

**AGREEMENT FOR THE
PROVISION OF A CLINICAL REVIEW
FOLLOWING A DEATH IN PRISON OR
APPROVED PREMISES
TO THE
PRISONS AND PROBATION
OMBUDSMAN
BY
HEALTHCARE INSPECTORATE
WALES**

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1. Introduction

This agreement sets out the Prisons and Probation Ombudsman's (PPO) requirements for completion of a clinical review following a death in prison or approved premises by Healthcare Inspectorate Wales (HIW), and is made under section 83 of the Government of Wales Act 2006. HIW as the healthcare inspectorate arm of the Welsh Assembly Government, exercises functions of the Welsh Ministers. Through this agreement HIW will provide services that meet, or improve upon, the standard of service agreed with the PPO in terms of quality and timeliness.

In this agreement the PPO and HIW together will be known as the "parties".

This is a continuing agreement which will take effect from 1 April 2008. The agreement will be reviewed quarterly, and will be subject to a formal review annually.

Purpose of the Agreement

The purpose of this agreement is to ensure that both parties work together to:

- ... establish the circumstances and events surrounding a death in a Welsh prison, young offenders' institution (YOI) and probation approved premises; and
- ... examine whether any change in operational methods, policy, practice or management arrangements in prisons would help prevent a recurrence.

This agreement also clarifies the role and responsibilities of both parties in the clinical review process.

Common values/shared goals

The parties have a shared commitment to decency and fairness in custodial establishments, including prisons, young offenders' institutions and approved premises. There is also a mutual interest regarding judgments on the conditions for and treatment of those living in establishments where a death occurs.

2. Objectives of the PPO and HIW

The Prisons and Probation Ombudsman

The Ombudsman investigates the circumstances of the deaths of:

- ... Prisoners (including those held in contracted prisons, secure training centres and young offender institutions). This includes people who are temporarily absent from the prison but are still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently unless the Ombudsman uses his discretion.
- ... Residents of National Probation Service approved premises (including voluntary residents).
- ... Residents of immigration detention accommodation and persons under Immigration Service managed escort.

The aims of the PPO's investigation are to:

- ... Establish the circumstances and events surrounding the death, especially as regards management of the individual by the relevant Service or Services, but including relevant outside factors.
- ... Examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence.
- ... In conjunction with NHS organisations where appropriate, examine relevant health issues and assess clinical care.
- ... Provide explanations and insight for the bereaved relatives.
- ... Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

Healthcare Inspectorate Wales

HIW's core responsibility is to undertake reviews and investigations into the provision of NHS funded care by or for Welsh NHS organisations, in order to provide independent assurance about, and to support the continuous improvement in, the quality and safety of Welsh NHS funded care. The frameworks of Clinical Governance and Healthcare Standards set by the Welsh Assembly Government are central to the way in which HIW assesses Welsh NHS organisations and Welsh NHS funded care. In this respect, HIW is committed to:

- ... strengthening the voice of patients and the public in the way health services are reviewed;
- ... working with others to improve services across sectors and agencies;
- ... working with other regulators/inspectionates to ensure that the public, NHS organisations and the Assembly receive useful, accessible and relevant information about the quality and safety of Welsh NHS funded care; and

- ... developing more effective and co-ordinated approaches to the review and regulation of the NHS in Wales.

HIW will ensure that skill, care and diligence are exercised in carrying out these services properly and efficiently in accordance with the agreement. HIW will keep the PPO informed of any foreseeable or actual changes in circumstances, which are likely to affect its ability to deliver the services specified.

HIW will arrange for staff of appropriate qualifications, skills and experience to provide the services identified in this agreement. The clinical reviewer will be independent of the provision of clinical care received by the deceased and will not have any management responsibility for its provision.

3. Principles of Delivery

Responsibilities of the PPO

The PPO will inform (by electronic and hard copy) HIW on the day of the notification of a death in a Welsh prison, YOI or approved premises, and wherever possible include the name of the lead investigator.

The PPO lead investigator will:

- ... provide HIW with a summary of the main clinical issues;
- ... forward a copy of the paperwork needed to complete the clinical review;
- ... supply additional records at the request of the clinical reviewer;
- ... contact the clinical reviewer and agree a joint approach to the clinical aspects of the investigation, including any specific questions asked by the family;
- ... determine the time scale for the review in consultation with HIW
- ... provide a copy of the post mortem report;
- ... check that any clinical terms have been correctly interpreted;
- ... provide a copy of the draft PPO report with an invitation to respond and comment within 20 working days;
- ... provide a copy of the final report in Welsh as well as in English;
- ... inform the reviewer of the arrangements for the inquest;
- ... publish a redacted version of the report on the PPO web-site after the inquest; and
- ... send a copy of the final report to HIW and the Welsh Assembly Government.

Responsibilities of HIW

The HIW clinical reviewer will:

- ... provide the name and contact details for the clinical reviewer;
- ... contact the lead investigator to discuss the case and/ or arrange to meet to discuss the case and arrange joint interviews if required
- ... review the material and arrange, if necessary, a specialist reviewer to interview prison staff and assist with the clinical review report;
- ... request more material from the lead investigator if required;
- ... request to attend interviews with prison staff, to help inform the clinical review;
- ... advise on any matters regarding secondary NHS care of the deceased, including handling any concerns the family may have;
- ... brief the PPO lead investigator about the progress of the clinical review;
- ... prepare the draft clinical review in accordance with the PPO guidance. Where clinical language is used, a lay alternative will be provided; respond to any feedback from the family or the service which concerns clinical matters;
- ... send the final clinical review to PPO lead investigator for inclusion in the PPO report; and

... respond to the draft PPO report within 20 working days..

Recommendations about NHS care and commissioning will be followed up by HIW separately.

Signatories to the Agreement

The signatories to this agreement are the Prisons and Probation Ombudsman (on behalf of PPO) and the Chief Executive of Healthcare Inspectorate Wales (on behalf of the Welsh Ministers).

Signature: Prisons and Probation Ombudsman, Stephen Shaw

_____ Date ___/___/2008

Signature: Chief Executive of Healthcare Inspectorate Wales, Dr Peter Higson on behalf of the Welsh Ministers

_____ Date ___/___/2008

Officials responsible for the day-to-day management of the agreement are set out below. If no such person is listed the parties above retain day-to-day responsibility.

Jane Webb, Deputy Ombudsman, Fatal Incident Investigation Team, PPO
Mandy Collins, Deputy Chief Executive, HIW
Dr Caroline Jones, Investigations Manager, HIW
Susan Beavis, Inspections Manager, HIW
Lesley Johnston, Inspections Manager, HIW

TERMS OF REFERENCE FOR INVESTIGATION OF DEATHS

1. The Ombudsman will investigate the circumstances of the deaths of the following categories of person:
 - Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently. However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.
 - Residents of National Probation Service approved premises (including voluntary residents).
 - Residents of immigration detention accommodation and persons under Immigration Service managed escort.
2. The Ombudsman will act on notification of a death from the relevant Service. The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, the National Probation Service (including area boards) and the Immigration Service are responsible, or would be responsible if not contracted for elsewhere by the Home Secretary or area boards. It will therefore include services commissioned by the Home Secretary from outside the public sector.
3. The aims of the Ombudsman's investigation will be to:
 - Establish the circumstances and events surrounding the death, especially as regards management of the individual by the relevant Service or Services, but including relevant outside factors.
 - Examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence.
 - In conjunction with the NHS where appropriate, examine relevant health issues and assess clinical care.
 - Provide explanations and insight for the bereaved relatives.
 - Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.
4. Within that framework, the Ombudsman will set terms of reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph 1 where a common factor is suggested.

Clinical Issues

5. The Ombudsman will be responsible for investigating clinical issues relevant to the death where the healthcare services were commissioned by the Prison Service (until March 2006), by a contractually managed prison or by IND. The Ombudsman will obtain clinical advice as necessary, and will make efforts to involve the local Primary Care Trust (in Wales, Healthcare Inspectorate Wales) in the investigation. Where the healthcare services were commissioned by the NHS, the NHS will have the lead responsibility for investigating clinical issues under their existing procedures. The Ombudsman will ensure as far as possible that the Ombudsman's investigation dovetails with that of the NHS.

Other Investigations

6. Investigation by the police will take precedence over the Ombudsman's investigation. If at any time subsequently the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police. If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the relevant Service, the Ombudsman will alert the relevant Service. If at any time findings emerge from the Ombudsman's investigation which the Ombudsman considers require immediate action by the relevant Service, the Ombudsman will alert the relevant Service to those findings.
7. The Ombudsman and the Inspectorates of Prisons and Probation will work together to ensure that relevant knowledge and expertise is shared, especially in relation to conditions for prisoners and detainees generally and judgements about professional probation issues.

Disclosure of Information

8. Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in exceptional circumstances of the kind listed in the relevant paragraph of the terms of reference for complaints). For that purpose, the Ombudsman will be able to share information with specialist advisors and with other investigating bodies, such as the NHS and social services. Before the inquest, the Ombudsman will seek the Coroner's advice regarding disclosure. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Reports of Investigations

9. The Ombudsman will produce a written report of each investigation which, following consultation with the Coroner where appropriate, the Ombudsman will send to the relevant Service, the Coroner, the family of the deceased and any other persons identified by the Coroner as properly interested persons. The report may include recommendations to the relevant Service and the responses to those recommendations.

10. The Ombudsman will send a draft of the report in advance to the relevant Service, to allow the Service to respond to recommendations and draw attention to any factual inaccuracies or omissions or material that they consider should not be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The Ombudsman will have discretion to send a draft of the report, in whole or part, in advance to any of the other parties referred to in paragraph 9.

Review of Reports

11. The Ombudsman will be able to review the report of an investigation, make further enquiries, and issue a further report and recommendations if the Ombudsman considers it necessary to do so in the light of subsequent information or representations, in particular following the inquest. The Ombudsman will send a proposed published report to the parties referred to in paragraph 9, the relevant Inspectorate and the Home Secretary (or appropriate representative). If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Publication of Reports

12. Taking into account any views of the recipients of the proposed published report regarding publication, and the legal position on data protection and privacy laws, the Ombudsman will publish the report on the Ombudsman's website.

Follow-up of Recommendations

13. The relevant Service will provide the Ombudsman with a response indicating the steps to be taken by the Service within set timeframes to deal with the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the Service as to its suitability, append it to the report at any stage.

Annual, Other and Special Reports

14. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Home Secretary, which the Home Secretary will lay before Parliament. The Ombudsman may also publish material from published reports in other reports.

15. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Home Secretary, which the Home Secretary will lay before Parliament.

The annex contains a more detailed description of the usual reporting procedure.

Clinical reviewer's selection criteria

HIW may engage the services of a Peer clinical reviewer (from amongst the professional groups set out below) who has the requisite skills, knowledge and experience for the purpose of assisting HIW in carrying out its clinical reviews. The clinical reviewer will be independent of the provision of clinical care received by the deceased and will not have any management responsibility for its provision.

Peer Eligibility Criteria:

- ... **Medical:** Be a registered medical practitioner working at consultant level or equivalent with current clinical or management responsibility, and have up to date clinical practice and evidence of professional development.
- ... **Nursing:** Be a registered nurse with the Nursing & Midwifery Council (NMC), with current clinical or management responsibility, and have up to date clinical practice and evidence of professional development.
- ... **Other Health/Social Care Professionals:** Be on the relevant professional register if appropriate, with current clinical responsibility and up to date clinical practice, or current management responsibility, and evidence of professional development.
- ... **Ambulance Services:** At least 3 years experience within ambulance services, with evidence of professional development.
- ... **Pharmacist:** Relevant pharmacy qualification, experience of working within a hospital or community setting or the independent sector, with current clinical or management responsibility and evidence of professional development.

The clinical reviewer agrees and shall co-operate in full with all checks (and updated checks) deemed necessary by HIW to ensure he/she is a fit person to perform the Services. Such checks shall include an Enhanced check with the Criminal Records Bureau.

When performing Services for HIW, the clinical reviewer shall exercise all necessary care and skill and demonstrate the highest standards of integrity and probity.

The clinical reviewer shall keep confidential all data or other information which he/she acquires in the course of performing the Services and use such data or information only in the course of performing their duties.

The clinical reviewer shall, in carrying out his/her obligations under this Agreement comply with all legal requirements including, in particular, the Data Protection Act 1998 and any other applicable data protection legislation, and all relevant health and safety legislation.

The clinical reviewer is required to observe HIW's Code of Conduct for Reviewers/ Investigators/ Inspectors, including data protection and security provisions, and should ensure that there is no conflict of interest that will cause embarrassment to the PPO or to HIW.

UNDERTAKING A CLINICAL REVIEW FOLLOWING A DEATH IN CUSTODY

This guidance has been designed to support Healthcare Inspectorate Wales in undertaking clinical reviews as part of the Prisons and Probation Ombudsman's investigation process into deaths within remit. It is not designed to replace existing systems or processes and should be seen as guidance only.

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1. THE OMBUDSMAN'S INVESTIGATIONS

The Prisons and Probation Ombudsman (PPO) will investigate the circumstances of the deaths of the following categories of person:

- Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently. However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.
- Residents of National Probation Service approved premises (including voluntary residents).
- Residents of immigration detention accommodation and persons under Immigration Service managed escort.

The aims of the investigation will be to:

- Establish the circumstances and events surrounding the death, especially as regards management of the individual by the relevant service or services, but including relevant outside factors.
- Examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence.
- In conjunction with the NHS where appropriate, examine relevant health issues and assess clinical care.
- Provide explanations and insight for the bereaved relatives.
- Assist the Coroner's inquest in achieving fulfillment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

For the purpose of investigations, the Ombudsman has unfettered access to information, documents, establishments and individuals, including material and information provided to the services by other organisations. Further information about the types of documents available can be obtained from Prison Service Order (PSO) 2710.

The National Patient Safety Agency (NPSA) requires that "any unintended or unexpected incident that could have or did lead to harm for one or more persons receiving NHS funded healthcare", be investigated in a timely and appropriate manner.

Healthcare Inspectorate Wales (HIW) now takes the lead responsibility in conducting clinical reviews following a death in public prisons in Wales, from whatever cause, in partnership with the Prisons and Probation Ombudsman. Therefore when the death involves a prisoner, whether a self-inflicted death or from natural causes, the Ombudsman will approach HIW to request that a clinical review is carried out.

2. CLINICAL REVIEWS FOLLOWING A DEATH IN CUSTODY

Why?

Deaths in custody attract media and political interest. Any death in custody is subject to a police investigation and a coroner's inquest before a jury. Furthermore they may attract significant public interest and concern.

In England the Primary Care Trusts now have commissioning responsibility for the primary healthcare services in all public prisons. The Secretary of State has agreed that Primary Care Trusts will take the lead in investigating the clinical issues relating to deaths in custody. The arrangements in Wales rest with the Health Inspectorate Wales, who take the lead in all the clinical reviews. Therefore, the local Primary Care Trust, for all public prisons, will have the lead responsibility for arranging an independent investigation of the clinical issues under their existing procedures and may be required to attend the inquest. For privately managed prisons, the PPO and Department of Health will arrange for an independent clinical investigation to be carried out.

How and who?

A successful investigation requires that organisations focus on their key tasks, communicate effectively and collaborate with each other.

The investigation process should be commissioned by HIW. This should be carried out using the existing local mechanisms for reviewing serious untoward incidents or in accordance with the NPSA Root Cause Analysis process or by using a panel review process.

HIW will decide how and by whom the investigation will be undertaken. The lead reviewer should be any appropriately registered clinician or an appropriate multi-disciplinary review panel to meet the needs of the investigation. The reviewer or panel members must not be working in or directly involved in the delivery of care at the establishment under review. Neither should they have line management responsibilities for the staff delivering healthcare in the prison.

Where other providers have contributed to the care of the deceased, then the review should consult and/or involve representatives from such organisations in the review, as required. For example; mental health providers, drug and alcohol services and acute hospital trusts.

Aims of the review

The aim of the review is to consider the care the deceased received whilst in prison custody. An approach of HOW and WHY should be adopted, not WHO to blame.

- ... How when and where did the prisoner die?
- ... Is there any root cause(s) of the death?
- ... Was the clinical care equitable with the wider community?
- ... Are there any learning opportunities?
- ... Were local and national policies and procedures followed?
- ... Is there an opportunity to prevent future deaths in similar circumstances?
- ... Are there any examples of good practice?

The scope of the review

- ... To examine the provision of care and treatment, including risk assessment and risk management.
- ... To examine, to the extent necessary, the secondary care provided.
- ... To provide a chronology of the health and social care events leading up to the incident.
- ... To identify any care or service delivery failures along with the factors that contributed to these problems.
- ... To examine policy and practice.
- ... To identify any root cause(s) that inform the identification of learning opportunities to be included in the action plan.
- ... To make clear, sustainable recommendations for the health community and the prison service.
- ... To provide explanations and insight for the relatives of the deceased.

Interviewing

In some cases a review of the available documentation may be sufficient. However, in many cases, it will be desirable for interviews to be conducted with staff who have had significant dealings with the prisoner. The Ombudsman would be grateful if the clinical reviewer would consider conducting such interviews jointly with the PPO investigators.

What information is available to support the review process?

This is not an exhaustive list, but provides some guidance as to what documents may be available to enable the review to be carried out. PSO 2710 – Follow up to deaths in custody provides more information about the types of records a prisoner may have.

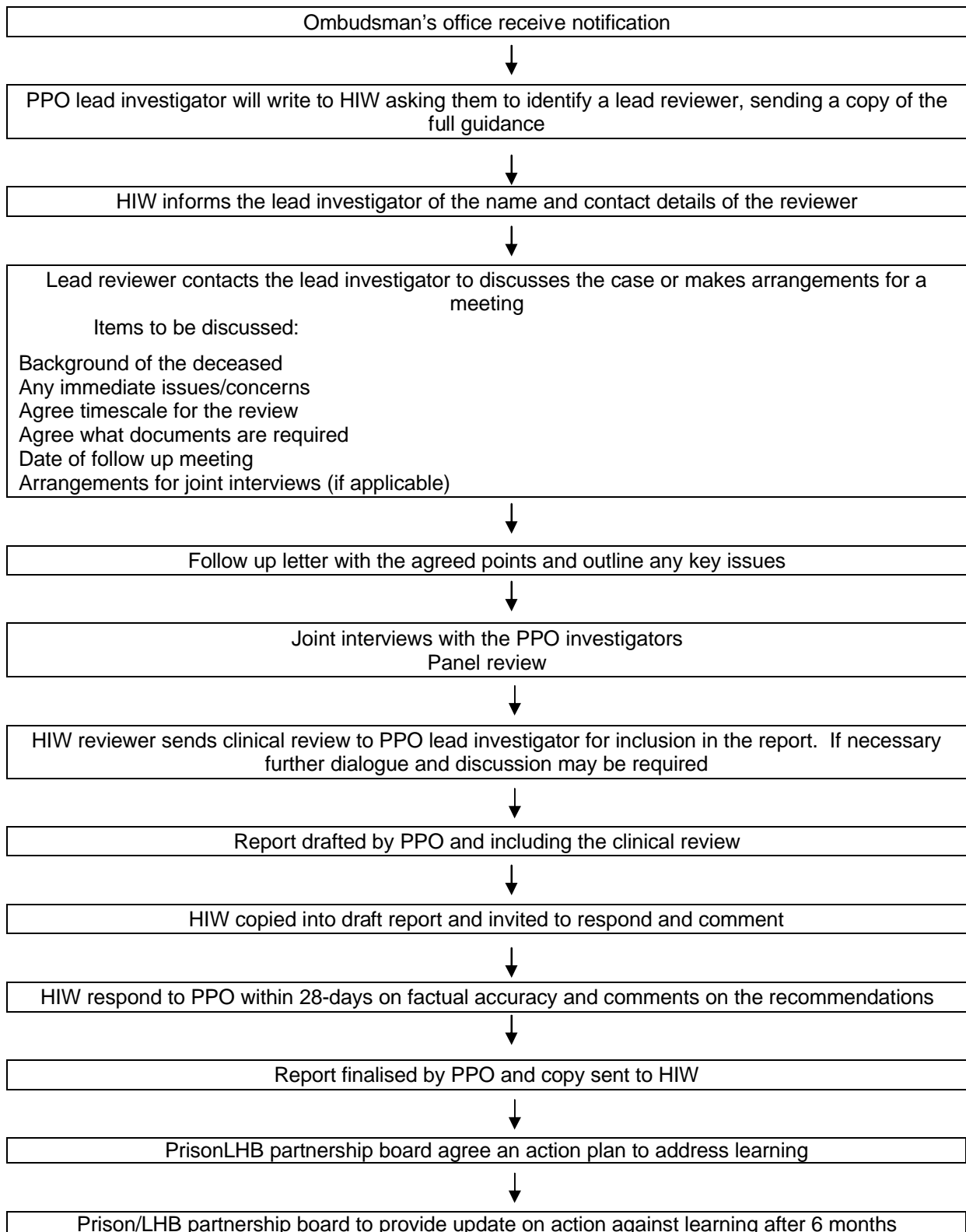
- ... The clinical record
- ... The prison records
- ... Police and prison statements
- ... GP records
- ... Acute trust records (if required)

- ... Mental Health Trust Records
- ... Post mortem results are often available from the PPO investigator
- ... Local policies and procedures
- ... Prison Service standards
- ... National Service Frameworks

What if more information is needed during the review?

- ... Contact the PPO Lead investigator
- ... Contact the prison healthcare manager
- ... Contact the coroner

3. THE PROCESS FOLLOWING NOTIFICATION OF A DEATH



4. PANEL REVIEWS AS A PROCESS FOR REVIEWING DEATHS

The panel review enables clinical reviewers to take a multi-disciplinary and multi-agency approach to reviewing the clinical care afforded to an individual and promote informed evidence based discussions and decision making.

Identifying a Lead Clinical Reviewer (LCR):

The LCR takes a central role in the organization and conduct of the clinical review.

The LCR should possess the following skills and expertise:

- ... Relevant clinical, administrative and managerial expertise.
- ... Co-coordinating, chairing and networking abilities.
- ... An understanding of the clinical review process.
- ... The training and capacity to give evidence in a Court of Law, including the Coroner's Court, if required.

The LCR must be given the time and resources required to lead the review and complete within the agreed timetable.

Setting up a panel review:

The LCR determines the agencies that were involved in the care of the deceased and selects suitable individuals to constitute a clinical review panel, ensuring that they have the following collective skills and expertise:

- ... Clinical governance expertise.
- ... Expert investigation skills such as root cause analysis (RCA) or similar.
- ... Excellent report writing skills.
- ... Interviewing and communication skills.
- ... Understanding of the clinical review process.
- ... Capacity to give evidence in a court of law or Coroner's court, if required.

The LCR will normally chair this panel.

Membership of the panel will be dependent on the chronology of health and social care events leading up to the death and identified issues and concerns. Panel members must **NOT** be working in the establishment under review or directly managing the staff involved.

Suggested panel membership:

Chair
Prison healthcare representative
Clinical governance
Specialists
PPO investigator
Governor or prison grade representative
Lay person - PAL / IMB

The PPO Investigator is encouraged to be a member of the review panel to give a social care aspect to the review and to gain a better understanding of the health services an individual received.

Where other service providers have been involved in the delivery of care e.g. mental health services, an appropriate representative is invited to be a panel member (preferably one not involved with the care of the deceased) or arrangements or made to consult a suitable representative or specialist.

The size of the panel will vary but experience suggests that small is best. Too many members may lead to appointment complications and extensions to timetables.

Write to each prospective panel member inviting them to participate and informing them of the clinical review process.

A documented briefing meeting is held for those participating in the investigation to outline the process; construct a timetable; address any concerns and to agree the terms of reference.

These are likely to include the following:

- ... To examine the provision of care and treatment, including risk assessment and risk management.
- ... To provide a chronology of the health and social care events leading up to the incident.
- ... To identify any care or service delivery failures along with the factors that contributed to these problems.
- ... To examine policy and practice.
- ... To identify any root cause(s) that inform the identification of learning opportunities to be included in the action plan.
- ... To make clear, sustainable recommendations for the health community and the prison service.
- ... To provide explanations and insight for the relatives of the deceased.

5. SUGGESTED AREAS FOR CONSIDERATION AS PART OF THE CLINICAL REVIEW

This list is not exhaustive but gives some guidance to suggested areas of investigation if appropriate and has been drawn up using learning opportunities and findings from previous investigations. The clinical review team should give due consideration to involving specialists to contribute to the review as required.

... **Family**

Ensure due consideration is given to any issues raised by the family.
Were arrangements for notifying the family of a serious illness timely?
Were links with the family appropriately considered and maintained?

... **Records and Record Keeping**

Record keeping is an integral part of the care process and is a tool of professional practice. It is not an optional extra to be fitted in if circumstances allow. The quality of records and record keeping should be considered against the standards laid down by the relevant professional bodies.

Are there regular documented audits of the standards of record keeping as required by the NMC/HPC and GMC?

Is the documentation and record keeping adequate and appropriate?

Are the records factual, consistent and accurate?

Written as soon as possible after the event has occurred, providing current information on the care and condition of the patient or client?

Written clearly and in such a manner the text cannot be erased?

Are they accurately dated, timed and signed, with the name and designation printed alongside the first entry?

Do they include abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subjective statements?

Are the entries respectful to the patient/client?

Are the entries consecutive?

Do they identify problems that have arisen and the action taken to rectify them?

Do they provide clear evidence of the care planned the decisions made, the care delivered and the information shared?

... **Reception Medical Screening**

Was the appropriate screen completed?

1st Health screen on the 1st night into reception

2nd Health screen completed within 5 days of receipt into prison

Was the screening process effective to establish the prisoner's past and current mental and physical history?

Did the screening process establish the nature and extent of substance misuse?

... **Mental health**

Did the prisoner have a mental health history?
Were attempts made to obtain their previous records?
Were they referred to local MH services?
Were they receiving appropriate MH care to meet their need?

... **Physical health**

Was an appropriate physical health history taken?
Was the prisoner referred to secondary care services in a timely manner?
Did the patient receive care appropriate to their need?
Were attempts made to obtain previous records from their GP or other specialist health provider?

... **Equitable care**

Was the care of the patient received comparable with the care they could expect to receive in the community?
Were external agencies involved in the care of the patient?
Was the care the patient received from the secondary care provider of an acceptable and appropriate standard?
Were appointments cancelled by the prison or by the external agencies?

... **Substance Misuse**

Was a full history of the drug and alcohol use obtained?
Was the prisoner referred to specialist clinical drug services?
Were they referred to other drug and alcohol support services?
Was the detoxification or maintenance regime appropriate?
Was the care they received appropriate to meet their needs?
Was the prisoner provided with appropriate discharge information and advice prior to release?
Is there evidence that CARATs and healthcare transferred appropriate and timely information to allow community services to provide ongoing care?

... **Suicide and self-harm**

Were there any key suicide or self-harm indicators identified?
Were these acted on and managed appropriately?
Was the prisoner on a suicide and / or self-harm support plan (Care map)?
Was the prisoner referred to local mental health services?
Were there any delays or disagreements in providing mental health assessment?
Were there any delays in transferring out to external mental health facilities?
Was there appropriate health care input into the prisoner's care / management plan?
Was the NICE guidance used to care for those at risk of suicide and self-harm?

... **Communication**

Was appropriate information passed between the health care department and other departments within the establishment?

Was appropriate information passed between health and social care agencies?

Is there an information sharing protocol locally agreed?

Was the standard of record keeping appropriate to ensure effective communication?

... **Policies and Procedures**

Are there local policies and procedures in place?

Do these meet Department of Health and Prison Service standards?

Have these been agreed with the local health and social care partnerships involved in the delivery of local prison health care?

... **Incident**

Was the clinical response to the presenting symptoms reasonable and appropriate?

Were there any delays or equipment shortages/failures?

Would any different care or treatment at any stage led to a different outcome?

Are there any lessons to be learnt?

... **Physical environment**

Is the physical environment in which primary health care is delivered fit for purpose?

Are there adapted cells available to meet the physical health needs of patients?

Do the interview rooms enable appropriate levels of confidentiality without compromising security?

Is the in-patient unit fit for purpose ensuring decent and humane conditions for the prisoner / patient?

... **Post incident support**

Did the staff involved in the incident receive appropriate and if required continuing clinical supervision and psychological support?

Did healthcare professionals participate in a post incident debrief?

... **Medicines management**

Is the pharmacy services equivalent to that in the community, including direct access to advice by appropriately trained pharmacy staff, information about the benefits and risks of medications and the self administration of medication?

Did the prisoner have access to their long term medications without gaps or delays?

Was the prescribing of medications appropriate to meet the patient's clinical need?

... ***Training and staff development***

Do the staffing levels and skills mix include appropriately trained medical, nursing, reception, administrative, discipline and other ancillary or specialist staff to reflect prisoners' needs?

Have the staff received appropriate training and development to meet the health needs of the prisoners they care caring for?

Are staff aware of how to access and use emergency medical equipment, including the resuscitation kit?

... ***Escorts and bed watches***

Did the patient receive health services that were not unnecessarily restricted by security procedures?

Was timely consideration given to temporary or compassionate release, if appropriate?

6. SUGGESTED REPORT STRUCTURE

The clinical report will form part of the Prisons and Probation Ombudsman's investigation report and the Ombudsman will usually draw from it in framing his own findings and conclusions. This is not a definitive 'report structure', but rather guidance to the report format if required for local use, as it is important to avoid any unnecessary duplication with health's own systems for investigating adverse clinical events.

Plain English should be used when drafting the report and technical terms must be explained. Please note the report will be read by the family of the deceased.

Introduction - a brief outline of the case.

Terms of reference

Membership of the Review Panel

Methodology

Outline medical history

... A brief overview of the prisoner's medical history prior to admission to prison, including any relevant family and medical history.

... A brief overview of the prisoner's physical and mental condition at the time of admission.

Background information

... Relevant and significant health and social care history.

Chronology of events, key findings and recommendations

... Chronological record of events from the medical records available. This is best presented in a tabular form.

Other issues of concern

... A review of the care the prisoner received whilst in custody from the prison health services compared with the services they could have expected to receive from a primary care provider in the community.

... A review of the care and management of the patient by the local secondary or tertiary care provider (if appropriate).

Recommendations

... The recommendations should be **SMART** and based around a holistic approach to the wider health and social care agenda.

Good practice

... Identify any areas of good practice.

7. LEARNING STRATEGY

Learning is integral to the clinical review process. It involves sharing good practice and learning lessons on how things may be improved. All prisons and LHBs must have processes in place for making sure that lessons are learnt, recommendations are put in place and improvements are sustainable

When the review team uncovers the need for urgent action at any stage of the review, this information is passed on to the LHB and/or prison without delay, so that appropriate action can be taken promptly

Following the clinical review dissemination of learning happens at different levels, locally, regionally and nationally, although specific systems and mechanisms may vary according to locality

The LHB / Prison Partnership Board disseminates learning and action planning to care and prison staff within the locality, including staff who were directly involved with the care and custody of the deceased. The prison and the LHB have mechanisms for the dissemination, implementation and monitoring of action plans.

Each Region has, or is developing, a network for the discussion and management of patient safety and quality issues. This network will develop as a forum for sharing learning from clinical reviews, monitoring action plans and disseminating learning. The network is likely to consist of representatives from SHA clinical governance, the Safer Custody Offender Policy Group and the Care Services Improvement Partnership (CSIP).

Learning from clinical reviews and PPO investigation reports is shared nationally through the following organisations: the NPSA, CSIP, Safer Custody Offender Policy Group and the PPO.

An update on the implementation of recommendations and action plans should be submitted to the PPO six months after the release of the final investigation report.

8. USEFUL LINKS

Prisons and Probation Ombudsman	www.ppo.gov.uk
Department of Health (prison health)	www.dh.gov.uk/priswonhealth
HM Prison Service	www.hmprisonservice.gov.uk
National Patient Safety Agency	www.nspa.nhs.uk
National Institute for Clinical Excellence	www.nice.org.uk
Health Service Ombudsman	www.ombudsman.org.uk
Healthcare Commission	www.healthcarecommission.org.uk
Her Majesty's Inspectorate of Prisons	www.homeoffice.gov.uk/justice/prisons/inspprisons