Prisons & Probation Ombudsman
Independent Investigations

Fatal incidents investigations

Post-investigation survey 2015-16

Foreword

Feedback from stakeholders is very important to the continuous improvement of our investigations into deaths in custody. To that end, our stakeholder survey was introduced two years ago, to allow custodial staff, healthcare professionals, and Coroners to give their opinions on the investigation process, as well as the reports we produce following these incidents. I am grateful for their feedback.

I am pleased that the survey results show my office is strong in the areas of communication with it's stakeholders, timeliness of reports, and that investigators show due sensitivity in their inquiries, given the upsetting nature of deaths in custody for all involved. Moreover, I am happy that stakeholders consider the recommendations we make to be clear (96%) and fair (94%), and believe that these bring about real changes within establishments that will improve conditions and help save lives.

This feedback has also allowed me to identify some specific actions for my office to improve our services. In particular, we will take steps to better understand healthcare within establishments, promote the broader 'learning lessons' purpose of investigations more widely, and further improve communication with liaison officers. Taking these steps will better enable my office to fulfil our vision, to carry out independent investigations to make custody and community supervision safer and fairer.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

Executive summary

- Overall, feedback about the investigative process and resulting reports was largely positive, though a few areas for improvement were identified.
- The majority of stakeholders have a high opinion of our investigators and the investigative process, with 99% of applicable respondents reporting they were contacted promptly and that the investigator was professional and courteous. The survey identified investigators as having a good understanding of the system in which they operate for 97% of applicable respondents. Further, 98% of stakeholders characterised the investigation as transparent, and 100% of stakeholders characterised the reports satisfactory or better, with 76% rating them 'good' or 'very good'.
- Our recommendations were well received, with 96% of respondents reporting they were clear and 94% characterising them as fair. Where recommendations were made, stakeholders reported that they brought about positive changes within their establishments.
- One of the strategic goals of the PPO is to identify collective learning for the services in remit to make custody safer and fairer. However, there is some evidence that staff in establishments are not fully aware of this role.
- There maybe scope for improving our investigators' understanding of healthcare roles within the system. Healthcare professionals, while not negative about investigations, tended to be less positive than liaison officers or establishment heads, and sometimes felt we did not have as thorough an understanding of the system in which they operate.
- While communication with stakeholders was mentioned as a particular strength, there is still more we could do to improve. Specifically, we can review information we give to liaison officers, and work with prisons to ensure a smooth liaison officer handover should this occur during the course of an investigation. We can also be sure to give information about availability and secondary contacts in the case of flexible working arrangements.
- While we have made good progress incorporating new technology, such as video-conferencing, in our interviews to make it more convenient for stakeholders, we must take corresponding steps to ensure consistency between video and in-person interviews.
- Stakeholders would welcome examples of good practice within establishments where we come across these, in order to learn from successes as well as mistakes.

Introduction

This report presents findings of the PPO's post-investigation survey. The aim of the survey is to collect feedback on the performance of the PPO from stakeholders who have been involved with an investigation into a death in custody. The survey collected feedback from establishment heads, establishment healthcare leads, and PPO liaison officers. The liaison officer is an officer appointed by the establishment to help facilitate the PPO investigation and act as a main point of contact for the investigator. Feedback was also collected from the healthcare commissioner for the establishment, and the Coroner responsible for the related inquest. By collecting this feedback, we aim to better understand these stakeholders' opinions of and experiences with the investigation process. We will use this information to consider what we can do to improve and ultimately better carry out our investigations.

The survey was first launched in March 2014 and the findings from the first year of the survey were reported last year. The questionnaire was then reviewed and re-launched in the summer of 2015. The responses analysed in this report are based on the re-launched survey and were collected from August 2015 through March 2016. While the number of responses to this year's survey was smaller than last year's, and the responses were collected over a shorter time period, we received enough to feel confident in making suggestions for changes based on this feedback.

This report is organised into a number of sections. The first outlines the methodology used to collect and analyse this data. The following sections summarise the findings, first analysing questions asked to all or most stakeholders, then turning to questions specific to individual roles. Tables and charts showing the data appear in appendices at the end.

A brief note on terminology

While the majority of deaths that the PPO investigates are of prisoners, we also investigate deaths of immigration removal centre detainees, probation approved premises residents, and young people in detention. Surveys were also sent out to relevant stakeholders relating to these incidents. Because of this, this report adopts 'catch-all' terminology using, for example, 'detainee' rather than prisoner or resident, and 'establishment' rather than prison or removal centre.

Verbatim responses from stakeholders were reported throughout and were anonymised where the stakeholder identified a detainee, member of staff, or institution.

Methods

Survey methods

In order to improve our investigations, the PPO regularly requests feedback from stakeholders. The post-investigation survey is one of the ways we do this. Once a fatal incident investigation is complete, where possible an invitation to complete the survey is sent to the appropriate establishment head, PPO liaison officer, healthcare commissioner and Coroner. The establishment head is also asked to forward the survey to the healthcare lead for that establishment.

The number of responses by role is shown below.

Role	Responses
Liaison officer	78
Head of establishment	37
Healthcare lead	30
Healthcare commissioner	36
Coroner	12
Total respondents	193

The number of responses covers 132 different investigations. Where the respondent answered most, or all, of the questions in the survey, they have been included in the analysis. Some questions were asked to all respondents; others were only relevant to certain stakeholder types. The number of responses received for each question varies as a result.

As illustrated in the above table, not all roles are proportionately represented. There are a number of potential causes for this. The high response rate from liaison officers may be partly due to how involved they are with the investigation, relative to the other stakeholders. Liaison officers are also more likely than other stakeholders to be involved in only one PPO fatal incident investigation. Other stakeholders – particularly Coroners and healthcare commissioners – may have been involved with multiple investigations and are asked to complete a survey related to each one. This can result in survey fatigue, and therefore non-response. The disproportionality in responses is also likely to be in part a result of the sampling method. As the PPO does not routinely record contact details for healthcare leads, we have to rely on establishment heads to forward surveys to them.

The collection period for data in this report is from August 2015 to the end of March 2016. Due to changes in the collection method that occurred over the summer of 2015, we unfortunately do not have a full year of consistent, comparable data for this survey. The collection period begins at the point the new survey was drafted and ends at the close of the

financial year. Furthermore, the collection period reflects the time investigations were completed and reports issued, and not the date of death. Most of the fatalities occurred in 2014-2015, though some could have occurred earlier depending on the nature or complexity of the investigation.

Analysis

Given the nature of the data collected and the small number of observations, the analysis here is based on unweighted descriptive statistics as well as verbatim qualitative responses to follow-up questions posed within the survey.

The analysis is informed by the qualitative responses, as well as the context of the investigations to which the responses refer. The survey asked the respondent's consent to share information within our organisation. While all responses are included in this report, only responses where stakeholders gave permission for their responses to be shared internally were supplemented with further context.

Where data is broken down by stakeholder type, this should be treated with caution due to the small base sizes. This is particularly true of Coroners, (where the response of one individual represents almost 10% of all Coroner responses), but base size should still be taken into account when considering data related to all stakeholder groups.

Fatal incident investigations

Relationship with stakeholders

The first set of questions we asked concerned the relationship with, and professionalism of, our investigators. On the whole, responses from our stakeholders were very positive. Of those stakeholders who are contacted directly by PPO investigators (healthcare-related stakeholders are contacted by other means), nearly all respondents to whom the question applied said they were **promptly contacted** – 99% of eligible respondents said. The exception to this was one liaison officer, though qualitative feedback offers no context to this.

During the investigation, we expect investigators to show an **understanding** of the systems in which our stakeholders operate. Feedback about this was positive – 97% said the investigator had a good understanding of the system. This was particularly the case with liaison officers who rarely had negative feedback to these questions.

> “
>
> *Very experienced investigator with sound knowledge of systems and issues involved.*
>
> *-Liaison officer*
> ”

Where there were negative responses, they more frequently come from stakeholders within healthcare. This was particularly the case when asked whether the PPO investigator understood the system in which they operated – a few healthcare commissioners and one healthcare lead noted that PPO investigators might not understand the size of teams, the resources available, or the pressure that investigations attract.

> “
>
> *...in general I would say that the PPO investigators are not aware of how small the health and justice teams are, and therefore how onerous compliance with the process is.*
>
> *-Healthcare commissioner*
> ”

The recommendations from the previous year’s survey suggested both reviewing channels of communication with healthcare and inviting feedback from healthcare commissioners. As a result, commissioners were invited to participate in the survey. However, the feedback received from these stakeholders suggests that the PPO could improve their understanding of the role of commissioners and the

environment within which they operate. One possible way to achieve this could be to invite healthcare commissioners or healthcare leads to present at a team meeting, so they can discuss their role, the context in which they work, and the associated difficulties and pressures. Furthermore, the PPO could discuss this finding with its contacts in healthcare, and encourage more active engagement with the investigative process.

Where appropriate, investigators should **keep relevant stakeholders informed** throughout the investigation. Again, feedback in this regard was positive, with 92% of applicable stakeholders reporting they were kept informed as the investigation progressed. Only three stakeholders (two liaison officers and a Coroner) responded 'no' to this question. Qualitative feedback about this was minimal. One liaison officer did identify a particular issue with conflicting schedules due to a flexible working arrangement on the part of the investigator, which they said could have been managed better. It is unclear what the investigator's arrangements were; however, we will encourage investigators with flexible working arrangements to note their schedule and a secondary contact in their introduction.

We strive to be **professional** throughout the investigation. Feedback from stakeholders suggests that, with a few exceptions, we achieve this goal.

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[The investigator] was very courteous and supportive in his approach.

-Establishment head

"

The majority of all respondents, 91%, agreed that the investigation was conducted in a professional and courteous manner, and a further 8% said they could not remember or the question was not applicable to them (ie: they did not have sufficient involvement in the investigation to have an opinion). Only 1% of respondents said the investigation was not conducted in a courteous or professional manner. Qualitative feedback on this question suggested that, in this instance, interviews with two governors were more confrontational than they were expecting:

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I feel that the interviews with both governors were quite confrontational and staff felt like they were being accused of something without being given the opportunity to explain. I have never had this experience with a member of the PPO before.

-Liaison officer

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The transcripts from the investigation in question were examined in order to understand the context of this feedback. While there was no evidence the investigator acted rudely or inappropriately during the interviews, some of the questions they asked during one interview were somewhat pointed, disagreeing with or challenging the interviewee, and this led the interviewee to suggest the investigator had already made up their mind about the incident. It is possible that this was a one-off situation – the questions occurred during the course of an investigation where it seemed the investigator was not given all necessary documentation or the documentation was incomplete, and the pointed questions could have been motivated by this omission. Nonetheless, we do not request feedback only to disregard it. The PPO consistently reviews how interviews are conducted in order to continually ensure appropriate rigor in the investigation process. Similarly, we are very aware that the way in which we conduct interviews impacts on perceptions of neutrality – something we take seriously. As we conduct interview training going forward, we will be mindful of these comments. Furthermore, we encourage this kind of feedback immediately post-investigation, so if our stakeholders have any particular concerns the can be addressed quickly and more appropriately.

Feedback from stakeholders in the previous year's survey suggested that the PPO could be more understanding of the difficulties involved in arranging interviews and, in particular, that we could try to make more use of technology rather than put pressure on an establishment to organise interviews over one day. This recommendation was taken on board, and we are now conducting more interviews over video link. While this has a number of benefits, we still must ensure that the content and quality of the information provided to interviewees during a video link interview is consistent with that provided to interviewees during face-to-face interviews.

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>
> *Although my interview was courteous and polite, it was difficult to interact as it was by Video Link. It felt impersonal and extremely formal. It was quite intimidating.*
>
> *-Healthcare lead*
>
> "

As feedback about our relationship with stakeholders was broadly positive, it is to be hoped that the negative comments made were in relation to isolated incidents. However, it is still important that we reflect on these incidents, and consider potential improvements. This might simply mean reaffirming practices that are already common across the office. As such, we will continue to ensure rigorousness in interview training, ensure stakeholders have necessary information to promote effective communication where the investigator has flexible working arrangements, and ensure that interviewees are given the same information during a Video Link interview that they would have during a face-to-face meeting.

Quality of investigation

At the conclusion of an investigation, the Ombudsman issues a report outlining findings and providing feedback and recommendations to the establishment and stakeholders. Feedback from stakeholders on the quality of investigations and reports was broadly positive. In this section, opinions as to the transparency of the investigation, whether expectations were met, fairness and clarity of recommendations, and the overall quality of the report are discussed in further detail.

Our investigations are independent and we strive to ensure that they and the resulting reports are **transparent**. Feedback in this regard is almost unanimously positive, with 98% of stakeholders responding 'yes' when asked if the investigation was transparent.

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[The investigation was] transparent, but caring towards those interviewed.

-Liaison officer

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From those who responded 'no' there was very little qualitative feedback, save one concern that the investigator was difficult to contact throughout the investigation.

We asked all stakeholders, save liaison officers, what they **expected** to get from the PPO investigation report. In general, expectations were similar, and reflected our aims in writing reports. Stakeholders wanted a clear account of what happened in the lead-up to a death in custody, along with recommendations for what might change to prevent similar events in the future.

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What did you expect to get out of the report?

...recommendations for improving care to other patients. It is always a good thing to have someone review your service, as they may see things that you miss.

-Healthcare lead

...independent investigation into death, including background/history, treatment, issues as to treatment/care, standard of end of life care.

-Coroner

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For the most part, stakeholders considered these expectations fulfilled, with 94% of overall respondents responding 'yes' when asked whether the report met their expectations.

Our stakeholders' evaluations of the **overall quality of the report** were positive – not one report was rated 'poor' or 'very poor'. Coroners, establishment heads, healthcare leads and

commissioners were asked about the overall quality of the report. We did not ask this question of liaison officers as the outcome of a report is not relevant to their involvement with the investigation (ie: they help facilitate the investigation, but are not responsible for implementing recommendations). For the purposes of this analysis, we will consider those who respond ‘very good’ or ‘good’ were positive about the quality of the report, and those who responded ‘satisfactory’ were neutral or mixed.

Overall, 76% of stakeholders were positive about the quality of the report. The remainder considered the report quality to be 'satisfactory’.

Some of those who rated the report ‘satisfactory’, raised concerns with the report’s recommendations or findings. However, in some instances where the respondent commented about the recommendations made, the report for that investigation actually included no recommendations. In these cases, there appeared to be some criticism of the establishment in the report which the stakeholder has interpreted as a recommendation, when in fact a formal recommendation was not made. It is important that stakeholders understand when the PPO is making a formal recommendation, and when we are not. To ensure this clarity, we will continue to be careful about language in our reports, and be particularly aware of this feedback when using critical language without making a recommendation. We also encourage the use of the post-draft fact check to raise any points that require clarification.

Related to this point, we also asked the stakeholders with responsibility for implementing recommendations about their perceptions of the **fairness** of the recommendations. Responses to this were reassuringly positive: 94% of respondents consider the recommendations in the report were fair.

As well as being fair, we aim to ensure that the recommendations we make are **clear**. We have been largely successful in achieving this – 96% of stakeholders said the recommendations in the report were clear or very clear.

Learning lessons

Our fatal incident investigations identify lessons specific to the establishment involved. However, we also seek to identify collective learning based on common themes found across our investigations, so that we can make broader recommendations about practice and policy which are relevant to multiple establishments. It is important that we recognise patterns and identify when there are lessons relevant to a broad audience, so that we can share those lessons appropriately. Similarly, when we repeatedly see the same problem occurring in a particular establishment, we will continue to reiterate the same recommendations until we can see that lessons have been learned and improvements have been made. When investigating a death, the investigator should identify any recommendations that have previously been made to that establishment, so that they can consider whether or not

improvement has occurred. However, qualitative feedback from stakeholders, when asked about the overall quality of the report, suggests that not all are aware of, or in agreement of, this process:

> *My view would be that the investigator or the PPO's office for whatever reason completes the report and then adds in information that looks at previous deaths at the establishment and across the service, which I do not understand, as that is not necessarily fair on all concerned.*
>
> *-Establishment head*

This could be an isolated concern; regardless, it is a significant one. Our third strategic objective, as found in our 2016-17 business plan is to 'improve our influence through the identification and sharing of lessons learned from our investigations.' This objective necessitates taking a broad rather than narrow approach to identifying lessons from across all of our fatal incident investigations, and where we see multiple occurrences of the same concern, we will absolutely use our investigation reports to highlight this. However, not all of our stakeholders may be fully aware of our broader function of identifying trends and developing collective learning. In order to underscore this objective, it may be prudent to take further steps to ensure stakeholders are made more aware of the learning lessons function of our investigations.

The liaison officer role

A liaison officer is a PPO investigator's main point of contact within the establishment. Following a death in custody, the establishment will appoint a liaison officer whose responsibilities fall outside the scope of the investigation. The liaison officer will provide all relevant documentation, provide access to the establishment and arrange interviews with staff and detainees.

81%, or 60 of the 74 liaison officers responding to this question, had **prior experience** in the role.

The liaison officer plays an important role in the investigation, and so it is imperative that they **understand their role**. We expect our investigators to clearly outline what is expected of them throughout the course of an investigation. Most investigators did explain the main liaison officer roles – in particular, outlining the investigation process (88% were given explanations) and explaining the provision of relevant documents (85%). Of those replying 'no' when asked if the investigation process had been explained to them, nearly all identified themselves as experienced liaison officers – they had fulfilled the role on at least one previous occasion and already understood the investigation process. One liaison officer who did not have the process explained, and did not have previous experience as a liaison officer was put in the role mid way through the investigation.

> *I was new to the role & [the detainee] died prior to taking on this role, it may have been explained to my predecessor.*

While this appears to be a rare occurrence, it is important that we work effectively with prisons in the event of liaison officer turnover mid-investigation, so the new liaison officer is not at a disadvantage, and the investigation is not hindered.

Notably, the proportion of liaison officers responding they were informed of particular aspects of their role has fallen since last years' results and, even then, it was recommended that we review the information provided to liaison officers at the beginning of an investigation. Perhaps, in light of these results, this guidance should be revisited.

Liaison officers are also responsible for coordinating interviews within the organisation. The vast majority of liaison officers felt they were given sufficient **notice of interviews**. Only one liaison officer said they were not given sufficient notice. This respondent was the one mentioned in the first section, who had trouble accessing an investigator who had a flexible working arrangement. This would underscore the recommendation made in the previous section: investigators who have such arrangements might have to take additional steps to maintain good communication with liaison officers.

Prior to conducting interviews, investigators **give notes** to those they wish to interview, giving information about both the investigation and interview process. These notes are usually given to the liaison officer to distribute to the interviewees (though, often, investigators also bring them to the interview in case interviewees have not read them previously). Of those included in the analysis, 85% of liaison officers (or 44 out of 52) said they were given notes for interviewees prior to the interview.

Where **transcripts of interviews** are made, the investigator will usually forward these to the liaison officer, who will send them to the interviewee to look over and verify for accuracy. We asked liaison officers whether there was a delay in receiving these. Only one liaison officer reported a delay in receiving transcripts. There was no qualitative feedback about this.

While fairness and impartiality are important core values of the organisation, we recognise that deaths in custody can take an emotional and psychological toll on the establishment staff involved. We try to be considerate of this and strive to conduct interviews with sensitivity and discretion.
Where comments about the **sensitivity of interview** were made to liaison officers, they were largely positive – 84% of comments were positive about the sensitivity of interviews.
It is important to note here that respondents could choose more than one reply – liaison officers could have received both positive and negative comments from different interviewees. As such, the figures shown above also include an option for those who have responded 'both'. Indeed, two of

the liaison officers who report receiving negative comments about the sensitivity of the interview also report receiving positive comments.

The survey also asked whether liaison officers received feedback about the **sensitivity of interviews from detainees**. Only 4 told us they received comments. Of these responses, three commented positively, and one negatively. However, a review of the documentation of the case attracting the negative comment about sensitivity toward prisoner interviewees shows that no prisoners were actually interviewed. Notably, this case also had a negative comment about staff interviewees – perhaps there was some confusion about the wording of the question. All qualitative feedback from this question was positive:

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[The detainee] felt the PPO interview took their feelings into account, the interviewer put the interviewed person at ease.

"

Establishment heads

While establishment heads are not always directly involved in investigations, they are often responsible for implementing recommendations that arise from the report. We asked establishment heads whether we **addressed recommendations to the appropriate individual** or organisation. In all but one case, we had.

The Ombudsman makes recommendations when the need for improvement has been recognised. For these recommendations to be effective in improving safety and fairness for those in custody, it is fundamental that actions are taken as a result. To try to gain an understanding of the impact of our recommendations, we asked establishment heads what changed at their establishment as a result of the investigation. These responses were verbatim and qualitative:

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We changed the procedure in relation to [the] risk assessment of prisoners taken to hospital to take into account the health of a prisoner, and therefore the actual risk they could pose given that it is likely to have significantly lessened.

Whilst we have very low levels of bullying/violence to other prisoners, we have strengthened our approach to dealing with these issues and now provide enhanced support for suspected victims.

[Recommendations have brought about] improved consideration on an individual case regarding appropriateness of restraints and daily operational discussions between governors, health and high security directorate when Cat A prisoners with serious conditions are

on external escort [and] improved processes by medical staff in relation to medication combinations.

"

Broadly speaking, feedback from establishment heads suggests our investigations and resulting recommendations bring about real changes within the establishment, making (as our vision suggests) custody safer and fairer.

Healthcare leads

The survey asked healthcare leads within the establishment for feedback on the clinical review and healthcare-related aspects of the investigation.

As part of an investigation into deaths in custody, a clinical reviewer, independent of the establishment and appointed by the NHS, will supplement the PPO investigator. Their responsibility is to determine whether the care the detainee received was equivalent to that they could have expected in the community. Clinical reviewers produce a report to this effect, outlining their findings.

We asked healthcare leads for feedback about the clinical review, where applicable. Most healthcare leads gave positive feedback.

90% of healthcare leads felt that clinical reviewers **understood the issues involved** in the investigation. Of those who said the clinical reviewer did not, there was little qualitative feedback. Looking at the case files for context does not help further explain these responses.

Where it is practicable and possible, clinical reviewers will conduct joint interviews with PPO investigators. In all investigations that the healthcare leads surveyed could remember, this was the case (15 of 28 responded 'yes'; 13 responded 'don't know/can't remember' to this question).

Similar to the question we asked of establishment heads, we also asked healthcare leads whether the recommendations were **addressed to the correct person**. In a little under 1/4 of cases where there were healthcare-related recommendations, healthcare leads considered they were addressed to the wrong person. Feedback suggests perhaps we generalise about the structure of healthcare at the establishment – in several cases, the respondent noted that the recommendations were made to the 'Head of Healthcare' when no such position existed. In these cases, multiple healthcare providers operated within the establishment and, while there were multiple healthcare leads for different teams in different healthcare areas (ie: Mental Health, Nursing), there was no specific 'Head' that oversaw all teams. As such, recommendations that should have been for a particular team to implement were being, in effect, addressed to a team that was not relevant to the investigation.

> *[The recommendations] are always addressed to the Head of Healthcare even though the post does not exist. There are currently 3 healthcare providers at [the establishment].*

This is a comment that we hear frequently, and we certainly take the point that recommendations should, wherever possible, be addressed to the most appropriate individual. However, all initial reports are sent to the National Offender Management Service for factual accuracy checks and amendment can therefore be made. This also raises a broader point. Specifically, it is problematic if we are to believe that there is no one taking responsibility for overall healthcare within a prison, or at least taking responsibility for implementation of recommendations across healthcare providers. In the absence of someone to lead on this function, it is possible that recommendations will be implemented ineffectively, inconsistently, or not at all. The result of this has far more serious consequences for the quality or longevity of the life of prisoners than merely misaddressing a recommendation. Ultimately, if we are uncertain, we will ascribe our recommendation to the Governor with whom responsibility stops.

As with establishment heads, we asked healthcare leads **what had changed** within their organisation as a result of the recommendations made in the report. A selection of responses are shown below:

> *New alert forms for those with medical conditions. Revised protocol for hospital appointments.*

> *Reviews of palliative care plans, training by external providers around pain control. Better communication with local hospital around information sharing.*

All instances where healthcare leads identified healthcare-related recommendations were made also report making changes as a result. Again, as with the case of establishment heads, it is heartening to see that our investigations are affecting positive change.

Healthcare commissioners

This survey was the first time healthcare commissioners were asked for their feedback about their involvement with the PPO. The questions posed were similar to those we asked healthcare leads with respect to recommendations (healthcare commissioners would have little involvement with the investigation process, and so would be unable to comment on this to the same extent as healthcare leads).

More than 80% of healthcare commissioners responded that there were **recommendations addressed to healthcare** in the report. Of those, more than 90% of respondents said the recommendations were **addressed to the appropriate individual**.

One response considered that recommendations about restraints should not have been directed at healthcare, another suggested that recommendations about ambulance services should be directed at Clinical Commissioning Group Commissioners.

Similar to establishment heads and healthcare leads, we also asked healthcare commissioners **what had changed** as a result of the investigation and associated recommendations. A selection of representative responses is included below:

> *The healthcare provider has undertaken a wide ranging review of its mental heath service.*

> *Referral processes for red flag symptoms and improved system of physical care.*

Overall, healthcare commissioners reported a number of important changes had taken place as a result of the PPO investigation report.

Coroners

While a PPO investigation is separate from the Inquest process, a copy of the PPO investigation report is sent to a Coroner to help with the inquest.

All Coroners who remember receiving the report received it before the inquest. Poor timeliness of PPO reports has previously been a major criticism from Coroners, so it is pleasing that this is now acknowledged as being good. Indeed, when asked what went well with the investigation, nearly half of the Coroner respondents spontaneously remarked in a positive way on the timing of investigations and investigation reports.

> *PPO investigation was timely and dealt with all of the issues of concern to the family and wider public interest.*

Only one Coroner remarked negatively about the length of time taken to complete an investigation, suggesting the investigation time had delayed the inquest. Closer inspection of this case showed the draft report was completed to time but the final report was a few weeks beyond its target date.

> *Chief Coroner's guidance requires Inquests to be completed within 6 months of the date of report of death to the Coroner. Delays in finalising PPO reports make this deadline difficult to meet.*

Unfortunately, despite transformed timeliness (in 2015-16, 100% of initial reports met PPO timescales compared to only 14% in 2010-11) the inexorable increase in demand for investigations at the same time as reducing resources (there was a 4.6% reduction in budget 2015-16) means that we are at the absolute limit of our capacity.

The majority of Coroners were positive about the quality of the investigation – 90% of responding Coroners rated the investigation good or very good, 10% rated the investigation satisfactory. This is important, as qualitative feedback suggested that our investigation is vital to the inquest:

> *[The investigation report] is invaluable and quite often defines the scope of the inquest.*

We should note here, that the number of responses by Coroners was relatively small – we received only 12 surveys from Coroners. This is likely because Coroners are involved in a higher number of investigations into deaths in custody than are, for example, liaison officers. As such, survey fatigue was likely driving the low response rate. In order to receive more meaningful results from a greater number of Coroners, we should consider how to better collect this information. Rather than sending out a survey following each investigation, it might be better to contact them at the end of the year for their feedback on all investigations in which they were involved.

The same is true for healthcare commissioners – while the response rate was not as low as with Coroners, we should similarly be concerned with overburdening them due to the volume of investigations with which they will be involved. The end of this section, we make a recommendation to change the way we receive feedback from these two groups of stakeholders.

To close the survey, we asked all respondents what went particularly well with investigations, and also asked them about areas for improvement. Feedback here was qualitative. Some verbatim comments are reproduced below and any trends are identified. The section concludes by noting some extra action points identified by stakeholders in their qualitative responses

Overall strengths and weaknesses

One of the most frequently mentioned strengths of the investigation process was **communication**. This was particularly commented upon by liaison officers and establishment heads:

> *Constant updates were a huge advantage in such complex matters.*
>
> *-Liaison officer*

Another frequently-mentioned strength was the **sensitivity** of the investigator. Qualitative feedback consistently emphasised that investigators acknowledged that deaths in custody were difficult for staff and detainees, and investigators were considerate of that:

> *Open honest discussions regarding the care, very supportive and aware of the sensitivities around deaths in custody, expected or otherwise.*
>
> *-Healthcare lead*

While Coroners were generally pleased with **timely** investigations, other stakeholders also commented on the promptness or timeliness of investigations and investigators' actions.

> *Any dealings I have had with the PPO in relation to this case have been dealt with promptly & no one has raised any issues with me.*
>
> *-Liaison officer*

There were one or two 'what could be improved' comments that mentioned timeliness of the investigation, but the number of those who mentioned it as a strength outweighed those who said timing could have been **improved**.

One theme from establishment heads suggested that, while we are good at investigating issues fully, we might consider also acknowledging things that go well, or highlighting best practices. This is a theme that is repeated from the previous year's report, and is worth highlighting again:

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Sometimes [investigations] do not acknowledge the work that has gone into trying to rectify recommendations or other factors which prevent some element of procedure from having been completed...Acknowledge the good work as well as focus full on actions.

-Establishment head

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Similar to the conclusions suggested earlier in this report, feedback from healthcare leads and commissioners suggests that it would be helpful if investigators had a greater understanding of healthcare systems within establishments.

“

Demonstrate a better understanding of the issues involved in these cases.

-Healthcare lead

“

Additionally, feedback suggests that healthcare commissioners and leads would welcome more involvement in the investigations, particularly at the level of agreeing the scope.

“

...I have the same comment to make regarding PPO investigations undertaken since coming in to post...the healthcare commissioner is rarely included in decisions made regarding the level of the investigation. This tends to be agreed between the investigator and the reviewer, and I would like to suggest... the Safety & Quality lead for NHS England would welcome the opportunity to be involved in this decision.

-Health commissioner

“

Overall, feedback from stakeholders about the investigation process and resulting reports was largely positive. However, several trends emerged which highlighted areas for improvement. The recommended actions resulting from the feedback are summarised in the following section.

Summary of actions

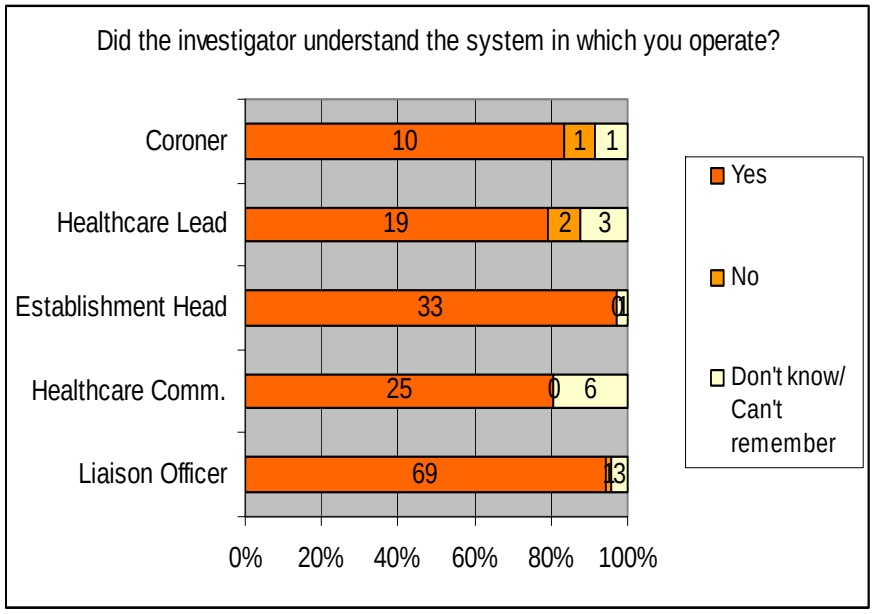
Action	Outcome	Impact	Delivery Date
Engage with NHS England and NOMS to clarify the processes for commissioning and delivery of healthcare. **Disseminate material to investigators.** **Invite commissioners and practitioners to PPO staff engagement and training events to increase understanding of processes and roles.**	Better understanding by investigators of the commissioning of healthcare, the ways in which healthcare is delivered, the responsibilities of practitioners, commissioners and the interface between healthcare practitioners and the environment within which they operate.	More appropriate findings and better targeted recommendations in investigation reports.	Initial conversations with NOMS and NHS England December 2016. Production and sharing of materials January 2017. Use of attendance by guest speakers at regular investigator team meetings and training events through 2017.
Review content of training in relation to interview techniques. **Masterclasses on case management.**	Appropriate sensitivity to the feelings of those interviewed.	Improvement in future feedback.	Review training package 1st quarter 2016 (tbc) Hold bi-monthly masterclasses.

Encourage stakeholders to give prompt post-investigation feedback and more appropriately.	Early identification and discussion of issues of substance or interpretation.	Avoidance of unnecessary delay in the production of final reports.	Ongoing.
Discussions with NOMS to ensure early and regular communication between investigator and establishment liaison officer.	Effective joint working, efficient preparation of documentation and scheduling of interviews.	Timely delivery of investigation process and production of reports.	Monthly meetings with NOMS Equality Rights and Decency Group and PSP RSCLs as necessary.
Review information shared with interviewees in relation to use of Video Link or other technology used for interviews.	The interviewee receives the same introduction and information as they would in a face-to-face interview.	Reassurance for interviewee and reduction in future concerns expressed through feedback.	Input to December and January team meetings.
Review structure of reports.	Improved clarity of reports, with continued focus on the formulation of findings and recommendations.	Clarity in discussions between PPO and establishments of reports.	Draft review to be submitted to PPO Executive Committee January 2017.
Review structure of investigation process and approach to sharing of findings from investigations.	Increased use of the post-draft fact check to raise any points for clarification and to provide the opportunity to refine findings and recommendations.	Promotion of the broader 'learning lessons' purpose of investigations at establishment and organisational level.	Internal discussions within FII management December 2016.

Highlight best practices where we find particularly good examples within learning lessons material, so institutions can learn from strengths as well as failings.	Learning Lessons bulletins or thematic reports include lessons on good practice we have observed during the course of an investigation, where we find evidence of this.	Broader impact of individual investigation findings by promoting good practice, where we have seen it, to a wider audience.	Ongoing, as new bulletins and thematic reports are researched.
Engage with incoming Chief Coroner and Coroners' Services Committee	Review processes for requesting feedback from Coroners and commissioners, without overburdening them with survey requests.	Proportionate and meaningful responses from Coroners to future surveys.	Initial meeting complete (November 2016), participation at CSC ongoing. Review of surveys and change in dissemination process complete.

Appendix A: Relationship with stakeholders

Understanding the system



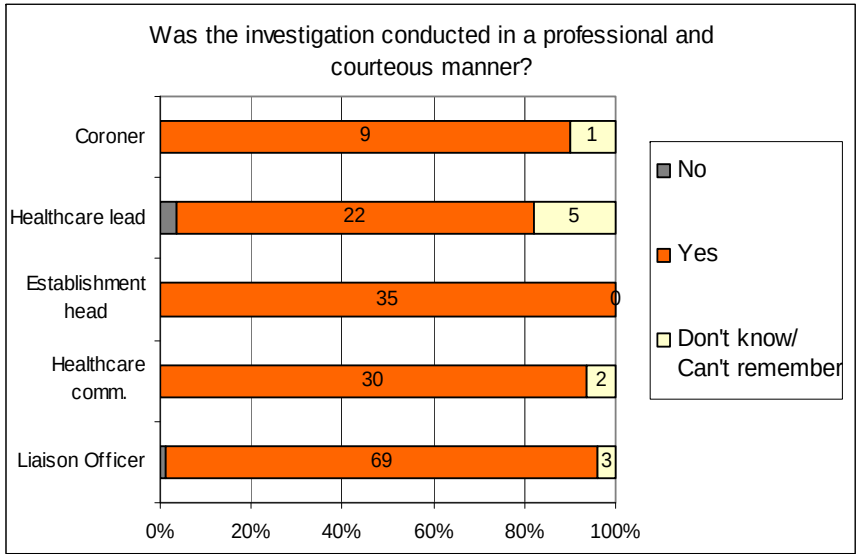
Bars show the proportion of the overall response within stakeholder role. Figures labelled on bars are raw numbers. Overall N=174

Did the investigator understand the system in which you operate?			
	No	Yes	Don't know/ Can't remember
Liaison officer	1	69	3
Healthcare commissioner	0	25	6
Establishment head	0	33	1
Healthcare lead	2	19	3
Coroner	1	10	1
Totals	4	156	14

Communication during investigation

Were you given adequate information about the investigation's progress?			
	No	Yes	Don't know/ Can't remember
Liaison officer	2	67	4
Establishment head	1	32	2
Coroner	1	10	0
Totals	4	109	6

Professionalism of investigation

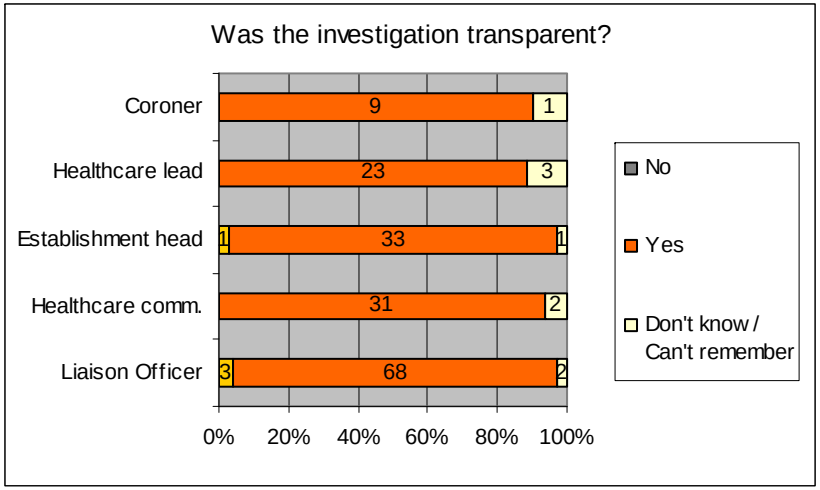


Bars show the proportion of the overall response within stakeholder role.
Figures labelled on bars are raw numbers. Overall N=178

Was the investigation conducted in a professional and courteous manner?			
	No	Yes	Don't know/ Can't remember
Liaison officer	1	69	3
Healthcare commissioner	0	30	2
Establishment head	0	35	0
Healthcare lead	1	22	5
Coroner	0	9	1

Appendix B: Quality of investigation

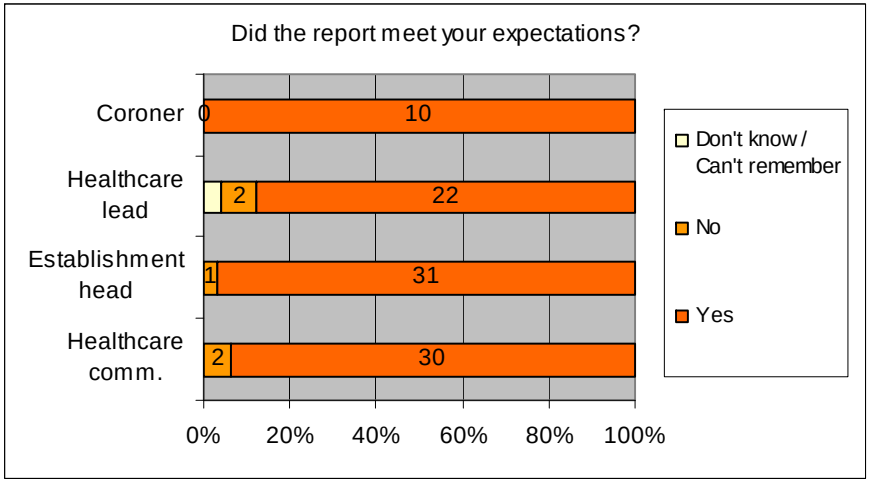
Transparency



Overall N=177

Was the investigation transparent?			
	No	Yes	Don't know/ Can't remember
Liaison officer	3	68	2
Healthcare commissioner	0	31	2
Establishment head	1	33	1
Healthcare lead	0	23	3
Coroner	0	9	1
Totals	4	164	9

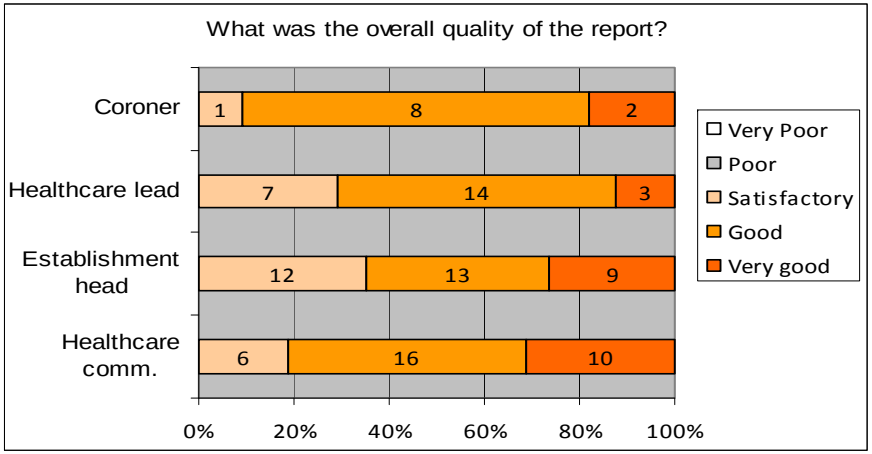
Meeting Expectations



Overall N=99

Did the report meet your expectations?			
	No	Yes	Don't know/ Can't remember
Healthcare commissioner	2	30	0
Establishment head	1	31	0
Healthcare lead	2	22	1
Coroner	0	10	0
Totals	5	93	1

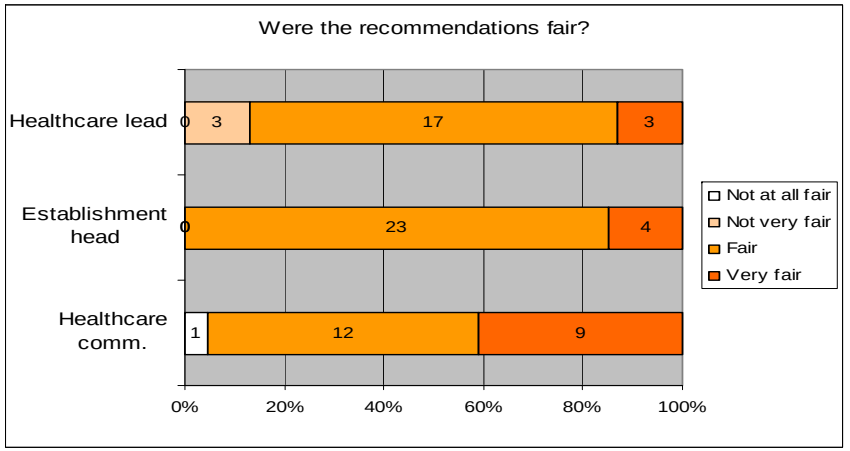
Overall quality of report



Bars show the proportion of the overall response within stakeholder role. Figures labelled on bars are raw numbers. Overall N=101

What was the overall quality of the report?					
	Very Poor	Poor	Satisfactory	Good	Very good
Healthcare commissioner	0	0	6	16	10
Establishment head	0	0	12	13	9
Healthcare lead	0	0	7	14	3
Coroner	0	0	1	8	2
Totals	0	0	26	51	24

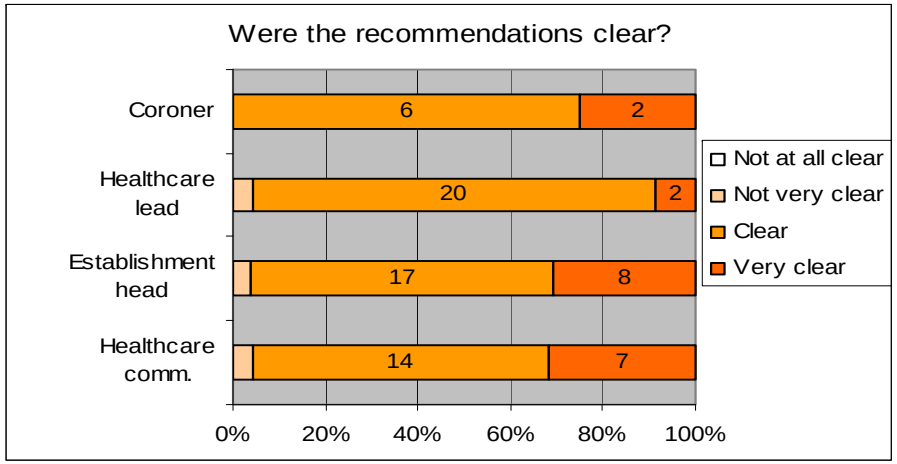
Fairness



Bars show the proportion of the overall response within stakeholder role. Figures labelled on bars are raw numbers. Overall N=72

Were the recommendations fair?					
	Not applicable	Not at all fair	Not very fair	Fair	Very fair
Healthcare commissioner	1	1	0	12	9
Establishment head	0	0	0	23	4
Healthcare lead	0	0	3	17	3
Totals	1	1	3	52	16

Clarity



Bars show the proportion of the overall response within stakeholder role.
Figures labelled on bars are raw numbers. Overall N=79

Were the recommendations clear?					
	N/A	Not at all clear	Not very clear	Clear	Very clear
Healthcare comm.	1	0	1	14	7
Establishment head	1	0	1	17	8
Healthcare lead	0	0	1	20	2
Coroner	0	0	0	6	2
Totals	2	0	3	57	19

Appendix C: Data on role-specific questions

Liaison Officers

Were the following aspects of your role explained to you?

Role	Yes, explained
Was the investigation process explained to you?	88%
Providing the investigator with all relevant information and documentation	85%
Arranging for the investigator to be met on arrival	70%
Coordinating interviews with prisoners, members of prison staff and healthcare staff	70%
Allocating a suitable work space and interview room for the investigator	68%
The provision of keys, if required	41%

Organising Interviews

	#	Yes	No
Have you been a liaison officer before?	74	81%	19%
Were you given sufficient notice of interviews?	56	98%	2%
Were you provided with notes for interviewees	53	85%	15%
Was there a delay receiving transcripts?	49	2%	98%

Sensitivity of Interviews

	None	+	-	Both	Don't know
Did staff make comments about sensitivity of interviews?	39	15	1	2	2
Did detainees make comments about sensitivity of interviews?	39	4	1	0	4

Establishment heads

	#	No	Yes
Were the recommendations addressed to the appropriate individual?	26	4%	96%

Healthcare leads

	#	No	Yes
Did the clinical reviewer understand the issues involved in the investigation?	20	10%	90%
Were the healthcare recommendations addressed to the appropriate individual?	23	22%	78%

Healthcare commissioners

	#	No	Yes
Were there recommendations made in the report which were addressed to healthcare?	29	17%	83%
Were the healthcare recommendations addressed to the appropriate individual?	22	9%	91%

Coroners

	#	Yes, draft	Yes, draft & final	Can't remember
Did you receive the investigation report ahead of the inquest?	12	33%	59%	8%