Prisons & Probation Ombudsman
Independent Investigations

Learning Lessons Seminar 2016

Deaths from natural causes

Thursday 1st September, 2016

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Housekeeping

- Fire exits
- No fire drills
- Lunch at 1.15pm in the Dining Room
- Slides will be emailed
- Taxis

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Agenda

10.30	Introduction
10:40	Deaths from natural causes
	What PPO investigations involve
	Learning lessons
	Recent case studies
	Q&A
12:15	Response from Paul Baker (NOMS)
	Q&A
13:15	Lunch
14:00	Table discussion
	Feedback to panel and discussion
15:30	Next steps and close

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Introduction

- Delighted to welcome Paul Baker DDC, delegates from prisons, senior NOMS staff and, of course, my own staff.
- PPO created in 1994 to independently investigate prisoner complaints. Took on investigation of deaths in custody in 2004.
- Our vision is to carry out independent investigations to make custody and offender supervision safer and fairer.
- This is the third annual series of seminars intended to use PPO lessons from investigations to support prison staff to improve safety and fairness.

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Introduction

- PPO fatal incident investigations have 4 aims:
  - Establish circumstances of death including good and bad practice
  - Provide explanation to the bereaved family
  - Assist the coroner
  - Identify learning for improvement

- Learning comes from individual investigations but increasingly from thematic learning looking across investigations.

- We will look at both these sources of learning and then discuss and debate.

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Introduction

- Most deaths in prison are from natural causes.
- While prisoners of all ages die of natural causes, most deaths are from age related conditions – and the average age of these deceased prisoners 2015-16 was 61
- The explanation is obvious – a rapidly ageing prison population because of longer sentences and more late in life prosecutions for historic sex offences
- The results are stark: those over 60 are now the fastest growing segment of the population and their numbers have tripled in 15 years. There are more than 100 prisoners over 80 and quite a few over 90.

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- And projections are all upwards: by 2020, NOMS expect there to be 15,000 prisoners over 50 and 5,200 over 60.
- With rising age comes more age related conditions and – inevitably - death and there was another 10% rise in natural cause deaths 2015-16.
- The result: prisons designed for young men are increasingly having to adjust to the largely unexpected, unplanned and under-resourced roles of secure care home and hospice.
- Managing old age and even death is increasingly a routine task for many prison staff .

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Introduction

- Unfortunately, little strategic grip of this major penal change - astonishingly, there is no properly resourced national strategy for older prisoners to guide staff. Prisons and their healthcare partners left too respond in a piecemeal fashion

- Commendably, PPO reports show some prisons have made impressive adjustments (e.g. in palliative care)

- But little consistency and we often repeat the same recommendations (e.g. about variable social and health care, problems with the prison estate and clashes with traditional prison policies, such as use of restraints on the terminally ill).

- Today is about learning lessons or at least understanding the obstacles to improvement, so that the PPO can contribute to you achieving an appropriate and humane approach to the growing numbers of prisoners who will die in your care.

What PPO natural causes investigations involve

Karen Cracknell, Assistant Ombudsman

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Fatal incidents overview

- We investigate all deaths in prisons, IRCs, Approved Premises (and others in remit) from any cause
- Family Liaison Officer contacts next of kin regarding any concerns they may have about care, and remains in contact at key points until the final report is issued.
- Clinical Review for all prison and IRC deaths – rarely for approved premises
- Reports make recommendations for improvement and contribute to the inquest

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Some data

- 304 deaths in total 2015/16 – 21% rise
- 172 of these were from Natural Causes (up 42% in five years)
- Average age at death is 61 years
- Steady annual increase in deaths from natural causes

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Types of natural cause investigation

- Foreseeable – when there has been a terminal diagnosis and the death is expected (e.g. cancer)
- Unforeseeable – when death was not expected/sudden (e.g. heart attack)

Impact on investigation

- Proportionality
- Style of investigation – desk based or interviews
- Format of report – set issues/key events

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Preparation

- Notification and allocation
- Notices/letters sent
- Check on previous deaths - similarities
- Contact establishment/liaison officer
- Request relevant records
- Contact police and coroner
- Check HMIP and IMB reports
- Media interest
- Allocation of clinical reviewer by NHS England

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Investigation

Foreseeable – issues led

- No need to visit establishment
- Examine records and extract relevant information under specific headings
  - Diagnosis and informing
  - Clinical care (including palliative)
  - Location
  - Restraints, security and escorts
  - Family liaison
  - Compassionate release

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Foreseeable

- Clinical review – key evidence – partnership working
- Case reviews, initial report and validation
- Feedback from next of kin and service
- Final report
- Inquest and report on website (anonymised of all but deceased's name)

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Unforeseeable – key events and findings

- Opening visit
- Arrangements for subsequent visit and interviews (staff and prisoners)
- Review records
- Interviews generally recorded and transcribed
- Involve clinical reviewer
- Case reviews, report and validation
- Initial and final reports
- Inquest and anonymised reports

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Things that help us:

- Copies of relevant records (no originals and not everything)
- Include escort risk assessments
- Redacted copies without delay when requested
- Suitability of liaison officer
- Staff attendance at interviews
- Liaison with healthcare
- Digital recorders

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Family liaison

- Important part of what we do.
- Next of kin details and funeral date.
- First contact, usually by telephone, within 4 weeks or after funeral (whichever is first) – what issues/concerns? Signposts to support organisations.
- FLO and Investigator agree what family concerns can be covered by the investigation (ie: in remit)

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Family Liaison (cont.)

- FLO inputs into case review 2 to ensure any agreed family concerns have been covered
- FLO will prepare the next of kin before send out the initial report (it can be distressing)
- Next of kin have 8 weeks to consider the factual accuracy of the report – FLO speaks to them at 4 weeks and then again at 8 weeks.
- Any comments are considered by the FLO and investigator before the report is finalised

Learning Lessons

Christine Stuart, Senior Research Officer

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Learning lessons from fatal incident investigations

- Our investigations often identify areas for improvement and result in recommendations being made to a specific establishment or individual
- But there is also much to be learned from collective analysis of our investigations
- The learning lessons team work to collect standardised information about investigations, so that we can look for trends and identify common themes

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The ageing prison population

- One of the most notable trends from our natural cause death investigations is the increased number of elderly prisoners
- From 2004 to 2014, the number of prisoners aged 60+ increased by 125% (The total prison population increased by only 15%)
- In the last 2 years, the number of prisoners aged 60+ increased by another 22% (the total prison population increased by less than 1%)
- In March 2016 there were 4,373 prisoners aged 60+
- In June 2015 there were 134 people in prison aged 80+
- Older prisoners are now a central part of our learning lessons agenda

Palliative care and risk assessment

Christine Stuart, Senior Research Officer
Steven Thompson, Investigator

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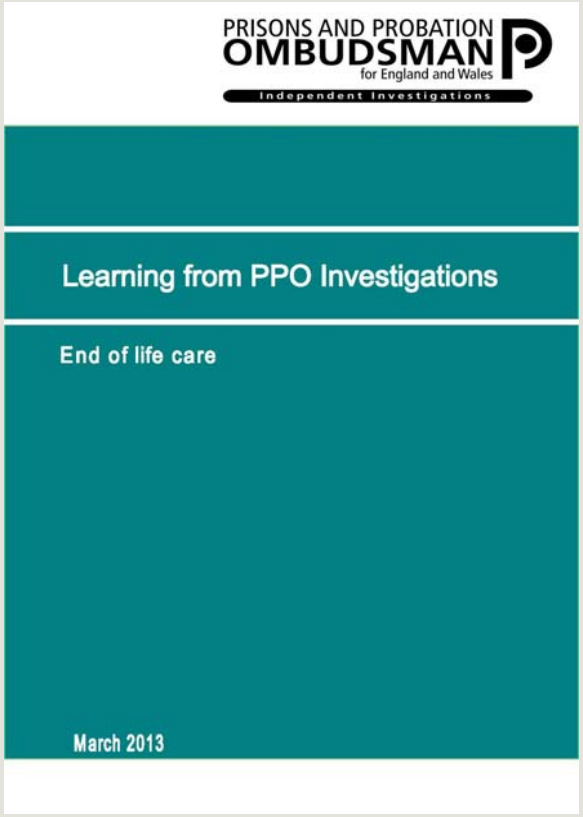
PPO thematic report: end of life care



Published March 2013

Review of PPO fatal incident investigations into foreseeable natural cause deaths, and the end of life care that prisoners received

Available online:
http://www.ppo.gov.uk/?p=3733

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PPO thematic report: end of life care

- Report on the death of 214 prisoners whose death was foreseeable, due to a terminal or incurable disease, and who died between 2007 and 2012
- The statistics presented today have been updated.
- All stats presented relate to a sample of 286 foreseeable deaths, which occurred between 2010 and 2015:
  - 82% were aged 50+
  - 62% were aged 60+
  - 31% were aged 70+

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Foreseeable deaths

- Increasing in number, especially with the ageing prison population
- In 2015/16, the PPO started investigations into 172 deaths from natural cause – up 10% on the year before
- Palliative care is a feature in a large percentage of foreseeable deaths
- We are looking at whether care was equivalent to that in the community

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Lesson one: end of life care plans

- Among those aged 50+, a palliative care plan was known to have been put in place in 74% of cases.
- An end of life care plan should be implemented for every prisoner diagnosed with a terminal illness. The plan should follow the six step pathway as set out in the National End of Life Care Programme prison guide.
- We found equivalent care in 87% of deaths

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Lesson two: family involvement

- Where a palliative care plan was in place for those aged 50+, families were involved only 48% of the time
- Where appropriate, and where they choose to be, families should be involved in the palliative care planning
- Contact details need to be kept up to date
- Family liaison officers appointed too late to allow effective family engagement
- Should be opportunity and support for family reconciliation

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Lesson three: compassionate release

- In 44% of foreseeable deaths where compassionate release was considered, the prisoner was still awaiting an outcome at the time of death
- In 26% of cases where ROTL was considered, a decision had yet to be made at the time of death
- Where appropriate, applications for early release on compassionate grounds should be completed at the earliest possible opportunity

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Successes

- The Prison Service and its NHS and charitable sector partners have increasingly risen to the challenge of providing palliative care and provision has undoubtedly improved
- 2011 NHS guidelines for delivering end of life care in prison
- Dedicated palliative care suites in at least 10 prisons
- But some excellent and compassionate work, bringing families together as death drew near

“Arguably, one of the most important tests of the humanity of a prison system is the way it manages the most vulnerable in its care. There are few groups more vulnerable than the seriously or terminally ill.”

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Case Study One: Palliative care

- Mr O diagnosed with chronic lung disease
- Transferred to a prison with a palliative care suite
- End of life care plans created, regularly reviewed and medication adjusted.
- DNACPR discussed.
- Commendable care and well documented care plans.

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Case Study Two: Palliative care

- Mr L died of chronic lung disease.
- ERCG considered.
- Moved to palliative care suite on the prisons wellbeing unit.
- Cell door to remain unlocked.
- Some care plans but no clear end of life plan, no monitoring over night, lack of clarity regarding function of wellbeing unit.

Restraints & Risk Assessment

Christine Stuart, Senior Research Officer
Althea Clarke-Ramsey, Investigator

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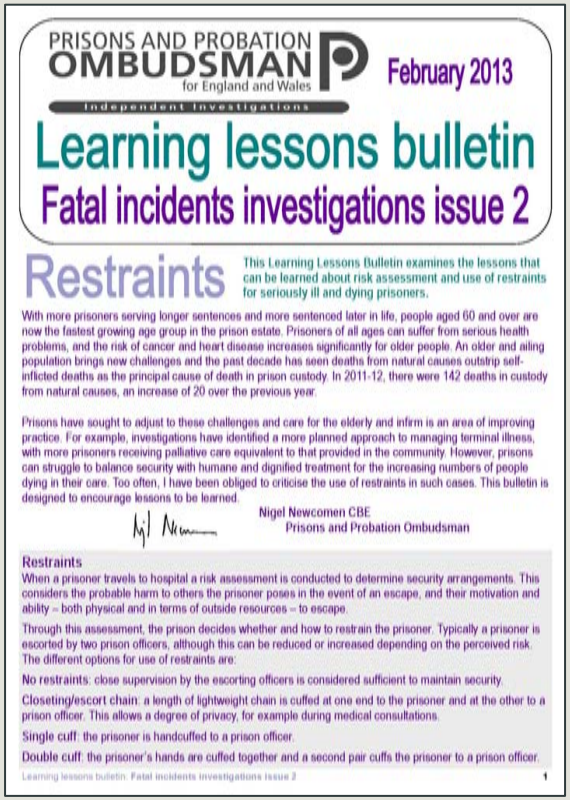
PPO bulletin: restraints



PRISONS AND PROBATION OMBUDSMAN for England and Wales
Independent Investigations
February 2013

Learning lessons bulletin
Fatal incidents investigations issue 2

Restraints

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

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

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

Restraints

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

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

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

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

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

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

Learning lessons bulletin: Fatal incidents investigations issue 2 1

Published February 2013

Review of risk assessment and use of restraints for seriously ill and dying prisoners

Available online:
http://www.ppo.gov.uk/?p=3718

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Use of restraints

- Report on the death of 500 prisoners who died from natural causes between 2007 and 2012
- The statistics presented today have been updated
- All stats presented relate to a sample of 701 natural cause deaths, which occurred between 2010 and 2015:
  - 72% were aged 50+
  - 52% were aged 60+
  - 26% were aged 70+

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Use of restraints

Looking specifically at the 60+ age group:

- 77% had been admitted to a hospital or hospice in the months leading up to their death
- 66% of those were restrained
- This includes 18 prisoners who were in their 80s, one 92 year old and one 94 year old

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Use of restraints

- In 65% of all cases where restraints were used our investigator considered that the level of restraints was inappropriate
- There is a balance to be found between decency and security - too often we find an overly risk averse approach
- Restraints are often excessive, left on too long, or unnecessary

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Use of restraints

- Restraints routinely used based on the prisoner's security category, offence, or long previously assessed risk
- Current risk and current circumstances are too rarely considered
- Prisoners frequently remained in restraints when their condition had seriously declined
- The level of restraints should be regularly reviewed, particularly when circumstances change

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Use of restraints

- Frail, immobile and even unconscious prisoners were restrained as they were sick and dying
- We have seen cases where the prisoner was still chained to an officer when they died
- Escorting staff should not have to go through the trauma of being chained to someone as they die
- A terminally ill prisoner should never need to die in restraints
- This is unlawful as well as inhumane

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The Graham Judgement

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

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The Graham Judgement (cont.)

The case emphasised the importance of the individual circumstances when considering risk.

A prisoner might pose a risk of escape when well, this is not necessarily the case when they are ill.

The judgment says that medical opinion regarding the prisoner's ability to escape (given their condition) must be considered as part of the risk assessment.

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Advice for prisons

- Advice for prisons in outlined in the National Security Framework and a concordat between NOMS and the NHS
- Concordat – using restraints on terminally or seriously ill patients is inhumane, unless explicitly justified by security considerations

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Restraints: lessons

1. Sufficient weight should be given to a prisoner's current health and mobility when considering the risk they pose to the public
2. If concerns about restraints are raised by escort or medical staff these should be responded to
3. Medical opinion should be a key consideration in any risk assessment
4. The level of restraints should be reviewed according to changes in the prisoner's condition, and not just when a routine assessment is due

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Restraints: Case study 1

- Mr A had high blood pressure but stopped taking his medication.
- Collapsed and was unconscious. Emergency response two nurses and a GP attended.
- Manager authorised restraints - double cuff, yet cat C prisoner and low risk.
- Healthcare input limited. Healthcare staff said they had not completed form.
- In the ambulance, departure delayed as the escorts tried to apply double cuff. The despatching officer then said use an escort chain.
- At A & E, Dr requested removal of restraints for emergency treatment
- Escorts given approval from duty manager for cuffs to come off.

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Restraints: Case study 2

- Mr H elderly prisoner suffering from pneumonia and lung disease.
- When his condition declined, risk assessment was completed for hospital admission. Healthcare staff did not raise any objections or outline his medical condition. Manager authorised the use of an escort chain.
- In hospital nurses told the escorts Mr H would die within the next few hours.
- Escorts rang the prison. Several managers are told this but none of them want to make the decision to remove the cuffs.
- It was inhumane that Mr H died while handcuffed to a prison officer; it was also potentially traumatic for the staff involved.

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Restraints: Case study 3

- Mr W diagnosed with heart disease, lung disease and advanced dementia.
- Mr W had a poor custodial record. Incidents of aggression. Non compliant behaviour. Assessed as medium risk.
- Media interest due to the nature of his conviction.
- Fully considered risk assessment. Healthcare staff noted his current condition. Suspected pneumonia. Limited mobility.
- Manager noted that with two escorts and as he was elderly, frail and immobile, restraints were not necessary.

Dementia and fatal incidents investigations

Christine Stuart, Senior Research Officer
Nicole Briggs, Investigator

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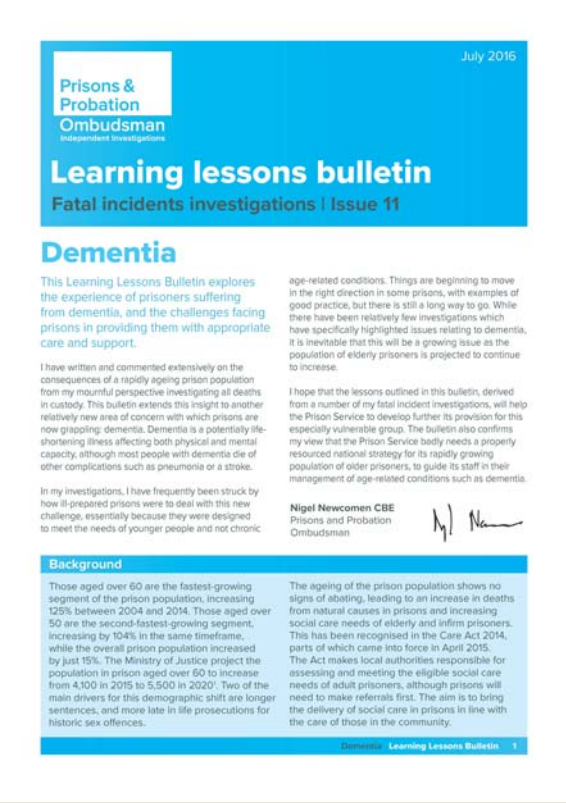
PPO Bulletin: Dementia



July 2016

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Learning lessons bulletin
Fatal incidents investigations | Issue 11

Dementia

This Learning Lessons Bulletin explores the experience of prisoners suffering from dementia, and the challenges facing prisons in providing them with appropriate care and support.

I have written and commented extensively on the consequences of a rapidly ageing prison population from my mournful perspective investigating all deaths in custody. This bulletin extends this insight to another relatively new area of concern with which prisons are now grappling: dementia. Dementia is a potentially life-shortening illness affecting both physical and mental capacity, although most people with dementia die of other complications such as pneumonia or a stroke.

In my investigations, I have frequently been struck by how ill-prepared prisons were to deal with this new challenge, essentially because they were designed to meet the needs of younger people and not chronic age-related conditions. Things are beginning to move in the right direction in some prisons, with examples of good practice, but there is still a long way to go. While there have been relatively few investigations which have specifically highlighted issues relating to dementia, it is inevitable that this will be a growing issue as the population of elderly prisoners is projected to continue to increase.

I hope that the lessons outlined in this bulletin, derived from a number of my fatal incident investigations, will help the Prison Service to develop further its provision for this especially vulnerable group. The bulletin also confirms my view that the Prison Service badly needs a properly resourced national strategy for its rapidly growing population of older prisoners, to guide its staff in their management of age-related conditions such as dementia.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

Background

Those aged over 60 are the fastest-growing segment of the prison population, increasing 125% between 2004 and 2014. Those aged over 50 are the second-fastest-growing segment, increasing by 104% in the same timeframe, while the overall prison population increased by just 15%. The Ministry of Justice project the population in prison aged over 60 to increase from 4,100 in 2015 to 5,500 in 2020[1]. Two of the main drivers for this demographic shift are longer sentences, and more late in life prosecutions for historic sex offences.

The ageing of the prison population shows no signs of abating, leading to an increase in deaths from natural causes in prisons and increasing social care needs of elderly and infirm prisoners. This has been recognised in the Care Act 2014, parts of which came into force in April 2015. The Act makes local authorities responsible for assessing and meeting the eligible social care needs of adult prisoners, although prisons will need to make referrals first. The aim is to bring the delivery of social care in prisons in line with the care of those in the community.

Dementia: Learning Lessons Bulletin 1

Published July 2016

Explores the experience of prisoners suffering from dementia, and the challenges facing prisons in providing them with appropriate care and support.

Available online: http://www.ppo.gov.uk/?p=7500

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Dementia

- The number of prisoners affected is unknown
- The Mental Health Foundation estimated that approximately 5% of prisoners over 55 years old have dementia
- If this is true, there are likely to be several hundred prisons suffering from dementia
- It is likely that many prisoners with mild dementia go unnoticed

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Lesson 1: Decision making

- May lose the capacity to make important decisions
- This can include the decision about whether they want to be resuscitated if their heart or breathing stops
- Support should be given to prisoners with dementia to help them make informed decisions. They should have access to independent advocates where there are no other independent people, such as families or friends, to represent their interests
- There needs to be appropriate assessments and documented decisions

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Lesson 2: Social Care

- Where a prisoner meets the eligibility criteria for social care, local authorities are responsible for meeting their needs
- Where they do not, the local authority should help the prison to develop a support plan
- Overall responsibility for delivering that plan rests with the prison
- Neglectful treatment can occur when there is poor communication between prisons and local authorities
- All prisons should have a local lead for adult social care, to liaise with local authority, NHS and third sector partners

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Lesson 3: Prisoner Carers

- Prisoners with dementia are likely to need additional support with day to day tasks
- Much of the social care delivered in prisons is provided by other prisoners
- This can provide essential support to prisoners with dementia and help the carer to develop a skill and make a positive contribution
- Prisoner carers must be given appropriate training and necessary safeguards need to be put in place

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Lesson 4: Family Contact

- Retaining contact with family can be important for a prisoner's wellbeing
- Where possible, families should be included in discussions and decisions about their relative's care
- Remembering to make phone calls or coping with the process of doing so can be particularly difficult for prisoners with dementia
- Prisons should make reasonable adjustments to help prisoners with dementia and their families to keep in touch

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Case Study 1

- Mr A was 63 years old when sent to prison. He had several health problems, particularly vascular dementia. Professionals assessed him and made a disability care plan, gave appropriate medication and monitored him.
- However, no one took overall responsibility to ensure that all his needs were met. Healthcare staff decided that the cause of his dementia was largely physical, and the mental health team did not assess him for almost a year.
- Mr A did not always remember to take his medication and his personal hygiene deteriorated. This caused painful feet, but a referral to a podiatrist never happened
- A healthcare manager at the prison said that Mr A would have had to make a written application to see a podiatrist himself, if he wanted to be treated. We found this to be neglectful for a man with his poor mental capacity.
- He was restrained up to two days before he died.

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Case Study 2

- When Mr B, aged 63, had a number of complex health problems.
- Mr B's physical health deteriorated. He had a number of falls, was advised not to leave his cell, and was given a wheelchair. He was also later diagnosed with dementia.
- Mr B was appropriately referred to hospital and local community services. An external social care provider visited the prison but he declined their help.
- However, Mr B received support from other prisoners. One of Mr B's friends and another prisoner both took short wheelchair pushing courses and took him to areas of the prison he would not have been able to get on his own, including the healthcare centre and visits room.
- One of these prisoners took on a full caring role for Mr B.
- In the final months of his life, the support of his prisoner carer helped Mr B to carryout his daily tasks, with as much normality and dignity as possible. Mr B died from hypertensive heart disease, aged 73.

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Case Study 3

- Mr A was remanded to prison at the age of 88, already suffering from dementia and associated psychosis, and other chronic health problems.
- His condition deteriorated quickly so he could not write or use the phone without help. When Mr A's family phoned the prison to check how he was, no effort was made to get him to the phone, and he was unable to speak to them.
- The prison made no arrangements to help him keep in contact with his family. On one occasion, his family came to visit him but Mr A was not able to get to the visits hall because the lift was not working and he could not use the stairs due to his disabilities. There had been no communication between healthcare staff and prison staff to work around this problem in advance, so Mr A's family were unable to see him that day. Visits were subsequently organised in the healthcare centre, but Mr A's family had been distressed about the lack of contact with him before this

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Questions?

Response from NOMS

Paul Baker

Deputy Director of Custody, London and Thames Valley

Afternoon Session

Please see the seating plan for your table for this afternoon’s discussion.

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Discussion

- What are the barriers to implementing PPO recommendations and how do you overcome them?

- What good practice is there and how can it be shared?

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Next steps

- PPO will:
  - Share slides & contact lists
  - Collate the discussion findings and disseminate more widely
  - Continue to investigate independently and robustly to identify learning in both individual cases and thematically
  - Learn from your feedback on this seminar
- What will you do?

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Farewell

- Thank you for your attendance and participation
- Please complete an evaluation form
- The PPO wishes you well in efforts to improve safety and fairness in custody

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Contact details

If you have any questions following the seminar please contact PPOComms@ppo.gsi.gov.uk

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