

Learning from PPO investigations

Making recommendations

July 2013

Contents

Foreword

1. Investigations	6
1.1 Complaints	6
1.2 Fatal incidents	6
1.3 Outcome of investigations	6
1.4 Following recommendations	7
1. The database - learning from across investigations	7
2.1 Overview of the data	8
1. Complaints	9
3.1 Themes	9
3.1.1 Quashed adjudications	9
3.1.2 Payments and compensation	10
3.1.3 Apologies	11
3.1.4 Use of Force	12
3.2 Cases without recommendations	13
4. Fatal incidents	14
4.1 Themes	17
4.1.1 Sharing and accessing information	17
4.1.2 Chronic diseases	19
4.1.3 Hospital	20
4.1.4 Mental health	22
4.1.5 Drugs, alcohol and withdrawal	22
4.1.6 Self-harm	24
4.1.7 Prisoners' families	25
1. Rejected recommendations	27
5.1 Themes	27
5.1.1 Insufficient resources	27
5.1.2 Outside the prison's remit	27
5.1.3 Already existing practice	28
5.1.4 Interpretation of national instructions	28
5.1.5 Rejecting the substance of a recommendation	28
5.2 Accepted?	29
6. Commendations	30
7. Learning from PPO recommendations	31
Endnotes	32

Foreword



My staff and I make recommendations following both fatal incident and complaint investigations and these are nearly always accepted by the organisations within my remit. Thus, while our independent investigations provide transparency to those affected by a death and a means to obtain resolution to those with a complaint, it is our recommendations that have the greatest potential to ensure that wrongs are put right and that lessons are learned.

It was for this reason that, on appointment as Ombudsman, one of my priorities was to ensure that the recommendations coming from my office were as effective and influential as possible. This was in line with my new vision that we should make “a significant contribution to safer, fairer custody and offender supervision”. In particular, I wanted to ensure that our recommendations were assertive and clear about what was expected, with specific, time-bounded and tangible outcomes. In other words, were more likely to make a difference. New guidelines for recommendations were introduced in April 2012 and, at the same time, we began collating all the recommendations made into a single database.

There are limits to how far we can follow-up progress once a recommendation has been made and accepted, although the services in remit are required to provide an action plan. I have therefore ensured that we work more closely with my old colleagues in HM Inspectorate of Prisons so that

they can follow-up progress on our recommendations when they later inspect an establishment and that, together, we can pursue improvement.

The recommendations database is intended to improve our own practice and consistency, but also to enable more effective analysis of trends and identification of action points where similar recommendations have been made in a number of cases or to a number of establishments. This report is the first of an annual series, providing an overview of the recommendations made in the year 2012/13 and the main themes identified by them. Most of these themes are not new and I hope that by sharing learning in this way we can reduce the number of times I have to make similar recommendations in the future. My ambition is to encourage wider learning of lessons and so help support improvement in the services I investigate.

I am grateful to my colleague Helen Stacey for her work on the database and on this report.

A handwritten signature in black ink, appearing to read 'Nigel Newcomen'.

Nigel Newcomen
Prisons and Probation Ombudsman

1. Investigations

1.1 Complaints

The Ombudsman investigates complaints from current and former prisoners, people under probation supervision, residents of approved premises¹, and immigration detainees. The Ombudsman investigates complaints about the decision and actions (including failures or refusals to act) relating to the management, supervision, care, and treatment of the complainant. For a complaint to be eligible for investigation the prison, probation or immigration service (known as services in remit) must already have had an opportunity to respond to and address the complaint. The Ombudsman's Terms of Reference² make clear his remit covers both public and private establishments, staff employed directly by the services and others working as agents or contractors. The full criteria for the Ombudsman's role in investigating complaints are set out in the Terms of Reference. The aim of the complaint investigation is to resolve the matter and the Ombudsman may do this in whatever way he sees fit, including by mediation.

1.2 Fatal Incidents

Another principal function of the Ombudsman's office is to investigate the circumstances of deaths in prison custody (including Young Offender Institutions (YOIs) and Secure Training Centres (STCs)), immigration detention and approved premises. Fatal incident investigations aim to:

- establish the circumstances and events surrounding the death, especially regarding the management of the individual by the relevant authority or authorities within remit, 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 National Health Service (NHS) where appropriate, examine relevant health issues and assess clinical care;

- provide explanations and insight for the bereaved relatives;
- assist the Coroner's inquest and help fulfil the UK's obligations 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 learned³.

1.3 Outcome of investigations

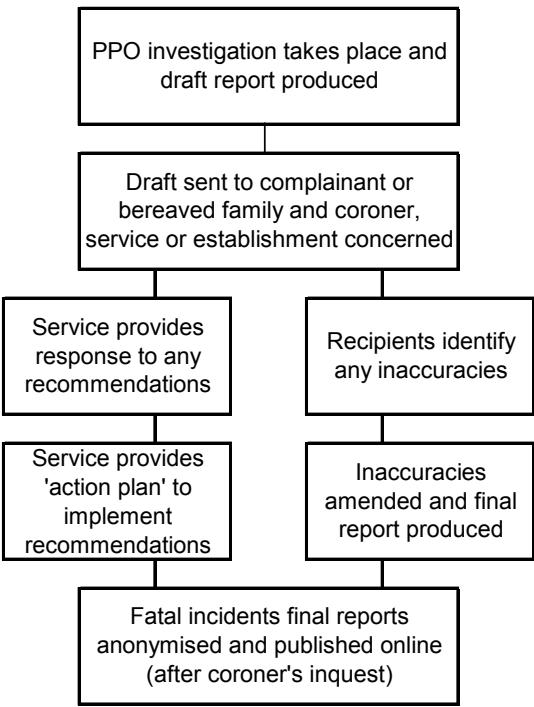
The Ombudsman's investigations often result in recommendations. The aim is to make focussed recommendations with a specific suggestion for remedial action, such as amending a policy or adopting new procedures. The Ombudsman may make recommendations to the authorities within remit, relevant Secretaries of State, or to any other body or individual that the Ombudsman considers appropriate given their role, duties and powers.

The principal reason for recommendations in fatal incident cases is to identify steps that might help prevent a similar sequence of events occurring again. This might be aimed at reducing deaths in custody but recommendations, particularly following deaths from natural causes, also aim to ensure the ill and dying – and their families – are treated with appropriate care and dignity.

Recommendations following an investigation of a complaint also aim, where possible, to identify measures that would prevent a recurrence. However, reflecting the different nature of the investigation, they will also seek to resolve the situation which gave rise to the complaint or offer some other form of appropriate redress for the individual. The acknowledgement that something has gone wrong and an apology can be important to many complainants.

1.4 Following up recommendations

Figure 1.1 PPO recommendation process



Unfortunately the Ombudsman does not have the resources to return to establishments to monitor progress on recommendations. Instead, the action plans provide a way to check how establishments plan to implement recommendations. Action plans in response to fatal incident investigations are discussed alongside the main thematic areas of recommendations in section 4.1.

The Ombudsman also shares information about his investigations, particularly about recommendations made, with Her Majesty’s Inspectorate of Prisons (HMI Prisons). HMI Prisons’ inspection teams are therefore able to review processes for implementing and monitoring progress on recommendations, and to follow-up on any areas of concern. After an inspection, HMI Prisons provides summary feedback to the Ombudsman outlining progress against fatal incident investigations recommendations (and occasionally also complaint investigation recommendations). The feedback highlights examples of specific action taken, raises concerns where this has not happened and provides information on the establishment’s processes for monitoring and reviewing the implementation of recommendations.

2. The database – learning lessons across investigations

The database currently holds recommendations made since the introduction of a SMARTER system of recommendations at the beginning of April 2012. The PPO defines a recommendation as a clear instruction issued to any authority overseen by the PPO. Recommendations outline a course of action that will prevent, improve or remedy an undesirable outcome or event. This can include recommendations for disciplinary action and recommendations for formal appraisal⁴. From April 2012 recommendations have been drafted in accordance with the SMARTER acronym. Recommendations are:

Specific	focussed on one area of practice or
Measurable	focussed on an identifiable outcome
Accountable	addressed to a member of staff in a named post who is responsible for implementation
Realistic	reasonable and proportionate to the issue identified in investigation
Time bound	give an expected timeframe for implementation
Effective	make a real difference when implemented
Reviewed	reviewed in subsequent cases. Action plans should be checked to ensure they are appropriate

Alongside the new guidelines for SMARTER recommendations, a database of recommendations was created. This central collection of both complaint and fatal incident recommendations is a new development, intended to strengthen our ability to identify learning from common themes emerging across different investigations. This report is the first to consider all of the information held (up to the end of March 2013). The database is used on an ongoing basis as a resource to inform and guide other PPO learning lessons work, improve the consistency of the recommendations we make, and to aid investigations.

Recommendations are added to the database at the end of an investigation. For fatal incident investigations this is when the final report is issued which allows the service's response and action plan to be included. While the investigations in this report were completed in 2012/13 the death or the incident leading to the complaint may have occurred earlier than this.

2.1 Overview of the data

Between 1 April 2012 and 31 March 2013 there were 1603 recommendations made from 482 completed investigations. The nature of the complaint investigations and fatal incident investigations are different and this was reflected in the number of formal recommendations made. As shown in table 2.1 it was less common to find formal recommendations being made following investigations into complaints (36% of upheld complaints) than following a death (93% of cases).

Only in exceptional circumstances were recommendations made following a complaint which the Ombudsman has investigated but not upheld.

Investigations into fatal incidents tended to lead to a higher number of recommendations in individual cases than following a complaint (table 2.2). Investigations into a self-inflicted death in custody led to a greater number of recommendations than those involving a death from natural causes.

The majority of the Ombudsman's work involves prisons and, therefore, most recommendations were as a result of complaints from prisoners or deaths in prisons (table 2.3).

Table 2.1: Formal recommendations 2012/13

Investigation	Cases with recommendations	Percentage with recommendations	Cases without recommendations	Total
Complaint (Upheld)	231	36%	414	645
Complaint (Rejected)	25	2%	1412	1437
Fatal incident	226	93%	16	242
<i>Total</i>	<i>482</i>	<i>21%</i>	<i>1,842</i>	<i>2324</i>

Table 2.2: Average number of formal recommendations per case

Type of investigation	Investigations with recommendations	Number of recommendations	Average recommendations per case
Complaint	256	534	2
Fatal incident - Natural causes	144	567	4
Fatal incident - Self-inflicted	71	446	6
Fatal incident - Other non-natural	11	56	5
<i>Total</i>	<i>482</i>	<i>1603</i>	<i>3</i>

Table 2.3: Investigations with recommendations, by service in remit

Service in remit	Complaint investigations with recommendations	Fatal incident investigations with recommendations
Prison	94%	95%
Probation	4%	4%
Immigration	2%	1%
<i>Total investigations with recommendations</i>	<i>256</i>	<i>226</i>

3. Complaints

When recommendations from complaint investigations are entered onto the database they are categorised according to the nature of the complaint. Figure 3.1 shows the categories of complaints upheld in 2012/13 and in which cases recommendations were made. This shows that formal recommendations were made most often when complaints about equality issues, adjudications⁵, staff behaviour, or probation⁶ were upheld. Recommendations were less common following complaints about property and administration issues. Often when complaints are upheld without recommendations it is because a resolution has been reached, for example by mediation, before the case has reached the stage for recommendations.

3.1 Themes

3.1.1 Quashed adjudications

A fifth (122) of complaint investigation recommendations made were about adjudications. When complaints about adjudications were upheld it was normally because the investigation uncovered a significant flaw in how the hearing was

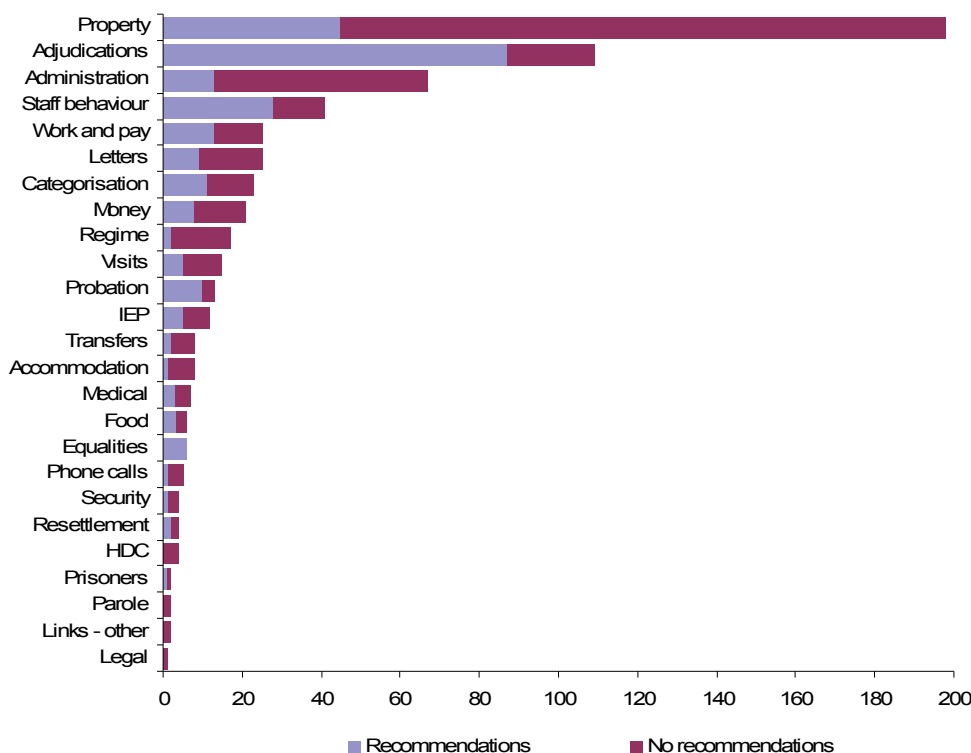
conducted or recorded. In 80 per cent (87) of cases where adjudication complaints were upheld a formal recommendation was made. The overwhelming majority of these recommendations were to quash (annul and set aside) the finding of guilt. Many punishments included loss of earnings from prison jobs and, where this happened, the recommendation to quash a finding of guilt normally also involved reimbursing the prisoner for this loss.

“It is recommended that the finding of guilt be quashed and the lost earnings refunded.”

Even when an adjudication is quashed, including when there is recompense for loss of earnings, it is not always possible entirely to off-set the impact of punishments imposed. A reduced income can limit a prisoner’s ability to purchase credit to telephone friends and family, and they might also have spent time confined to cell or with limited access to facilities such as the gym.

The remaining recommendations mostly concerned ensuring staff are properly trained and aware of the right procedures in order to reduce the likelihood of

Figure 3.1: Complaints upheld in 2012/13 by category⁷



future adjudication hearings being found to be flawed.

“I also recommend that the Governor should ensure that all staff who conduct adjudications receive refresher training in the conduct of adjudications within three months of the date of this report.”

“I recommend the Governor issues a notice of guidance to adjudicators reminding them...to complete the DIS3 paperwork correctly and to record on the DIS3 their reasons for finding the charge proved.”

Another recurring type of recommendation is for establishments to ensure that certain things, such as removal of all access to the gym⁸ or 100 per cent loss of earnings, are not imposed as punishments. Punishments must always be both legitimate and proportionate.

3.1.2 Payments and compensation

The focus of recommendations is often on the future, to put measures in place to prevent a recurrence, but in some complaint cases there is still the opportunity to redress what has gone wrong and to try to mitigate the impact this has on individuals. Payments are an important part of this, and recommendations were made when prisoners, detainees, or those under probation supervision have been left financially worse off. Adjudication punishments, which impose loss of earnings, or lead to it through cellular confinement, are a clear example of this and made up 44 per cent (49 of 111) of recommendations which proposed a payment to the complainant.

Property cases made up the next largest group where payments were recommended (37 in total). Most concerned missing property, although there were several about property being damaged or confiscated and not returned. Prisoners are normally responsible for their own property but there are circumstances when the establishment becomes responsible for it. Property can be kept in storage rather than ‘in possession’. Prohibited and more valuable items are required to be stored in

this way. Cells are sometimes ‘cleared’ with all the property removed in the prisoner’s absence. The establishment is also responsible for property when prisoners are transferred. Payments may be recommended when property is lost or damaged while it is in the care of the establishment.

Recommendations for payments were based on the amount paid, either evidenced or using prices for comparable items, minus wear and tear when relevant. The payment does not generally compensate for the inconvenience caused or attempt to judge the sentimental value of the items. Often complaints involved lost items of clothing, or damage to electrical goods but in some cases high value items of jewellery or watches had gone missing while in the establishment’s possession. The recommendations ranged from reimbursing pin phone credit to paying the equivalent value of missing jewellery and watches. Mostly the payments were of small amounts; of the 37 payments two thirds (25) were of £150 or less.

While the loss of valuable property is clearly a serious issue, the impact of more common loss and damage of minor value items should not be underestimated. Most prisoners have few possessions and there are strict limits on the volume of property permitted. Replacing even basic items such as jeans or shoes without access to the high street or online vendors can be difficult and time-consuming, particularly when individuals are reliant on friends, family and whatever is both available and affordable from approved mail-order catalogues.

The other main reason for recommending financial recompense involved complaints about loss of prison jobs. Establishments were asked to reimburse earnings in several cases where the decision to dismiss an individual from their job was not taken or evidenced properly. In these cases, the recommendation was often to provide the individual with what they would have earned from the date of dismissal to the date they were re-employed, minus any unemployment pay received.

“It is recommended that the Director reimburses [the complainant] for any loss of pay resulting from his sacking, and apologises to him for there being no written record of the concerns which led to his sacking.”

3.1.3 Apologies

Around a tenth of recommendations (66, 12%) were for the establishment to apologise - generally in writing - to the complainant or, in a small number of cases, to a member of their family. The types of case in which an apology was considered to be required are shown in figure 3.2. Complaints about staff behaviour, which led to the most recommendations for apologies, covered a broad range of complaints. An apology is an important acknowledgement of a wrong done but, particularly when it has to be recommended by an outside body, it is not a panacea and may not prevent the same thing happening again in the future.

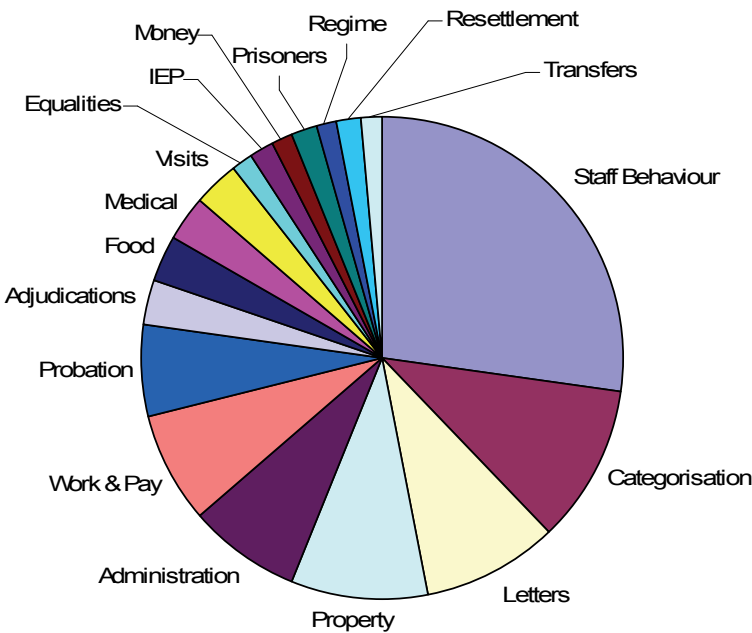
A common theme in recommendations regarding complaints about staff behaviour was the need for an apology to be given for shortcomings in the prison’s initial internal investigation into the complaint. In some cases, this was because the findings of the investigation had not been properly shared with the complainant, in others because

there had been long delays in the process. In some cases the recommendation was for an apology for the inadequacy, or even lack, of an investigation following a complaint. For instance, following one complaint which alleged staff had used excessive force during a restraint, with a possible racial element, it was recommended that:

“The Governor issues an apology to [the complainant] for not investigating his allegation against [the staff member] under the national policy.”

The substantive complaint was not upheld because there was no evidence that the officer’s use of restraint techniques had been incorrect, or unjustified, but the Ombudsman was concerned about the establishment’s response to the complaint. The apology was only one of a series of recommendations, the others aimed at improving this response to serious complaints for the future. This included ensuring all officers have up to date control and restraint training, developing procedures to ensure a prisoner’s requests for police involvement are acted on, and providing guidance for staff on the additional requirements when a complaint raises equalities issues.

Figure 3.2: Recommendations to apologise, by complaint category



Internal investigations were also a common issue in the recommendations for an apology following other complaints which were not related to staff behaviour. For example, Mr A complained to the prison about finding plastic in his food. When he complained to the Ombudsman, his concerns were as much about the lack of investigation by the prison as about the original incident. The recommendation was for the prison to apologise to Mr A and put processes in place to ensure complaints are responded to within the correct timescales and by appropriate staff⁹. As with Mr A's case, recommendations for an apology were often made alongside recommendations about the correct procedures for handling complaints:

"The Governor issues a notice to staff reminding them that complaints must be answered quickly and fully in line with Prison Service Instruction 2/2012."

Particularly where the upheld complaint was about an assault by staff, recommendations were often made to apologise for the way the individual was treated. Sometimes the Governor was asked to apologise on behalf of the establishment, in others the recommendation was for the apology to be made by the member, or members, of staff concerned. Given the serious nature of the complaints, an apology is usually only a starting point for the establishment, designed to make amends and acknowledge the failing to the complainant before taking action to reduce the risk of the same things happening again in the future.

"I recommend that the Governor apologises to [the complainant] for the fact that incorrect control and restraint techniques were used to restrain him, that he was not appropriately debriefed after the incidents, and that no internal investigation was commissioned as a result of his complaint."

The investigation concluded that the use of control and restraint had been reasonable and proportionate in the circumstances but its application had not been well managed, with incorrect techniques used. The apology was one of

eight recommendations made, and some changes had already been implemented by the establishment. The report was copied to HM Chief Inspector of Prisons to enable him to keep the use of force at the establishment under review.

3.1.4 Use of force

Using force on a prisoner must be justified and accord with prescribed conditions: that it is reasonable in the circumstances, it is necessary, no more force is used than needed, and it is proportionate to the seriousness of the circumstances. In a secure environment such as a prison, YOI, or immigration centre this will normally mean force is only appropriate when required to prevent someone harming staff, another detainee, or themselves. Even when force is used justifiably and the correct techniques used – control and restraint – it is likely to be extremely distressing to the individual and they may well ask for it to be investigated as a possible assault. It is, therefore, an important function of the Ombudsman in such cases to assess whether force was appropriate in all the circumstances, and that this was fully evidenced and documented.

When complaints that force has been used inappropriately were upheld, the recommendations tended to focus on improvements in use of de-escalation, documentation of the incidents, and the appropriate internal investigation. In cases involving young people and children there are additional requirements so recommendations also consider whether staff effectively talked through the incident with the child (known as a debrief), and the effectiveness of the YOI's child protection and safeguarding processes. The recommendations in the case below are representative of many cases about use of force incidents:

"The Governor satisfies himself that procedures are in place to ensure that:

- *Trainees are always debriefed by the Duty Manager or another appropriate person after the use of force and that a record of this discussion is placed on the trainee's file.*

- *The Safeguards Manager always carries out an investigation into whether the force used was appropriate, carried out correctly by staff, whether any injuries were sustained and whether the trainee wishes to make a complaint, and always considers whether there are any Child Protection issues or if further investigation is required.*
- *Where a complaint is made, the YOI always carries out an internal investigation and is not absolved of the need to do so because the police and social services decide not to take any further action."*

In cases about adults, child protection issues do not arise but there are still requirements for the establishment to investigate whether the force was appropriate and carried out correctly. One stage of this is to ensure that use of force is avoided wherever possible by attempting to diffuse tense or threatening situations at the outset.

"The Governor reminds staff that they must record what de-escalation techniques have been used."

Where force is used, it must be documented and investigated fully:

"The Governor issues a Notice to Staff reminding them that Annex A Use of Force Statements must provide a full and accurate account of events, including any problems encountered."

"The Governor reminds managers that internal investigations into use of force incidents must be challenging and robust and consider whether the use of force was reasonable, necessary and proportionate."

CCTV can be extremely important in establishing the exact sequence of events, particularly as incidents leading to use of force can take place very quickly. Even where available footage does not directly show the incident, it should be retained,

particularly if the individual has complained and there are ongoing investigations:

"In cases where a prisoner makes a serious allegation of assault, any CCTV footage of the C&R is immediately retained for a period of three months whether or not it directly shows the alleged incident."

3.2 Cases without recommendations

A little over a third of upheld complaints led to formal recommendations being made (table 2.1). As can be seen in figure 3.1 at the beginning of this chapter, recommendations were more common in some types of complaints than others. The two largest categories of complaint, property and adjudications, demonstrate this. Most upheld adjudications complaints led to recommendations being made (80%), whereas this happened in around a quarter of property cases (24%). This section looks more closely at property complaints to explore the cases without recommendations.

Upheld complaints are categorised in three ways: upheld, upheld with a mediated settlement, and partially upheld. Upheld cases are where the investigation finds in favour of the complainant and usually a solution is proposed in the report. In mediated cases this solution has been reached by agreement between the complainant and the service or establishment, with the PPO acting as the third party to help negotiate the resolution. Complaints are partially upheld when the investigation finds in favour of the complainant in some respects but not in all. In cases where recommendations were made, 85 per cent were upheld and 15 per cent partially upheld. By contrast, the majority of cases where no recommendations were made were resolved by mediation (61%). These tend to have the same outcomes as the cases which are upheld with recommendations. For example that compensation is paid for missing or damaged items, and wrongly confiscated or mislaid items returned.

In a quarter of cases without recommendations, the complaint was upheld. In these cases, the

Ombudsman found in favour of the complainant, however no recommendations were made largely because there had already been action taken by staff to resolve the issue. This negated the need for the Ombudsman to make any formal recommendations. For example, when Mr B's radio was stolen by another prisoner, it was found by staff and initially retained as evidence. He complained to the Ombudsman when it was not subsequently returned. The investigation found it had been placed in his stored property and the Ombudsman agreed that it should have been returned to Mr B personally but as this was done as a result of our enquiries during the investigation, no recommendation was needed. In other cases when enquiries have highlighted to Governors that an individual's property is missing or damaged, compensation has been arranged directly between the complainant and the establishment during the course of the PPO investigation. At other times, the PPO's suggestion of a reasonable amount of compensation is acted on before a formal recommendation is made.

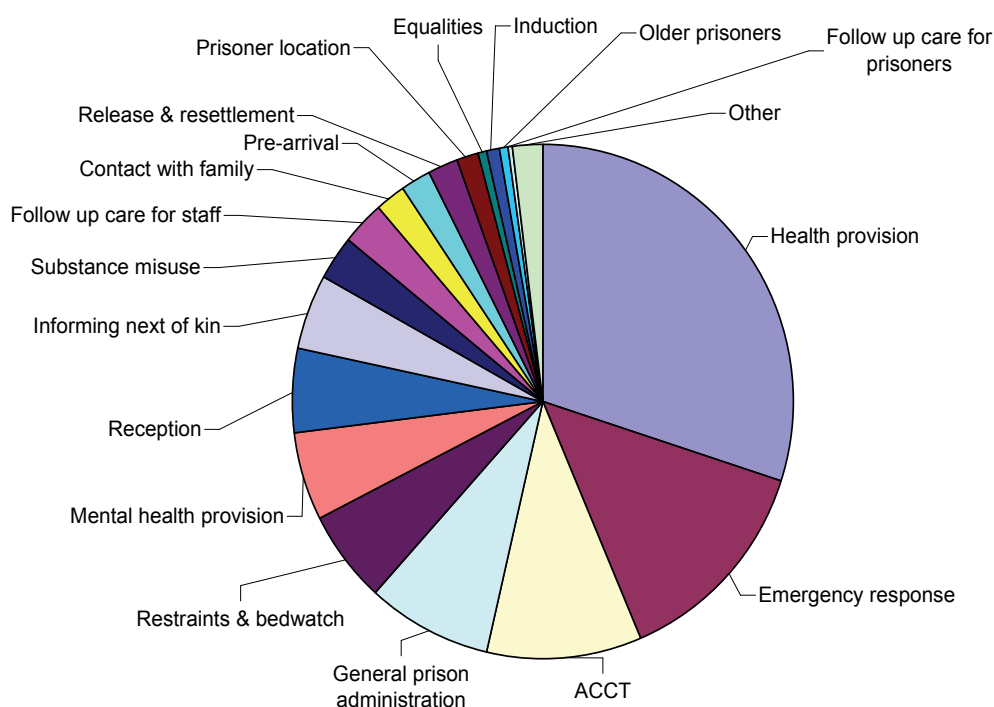
4. Fatal incidents

A single fatal incident investigation can raise issues across any aspect of prison life. Figure 4.1 shows the breakdown of the 1069 fatal incident recommendations by category. Unlike complaint recommendations, which have been categorised in the previous section by the nature of the complaint, fatal incident recommendations are categorised according to the area of practice targeted by the recommendation¹⁰.

The three largest categories - 'health provision', 'emergency response' and 'ACCT'¹¹ - together make up over half of all recommendations made after fatal incident investigations.

The database had 322 recommendations in the 'health provision' category. They highlight some of the major concerns following an investigation such as the reliability of medical records, administration and prescription of medication, the need to communicate medical information with others - such as wing staff and doctors in outside hospitals - and management of chronic diseases such as diabetes and epilepsy. As part of our internal learning from this work we are looking to change the health provision category and introduce several,

Figure 4.1: Fatal incident recommendations by category



more precise categories such as ‘palliative care provision’. The new categories will reflect recent changes to the structure of fatal incident investigation reports.

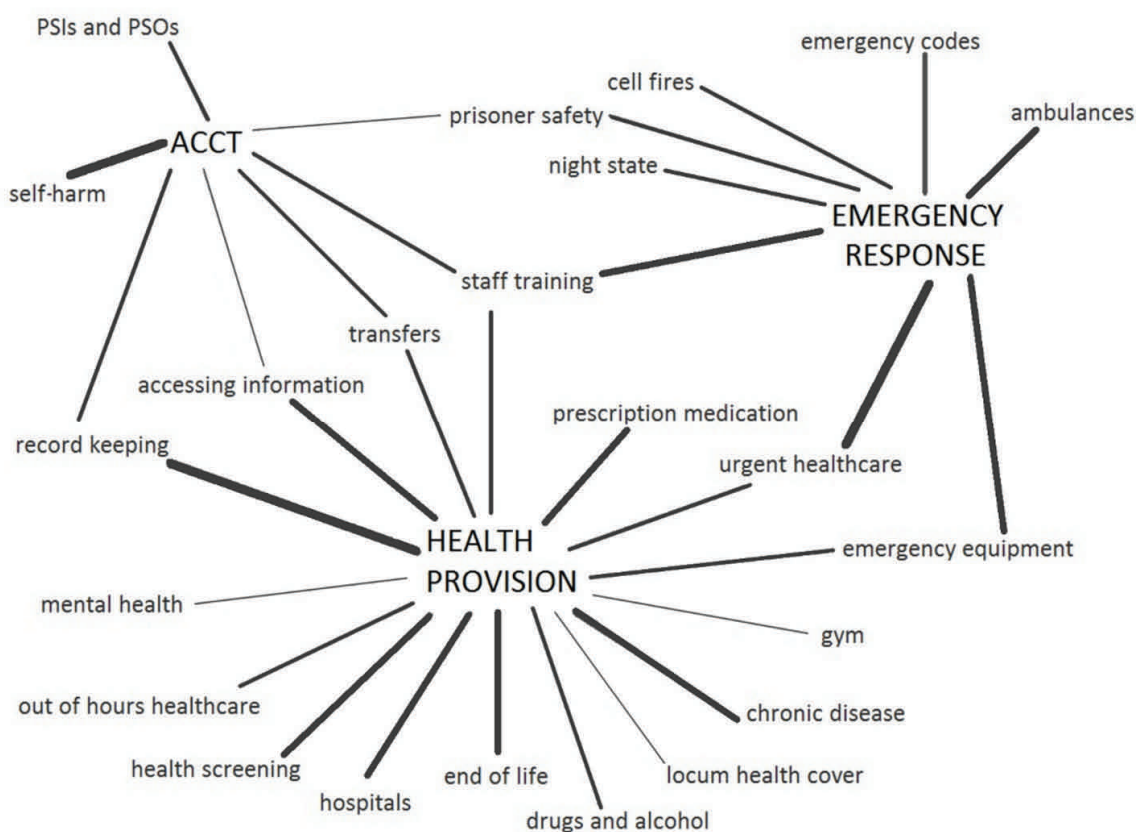
There were 143 recommendations in the ‘emergency response’ category. These included having appropriate contingency plans for medical emergencies, ensuring policies for resuscitation and responses to symptoms such as chest pain are in-line with normal practice in the NHS. Other common recommendations were to train more staff in basic life support techniques, and improve access to emergency equipment such as defibrillators, resuscitation mouth-shields, and smoke hoods¹². The Ombudsman works closely with HMI Prisons to ensure that inspectors are aware of his recommendations. This can highlight concerns about inaction. For example, following an inspection in one establishment, HMI Prisons noted: “that not all of the recommendations made in the Ombudsman’s report on deaths in custody have been addressed ... *In particular the recommendation that the emergency bag held in C/*

D wings should be replicated in other wing areas has not been met.”

There were 109 recommendations made in the ACCT category. Under ACCT the person is monitored more frequently and the frequency of such ‘observations’ is set depending on the perceived severity of risk to themselves. ACCT procedures are used in YOIs and in prisons. In immigration centres a very similar process - Assessment, Care in Detention and Teamwork (ACDT) - is used. Looking at ACCT recommendations particular concerns emerge about the integrity and storage of ACCT records, staff training to administer ACCT, correct implementation of ACCT processes (set out in Prison Service Instruction 64/2011), and the links to treatment of addiction or mental health issues.

Figure 4.2 shows the main kinds of recommendations made in these three categories. Thicker lines identify the most common themes in that category and the links also demonstrate that

Figure 4.2: Themes in ACCT, Health Provision and Emergency Response recommendations¹³



the categories do not exist in isolation. Many themes run across different types of investigation and categories of recommendation. The main thematic areas in fatal incident recommendations are explored in more detail in the next section.

The nature of recommendations made often differs according to whether the investigation concerns a death from natural causes, or one that was self-inflicted. The majority of natural cause deaths investigated by the Ombudsman, like natural deaths in the community, are from long term conditions such as cancers or heart diseases. In many cases, there will have been a significant period of medical intervention (diagnosis and

treatment) leading up to the death and this was reflected in the fact that 43% of recommendations in natural cause cases were about the provision of healthcare.

In self-inflicted death investigations, the biggest single category of recommendations was about ACCT (21%) and those about the emergency response to the incident (16%) the next most frequent. Figures 4.3 and 4.4 show the ten most common categories for recommendations following natural and self-inflicted deaths¹⁴. The remaining categories contained fewer than ten recommendations each and have been grouped.

Figure 4.3: Recommendations following natural cause deaths by category

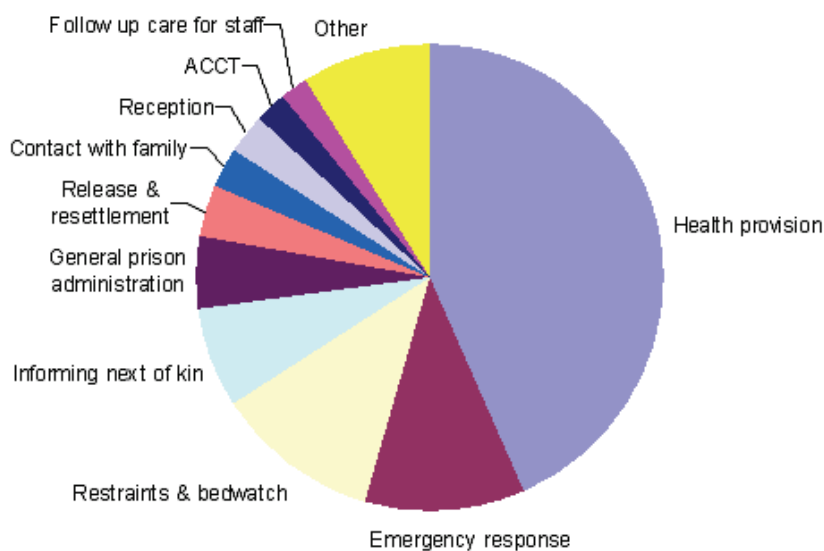
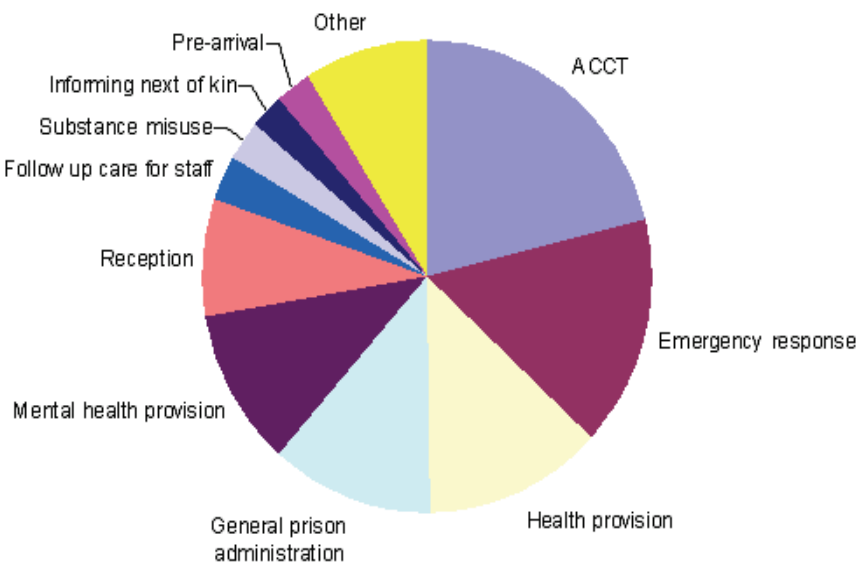


Figure 4.4: Recommendations following self-inflicted deaths by category



4.1 Themes

In the 1069 fatal incident recommendations a number of common themes emerged across the different categories of recommendations. These highlight overlapping areas where recommendations have been made most often. Although presented separately the themes are inter-related and overlapping, these relationships can be seen in the 'word cloud' chart of related themes at the beginning of each sub-section.

As this is the first piece of work specifically about recommendations it was decided to analyse recommendations from all fatal incident investigations together. Some themes, such as chronic diseases, are more relevant in natural cause deaths while others, such as self-harm, are more relevant to self-inflicted deaths. A comparative analysis of the differences in recommendations for foreseen natural deaths, unforeseen natural deaths, and self-inflicted deaths is something we hope to explore in future research.

4.1.1 Sharing and accessing information

Difficulties in accessing relevant information, or lack of communication with others, arise in many of the main categories of recommendations including healthcare provision, prison reception, and general prison administration. The word cloud (figure 4.5) shows sharing and accessing information is related to the other themes running across recommendations. Sharing information about

healthcare has to be done with particular care given medical confidentiality so it is perhaps expected to see the links to themes such as mental healthcare, management of chronic disease, hospitals, and prisoner safety.

One of the main issues related to both hospitals and health screening was the need for systems to communicate with doctors outside the prison. For example, the PPO recommendations stress that when a prisoner first arrives previous medical records from the community should be routinely requested. This is particularly important for people arriving with pre-existing chronic conditions.

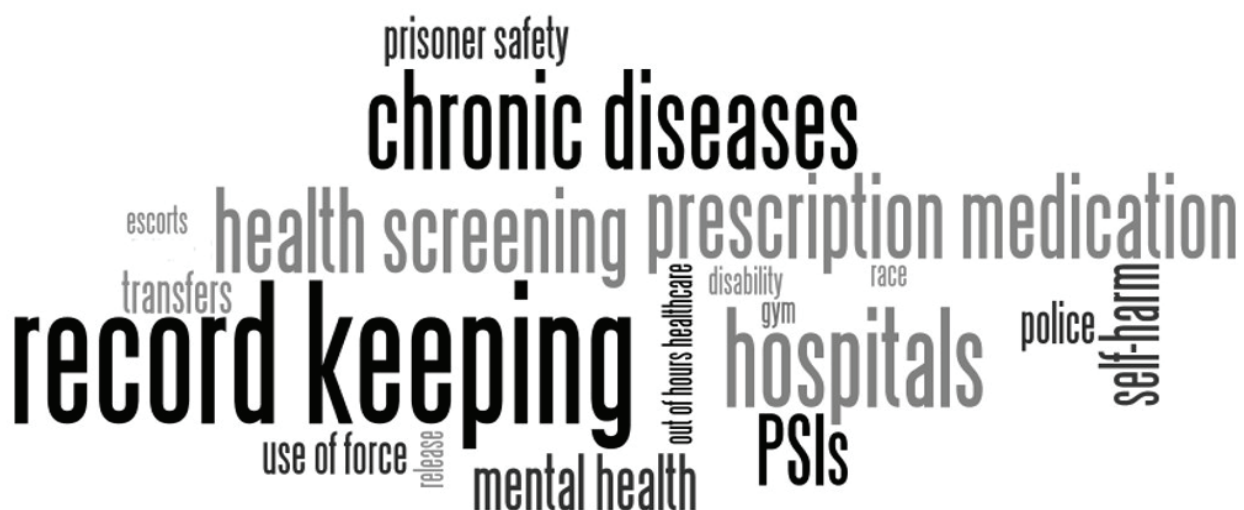
"The Head of Healthcare should ensure that healthcare staff request GP [General Practitioner] records within 24 hours of a prisoner's arrival."

Once received there also needs to be a process to ensure the information is accessed and effectively used:

"The Head of Healthcare should put in place a robust process to request and review past medical history from a prisoner's community GP."

Although most of the recommendations about this were accepted, the responses vary significantly. Some establishments responded that processes have been put in place to request past medical records as a matter of course. Others mentioned

Figure 4.5: Themes linked to sharing and accessing information



that while records will be requested, it is not always possible where people have not been registered with a GP or decline to provide the necessary contact details. A few establishments specified particular circumstances under which records will be sought:

“Where applicable this [requesting records following new receptions] was implemented for patients who had a community GP and the request is triggered by a GP or any practitioner where there appears to be gaps in the patient’s medical history.”

In one case, the recommendation to seek records routinely was rejected:

“We do seek clarification / confirmation from GPs in relation to prescription medication. Extensive medical records are requested on an individual basis for specific clinical decision making, but not for all patients, this would not be operationally viable.”

Such recommendations primarily focussed on the lines of communication with GPs in the community. Both prison and external healthcare records are now computerised, however it was a recurring theme that efficient and timely communication of results and records between healthcare providers is not always achieved. Where delays occur or information is simply not shared, this can lead to inconsistent or inadequate treatment:

“The Head of Healthcare should ensure that protocols are in place with the NHS locally to clarify lines of responsibility for [the prison], so that effective treatment and care of prisoners is maintained.”

“The Head of Healthcare should ensure that a robust, auditable system is adopted to draw to the attention of relevant clinicians all appropriate letters and other external documents, and that these are dated and their receipt recorded.”

Other communication difficulties often arise in

prisons, particularly when information held by the healthcare team is relevant to other staff.

“The Governor and the Head of Healthcare should ensure that a protocol is agreed to enable important medical information to be shared with prison officers to allow them to identify prisoners who might be at risk of deteriorating health.”

Several recommendations identified the need for staff to have the permissions and the skills to access records held on SystemOne (the computerised database for healthcare information). Several recommendations explicitly raise the issue of mental health staff not having access and as SystemOne holds the information about medical history and any current treatments this lack of access is a big concern. Unless mental health teams, healthcare and prison officers are able to share information, a full assessment of whether a prisoner is a risk to themselves or to others is not possible.

“The Governor and Head of Healthcare should review the management of medical records to ensure that all clinical staff, including the mental health team, have appropriate access to the SystemOne record system and that this is used as the primary record of all care.”

“The Head of Healthcare should ensure that Registered Mental Health Nurses working within [the prison] are given access to the electronic clinical recording system ... as a matter of priority. This will enable them to access the full mental health history to assist in making informed decisions about care planning and risk assessment.”

Some establishment action plans described the development of formal protocols with their local NHS to govern sharing of information, although given recent changes and the removal of Primary Care Trusts (PCTs) these protocols may now need to be re-visited. Others planned to set up internal processes to improve communication, such as a ten day follow-up if no information has been

received after hospital treatment or tests outside the establishment. One establishment referred to all their staff having subsequently had training on information governance and safeguarding which:

“protects the right of patients in relation to information given and shared”. Healthcare in prisons is expected to be of an equivalent standard to that given in the community so patient information should be available to different medical professionals to the same degree it is shared in the community.

Similar issues arise with other non-medical information, particularly when this needs to be available to more than one service or agency. For example, the Person Escort Record (PER) holds information on prisoners and detainees when they are transferred, this includes information about the risk they pose to others in the event of an escape and any known risk of self-harm.

“The Director should liaise with the Court Service to ensure the inclusion of appropriate risk information on prisoner documents, including supplementary warrants.”

“The Governor should ensure that person escort records (PERs) contain sufficiently detailed information about known risks.”

4.1.2 Chronic diseases

Chronic conditions are diseases of long duration and generally slow progression¹⁵ such as heart disease, diabetes and epilepsy. Recommendations about management of chronic disease tended to arise following investigations into deaths from natural causes. The majority (83%) were about health provision, the remainder focused on the prison reception process and on where the prisoner was located.

The word cloud (figure 4.6) shows how chronic disease was linked to other themes in the recommendations. As might be expected, recommendations about chronic diseases were also concerned with the provision of treatment and health services but also with record keeping to properly document treatment and the progression of the condition, and to ensuring staff have and share the information as needed. Staff training - both to improve record keeping and in the NHS procedures for managing chronic illness - was another recurring link.

One focus of the recommendations was on access to information during and following the reception process into prisons or immigration centres. Recommendations refer to the particular importance of ensuring previous (community) medical records are obtained for prisoners with chronic health conditions. The reception healthcare screening questionnaire must also be adequate to

Figure 4.6: Themes linked to chronic disease



identify details of the severity and management of any long term illnesses and it has also been recommended that a secondary screen by a GP be an automatic requirement for prisoners with chronic conditions.

“The Head of Healthcare should ensure that reception staff request community GP records for all new arrivals in prison, with particular priority for those who report a chronic disease or other significant condition in their medical history.”

In order to provide a standard of health service equivalent to that provided in the community, prisons and immigration centres need to manage chronic conditions in line with the relevant National Institute for Health and Care Excellence (NICE) guidelines and the NHS Quality Outcomes Framework. This should mean that those with complex or chronic health conditions have a coordinated single case management plan which is regularly reviewed and updated, and followed by all staff. Several recommendations reinforced the need to ensure repeat medications are reviewed every six months and that clinics for chronic conditions take place at least once a year.

“The Head of Healthcare should adopt a system of review for chronic medical conditions in line with the NHS Quality Outcomes Framework and ensure that the clinical team are aware of the full medical history of those with chronic health issues and review repeat medications every six months.”

“The Head of Healthcare should ensure that clinics for life long conditions are held annually, in line with NICE guidelines.”

Similar recommendations were made to a number of establishments but their action plans suggested considerable variation in how they intended to ensure that care for individuals with chronic conditions was in line with national best practice and was to be kept under review. Some establishments replied that they had updated their policies to manage such conditions and had ensured staff understand the requirements under

NICE and NHS guidelines. One prison’s action plan included establishing a regular meeting (at least monthly) between the Head of Custody, the Head of Residence and the PCT Practice Manager to discuss the specific requirements of prisoners with chronic illnesses. This included their clinical care and other related issues such as whether their condition impacted on their location in the prison; such as being on the ground floor for people whose condition causes mobility problems or, for conditions like epilepsy, whether it would be better for the person to be in a shared cell.

Findings from prison inspections suggest that implementation of action plans is variable. For instance in one case, HMI Prisons found that although: *“information from investigations by the Prisons and Probation Ombudsman was routinely discussed at the safer prisons meetings ... required actions were not always included in a continuous improvement plan”*¹⁶.

However, in a second case also involving recommendations for improved care for chronic conditions, the inspection team reported that the PPO recommendations following deaths from natural causes were regularly reviewed by the Head of Healthcare.

Although many of the recommendations made were about managing long term conditions in general, some refer specifically to a particular condition, most commonly diabetes. Managing diabetes in prison needs healthcare staff to know what to look for in those at risk and regularly monitor blood sugar (or ensure self-monitoring is recorded). One establishment ensured their diabetic link nurse received update training so they could then train other staff, and they also re-established their ‘Well Man’¹⁷ clinic to help identify and monitor those at risk of developing diabetes (and other conditions). Other establishments introduced ‘long term condition’ nurses specifically to help manage and monitor chronic conditions.

4.1.3 Hospital

Prisoners are often taken, under escort, to hospital

Figure 4.7: Themes linked to hospitals



both in the normal course of treatment or diagnosis, and as emergency cases either following a medical crisis or a suicide attempt. Not all the deaths investigated by the Ombudsman are unexpected; those who died of natural causes have often been ill for an extended period and have attended hospital on numerous occasions for diagnosis and treatment or palliative care¹⁸. Themes of end of life care, accessing and sharing information, and issues around contact with the prisoner's family all appear as related to hospital care in figure 4.7.

Recommendations about attending hospitals have often been about escort arrangements and use of restraints. Most of these recommendations reminded establishments of the need to balance humanity and security when assessing the risk an individual poses to others in their current state of health, and using this to guide any use of handcuffs or escorts chains. They focussed on the need to include medical opinion of the individual's state of health, the impact this has on risk and their ability to escape, and to review both the risk assessment and use of restraints in light of any changes in the prisoner's health or location. Recommendations about improving the risk assessment for restraints were made to a significant number of establishments following natural cause deaths, sometimes in more than one case at the same prison. Guidance has now been included in a recent Learning Lessons Bulletin¹⁹, published by the PPO with the aim of improving practice across all prisons and reducing the need to repeat such

recommendations in future.

One establishment's action plan detailed how they had updated the risk assessment form to require an individual health assessment. Implementing this recommendation for most establishments would mean a change in emphasis in the assessment, giving more weight to limitations posed by an individual's current state of health, and reinforcing this message to staff. Redesigning the form on which the assessment is completed may help to embed this change but staff also need to be supported in ensuring an appropriate balance between a prisoner's state of health and their security risk. In an inspection at a prison criticised in a PPO report, HMI Prisons inspectors reported that: "it was suspected that restraints were still used for men who were out at external hospital at end of life/very frail" although without recorded statistics and monitoring this was very difficult to verify.

Other issues relating to escort arrangements include missed appointments due to there being no available staff to provide an escort²⁰. Not only are missed appointments disruptive for the individual and the NHS but, for diseases such as cancer and heart disease, the speed of diagnosis and treatment can be critical and the difference between life and death in some cases:

"The Head of Healthcare should ensure an appropriate and clinically informed approach to

prioritising external medical appointments in the event of insufficient escort staff for all appointments.”

“The Head of Healthcare should monitor the number of cancelled and missed hospital appointments and put in place a system to reduce these should any pattern be identified.”

4.1.4 Mental health

In many ways recommendations about mental health treatment mirror those about the treatment of physical conditions: related themes (figure 4.8) include the need for clear and comprehensive record keeping, effective communication with others involved in the individual’s care, and ensuring staff have the knowledge and ability to access the information they require.

There is a strong emphasis in the recommendations on ensuring referrals for mental health assessment or treatment are made promptly, particularly in circumstances such as where an individual is self-harming or has a known history of domestic violence. A second aspect, sometimes explained by resource constraints faced by mental health teams, relates to recommendations where referrals were made but were not followed-up promptly.

“The Head of Healthcare should ensure that all mental health referrals are followed-up within a timely manner, to ensure prisoners receive effective

care.”

“The Head of Healthcare should ensure that the referral process and priorities for mental health assessments are clear and fully understood by healthcare staff, and that referrals are appropriately monitored.”

This second recommendation led to the establishment changing its referral and management system for mental health services. The action plan explained that Registered Mental Health Nurses (RMNs) had since taken over case management and a new clinical lead for mental health had been appointed. RMNs were placed in the establishment’s reception to ensure identification of mental health information and improved screening of prisoners for mental health issues.

4.1.5 Drugs, alcohol and withdrawal

The process of detoxification from drugs or alcohol places both physical and emotional stresses on the individuals concerned. Addicted prisoners are referred to the Integrated Drug Treatment System (IDTS) which is managed by specialist healthcare staff. In many establishments there are specific wings set aside for IDTS prisoners. Issues around drugs and alcohol are closely interlinked with other themes (figure 4.9), particularly healthcare, prisoner safety and self-harm.

Figure 4.8: Themes linked to mental health



Figure 4.9: Themes linked to drugs and alcohol



The process of withdrawal places people at greater risk of suicide and self-harm. A significant proportion of the recommendations in this area were that staff should be made aware of this and monitor the risk.

“The Head of Healthcare should ensure that all prisoners referred for an alcohol detoxification assessment receive prompt and supportive treatment, backed up by regular monitoring, in line with IDTS policies and procedures.”

Recommendations also highlighted the need for close working between healthcare, mental health or counselling services, and IDTS teams. Multidisciplinary working is needed to manage both the increased risk of self-harm and to avoid harmful interactions between medications to help with detoxification and those prescribed for other conditions. In addition, all prescriptions, from whichever service, need to be recorded on the SystemOne computerised recording system and appropriate information must be accessible to different teams.

“The Head of Healthcare and Governor should undertake an immediate formal review of the clinical protocols, policies and compacts relating to IDTS and ensure that a full multidisciplinary approach to the service is established.”

In this particular case, the prison action plan

detailed a lot of work to address the recommendation. At the time of the PPO investigation, locum GPs had been running the IDTS program. Since then, a permanent GP and a clinical lead had been appointed to IDTS. The other IDTS staff had previously been employed through an agency but all were now directly employed by the prison. A new audit process for IDTS was also implemented and work was undertaken to improve communication between healthcare, the Counselling, Assessment, Referral, Advice and Throughcare workers (CARATS)²¹, and wing staff at the establishment. The establishment reported that they had since: *“been recognised by PCT Commissioners as leading the way with reduction of prisoners to detox”*.

There are particular health risks associated with drug maintenance or detoxification treatments using methadone. Governors and Heads of Healthcare were asked to ensure their staff are aware of the symptoms of toxicity, and also to ensure patients are aware that non-compliance with the prescription (or mixing methadone with other drugs) can be fatal.

“The Director should ensure that prisoners on methadone maintenance and detoxification regimes who report unwell are checked regularly and that staff understand the common symptoms of drug-induced unconsciousness and drug intoxication and know how to respond.”

Figure 4.10: Themes linked to self-harm



4.1.6 Self-harm

Recommendations about self-harm were linked to themes of good record keeping, mental health and prisoner safety. PSIs²² appears prominently in the cloud (figure 4.10) because recommendations are focused on the correct use ACCT procedures such as what is required when opening an ACCT, monitoring the individual (known as observations), the requirements for ACCT case reviews, and closure of the ACCT. The procedures for ACCT are set out in PSI 64/2011.

Recommendations mostly focussed on the stages of the ACCT process and the guidance in the PSI for each step. Firstly recommendations look at when an ACCT should be opened:

“The Governor should ensure that an ACCT is opened whenever a prisoner has recently self-harmed or expressed suicidal intent.”

Once an ACCT is open there are a series of processes and reviews that must be undertaken correctly:

“The Governor should ensure that ACCT observations are of sufficient frequency and at unpredictable times, and that staff actively engage with prisoners at risk.”

“The Governor should ensure that the frequency of ACCT conversations and observations take into account all relevant risk factors.”

Reviewing the ACCT:

“The Governor and the Head of Healthcare should ensure that all staff are familiar with and follow ACCT guidance. In particular case reviews should be multi-disciplinary, ACCTs should not be closed unless all the goals of caremaps have been achieved and the document should be completed correctly.”

Finally, when the prisoner is at a sufficiently low level of risk, the ACCT can be closed:

“The Governor should ensure that staff conduct ACCT case reviews and post-closure reviews in accordance with national policy and guidelines.”

Recommendations also focus on the need to review ACCTs or reassess risk of self-harm at key points in a prisoner's time in custody. In particular, staff must pay careful attention to continuous care if prisoners on open ACCTs need to be transferred. People who have had a change of status, such as being sentenced or returning from court, should also have their risk of suicide and self-harm assessed.

“The Governor should ensure that case reviews are held within 24 hours for prisoners arriving [at the establishment] on open ACCTs.”

“The Governor should ensure that ACCT documents accompany all transferring prisoners.”

“The Governor and Head of Healthcare should ensure that all prisoners returning to the prison after events which could involve a change in status, including court appearances and being questioned by the police, should be assessed for potential health or suicide and self-harm issues.”

As the recommendations so closely follow the national policy instructions, one of the most common responses from establishments was that they will issue guidance or training to their staff on these matters. One action plan said:

“All relevant managers will be detailed to attend the ACCT Case Manager Training if they have not attended during the last 12 months. A Notice to Staff will be published to remind all staff that if a prisoner transferred into the establishment on an ACCT document, a case review must be convened on their arrival.”

One prison responded that a local ACCT support

aid had been produced with all the relevant requirements set out clearly for staff who act as ACCT case managers. Several establishments' action plans showed new management checks in response to ACCT recommendations including one which implemented a new audit of their Safer Custody work, while another established monthly checks on the documentation of ACCTs closed the previous month.

4.1.7 Prisoners' families

Recommendations often focussed on liaison with prisoners' families. Most often this is to provide support to the family following a death and, mostly in natural cause deaths, during the final stages of illness as well. Where a prisoner experiences a serious illness, assuming they and their family consent, the family should be kept informed and involved from an earlier stage. A separate aspect of liaison with families is when the family wishes to communicate information about a risk of self-harm to the prison; recommendations in this area tend to focus on how effectively prisons use and share such information. The word cloud (figure 4.11) shows these links, with families being connected to other themes such as end of life care, self-harm and safety.

Family liaison officers or another appropriate member of staff should be appointed as a clear

Figure 4.11: Themes linked to families



point of contact when a prisoner is diagnosed as seriously ill or having a terminal condition. This requires a co-ordinated approach with input from medical staff to advise on the nature and severity of their condition.

“We recommend that the Governor extends the family liaison officer role to include offering advice and support to the families of prisoners who are seriously ill and in outside hospital.”

“The Director should ensure that a family liaison officer is appointed when a prisoner is assessed as seriously ill and that appropriate and timely arrangements are made for early contact with families.”

The recommendations also highlighted that, in a number of cases, the next of kin details were missing or inaccurate. Sometimes, where people had refused or been unable to provide the details, such omissions have been unavoidable. However, the PPO recommends that in addition to requesting these on reception to the establishment, the details should be reviewed annually and especially when a prisoner is admitted to hospital. Several establishments have responded that annual reviews and audits have been put in place to ensure this information is as complete and accurate as possible.

“The Governor should ensure that details of next of kin and others to be contacted in an emergency should be held for every prisoner so that they can be informed of a prisoner’s serious illness or death as soon as possible.”

Liaison with families is often a particular issue in natural cause deaths, especially if there has been a long illness where there are greater risks of a breakdown or misunderstanding in communications between establishments, the individual and their family.

Recommendations were also made to establishments after both natural and self-inflicted deaths that families should be informed promptly.

Wherever possible this should be face-to-face by a member of staff from the prison.

“The Director should make every effort to ensure that the news of a prisoner’s death is given to the next of kin promptly and in person by someone from the prison. When this is impractical, staff from a nearby prison should be used and failing that, the police.”

Investigations into some self-inflicted deaths also found that, when families have communicated concerns to the establishment, this risk information was not always shared or acted on sufficiently. Following such recommendations, action plans from several establishments suggested that guidance for staff on what action to take in these situations has been developed, or redrafted, and circulated.

“The Governor should ensure that telephone calls from families expressing concern about the wellbeing of a prisoner are noted and logged and dealt with appropriately.”

5. Rejected recommendations

The database of 1603 recommendations contained 42 which had been rejected by the services investigated. These occurred in 34 fatal incident investigations and one complaint investigation (about a 'work and pay' issue). In two fatal incidents investigations three recommendations were rejected, in three two were rejected, and in the others only one was rejected. Overall, however, only a very small proportion of recommendations are rejected (four per cent of fatal incident and less than one per cent of complaint recommendations). Nevertheless, we do not expect to see any rejections as recommendations are not made lightly, are based on evidence from PPO investigations, and are intended to help establishments learn lessons for the future.

5.1 Themes

Overall, 14 recommendations about health provision were rejected (table 5.1), however given that this is the largest category for fatal incidents recommendations it does not seem a disproportionate amount. One or two recommendations have been rejected more than once but, overall, the matters they concern are very varied. The reasons given for the rejection of the recommendations which are explored below.

5.1.1 Insufficient resources

A number of the responses made reference to a

lack of available resource to implement the action. As financial pressures on prisons and healthcare commissioners increase, rejections of recommendations that have cost implications might also be expected to increase.

After the death of a young adult it was recommended that the YOI should have qualified family support workers to help the young people maintain contact with their families. This was rejected as the establishment said they would be unable to fund such a post. The establishment proposed an alternative for this support to be provided by a combination of personal officers, the chaplaincy, the Offender Management Unit (OMU) and a named charity working in the establishment.

The UK Border Agency²³ also cited resource constraints when they rejected a recommendation that all immigration removal centres should use electronic medical records but added that they recognised it was desirable and, as the NHS was taking over commissioning these health services, it might become a possibility in due course.

5.1.2 Outside the prison's remit

A small number of recommendations were rejected because the establishment felt the action was not within their remit (or sometimes not within their power to achieve). One such recommendation was

Table 5.1: Rejected recommendations by category

Category	Number rejected	Number accepted or partially accepted	Unknown & awaiting response	Percent rejected
Health provision	14	305	3	4%
Emergency response	5	135	3	3%
Informing next of kin	4	45	2	8%
Release and resettlement	3	16	1	15%
Restraints and bedwatch	3	59	2	5%
ACCT	2	101	6	2%
Follow-up care for staff	2	25	0	7%
Mental health provision	2	56	0	3%
Contact with family	1	21	0	5%
General prison administration	1	81	1	1%
IEP	1	0	0	~
Pre-arrival	1	18	1	5%
Prisoner location	1	13	0	7%
Substance misuse	1	31	0	3%
Work and pay (Complaint)	1	32	13	2%

that GPs working in the establishment should also be working in the community to ensure that they remain aware of developments in practice. The prison commented that GPs were working in the community but to enforce this was not within their power as healthcare was contracted out to a private provider whose responsibility it was to provide appropriately skilled medical staff.

In another case, it was recommended that the prison put in place protocols with local police to ensure records of medical treatment given in police custody were shared. The establishment rejected this recommendation as they received prisoners from police forces across the country, not only the local police.

5.1.3 Already existing practice

Sometimes recommendations were rejected because the establishment felt their actions and processes already achieved the outcome intended by the recommendation. For example, the following recommendation was rejected:

“The Director should ensure that use of restraints for prisoners being taken to hospital are fully justified by a risk assessment and take into account and record how the prisoner’s health and physical condition impact on his risk while outside the prison.”

The establishment responded that the officer had discussed with the paramedic whether the restraints were appropriate ‘in medical terms’ and the Director of the establishment felt the judgement on whether restraints were used was: “reasonable and appropriate”. In effect, the substance of the recommendation was not rejected but the response highlighted a difference of opinion as to whether this had been met in that particular case. However, the recommendation would not have been made if the risk assessment was felt by the investigation to have been adequate and had evidenced an appropriate use of restraints.

Similarly, another case led to a recommendation that “sufficient” frontline staff be trained in first aid

and basic life support. This was rejected because the establishment felt sufficient staff were already trained, although the recommendation had been made because the investigation had identified that this appears not to have been the case.

5.1.4 Interpretation of national instructions

Recommendations are also rejected when policies and guidance, for example contained in PSIs and PSOs, are interpreted differently. A hot de-brief is held with staff after every death in custody and an investigation led to a recommendation that, according to the PSI, all the staff involved should be invited to attend. The establishment’s response was that their local contingency plans reflect national instructions’ and that all staff involved in the 12 hours leading to the death had been invited.

The sole complaint recommendation rejected was also rejected on the basis of national instructions, but this was because national instructions had changed. The PPO recommended that all evidence collected in the course of an internal investigation into a prisoner’s complaint be retained, as some of it was unavailable when the PPO came to investigate. However, the recommendation was based on PSO 2510 which was replaced by PSI 2/2012 and which did not contain the same requirement.

5.1.5 Rejecting the substance of a recommendation

In one case the recommendation was rejected because the establishment felt the outcome intended by the recommendation was inappropriate. The recommendation was:

“The Head of Healthcare should conduct an audit of instances when medicines are found to be unavailable from the pharmacy and take action to remedy this.”

This was rejected because: “it is inevitable that [the] pharmacy are unable to hold every drug item within the British National Formulary (BNF)”. The response went on to state that drugs would normally be available within 24 hours. The Clinical

Reviewer²⁴ agreed that to hold the whole BNF is unrealistic but said she: *“would expect the pharmacy to maintain stocks of those drugs being prescribed routinely for particular prisoners”*, which had been the issue in the investigation.

5.2 Accepted?

Following the introduction of the SMARTER guidelines, recommendations should be outcome focused, specifying the expected outcome for the establishment to achieve by implementing changes to practice or processes. The plan for the implementation of the recommendation is set out in the establishment’s action plan which is copied to the PPO. The action plan is specific to each individual case so establishments may have more than one plan to deliver at once, although most establishments have a master action plan distilling recommendations from all the investigative and regulatory bodies with which they deal.

Sometimes action plans show that a recommendation has been accepted but the response indicates that the establishment intends to take no further action. Sometimes this is because changes have already taken place that secure the outcome specified in a recommendation. For example, the following recommendation:

“The Head of Healthcare must ensure that prisoners’ medical records are properly maintained”,

led to this response:

“Since this period of time, all medical records are held on SystmOne, therefore there is one single continuous record for each patient.”

However, it was not always clear from action plans whether the response is explaining changes which have subsequently been made or whether the response is stating the policies and processes that were in place at the time of the death with the implication that these were sufficient. The latter would be more appropriate to be marked as a

rejection of the recommendation if the establishment was maintaining that the desired outcome had already been achieved. For example, the recommendation that:

“The Head of Healthcare should ensure that all mental health referrals are followed-up [in] a timely manner, to ensure prisoners receive effective care.”

was returned to the PPO as accepted while the response on the action plan said:

“The Head of Healthcare agrees with the recommendation, however, processes are already in place and have been since [before the death].”

Occasionally the response to an ‘accepted’ recommendation reads more as a reason why the recommendation will not be acted upon. For example, it appears the following recommendation would more properly be marked as ‘rejected’ as the establishment response disputes the relevance of the recommendation to the case:

“The Governor and Head of Healthcare should ensure that healthcare staff are appropriately selected, supported and trained to work in a prison setting and demonstrate appropriate levels of professional care which ensure that the needs of their patients are always put first.”

The response:

“All healthcare staff are recruited via the established NHS Code of Practice that includes a vigorous selection and checking procedure. There is little corroborative evidence in either the Clinical Review or the PPO report and its appendices to indicate that issues relating to recruitment and training substantially contributed to this case.”

When the PPO receives rejections, or accepted recommendations where the response actually indicates rejection, and where the actions proposed appear inadequate, the National Offender Management Service will usually be asked to

further consider its response. If necessary, this can be escalated by the PPO to senior managers in the service concerned. Responses to recommendations are also included in the anonymised versions of fatal incident reports which are public documents, available online.

6. Commendations

Investigations do not just focus on areas for improvement; they uncover examples of commendable actions by staff, other prisoners and establishments. Currently the database holds 13 examples of commendation; however we are aware that this is not a complete record and this is an area for future development.

The main theme in the examples was a focus on supporting people receiving palliative care. This reflects a recent PPO publication which found that end of life care in prisons was an area of improving practice and often equivalent to care provided in the community:

“We consider that the placement of a folder containing Mr D’s ‘Do not resuscitate’ form and a list of his clinical diagnoses and medications on the wing and in the gate was an example of good practice. This ensured that wing staff and hospital staff were fully aware of his wishes about resuscitation.”

“We make one commendation in this report. The Senior Officer acted diligently and sympathetically with Mr E and his family, and went out of his way to enable the family to visit.”

7. Learning from PPO recommendations

Looking over a year's worth of recommendations it becomes clear from the way in which very similar recommendations are made that there are often important learning points from investigations that apply much more widely than just to one particular case or in one specific place. In addition, to support improvement in establishments the PPO needs to continue to strive towards consistent, SMARTER recommendations which use precise language to detail specific, measurable outcomes.

This report was designed to help services understand some of the more common issues arising from PPO investigations and, where relevant, take action pre-emptively. The themes highlighted in the report are those felt to have widest resonance across the estate. In our investigations, our recommendations and our research we will continue to work to encourage the learning of lessons and support improvements. During investigations, through the action plans and in liaison with colleagues in HMI Prisons, we will also monitor progress in addressing the issues identified in investigations so that there is assurance that improvements are made, sustained and future investigations do not have to repeat the same recommendations.

We will continue to maintain and develop the recommendations database so that it provides an important resource for investigators and those investigated, and publish further comparative analyses of recommendations from the different types of investigation and changes over time. The hope is for it to become a key tool in supporting the learning of lessons and in contributing to fairer safer custody.

Endnotes

1. Formerly known as bail hostels.
2. PPO Terms of Reference 2009. Online http://www.ppo.gov.uk/docs/tor_june_2009.pdf
3. Reproduced from PPO Terms of Reference 2009. Online http://www.ppo.gov.uk/docs/tor_june_2009.pdf
4. A recommendation for formal appraisal can be made when a member of staff has a) performed duties above and beyond those expected in their role and b) has not already been appraised for doing so.
5. Adjudications are the internal disciplinary hearings conducted in prisons.
6. Complaints about probation can be received both from those under supervision in the community and from prisons where probation Offender Managers work with prisoners during their sentence.
7. On the chart IEP stands for Incentives and Earned Privileges, a system to promote and reward good behaviour. HDC for Home Detention Curfew, this is the electronic tagging system used to aid supervision of some prisoners who are released before the end of their sentence. There were also 22 complaints upheld in the 'miscellaneous' category. This category has not been included on the chart because it is no longer in use. Cases and recommendations when the complaint was rejected are not included on this chart.
8. Prisoners are required to be given the opportunity to exercise; this entitlement is normally referred to as 'statutory gym'. Further access to the gym over this level may be suspended as a punishment. Extra gym access is often offered as an incentive for good behaviour under the Incentives and Earned Privileges (IEP) schemes in prisons.
9. The system for complaints in prisons has two stages. If the complainant is not satisfied with the first response they can appeal and the second response should be from a more senior member of staff. (PSI 02/2012).
10. The 'other' category contains recommendations about purposeful activity, segregation, anti-social behaviour or bullying, foreign national prisoners, legal issues, use of force, adjudications, and Incentives and Earned Privileges (IEP). These were grouped because each individually contained fewer than five recommendations.
11. ACCT stands for Assessment, Care in Custody & Teamwork. This is the process used for individuals who have self-harmed or are at risk of self-harm and suicide.
12. A smoke hood is a protective device similar in concept to a gas mask used to protect against smoke inhalation when tackling emergencies such as a cell fire. They are not equivalent to the equipment used by fire-fighters and are more appropriate for small fires or escape/evacuation.
13. PSI stands for Prison Service Instruction. There are a number of rules, regulations and guidelines by which all prisons are run. These are outlined in Prison Service Instructions (PSIs) and Prison Service Orders (PSOs). From August 2009, all Prison Service operating instructions are published

as PSIs

14. 'General Prison Administration' covers a wide range of issues related to the day to day running of the prison such as the procedures for unlocking prisoners, or prisoner's contact with personal officers assigned to them.
15. World Health Organisation definition (http://www.who.int/topics/chronic_diseases/en/).
16. HMI Prisons feedback to the PPO can sometimes highlight action taken on individual recommendations but more commonly the response gives an insight into the prison's approach to action planning and implementation of the recommendations in general.
17. Well Man clinics offer a range of health checks for men including checks on blood pressure and cholestrol. Some GP surgeries in the community offer this service, as do private clinics. They are not intended to be a replacement for seeing a GP for those who feel ill or need medical advice.
18. Detailed examination of the lessons from providing end of life care to prisoners and detainees has been published separately in "Learning from PPO investigations: End of life care (March 2013)".
19. A fuller discussion of the lessons that can be learned about risk assessment and use of restraints for seriously ill and dying prisoners is in "Learning lessons bulletin: Fatal incidents investigations issue 2 (February 2013)".
20. Typically two members of staff will escort prisoners, although in some cases this is reduced or increased depending on the risk of escape and of harm to others that the prisoner is judged to present.
21. Counselling, Assessment, Referral, Advice and Throughcare services (CARATs) teams provide interventions and services for prisoners with drug and alcohol problems.
22. Op. cit. (13)
23. Now subsumed by the Home Office.
24. Following a death the Clinical Reviewer is appointed by the NHS in the area where the establishment is located (previously the local PCT). They are a medical specialist, independent of the establishment under scrutiny, who works with the PPO investigator providing insight into the clinical care given in each case. In particular the clinical reviewer is in the best position to judge whether the care is equivalent to that provided in the community.

**For further information on this paper and other PPO research,
please contact:**

Helen Stacey, Research Officer

Helen.stacey@ppo.gsi.gov.uk or 020 7035 2323

All publications available online at www.ppo.gov.uk

Please e-mail PPOComms@ppo.gsi.gov.uk to join our mailing list.

©Crown copyright 2013

www.ppo.gov.uk