

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

**PART 1  
GUIDANCE ON COMMISSIONING  
FOR HEALTH INSPECTORATE WALES**

**November 2014**

## BACKGROUND

- 1.1 The **Prisons and Probations Ombudsman (PPO)** is remitted to investigate the circumstances surrounding the deaths of the following:
  - Prisoners and young people in detention (including those in Young Offender Institutions and Secure Training Centres)
  - Residents of Approved Premises (including voluntary residents)
  - Residents of Immigration Removal Centres, short term holding facilities and persons under managed escort.
  - People in court premises or accommodation who have been sentenced or remanded into custody.
  - And any other groups as described in the Ombudsman's Terms of Reference (<http://www.ppo.gov.uk/about/vision-and-values/terms-of-reference/>)
- 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), Youth Justice Board and the 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 (HIW in Wales)** have commissioning responsibility for all the healthcare services in all public prisons 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 NHS Area Team in respect of **all prisons and immigration detention 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.
- 1.8 For the purposes of clinical review, the following NHS definition of a Serious Incident is used:

'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 detention, including those under escort**
- **Court premises (when the deceased has been remanded or sentenced into custody)**
- **And any other groups that fall within the Ombudsman's remit**
  
- **Persons released temporarily 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 occasion, there may be particular clinical concerns that require a clinical review. In such cases the NHS Area Team (HIW in Wales) 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 Health Inspectorate Wales (HIW) 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. HIW should commission the review within 5 working days 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 and 60 working days for other deaths** of this initial communication (see annex A for PPO escalation process)
- 2.3 HIW will request copies of the clinical record directly from the establishment. The PPO will arrange for any additional 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)
- 2.4 HIW will be responsible for arranging access to relevant community NHS records to assist the clinical reviewer. Suggested wording is attached to this guidance at Annex B.
- 2.5 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 first contact by the PPO) by HIW with the PPO investigator in conversation with the appointed clinical reviewer.** 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 occasion, evidence may come to light that requires the level of review to be reconsidered – in such cases the PPO investigator, clinical reviewer and HIW should agree the revised level, and document accordingly.

### 2.6 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. The PPO record and provide transcripts for some interviews. Clearly recorded interviews are a Coroner's requirement which would include appropriate written records of an interview.
- 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 HIW is responsible for assisting the clinical reviewer to gain access to relevant NHS records (see para 2.4) and key health professionals who are relevant to the investigation.
- 2.13 HIW 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 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 HIW for quality assurance with 35 working days (7 weeks).
- 2.16 The HIW 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. In relation to HIW clinical reports, the clinical reviewer should not be named in the draft or final PPO report.
- 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, HIW should note that issues of clarification sometimes arise following the consultation period (see para 2.18d).**
- 2.18 **Stages following the PPO investigation and clinical review:**
  - a) The PPO investigator writes a draft report including relevant clinical issues and 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 HIW and the 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 more investigation to take place, which may include clinical matters.**
- e) The report is finalised, including the response to any recommendations, and is often 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) advance disclosure is provided where there is serious criticism, usually involving recommendation for disciplinary action against an individual member of staff (see para 2.19). If the final report (e) goes on to make serious criticisms of a member of staff, it may recommend that the appropriate disciplinary procedures are implemented, and may in extreme cases, recommend referral to the appropriate regulatory body. HIW should undertake such a referral.

- 2.19 **Advance Disclosure** - The PPO operates on the basis of full and simultaneous disclosure to all parties to the investigation. However from time to time, serious criticism, usually involving recommendation for disciplinary action against individuals, is made in the draft report. In these cases the draft report will be advance 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 is subject to the Data Protection Act 1998 and the Freedom of Information Act 2000. The Ombudsman follows Government policy that official information should be made available unless it is clearly not in the public interest to do so. The Ombudsman's disclosure policy (<http://www.ppo.gov.uk/disclosure-policy.html>) describes the level of disclosure as applied to fatal incident investigations. This includes both the PPO investigation report and the clinical review report.

### 3. **LEARNING STRATEGY**

- 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 Welsh establishments and HIW should have processes in place for making sure that lessons are learned, recommendations are implemented and improvements are sustainable.
- 3.2 HIW 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 HIW 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 (EDRG) and HIW.

#### 4. REVIEW

4.1 The guidance will be reviewed annually with review meetings attended by key representatives throughout the year. Lead contacts will include:

##### **PPO**

Deputy Ombudsman: Learning Lessons and Strategic Support  
Assistant Ombudsman: Fatal Incident Investigations

##### **HIW**

Head of Investigation

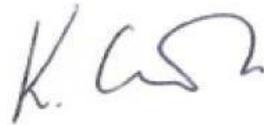
Signed



Nigel Newcomen CBE  
Prisons and Probation Ombudsman

Date: 16.06.15

Signed



Dr Kate Chamberlain  
Chief Executive Health Inspectorate Wales

Date: 16.06.15

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

Support team (on behalf of investigator) will HIW to request a clinical reviewer, **within one working day** of notification of death.

HIW 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 HIW, 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 HIW 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 Chief Inspector HIW 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 HIW to Caldicott Guardian  
regarding release of medical records of deceased person**

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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 Health Inspectorate Wales (HIW).

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 HIW. 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