

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

10 March 2011

Present:

Mary Piper, Offender Health (OH)
Thea Walton, Prisons and Probation Ombudsman's Office (PPO)
Poppy Harrison, Youth Justice Board (YJB)
Trevor Brading, Serco
Gordon Morrison (PPO)
Sean Langley, National Offender Management Service (NOMS Approved Premises)
Sue Gauge (PPO)
Rachel Gyford (PPO)
Susannah Eagle (PPO)
Ann Gilbert (PPO)
Matthew Leng, Independent Advisory Panel (IAP)
Barbara Treen NOMS (Women)
Steve Lusted (PPO)
Claire Smith (OH)

Apologies:

Debra Baldwin (OSRR), Duncan Partridge (United Kingdom Border Agency)

1. Minutes of the last meeting were agreed
 - Thea Walton said that she and Jane Boys had met to discuss escalating clinical review problems.
 - PPO now have copies of all OSRR Quick Time Learning Bulletins
 - Poppy Harrison able to update group on young women's estate at this meeting.
 - Changes since the last meeting: PPO assured of future existence and recruitment of permanent Ombudsman underway. Due to budget cuts, PPO will be looking closely at internal processes and procedures over the coming months, however our Terms of Reference remain unchanged.

Action point: Gordon Morrison to supply Mary Piper with a copy of his gym related deaths paper.

2. PPO report

Gordon Morrison provided the PPO report, which led to some group discussion.

 - Mary Piper asked whether PCTs were performing any better in relation to the timeliness of clinical reviews. Thea Walton said that it was difficult to comment on this as the PPO has not historically gathered detailed information on clinical reviews (although this is now being gathered). Gordon Morrison commented that there were still problems with clinical reviews.
 - Trevor Brading commented that it seemed a number of coroners were now dealing with inquests without involving the PPO. Thea Walton explained that it is a very mixed picture, with some coroners refusing to schedule inquests until they had received our final report and always calling the investigator to give evidence, while others did not. Mary Piper asked why they would not include the PPO. Thea explained that this was largely down to each coroner's preference. Mary also asked if the PCT delay in issuing clinical

reviews was ever responsible for holding up inquests. Thea confirmed that this can be the case, largely because they can delay the PPO.

3. Women

Barbara Treen updated the group on the women's estate. There has been a recent death at Bronzefield, which is looking like natural causes.

The women's team have been asked to carry out training for Women's Centres in relation to self harm. They hope to invite Approved Premises leads too.

4. Approved premises

Sean Langley updated the group, noting that it looks like there will have been 12 AP deaths this financial year (unless there are any changes before the end of March). This is the lowest figure for some time.

A recent inquest involving the death of an AP resident has led to a Rule 43 letter. NOMS have rejected some points but the Probation Trust has generally accepted most of the findings.

Sean clarified that learning from PPO investigations is shared with all Probation Trusts.

Action point: Barbara Treen asked if the Women's Team could be copied in to any learning bulletins.

A new specification for APs will shortly be formally implemented. The specification sets out service elements covering suicide/self harm and well being and makes the duties on APs more clear. A manual giving guidance and instruction will be issued behind the specification. The manual will include recent PPO recommendations and will be updated periodically.

The group asked if it was possible to identify good practice or learning helping to reduce the numbers of deaths in APs. Sean explained that the number of self inflicted deaths was low but that this was where staff could make the most impact. However, he said it was hard to distinguish any particular factors reducing the number of deaths.

5. Youth Justice Board

Poppy Harrison gave the update. The Government has proposed that the YJB should be abolished as a non-departmental public body. The functions of the Board will largely move to a distinct unit within the MoJ, probably by the end of March 2012.

Restructuring following reductions in staff mean that community and custodial serious incident will be brought under one umbrella, including the YJB's lead on safeguarding and public protection, to provide a more consistent approach.

There have been no deaths of young people since 2007. However there have been 3 deaths of 18 yr olds who had some involvement with the YJB/YOTs and so the YJB is assisting with these investigations as relevant.

The second Adam Rickwood inquest concluded in January. So far, no Rule 43 letter has been issued. The YJB has already brought in a range of improvements, however they have approached the coroner for any areas where further development is needed and will then develop an action plan.

In terms of the use of restraint, the policy has now changed. Nose distraction techniques are now banned, although other distraction techniques are allowed in limited circumstances. Use of all distraction techniques has dropped. A new behaviour management system is due to be in place within 12 months.

Trevor Brading commented that the inquest hearing had highlighted a number of other important factors in Adam's death. Group discussed the impact of young people being placed some distance from home. This is particularly relevant for girls, due to the small number of facilities for them.

Work to begin on analysing rates of suicide in custody compared with young people in the community.

Girls: there have not been any deaths of girls in custody since the YJB started. However, self harm levels are higher than those for boys and there is continuing work looking at three non-fatal cases where there are allegations of Article 2 engagement. Poppy commented that work would begin shortly to increase understanding of girls who self harm in custody and whether there are examples of effective practice which can be shared by the YJB in terms of prevention and treatment.

6. Independent Advisory Panel

Matthew updated the group. Jane Boys leaves the IAP in March to begin maternity leave, however, her post was made redundant in any case. Laura McCaughlin will cover Jane's post in the meantime and Matthew will attend the liaison meetings.

The next Ministerial Board is on 16 March. The working groups on mental health will present then, both contain recommendations.

Action point: Matthew to update group on recommendations at next meeting.

The IAP has commissioned an organisation (Caring Solutions) to review restraint related deaths (where death occurs during or shortly after restraint, or where restraint is mentioned at inquest), with an interim report due by June 2011, and the final report by October 2011.

Stakeholder conference took place last week – and has provoked positive feedback so far. Next bulletin in March will contain overview of the day.

IAP will be commissioning analysis of all recommendations in Rule 43 letters and narrative verdicts. Work hopefully to be completed by October 2011.

7. Offender Health

Mary Piper told the group that the planned changes to the NHS will not affect those in custodial settings. The commissioning of healthcare in prisons and other custodial settings will be the responsibility of the NHS Commissioning Board. Public Health England (who will cover drugs, infectious diseases, etc) will be responsible for prisoners/custodial settings. There is a possibility, therefore, of developing a more specified service, which Mary sees as a positive.

In terms of clinical reviews, the performance management of reviewers may rest with the Commissioning Board.

Ken Clarke is due to meet Andrew Lansley soon and the timeliness of clinical reviews is on the agenda for discussion.

Action point: PPO to provide Mary with clinical review stats quarterly

Mary said that OH had done well in the spending review, taking over responsibility for all drug treatment in prison and had been given the requisite budget to do so. In addition, over time, OH has a significant budget to develop a service to increase diversion from custody.

8. Serco

Trevor Brading introduced himself and the work of Serco to the group. Trevor is the senior investigator, responsible for investigating serious incidents. He is developing systems for sharing the learning and improvement across the division. Trevor has developed a strategy for preventing/reducing the number of serious incidents, which he outlined to the group. There are four strands to the strategy: learning, training and development, continuous improvement, review and assessment and case management. This is underpinned by an action plan, including training for new staff.

Trevor has developed a register of recommendations – both PPO and internal, which will be maintained and updated.

Action point: PPO and IAP asked for sight of the register. Trevor happy to bring to next meeting for discussion.

9. AOB

Suggested themes for next meeting:

- AP learning
- IAP work due to be published before next meeting
- PPO analysis of self inflicted deaths data

PPO asked about timing of permanent Ombudsman appointment. Suggested timeframe is that new Ombudsman may be in post by July 2011.

Date of next meeting:

9 June 2011