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Mr Alan Romilly Craze, Senior Coroner for the
area of East Sussex
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18th December 2019

Dear Mr Craze,

Re: Regulation 28 Report to Prevent Future Deaths –
Mr Justin Peter GALLAGHER, who died in HMP Lewes 17th June 2016.

Thank you for your Regulation 28 Report (hereinafter the 'report') dated 16 August 2019 concerning the death of Justin Peter Gallagher on 17 June 2016. Firstly, I would like to express my deep condolences to Mr Gallagher's family.

I note that your recent inquest concluded Mr Gallagher's death was as a result of Hypoxic brain injury caused by a heart attack brought on by laryngeal cancer.

Following the inquest, you now raise concerns in your report to NHS England regarding:

1. The prison never obtained his previous medical history. No proper care plan was drafted for him and there was no single clinician responsible for his care.
2. A number of external hospital appointments were cancelled at short notice because of lack of resources (no available escorts etc.) and there was no system available for rearranging such visits.
3. The deceased died of cancer but this had never been diagnosed and opportunities to have discovered his condition were missed.
4. There was no involvement of the family and so a source of important information was missed
5. The underlying problem was that healthcare in the prison was the responsibility of three different organisations, namely the prison service, the local mental health NHS trust (who were given the responsibility for dealing with all the physical health matters and running the healthcare centre), and a separate organisation who supplied GPs. These three organisations had entirely separate database systems.

Firstly, I would like to advise you that following Mr Gallagher's death in June 2016, in line with the Prisons and Probation Ombudsman's requirements, NHS England commissioned an independent clinical review into the care received by Mr Gallagher whilst a prisoner in HMP Lewes to consider whether it was equivalent to that he could have expected to receive in the community. The clinical reviewer was required to identify any improvements that could be made and make appropriate recommendations.

The review made a number of recommendations and an action plan was agreed with providers of healthcare at HMP Lewes, which was completed by 1 April 2017. A copy of this action plan is attached as annex A.

Further joint inspections by Her Majesty's Inspectorate of Prisons (HMIP) and The Care Quality Commission (CQC), and specific quality visits carried out by the commissioners, have resulted in a number of the recommendations being repeated to ensure that the changes were embedded. In addition, a further Service Development Improvement Plan was agreed in April 2018, and I can advise this was last updated in July 2019. The relevant actions within the plan are listed below in response to your individual concerns which I look to respond to in turn. When responding I am also mindful of the similar concerns raised in the report following the more recent death of Mr Martin Leslie Haines who also sadly died whilst detained at HMP Lewes in March 2018:

1. The prison never obtained his previous medical history. No proper care plan was drafted for him and there was no single clinician responsible for his care.

All providers are contracted using the NHS Standard Contract. Service Specifications within the contract set out clear expectations in relation to service delivery. In this instance, the Primary Care Service Specification sets out a requirement for the provider to carry out *"an in-depth assessment of health needs within 72 hours of arrival..... accurate clinical care must be maintained and any referrals for follow up and further assessment or intervention must be discussed and undertaken. Reasonable efforts should be made to source clinical history, GP etc."*

NICE Guidelines 57: Physical health of people in prison (November 2016)[1] covers assessing, diagnosing and managing physical health problems of people in prison and includes the following recommendations:

- A first health assessment on reception into prison;
- Arrange for the person's medical records to be transferred from primary and secondary care to the prison healthcare team on entry to prison; and
- A healthcare profession should carry out a second-stage health assessment for very person in prison.

Mr Gallagher arrived at HMP Lewes on 29th March 2016 and underwent a first screen on that day. A copy of his summary care record was obtained via the NHS Spine portal the following day, along with a medication summary, but attempts to obtain a more detailed history from GP/Consultants were unfortunately not followed up.

The Clinical Reviewer recommended that the Head of Healthcare at HMP Lewes should ensure that the past medical history is obtained for new prisoners with chronic conditions, and that their care should be assigned to a name clinician. I can confirm an action plan was implemented with all actions achieved by 1 April 2017 which included:

- implementation of a more robust administrative process which ensures that community medical records for newly arrived prisoners are requested within a week in line with NICE Guidelines 57, PSO 3050;
- an audit of healthcare record requests in March 2017 to ensure the process was effective and efficient. As a result of your report I can confirm commissioners have asked SPFT to undertake a further audit which was completed in November with the outcome due to be shared by the end of December 2019. A CQC focus visit took place on 21 and 22 October 2019 and it was reported to the commissioners that record keeping and care planning in particular had significantly improved with the input of additional resources to support this process;

[1] https://www.nice.org.uk/guidance/ng57/chapter/recommendations#on-entry-into-prison

- the running of a regular report via SystmOne to ensure that healthcare records have been requested; and
- a nominated member of staff checking that all newly arrived prisoners have been offered a full general health assessment to include the drafting of a care plan within 7 days of arrival. The checks to be noted on an internal document which is shared with all healthcare staff.
- New prisoners with chronic conditions are assigned to a named clinician. Depending upon the condition this may be a GP, Specialist Nurse or Primary Care Nurse.

2. ***A number of external hospital appointments were cancelled at short notice because of lack of resources (no available escorts, etc) and there was no system available for rearranging such visits.***

Regional commissioners are aware that there is an ongoing shortage of trained officers at HMP Lewes which can result in a restricted regime resulting in less access to healthcare and attendance at external hospital appointments. There also continues to be issues with the re-booking of appointments and commissioners are working with Sussex Partnership Foundation Trust (SPFT) to resolve this.

I can confirm SPFT have implemented a revised process to ensure there is a clinical review of any appointments which are postponed. This includes a review by the GP to assess clinical need and risk. Where the demand for external escorts exceeds availability, the GP will prioritise appointment attendance based on clinical need and any appointment cancelled is to be automatically re-booked with the hospital trust. This revised process including clinical review will suitably prioritise and prevent future failings to re-arrange cancelled appointments. The monitoring of this by the commissioners will take place at monthly Contract Review Meetings (CRM) and any concerns will be reported to the monthly Partnership Board (PB) and if further escalation is required it will be dealt with at the monthly Local Delivery and Quality Board (LDQB).

3. ***The deceased died of cancer but this had never been diagnosed and opportunities to have discovered his condition were missed***

The Clinical Reviewer's report states that Mr Gallagher had been diagnosed with laryngeal cancer 2 years prior to reception at HMP Lewes, and that Mr Gallagher died from events caused by the recurrence of a laryngeal tumour that had been treated the previous year with radiotherapy.

It is however apparent from the Clinical Reviewer's report that there were several factors that may have hindered the diagnosis of this recurrence not least because of Mr Gallagher's complex medical history, including:

a) Limited knowledge of past history;
b) Deferred outpatient appointments;
c) Continuity of care; and
d) Mental health.

Commissioners agreed a Service Development Plan with the healthcare providers (SPFT and Medco), which included the introduction of a named clinician for all patients with chronic illnesses; reinforcement of the requirement for a clinician to be involved in any decision to postpone out-patient appointments; and a work plan to reduce the number of cancelled appointments. Commissioners recognised the need for improved clinical oversight and scrutiny and this takes place via the local governance arrangements. The process is that SPFT and Medco revisit the findings of Mr Haines Clinical Review and

ensure all lessons learned have been implemented and identify any further training requirements for staff. This will include GPs discussing the case with their RO. Commissioners now also make it a requirement that cancelled appointments are reviewed at a multi-disciplinary team meeting and a risk assessment completed for each prisoner. Provider(s) will be required to submit a report to contract meetings to ensure full oversight by the prison governor and commissioners. In addition, in 2018 Commissioners introduced enhanced quality surveillance and support for providers. This was achieved through newly created Health and Justice Quality and Safety Manager posts in South East Region. These posts are clinical roles that bring additional oversight and support to the quality of healthcare delivery.

Commissioners have monitored the implementation of these recommendations and since 2017, have served Contract Notices in June 2018 and November 2018 to SPFT relating to poor performance. These notices have included the potential for financial penalties if action plans were not completed satisfactorily but were not required on either occasion.

4. There was no involvement of the family and so a source of important information was missed.

Providers do not routinely link with family members but where it is considered appropriate or necessary they will look to obtain the permission of the patient to do so. In this case, Mr Gallagher's father had provided a letter outlining the importance of his out-patient follow ups and compliance in taking his Hydrocortisone for adrenal insufficiency. Unfortunately the re-booking of appointments for Mr Gallagher was not based on clinical need but on availability of out-patient appointments, in hindsight it is acknowledged that the clinician (GP) could have been informed of the new dates so that a decision on clinical appropriateness of timings could be considered. As above I am happy to report that these additional measures are now in place.

5. The underlying problem was that healthcare in the prison was the responsibility of three different organisations, namely the prison service, the local mental health NHS trust (who were given the responsibility for dealing with all the physical health matters and running the healthcare centre), and a separate organisation who supplied GPs. These three organisations had entirely different database systems.

In 2017, NHS England (NHSE) reviewed the model of commissioning in Kent, Surrey and Sussex as it was becoming increasingly apparent that the model was not delivering the benefits anticipated and services were not integrating effectively. In line with other prison groups in England, NHSE made the decision to commission services using a Prime Provider model. I can confirm that this model ensures a single contract and provider, and therefore better accountability for the delivery of integrated healthcare in a prison (or group of prisons). This will negate any communication issues and the single provider will use one database system only.

This model has been found to be more effective in management of services, and the development and delivery of integrated pathways between the different healthcare teams within a prison. Commissioners have worked closely with Governors to ensure that they are able to provide officer support (enablement) to increase healthcare access to prisoners including supervision of medications, movement of prisoners to and from appointments and out of hours access where required.

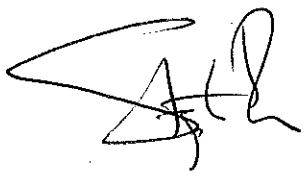
The current healthcare contracts with existing providers end in March 2020 (SPFT and Medco) and October 2020 (Forward Trust) respectively. NHSE have undertaken a procurement process for the provision of these services after those dates.

NHSE awarded the contract to Care UK in October 2019 and the services are currently being mobilised for a delivery start date of April 2020. Monthly Mobilisation Boards have been established and include all incumbent providers, the prison, social care and the new provider. These Boards are overseen by NHSE Commissioners.

Once the contract starts the NHSE governance process will have oversight via Contract Review Meetings, Partnership Boards and Local Delivery Quality Boards.

Thank you for bringing these important patient safety issues to my attention. I hope the information in this response, alongside the associated response regarding the death of Mr Haines, provides you with the detailed context of the steps and measures being implemented at HMP Lewes in order to improve the healthcare in the prison to prevent future deaths. However should you require any further information please do not hesitate to contact me.

Yours sincerely,



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