PROVIDING FEEDBACK AND COMMENT ON HSIB REPORTS

At HSIB we welcome feedback on our investigation reports. The best way to share your views and comments is to email us at enquiries@hsib.org.uk. We aim to provide a response to all correspondence within five working days.

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www.hsib.org.uk/tell-us-what-you-think
ABOUT HSIB


Most harm in healthcare results from problems within the systems and processes that determine how care is delivered. Our investigations identify the contributory factors that have led to harm or have the potential to cause harm to patients. The recommendations we make aim to improve healthcare systems and processes in order to reduce risk and improve safety.

Our organisation values independence, transparency, objectivity, expertise and learning for improvement.

We work closely with patients, families and healthcare staff affected by patient safety incidents, and we never attribute blame or liability to individuals.

OUR INDEPENDENCE

We are funded by the Department of Health and Social Care and sponsored by NHS England and NHS Improvement, but we operate independently.

Following recommendations from a parliamentary select committee in August 2018, we expect that a Bill for establishing the Health Service Safety Investigations Body (HSSIB) will be introduced to Parliament soon. The Bill will establish our full statutory independence and enshrine our right to conduct national investigations under protected disclosure. This provision, commonly known as ‘safe space’, enables staff to share their experience of a patient safety incident without fear of reprisal. It does not prevent us from sharing important details with families, regulators or organisations about an incident or to address immediate risks to patient safety.

The Health Service Safety Investigations Bill will also establish our responsibility for NHS maternity investigations that meet specific criteria. Full information about the draft Bill is available on the Department of Health and Social Care website.
OUR INVESTIGATIONS

Our team of investigators and analysts have diverse experience working in healthcare and other safety critical industries and are trained in human factors and safety science. We consult widely in England and internationally to ensure that our work is informed by appropriate clinical and other relevant expertise.

We undertake patient safety investigations through two programmes.

NATIONAL INVESTIGATIONS

Our national investigations can encompass any patient safety concern that occurred within NHS-funded care in England after 1 April 2017. We consider the requirement to investigate potential incidents or issues based on wide sources of information including that provided by healthcare organisations and our own research and analysis of NHS patient safety systems.

We decide what to investigate based on the scale of risk and harm, the impact on individuals involved and on public confidence in the healthcare system, as well as the potential for learning to prevent future harm. We welcome information about patient safety concerns from the public, but we do not replace local investigations and cannot investigate on behalf of families, staff, organisations or regulators.

Our investigation reports identify opportunities for relevant organisations with power to make appropriate improvements through:

- ‘Safety recommendations’ made with the specific intention of preventing future, similar events.
- ‘Safety observations’ with suggested actions for wider learning and improvement.

Our reports also identify actions required during an investigation to immediately improve patient safety. Organisations subject to our safety recommendations are requested to respond to us within 90 days. These responses are published on our investigation pages.

Find out more in the investigations section.

MATERNITY INVESTIGATIONS

From 1 April 2018, we became responsible for all patient safety investigations of maternity incidents occurring in the NHS which meet criteria for the Each Baby Counts programme.

The purpose of this programme is to achieve rapid learning and improvement in maternity services, and to identify common themes that offer opportunity for system-wide change. For these incidents HSIB’s investigation replaces the local investigation, although the trust remains responsible for Duty of Candour and for referring the incident to us.

We work closely with parents and families, healthcare staff and organisations during an investigation. Our reports are provided directly to the families involved and to the trust. The trust is responsible for actioning any safety recommendations we make as a result of these investigations.

We have been operating in all trusts since 1 April 2019. Our longer-term aim is to make safety recommendations to national organisations for system-level improvements in maternity services. These will be based on common themes arising from our trust-level investigations.

Find out more in the maternity investigations section.
EXECUTIVE SUMMARY

The reference event
Martin, a 43-year-old man, was being held at a Category B local prison. Martin had epilepsy since childhood, and at the time was taking the anti-epilepsy medicine Tegretol (carbamazepine) Prolonged Release (400mg) twice a day. He was also taking other types of medication for different conditions.

Martin was assessed as suitable for transfer to a Category C prison and placed on a transfer list. He would be moved the next day (Friday). On Friday morning, after the necessary procedures had been carried out, he was taken to the Category C prison, where he arrived at 11:35 hours. Later in the day, a nurse in the healthcare department assessed Martin’s health. At 15:02 hours she noted in Martin’s electronic health record that he had been transferred without any medication. She sent a message to the healthcare provider’s doctors, via the prison’s computerised healthcare system, which said, ‘Please could you prescribe all this mans [sic] meds – not arrived with any meds – we will arrange a delivery tomorrow.’

The prison’s general practitioner (GP) was absent due to illness and there was no one else available on site who could prescribe the medication. The duty manager for the healthcare provider, who was a GP, carried out the task remotely. She electronically prescribed Martin’s medication at 19:16 hours on Friday evening; however, the prescription for epilepsy medication was omitted.

The following morning (Saturday) a nurse realised that Martin’s epilepsy medication had not been prescribed, so she sent another message asking for this to be done. However, the medication was not a standard item held in stock and the prison did not have any at the time. This meant that a signed prescription form was needed so that staff could acquire it from the local pharmacy. There was no authorised prescriber available until Monday, so it was not possible to get the medication until then.

At 15:01 hours on Sunday Martin had two epileptic seizures in his cell, followed by two smaller seizures that took place while an ambulance crew were tending to him. He was taken to the local emergency department (ED) where he was assessed and given Tegretol. Martin spent the next three hours in the ED; he was then taken back to the prison.

On Monday Martin’s prescription was signed and his medication acquired. Since then he has received it twice daily.

The national investigation
The Healthcare Safety Investigation Branch (HSIB) identified the risk of a lack of continuity of healthcare for prisoners with long-term chronic health conditions, who were being transferred within the prison system; the reference event highlighted this risk. Following initial information-gathering and evaluation of the safety issues against the HSIB criteria for investigation, HSIB’s Chief Investigator authorised a national safety investigation.

The investigation reviewed the entire event, from the start of Martin’s internment through to the moment where his medication was acquired by the Category C prison. The investigation followed the pathway of care and the processes that were involved, including the healthcare aspects and the operational side of the prison, to understand the decisions made. The human factors that may influence decision-making at all levels throughout the transfer process were considered, along with the complexity of the environment and the system in which staff work.

This investigation focused on the routine transfer of prisoners around the prison system. The scope of the investigation included the communication of healthcare and prison information between different environments and locations, and the inspection of prison transfer processes by the Care Quality Commission (CQC) and Her Majesty’s Inspectorate of Prisons (HMIP). The investigation identified opportunities and remedies that could be applied across the system to reduce the risk to prisoners being transferred between prisons within the prison system and to those being released into the community.

1 Local prisons house prisoners who are taken directly from court in the local area after being put on remand or given a custodial sentence.
**Findings**

- Prison healthcare departments where there is only one authorised prescriber on site, particularly during core hours when transfers occur, create single points of failure that may put prisoners with medication requirements at risk.

- There are two key IT systems in use in prisons – one for healthcare records and one for the operational needs of the prisons. These systems have no interoperability, which causes inefficiency within the prison system and makes it impossible to automatically share essential information across the prison service.

- CQC and HMIP inspections focus more on prisoners being released into the community than on the routine transfer of prisoners between prisons.

- NHS England/Improvement health and justice regional commissioning teams apply varying levels of oversight and governance of the healthcare services, resulting in poor incident investigations and reports.

**HSIB MAKES THE FOLLOWING SAFETY OBSERVATIONS**

1. It would be beneficial for healthcare providers to ensure that there are robust mechanisms in place for accessing urgently needed medicines in order to minimise the risk of patients missing doses.

2. There may be benefits to prisons’ healthcare providers having sufficient numbers of authorised prescribers to ensure that a safe prescribing environment is maintained in prisons to meet the standards of service provision they are contracted to provide.

**HSIB MAKES THE FOLLOWING SAFETY RECOMMENDATIONS**

**Recommendation 2019/047:**
It is recommended that the Care Quality Commission amends its inspection criteria to ensure that inter-prison transfer processes are fully encapsulated within the inspection schedule to assure the provision of care throughout.

**Recommendation 2019/048:**
It is recommended that the National Prison Healthcare Board for England oversees work to implement interoperability between SystmOne and the Prison-National Offender Management Information System, enabling sharing of essential information across the prison service which does not impinge on the confidentiality requirements of either system.

**Recommendation 2019/049:**
It is recommended that NHS England/Improvement health and justice national commissioning team review how they monitor and assure the provision of healthcare in prisons to reduce variability in standards, particularly in the areas of incident reporting and investigations.
FURTHER INFORMATION

More information about HSIB – including its team, investigations and history – is available at www.hsib.org.uk

If you would like to request an investigation then please read our guidance before submitting a safety awareness form.

@hsib_org is our Twitter handle. We use this feed to raise awareness of our work and to direct followers to our publications, news and events.

CONTACT US

If you would like a response to a query or concern please contact us via email using enquiries@hsib.org.uk

We monitor this inbox during normal office hours - Monday to Fridays (not bank holidays) from 0900hrs to 1700hrs. We aim to respond to enquiries within five working days.

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