Prevention of Future Deaths report

Thank you for your Regulation 28 Prevention of Future Deaths Report dated 23 January 2019, issued following the inquest into the death of Tyrone Givans. Care UK would like to express its condolences to Tyrone's family and friends.

Care UK is the provider of healthcare services at HMP Pentonville. Care UK makes the following comments in response to the issues identified within the report:

Drugs – Spice

Care UK acknowledges the problem presented by the supply and distribution of illicit drugs within HMP Pentonville and across the prison estate. Care UK is committed to working with partner agencies throughout the estate in supporting efforts to tackle illicit substance supply and trading, and to feed in to disciplinary, support and education processes requiring multidisciplinary team input and engagement. In addition, healthcare continue to treat and educate the prison population as to the dangers associated with the use of illicit drugs, including Spice. This management of people using psychoactive substances (PS) is supported by a Care UK's PS strategy and Local Operating Procedures.

Reception into prison

The evidence given at inquest confirmed that an erroneous spelling of Tyrone's surname during his time in police custody was replicated by HMCTS in the warrant authorising his detention and again by discipline staff on his entry into HMP Pentonville on 7 February 2018. This resulted in the uploading or creation of a new medical record set for Tyrone on 8 February 2018 when NOMIS interfaced with SystmOne. The new record did not include his historical medical information or that from his reception medical screening on 7 February 2018.

Unfortunately, the creation of a new set of medical records for Tyrone was not identified, or if it was, it was not queried by clinicians who accessed those records on and after 8 February 2018.

Care UK has shared the learning from the inquest, including the existence of the anomaly which can cause the creation of more than one set of medical records for the same patient (for example

should they be allocated a new prison number and NOMIS record as a result of a different spelling of their name) with its clinical team at HMP Pentonville and across its prison healthcare estate. This has been by way of a discussion at Care UK's national Quality Assurance meeting and a cascading of the minutes of that meeting to all sites via regional Quality Assurance meetings.

In addition, NHSE are running a project to provide a new functionality in SystmOne whereby patient records are now matched to the NHS Spine, rather than the warrant. HMP Pentonville was one of the first pilot sites but this will be rolled out across the country.

Clinicians have also been reminded to thoroughly review relevant records and to query apparently missing records or other anomalies. In addition, at HMP Pentonville, the structure of the clinics has been altered to minimise interruption and disruption by other patients, which transpired as a concern through GP evidence in the inquest. All healthcare reception staff at HMP Pentonville have attended a 3 day NHS England run reception screening course titled "Reducing Deaths in Custody".

Tyrone's disability

Care UK acknowledges that the identification of Tyrone's disability and the communication of his need for hearing aids, and possibly for other adjustments, could have been better handled. As the Head of Healthcare, [redacted], and Deputy Head of Healthcare, [redacted], explained in evidence, changes have been made to systems of communication within healthcare and between healthcare and the prison. This includes involving the input of senior management in ensuring that action is taken and information is communicated by and to the most appropriate individual where unusual situations arise; increased awareness of, and referrals to, the prison's equalities officer and a reminder to healthcare staff regarding making notes of wing conversations in the SystmOne medical records.

A new Health and Wellbeing model has been implemented at HMP Pentonville with effect from 14 May 2018. In addition to its primary purpose, which is to deliver primary care mental health treatment whilst preventing silo working, reducing duplicate referrals and the time patients wait to be seen and preventing patients having the same conversation multiple times to various professionals, this acts as an additional safety net for patients coming into prison. We are confident that this would have identified Tyrone's disability and enabled better management of his care.

Care UK welcomes your suggestion that the first night form could be adapted to include an equalities/disabilities component. The SystmOne first night template is mandated by NHS England and whilst Care UK is more than willing to adapt the screening process, this will require discussions with NHS England. We will therefore forward your report and this response to them and work with them in the development of this additional safeguard.

We are committed to providing a high quality healthcare service at HMP Pentonville and are doing everything we can to ensure those detained there are as safe as possible and receive the best quality care. We will ensure that the lessons learnt following Tyrone's death are not just implemented at HMP Pentonville but across Care UK's services.

We trust that the above responses provide the information that you require but please do not hesitate to contact us if Care UK can be of any further assistance.

Yours faithfully

[redacted]
Head of Healthcare
HMP Pentonville

On behalf of Care UK