Shared Insights

Overview of inquests in relation to deaths in custody

Stephen Kennedy, General Manager Nottinghamshire Healthcare NHS Foundation Trust

Dr Paul MacAllister, Consultant Forensic Psychiatrist - Clinical Director, Devon Community Forensic and Prison Service - Devon Partnership NHS Trust

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Nottinghamshire Healthcare NHS Foundation Trust

Devon Partnership NHS Trust

brownejacobson LLP

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Samantha Paxman, Partner and Barrister, Browne Jacobson's Barristers Team

Prison death inquests tend to be more complex than others for a number of reasons:

- Often Article 2 and with a jury if unnatural death. By its very nature, this means a longer more complex inquest with wider scope. A jury requires discussion in laymen's terms.
- Also it often takes longer to get to a final hearing particularly at the moment due to covid delays.
- This delay can lead to problems in obtaining disclosure and engaging witnesses (it's good to engage from the outset and keep them updated).

Three Key Themes:

- Documentation Provision
  - Dated or scant documentation may not be comprehensive which can limit your ability to justify decisions further down the line and lead to difficult questions from the Coroner.
  - Policies relevant at the time of death may not be those in place now. Disclose what was in place at the time.
  - Up to date evidence of prevention of future deaths and learnings also to be evidenced.
- Communication
  - There are often many organisations involved: healthcare, mental and physical health teams, prison, substance misuse, probation.
  - Often there is a focus on the extent of the collaboration between prison and healthcare.
- Decision making
  - The inquest will often focus on processes in prisons regarding ACCT reviews (those at risk of suicide or self-harm)/ segregation/ transfer/ release. The processes may be controlled by the prison but other organisations are involved in decision making and the Coroner will scrutinise the process and rationale for the decision.
  - Who was involved?
  - Was there a holistic picture for all involved?
  - Was the correct decision made at the time?
  - Can the decision be supported by evidence?
  - Missing information can become a key factor for the Coroner to explore.

Samantha Paxman
Partner (Barrister)
Nottingham
samantha.paxman@brownejacobson.com
+44 (0)115 976 6062

Sarah Stork
Senior Associate
Nottingham
sarah.stork@brownejacobson.com
+44 (0)115 908 4870

Healthcare in a prison setting - managing the unique challenges

Integration

- Setting – The healthcare provider is not in control of the building or the culture, policies or prison staff. Think about how you can influence the prison culture from a mental health perspective
- Multiple organisations - Frustrations of Coroners regarding who is responsible for what, concerns about weak spots and issues falling through the gaps, multiple Trusts with multiple legal teams, commissioners/commissioning arrangements. Know which organisation is responsible/ accountable for what and collaborate.
- New prison tendering seeking more "integration"-what is the role of MHTs in prison? The recommissioning of prison contracts concentrates on integration of services: quite often different organisations, different Trusts, different systems, does the information follow the patient in the right way?
- Shift in public awareness of "MH"- SMI, causative links between mental illness and risk, expectations that MHTs responsible for managing all MH risk, jury expectations .

Prison led policies/collaboration between prison and healthcare staff

- Lack of input – Healthcare providers are no longer given the opportunity to review accuracy of PPO reports and amend.
- Prison policy vs Healthcare policy – Healthcare providers expected to follow prison policies but have no input into them and they can be out of date.
- Healthcare not invited to discussions e.g. setting observation levels, and then asked why they weren't present - down to prison led processes.
- Collaborative approach with the prison is key both generally and at inquest.

Discharge, continuity of care in the community and transfer under the MHA

- Integration - interfaces and transitions of care-documentation, review of documentation/evidence received, processes adhered to the letter – what is known does not get lost.
- CPA has been the process to manage this for decades now, helps make clear whose role is what.
- CMHF happening-end of CPA in the community, end of CCO roles.
- Emphasis upon "shared" responsibility. Keyworkers. Unclear how will be implemented in many areas.
- CPA remaining (for now) in secure MH and prison.
- If risks - Assessment, Care in Custody and Teamwork (ACCT), observations, safer cell, transfer under MHA.
- June 2021 prison transfer guidance -14 days assessment and 14 days transfer/admission. Do services have systems and processes in place to ensure compliance with this?
- Resource implications – are there enough beds? (Seclusions, OOA transfers etc).
- Secure service access assessment specification being reviewed - outcome focussed - parity, levelling up - all transfers same guidance.
- Big change for secure services.
- PICU transfer guidance - draft shared with medical directors
- Commissioning changes - NHSE H+J, ICS, PCs.

When things go wrong

Investigations

Embedding learning and implementing change

How we can help

Assisting the PPO investigation

- Having contemporaneous factual accounts of events is useful – consider asking staff to record their account as soon as practicable after the incident.
- Offer support to staff giving evidence to the PPO (e.g. being accompanied to statement meeting).
- Keep a log of what is asked to get a steer of what the PPO are looking at. Interview notes will be useful.
- Delays in receiving disclosure of the report are common - actively ask the Coroner's office for the PPO report.

Embedding learning and implementing change

- As well as evidence that changes are being made, Coroners look for ongoing quality assurance of how new systems and changes in practice are embedded.
- Provide audit results to demonstrate meaningful change. Think about timing the audit so you have long enough before the inquest to rectify any issues raised. Balance this with allowing enough time before the audit for new systems to take effect.
- Test your organisational change evidence with the factual witnesses who may be asked by the Coroner whether they have seen the change implemented in practice.
- Maintain focus after the inquest. Coroners are likely to be looking for themes and 'problem' issues from earlier inquests.
- For review of records etc. there should be continuous audit with regular supervisions of all staff including random documentation checks. The quality of the supervision is key. Consider how much work you look at, actual detail of care plans etc
- Have a clear directorate-wide learning from experience (LFE) programme, which includes all learning, not just directorate level. Show how you learn from it and how you share that learning.
- Take a joint approach with the prison to any improvement plan where possible, even if recommendations are prison specific, work towards them together.
- Lack of shared notes/one central record leads to reliance on information sharing agreements and protocols between different providers. Most places are working towards integrated electronic records and systems that talk to one another efficiently.

How we can help

- Expert advice and representation at offender health inquests - from initial preparation to final hearing;
- Management of civil claims made by prisoners or arising from the death of a prisoner;
- Training to staff in relation to the inquest process and giving evidence in hearings;
- Training and advice on internal investigations and report writing;
- Drafting memorandum of understanding between organisations.

Contact us

Lorna Hardman
Partner

Nottingham
lorna.hardman@brownejacobson.com
+44 (0)115 976 6228

Simon Tait
Partner

Nottingham
simon.tait@brownejacobson.com
+44 (0)115 976 6559

Damian Whitlam
Partner

Nottingham
damian.whitlam@brownejacobson.com
+44 (0)330 045 2332

Samantha Paxman
Partner (Barrister)

Nottingham
samantha.paxman@brownejacobson.com
+44 (0)115 976 6062

Sarah Stork
Senior Associate

Nottingham
sarah.stork@brownejacobson.com
+44 (0)115 908 4870

Sarah Vince
Barrister (Senior Associate)

Birmingham
sarah.vince@brownejacobson.com
+44 (0)330 045 2269

Contact us

Birmingham office

Victoria House
Victoria Square
Birmingham
B2 4BU

+44 (0)121 237 3900
+44 (0)121 236 1291

Exeter office

1st Floor
The Mount
72 Paris Street
Exeter
EX1 2JY

+44 (0)370 270 6000
+44 (0)1392 458801

London office

15th Floor
6 Bevis Marks
London
EC3A 7BA

+44 (0)20 7337 1000
+44 (0)20 7929 1724

Manchester office

3rd Floor
No.1 Spinningfields
1 Hardman Square
Spinningfields
Manchester
M3 3EB

+44 (0)370 270 6000
+44 (0)161 375 0068

Nottingham office

Mowbray House
Castle Meadow Road
Nottingham
NG2 1BJ

+44 (0)115 976 6000
+44 (0)115 947 5246

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