

SERVICE SPECIFICATION

**Independent Clinical Reviews into Deaths in Custody**

**1** Background

# 1.1 Policy Context

1.1.1 Since April 2004, the Prison and Probation Ombudsman (PPO) have been responsible for carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration removal centres. The PPO has responsibility for the overall investigation process and formally engages with NHS England to commission a review of the clinical care the individual received whilst in custody or detention, which forms part of the overall PPO Investigation.

1.1.2 NHS England Health and Justice is responsible for the direct commissioning of primary care, secondary care, mental health and substance misuse services for people in secure and detained settings. 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 to those who die in secure and detained settings, including whether referrals to secondary healthcare were made appropriately.

1.1.3 The purpose of the clinical review is to assess the healthcare the deceased received whilst in custody and the review will form part of the PPO investigation and subsequent PPO report.

1.1.4 The clinical review (CR) includes past and current medical history and any significant clinical events leading up to the death of the individual, and particularly examines and assesses the equivalence of quality of care and access to care in custody as compared to what the individual could have expected in the community.

1.1.5 Clinical reviewers’ support the PPO to investigate all deaths under Article 2 (Right to life) of the Human Rights Act 1998.

1.1.6 The key policy document for Clinical Reviewers is: **Guidelines for Health & Justice Clinical Reviewers.** Most of the content of this specification has been derived from this document. The document can be found at: [https://www.england.nhs.uk/wpcontent/uploads/2018/10/guidelines-for-health-and-justice-clinical-reviewer.pdf](https://www.england.nhs.uk/wp-content/uploads/2018/10/guidelines-for-health-and-justice-clinical-reviewer.pdf)

1.1.7 The Provider should also ensure they are operating in line with:

NHS England’s **National Serious Incident Framework 2015**, or any superseding document ([https://www.england.nhs.uk/wp-content/uploads/2015/04/seriousincidnt-framwrk-upd.pdf)](https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf)

 **PPO Terms of Reference** [(http://www.ppo.gov.uk/app/uploads/2017/04/PPOTerms-of-reference-2017.pdf)](http://www.ppo.gov.uk/app/uploads/2017/04/PPO-Terms-of-reference-2017.pdf)

# 2 Aims of the Service

2.1.1 The aims of the Service are:

* To provide high quality reviews into deaths in custody;
* To identify opportunities for learning and service improvement;
* To work effectively in partnership with the PPO, Healthcare Providers, Custodial

Providers (HM Prison and Probation Service (HMPPS), Youth Custody Service (YCS),

HM Courts and Tribunals Service (HMCTS) and private operators) and the Home Office (HO);

* To produce clinical reviews that are accessible and meaningful for family members of the deceased as well as healthcare professionals;
* To support the overall PPO investigation process into deaths in custody.

# 3 Service Remit

3.1.1 The Service will be provided following the death in custody or detention of an inmates and detainees of:

* Prisons
* Young Offenders’ Institutions (YOIs)
* Secure Training Centres (STCs)
* Secure Children’s Homes (SCHs)
* Immigration Removal Centre (IRCs) s, Short Term Holding Centres and detainees being moved under escort
* Probation Approved Premises
* Court cells (when the person has been remanded or sentenced)

3.1.2 In London, the following establishments currently fall within scope of the service:

* HMP Belmarsh
* HMP Brixton
* HMP ISIS
* HMP Pentonville

HMP Thameside

* HMP Wandsworth
* HMP Wormwood Scrubs
* HMYOI Feltham
* IRC Colnbrook
* IRC Harmondsworth
* All London Criminal Courts

3.1.3 Any future establishment that meets the service remit that opens in London will also fall into scope of the service.

3.1.4 The PPO also has the discretion to investigate deaths of individuals who have been recently released from the establishments listed in paragraph 3.1.1.

3.1.5 Police custody falls outside the scope of this service.

3.1.6 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’*

3.1.7 In addition, the PPO also investigates deaths by natural causes, which are also subject to a clinical review

# 4 Clinical Review Standards

## 4.1 Purpose

4.1.1 The purpose of a CR 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, 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.

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

## 4.2 Classification of Deaths in Custody

4.2.1 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.

* 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 or heart attack.
* Self-inflicted:
* The death of a person who has apparently taken his or her own life irrespective of intent
* 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). This may not be clear until the toxicology report has been received.
* Homicide
* Where cause of death is unclear during the CR and PPO investigation

## 4.3 Governing Principles

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

* Healthcare services are provided that are safe and meet the same standards and quality of care 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 wider London 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

4.3.2 The aims of the CR 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
* Identify any good practice to support improvement work across the criminal justice system.

4.3.3 In addition, the CR will identify opportunities for learning and to make clear, measurable, timely and sustainable recommendations to healthcare organisations, commissioners, and health & justice policy leads.

4.3.4 If the CR 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 Commissioning Team. This may include referring healthcare professionals to the Nursing and Midwifery Council (NMC) or General Medical Council (GMC) after discussion with the Commissioner.

## 4.4 Levels of Review

4.4.1 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 service 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 additional subject matter expertise for a particular element of their healthcare.

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

4.4.2 The level of review will be agreed within five days of the death or first contact by the PPO, by the NHS England Health and Justice regional commissioning team and the PPO investigator in conversation with the appointed Clinical Reviewer.

4.4.3 The level of CR will be based upon the nature and circumstances of the death. If the timeline of five working days cannot be met, a revised deadline must be agreed between the PPO and the NHS England Health & Justice Commissioner.

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

4.4.5 Where the CR 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.

4.4.6 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) and where possible these should be attended. The record keeping for any other interviews should be undertaken by the PPO Investigator.

4.4.7 Expert views on the care provided can be sought from appropriate, independent health professionals (Team Reviewers). These may be provided directly by the Lead Reviewer or by arrangement with NHS England Health and Justice Commissioners from the Pool of Team Reviewers.

## 4.5 Drafting the Report

4.5.1 When drafting the report the Clinical Reviewer should use the national Clinical Review Report templates appropriate to the death and investigation outlined in the

**Guidelines for Health and Justice Clinical Reviewers**

[**(**https://www.england.nhs.uk/wp-content/uploads/2018/10/guidelines-for-healthand-justice-clinical-reviewer.pdf)](https://www.england.nhs.uk/wp-content/uploads/2018/10/guidelines-for-health-and-justice-clinical-reviewer.pdf) and follow the PPO requirements, that:

* Events are clearly and concisely stated and use plain English avoiding using technical language or jargon 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 or interview transcript;
* 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.

4.5.2 The Clinical Review report should identify:

* Whether the care was provided in accordance with the principles, outlined in section 4.3 above;
* Areas of good practice;
* Areas of opportunities for service improvement;
* 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.

4.5.3 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

## 4.6 Quality Assurance

4.6.1 Lead Reviewers are expected to undertake their own internal quality assurance on their draft CR they produce to ensure that the CR meets the required standards and that the content is as accurate as possible before submitting a draft to NHS England for quality assurance.

4.6.2 Prior to submitting the clinical review report to the NHS England and the PPO Investigator the Lead Reviewer must share a copy of the draft CR report with any Team Reviewers or other clinical experts who have contributed to ensure their views are appropriately represented.

4.6.3 The Clinical Reviewer must submit, via secure email, a draft CR report to NHS England, 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.

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

4.6.5 NHS England Health & Justice (London) will then quality assure the draft CR reports and provide feedback and comments using the National Quality Assurance Template and process (please refer to the Guidelines for Health and Justice Clinical Reviewers).

4.6.6 The outcome of the Quality Assurance process will be returned to the Lead Clinical Reviewer by NHS England Health & Justice (London) within five working days to allow review of comments and feedback.

4.6.7 The Lead Reviewer will submit a final draft report to NHS England Health & Justice 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

4.6.8 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 likely to only be agreed under exceptional circumstances (such as the inability to interview staff within the expected timeframes).

4.6.9 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.

## 4.7 Post Investigation

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

* The PPO investigator writes a draft report including the clinical issues and relevant recommendations.
* 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 six 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 eight weeks to feedback. In addition, the NHS England Health and Justice Teams and the Clinical Reviewer receive a copy of the initial report to check for factual accuracy.
* The Director/Governor/Centre Manager of the establishment 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.
* More questions may be asked, and occasionally it may be necessary for further investigation to take place, which may include clinical matters.
* 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.
* Both the PPO investigator and Clinical Reviewer may be called to give evidence at the inquest.
* 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.

## 4.8 Publication of the Report

4.8.1 Evidence provided to the PPO may be shared with specialist advisers, with other investigating bodies including the police, NMC and GMC, and with bereaved relatives.

4.8.2 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.

4.8.3 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.

4.8.4 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.

4.8.5 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. This applies to both the PPO investigation report and the clinical review report. Up to date information on PPO polices can be found in the PPO’s terms of reference which is published on the website www.ppo.gov.uk.

# 5 The Instruction Process

## 5.1 Reporting of a Death in Custody

5.1.1 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 to request the commissioning of a clinical review report.

5.1.2 The letter from the PPO will include the names of the deceased, date and location of death and provide the name and contact details of the PPO Lead Investigator for the case. This will occur within one working day of the PPO being notified of the death.

5.1.3 In all cases it is the responsibility of the establishment healthcare service to inform the NHS England commissioner of all deaths via a locally agreed reporting route within 72 hours of the death occurring (inclusive of bank holidays and weekends).

5.1.4 The Healthcare provider must also comply with the NHS Serious Incident Framework and must report all Serious Incidents in accordance with the requirements of that Framework.

5.1.5 Healthcare providers will be expected to undertake an initial review within 72 hours from identification of death. This is 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. Where this review has been completed by the time of investigation, this review and any subsequent full internal review (if completed by the close of the PPO’s investigation) will be shared with the Lead Reviewer.

## 5.2 Instructing a Clinical Reviewer

5.2.1 Upon notification by the PPO or Healthcare Provider of a death in Custody, NHS England London’s Health and Justice Commissioning Team will seek to appoint a Provider from the Framework, as per the terms of contract award contained in the framework.

5.2.2 NHS England will contact the potential Provider via email (nhs.net). The potential provider MUST then respond to this email within 24 hours (via email or telephone) to confirm they are available to complete the CR. If no response is received within 24 hours, NHS England will approach the next provider due to be awarded work under the Framework.

5.2.3 NHS England is required by the PPO to appoint a named Lead Reviewer within five days of notification of a death in custody. Within this time NHS England, the PPO and the Lead Reviewer will agree on the initial level of the CR.

5.2.4 The appointed Clinical Reviewer(s) MUST have knowledge and experience relevant to the healthcare received by the deceased and issues surrounding the death. For Level 2 and Level 3 reviews where a Lead Reviewer does not have this knowledge and experience subject matter expertise in the form of Team Reviewers will be appointed to assist the Lead Reviewer. These may be In House Team Reviewers or Pool Team Reviewers.

5.2.5 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.

5.2.6 The Clinical Reviewer MUST declare any conflict of interest to NHS England Health & Justice (London) and confirm there are no actual or potential conflicts in undertaking a CR at the outset of the CR.

5.2.7 The Clinical Reviewer MUST confirm to NHS England Health & Justice 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 at the outset of the CR.

5.2.8 The Clinical Reviewer MUST confirm to NHS England (Health & Justice) their adherence to all standards for professionalism, honesty and integrity, in accordance with the General Medical Council (GMC) or Nursing and Midwifery Council (NMC) code of professional conduct at least annually.

# 6 Clinical Reviewer Requirements

## 6.1 General Requirements

6.1.1 The term Clinical Reviewer is used to refer to all clinicians involved in undertaking a Clinical Review. However, in London we have further defined two types of clinical reviewer, which will be detailed below:

* Lead Reviewers
* Team Reviewers

6.1.2 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.

6.1.3 To ensure objectivity and to protect the independence of the PPO, Clinical Reviewers 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.

## 6.2 Subject Matter Expertise

6.2.1 Commissioners require all Clinical Reviewers to state the areas they hold subject matter expertise in, and to refresh this statement at least annually. Commissioners will use this information to ensure that the appropriate Clinical Reviewers are appointed to each review. Where gaps exist, Team Reviewers will be brought in to support the Lead Reviewer.

6.2.2 No specific subject matter expertise will be required for Level 1 Reviews. Furthermore, it is not a requirement for every Clinical Reviewer to hold all the areas of subject matter expertise.

6.2.3 The areas of subject matter expertise NHS England requires are:

* **Primary Care**: the provision of primary healthcare such as GP services, practice and district nursing.
* **Urgent Care:** the provision of urgent care relevant to the care likely to be provided in secure establishments, i.e. the treatment of minor injuries, resuscitation, and emergency responses.
* **Long Term Condition Management:** the management of long term health conditions such as diabetes, high blood pressure and other chronic illnesses.
* **Mental Health:** the provision of primary and secondary mental healthcare including psychological treatment.
* **Intellectual Disability and Neurodevelopmental Disorders:** the provision of care and an understanding of the needs of patients with learning disabilities, cognitive impairment and neurodevelopmental disorders (including autistic spectrum conditions).
* **Palliative/End of Life Care**
* **Substance Misuse:** the provision of both clinical and psychosocial substance misuse treatment (both drug and alcohol misuse).

## 6.3 Lead Reviewers

6.3.1 Providers should ensure that Lead Reviewers meet the requirements set out in the Person Specification and Job Description included as Annex 1 to this specification.

6.3.2 Lead Reviewers should be either General Practitioners (GPs) or registered nurses:

* Doctor – is on the GMC register and holds a licence to practice
* Nurse – is registered with the NMC and with experience of working in a clinical setting which involves direct contact with patients.

6.3.3 Lead Reviewers should have relevant clinical experience. Although recent clinical practice (within the last two years) is preferred this is not a requirement in London (in this we diverge from the national guidelines).

6.3.4 The Lead Reviewer for each CR will undertake the full role of a Clinical Reviewer outlined in the **Guidelines for Health and Justice Clinical Reviews.**

6.3.5 The Lead 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;
* Ensuring they store and destroy information they receive securely as per information governance requirements.
* Ensuring that any and all electronic equipment or devices that they use when undertaking the CR are encrypted and/or capable of being wiped remotely.
* Where possible to carry out all record keeping relating to the CR electronically
* 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 the 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 CR;
* 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.

## 6.4 Team Reviewers

6.4.1 Team Reviewers are Clinical Reviewers who have been brought in to support the Lead Reviewer complete the CR through the provision of particular subject matter knowledge and experience.

6.4.2 Team Reviewers will work under the direction of the Lead Reviewer.

6.4.3 Team Reviewers will be engaged to complete specific aspects of the review and there is no requirement for them to be engaged for the whole duration of a CR.

6.4.4 Team Reviewers may only be appointed to Level 2 and Level 3 investigations.

6.4.5 Team Reviewers may be arranged by the Provider, where details have been provided to commissioners in advance. These will be referred to as “In House Team Reviewers”.

6.4.6 Where there is a requirement for a Team Reviewer with subject matter expertise not held by any of the Clinical Reviewers, a Team Reviewer will be appointed by the Commissioner, in consultation with the Lead Reviewer, from the pool of Team Reviewers appointed to Lot 2 of the Framework Agreement. These will be referred to as “Pool Team Reviewers”.

6.4.7 It is acceptable for a Lead Reviewer to be appointed as a Team Reviewer to one Clinical Review and act as Lead Reviewer on another so long as they meet the requirements to act as a Lead Reviewer.

6.4.8 It is expected that Team Reviewers are healthcare professionals, with appropriate professional registration, but Team Reviewers do not need to be solely Doctors or Nurses and may be drawn from a range of health and allied professions (i.e.

psychologists, substance misuse practitioners, social workers, physiotherapists etc.)

## 6.5 Security Clearances and Vetting

6.5.1 All Clinical Reviewers’ will be required to undergo HMPPS/HO/YCS local security clearance. For the IRCs and HMP Belmarsh this may include the need to obtain Counter Terrorism Clearance. Clearance must be obtained before undertaking any CR work unless prior permission from the Governor/Director/Centre Manager is obtained.

6.5.2 If any Lead Reviewer or Team Reviewer is not successful in obtaining clearance, they may not be able to work inside secure establishments. If a Lead Reviewer holds no appropriate clearance, they will no longer be eligible to provide CRs.

6.5.3 Clinical Reviewers shall co-operate in full with all HMPSS checks deemed necessary.

6.5.4 Clinical Reviewers 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.

6.5.5 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.

# 7 Roles and Responsibilities of Partners

## 7.1 The Prison and Probation Ombudsman (PPO)

7.1.1 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.

7.1.2 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.

7.1.3 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 are particular lessons to be learned.

7.1.4 With respect to its relationship with NHS England and healthcare providers, the PPO will:

* Provide feedback to the NHS England Health and Justice regional Commissioners and the 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.

7.1.5 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?

7.1.6 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. NHS England has 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.

## 7.2 The Role of NHS England and NHS Improvement’s Regional Health and Justice Commissioning Teams

7.2.1 NHS England regional Health and Justice Teams have the responsibility for the commissioning of healthcare services in prisons, IRCs, SCHs and YOIs in England and will take the lead in commissioning an independent CR into the healthcare received by the deceased.

7.2.2 Regional NHS England Health & Justice Commissioning Teams are responsible for:

* Commissioning Clinical Reviewers to undertake a CR investigation report in line with the Standard Operating Procedure for the provision of CR reports;
* Ensuring all commissioned CR reports are delivered within the described and agreed timeframes;
* Ensuring provision of high-quality CR reports through adoption of the nationally set quality assurance process;
* Providing assurance to agreed regional oversight teams and the Health & Justice Central Team around compliance to NHS England policies and governance in commissioning and completing CRs;
* Assuring and monitoring healthcare provider responses and action plans to address any recommendations made by the 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 CR 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 CR report

**7.3 Role of Her Majesty’s Prison and Probation Service**

# (HMPPS)/Home Office (HO) /Youth Custody Service (YCS)/Her Majesty’s Courts and Tribunal Service (HMCTS)

7.3.1 HMPPS/HO/YCS/HMCTS teams will:

 When the Clinical Reviewer is required to attend the establishment, 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.

## 7.4 Establishment Healthcare Providers

7.4.1 In London each prison, YOI and IRC has a lead healthcare provider – supported by a number of sub-contracted providers. Dental providers are currently subcontracted from the Lead Provider, but are in the process of transitioning to being directly commissioned. The table below outlines our current provision at the time of the Framework being advertised:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Establishment** | **Lead Provider** | **Mental Health** | **Substance Misuse Psychosocial** | **Dental** |
| HMP Belmarsh | Oxleas NHS  Foundation Trust | Oxleas NHS  Foundation Trust | Change, Grow Live | Tooth & Mouth  Ltd |
| HMP Brixton | Care UK | Barnet, Enfield and Haringey NHS Foundation Trust | The Forward Trust | Time for Teeth Ltd |
| HMP ISIS | Oxleas NHS  Foundation Trust | Oxleas NHS  Foundation Trust | Oxleas NHS  Foundation Trust | Tooth & Mouth  Ltd |
| HMP Pentonville | Care UK | Barnet, Enfield and Haringey NHS Foundation Trust | Phoenix Futures | Time for Teeth Ltd |
| HMP Thameside | Oxleas NHS  Foundation Trust | Oxleas NHS  Foundation Trust | Turning Point  (commissioned by  Serco/HMPPS) | Tooth & Mouth  Ltd |
| HMP Wandsworth | Oxleas NHS  Foundation Trust | South London and  Maudsley NHS  Foundation Trust | Change, Grow Live | Tooth & Mouth  Ltd |
| HMP Wormwood  Scrubs | Care UK | Barnet, Enfield and Haringey NHS Foundation Trust | The Forward Trust | Time for Teeth Ltd |
| HMYOI Feltham | Central North  West London NHS  Foundation Trust | Central North  West London NHS  Foundation Trust | Central North West  London NHS  Foundation Trust | Dr Abdul Khan |
| IRC Colnbrook & IRC Harmondsworth | Central North  West London NHS Foundation Trust | Central North  West London NHS Foundation Trust | Phoenix Futures | Time for Teeth Ltd |

7.4.2 The list above is not exhaustive and other sub-contracted providers operate in our establishments providing services such as optometry, podiatry and physiotherapy.

7.4.3 At courts, NHS England and NHS Improvement London Region only currently commission Liaison and Diversion services. These services are not provided exclusively for people detained in custody at court and operate primarily in the court facilities rather than court cells. In the future it is likely that court-based healthcare will be commissioned but these arrangements have not yet been finalised.

7.4.4 There are currently no other contexts in scope of the service which NHS England commissions healthcare services for, however, a secure children’s home for London is in the early stages of development and if opened will fall under scope.

7.4.5 Healthcare providers will:

* 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 the PPO office as required.

# 8 Patient and Family Involvement

8.1.1 Clinical Reviewers are not expected to have direct contact with family members or the nominated next of kin of the deceased. The PPO’s family liaison office will lead on liaising with the family or nominated next of kin.

8.1.2 However, Clinical Reviewers must still ensure they are responsive to the concerns of family members and other interested members of the public. Where family members have raised particular concerns with the PPO concerning healthcare provision, Clinical Reviewers should investigate these concerns as part of the CR.

8.1.3 It is also important that CRs are produced in such a way as to ensure they are accessible and intelligible to family members of the deceased as well as the health professionals involved in each case.

8.1.4 Clinical Reviewers may also wish to comment, in their review, on the Healthcare Provider’s actions to meet the duty of candor to involve family members in their own internal investigations.

8.1.5 Clinical Reviewers may also be involved in the interviewing of non-healthcare staff and inmates, i.e. the deceased’s cell mate. Clinical Reviewers should ensure they conduct themselves in these interviews in a sensitive and respectful manner, acknowledging that staff members (including healthcare staff) and other inmates may also be experiencing loss and bereavement and may have been exposed to traumatic circumstances surrounding the death in custody.

# 9 Inquests

9.1.1 Both the PPO Investigator and Clinical Reviewers 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 CR. Each interested party may have their own legal representation and each may require the PPO investigator and Clinical Reviewers to give evidence.

9.1.2 NHS England will not pay for time spent at Inquests by Clinical Reviewers – it is expected that Clinical Reviewers will allow for this possibility in their overhead costs.

# 10 Quality and Clinical Governance

10.1.1 Clinical governance arrangements and structures will be in place which facilitate continuous service improvement by the utilisation and analysis of key information sources such as: Quality Assurance Feedback, Feedback from Coroners, Feedback from other stakeholders.

10.1.2 Clinical governance concerns both clinical and non-clinical staff and acknowledges everyone’s contribution to the patient’s experience. Good integrated governance should combine and create consensus around the concerns of all staff, patients and their families. Key to effective governance is the availability of information sources on which to base decisions.

10.1.3 The Lead Reviewer has the responsibility to ensure clinical governance for Team Reviewers.

10.1.4 The Lead Reviewer will use a variety of methods to ensure that a high-quality service is provided.

10.1.5 The Lead Reviewer will ensure that they fully participate in the Quality Assurance structures set out in section 5.6.

10.1.6 The Lead Reviewer will supply any other reasonable information to enable the Commissioners to monitor the quality of CRs and compliance with performance targets.

# 11 Safeguarding

11.1.1 NHS England is dedicated to ensuring that the principles and duties of safeguarding adults and children are holistically, consistently and conscientiously applied with the wellbeing of all at the heart of what we do.

11.1.2 Within prisons, governors are responsible for safeguarding.

11.1.3 The Provider is required to follow the statutory guidance and pan-London procedures in place for Safeguarding Children and Adults at Risk as well as the Safeguarding Policies of the secure establishments they are operating within. This includes the need to manage allegations against staff.

11.1.4 The Provider must demonstrate how it meets the legislative and statutory requirements for safeguarding and Prevent. This should include a description of the accountability and leadership structure; policies, procedures and training plans relating to safeguarding adults, safeguarding children and Prevent; and quality improvement plans showing how the Provider coordinates learning from safeguarding incidents.

11.1.5 The Provider should include information regarding dealing with allegations against staff, information sharing and how the Provider works with secure establishments and Local Authorities to safeguard those at risk of abuse.

11.1.6 The Provider should include how it works to address the factors that contribute to radicalisation, such as peer pressure, family tension, low self-esteem and mental health issues, which make the prison population vulnerable to radicalisation.

# 12 Training and Development

12.1.1 The Lead Reviewer must ensure Clinical Reviewers have access to appropriate learning and development opportunities which will be a combination of e-learning, practice based and accredited learning at the appropriate academic level to enable personal and practice development. Education and training needs can also be met through, for example, local skills training, e-learning, seminars, shadowing, clinical placement exchanges and rotation programmes.

12.1.2 The Lead Reviewer will develop a profile of mandatory training and required annual update of existing competencies, in line with national standards, that must be undertaken by all Clinical Reviewers and updated regularly.

12.1.3 The Commissioner will support the Provider through the provision of orientation and induction to our local secure establishments, the PPO and our healthcare providers.

# 13 Information Governance

## 13.1 Overarching Requirements

13.1.1 Clinical Reviewers must comply with the data protection legislation, including the EU GDPR and the Data Protection Act 2018.

 Any personal electronic equipment used by the Clinical Reviewer in carrying out his/her role complies with information governance requirements.

## 13.2 Confidentiality

13.2.1 While fulfilling their role, the Clinical Reviewer will have knowledge, or access to, information which is confidential to NHS England, practices, individual performers and members of staff. Confidential information must be treated in accordance with the Common Law Duty of Confidentiality.

## 13.3 Access to Medical Records

13.3.1 The Clinical Reviewer will be provided access to the total healthcare record of the deceased during their current incarceration by the Healthcare Provider. This MUST include the following (please note list is not exhaustive):

* SystmOne records, including any paper-based documents waiting scanning. If SystmOne is not used, then any other primary care? healthcare records must be reviewed;
* Mental health records if not held on SystmOne, if applicable;
* Substance Misuse records, both clinical and psychosocial. These are normally held on SystmOne but paper records are also sometimes used;
* If applicable, any additional healthcare records that may be relevant i.e. dental optician, social care, fluid balance charts and care plans etc.

13.3.2 If necessary, NHS England Health & Justice regional Commissioning Team will attempt to assist the Provider with the accessing of such records.

13.3.3 A 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. A 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 outpatients 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) Footage.

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

13.3.5 Following any request for additional records, the Healthcare Provider will be asked to provide these within five working days. If the Clinical Reviewer is unable to access any of the above medical records for the deceased, they must notify the Health and Justice Commissioner within 24 hours.

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

## 13.4 Record Storage and Destruction

13.4.1 NHS England will ensure that all paper and electronic records and files returned by the Clinical Reviewer are stored in a safe and confidential manner. .

13.4.2 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 and Reviewers should note that issues of clarification sometimes arise following the consultation period.

# 14 Insurance

14.1.1 NHS England requires Clinical Reviewers to obtain indemnity cover from their professional union or medical defence organisation in respect of any claims made against them whilst performing the clinical reviewer role.

14.1.2 It is the responsibility of the Clinical Reviewer to contact their current indemnity cover provider and inform them that they are commencing this type of work. NHS England will need to be provided with evidence that the Clinical Reviewer has the necessary cover and arrangements in place.

# 15 Payment

15.1.1 CRs will be paid for based on the rate cards submitted during the tendering process.

15.1.2 After the agreement with the Commissioner and the PPO as to the Level of each review the Lead Reviewer will provide the Commissioner with an estimated time commitment.

15.1.3 The Commissioner will then use the submitted rate card and payment calculator to estimate the cost of the review. These will be included in Annex 2 of this specification.

15.1.4 NHS England will pay half the estimated cost of a Clinical Review in advance.

15.1.5 Upon completion of the CR the provider will submit a final rate card and payment calculator (contained in Annex 2). NHS England will then pay the remainder of the cost of the review, less the advance payment.

15.1.6 Invoices should be sent to NHS SBS and must include a PO number which will be issued to Providers as soon as possible after instruction.

**16 Annex 1: Person Specification/Job Description**

# 17 Annex 2: Payment Calculator

17.1.1 *Insert from successful bidder’s FMTs*