

**Prisons and Probation Ombudsman
Fatal Incidents Investigations Stakeholder Liaison Meeting**

17 June 2010

Present:

Mary Piper, Offender Health (OH)	Amar Shah, National Patient Safety Agency (NPSA)
Jane Webb, Prisons and Probation Ombudsman's Office (PPO)	Gordon Morrison (PPO)
Roger Cullen, Youth Justice Board (YJB)	Sean Langley, National Offender Management Service (NOMS Approved Premises)
David Ryan-Mills (PPO)	Susannah Eagle (PPO)
Jo Howells (PPO)	Karen Johnson (PPO)
Sarah Stolworthy (PPO)	Sue Gauge (PPO)
Karen Cracknell (PPO)	Paul Cotton (PPO)
Jane Boys, Independent Advisory Panel (IAP)	Barbara Treen NOMS (Women)
Paul Minos, NOMS Offender Safety Rights and Responsibilities (OSRR)	Kate Eves (OSRR)

Apologies:

Debra Baldwin (OSRR), Claire Smith (OH), Duncan Partridge (United Kingdom Border Agency), Mark Freeman (OH), Kevin Cleary (NPSA)

1. Minutes of the last meeting were agreed
Jane Webb reminded attendees that the minutes of the liaison meetings will be published on the PPO website and asked all to be mindful of this when checking them at draft stage.

Action points –
 - The FII DVD is now on the Prison Service website. Jane suggested that other useful PPO publications could also be put on the Prison Service website and welcomed suggestions.
 - Kate explained that work on the spike of gym related deaths in 2009 suggested at the last meeting had been postponed given that OH was currently doing work that covers this. OSRR will continue to monitor. Jane and Gordon agreed it was important the learning was not lost. Mary said that the OH work was likely to centre on emergency response; ensuring the criteria for gym use was sufficiently rigorous and staff training.
 - David said that he had provided a breakdown of deaths by age but that this had been superseded by data produced by OSRR. The link to this data will be provided to the group.
 - Mary agreed to share the paper she prepared for the IAP with the group.

2. PPO report
Gordon presented the PPO report which appears in full at the end of these minutes. Jane added that the office was not complacent about the number of overdue reports, however, she highlighted extenuating circumstances including:
 - overdue clinical reviews (discussion between PPO, OH and NPSA ongoing)
 - some cases have previously been suspended for police enquiries
 - FII staffing issues

Jo talked about the new policy of contacting bereaved families within three weeks of the death rather than four and the extension to their period for feedback on the draft report. Kate asked if this was likely to impact on the timescales for issuing final reports. Jane agreed that it would and said she and Debra had discussed whether the deadlines for feedback from services in remit should also be extended. They agree that these deadlines will not be amended.

Paul Cotton presented two investigations where the emergency response had been an issue. The key issues in both cases were discussed.

- Roger asked about repeat recommendations. Mary explained that death in custody reports are sent to the Primary Care Trust who should help the prison/healthcare provider find a solution. Jane said that the PPO will escalate reports where repeat recommendations are made, if necessary to the NOMS Chief Operating Officer. Mary suggested that the reports should also be escalated to the Director of OH. Kate added that repeat recommendations should form part of the establishment's continuous improvement plan.
- Mary highlighted that a key issue was staff training/education. The group discussed how this could be improved. All agreed that a laminated card outlining symptoms to be alert to and action to take in response would be helpful and easy to produce/distribute. Jane Boys said this was something the IAP could support. Paul said that most prisons have established contingency plans, the problem was making sure staff followed them. Kate explained that Heartstart training was no longer part of POELT and OSRRG was considering alternative emergency response training. Currently, each Governor decides the provision of first aid training across the establishment. Kate said that the health and safety committee sat within HR and is chaired by the head of the department. An options paper re: emergency response is under consideration. Barbara agreed there is a case for making this a higher priority.

Action: IAP, OH and NPSA to work on producing a laminated card with brief details of emergency health problems.

- Roger asked how PPO reports were dealt with at inquest. Jane said that was best answered by a coroner, but that the PPO experience was that each coroner had a different approach.

3. Offender Safety, Rights and Responsibilities report

Kate presented the OSRR report, explaining that the name of the group had changed from SCOP to the Offender Safety, Rights and Responsibilities Group. The structure and remit of the group remains the same.

There have been 29 self-inflicted deaths this calendar year (as compared with 33 by the same point in 2009).

In the last few months the National Safer Custody Learning Team has carried out visits to establishments where there have been a cluster of three deaths in three months. They are visiting at the request of the Director of Offender Management and aim to provide support to the Governor and DOM. The team carry out health checks of the establishment's broad safer custody policies, highlight good practice and areas needing improvement. This service will be developed in the coming months. Gordon asked who was involved in the visits. Kate said it was largely members of the Learning Team, but those with expertise in other areas are invited as appropriate. Following a visit, the team produce a report for the DOM.

Oxford University will be analysing data on 100,000 incidents of self harm over the past 5 years to identify trends, etc. This will inform an evidence based self harm strategy. The research is in its early stages currently.

The research project will cover all recorded self harm for a specific period of time and will include all prisoners held in custody (including those in YOIs)

Members of OSRR are meeting with the research team next month to agree timescales. OSRR's intention is to develop a self harm strategy for implementation from April 2011.

The Samaritans/NOMS conference takes place on 25/26 June.

Kate's team now covers safer custody issues in the high secure estate. There is no specific update to bring to the group this quarter.

David asked about Safer Custody News. Kate explained the format was changing to align more closely with the learning workshops being held. A smaller publication was being designed, which would hopefully be more readable and accessible. The new version is due out at the end of the summer.

Sue asked about the statistics Michael Keane used to circulate. Kate and Paul said that Michael has moved groups but still produces statistics. Paul said Michael is happy to respond to individual requests, but that the stats are now produced annually and possibly not monthly any more. Kate said she would check this.

4. Women

Barbara talked about work being carried out in conjunction with OH and approved premises focusing on levels of self harm by women in APs and communication issues.

WASP has been delivered to over 1,000 staff and continues. It covers coping with self harm, the importance of activity and distraction, etc. The group are piloting a new programme for those working in the community, eg police, probation and health services.

5. Approved premises

Sean said that in the last calendar year there had been 11 deaths in APs. In the calendar year to date there have been two, with one happening in the last few days. Sean mentioned concerns that prisons are not always passing on health related information when a prisoner is released to an AP and that a GP in one area was about to formally complain about this. Mary said that the move to AP was planned three months in advance so there was no excuse for information not being passed from prison to the community. Kate said this is covered in the PSI anyway. Sean said that sometimes ACCT documents are not passed to the community. Paul highlighted that this is mandated in PSO 2700, and that AP staff should be invited to final ACCT case reviews. He noted that, again, the policies are in place but staff do not always adhere to them. Jane acknowledged that, following the discussion, members of the group may be prompted into action.

The Oxford University research on self harm will hopefully include data gathered from APs, if the data can be gathered in time. In any case, APs will be asked to begin collecting self harm data in the same format as prisons so it can be compared.

The ACCT derived process used in the North West is under review. APs and OH are carrying out the review and if it is thought successful, the process will be rolled out across all APs. Jane asked that PPO be consulted. Sean also said that security in all APs was being reviewed and this provides an opportunity to consider whether "safe rooms" could be developed.

6. United Kingdom Border Agency

Although Duncan could not be at the meeting, he had provided Jane with an update.

- The FII DVD is to be shown at all staff training sessions.
- He thanked David for providing a list of national recommendations, UKBA are looking at those with relevance to the service.

- UKBA will be producing quicktime learning bulletins similar to OSRRG. Jane said that it would be useful if such examples of good practice in the group could be shared with the IAP. Jane Boys agreed to do so.

7. Youth Justice Board

Roger presented the YJB report. He noted that the YJB has far fewer DICs but that relevant national recommendations will be followed through.

He said that at a recent inquest into the death of a young person the jury asked questions about the use of targets in youth justice work and whether this impeded the service delivered. This matter is being considered. A second inquest into the death of a young person who died in 2004 will probably take place in early 2011 - the verdict of the first having been set aside after Judicial Review. The inquest is likely to concentrate on the use of restraint and the legality of this.

The PPO is carrying out an investigation into the death of young man who died shortly after his 18th birthday and the YJB is involved in this. There may be lessons to learn re: the handover between the youth and adult justice systems. A second case was referred to the PPO as a possible discretionary case (an 18 year old absconded from court and died in a car accident while unlawfully at large). The PPO decided not to investigate on this occasion. However the YJB agrees to continue to refer such cases to the PPO. In this instance, the YJB is looking to see if any lessons can be learned.

The YJB is also doing work on near death cases.

8. Independent Advisory Panel on Deaths in Custody

Jane Boys provided an overview of the three tiers of the Ministerial Council on Deaths in Custody – the Ministerial Board, the Independent Advisory Panel and the Stakeholder and Practitioner Group. She said that members of the liaison group were represented on the Stakeholder and Practitioner Group.. She explained that the aim of the Council was to bring about a reduction in the number of deaths in state custody, which included those that occur in prisons, police custody, immigration detention, approved premises and the deaths of those detained under the Mental Health Act and to share learning and information about means of preventing deaths in custody.

She reported that the work of the IAP would primarily be taken forward via working groups led by a member of the Panel. The areas that these groups were considering in the first instance were:

- Article 2 Compliant Investigations
- Cross Sector Learning
- Physical Restraint
- Information Flow through the Criminal Justice System
- Risks relating to the Transfer and Escorting of Detainees
- Deaths of Patients Detained under the Mental Health Act

Jane said that the IAP recently held a listening event with bereaved families. Sixteen family members attended and it was an interesting and insightful day. A full report would be produced and published on the website shortly. She said that in terms of next steps, the IAP planned to work with the co-sponsors of the Ministerial Council to explore whether a standardised cross sector approach for the key information sources shared with families following a bereavement could be developed. Jane Webb said that the PPO supported any improvements to contact with bereaved families.

She reported that a cross sector restraint workshop had been held in May, which was well attended and a report of the day would be published on the IAP's website in due course. The aim was to produce a set of common principles around the use of restraint to be used across the custodial estates.

She said that budget allowing, a stakeholder consultation event would take place in October/November 2010 and the IAP's first annual report would be published in November.

9. Offender Health/NPSA

Mary and Amar jointly presented on this occasion. Jane apologised that NPSA had not been given a slot on the agenda and said that she would make sure this was done at the next meeting.

Mary talked about a number of developments forthcoming since the election of the coalition government, including a white paper on a new independent NHS and a public health white paper.

OH and MoJ are discussing whether the approach to drug use in prison should support abstinence or a drug free approach.

A pre-election submission to transfer healthcare provided in police stations to PCTs is being considered.

The National Confidential Inquiry into Suicides and Homicides will publish their report soon and Mary agreed to share this with the group once it has been published.

Gordon asked when the report was due. Mary explained that there was a 100 day hiatus following the election of the new government, so it could be as little as a month until it is published, but could be longer.

Barbara asked how the Bradley Report was being incorporated into OH work and Mary said it was incorporated into each work stream.

Amar said that the NPSA was eight years old but had only recently begun work in prisons. A group has been set up to help support this work. Safety improvement work has been scoped and a number of ideas have been taken on and will be piloted in some establishments:

- Suicide prevention
- Physical health deterioration
- Learning disabilities
- Safer medication

10. AOB

Sean asked about the current situation with near deaths. Jane said this is on the PPO agenda and she had discussed it with OSRR earlier in the week. Currently three cases have completed stage 1 and 2 will proceed to stage 2. She understands that the learning will go through the same processes as for deaths in custody. Jane had asked when a decision would be made about responsibility for investigating near deaths and been told that it was still being considered. The threshold for investigation has yet to be defined and, in the meantime, no long term decisions would be made.

The theme of the next meeting will be women and Barbara agreed to present information about the lower number of deaths and the work to keep women prisoners safe.

Date of next meeting:

9 September 2010

Prisons and Probation Ombudsman report

New Investigations

- Since the last liaison meeting on 4 March 2010, investigations have been opened into the deaths of 56 prisoners, three residents of approved premises and one immigration detainee.
- Of the 56 prisoners, 33 deaths were due to natural causes, 17 were apparently self-inflicted whilst the remaining six await classification. One of the self-inflicted deaths occurred in a young offender's institution.
- Two of the deaths of approved premise residents were due to natural causes and the other apparently self-inflicted, whilst the death of the immigration detainee awaits classification.
- The office has opened 100 investigations in the calendar year to date (15 June 2010). This is significantly more than in the corresponding period in 2009, where 87 investigations were opened.
- The number of investigations into self-inflicted deaths (prisons only) in the calendar year-to-date stands at 29, with a further seven deaths awaiting classification. This is broadly consistent with the number recorded over the same period in 2009.

Reports Issued

- Since the last liaison meeting the office has issued 50 draft reports and finalised a further 45.
- As of 1 June 2010, the number of overdue drafts (48) is fewer than three months previously (52). Five of these overdue reports still date back to the 2008-09 reporting year, however this is a significant reduction in the number of very overdue cases reported on at the last liaison meeting
- As of 1 June 2010, the number of overdue final reports stands at 42. Three months previous this figure was 35.

Other Publications

- The FII DVD, previewed at the last liaison meeting, has been launched and distributed amongst key stakeholders.
- The PPO Business Plan 2010-11 is now available in hard copy and online
- A combined stakeholder report 'PPO Perceptions' is to be distributed by the end of June. The report incorporates the findings of three stakeholder surveys completed in 2009: a general stakeholder survey, a survey of complainants and feedback from bereaved families.

Arrivals and Departures

- Karen Cracknell has become our sixth team leader and Louise Baker leaves in July.
- Peter Nottage and Bryan Woodward, who have been on secondment to us, are returning to NOMS next month. Their operational expertise and commitment to our work will be greatly missed.
- Marta Rodrigues has just arrived to take over the post of Support Team manager and Mr Rindee Dale has joined our FLO team.
- Due to long term sick leave, absence for other reasons and imminent departures, over 25% of our investigators are not in a position to accept new cases

New Policy

- In response to concerns expressed by families during our first ever Bereaved Families Survey (report by Sue Gauge in February 2010) we have decided that families may be contacted by the relevant FLO three weeks after the death, rather than the previous four and that they will be given eight weeks to consider a draft report, rather than the previous four.