Guidelines for Health & Justice Clinical Reviewers

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1 Introduction

1.1 This document provides NHS England Health & Justice Commissioning Teams and Clinical Reviewers with national operating procedures and guidelines for the provision of Clinical Review reports to the Prisons and Probation Ombudsman (PPO).

2 Background

2.1 From 1 April 2004, under the terms of reference from the Home Secretary, the Prisons and Probation Ombudsman (PPO) is remitted to investigate all deaths in prisons, other secure settings, approved premises and court premises. A death shortly after release may also be investigated and require a clinical review; the decision to investigate or not is at the discretion of the PPO. The PPO's terms of reference can be found at: http://www.ppo.gov.uk/about/vision-and-values/terms-of-reference/.

2.2 The Prisons and Probation Ombudsman is appointed by the Secretary of State for Justice. The PPO is wholly independent. This includes independence from Her Majesty's Prison and Probation Service (HMPPS), the National Probation Service for England and Wales and the Community Rehabilitation Companies for England and Wales (probation), any individual Local Authority, the Home Office, the Youth Custody Service (YCS) providers of youth secure accommodation, the Department for Education, the Department of Health and Social Care and NHS England. This enables the PPO to execute fair and impartial investigations, making recommendations for change where necessary, without fear or favour. The actual independence of the PPO from the authorities in remit is an absolute and necessary function of the role.

The PPO investigation aims to identify the underlying cause of the incident:

- What happened – was the incident linked to care and service delivery?
- How it happened – did human behaviour play a part?
- Why it happened – are there any contributing factors?

2.3 The PPO investigation includes examining the clinical issues relevant to each death, clinical issues relevant to any death in custody are required to be examined. The Secretary of State for Health has agreed that NHS England will take the lead responsibility for arranging an independent investigation of the clinical care provided, including whether referrals to secondary healthcare were made appropriately. This responsibility has been delegated to the NHS England regional Health and Justice Teams in England and to the Healthcare Inspectorate Wales (HIW) for Welsh deaths in custody.

2.4 When a death in custody occurs the PPO will approach NHS England regional Health and Justice Teams, or HIW for Welsh cases, and request that an independent investigation of the clinical care provided is carried out. In all

cases the clinical review will form part of the PPO investigation and subsequent PPO report.

2.5 NHS England requires its commissioned healthcare service providers to deliver an initial review of the circumstances and healthcare provided (sometimes known as a 72 hour review) for each death in custody and to operate their investigations in alignment with the NHS England Serious Incident (SI) Framework (2015)[1] or any subsequent versions.

2.6 For the purposes of a death in custody the following NHS definition of a Serious Incident is used in relation to a death:

'*A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in unexpected or avoidable death of one or more patients*'

In addition, the PPO also investigates deaths by natural causes, which are also subject to a clinical review and has discretion over deaths post release.

3 Scope

3.1 This standard operating framework provides an overview of the arrangements for investigating deaths that occur in NHS funded Health and Justice Services (commissioned by NHS England) where the PPO have a remit to investigate the circumstances surrounding the deaths of the following:

- Prisoners and trainees (including those in Young Offender Institutions and Secure Training Centres)
- Residents of Approved Premises (including voluntary residents)
- Residents of Immigration Removal Centres, short term holding centres and persons under managed escort.
- Residents of Secure Children's Home
- People in court premises or accommodation who have been sentenced or remanded into custody.

3.2 In support of the PPO investigation NHS England regional Health and Justice Commissioners (or equivalent) will be asked to provide a clinical review.

3.3 This standard operating framework supersedes the following documents:

- Clinical Review Following a Death in Custody Investigated by the Prisons and Probation Ombudsman, Part 1: Guidance for Commissioning Bodies. Updated September 2014
- Clinical Review Following a Death in Custody Investigated by the Prisons and Probation Ombudsman, Part 2: Guidance for Clinical Reviewers. Updated September 2014

[1] NHS England Serious Incident Framework, March 2015

3.4 This document should be read in conjunction with:

- NHS England National Serious Incident Framework 2015, or any superseding document
- PPO Terms of Reference

4 Roles and Responsibilities

4.1 The roles and responsibilities of all key staff involved in the clinical review process are clearly outlined below.

4.2 ***NHS England Health & Justice Central Support Team***

Responsible for developing national guidance on:

- Clinical Reviewer processes (including engagement, procurement and commissioning);
- Standards for Quality Assuring clinical reviews and Clinical Reviewers';
- Payment framework and finance processes;
- Liaise with Prisons and Probation Ombudsman nationally regarding the quality and effectiveness of the provision of clinical review reports;
- Gain assurance from regional Health and Justice Commissioning Teams that learning has been identified.

4.3 ***NHS England Regional Health & Justice Commissioning Teams***

NHS England regional Health and Justice Teams have the responsibility for the commissioning of healthcare services in prisons, immigration removal centres, secure childrens homes and young offenders institutes in England and will take the lead in commissioning an independent investigation into the healthcare received by the deceased.

Regional Health & Justice Commissioning Teams are responsible for:

- Commissioning clinical reviewers to undertake a clinical review investigation report in line with the Standard Operating Procedure for the provision of Clinical Review Reports;
- Ensure all commissioned clinical review reports are delivered within the described and agreed timeframes;
- Ensuring provision of high quality clinical review reports through adoption of the nationally set quality assurance process;
- Providing assurance to agreed regional oversight team and Health & Justice central Team around compliance to NHS England policies and governance in commissioning and completing clinical reviews;
- Assure and monitor healthcare provider responses and action plans to address any recommendations made by PPO;

- Ensuring that the pool of clinicians available is sufficient to enable a reviewer to be secured within the PPOs required appointment timetable;
- Managing the process from receipt of information regarding the death from the provider organisation until the clinical review report has been completed and forwarded to the PPO;
- Formally notify the PPO investigator by letter of the name of the Clinical Reviewer, date that the case was assigned to the Clinical Reviewer and the expected date of completion of the report.

4.4 *Prisons Probation Ombudsman*

- The PPO is wholly independent and will investigate the circumstances of the deaths of adults and young people including those in youth detention accommodation and those placed in Secure Children's Homes on a welfare basis.

- The PPO will investigate decisions and actions (including failures or refusals to act) relating to the management, supervision, care and treatment of prisoners, detainees, offenders under probation supervision or young people in secure accommodation

- The PPO can also investigate the death of someone who has recently been released from the custody of the above establishments if they or he/she feels there is particular lessons to be learned.

- Provide feedback to NHS England Health and Justice regional Commissioners and Central Support Team on the quality and provision of clinical review reports.

- Provide input into the development and revision of national guidelines to support the regional Health and Justice Commissioners in carrying out their role

- Ensure that the appropriate Health & Justice Commissioners are informed of details of a death in custody by secure email

4.5 *Clinical Reviewer*

The role of the clinical reviewer is to examine the clinical care **pertinent to the death**, provided to the deceased, whilst in custody, and to determine whether the care was equivalent, in accordance with national guidance, standards and local policy, to the care that one could expect to receive in the community. The approach is to determine how and why events took place, not to proportion blame or provide an expert witness opinion

A Clinical Reviewer is NOT an Expert Witness.

It is important that the clinical reviewer and PPO investigator work in partnership to ensure a proportionate but full investigation of the circumstances surrounding

the death. As part of the clinical review process the reviewer will be required to attend and present at inquest hearings.

The Clinical Reviewer is responsible for:

- Reviewing and commenting on the clinical care pertinent to the death of the deceased received in relation to his/her cause of death while in custody or detention and not providing commentary on detention or security regimes and processes.

- Ensuring they use a secure, encrypted e-mail account (nhs.net) for all electronic communication and the transfer and receipt of any confidential information, as per Information Governance requirements.

- Liaising with the PPO investigating officer and key personnel within the prison prior to carrying out the review

- Conducting the review and writing a fact based report in accordance with guidance issued by NHS England and PPO

- Notifying NHS England regional Health & Justice Commissioners immediately of any difficulties in accessing the establishment or obtaining information which is required to carry out the clinical review

- Attending the Coroner's court if summoned by the respective Coroner

- When other providers have contributed to the care of the deceased, then the reviewer should liaise with representatives from such organisations in the review, as required. e.g. mental health providers, drug and alcohol services and acute hospital trusts

4.6 *Her Majesty's Prison and Probation Service (HMPPS)/Home Office (HO) /Youth Custody Service (YCS)*

In all cases it is the responsibility of the establishment healthcare department, to inform NHS England regional Commissioners of all deaths via the locally agreed process.

HMPPS/HO/YCS teams will:

- When the Clinical Reviewer is required to attend the establishment, they should arrange timely access to the establishment and ensure they have access to staff for interviews, access to all relevant documentation, information and, if required arrange access

- Ensure the maintenance of an accurate database of all deaths in custody

4.7 *Establishment healthcare provider*

- Ensure that the appropriate clinical governance teams and NHS England Health & Justice regional Commissioning Teams are informed of details of a death in custody by secure email.

- Undertake an initial review of the circumstances and healthcare received by the deceased and share with NHS England Health and Justice regional commissioning team within 72 hours of the death.

- Ensure that case notes are prepared and sent to the Clinical Reviewer within 72 hours of the request by the Health and Justice regional Commissioners by secure method that is compliant with Information Governance requirements.

- When the clinical reviewer is required to attend the establishment, arrange timely access to the establishment and will ensure the reviewer has access to all relevant documentation, information and, where required, will arrange appropriate access to staff for interviews.

- Ensure an appropriate level of liaison with the Clinical Reviewer and PPO office as required.

5 Classification of deaths in custody

The following classifications of types of death are used by both HMPPS/HO/YCS and PPO and should be used in all correspondence and data collection exercises relating to deaths in prison, IRC, STC, YOIs and SCHs to ensure clarity and consistency.

5.1 **Natural cause:**

- Expected/foreseeable deaths - all deaths where there is an end of life/palliative care plan, including a signed Do Not Attempt Cardio Pulmonary, Resuscitation.

- Unexpected/non-foreseeable deaths - all disease related deaths, primarily attributed to disease, an illness or malfunction of the body not directly influenced by external forces, and is not expected, e.g. stroke, heart attack.

5.2 **Self-inflicted:**

- The death of a person who has apparently taken his or her own life irrespective of intent

5.3 **Other Non-Natural:**

- Drug related or suspected drug related
  Deaths where the underlying cause is poisoning, drug abuse, or drug dependence and where any of the substances are controlled under the Misuse of Drugs Act (1971). ONS Health Statistics

Quarterly 31 (2006). This may not be clear until the toxicology report has been received.

- Homicide
- Where cause of death is unclear during the Clinical Review and PPO investigation

6 Reporting a Death in Custody

6.1 HMPPS/HO/YCS will inform the PPO of a death in custody immediately. The PPO will write to the NHS England Health and Justice regional Commissioning Team lead to request the commissioning of a clinical review report. The letter will include the names of the deceased, date and location of death and provide name and contact details of the PPO Lead Investigator for the case. This will occur within 1 working day of the PPO being notified of the death.

6.2 In all cases it is the responsibility of the establishment healthcare department to inform the NHS England commissioner of all deaths via a locally agreed reporting route.

6.3 *NHS Standard Contract (shorter version); Section SC33; Incidents Requiring Reporting stipulates:*

The Provider must notify deaths, Serious Incidents and other incidents to Care Quality Commission (CQC), and to any relevant Regulatory or Supervisory Body or other official body, in accordance with Good Practice, Law and Guidance.

The Provider must comply with the NHS Serious Incident Framework and the Never Events Policy Framework, and must report all Serious Incidents and Never Events in accordance with the requirements of those Frameworks.

The Parties must comply with their respective obligations in relation to deaths and other incidents in connection with the Services under Schedule 6C (Incidents Requiring Reporting Procedure) and under Schedule 6A (Reporting Requirements).

If a notification the Provider gives to any relevant Regulatory or Supervisory Body directly or indirectly concerns any Service User, the Provider must send a copy of it to the relevant Commissioner, in accordance with the timescales set out in Schedule 6C (Incidents Requiring Reporting Procedure) and in Schedule 6A (Reporting Requirements).

The Commissioners may (subject to Law) use any information provided by the Provider under this SC33, Schedule 6C (Incidents Requiring Reporting Procedure) and Schedule 6A (Reporting Requirements) in any report which they make in connection with Serious Incidents.

6.4 The NHS England Health & Justice regional Commissioning team must be informed of any death in custody within 72 hours of the deaths occurring (this

includes weekends/bank holidays) as per the NHS England Serious Incident Framework. NHS England Health & Justice regional commissioning teams to agree with the healthcare provider the method of communication and documentation.

Initial or 72 hour Review Report

6.6 Providers will be expected to undertake an initial review within 72 hours from identification of death (this includes weekends/bank holidays), a standard template to support this is at ***Appendix A.*** This to identify any **actions required to ensure, or provide assurance that,** the safety of staff, patients and the public is protected; this review is required to be completed and returned to NHS England Health & Justice regional commissioners within 72 hours from the identification of the death. Any extension to this timescale must be in discussion and agreement with the Commissioning Team.

7 Instructing a Clinical Reviewer

7.1 The PPO will contact the NHS England regional Health and Justice Commissioning team, via electronic letter, requesting a clinical review, outlining the details of the deceased and expertise required. NHS England health & Justice regional commissioners are required to acknowledge receipt within **24hrs** of receiving the notification.

7.2 The NHS England Health and Justice regional commissioning team will:

a) appoint a clinical reviewer with the required clinical expertise from their bank of clinical reviewers and inform the PPO of their name and contact details **within 5 working days of the death**;

or

b) inform the third party provider of the request who will appoint a clinical reviewer with the required expertise and inform both PPO and NHS England regional Health & Justice Commissioners **within 5 working dates of the death.**

7.3 **The appointed clinical reviewer MUST have knowledge and experience relevant to the healthcare received by the deceased and issues surrounding the death.**

7.4 If the clinical reviewer uncovers the need for urgent action at any stage of the review, this information should be passed to the NHS England Health and Justice regional commissioning team and the establishment without delay in order that appropriate action may be taken promptly.

7.5 The NHS England Health and Justice regional commissioning team must have an agreed process in place for informing the PPO's office of their name and contact number.

7.6 The Clinical Reviewer **MUST** make contact with the PPO investigator within **5 working days** to agree level of review before conducting review. The level of review required must also be agreed with the NHS England Health & Justice regional commissioning team.

7.7 The Clinical Reviewer **MUST** work collaboratively with the PPO and agree the level of review and communication. The agreed level of review must be communicated and agreed with the NHS England Health & Justice regional commissioning team.

7.8 The Clinical Reviewer **MUST** declare any conflict of interest and confirm there are no actual or potential conflicts in undertaking clinical review.

7.9 The Clinical Reviewer **MUST** confirm they have not previously worked at the establishment either in their capacity as a qualified healthcare professional or in any other employed or voluntary capacity.

7.10 The Clinical Reviewer **MUST** confirm their adherence to all standards for professionalism, honesty and integrity, in accordance with the General Medical Council (GMC), Nursing and Midwifery Council (NMC) code of professional conduct.

8 Access to Medical Records

8.1 The Clinical Reviewer will require access to the total healthcare record of the deceased during their current incarceration. This MUST include the following below please note list is not exhaustive:

- SystmOne records, including any paper based documents waiting scanning. If SystmOne is not used, then the GP healthcare records must be reviewed
- Mental health records if not held on SystmOne, if applicable
- SMS records, both clinical and psychosocial, if applicable any additional healthcare records that may be relevant i.e. dental optician social care, fluid balance charts and care plans etc

8.2 NHS England Health & Justice regional commissioning team, or the third party provider where regional Health and Justice Teams have procured one, will arrange for the establishment healthcare records and electronic records to be provided to the clinical reviewer.

8.3 Clinical Reviewer may require access to additional documentation. Where this is the case, a clear rationale should be provided as to why these notes are required. Clinical Reviewer may require access to the following documents below;

- SystmOne records from the previous establishment the person was incarcerated in, including Mental Health records and Substance Misuse Service records, if not documented in SystmOne;

- Personality Disorder service records
- Hospital records relating to any recent out patients appointments or admissions;
- Ambulance records regarding any emergency calls to attend to the deceased;
- Out of Hours records for any phone calls or visits undertaken to the deceased;
- Secondary care notes, if not held on SystmOne;
- All community records (such as Substance Misuse Services, Mental health) if applicable;
- CCTV footage*
- Body Worn Vest Camera (BWVC)*

** The PPO investigator will review all evidence initially and inform Clinical Reviewer if there is any health input during the incident viewed*

8.4 Any request for additional records, such as above, the provider will be asked to provide **within 5 working days**. If the Clinical Reviewer is unable to access any of the above medical records for the deceased, they must notify Health and Justice Commissioner within 24 hours.

8.5 NHS England Health and Justice regional commissioning teams will be responsible for making Data Protection Application(s) under s31 Data Protection Act 1998 (or any subsequent version) to access relevant NHS records to assist the Clinical Reviewer.

8.6 The PPO investigator will arrange for copies of any other relevant service held records to be made available to the Clinical Reviewer.

9 The Clinical Review

9.1 The purpose of a clinical review is to support the aims of the PPO investigation, which are to:

- Establish the circumstances and events surrounding the death, in particular the health care the deceased received, whilst in custody or detention;

- The management of the individual by the relevant authority or authorities within remit, but also including any relevant external factors;

- Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence;

- In conjunction with NHS England or the relevant authority where appropriate, examine relevant healthcare received whilst in custody or detention and assess clinical care pertinent to the death;

- Provide explanations and insight for the bereaved relatives; and

- Help fulfil the investigative obligation arising under Article 2 of the European Convention on Human Rights ('the right to life') by working together with Coroners to ensure 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 made clear.

A Clinical Review investigation and report is NOT an Expert Witness statement

9.2 The following are the principles against which the care delivered to a prisoner or detainee should be assessed on:

- Services are provided that are safe and meet the same standards and quality of care, as a minimum, that can be expected in the community.

- Prisoners or detainees have timely access to the same range of services as per the needs of the population.

- Services are delivered in accordance with national standards such as NICE Guidelines, Prison Service Instructions (PSI) Prison Services Orders (PSO), Detention Service Orders (DSOs) and best practice

- Services are delivered in partnership with HMPPS/HO/YCS and other healthcare providers including those within the community.

- Services are integrated and work together to deliver care based on patient needs

- Services support continuity of care on reception, transfer and release or discharge.

- Services contribute to the reduction of health inequalities through a thorough understanding of health needs.

- Services support the reduction of health risk factors

9.3 The PPO identifies 3 levels of clinical review to be undertaken. These levels are determined by the methodology required of the investigation **NOT** the type or cause of death. These levels are:

Level 1 – single Clinical Reviewer carrying out a desk based review of records and report may include telephone calls to the healthcare department for clarification. This is predominantly used for natural cause deaths where in an

initial review of the healthcare records no issues are identified that would necessitate interviewing staff.

Level 2 –single Clinical Reviewer carrying out a review of records, interviews with healthcare staff at the establishment and report. Self-inflicted deaths can involve individuals with complex health needs and may require an expert review of a particular element of their healthcare, such as a forensic psychiatrist and drug misuse and dependence.

Level 3 – Complex healthcare with multi-disciplinary input requiring a panel review, with a lead reviewer, to review records and interview relevant staff i.e. forensic psychologist, psychology services.

9.4 The level of review **MUST** be agreed within 5 days of the death or first contact by PPO, by the NHS England Health and Justice regional commissioning team and the PPO investigator in conversation with the appointed Clinical Reviewer. The level of clinical review will be based upon the nature and circumstances of the death. If the timeline of 5 working days cannot be met, a revised deadline must be agreed between PPO and the NHS England Health & Justice Commissioner.

9.5 If, during the course of the investigation information comes to light that would require a change in the level of clinical review, a discussion **MUST** take place between Clinical Reviewer, PPO and Health and Justice regional commissioning team to agree the revised level of review.

9.6 The aims of the clinical review are to:

- 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 relevant health issues and assess the clinical care;
- Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence;
- Identify any root causes that inform the identification of learning opportunities;
- Make SMART (Specific, Measureable, Achievable, Realistic and Timely) recommendations for the health community and service.;
- Provide explanations and insight for the bereaved relatives to aid understanding of care whilst in custody or detention; and
- Identify any good practice to support improvement work across the criminal justice system.

9.7 In addition the review will identify opportunities for learning and to make clear, measurable, timely and sustainable recommendations to healthcare organisations, commissioners and policy leads.

9.8 In order to ensure objectivity and to protect the independence of the PPO, the Clinical Reviewer must:

- Be impartial having no pre conceived opinions regarding the establishment's healthcare or the healthcare provider;
- Not be working in or directly involved in the delivery or direct commissioning of care at the establishment under review or be a shareholder if a private provider organisation;
- Have no line management responsibilities for the staff delivering healthcare in the establishment;
- Be able to complete the review within the time scales set out by the PPO;
- Have knowledge of care delivered within a custodial environment

9.9 Evidence provided to the PPO may be shared with specialist advisers, with other investigating bodies including the police, and with bereaved relatives. The PPO will only share information that is necessary for the purposes of the Ombudsman's investigation, for the inquest or for a criminal investigation.

9.10 The report and the evidence, on which it relies, will normally be given to the Coroner, the relevant service providers, the deceased's next of kin and any other people whom the Coroner considers have an interest in the inquest. All evidence used at Coroners Inquests is confined to the issues covered by the Terms of Reference and the scope of the investigation. Therefore clinical care provided to the deceased in hospital or in the community is excluded from the evidence.

9.11 The report, without the accompanying evidence, will be made public at a later date in a form that omits the names of witnesses and others associated with the events redacted.

10 Clinical Review Investigation

10.1 Where the clinical review has been agreed as a level 2 investigation the PPO has a preference for joint interviews, which give a greater understanding and clearer picture of the care received across disciplines. The PPO Investigator will record and provide transcripts of all interviews to the Clinical Reviewer. Clearly recorded interviews are a Coroner's requirement. The Clinical Reviewer should be the lead interviewer for any interviews with healthcare staff. There is no expectation that the Clinical Reviewer attends any other interviews, however the investigator may ask for the Clinical Reviewer to

attend relevant interviews (for example where a member of establishment staff has attempted resuscitation).

10.2 Expert views on the care provided can be sought from appropriate, independent health professionals, to be determined by the Clinical Reviewer.

10.3 If the Clinical Reviewer uncovers the need for urgent action at any stage of the review, this information should be passed to the identified contact in the NHS England Health and Justice regional commissioning team who will take appropriate action.

11 The Clinical Review Report

11.1 When drafting the report the Clinical Reviewer should use the national Clinical Review Report templates appropriate to the death and investigation, i.e. Foreseeable death Clinical Reviewer template ***(Appendix B)***; Unforeseeable death Clinical Reviewer template ***(Appendix C)*** and follow PPO requirements:

- Events are clearly and concisely stated and using plain English refraining from using technical language (jargon free) and providing full explanation for use of abbreviations;
- All key dates are detailed and recorded in full (date, month and year);
- Where reference is made to statements made during interviews these are clearly notated and the individual's comments included verbatim from their signed statement;
- The Clinical Reviewer should avoid interpretation of another's verbal comments;
- The report is impartial, objective and based on fact not opinion;
- Where the Clinical Reviewer is stating their professional opinion this should be identified as such and be backed up by evidence, such as current clinical guidelines or professional practice, at all times;
- Where national guidance is referred to this should be referenced in full.

11.2 The Clinical Review report should identify:

a. Whether the care was provide in accordance with the principles, outlined in section 11.2, and aims, outlined in section 11 above;

b. Areas of good practice;

c. Areas of opportunities for service improvement;

d. A list of recommendations, where relevant, for the healthcare provider and/or commissioner to support improvement or continuous improvement in the care within the secure and detained environment.

11.3 Whist every effort is made to ensure that all investigations are completed in a timely manner, there are instances when this is impossible due to circumstances which are beyond the immediate control of the reporting organisation. Such delays may be caused by:

- Awaiting Coroners inquests
- Awaiting forensic post mortem findings
- Awaiting toxicology results
- Awaiting outcomes of court proceedings
- In direct response to a Police request under a Memorandum of Understanding

11.4 Where healthcare providers are required to complete their own investigation into the death in custody, the report will be reviewed as per the recommendations and timescales within the Serious Incident Framework 2015. Healthcare providers are expected to ensure that additional learning and recommendations identified through the clinical review are reflected within their own report and action plan.

11.5 Advanced Disclosure - The PPO operates on the basis of full and simultaneous disclosure to all parties to the investigation. However from time to time, specific and substantial criticisms are made of individuals in the draft report. In these cases the draft report will be advanced disclosed to the service in remit. The purpose of this is to allow the individual who has been criticised the opportunity to check that their actions and accounts are described accurately. The PPO's disclosure policy is published on the website www.ppo.gov.uk and applies to both the PPO investigation report and the clinical review report.

NOTE: At the consultation stage advanced disclosure is provided if an individual member of staff is criticised. If the final report goes on to make serious criticisms of a member of staff, it will recommend that the appropriate disciplinary procedures are implemented, and may in extreme cases, recommend referral to the appropriate regulatory body. NHS England regional Health and Justice Commissioning Teams should ensure a referral has been made.

12 Quality Assurance and Authorisation

12.1 Prior to submitting the clinical review report to the NHS England regional Health & Justice Commissioning Team and the PPO Investigator the Clinical Reviewer must share a copy of the draft clinical review report with any clinical

experts who have contributed to ensure their views are appropriately represented.

12.2 The Clinical Reviewer must submit a draft report to NHS England Health and Justice regional commissioning team, for quality assurance within:

- **35 working days** for a level 1 clinical review report; or
- **45 working days** for a level 2 clinical review report

At the same time, the draft report should be sent to the PPO investigator to check it meets the needs of the investigation.

12.3 NHS England Health and Justice regional commissioning teams are required to quality assure the draft reports and provide feedback and comments using the National Quality Assurance Template and process **(*Appendix D*)**. The outcome of the Quality Assurance process is to be returned to the Clinical Reviewer within **5 working days** to allow review of comments and feedback.

12.4 Clinical Reviewer will submit a final draft report to NHS England Health and Justice regional commissioning team with any amendments or responses to the Quality Assurance comments within:

- **45 working days** for a level 1 clinical review report; or
- **55 working days** for a level 2 clinical review report

12.5 NHS England Health and Justice regional commissioning team will review, approve and submit the final draft report to PPO for inclusion into the PPO investigation report.

12.6 The PPO requires the final clinical review report to be with their office within **50 working days** for a level 1 clinical review report and **60 working days** for a level 2 clinical review report. An extension is only likely to only be agreed under exceptional circumstances (such as the inability to interview staff within the expected timeframes).

12.7 It is not necessary to redact or anonymise the clinical review report. The PPO investigation report will name any individual pertinent to the case, this will include healthcare staff. The PPO report is redacted before being made public and the clinical review report is not made public.

12.8 **Record storage and destruction**

NHS England Health and Justice regional commissioning teams will ensure that all paper and electronic records and files returned by the Clinical Reviewer are stored in a safe and confidential manner. It remains the responsibility of the NHS England regional Health and Justice regional commissioning teams to observe General Data Protection Regulations, Information Governance and the NHS Record Retention

schedule for any stored information. All record destruction must be undertaken in a secure manner.

NHS England Health and Justice regional commissioning teams must seek specialist advice from their regional Information Governance Team regarding storage and destruction of any records relating to clinical review investigations.

The PPO investigator may from time to time, need to contact the Clinical Reviewer if there are matters which require further exploration, clarification or correction. Ideally this will be within 30 working days of receipt of the final clinical review report. However NHS England Health and Justice regional commissioning teams and reviewers should note that issues of clarification sometimes arise following the consultation period.

13 Stages following the PPO investigation

13.1 Below are the stages following the PPO investigation and clinical review:

a) The PPO investigator writes a draft report including the clinical issues and relevant recommendations.

b) The initial report is issued to the establishment Director/Governor/Centre Manager, who should ensure a copy is received by the Head of Healthcare, and has 4 weeks to provide feedback on the factual accuracy and a response to all recommendations. A copy is sent to the deceased's family who have up to a maximum of 8 weeks to feedback. In addition the NHS England Health and Justice Teams and the Clinical Reviewer receive a copy of the initial report for factual accuracy check.

c) The Director/Governor/Centre Manager and healthcare provider are asked to provide an action plan in response to any recommendations. The Health and Justice Commissioning Team must ensure that there is an agreed process with their healthcare providers for sharing requests for action plans, oversight and monitoring implementation of all actions, and for communicating with governors/directors/centre managers in this regard.

d) More questions may be asked, and occasionally it may be necessary for further investigation to take place, which may include clinical matters.

e) The report is finalised, including the response to any recommendations, and is sent to the Coroner as part of the evidence to prepare for the inquest.

f) Both the PPO investigator and Clinical Reviewer may be called to give evidence at the inquest.

g) After the inquest, the appendices (including the clinical review report) are removed from the PPO report, the PPO report is anonymised and published on the PPO website.

13.2 When the PPO report is published on the PPO website, all appendices are removed (this includes the clinical review).

14 Security and Establishment Access

14.1 All Clinical Reviewers' will be required to undergo HMPPS/Home Office/YCS local security clearance. This will ensure easier access to all establishments.

14.2 The Clinical Reviewer shall co-operate in full with all checks (and checks) deemed necessary.

14.3 The Clinical Reviewer will have responsibility for ensuring high levels of security, in common with all staff within the establishment. Security Information Reports (SIRs) can be used to report any matters of concern.

14.4 The Clinical Reviewer will observe and adhere to Prison Service Professional Standards. The Governor/Director/Centre Manager of the establishment will reserve the right to immediately exclude any worker from the establishment should a breach of security or other instance of gross misconduct be evident.

15 Inquests

15.1 Both the PPO investigator and the Clinical Reviewer may be called to give evidence at inquest. Although the inquest should not be an adversarial process, the interested parties (which include the bereaved family and specific members of staff from the service concerned) may have different perspectives of the individual's care and management than that identified by the PPO investigation and/or 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.

Annex 1 – Clinical Review process summary

Reporting a death in custody and detention

Her Majesty's Prison and Probation Service or Home Office or Youth Custody Service will inform the PPO of a death in custody (DIC) **immediately.**

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The PPO will contact the lead within NHS England Health and Justice Commissioning Team via the Head of Health and Justice, with details of the PPO Lead Investigator for the case. **This will occur within 1 working day** of the PPO being notified of the death.

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72 hour review

- The Commissioner and Heads of Health and Justice must be informed of any serious incident within 72 hours from time of death (this includes weekends/bank holidays)
- Providers to complete Appendix A: Death in Custody initial review of facts 72 hour report template
- This will be required to be completed and returned to NHS England commissioners within **72 hours** from the identification of the death.

Any extension to this timescale must be in discussion and agreement with the commissioning team.

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Instructing a Clinical Reviewer

The PPO will contact the NHS England Health and Justice Commissioning team requesting a clinical review and expertise required and level of review via an email within **24hrs** of receiving the notification.

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Level of review (Level 1-3)

Level of review must be agreed within **5 working days** by NHS England Health and Justice Commissioning team and agreed with the PPO investigator. *If timeline of 5 working days cannot be met a revised deadline must be agreed.*

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The PPO, Health and Justice Commissioning team will arrange for the healthcare records and any other relevant records from the establishment concerned to be provided to the Clinical Reviewer.

If clinical reviewer is unable to access medical records for the deceased, they must notify Health and Justice Commissioner within 24 hours.

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Clinical reviewer conducts the investigation in accordance with death in custody standard operating framework.

Death in custody

- Report to:
  - HMPPS/Home Office/YCS
  - NHS England H & J regional commissioner
- An initial review of the healthcare records by the healthcare provider to determine level of review. MUST be shared with NHS England H & J regional commissioner within 72 hours

PPO and Clinical Reviewer to agree level of review within **5 days** of death or first contact with the PPO.

Level 1

Single clinical reviewer carrying out a desk based review of records and report.

Level 2

Single clinical reviewer carrying out a review of records, interviews with healthcare staff at the establishment and report.

Level 3

Complex healthcare with multi-disciplinary input requiring a panel review, with a lead reviewer, to review records and interview relevant staff i.e. forensic psychologist, psychology services.

Some self-inflicted deaths can involve individuals with complex health needs and may require an expert review of a particular element of their healthcare, such as a forensic psychiatrist and substance misuse

A draft report should be submitted by the clinical reviewer to the healthcare providers/Health and Justice Commissioners for factual accuracy for **35 workings (7 weeks)** for natural/expected deaths and **45 working days (9 weeks)** for all other unexpected including unexpected natural causes and self-harm/suicide and homicide death.

The final draft is presented to the NHS England Health and Justice Teams (SI/DIC assurance group/Medical & Nursing) for approval and agreement with comments and returned to the clinical reviewer **within 5 working days** to allow any changes to be made prior to sending the final report to the PPO investigator.

The final clinical review report should be received by the PPO within **50 working days (10 weeks)** for a natural causes/expected death and **60 working days (12 weeks**) for any other death.

Progress against recommendations monitored quarterly by AT and by Health and Justice Commissioning Team against healthcare provider contract

Clinical reviewer attends inquest *(if requested by the Coroner)*

Recommendations and any learning to be shared at the regional and local Forum/ Group

Annex 2 – Glossary of Terms

BWVC	Body Worn Video Camera
CQC	Care Quality Commission
DIC	Deaths in Custody
DSO	Detention Service Orders
GMC	General Medical Council
HIW	Healthcare Inspectorate Wales
HMPPS	Her Majesty's Prison and Probation Service
HO	Home Office
IRCs	Immigration Removal Centres
NMC	Nursing and Midwifery Council
PPO	Prison and Probation Ombudsman
PSO	Prison Service Instructions
PSI	Prison Service Orders
RCA	Root Cause Analysis
STCs	Secure Training Centres
SI	Serious Incident
SMART	Specific, Measureable, Achievable, Realistic and Timely
YCS	Youth Custody Service
YOIs	Young Offender Institutes