

CLINICAL REVIEW FOLLOWING A DEATH IN CUSTODY INVESTIGATED BY THE PRISONS AND PROBATION OMBUDSMAN

PART 1 - GUIDANCE FOR COMMISSIONING BODIES

Updated September 2014

BACKGROUND

- 1.1 The **Prisons and Probations Ombudsman (PPO)** is remitted¹ to investigate the circumstances surrounding the deaths of the following:
 - Prisoners and trainees (including those in Young Offender Institutions and Secure Training Centres)
 - Residents of Approved Premises (including voluntary residents)
 - Residents of Immigration Reception and Removal Centres, short term holding centres and persons under managed escort.
 - People in court premises or accommodation who have been sentenced or remanded into custody.
- 1.2 This includes people temporarily absent from the establishment but still in custody (for example under escort, at court or in hospital). It also includes those on Release on Temporary Licence.
- 1.3 The PPO has the discretion to investigate other cases that raise issues about the care provided by the relevant Service, including those recently released from custody.
- 1.4 The Ombudsman is appointed by the Secretary of State for Justice and is independent of the National Offender Management Service (covering Prisons and Probation Services), Youth Justice Board and Home Office. As part of the PPO investigation, clinical issues relevant to any death in custody are required to be examined.
- 1.5 **NHS Area Teams** (or equivalent bodies) have commissioning responsibility for all the healthcare services in all prisons (and shortly all immigration facilities) in England. A death in custody is regarded as a Serious Incident (SI) in line with similar incidents in relation to community NHS funded services, and as such should be subject to an investigation.
- 1.6 The Secretary of State for Health has agreed that NHS Area Teams will take the lead in investigating the clinical issues relating to deaths in custody. Therefore, in England the local Area Team (or equivalent) in respect of **all prisons and immigration facilities**, has the lead responsibility for arranging an independent investigation of the clinical care provided, including whether referrals to secondary healthcare were made appropriately. By agreement, Healthcare Inspectorate Wales (HIW) will review the clinical care provided to those who die in the custody of prisons based in Wales. **In both cases the clinical review will form part of the PPO investigation and subsequent PPO report.**
- 1.7 A **SI investigation** will often meet the needs of a clinical review for PPO purposes, so long as this is carried out by a clinician who is not involved in, or responsible for, the commissioning or provision of the healthcare service where the death occurred. This ensures objectivity and independence, a PPO requirement. **However a clinical review should not be used to replace a SI investigation.**
- 1.8 For the purposes of clinical review, the following NHS definition of a Serious Incident is used:

¹ The Ombudsman's full Fatal Incidents remit is available www.ppo.gov.uk

‘A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in unexpected or avoidable death of one or more patients’

In addition, the PPO also investigates deaths by natural causes, which are also subject to a clinical review.

1.9 This document covers the clinical review commissioning arrangements for deaths that occur in:

- **Prisons**
- **Young Offender Institutions**
- **Secure Training Centres**
- **Immigration Reception and Removal Centres**
- **Court premises (when the deceased has been remanded or sentenced into custody)**
- **Persons released on temporary licence are also included.**

1.10 **Approved premises** – residents of approved premises are responsible for arranging their own healthcare and usually register with a General Practitioner. However on occasions, there may be particular clinical concerns that require a clinical review. In such cases the Area Team (or equivalent) will be asked to provide a clinical review.

2. COMMISSIONING ARRANGEMENTS

- 2.1 The National Offender Management Service will inform the PPO of a death in custody immediately.
- 2.2 The PPO will contact the Area Team commissioner, requesting a clinical review via e mail usually within **1 working day** of receiving the notification. This will include contact details of the PPO investigator. The Area Team should commission the review within 5 working days of the request and inform the PPO investigator of the name and contact details of the reviewer. The final clinical review should be received by the PPO within **50 working days (for natural causes deaths) and 60 working days (for other deaths)** of this initial communication (see annex A for PPO escalation process)
- 2.3 The Area Team (or equivalent) which commissions the healthcare in the custodial environment in which the offender/detainee was held, will be responsible for commissioning the clinical review.
- 2.4 The Area Team process will be based upon the NHS centralised Serious Incident (SI) reporting process and the NHS Strategic Executive Information System (STEIS) will be used.
- 2.5 The Area Team (or equivalent) will be responsible requesting access relevant NHS records to assist the clinical reviewer. Suggesting wording is attached to this guidance at Annex B.
- 2.6 The PPO has unfettered access to all prison documentation relating to the deceased. The relevant NHS Area Team should arrange for the prison healthcare records to be provided to the clinical reviewer. The PPO will arrange for any other relevant records from the establishment concerned to be provided to the clinical reviewer (this will include any ACCT documents in the event of a self-inflicted death).

2.7 **There are three levels of review:**

Level 1 - Single clinical reviewer - Desk based review of records and report
Level 2 – Single clinical reviewer - Review of records, interviews with healthcare staff at the establishment and report
Level 3 – Panel review with lead reviewer – Review of records, interviews with healthcare staff and others as appropriate – complex case with multi-disciplinary input.

The level of review must be agreed (within five days of the appointment of the clinical reviewer) by the PPO investigator and appointed clinical reviewer, this must be agreed by the commissioner. A level 1 review must not be considered a default position. The level of review must be documented with the reasons for that level. On occasions, evidence may come to light that requires the level of review to be reconsidered – in such cases the PPO investigator, clinical reviewer and commissioning Area Team should agree the revised level, and document accordingly.

2.8 **The clinical review will be carried out by:**

- An appropriately registered healthcare professional with clinical expertise in the main area to be covered by the review

OR

- An appropriately qualified multi-disciplinary review panel (members should include prison healthcare representative, clinical governance, NHS clinical specialists relevant to the death, PPO investigator, Governor or prison representative, lay person).

2.9 In order to ensure objectivity and to protect the independence of the PPO, the reviewer must not be involved in, or responsible for, the commissioning or provision of the healthcare service where the death in custody occurred. (Clinical reviews through a private contractor may be commissioned but the cost will be borne by the commissioning organisation).

2.10 The person appointed to carry out the clinical review must make early contact with the PPO investigator, before commencing any work, to agree parameters of the investigation and to discuss any interviews which should be conducted jointly with the PPO investigator. The PPO has a preference for joint interviews, which give a greater understanding and clearer picture of the care received across disciplines. In addition the PPO record and provide transcripts of all interviews. Clearly recorded interviews are a Coroner's requirement.

2.11 The clinical reviewer should be the lead interviewer for any interviews with healthcare staff. There is no expectation the clinical reviewer attends any other interviews, however the investigator may ask for the clinical reviewer to attend relevant interviews (for example where a member of prison staff has attempted resuscitation).

2.12 The Area Team (or equivalent) is responsible for assisting the clinical reviewer to gain access to relevant NHS records (see para 2.5) and key health professionals who are relevant to the investigation.

2.13 The Area Team (or equivalent) should provide the clinical reviewer with the time and resources, including administrative support, necessary to enable them to carry out and complete the review within the agreed timetable.

2.14 The PPO has a target to issue the draft report of a death due to natural causes within 100 working days (20 weeks) and the draft report of any other death within 130 working days (26 weeks). To allow clinical matters to be fully integrated into the PPO report, the finalised clinical review report should be with the PPO investigator within **50 working days** (10 weeks) for natural causes deaths and **60 working days** (12 weeks) for other deaths, of the initial correspondence from the PPO.

2.15 A draft report should be submitted by the clinical reviewer to the Area Team (or equivalent) for quality assurance with 35 working days (7 weeks) for natural causes deaths and 45 working days (9 weeks) for other deaths. At this time it should be copied to the PPO investigator to ensure it meets the needs of the investigation. The PPO investigator will give feedback with 5 working days.

2.16 The Area Team (or equivalent) quality assured draft and comments will be returned to the clinical reviewer within 10 working days to allow any changes to be made prior to sending the final report to the PPO investigator. **NB:** It is not necessary to redact or anonymise the clinical review report. The PPO investigation report will name any individual pertinent to the case, this will include healthcare staff. The PPO report is anonymised before being made public and the clinical review report is not made public.

2.17 The PPO investigator may, from time to time, need to contact the clinical reviewer if there are matters which require further exploration, clarification or correction. Ideally this will be within 30 working days of receipt of the final clinical review report. **However Area Teams (or equivalent) should note that issues of clarification sometimes arise following the consultation period (see para 2.18d).**

2.18 **Central Administrative Process (using STEIS)**

- The commissioner is responsible for putting the incident onto STEIS
- All requests from the PPO to be logged.
- Identify the commissioner of the clinical review and send out the template, written process and timely (50/60 working days) reminders.
- Receive copy of draft report (35/45 days) for quality assurance at appropriate level within the Area Team (or equivalent).
- Return the draft (with 10 working days) to the reviewer with amendments/comments.
- Receive the final report and collate the recommendations – send final report to PPO.
- Recommendations and any learning to be shared at the Strategic Safer Custody Forum (or other agreed forum).

2.18 **Stages following the PPO investigation and clinical review:**

- a) The PPO investigator writes a draft report including the clinical issues and relevant recommendations.
- b) The draft report is issued to the family (who have up to a maximum of 8 weeks to feed back) and the service (who have 4 weeks to feed back). In addition the Area Team (or equivalent and clinical reviewer receive a full copy of the draft report.
- c) The service and healthcare provider are asked to provide an action plan in response to any recommendations.
- d) **More questions may be asked, and occasionally it may be necessary for further investigation to take place, which may include clinical matters.**
- e) The report is finalised, including the response to any recommendations, and is used by the Coroner to prepare for the inquest.
- f) Both the PPO investigator and clinical reviewer may be called to give evidence at the inquest.
- g) After the inquest, the annexes (including the clinical review report) are removed from the PPO report – the PPO report is anonymised and published on the PPO website.

NOTE: At the consultation stage (b) advanced disclosure is made if an individual member of staff is criticised (see para 2.19 below). If the final report (e) goes on to make serious criticisms of a member of staff, it will recommend that the appropriate disciplinary procedures are implemented, and may in extreme cases, recommend referral to the appropriate regulatory body. The Area Team (or equivalent) should undertake such a referral.

2.19 **Advanced Disclosure** - The PPO operates on the basis of full and simultaneous disclosure to all parties to the investigation. However from time to time, specific and substantial criticisms are made of individuals in the draft report. In these cases the draft report will be advanced disclosed to the service in remit. The purpose of this is to allow the individual who has been criticised the opportunity to check that their actions and accounts are described accurately.

2.20 The PPO's disclosure policy is published on the website www.ppo.gov.uk and applies to both the PPO investigation report and the clinical review report.

3. LEARNING LESSONS

- 3.1 Learning is integral to the clinical review process. It involves sharing good practice and learning lessons on how things should be improved. All establishments and Area Teams (or equivalent bodies) should have processes in place for making sure that lessons are learned, recommendations are implemented and improvements are sustainable.
- 3.2 The commissioning Area Team (or equivalent) will be responsible for sharing the recommendations and any learning from the clinical review with partner organisations. This should be achieved through a Safer Custody Forum or similar regular meeting of partners.
- 3.3 If the clinical reviewer uncovers the need for urgent action at any stage of the review, this information should be passed to the Area Team (or equivalent body) and the establishment without delay, so that appropriate action may be taken promptly.
- 3.4 Learning from clinical reviews and PPO investigation reports is shared nationally through NOMs (Equality, Decency and Rights Group) and Department of Health (Offender Health).
- 3.5 An update on the implementation of all recommendations and actions plans should be submitted to the PPO six months after the release of the final PPO investigation report. *This is co-ordinated by NOMS Equality, Decency and Rights Group (EDRG).*

The PPO escalation process for the late commissioning of clinical reviews is as follows:

PPO support team (on behalf of investigator) will contact Area Team (or equivalent) Commissioning Officer to request a clinical reviewer, **within one working day** of notification of death.

Commissioning Officer to inform investigator of clinical reviewer **within 5 working days**.

If investigator has not been informed of clinical reviewer within **5 working days**, they will e mail a reminder to the Commissioning Officer, copying to the Assistant Ombudsman.

Escalation – after a **further 5 working days**, if a reviewer has not been identified, the Assistant Ombudsman will e mail the Commissioning Officer reminding them of the timescales involved and their responsibility to commission the review.

Escalation – if a clinical reviewer has not been appointed **within 3 working weeks** of the original commissioning letter, the Deputy Ombudsman will write to the National Commissioning Board to raise the concern that the review is unlikely to be completed and the final report available to the Prisons and Probation Ombudsman within the agreed timescale of 10 working weeks.

**Suggested wording of letter from Area Team (or equivalent)
regarding release of medical records of deceased person**

Dear

**Re: Investigation into the circumstances surrounding the death of (enter name) while
in the custody of (enter establishment) – Clinical Review**

The Prisons and Probation Ombudsman is investigating the death of the above named person and a review of the clinical care received by the deceased is an important and integral part of the process.

The clinical care is reviewed under the Ombudsman's Terms of Reference, by an appropriately registered healthcare professional or an appropriate qualified multi-disciplinary panel. This review is commissioned by the Area Team (or equivalent).

In order to complete a thorough and reasoned review, the clinical reviewer requires access to the deceased's medical records. Those held by *(insert establishment concerned)* will be made available through the Ombudsman's unfettered access to all records within the service. Similarly records held in the community should be released to the NHS Area Team/Clinical reviewer. The Ombudsman's terms of reference state:

"The Head of the relevant authority (or the Secretary of State for Justice, Home Secretary or the Secretary of State for Children, Schools and Families where appropriate) will ensure that the Ombudsman has unfettered access to the relevant documents. This includes classified material and information entrusted to that authority by other organisations, provided this is solely for the purpose of investigations within the Ombudsman's Terms of Reference."

The health records of a deceased person can lawfully be disclosed to the PPO, as such disclosure is not covered by the Data Protection Act and is justified in the public interest, this means there is no breach of confidence.

Please would you release the medical records of *(insert name of deceased)* with immediate effect – the clinical review needs to be carried out and the report written by *(insert final report date)*.

Thank you for your co-operation.

Yours