



*National Patient Safety Agency*

**National Reporting and Learning Service**

# **UNDERTAKING A CLINICAL REVIEW FOLLOWING A DEATH IN CUSTODY**

**July 2009**

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## THE OMBUDSMAN'S INVESTIGATIONS

1. The Prisons and Probation Ombudsman (PPO) investigates the circumstances of the deaths of the following people:
  - Prisoners and trainees (including those in Young Offender Institutions and Secure Training Centres). This includes people temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital), and also those on Release on Temporary Licence. It generally excludes people who have been permanently released from custody.
  - Residents of approved premises (including voluntary residents).
  - Residents of immigration reception and removal centres, short term holding centres and persons under managed escort.
  - People in court premises or accommodation who have been sentenced or remanded in custody.

The Ombudsman has the discretion to investigate, to the extent appropriate, other cases that raise issues about the care provided by the relevant Service.

2. This document applies to the investigation of deaths in each category except those in probation approved premises (commonly known as bail hostels). Residents of approved premises register with a community general practitioner and are responsible for arranging their own healthcare. Nevertheless, because of particular clinical concerns, the investigator may ask the PCT to conduct a clinical review following the death of a resident of an approved premises. The Ombudsman appreciates the PCT's cooperation with the request and the content of this document applies to any review of the death of an approved premises' resident.
3. The aims of the Ombudsman's investigation are to:
  - In conjunction with the NHS where appropriate, examine relevant health issues and assess the clinical care.
  - Establish the circumstances and events surrounding the death, especially as regards management of the individual by the relevant service or services, 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 NHS where appropriate, examine relevant health issues and assess clinical care.
  - Provide explanations and insight for the bereaved relatives.
  - Assist the Coroner's inquest in achieving fulfillment of the investigative obligation 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 learned.
4. The Ombudsman allocates an investigator to consider the circumstances of each death. The investigator and clinical reviewer should work closely together throughout the investigation. A family liaison officer is also allocated by the Ombudsman and is

responsible for asking the bereaved family whether they have any questions which the investigator and clinical reviewer should address.

5. For the purpose of investigations, the Ombudsman has unfettered access to information, documents, establishments and individuals, including material and information provided to the services by other organisations. This includes the prison's clinical records, including any electronic records, which should be one of the first documents to be requested. The Ombudsman's investigator will arrange for copies of the documents, including the clinical records, to be provided for the clinical reviewer. Further information about the types of documents available can be obtained from Prison Service Order (PSO) 2710.
6. The Ombudsman operates on the basis of full disclosure of his investigation, including relevant records, interviews and the report, to the bereaved family and the service in remit. The only exceptions are:
  - The redaction of information which could jeopardize the security of the establishment or breach the confidentiality of other prisoners.
  - As laid out in the Data Protection Act where permitting access to the data would be likely to cause serious harm to the physical or mental health or condition of any other person.

The office's disclosure policy is published on the website ([www.ppo.gov.uk](http://www.ppo.gov.uk)) and applies equally to the clinical reviewer.

7. The Ombudsman's investigator will consider every aspect of the prisoner's care, including a lay perspective on healthcare. The investigation and clinical review should be consistent and complementary.
8. Prisoners have often been in more than one establishment and the Ombudsman's investigator and clinical reviewer should decide on the scope of the investigation according to the circumstances of the case. For example, the review would consider the healthcare provided in more than one establishment if the prisoner was transferred and died shortly after arrival at another prison.
9. The Ombudsman's Terms of Reference are restricted to considering the care provided by and at the services in remit. It may be appropriate for the reviewer to access records from the hospital or ambulance service to address issues which do come into the Ombudsman's own investigation. The Ombudsman will not make recommendations to NHS care such as secondary healthcare, community mental health services and the ambulance service. If the reviewer, on behalf of the PCT, considers that such healthcare provision is relevant, they may comment on it in the clinical review and draw it to the attention of the healthcare provider.
10. Any urgent matters which are identified in the course of the investigation, including healthcare issues, should be reported to the prison Governor at the earliest opportunity.
11. The Ombudsman has a target to issue the draft report of a death due to natural causes within 20 weeks and the draft report of any other death within 26 weeks. The clinical reviewer will be asked to complete their review within ten weeks of the notification. The investigator will ensure that the relevant issues have been fully addressed and the

review incorporated into the Ombudsman's report. The investigator will consult the reviewer if there are matters which require further exploration, clarification or correction such as providing a Plain English alternative. More information about the investigator's role is available in the Investigation Manual published on the Ombudsman's website. Any serious concerns about an individual member of staff will be directed, if necessary, to the relevant regulatory body.

12. The following stages take place once the PPO investigation and the clinical review are complete:
- The Ombudsman's investigator drafts the report which incorporates the clinical issues and recommendations.
  - The draft report is issued to the family and Service(s) who have a period of time to give feedback. Advance disclosure is provided if an individual member of staff is criticised.
  - The service in remit and the healthcare provider are asked to provide an action plan in response to the recommendations. More questions may be asked and, occasionally, more investigation is needed which may include clinical matters.
  - The report is finalised, including the response to the recommendations, and is used by the coroner to prepare for the inquest.
  - A final report which makes serious criticisms of a member of staff will recommend that the appropriate disciplinary procedures are implemented, and may in extreme cases, recommend referral to the appropriate regulatory body.
  - Both the Ombudsman's investigator and the clinical reviewer may be called to give evidence at the inquest. Although the inquest should not be an adversarial process, the interested parties (which include the bereaved family, the service where the death took place and may include specific members of staff) may have different perspectives of the individual's management as identified by the PPO investigation and/or the 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.
  - After the inquest, the annexes, including the clinical review, are removed and the Ombudsman's report is anonymised and published on the website.

## CLINICAL REVIEWS

13. Primary Care Trusts have commissioning responsibility for the primary healthcare services in all public prisons in England. The Secretary of State for Health has agreed that Primary Care Trusts will take the lead in investigating the clinical issues relating to deaths in custody. Therefore, the local Primary Care Trust, for all public prisons, has the lead responsibility for arranging an independent investigation of the clinical issues under their existing procedures and may be required to attend the inquest. For privately managed prisons, the PPO and Department of Health will arrange for an independent clinical investigation to be carried out. The arrangements in Wales rest with the Health Inspectorate Wales, who take the lead in all the clinical reviews.

14. The Ombudsman's Terms of Reference state that:

### Clinical issues

The Ombudsman's investigation includes examining the clinical issues relevant to each death in custody – such deaths are regarded by the National Patient Safety Agency (NPSA) as a serious untoward incident (SUI). In the case of deaths in public prisons and immigration facilities, the Ombudsman will ask the local Primary Care Trust or, in Wales, the Healthcare Inspectorate Wales (HIW) to review the clinical care provided, including whether referrals to secondary healthcare were made appropriately. Prior to the clinical review, the PCT will inform the NPSA of the SUI. In all other cases (including when healthcare services are commissioned from a private contractor) the Ombudsman will obtain clinical advice as necessary, and may seek to involve the relevant PCT in any investigation. The clinical reviewer will be independent of the prison's healthcare. Where appropriate, the reviewer will conduct joint interviews with the Ombudsman's investigator.

15. A clinical review is required regardless of whether an internal Serious Untoward Incident (SUI) investigation is being carried out. Subject to the suitability of the SUI arrangements, and especially the independence of the SUI investigator (see below), it may be appropriate for the SUI report to form the clinical review. Advice should be sought from the PPO investigator.

### **Selection of the clinical reviewer**

16. The PCT will decide how and by whom the investigation will be undertaken. The lead reviewer should be:

- an appropriately registered healthcare professional with clinical expertise in the area to be covered in the review
- or an appropriate multi-disciplinary review panel.

The reviewer or panel members must not be working in or directly involved or have supervisory links with the delivery of care at the establishment under review. Neither should they have line management responsibilities for the staff delivering healthcare in the prison. It is also undesirable for a reviewer to undertake all the reviews at a prison and care should be taken that their independence is not jeopardized by becoming over familiar with the establishment.

17. The Ombudsman's view is that clinical reviews are a vital element of his investigations and that the independence of the reviewer is essential. Failure to provide a properly independent reviewer puts the Ombudsman's investigation at risk of challenge by interested parties to the inquest and also by the coroner. The person responsible for the review should therefore be independent of those involved in providing healthcare and responding to the events.
18. When other health service providers have contributed to the care of the deceased, then the review should consult and/or involve representatives from such organisations in the review, as required. For example; mental health providers and the prison's in reach mental health team, drug and alcohol services and acute hospital trusts.
19. From time to time the Ombudsman considers that the clinical reviewer or panel members are not appropriate to conduct the review, either because they do not have the appropriate clinical expertise or because they have been involved with the care of the prisoner. In such situations the investigator will ask the PCT Chief Executive to consider appointing an alternative reviewer. If the Ombudsman remains dissatisfied, the Director of Offender Health at the Department of Health, will be asked to intervene.

#### **Panel reviews**

20. The panel review enables clinical reviewers to take a multi-disciplinary and multi-agency approach to reviewing the clinical care afforded to an individual and promote informed evidence based discussions, peer review and decision making.

#### **Identifying a Lead Clinical Reviewer (LCR)**

21. The LCR takes a central role in the organisation and conduct of the clinical review. The LCR should possess the following skills and expertise:
  - Relevant experience in the healthcare area under review.
  - An understanding of healthcare in custodial settings.
  - Relevant clinical, administrative and managerial expertise.
  - Co-coordinating, chairing and networking abilities.
  - An understanding of the clinical review process.
  - The training and capacity to give evidence in a Court of Law, including the Coroner's Court, if required.
22. The LCR must be given the time and resources, including administrative support, necessary to be able to lead the review, chair the panel and complete the review within the agreed timetable.
23. Membership of the panel will be dependent on the chronology of health and social care events leading up to the death and identified issues and concerns. Panel members must not work in the establishment(s) under review, directly manage the staff involved or have supervisory links. The size of the panel will vary but experience suggests that small is best. Too many members may lead to appointment complications and extensions to timetables.

24. Suggestions for panel membership include the following:
- LCR/ Chair
  - Prison healthcare representative
  - Clinical governance
  - Specialists
  - PPO investigator
  - Governor or prison grade representative
  - Lay person
25. The PPO investigator should be invited to join the review panel to give a lay perspective to the review, gain a better understanding of the health services an individual received and ensure that the family's concerns are addressed.
26. When other service providers have been involved in the delivery of care (eg mental health services), an appropriate specialist should be invited to be a panel member. Specialist members should not work in the prison where the death took place or be involved with the care of the deceased.
27. A documented briefing meeting should be held for panel members to outline the process, construct a timetable, address any concerns and agree the terms of reference. They are likely to include the following:
- To examine the provision of care and treatment, including risk assessment and risk management.
  - To provide a chronology of the health and social care events leading up to the death.
  - To identify any care or service delivery failures along with the factors that contributed to these problems.
  - To examine policy and practice.
  - To identify any root cause(s) that inform the identification of learning opportunities to be included in the action plan.
  - To make clear, sustainable recommendations for the health community and the prison service.
  - To provide explanations and insight for the relatives of the deceased.

## **AIMS OF THE CLINICAL REVIEW**

28. The aim of the review is to consider the care the deceased received whilst in prison custody. An approach of HOW and WHY should be adopted, not WHO was to blame.
- How when and where did the prisoner die?
  - Is there any root cause(s) of the death?
  - Was the clinical care equitable with the wider community?
  - Are there any learning opportunities?
  - Were local and national policies and procedures followed?
  - Is there an opportunity to prevent future deaths in similar circumstances?
  - Are there any examples of good practice?

## **The scope of the clinical review**

29. The clinical review process should be carried out using the existing local and Strategic Health Authority (SHA) mechanisms for reviewing serious untoward incidents or in accordance with the NPSA Root Cause Analysis process or by using a panel review process. The National Patient Safety Agency (NPSA) requires that “any unintended or unexpected incident that could have or did lead to harm for one or more persons receiving NHS funded healthcare”, be investigated in a timely and appropriate manner.
30. The review should:
- Examine the provision of clinical care and treatment, including risk assessment and risk management.
  - Examine, to the extent necessary, the secondary care provided.
  - 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 cause(s) that inform the identification of learning opportunities to be included in the action plan.
  - Make timely, clear and sustainable recommendations for the health community and the prison service.
  - Provide explanations and insight for the relatives of the deceased.

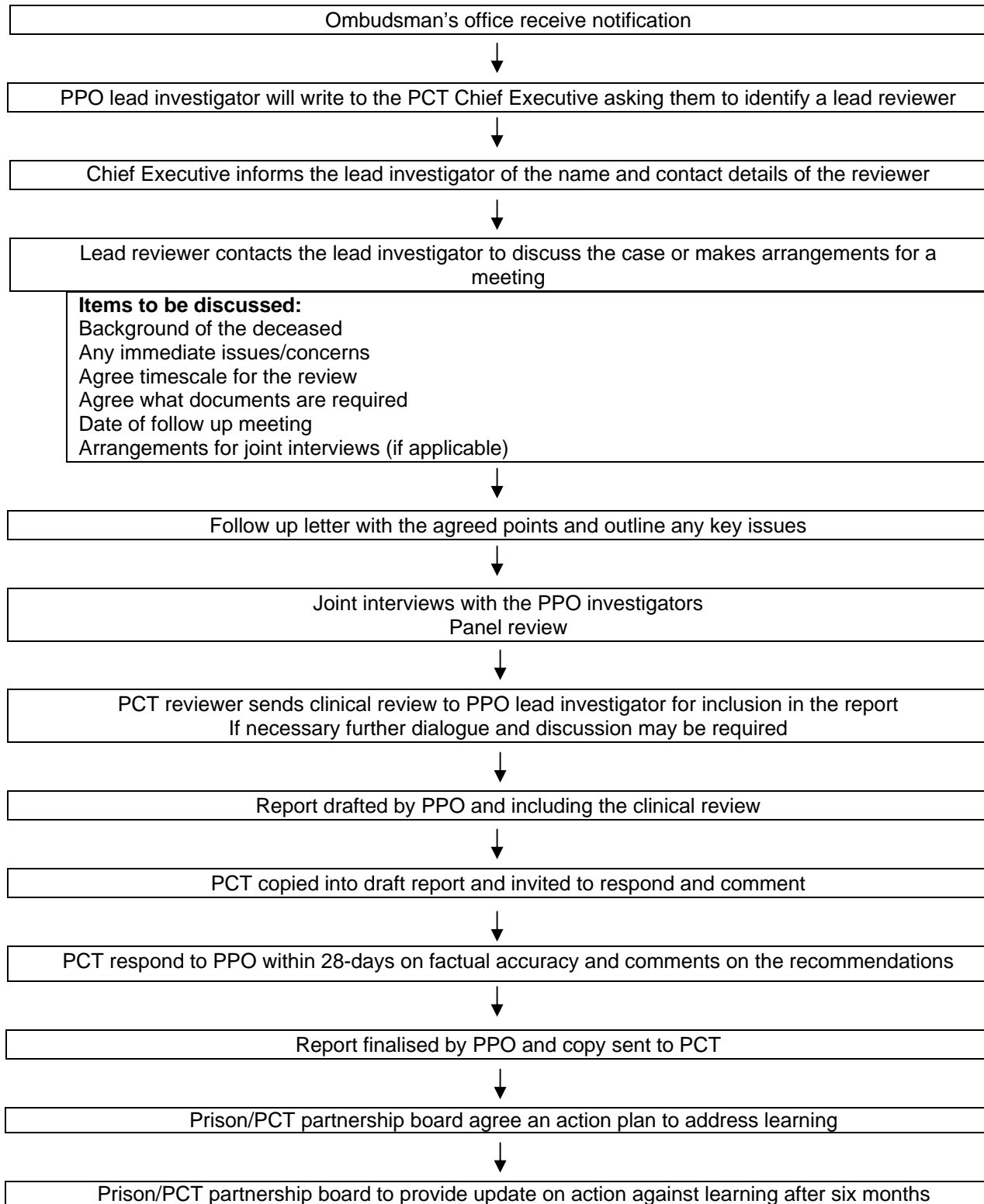
## **Interviewing staff and prisoners**

31. In some cases a review of the available documentation may be sufficient for the reviewer. However, in the majority of cases, the healthcare staff who have had significant dealings with the prisoner should be interviewed. The Ombudsman’s investigator and the clinical reviewer should conduct such interviews jointly. Each interviewee is entitled to be accompanied by a friend or Trade Union representative. The interviews will be recorded and the Ombudsman’s office will prepare a transcript which is checked and signed by the interviewee. The interview transcripts will be forwarded to the clinical reviewer as soon as they are available. The transcript is annexed to the Ombudsman’s report when it is issued to the bereaved family and the service in remit.

### **What information is available to support the review process?**

32. This is not an exhaustive list, but provides some guidance as to what documents may be available to enable the review to be carried out. PSO 2710 – Follow up to deaths in custody provides more information about the types of records a prisoner may have.
- The clinical record
  - The prison records
  - Police and prison statements
  - GP records
  - Acute trust records (if required)
  - Mental Health Trust Records
  - Post mortem results are available from the PPO investigator subject to their release by the Coroner
  - Local policies and procedures
  - Prison Service standards
  - National Service Frameworks
33. More information may be needed during the review, and the Ombudsman's investigator should be asked to obtain it.

## THE PROCESS FOLLOWING NOTIFICATION OF A DEATH



## **SUGGESTED AREAS FOR CONSIDERATION AS PART OF THE CLINICAL REVIEW**

34. This list is not exhaustive but gives some guidance to suggested areas of investigation if appropriate and has been drawn up using learning opportunities and findings from previous investigations. The clinical reviewer or panel should consider involving specialists to contribute to the review as required.

### **Family**

35. Care should be taken to respect the privacy and dignity of the deceased who may have withheld information from the 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 issues raised by the family.
  - Were arrangements for notifying the family of a serious illness timely?
  - Were links with the family appropriately considered and maintained?

### **Records and Record Keeping**

36. Record keeping is an integral part of the care process and is a tool of professional practice. It is not an optional extra to be fitted in if circumstances allow. The quality of records and record keeping should be considered against the standards laid down by the relevant professional bodies.
37. Are there regular documented audits of the standards of record keeping as required by the NMC/HPC and GMC?
- Is the documentation and record keeping adequate and appropriate?
  - Are the records factual, consistent and accurate?
  - Written as soon as possible after the event has occurred, providing current information on the care and condition of the patient or client?
  - Written clearly and in such a manner 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 and offensive subjective statements?
  - Are the entries respectful to the patient/client?
  - Are the entries 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?

### **Reception Medical Screening**

- Was the appropriate screen completed?
- 1<sup>st</sup> Health screen on the 1<sup>st</sup> night into reception
- 2<sup>nd</sup> Health screen completed within 5 days of receipt into prison
- 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 substance misuse?

## **Mental health**

- Did the prisoner have a mental health history?
- Were attempts made to obtain their previous records?
- Was the correct mental health diagnosis made in custody?
- Were they referred to local MH services?
- Were they receiving appropriate MH care to meet their need?

## **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 GP or other specialist health provider?
- If a terminal illness had been diagnosed, was Release on Temporary Licence/ Compassionate Release recommended to the prison authorities? If not, why not?

## **Equitable care**

- Was the care of the prisoner received comparable with the care they could expect to receive in the community?
- Was the care consistent with National Service Frameworks?
- Were external agencies involved in the care of the prisoner if considered necessary?
- Were appointments cancelled by the prison or by the external agencies?

## **Substance Misuse**

- Was a full history of the drug and alcohol use obtained?
- Was the prisoner referred to specialist clinical drug services?
- Were they referred to other drug and 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?

## **Suicide and self-harm**

- Were there any key suicide or self-harm indicators identified?
- Were these acted on and managed appropriately?
- Was the prisoner on a suicide and/or self-harm (Assessment, Care in Custody and Teamwork) support plan?
- Was the ACCT plan referred to in the 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 health care input into the prisoner's care/management plan?
- Was the NICE guidance used to care for those at risk of suicide and self-harm?

### **Communication**

- Was the prisoner consulted about their care plan?
- Was appropriate information passed between the health care department and other departments within the establishment?
- Were any Medical in Confidence issues appropriately dealt with?
- Was appropriate information passed between health and social care agencies?
- Is there an information sharing protocol locally agreed?
- Was the standard of record keeping appropriate to ensure effective communication?

### **Policies and Procedures**

- Are there local policies and procedures in place?
- Do these 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?

### **Incident**

- Was the clinical response to the presenting symptoms 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 learnt?
- Is the clinical governance arrangement satisfactory?

### **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 health needs of patients?
- Do the interview 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?

### **Post incident support**

- Did the staff involved in the incident receive appropriate and if required continuing clinical supervision and psychological support?
- Did healthcare professionals participate in a post incident debrief?

### **Medicines management**

- Is the 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?

### **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 the staff received appropriate training and development to meet the health needs of the prisoners they care 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?

### **Escorts and bed watches**

- 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?

## **SUGGESTED STRUCTURE FOR THE CLINICAL REVIEW**

38. The National Patient Safety Agency and the Department of Health have agreed that the NPSA template for investigating Serious Untoward Incidents is a suitable format for the Ombudsman's clinical review.
39. Plain English should be used when drafting the report and technical terms must be explained. The review will be read by a wide audience, including the family of the deceased, and not all will have clinical expertise.

**Introduction** - a brief outline of the case.

**Terms of reference**

**Reviewer's professional qualifications and experience (relevant to the case under review)**

**Membership of the Review Panel (if appropriate)**

**Methodology**

**Outline medical history**

- A brief overview of the prisoner's medical history prior to admission to prison, including any relevant medical history.
- A brief overview of the prisoner's physical and mental condition at the time of admission.

**Background information** – including relevant and significant health and social care history.

**Chronology of events, key findings and recommendations** - chronological record of events from the medical records available. This is best presented in a tabular form.

**Other issues of concern**

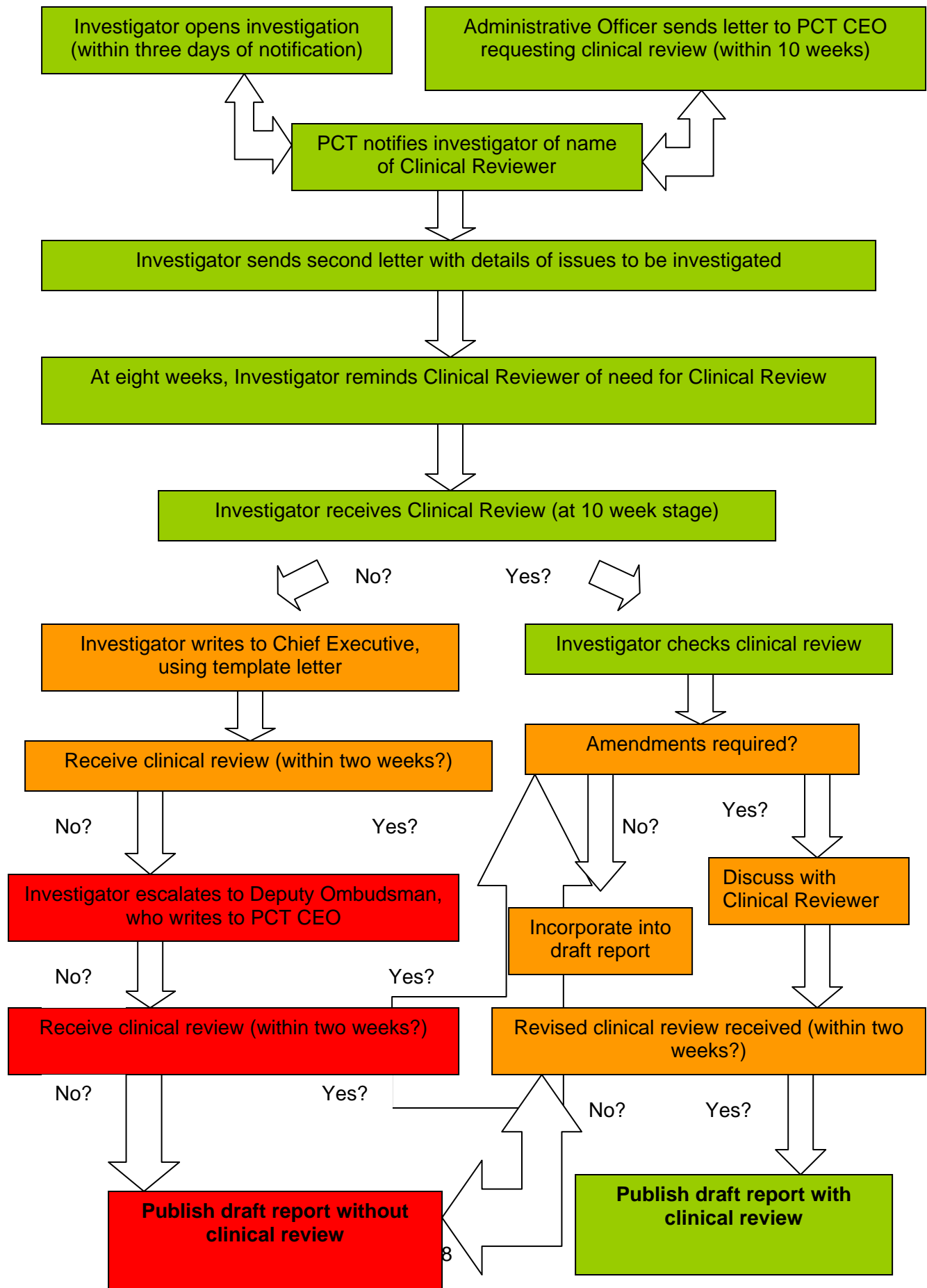
- A review of the care the prisoner received whilst in custody from the prison health services compared with the services they could have expected to receive from a primary care provider in the community.
- A review of the care and management of the prisoner by the local secondary or tertiary care provider (if appropriate).

**Recommendations** - the recommendations should be **Specific, Measurable, Achievable, Realistic and Timebound** and based around a holistic approach to the wider health and social care agenda.

**Good practice** - identify any areas of good practice.

## **PPO ACTIONS IN THE EVENT OF A DELAYED CLINICAL REVIEW**

37. The quality and timeliness of clinical reviews are a major consideration for the Ombudsman's office and the cooperation of the clinical reviewer and the PCT is much appreciated. In the event of a delay of more than a month in the appointment of a suitably qualified and experienced reviewer being appointed, or if the review is over a month late, the investigator will write to the PCT, copied to the Director of Offender Health at the Department of Health. The relevant Strategic Health Authority would then be asked to intervene.
38. The PPO has a target that the draft report of every death due to natural causes will be published within 20 weeks and the report of every other death will be published within 26 weeks. The targets are rarely met and a recent survey found that there were 69 overdue draft reports of which 51 were delayed by the clinical review. At the same time an analysis of 53 clinical reviews found that only nine had been received early or on time and the remainder ranged from one month to ten months late with the average timescale being 3.5 months late. Eight reviews were still outstanding and these ranged from one to four months overdue, with an average delay to date of nearly three months.
39. Delays have a wide impact. Within the PPO office they take up investigators' and managers' time, which is spent dealing with the cause of the delay rather than focusing on investigations. This has a domino effect on other cases and is not good for office morale or for the achievement of annual appraisal objectives. Externally the delays issuing reports affect many people, most particularly the bereaved families. It is only when the report is issued that many families realise that there are issues about the care that their relative received and then appoint legal representation, which in turn adds to the delays. Other agencies affected by delays are the services in remit. Their staff have to wait to see the judgements of their work and the establishment does not have the PPO's recommendations, which delays the implementation of good practice. PCTs as providers and commissioners of prison healthcare are also affected in that their staff are also part of the investigation and recommendations are frequently made regarding improvements to healthcare. Finally coroners are frequently frustrated by delayed PPO reports which impact on the inquest process. Occasionally the inquest is held without the assistance of the PPO report.
40. The flow chart overleaf outlines the steps which the investigator will take if the review is delayed including correspondence with the PCT, copied to Offender Health. Consideration will be given to publishing the report without the benefit of the clinical review. In such cases, the PPO may make a recommendation to the PCT about the absence of a review.



## LEARNING STRATEGY

41. Learning is integral to the clinical review process. It involves sharing good practice and learning lessons on how things may be improved. All prisons and PCTs must have processes in place for making sure that lessons are learnt, recommendations are put in place and improvements are sustainable.
42. When the review team uncovers the need for urgent action at any stage of the review, this information is passed on to the PCT and/or prison without delay, so that appropriate action can be taken promptly.
43. Following the clinical review dissemination of learning happens at different levels, locally, regionally and nationally, although specific systems and mechanisms may vary according to locality.
44. The PCT/Prison Partnership Board disseminates learning and action planning to care and prison staff within the locality, including staff who were directly involved with the care and custody of the deceased. The prison and the PCT have mechanisms for the dissemination, implementation and monitoring of action plans.
45. Each Region has, or is developing, a network for the discussion and management of patient safety and quality issues. This network will develop as a forum for sharing learning from clinical reviews, monitoring action plans and disseminating learning. The network is likely to consist of representatives from SHA clinical governance, the NOMS Safer Custody Group and the Care Services Improvement Partnership (CSIP).
46. Learning from clinical reviews and PPO investigation reports is shared nationally through the following organisations: the NPSA (and then to the Care Quality Commission), Safer Custody Offender Policy Group and the PPO.
47. An update on the implementation of recommendations and action plans should be submitted to the PPO six months after the release of the final investigation report.

## USEFUL LINKS

Prisons and Probation Ombudsman	<a href="http://www.ppo.gov.uk">www.ppo.gov.uk</a>
Department of Health (prison health)	<a href="http://www.dh.gov.uk/prisonhealth">www.dh.gov.uk/prisonhealth</a>
HM Prison Service	<a href="http://www.hmprisonservice.gov.uk">www.hmprisonservice.gov.uk</a>
National Patient Safety Agency	<a href="http://www.npsa.nhs.uk">www.npsa.nhs.uk</a>
National Institute for Clinical Excellence	<a href="http://www.nice.org.uk">www.nice.org.uk</a>
Health Service Ombudsman	<a href="http://www.ombudsman.org.uk">www.ombudsman.org.uk</a>
Care Quality Commission	<a href="http://www.cqc.org.uk">www.cqc.org.uk</a>
Her Majesty's Inspectorate of Prisons	<a href="http://www.inspectorates.homeoffice.gov.uk/hmiprisons">www.inspectorates.homeoffice.gov.uk/hmiprisons</a>