Making a Difference Anniversary Seminar Series

Natural cause deaths

4 November 2014

Nigel Newcomen

Prisons and Probation Ombudsman

PRISONS AND PROBATION OMBUDSMAN for England and Wales
Independent Investigations

Agenda

11.00	Introduction
11.10	What PPO investigations involve
11.30	Learning Lessons
11.50	Recent case studies
12.10	Response from Claudia Sturt
12:30	Q&A
12.45	Lunch
13.30	Table discussions
14:45	Feedback to panel
15:05	Next steps and close

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Introduction

- PPO was created in 1994 to independently investigate prisoner complaints. We took on investigation of deaths in custody in 2004
- Our vision is to be a leading investigatory body, a model to others, that makes a *significant contribution to safer, fairer custody and offender supervision*
- New anniversary series of seminars aims to use PPO learning from investigations to support prison staff to improve safety and fairness
- I'm delighted to welcome delegates from prisons, senior NOMS staff and, of course, my own staff

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Introduction

- PPO fatal incident investigations have 4 aims:
  - Establish circumstances of death including good and bad practice
  - Provide explanation to the bereaved family
  - Assist the coroner
  - Identify learning for improvement
- Learning comes from individual investigations but increasingly from thematic learning looking across investigations
- We will look at both these sources of learning and then discuss and debate

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Introduction

- Even with the dreadful recent increase in self-inflicted deaths, most deaths in prison are from natural causes
- While prisoners of all ages die of natural causes, the rapidly ageing population means year on year rises in such deaths are expected for the foreseeable future – and there was another 7% rise 2013-14
- The figures are stark: with ever longer sentences and more late in life prosecutions (particularly for historic sex offences), those over 60 are now the fastest growing segment of the population. There are more than 100 prisoners over 80 and quite a few over 90
- Prisons designed for young men are having to adjust to the largely unexpected, unplanned and under-resourced roles of secure care home and hospice

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Introduction

- PPO reports show some prisons have made impressive adjustments (eg. in palliative care), but PPO also often must repeat the same recommendations (eg. about variable care and clashes with traditional prison policies, such as use of restraints on the terminally ill)

- Today is about learning lessons or at least understanding the obstacles to improvement, so that the PPO can contribute to you achieving an appropriately humane approach to end of life care in prison

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What PPO investigations involve

Claire Parkin - *Investigator*

Nicole Briggs - *Investigator*

Laura Spargo - *Family Liaison Officer*

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What PPO investigations involve

Types of investigation:

- Natural Causes (foreseeable & unforeseeable) – 60%
- Self-inflicted – 32%
- Other: including homicide, drug overdose – 8%

Where?

- Prisons
- YOIs
- Immigration Removal Centres
- Approved Premises
- Secure Training Centres
- Courts and Escort Vehicles

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What PPO Investigations involve

Types of deaths

- Foreseeable – e.g. cancer, COPD (chronic obstructive pulmonary disorder)
- Unforeseeable – e.g. aneurysms, pulmonary embolisms, heart attacks

Impact on investigation

- Proportionality considerations
- Investigation scope
- Reporting format - set issues for foreseeable – key events and issues for others

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What PPO investigations involve

Advance Preparation in the office

- Notification of death
- Allocation to investigator
- Notices sent to stakeholders
- Check previous deaths in the establishment
- Contact establishment
- Request records be made available
- Contact police and coroner
- Check HMIP and IMB reports
- Media interest
- Allocation of clinical reviewer

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What PPO investigations involve

Opening the investigation

Foreseeable

- Telephone and email contact with prison (Gov/liaison officer / FLO / IMB / POA)
- Request papers
- Request details (circumstances/family/funeral)

Unforeseeable

- Meet with Governor/Equivalent/Representative
- Other members of staff
- Visit relevant areas
- Collection of documents
- Interview prisoners
- Obtain NOK details for FLO and funeral date
- Case suspension?

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What PPO investigations involve

Gathering evidence and identifying potential issues

- Examine documentation
- Speak to police
- Construct timeline of events
- Identify potential issues – ‘issues led’ or ‘key events’?
- FLO contacts family
- Family visit?
- Collaboration with clinical reviewer
- Case review with manager

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What PPO investigations involve

Interviewing and providing feedback

- Interview staff and prisoners
- Involve clinical reviewer
- Provide verbal feedback to Governor/Representative/Equivalent
- Written feedback

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What PPO investigations involve

Completion of report

- Obtain clinical review
- Case review with manager
- Aim to write in parallel with investigation
- Validation process: FLO, Assistant Ombudsman, Deputy Ombudsman, Ombudsman
- Make recommendations
- Annexes

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What PPO investigations involve

Issuing the report

- Advanced disclosure
- Support team issue draft report to prison, NHS, coroner
- FLO contacts family and issues report to them
- Receive feedback and action plans (family and prison)
- Case review with manager
- Issue Final report (including FLO input)
- Inquest
- Publish anonymised report on website

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What PPO Investigations involve

What would help:

- Copies of documents only
- Include risk assessments
- Redacted copies
- Advance preparation?
- Suitability of liaison officer
- Interview attendance
- Liaise with healthcare
- Digital recorders

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Learning Lessons

Sarah Colover - *Research Officer*

Helen Stacey - *Research Officer*

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PPO thematic report: End of life care

- Report on death of 214 prisoners whose death was foreseeable, due to a terminal or incurable disease.
- 29% of prisoners did not have a palliative care plan in place.

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Lesson 1: National guidelines

- **Implement an end of life care plan for every prisoner diagnosed with a terminal illness. The plan should follow the six step pathway as set out in the National End of Life Care Programme prison guide.**

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Lesson 2: Early release

- **Ensure that where appropriate, applications for early release on compassionate grounds are completed at the earliest possible opportunity.**

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Lesson 3: Families

- **Ensure that families are involved (where appropriate and where they choose to be) in the palliative care planning.**

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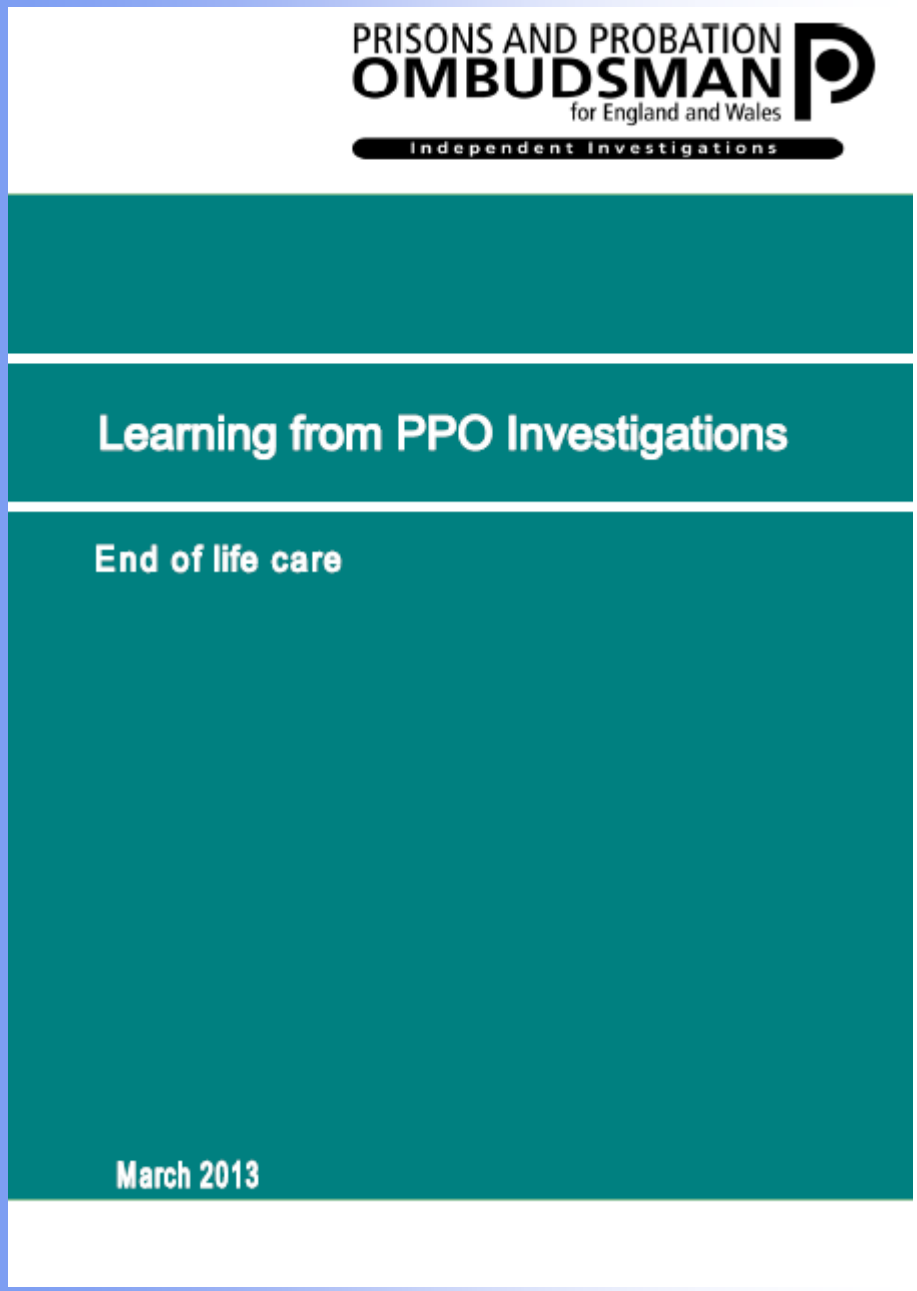

- PPO Thematic report
- March 2013

http://www.ppo.gov.uk/document/learning-lessons-reports/

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PPO bulletin: Use of restraints

With restraints there is a balance between decency and security but PPO investigations too often find overly risk averse approach.

Frail, immobile and even unconscious prisoners were restrained as they were sick and dying.

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Guidance and law

Risk of escape and harm is not fixed. Use of restraints must be based on assessment of the individual's risk **at that time and place.**

A prisoner who may escape or cause harm when healthy will **not necessarily pose a risk when ill**.

Because there was not an adequate assessment of his individual risk, use of restraints while Mr Graham received life saving treatment amounted to **inhuman and degrading treatment**, breaching Article 3.

Guidelines are in the Prison Service & NHS concordat 'Prisoner Escort & Bedwatch Function'.

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Risk Assessment

- Evidence of potential for harm (including to public or hospital staff) and escape risk
- Context: route, destination, other locations
- Medical opinion about the health and mobility of the prisoner – how does this impact on risk?

- Is the treatment life saving?
- Is the use and level of security proportionate?

- Reassess & escalate if concerns are raised
- Reassess when health or context changes

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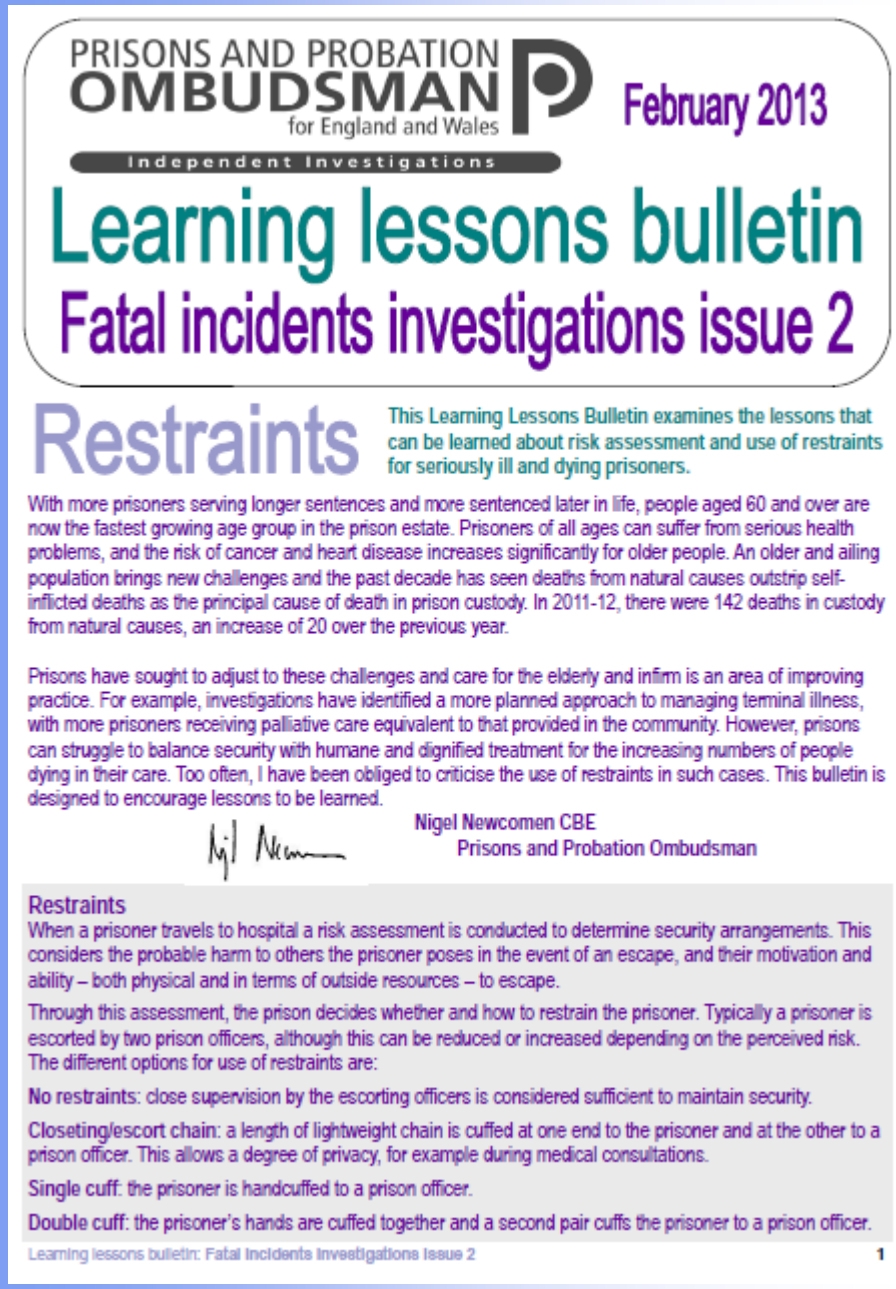

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Learning lessons bulletin

Fatal incidents investigations issue 2

Restraints

This Learning Lessons Bulletin examines the lessons that can be learned about risk assessment and use of restraints for seriously ill and dying prisoners.

With more prisoners serving longer sentences and more sentenced later in life, people aged 60 and over are now the fastest growing age group in the prison estate. Prisoners of all ages can suffer from serious health problems, and the risk of cancer and heart disease increases significantly for older people. An older and ailing population brings new challenges and the past decade has seen deaths from natural causes outstrip self-inflicted deaths as the principal cause of death in prison custody. In 2011-12, there were 142 deaths in custody from natural causes, an increase of 20 over the previous year.

Prisons have sought to adjust to these challenges and care for the elderly and infirm is an area of improving practice. For example, investigations have identified a more planned approach to managing terminal illness, with more prisoners receiving palliative care equivalent to that provided in the community. However, prisons can struggle to balance security with humane and dignified treatment for the increasing numbers of people dying in their care. Too often, I have been obliged to criticise the use of restraints in such cases. This bulletin is designed to encourage lessons to be learned.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

Restraints

When a prisoner travels to hospital a risk assessment is conducted to determine security arrangements. This considers the probable harm to others the prisoner poses in the event of an escape, and their motivation and ability – both physical and in terms of outside resources – to escape.

Through this assessment, the prison decides whether and how to restrain the prisoner. Typically a prisoner is escorted by two prison officers, although this can be reduced or increased depending on the perceived risk. The different options for use of restraints are:

No restraints: close supervision by the escorting officers is considered sufficient to maintain security.

Closeting/escort chain: a length of lightweight chain is cuffed at one end to the prisoner and at the other to a prison officer. This allows a degree of privacy, for example during medical consultations.

Single cuff: the prisoner is handcuffed to a prison officer.

Double cuff: the prisoner's hands are cuffed together and a second pair cuffs the prisoner to a prison officer.

- PPO Thematic report
- February 2013

http://www.ppo.gov.uk/document/learning-lessons-reports/

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Case studies

Michael Loughlin - *Deputy Ombudsman*

Karen Cracknell - *Assistant Ombudsman*

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Palliative Care

- When active treatment is no longer possible
- Care moves from active treatment to giving comfort and control of symptoms such as pain and sickness

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End of life care

- Care over the last days of life
- Considers the palliative care of the patient (including anticipatory prescribing of symptom relieving medication) and support needs of patient and family (beyond bereavement)
- Includes the management of pain and other symptoms also the provision of psychological, social, spiritual and practical support

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Case study 1: Palliative care

- Mr X entered custody in 2011. He had a number of chronic conditions.
- Referred to hospital for an urgent chest X-ray for a suspicious lump and chest pain.
- Admitted to hospital with chest infection and diagnosed with lung cancer with secondary cancers to the spine shortly after.
- On discharge he was relocated to the healthcare centre at the prison.
- He began a course of radiotherapy and chemotherapy which proved unsuccessful and his prognosis was assessed as a matter of months.
- Mr X moved to the palliative care suite where he died sooner than expected.
- The PPO made two recommendations about medical referrals and restraints.

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Case study 1: Good Practice

- Mr X requested to remain on the wing with a family member for as long as possible, and every effort was made to respect his wishes.
- The diagnosis and prognosis was explained to Mr X and his family appropriately, and they were updated about the outcome of MDT meetings.
- Mr X was referred to palliative care with input from a specialist palliative care nurse, close communication with Macmillan and the secondary palliative care teams.
- Mr X and his relative attended regular MDT meetings, which enabled them to have input into his care.
- Pain management was considered and discussed with Mr X and reviewed daily.
- Extra and extended family visits were allowed and arranged where possible in a private room.

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Case study 1: Good Practice (2)

- Mr X's NOK was allowed to support him at two hospital appointments.
- When Mr X was moved to healthcare, his relative was moved into the cell next to him for support and stayed until Mr X died.
- Security clearance was arranged in advance for the NOK and another family member to allow access out of hours in preparation for end of life stages.
- An open door policy was arranged for Mr X and arrangements made for his relative to be unlocked during Mr X's final hours.
- Arrangements were being made to allow Mr X and his family to have a final meal together showing a holistic approach to end of life care.
- Compassionate release was considered but Mr X died sooner than expected and before a decision was made.

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Case study 2: Restraints

- Miss Y went to prison in 2012 for causing death by dangerous driving. She had myotonic muscular dystrophy.
- Her mobility and health declined considerably over the next two years.
- In 2013 she was eligible for ROTL and left the prison unaccompanied and unrestrained on a number of occasions including overnight for family visits.
- In April 2014 Miss Y collapsed with breathing difficulties and was taken to hospital. She was restrained with a single cuff and escorted by two officers.
- Risk assessment – medium risk to public, low risk of hostage-taking, escape and outside assistance.
- Medical section of risk assessment – short of breath, cyanosed and needing oxygen. No mention of poor mobility and no objections to use of restraints.
- A hospital doctor requested the restraints be removed.
- The next day she was released on temporary licence and died shortly afterwards.

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Case study 2: Issues and recommendation

- Previously ROTL'd.
- Very poor mobility and health but risk assessment did not reflect this.
- She should not have been restrained.

PPO made one recommendation:

- The Governor and Head of Healthcare should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, that assessments fully take into account the health of a prisoner, are based on the actual risk the prisoner presents at the time.

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Case study 3: Restraints

- Mr Z was 77 years old. He suffered from heart disease, type 2 diabetes, pneumonia, rheumatoid arthritis, urinary tract infection, poor vision and dementia. Healthcare staff saw him frequently. Prison GP noted deterioration in health and arranged for him to be admitted to hospital.

- Escort risk assessment indicated low risk to public, potential to escape and further offending. No medical objections to use of restraints but pointed out Mr Z used crutches or a wheelchair and his medical condition meant he was unable to mobilise and was very confused. Nurse concluded that “at best only able to be mobile with frame for a few steps.”

- Mr Z was restrained by an escort chain and accompanied by two officers. He had high temperature, leg sores, and low blood pressure. He was diagnosed with pneumonia and given antibiotics. Confined to bed and not mobile.

- Mr Z asked escorting officers if someone could contact his brother but no-one did this. Risk assessment was reviewed by the operational manager but no changes made.

- Mr Z began having serious breathing difficulties. One escort contacted prison to ask if restraints could be removed. But before they replied Mr Z became unresponsive and the escort removed the chain. Mr Z could not be resuscitated and died.

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Case study 3: Issues

- Although the nurse made it clear that he was immobile she did not object to the use of restraints.
- As the assessment indicated that Mr Z was low risk to public (and of escape) and that his health and mobility were poor, it is difficult to understand how managers concluded that restraints were necessary.
- When Mr Z asked for his brother to be notified that he was seriously ill, no-one did this.
- At the very least, escort chain should have been removed when the officer called the prison not long before Mr Z died.
- Unacceptable that a very ill and immobile elderly man should be chained to an officer until he died.

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Case study 3: Recommendations

We made two recommendations:

1. The Governor should ensure staff notify next of kin as soon as possible when a prisoner becomes seriously ill.

2. The Governor and Head of Healthcare should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, that assessments fully take into account the health of a prisoner, are based on the actual risk the prisoner presents at the time and are frequently reviewed.

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The Graham Judgement

In 2007, in the case of Graham v the Secretary of State for Justice, the High Court held that using handcuffs on Mr Graham while he was receiving life-saving chemotherapy infringed Article 3 of the Human Rights Act (inhuman or degrading treatment).

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The Graham Judgement

- The judgement focussed on the importance of the individual circumstances when considering risk.
- A prisoner might pose a risk of escape when well, this is not necessarily the case when they are ill.
- The judgement says that medical opinion regarding the prisoner's ability to escape (given their condition) must be considered as part of the risk assessment.

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Response from NOMS

Claudia Sturt

Deputy Director of Custody

NOMS

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Discussion

- What are the barriers to implementing PPO recommendations and how do you overcome them?
- Why do the same problems keep occurring?
- What good practice is there and how can it be shared?

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Next steps

- PPO will:
  - Share slides, contact lists and publications discussed on the day
  - Look into producing a training package using our learning
  - Continue to investigate independently and robustly to identify learning in both individual cases and thematically
- What will you do?

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Contact details

If you have any questions following the seminar please contact

Learning.lessons@ppo.gsi.gov.uk

Have you seen our new website? Our learning lessons publications and anonymised fatal incident reports are now easily accessible at www.ppo.gov.uk

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