

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

**PART 2 - GUIDANCE FOR CLINICAL
REVIEWERS**

Updated September 2014

1. INTRODUCTION

You have been commissioned by the NHS Area Team (or equivalent body) to carry out or lead a clinical review relating to the death of a person in the custody (or released on temporary licence) of a:

- **Prison**
- **Young Offender Institution**
- **Secure Training Centre**
- **Immigration Reception or Removal Centre**
- **Court premises (when the deceased has been remanded or sentenced into custody)**
- **Approved premises**

This review forms part of the Prisons and Probation Ombudsman's (PPO) investigation into the circumstances surrounding the death. The PPO is remitted to investigate all deaths that occur in the above listed premises.

The commissioning Area Team (or equivalent) will have provided you with contact details of the PPO investigator in this case. You will need to make early contact to agree the parameters of the investigation and what, if any, interviews need to be carried out.

It is important that the clinical reviewer and PPO investigator work in partnership to ensure a proportionate but full investigation of the circumstances surrounding the death.

The clinical reviewer should inform the Area Team within 72 hours of being commissioned if there are any immediate concerns regarding the healthcare provided.

Prior to the review commencing the reviewer and the PPO investigator will have agreed on a level 1, 2 or 3 review, and this will be agreed by the commissioning Area Team:

- **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.

In the case of a foreseeable death, the PPO investigator will also decide whether this will be an issues led investigation, in which case the clinical review will need to use the issue based template (Annex A).

This document has been prepared to provide a consistent and clear approach to the review and subsequent report, including clear timescales and quality assurance.

2. AIMS OF THE CLINICAL REVIEW

The aim of the review is to consider the clinical care the deceased received while in prison custody.

An approach of **how** and **why** should be adopted. Not who was to blame. The following key questions should be covered:

- How and when did the prisoner die?
- Is there any root cause(s) of the death?
- Was the clinical care equivalent to what might have been expected in the wider community?
- Are there any learning opportunities?
- Were local and national policies and procedures (both prison and NHS) followed?
- Is there an opportunity to prevent future deaths in similar circumstances?
- Are there any examples of good practice?

The review should:

- Examine the provision of clinical care and treatment, including risk assessment and risk management.
- Examine any secondary care provided (to the extent necessary for the review)
- Provide a chronology of the health and social care events leading up to the incident.
- Identify any care or service delivery failures along with the factors that contributed to these problems.
- Examine policy and practice.
- Identify any root causes(s) that inform the identification of learning opportunities.
- Make timely, clear and sustainable recommendations for the health community and service.
- Provide explanations and insight for the relatives of the deceased.

Information available to support the clinical review

This is not an exhaustive list, but provides some guidance:

- PSI 64/2011 Safer Custody (which also includes the follow up to deaths in custody (PSO 2710) provides more information about the types of records a prisoner may have.
- Clinical prison health care record
- Prison records (including ACCT documents if relevant)
- Police and prison statements
- GP records
- Acute NHS trust records
- Mental health Trust records
- Post-mortem results and toxicology
- Local policies and procedures (both prison and NHS)
- Prison Service standards

For the purpose of investigations the PPO has unfettered access to information, documents, establishments and individuals, including material and information

provided to the services (in remit) by other organisations. This includes the prison's clinical records (both paper and electronic). The relevant NHS Area team will arrange for the prison healthcare records to be provided to the clinical reviewer. The PPO investigator will arrange for copies of any other relevant service held records to be made available to the clinical reviewer.

NHS records outside of the prison context should be obtained by the Area Team (or equivalent body).

Interviewing staff and prisoners

Prior to the review commencing, the commissioning organisation, the reviewer and the PPO investigator will have agreed on a level 1, 2 or 3 review:

- Level 1 will **not require** any interviews by the clinical reviewer.
- Levels 2 and 3 will require interviews.

Healthcare staff who have had significant dealings with the deceased should be interviewed. The clinical reviewer and PPO investigator should conduct such interviews jointly, with the clinical reviewer leading. The PPO has a preference for joint interviews, which give a greater understanding and clearer picture of the care received across disciplines. Joint interviews will be recorded and transcripts (signed and agreed by the interviewee) will be annexed to the PPO report. Coroners require that any interview carried out in relation to the investigation is appropriately recorded (either through a recording device and transcript or by clear notes of interview). The PPO recording devices are accepted by the prison service.

There is no expectation the clinical reviewer attends any non-healthcare interviews. However, on occasions the investigator may ask for the clinical reviewer to attend relevant interviews (for example where a member of prison staff has attempted resuscitation).

3. SUGGESTED AREAS FOR CONSIDERATION

The majority of PPO investigations are into deaths that occur in a prison setting. While this is not an exhaustive list, it has been prepared using learning opportunities and findings from previous investigations (mainly prison). The clinical reviewer or panel should consider involving specialists to contribute as required. When carrying out a desk-based clinical review, a proportionate approach should be taken.

i) Family

Care should be taken to respect the privacy and dignity of the deceased, who may have withheld information from their family. It will be necessary to consider information which is relevant to the circumstances of the death, but other information should not be disclosed.

Ensure that due consideration is given to any clinical issues raised by the family (which will be provided by the PPO investigator)

Were arrangements for notifying the family of a serious illness timely?

Were links with the family appropriately considered and maintained by healthcare staff?

ii) Records and record keeping

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

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

Is the documentation and records keeping adequate and appropriate?

Are the records factual, consistent and accurate?

Have they been completed as soon as possible after the event, providing current information on the care and condition of the patient or client?

Are they written clearly and in a way that ensures the text cannot be erased?

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

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

Are the entries respectful to the patient or client?

Are they consecutive?

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

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

Is SysmOne used effectively?

iii) Reception medical screening

Was the appropriate screen completed?

First health screen on the first night into reception

Second health screen completed within 5 days of arrival into establishment

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

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

iv) Mental health

Did the prisoner have a mental health history?
Were attempts made to obtain their previous records (both prison and NHS)?
Was the correct mental health diagnosis made in custody?
Were they referred to local mental health services?
Were they receiving appropriate mental health care to meet their needs?
Were relevant NICE/NHS guidelines followed?

v) Physical health

Was an appropriate physical health history taken?
Was the correct physical health diagnosis made in custody?
Was the prisoner referred to secondary care services in a timely manner?
Did the prisoner receive care appropriate to their need?
If the prisoner was disabled, did they have full access to healthcare services and facilities?
Were attempts made to obtain previous records from their community GP or other specialist health provider?
If a terminal illness had been diagnosed, was appropriate palliative care provided using accepted pathways.
If a terminal illness had been diagnosed was Release on Temporary Licence or Compassionate Release appropriately recommended to the prison authorities? If not, why not?
Were relevant NICE/NHS guidelines followed?

vi) Equivalent care

Was the care the prisoner received equal to that they could have expected to receive in the community?
Was the care consistent with National Health Service Frameworks?
Were external agencies involved in the care of the prisoner if considered necessary?
Were appointments (both internal and external to the prison) attended regularly?
If not, were they cancelled by the prison or external agencies? Why?

vii) Substance misuse

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

viii) Suicide and self-harm

Were there any key clinical suicide or self-harm indicators identified?
Were these acted upon and managed appropriately?

Was the prisoner on a suicide and/or self-harm support plan (Assessment, Care in Custody and Teamwork – ACCT)?
Was the ACCT plan referred to in the clinical care plan?
Was the prisoner referred to local mental health services?
Were there any delays or disagreements in providing mental health assessment?
Were there any delays in transferring out to external mental health facilities?
Was there appropriate healthcare input into the prisoners ACCT plan (both CAREMAP and review meetings)?
Were relevant NICE guidelines followed?

ix) Policies and procedures

Are there local policies and procedures in place that meet with relevant NICE/NHS guidelines?
Do these also meet Department of Health and Prison Service standards?
Have these been agreed with the local health and social care partnerships involved in the delivery of local prison healthcare?

x) Incident/emergency response

Was the clinical response to symptoms presented reasonable and appropriate?
Were there any delays or equipment shortages/failures?
Would any different care or treatment at any stage, led to a different outcome?
Are there any lessons to be learned?
Were the clinical governance arrangements satisfactory?
Was the clinical emergency response appropriate?
Was any resuscitation used appropriately? (please include when resuscitation was not appropriate eg: when someone is clearly dead)

xi) Physical environment

Is the physical environment in which primary health care is delivered fit for purpose?
Are there adapted cells available to meet the physical needs of patients?
Do the consultation rooms enable appropriate levels of confidentiality without compromising security?
Is the in-patient unit fit for purpose, ensuring decent and humane conditions for the prisoner?

xii) Support for staff

Did the healthcare staff involved in the incident receive appropriate support, both in terms of clinical supervision and psychological support?
Did healthcare professionals participate in a post incident debrief?

xiii) Medicines Management

Are pharmacy services equivalent to that in the community, including direct access to advice by appropriately trained pharmacy staff, information about the benefits and risks of medications and the self administration of medication?
Did the prisoner have access to their long term medications without gaps or delays?
Was the prescribing of medications appropriate to meet the patient's clinical need?

xiv) Training and Staff development

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

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

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

Does the healthcare team have regular team practice sessions on the use of their emergency procedures?

xv) Escorts and bedwatch

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

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

4. STRUCTURE OF THE CLINICAL REVIEW REPORT

Plain English should be used and technical terms should be explained (remember the review will be read by a wide audience, including the family of the deceased). Please use the relevant template – Annex A for foreseeable deaths (issues led format) and Annex B for other deaths (standard format).

Any recommendations made should be based on the guidance at Annex C.

It is not necessary to remove names of prisoners or staff – the clinical review will be annexed to the PPO report, which will include names of relevant persons involved. The PPO report is sent to the family, the Coroner, the service and any other properly interested person. The clinical review is not made public. After inquest, the PPO report is anonymised and put on the PPO website, at this stage the clinical review has been removed, along with other appendices.

5. TIMESCALES AND PPO ESCALATION PROCESS

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

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 a natural causes death and **60 working days** (12 weeks) for any other death, of the initial correspondence from the PPO.

A draft report should be submitted by the clinical reviewer to the Area Team (or equivalent) for quality assurance with **35 working days** (7 weeks) for a natural causes death and **45 working days** (9 weeks) for any other death. At the same time it should be sent to the PPO investigator to check it meets the needs of the investigation.

The Area Team (or equivalent) quality assured draft and comments will be returned to the clinical reviewer within **10 working days** to allow any changes to be made prior to sending the final report to the PPO investigator.

The PPO investigator may, from time to time, need to contact the clinical reviewer if there are matters which require further exploration, clarification or correction. Ideally this will be within 30 working days of receipt of the final clinical review report. **However Area Teams (or equivalent) and reviewers should note that issues of clarification sometimes arise following the consultation period (6.1 d).**

If there are good reasons to do so, an extension to the time limit can be agreed with the PPO investigator (in consultation with the Assistant Ombudsman). Any extension should be confirmed in writing. The timeliness of the clinical review report is important and when late, can adversely impact on the delivery of the Ombudsman's investigation report. As a result a robust escalation process has been introduced.

The PPO escalation process for the late delivery of final clinical review reports is as follows:

A final agreed copy of the clinical review report should be received by the investigator **within 50/60 working days** of the original commissioning letter,

An extension to the time limit may be agreed if there are good reasons to do so, and with the Assistant Ombudsman's approval. An agreed extension should be documented.

Escalation - if an extension had not been agreed and the report is not received by the 50/60 working day deadline – the investigator will contact the reviewer to ascertain an expected date of delivery. The Assistant Ombudsman will inform the Commissioning Officer that the review is now overdue.

Escalation - if the report is not received by the extended date (in either case) – the Assistant Ombudsman will contact the reviewer reminding them of the agreed timescales and extensions. The Assistant Ombudsman will also write to the Commissioning Officer informing them of the late review.

In each case, when a review is received outside of the agreed timescales, the Deputy Ombudsman will inform the National Commissioning Board.

6. STAGES FOLLOWING THE PPO INVESTIGATION AND CLINICAL REVIEW

There are a number of stages following the investigation and clinical review that the reviewer should be aware of, as follows:

- The PPO investigator writes a draft report including the clinical issues and relevant recommendations.
- The draft report is issued to the family (who have up to 8 weeks to feed back) and the service (who have 4 weeks to feed back). Copies will be sent to the NHS Area team and clinical reviewer for factual accuracy checking.
- The service and healthcare provider are asked to provide an action plan in response to any recommendations.
- **More questions may be asked, and occasionally it may be necessary for further investigation to take place, which may include clinical matters.**
- The report is finalised, including the response to any recommendations, and is used by the Coroner to prepare for the inquest.
- Inquest - both the PPO investigator and clinical reviewer may be called to give evidence at the inquest.
- After the inquest, the annexes (including the clinical review report) are removed from the PPO report – the report is anonymised and published on the PPO website.

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

Inquests

Both the PPO investigator and the clinical reviewer may be called to give evidence at inquest. Although the inquest should not be an adversarial process, the interested parties (which include the bereaved family and specific members of staff from the service concerned) may have different perspectives of the individual's care and management than that identified by the PPO investigation and/or clinical review. Each interested party may have their own legal representation and each may require the PPO investigator and the clinical reviewer to give evidence.



Clinical Review

for

[Name]
[Date of death]
[Establishment]

Carried out by [name of reviewer]
Date of final clinical review report: [date]

1. Terms of Reference

The aim of the review is to consider the clinical care the deceased received in relation to his/her cause of death while in prison custody.

The approach of **how** and **why** should be adopted, not who was to blame. The following key questions should be covered in relation to the death:

- How and when did the prisoner die?
- Is there any root cause(s) of the death?
- Was the clinical care equal to that which could have been expected in the community?
- Are there any learning opportunities?
- Were local and national policies and procedures (both prison and NHS) followed?
- Is there an opportunity to prevent future deaths in similar circumstances?
- Are there any examples of good practice?

The review should:

- Examine the provision of clinical care and treatment, including both risk assessment and risk management.
- Examine any secondary care provided (to the extent necessary for the review)
- Provide a chronology of the health and social care events leading up to the incident.
- Identify any care or service delivery failings along with the factors that contributed to these problems.
- Examine policy and practice.
- Identify any root causes(s) that inform the identification of learning opportunities.
- Make timely, clear and sustainable recommendations for the prison health care provider and service.
- Provide explanations and insight for the relatives of the deceased.

2. Methodology

This is a Level 1 review - healthcare and other relevant records have been reviewed and the report written based on documentary evidence and discussion with the PPO investigator.

The following Prison Service Orders and Information (PSO or PSI) should be considered when appropriate:

*PSI 03/2013 – Emergency response
PSI 64/2011 – Safer custody
PSO 3050 – Continuity of healthcare*

Appendix A – chronology of events leading up to and post diagnosis. *Include dates, times and names of staff.*

3. Clinical Reviewer

Details of the clinical reviewer, qualifications, area(s) of specialism etc.

4. Conflict of interest statement

The clinical reviewer is required to confirm there are no actual or potential conflicts of interest. This has to be declared in this paragraph of the report.

Examples of conflicts of interest include:

- *Having a financial interest (e.g. holding shares, options or partnership agreements) in the healthcare provider of this clinical review*
- *Having a financial or any other personal interest in the healthcare provider of this clinical review*
- *If you are employed by, or providing services to, the healthcare provider/establishment of this clinical review*
- *Receiving any kind of monetary or non-monetary payment or incentive (including hospitality or commercial sponsorship) from the healthcare provider of this clinical review*
- *Canvassing, or negotiating with, any person with a view to entering into any of the arrangements outlined above;*
- *Having a close family member (which includes unmarried partners) who fall into any of the categories outlined above; and*
- *Having any other close relationship (current or historical) with the healthcare provider/establishment*

The above is a non-exhaustive list of examples, and it is the clinical reviewers responsibility to ensure that any and all potential conflicts – whether or not of the type listed above – are disclosed in writing to the commissioners of the review.

5. The diagnosis of [prisoners name] terminal illness and informing him of his condition

This section should contain anything relevant up to and including the diagnosis.

Please include whether referrals were made appropriately and in line with NHS/NICE guidelines (eg: two week referral for suspected cancer)

The clinical reviewer should conclude whether referrals and diagnosis was timely, and the prisoner was appropriately informed.

(Examples of issues to include in this section):

- *Was a referral to specialist secondary health service made at onset of symptoms?*
- *If cancer suspected, was the referral made within the two week rule?*
- *Was the appropriate information recorded in the medical record?*
- *Was the prisoner given full information on the reason for the referral?*
- *Following a diagnosis of terminal illness, was the patient informed in a timely manner?*
- *Were they offered sufficient support?*
- *Were they kept informed about ongoing appointments, treatments and prognosis?*

6. [Prisoner's name] clinical care

*This section should contain all relevant clinical input relating to medical treatment and nursing care **after** diagnosis. This should include palliative and end of life care eg: pain and symptom control, holistic assessment, advance care planning (including the appropriateness of DNACPR), with reference to appropriate NHS/NICE guidelines.*

The clinical reviewer should conclude whether medical treatment was appropriate and comment on any delays in receiving treatment.

(Examples of issues to include in this section):

- *Was the deceased able to attend hospital appointments etc without difficulty?*
- *On return to prison following appointments and treatments, were appropriate clinical and nursing checks carried out?*
- *Was there good communication between outside providers and prison healthcare?*
- *Was appropriate pain relief given at the appropriate times?*
- *Were decisions about whether medication is held in possession or not recorded in the file?*
- *Were any security related decisions, e.g. the use of a syringe driver noted in the file?*
- *Were appropriate comfort aids supplied e.g. mattresses, chairs, modified cell?*
- *Were palliative care agencies contacted?*
- *Were treatment care plans in place and agreed with the prisoner?*

7. [Prisoner's name] location

From a clinical perspective only, whether the location of the prisoner was appropriate and did not impede clinical care.

(Examples of issues to include in this section):

- *Was the prisoner able to stay in their cell until their condition dictated otherwise?*
- *Was the prison disability officer informed and an assessment of need carried out if appropriate?*

- *Was the prison equipped to care for prisoners with terminal illnesses or was transfer to such a prison considered/facilitated?*
- *Was consideration given to transfer the prisoner to a hospice or to hospital inpatients, taking into account security issues and accessibility to the family?*

8. Restraints, security and escorts – healthcare input into risk assessments

The Graham Judgement, High Court 2007 – made it clear that there should be appropriate healthcare input into risk assessments for the use of restraints. Healthcare should not merely state ‘no objection to the use of restraints’ they should give a clear account of the prisoner’s condition and how this impacts on their risk of escape.

Clinical reviewers should comment on this aspect of the risk assessments only.

9. Compassionate release – healthcare input into application process

Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

Clinical reviewers should comment on the healthcare input into compassionate release applications, particularly in relation to life expectancy.

10. Conclusion

Clinical reviewers overall conclusion about the clinical care the prisoner received including whether it was equivalent to that they could have expected in the community

11. Recommendations

Clear recommendations to relevant parties (head of healthcare or commissioners). Recommendations should be specific, short and to the point and relate to the clinical care in respect of the terminal condition.

Other findings to bring to the attention of the NHS Area Team (healthcare commissioners)

Anything uncovered by the clinical reviewer in relation to the healthcare provider at the establishment – that may not necessarily relate to the care of the prisoner concerned, or to the treatment of their terminal illness.

Other recommendations

That relate to the above paragraph

ANNEX B – other deaths (non-foreseeable) template



Clinical Review

for

**[Name]
[Date of death]
[Establishment]**

Carried out by [name of reviewer]
Date of final clinical review report: [date]

1. Terms of Reference

The aim of the review is to consider the clinical care the deceased received in relation to his/her cause of death while in prison custody.

The approach of **how** and **why** should be adopted, not who was to blame.

The following key questions should be covered in relation to the death:

- How and when did the prisoner die?
- Is there any root cause(s) of the death?
- Was the clinical care equal to that which could have been expected in the community?
- Are there any learning opportunities?
- Were local and national policies and procedures (both prison and NHS) followed?
- Is there an opportunity to prevent future deaths in similar circumstances?
- Are there any examples of good practice?

The review should:

- Examine the provision of clinical care and treatment, including both risk assessment and risk management.
- Examine any secondary care provided (to the extent necessary for the review)
- Provide a chronology of the health and social care events leading up to the incident.
- Identify any care or service delivery failings along with the factors that contributed to these problems.
- Examine policy and practice.
- Identify any root causes(s) that inform the identification of learning opportunities.
- Make timely, clear and sustainable recommendations for the prison health care provider and service.
- Provide explanations and insight for the relatives of the deceased.

2. Methodology

This is a [*Level 2 or 3 review – delete as appropriate*]

Level 2 – Single clinical reviewer - Review of records, interviews with healthcare staff at the establishment *carried out jointly with the PPO investigator* and report

Level 3 – Panel review with lead reviewer – Review of records, interviews with healthcare staff and others as appropriate *carried out jointly with the PPO investigator*.

The following Prison Service Orders and Information (PSO or PSI) should be considered when appropriate:

PSI 03/2013 – Emergency response
PSI 64/2011 – Safer custody
PSO 3050 – Continuity of healthcare
PSO 45/2010 – IDTS
PSO 1700 – Segregation
PSO 1600 – Use of Force
PSI 74/2011 – Early days in custody

Appendix A – chronology of clinical events leading up to death. *Include dates, times and full names of staff.*

3. Clinical Reviewer

Details of the clinical reviewer, qualifications, area(s) of specialism etc.

4. Conflict of interest statement

The clinical reviewer is required to confirm there are no actual or potential conflicts of interest. This has to be declared in this paragraph of the report.

Examples of conflicts of interest include:

- *Having a financial interest (e.g. holding shares, options or partnership agreements) in the healthcare provider of this clinical review*
- *Having a financial or any other personal interest in the healthcare provider of this clinical review*
- *If you are employed by, or providing services to, the healthcare provider/establishment of this clinical review*
- *Receiving any kind of monetary or non-monetary payment or incentive (including hospitality or commercial sponsorship) from the healthcare provider of this clinical review*
- *Canvassing, or negotiating with, any person with a view to entering into any of the arrangements outlined above;*
- *Having a close family member (which includes unmarried partners) who fall into any of the categories outlined above; and*
- *Having any other close relationship (current or historical) with the healthcare provider/establishment*

The above is a non-exhaustive list of examples, and it is the clinical reviewer's responsibility to ensure that any and all potential conflicts – whether or not of the type listed above – are disclosed in writing to the commissioners of the review.

5. Outline medical history

A brief bullet pointed section covering main aspects of medical history, including any mental health issues.

6. Key findings and issues of concern

This section should contain sub-headings highlighting the issues. It should cover all relevant treatment relating to the cause of death, including any substance misuse (IDTS); mental health treatment (including appropriate medication); physical health treatment (including appropriate medication); healthcare input into the ACCT process; emergency response (including the appropriateness of any resuscitation attempt).

Please refer to appropriate NHS/NICE guidelines and relevant prison/IRC policies.

If restraints were used:

The Graham Judgement, High Court 2007 – made it clear that there should be appropriate healthcare input into risk assessments for the use of restraints. Healthcare staff should not merely state ‘no objection to the use of restraints’ they should give a clear account of the prisoner’s condition and how this impacts on their risk of escape.

Clinical reviewers should comment on this aspect of the risk assessments only.

7. Conclusion

Clinical reviewers overall conclusion about the clinical care the deceased received including whether it was equivalent to that they could have expected in the community

8. Recommendations

Clear recommendations to the relevant stakeholders (Governor, head of healthcare or commissioners). Recommendations should be specific, short and to the point and must relate to the clinical care in respect of the cause of death (in the case of a self-inflicted death, this would include any mental health treatment/care).

Other findings to bring to the attention of the NHS Area Team (healthcare commissioners)

Anything uncovered by the clinical reviewer in relation to the healthcare provider at the establishment – that may not necessarily relate to the care and treatment of the prisoner concerned.

Other recommendations

That relate to the above paragraph

Making recommendations

When undertaking a clinical review into a death in custody, you may wish to make recommendations. The PPO encourages the use of the SMARTER acronym when making recommendations, to help ensure recommended changes are implemented:

Specific
Measurable
Accountable
Reasonable
Time bound
Effective
Reviewed

Guidance is now offered to help ensure the recommendations made in your clinical review achieve the change desired.

SMARTER Recommendations

Specific:

Recommendations should focus on one specific area of practice. Objectives should be clear, straightforward and emphasise what needs to happen, like a simple instruction. Use action words such as introduce, apologise, co-ordinate, organise, instruct, implement etc. Terms such as 'in addition' or 'also' should be avoided when drafting recommendations. When such terms are used, consider whether two separate recommendations may be more effective than one, e.g.

The head of healthcare at High Down should remind staff of the importance of fully completing the 'first reception health screen' form. She should also ensure that patients who need to see a doctor are referred appropriately by the reception nurse.

Instead, use:

The Head of Healthcare at High Down should ensure all 'first reception health screen' forms are completed in full.

The Head of Healthcare at High Down should ensure that patients who need to see a doctor are referred appropriately by the reception nurse.

Measurable:

The intended outcome of each recommendation should be measurable. Imagine you visit the prison again next year - will you be able to tell whether the recommendation has been implemented? Never use the term 'consider', and

ensure terms like 'remind' and 'review' are strengthened by recommending more formal actions:

The Head of Healthcare should consider whether there are adequate measures in place to monitor the distribution of medication to prisoners subject to ACCT procedures.

It would be easier to measure if the suggested review was formalised, e.g.

*The Head of Healthcare **should conduct a formal review** of medicine distribution to prisoners subject to ACCT procedures.*

Accountable

All recommendations must be directed to member of staff in a named post. The individual to whom the recommendation is directed to should be at the top of their respective hierarchy, i.e. the Head of Healthcare, or the appropriate lead at the NHS Area Team.

The use of informal language when completing a patient's medical records should be avoided

Should read:

***The Head of Healthcare should ensure** that the use of informal language when completing a patient's medical records should be avoided*

Reasonable

Recommendations should be reasonable and proportionate to the issue identified in investigation.

NOMS should consider issuing pouches containing gloves and a protective face mask to all medical and discipline staff who work with prisoners

This is perhaps unreasonable, given cost implications, and disproportionate, given that the prerequisite training for the use of such masks is not available to all staff anyhow. Instead use:

The Governor and Head of Healthcare of XXXXX should ensure that a cross section of discipline officers have up to date first aid qualifications and are able to access and use first aid equipment such as face masks

Time bound

There will be occasions where a recommendation needs to be addressed as a matter of urgency. This can be appropriately reflected in the drafting of the recommendation itself e.g.

The Head of Healthcare of XXXX should ensure, as a matter of urgency, that staff are, where necessary, trained in the management of diabetes.

Where possible, and where appropriate, a date by which action needs to be completed should be included.

Effective

When drafting a recommendation, always ask whether implementation will actually make a difference. Ensuring recommendations are measurable and will go some way to making sure they are effective. Historically, the most frequent area where recommendations are made is record keeping. The effectiveness of these recommendations may have much to do with the terminology used:

The head of healthcare should ensure that record keeping is improved

This recommendation is improved by referencing best practice and by suggesting specific action:

The Head of Healthcare of XXXX should ensure that an audit of record keeping; checking healthcare staff's compliance with Nursing and Midwifery Council professional standards takes place and the outcomes are acted upon

Reviewed (PPO/NHS Area Team responsibility)

Action plans received from establishments should be regularly reviewed to ensure that work is being taken forward appropriately. Recommendations not accepted, or accepted in part, should also be reviewed. Whilst some recommendations may be rejected due to semantics, others may be rejected due to operational reasons and in both cases it would be wise to take note.

Good Practice

As well as making formal recommendations, the clinical reviewer may also identify good practice that should be formally acknowledged in the report.

Good practice is **any practice implemented at a local level that could be usefully shared to promote learning** across the prison, probation or immigration estate.

eg: At HMP Liverpool, all prisoners aged 55 and over are seen at an Older Prisoners Clinic. This is good practice and should be shared with other establishments.