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Dr Richard Ian Brittain
HM Assistant Coroner for London Inner North

[redacted]

27th August 2021

Dear Sir

Re: Regulation 28: Prevention of Future Deaths report, Mr Khairul Mahmun RAHMAN

I write in response to your Regulation 28 Prevention of Future Deaths Report issued to Practice Plus Group on 2nd July 2021 following the inquest touching upon the death of Mr Khairul Rahman at HMP Pentonville. Practice Plus Group would like to express its sincere condolences to Mr Rahmun's family and friends.

Practice Plus Group notes that this report was received this report 6 weeks after the inquest concluded on 21st May 2021. The Chief Coroner's Guidance No. 5 'Reports to Prevent Future Deaths' sets out a timeline for the making of reports. It is disappointing to have received the report sometime after the 10 working days specified in the guidance had passed, given the effort taken to provide a written response to the concerns raised at the inquest.

This response addresses the matters of concern in so far as they relate to Practice Plus Group, the lead provider of healthcare services at HMP Pentonville since 1st May 2014.

Matter of Concern 1: There does not seem to be a robust system in place in the prison healthcare setting for contemporaneous or accurate retrospective documentation of the timing of clinical interactions. I heard evidence and received a further statement, following the conclusion of the inquest, which set out the difficulties that the prison environment causes, in terms of being able to document accurately. However, I remain concerned that the lack of accurate documentation means that subsequent review of the appropriateness of clinical care, in particular, response times is hampered.

Response:
Unfortunately, as a result of the prison environment the contemporaneous recording of clinical interactions on the electronic patient record (SystmOne) is often not possible. The limitations of the prison estate, notably the lack of Wi-Fi within HMP Pentonville makes the use of portable devices linking directly to SystmOne very challenging.

Although it is currently beyond Practice Plus Group's control to ensure all clinical interactions are contemporaneously recorded on SystmOne, we are committed to continuing to work closely with NHSE/I and HMPPS, via the NHSE/I Digital Assurance Board, to resolve the challenges with mobile connectivity in order to support the use of SystmOne when working on the wings or responding to emergencies.

Practice Plus Group regularly remind all staff of the importance of contemporaneous record keeping in accordance with Documentation and Record Keeping Guidelines, Nursing and Midwifery Council (2018). This is shared through full staff meetings, management supervision and clinical supervision. In addition a documentation audit for both prescribing and non-prescribing clinicians is undertaken regularly as part of the HIJ Audit Schedule for Practice Plus Group. The quality of record keeping in this case was commented on within the external clinical review:

The quality of records management at HMP Pentonville was good and in line with the Nursing and Midwifery Council (NMC) Code of Conduct, General Medical Council (GMC) Practice Guidelines and Health care Professional Council (HCPC) Standards of conduct, performance and ethics.

In addition to the above, Practice Plus Group has also recently updated a record keeping training package to be shared with all staff which includes the importance of correctly recording the time of any interaction within the SystmOne record when making retrospective entries. This will be made available to staff HMP Pentonville by 30th September 2021.

Practice Plus Group does not agree that response times to clinical care are hampered by the lack of contemporaneous documentation on SystmOne because treatment, escalation measures and/or referrals can be made prior to retrospective entry onto SystmOne. Indeed if a

staff member returned from the point of care to a central base in order to document notes in SystmOne between providing care to individual patients, response times may be significantly hampered by the travelling time.

Matter of Concern 2: The interval to further observations being undertaken were not inline with the NEWS2 scoring system and, in oral evidence, it was set out that prisoners were expected to self-report deterioration. This differs from latter information, provided after the conclusion of the inquest. However, it remains a concern.

The use of the NEWS2 scoring system remains unclear; the post-inquest information seemingly sets out both that this system was only to used after a positive COVID-19 result but also at daily handover.

Whilst recognising that the prison environment differs from a hospital setting, I remain concerned that the care provided was not as guided by the NEWS2 scoring system and that no alternative system appears to be in place that can be used effectively in the prison healthcare setting.

Response:
Practice Plus Group currently adopts the NEWS2 tool to support identification of the deteriorating patient, in order to aid clinical decision making.

Throughout the pandemic healthcare staff have been reminded regularly at daily handover meetings to use NEWS2 when carrying out observations. However NEWS2 has limitations and should be used in conjunction with clinical judgement taking into account examination and other clinical observations. As outlined to you in evidence by Dr [redacted], at the time of Mr Rahman's death low Oxygen (O2) saturations were considered a more important clinical indication of deterioration in all clinical settings, subsequently resulting in the roll out of patient held O2 monitors at home in both community and prison settings in 2021.

It is important to note that at the time of Mr Rahman's death there was no clinical guidance produced by NHS England to guide staff around the Management of COVID positive patients in a prison setting. In November 2020, Practice Plus Group developed the '*Monitoring of patients who test positive for COVID'* Policy and this was updated and communicated to all staff by email

on 24th December 2020. This policy supported clinical staff to identify those patients at highest risk of serious illness as a result of SARS-CoV-2 infection in order to provide enhanced monitoring of those patients. This policy exceeded the monitoring individuals were receiving in the community and provided bespoke guidance to manage the large populations in custodial settings, making the best use of the existing healthcare staff and resources. To put this in context, HMP Pentonville went into outbreak on 30th December 2020 and remained in outbreak throughout January 2021. Between December 2020 and January 2021, there were 181 patients who tested positive for SARS-CoV-2 and 43 healthcare staff absences from work due to COVID reasons.

Practice Plus Group recognises the importance of NEWS2 scoring to identify potential clinical deterioration and have begun a service improvement project to encourage the appropriate use of the tool and embedding this into practice. A '*Back to Basics'* workshop has been designed to '*Identify the Deteriorating Patient'* and ensure escalation of clinical abnormalities. This will be delivered for the healthcare team at HMP Pentonville by 30th November 2021. Within the delivery of the training, small laminated NEWS2 cards will be distributed as an immediate 'go to guide' to help support implementing the use of the NEWS2 within clinical assessment and identifying the deteriorating patient. Clinical teams will be advised to use NEWS2 when assessing patients who are acutely unwell to support clinical decision making and ensure that people who are seriously ill (both with COVID and with other diseases) are appropriately managed and admitted to hospital in a timely way, when appropriate.

I trust that the above response provides assurance that Practice Plus Group are committed to providing a high quality healthcare service at HMP Pentonville. In response to the specific concerns raised in relation to the death of Mr Rahman, we will ensure that the lessons learnt are implemented at HMP Pentonville and are shared across all of our healthcare services in prisons throughout England.

We would like to take the opportunity of inviting you to visit the healthcare team at HMP Pentonville should you wish to discuss further or review first-hand the improvements described above.

Yours sincerely,

Dr [redacted]
National Medical Director, Health in Justice Practice Plus Group

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