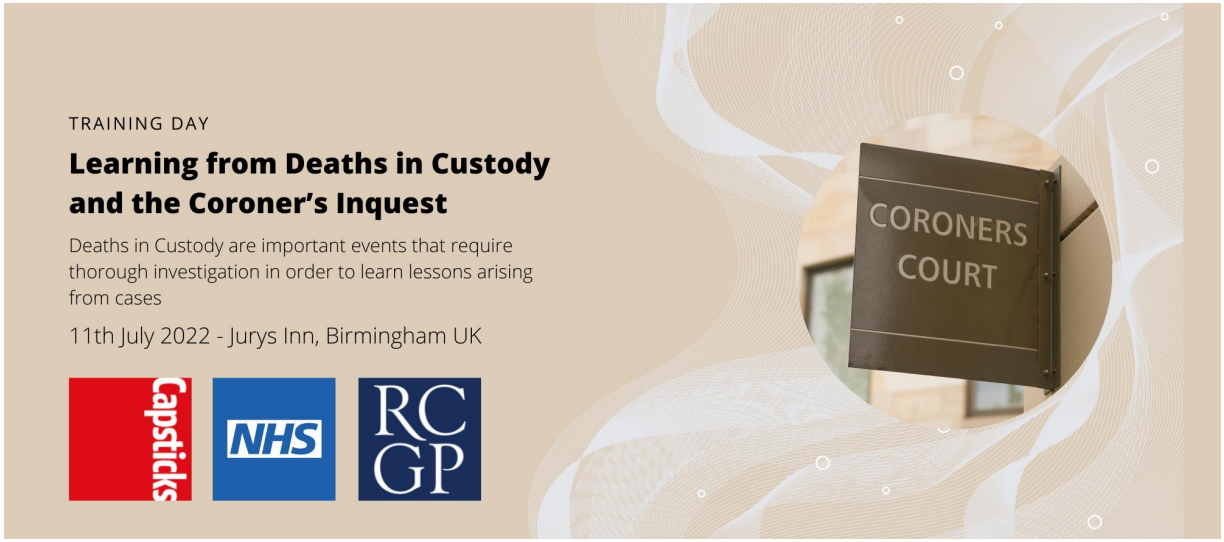
WELCOME TO

Learning from Deaths in Custody and the Coroner's Inquest – RCGP & Capsticks Solicitors LLP



SCAN ME

Monday 11th July 2022- 09:00am – 16:45pm – Jury's Inn Hotel Birmingham

Conference hosted by Convenzis Group Limited

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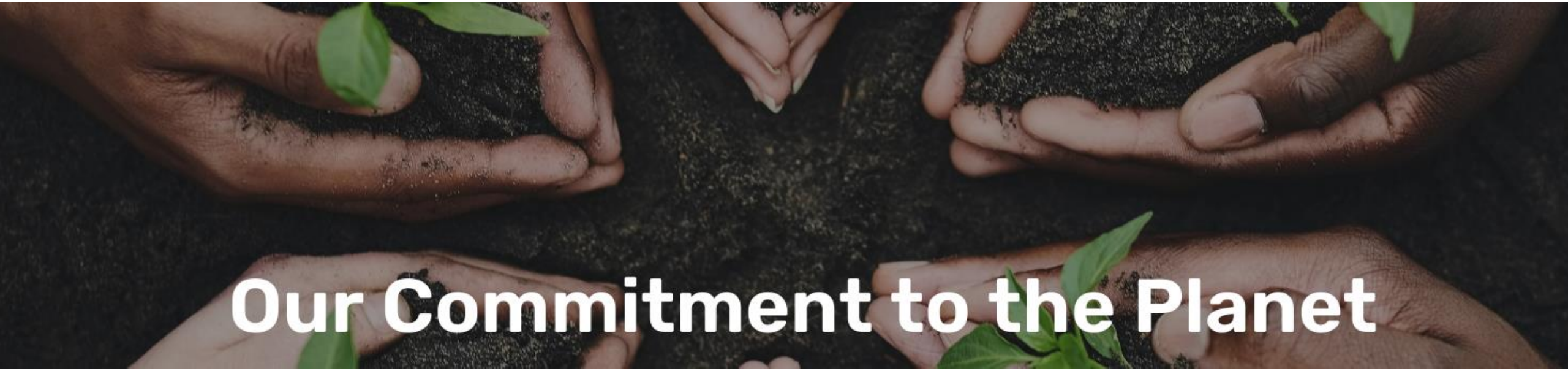


For Each Delegate Attending Our In-Person Event Today, we will be planting 1 tree with our Key Sustainability Partner

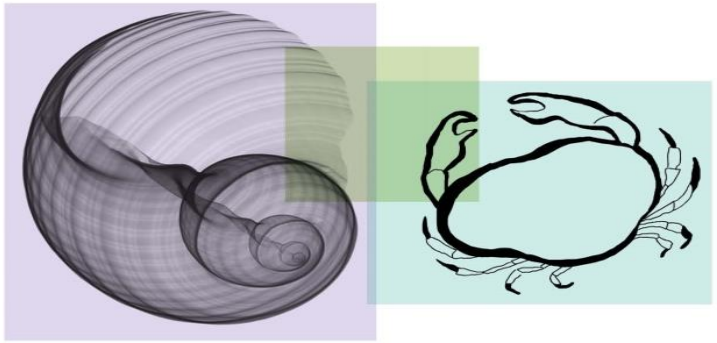
PLAY IT GREEN

Learning from Deaths in Custody and the Coroner's Inquest – RCGP & Capsticks Solicitors LLP

Event Chair – Opening Address

Naomi McMaster

Partner and leads the Health and Justice team
Capsticks



An Introduction to Deaths in Custody

Naomi McMaster, Partner

11 July 2022

Safety in Custody Statistics

12 months ending March 2022

- 287 deaths in prison custody.
- 183 deaths were due to natural causes (inc. COVID-19).
- 75 deaths were self-inflicted
- 28 ‘other’ deaths (25 yet to be classified).

The personal impact of deaths in custody

- Deceased’s family
- Other prisoners.
- You!

Key Themes (unnatural deaths)

- Assessing and managing risk of self-harm and suicide.
- Control and restraint.
- Emergency response.

Assessing and managing risk of self-harm and suicide

- Cross discipline responsibility.
- Lack of consideration of risk factors.
- Overreliance on the presentation of the individual or assurances provided by them.
- Information sharing.

Control and restraint

- Rise in public interest.
- Signs of distress.
- Communication.

Emergency Response

- Response bags.
- Misdiagnosis of hypostasis and rigor mortis.
- Adequacy of CPR.
- Communication.

DIC – What next?

- Police investigation.
- Serious Incident / Root Cause Analysis investigations.
- Prison and Probation Ombudsman.
- Inquest.
- Civil Claim.

Today's Agenda

- Defensible record keeping.
- Witness statement excellence.
- The PPO and Clinical Review Process.
- The Coroner's Inquiry.
- Witness evidence in action.
- Civil Claims arising out of deaths in custody.

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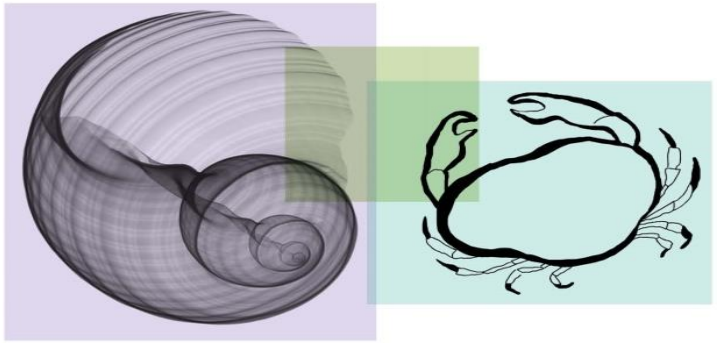
Learning from Deaths in Custody
and the Coroner's Inquest –
RCGP & Capsticks Solicitors LLP

Speaking Now

Lucy Houston

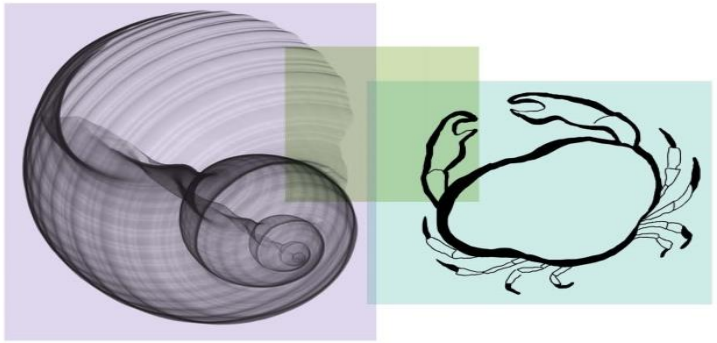
Associate at
Capsticks



Defensible Record Keeping

Lucy Houston, Associate

11 July 2022



The importance of good records

Guidance from Regulatory Bodies

- Keep full, clear and accurate records.
- Records should be completed at the time or in a timely manner.
- Records should include all relevant information.
- Records should provide colleagues who use them with all the information they need to know.
- Records should be completed without falsification.
- Records should be stored securely
- Patient confidentiality upheld.

Other guidance

- Local policies and SOPs.
- Forms.
- Prison Service Instructions.

Keeping good records – Clinical Benefits

- Communicating care and treatment effectively to other staff.
- Building a clear picture of an individual's history.
- Tracking trends and identifying risks in respect of substance misuse, bullying and self-harm.

Keeping good records – Personal benefits

- Confident you have documented appropriately to ensure best patient care moving forwards.
- There is a clear undisputable plan.
- Assists with recollection.
- Evidence the action you took and basis for your decision making if challenged at a later date.

Who looks at records?

- Your colleagues.
- Your patient and/or their relatives.
- Internal investigators.
- Regulators – HMIP/CQC.
- PPO / Clinical Reviewer.
- Coroners.
- Legal Teams.

What has been said about record keeping?

HM Inspectorate of Prisons / CQC

"Clinical records were of a reasonable standard, ***although some care plans needed to be more personalised."***

"The care records reviewed showed that, while the treatment provided was well documented, the ***choice of treatments offered was not always clear and…consistently recorded****."*

"…records for these prisoners were of variable quality, and some ***lacked evidence of meaningful interaction****."*

What has been said about record keeping?

Prison and Probation Ombudsman / Clinical Reviewer

"Without a clear record about what happened, we cannot reach as full a conclusion about the events that day as we would have wished."

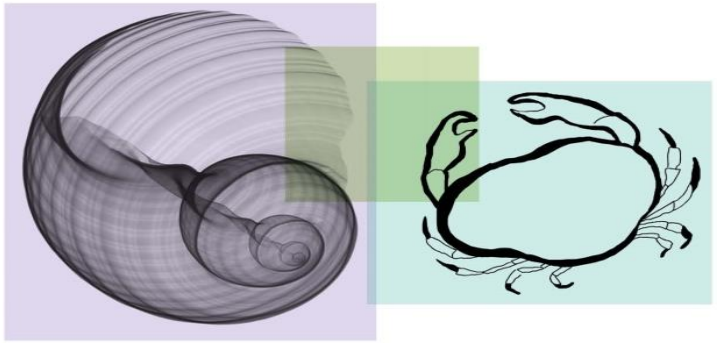
"…some of the record keeping was too brief to allow another clinician to understand the reasoning or to safely take over the care of the patient."

"Neither the nurse…nor the prison GP she consulted, documented the details of their discussion. Good record keeping is vital for continuing and shared understanding of decisions."

"She [a nurse] gave him advice and noted that she would ask the prison GP if any treatment was needed. The outcome was not recorded"

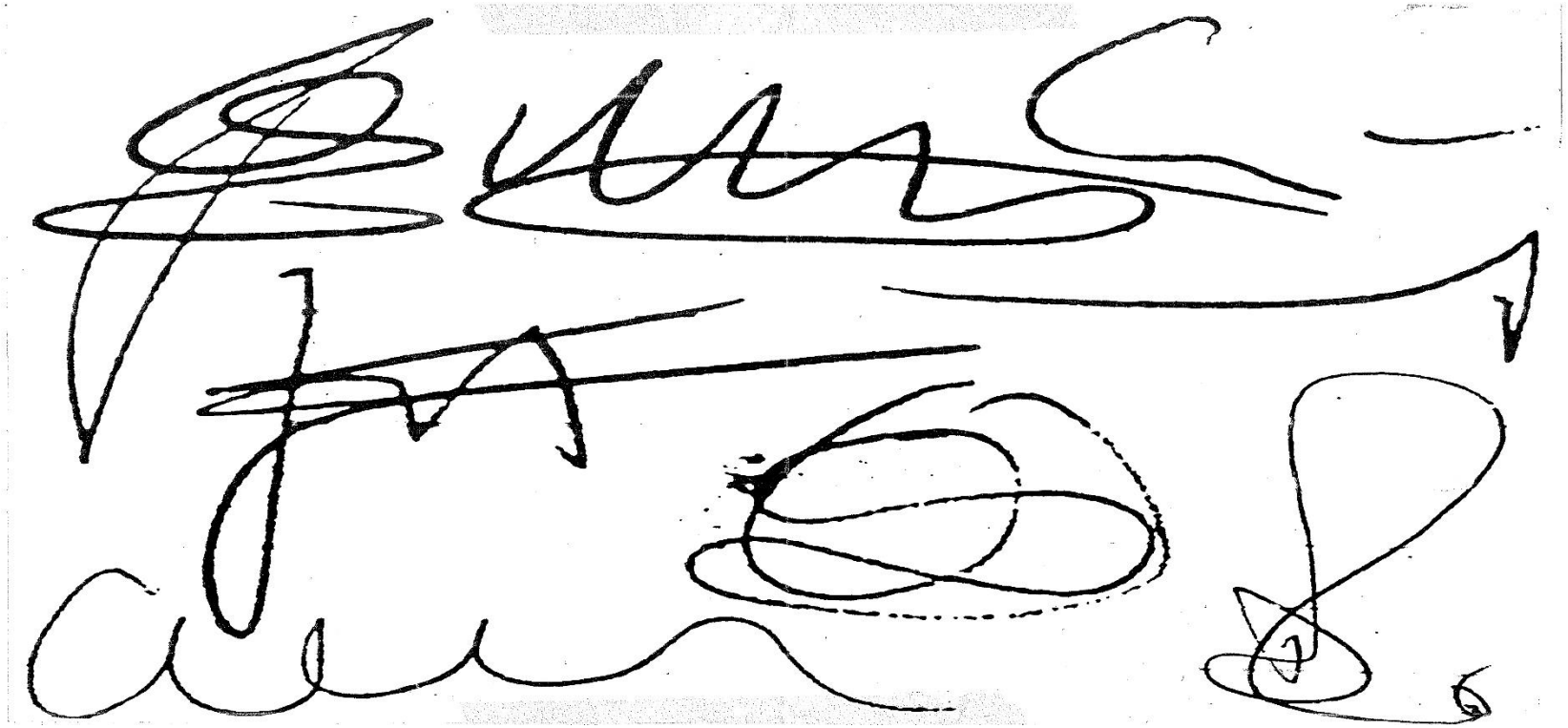
What has been said about record keeping?

- *“In my days in medicine, if it wasn’t written down it never happened, what do you have to say about that?”*



What does good record keeping look like?

What does good record keeping look like?



What does good record keeping look like?

- Contemporaneous notes.
- Include details of information and explanation given to patients
- No unnecessary, obscure abbreviations or jargon.
- Be factual, consistent and unambiguous.
- Alterations should be clear and auditable.
- Ensure there is a clear care plan.
- Does information need to be duplicated elsewhere?

What to bear in mind when making entries?

- What did I already know and what documents / information have I considered?
- What do I know now? What has the patient told me?
- What have I told the patient?
- What are my conclusions / plans ?
- What have I done and when?
- What am I going to do and when?
- Who needs to know what I know?
- Who may rely on this information moving forwards?

How can the below record be improved?

Entered in retrospect

I attended an ACCT review for Mr Smith.

Prior to the review, I looked at records and noted history. Hx 3xSH.

Mr Smith was in <mood.

Agreed follow up actions which have been included in paperwork and responsibility been allocated.

Follow up to be booked.

In summary…

- Make sure you are aware of your professional obligations.
- Familiarise yourself with local policies.
- Are the systems hindering you, speak up!
- Be clear, factual and unambiguous.
- Your notes should be legible and identifiable as yours.
- Clear care plan / way forward.
- Always review!

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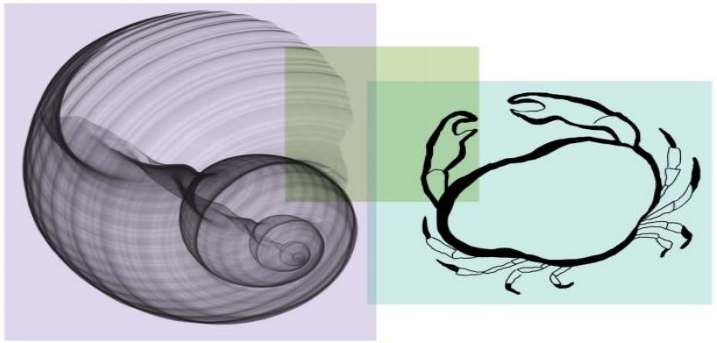
Speaking Now

Nadine Mansell

Senior Associate at Capsticks



Witness Statement Excellence

Nadine Mansell, Senior Associate

11 July 2022

What we will cover:

- Why are statements needed at Inquests?
- What should a statement include?
- Top tips!

Why are statements needed for an Inquest?

To provide clarity regarding:

- An individual's role / experience / involvement.
- The relevant background.
- What was seen / known at the time.
- What was expected to happen and what actually happened.
- Advice / recommendations / planning.

A statement from who?

- Identify the staff who were involved / provided care at the relevant time.
- Which witnesses are best placed to speak to which matters?
  - Is evidence required about specific care;
  - Any overview statement; or
  - About the providers' systems or the providers' involvement.
- Who made decisions or was part of the decision making process?
- If a potential witness is not available is there someone else who can speak to the same episode of care?
- Is factual or expert evidence being requested?

When to prepare a statement?

- Earlier is better, when memories are at their freshest. However, sometimes it is necessary to delay e.g. where there will be a criminal investigation / prosecution.
- You might like to make some notes whilst your memories are fresh but someone may want to see those notes.
- Keep in touch

What should the statement include?
(1) Background

- Your full name / work address.
- Your job title / speciality .
- Qualifications.
- Position: now, and at the time of the death.
- Relevant background experience.
- Experience working for the provider.
- Experience in post.
- Experience in task (where relevant).

What should the statement include?
(2) Content

- Documents reviewed when preparing the statement – individual's records, policies, local and national guidelines (NICE Guidelines, PSIs, etc.)
- Chronological order.
- Your recollection of events.
- What was discussed with the individual.
- What was discussed with your colleagues.
- What you recorded and the action you took.
- Reference to protocols and guidance.
- What your usual practice was at the time.
- Exhibit relevant documents (if any).
- Sign and date / statement of truth

Top Tips

DO:

- Make clear what is from memory, what is from the notes and what is based on usual practice.
- Use full sentences, dates / times.
- Explain the records – medical terms, test results, reasons for actions.
- Exhibit relevant key documents.
- Identify other staff involved.
- Make it as simple as possible - it may be read by non-medical people.
- Stick to the facts!
- Get support from your employer and the legal team.

Top Tips

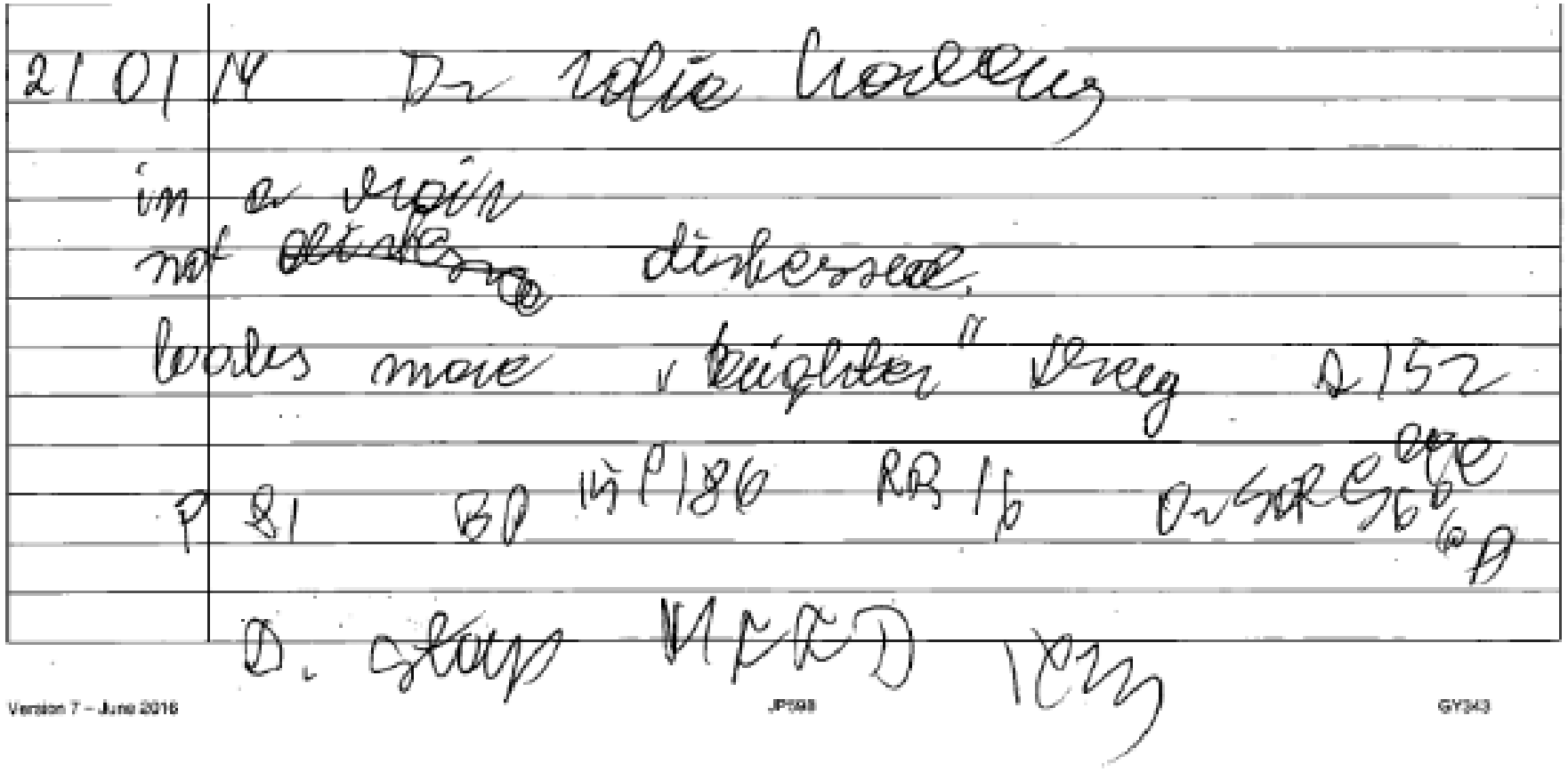
DO NOT:

- Just regurgitate the medical notes
- Use jargon / be ambiguous
- Speculate on what others were doing or thinking [unless something known as a fact]
- Attempt to write your statement without access to the records
- Be hostile, rude or unnecessarily defensive
- Have spelling mistakes or grammatical errors.
- Give opinion evidence
- Prepare a statement without the knowledge of your employer.
- Give opinions on the care given by other clinicians or blame other clinicians or departments

Is the evidence ‘now’ the same as it was ‘then’?

- The medical records are expected to provide an accurate and contemporaneous record:
  - Communicating care and treatment information to other staff effectively
  - Providing a clear picture of the patient’s history.
- Professional duties in relation to record keeping.
- BUT is everything recorded at the time (e.g. all options considered, treatments considered but dismissed) do you ‘show your working’ (thinking) or just your conclusions?
- If something isn’t written down, does that mean it never happened?

Perhaps evidence is required to transcribe (translate) entries in the records



Practical Issues

- Evolving drafts –third parties might seek copies of draft statement(s) (including handwritten notes from the time / types accounts for the internal investigation).
- Signature – ink is the gold standard.
- Data security – password protected?
- Individual(s) in a statement to be named or anonymised?

Why are statements important if you are called to give evidence?

- Giving evidence is not a memory test and therefore you will be expected to refer to your statement
- This means that the more detail in the statement the better it will assist you in giving evidence
- It is an opportunity to get all the relevant information down to clarify your involvement and reassure the Coroner that there weren't any concerns in respect of your involvement.
- If there were issues then it is an opportunity to explain these and provide additional information to support your position.

Is the evidence helpful?

- What do you think about the following:
  - I don’t remember anything!
  - Sue / John / someone told me that…
  - I thought maybe …
  - I think she thought that….
  - I wasn’t told….
  - I wasn’t trained to …
  - I didn’t think it was right but…

In summary…

- Understand the purpose of the statement.
- Address the matters chronologically – use headings if it assists.
- Be factual, consistent and unambiguous.
- Be thorough, open and fair
- Avoid language that could be misinterpreted.
- Remember the reader will not have your knowledge.
- If you are unsure whether something is relevant, ask! Often safer to include it.
- Consider the final version carefully.

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Learning from Deaths in Custody
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MORNING BREAK, NETWORKING & REFRESHMENTS

Prisons & Probation Ombudsman
Independent Investigations

The Prisons & Probation Ombudsman and Clinical Reviewer Process

Sarah Stolworthy & Tina Sullivan – PPO Senior Investigators

Prisons & Probation Ombudsman
Independent Investigations

What is the purpose of PPO investigations?

To understand what happened and to identify learning for the organisations whose actions we oversee so that the PPO makes a significant contribution to safer, fairer custody and offender supervision.

Fatal Incidents Investigations Started

	Total 21/22	% of Total 21/22
Natural	193	59%
Self-Inflicted	85	26%
Other Non-Natural	33	10%
Homicide	1	0%
Awaiting Classification	17	5%
Total	**329**	**100%**

Fatal Incidents Investigations Started

	Total 21/22	% of Total 21/22
Male Prisoners 21 and over	280	85%
Female Prisoners 21 and over	6	2%
Male Prisoners 18 to under 21	1	0%
Female Prisoners 18 to under 21	0	0%
Male Prisoners under 18	0	0%
Female Prisoners under 18	0	0%
Male Approved Premises Residents	12	4%
Female Approved Premises Residents	1	0%
Male IRC Residents	1	0%
Female IRC Residents	0	0%
Male Discretionary Cases	3	1%
Female Discretionary Cases	0	0%
Male Post Release Cases	22	7%
Female Post Release Cases	3	1%
Total	**329**	**100%**

Investigation process

1. Appointment of investigator/clinical reviewer
2. Gather and review information
3. Interviews (if needed)
4. Write and issue initial report
5. Feedback from establishment and next of kin
6. Write and issue final report
7. After inquest publish anonymised report on PPO website

Prisons & Probation Ombudsman
Independent Investigations

What to expect if you get called for interview:

Before interview:

- Write a note/statement
- Avoid assumptions that you have done something wrong
- Prepare
- Support
- Duties covered
- If you haven’t met the deceased - research

Prisons & Probation Ombudsman
Independent Investigations

During interview:

- Nerves/trauma
- Try not to be defensive
- If you don’t know/can’t remember – say so
- It is not a memory test
- Difficulties of virtual interviews

Prisons & Probation Ombudsman
Independent Investigations

After interview:

- Take a break
- Transcripts – sign and return
- Ask to see the report

Prisons & Probation Ombudsman
Independent Investigations

Examples of when it has not gone so well and good practice.

Prisons & Probation Ombudsman
Independent Investigations

Reflections and Questions?

Clinical Reviewer Process

Des McMorrow – Clinical Reviewer

Types of Review

- Foreseeable
- Non Foreseeable
- Levels 1, 2, 3

Levels of Review

- **Level 1** - Consists of a Clinical Reviewer and Prisons and Probation Ombudsman Investigator reviewing healthcare and other relevant records and produce a written report
- **Level 2** - Consists of a Clinical Reviewer and Prisons and Probation Ombudsman Investigator reviewing healthcare and other relevant records. Also interviewing healthcare and custodial staff at the prison where the death in custody occurred

Levels of Review

- **Level 3** - A review that consists of a panel of health professionals. With a review of healthcare and other relevant records, together with interviewing healthcare and custodial staff at the prison where the death in custody occurred

Process Level 2

- Clinical Reviewer & PPO discuss case
- Identify staff to interview
- PPO liaises with prison
- Clinical reviewer liaises with Head of Healthcare

Process Level 2

- Reception
- Physical Health
- Mental Health
- Substance Misuse
- Mental Capacity
- Any other health issue

Reception

- NICE Guidance (NG57)
- Communication
- Review of relevant information
- Referrals
- Medication reconciliation
- Alcohol Audit C
- Secondary health screen

Physical Care

- Any Long Term Conditions
- Care Planning
- Care Delivery
- Medication
- Treatment – Acute Hospital
- Refer to Clinical Standards NICE Guidance

Mental Health Care

- History
- Diagnosis
- Care Planning
- Care Delivery/Treatment
- Medication
- Information Sharing/Communication
- ACCT
- Consideration of MHA Transfer

Substance Misuse

- Evidence Based Assessment
- Interventions – Care Planning
- Detoxification
- Medication – 13 Week Reviews
- Illicit Use – PS etc
- Information Sharing

Mental Capacity

- Assessments
- Easy Read Material
- Understanding of Learning Disability
- Autism
- Support (External SALT)

Any Other Health Issue

- Referral Processes
- Service Delivery – Integration
- Communication
- Training
- Involvement with Safer Custody
- Vulnerabilities

Custodial Management & Partnership Working

- Information Sharing
- Prison Regime – Escorts/Bedwatch
- ACCT
- Risk Assessments
- Emergency Response

Conclusion

- Key Findings
- Equivalence
- Recommendations
- Any Immediate Concerns

Learning from Deaths in Custody
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LUNCH BREAK, NETWORKING & REFRESHMENTS

Learning from Deaths in Custody
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RCGP & Capsticks Solicitors LLP

Speaking Now

Nicholas Flanagan

Greater Manchester (North)
HM Assistant Coroner

THE INQUEST

A BRIEF GUIDE TO CORONIAL PROCEEDINGS WITH DEATHS IN CUSTODY

THE CONTEXT

- Main sources of deaths in custody – prison, police, mental health hospitals and immigration removal centres.
- Deaths in custody have increased almost year on year since 2012
- Self-harm incidents have increased – record high over 60,000 incidents in 2020. Need for inquests has only increased – and likely to continue post pandemic
- Disproportionately impacts on minority groups; BAME, disabled, LGBQT+ etc - all have much higher rates of death in detention (Source – MoJ)

THE INVESTIGATION

- Police, IOPC, CQC, PPO, HSE etc.
- Police normally first on the scene – embark on preliminary investigation and will ask coroner for a PM – often a forensic PM where any suspicious circumstances.
- Police mainly looking for third party involvement or suspicious circumstances.
- Do not tend to look for Gross Negligence Manslaughter or anything similar
- CPS only involved in later stages - looked at by special units in York and London.

THE INVESTIGATION (2)

- Coroners involved early in the process – often as part of out of hours duty, so body can be moved
- Duty to investigate is triggered because in custody and article 2 ECHR applies
- Post-Mortem may be held – s.14 of the 2009 Act.
- Chief Coroner's Guidance No 32 - body requires release asap
- Forensic PM ordinarily ordered when there is a reasonable suspicion that a crime has been committed: non-natural deaths in custody, where D is sharing a cell, use of drugs, assisted suicide or potential neglect all covered.
- Required because evidence at the criminal standard for a prosecution.

WHO INVESTIGATES?

- Multiple investigations in parallel – IOPC, PPO, CQC, internal trust/prison/DC investigations.
- Coroner's investigation MUST await police investigation and MAY await others
- Depending on the circumstances - witness statements may be prepared by police officers
- May also have forensic work: photograph taken and scene closures
- Unlikely to be fingerprints taken or DNA - little efficacy
- Within a few days/weeks, likely police close investigation if death is non-criminal.
- The Coroner's jurisdiction is mainly - potential suicides, accidents, overdoses etc

THE CORONERS' POWERS

- Coroners' Powers – relatively limited, c.f. High Court and Crown Court
- Duty to investigate: section 1(2)(c) 2009 Act - if the coroner has reason to suspect that the deceased died while in custody or otherwise in detention.
- Obligation is on the Prison/healthcare/police and other IPs to provide documents and disclosure to the coroner.
- There are powers for a coroner to require production of witnesses or documents under schedule 5. Can also enter and search – but very really used.
- Privilege – limited importance in inquests because not adversarial… probably doesn't apply.

WITNESS STATEMENTS

- Coroners (Inquest) Rules 2013 – Rule 23 – can admit written evidence, most applicable rules is that the evidence is unlikely to be disputed (23(1)(d))
- The Coroner must have given the evidence to the IPs in advance and allow for any objection
- PPO/HSE/CQC statements can also be relied upon – but consider consistency
- Contents of the statement – can avoid attendance at Court
- The importance of accurate, details and contemporaneous notes

FORMAT OF THE INQUEST

- Section 4 and section 6 of the 2009 Act state that an inquest is **always** required for a death in detention, even if the death is natural
- A jury is **only** required under section 7 if the coroner has reason to suspect that the deceased died in detention **and** was either violent, unnatural or unknown.
- A jury is also required if the death occurred from an act or omission from a police officer.
- A jury is not required if the cause of death is natural
- Juries are also sometimes required if there is sufficient reason for doing so, but more expensive in terms of time and resources

EVIDENCE AT THE INQUEST

- Mechanism – in person, but can be via video link or behind a screen (Rules 17 and 18). The test is simply whether it would improve the quality of the evidence of the witness.
- Rule 22 – Not obliged to answer any question that tend to incriminate
- Basic Rules:-

1. Understand the question
2. Clarify if necessary – including with reference to documents
3. Answer – but only if you are able

AIM OF THE INQUEST

- Statutory purpose of an Inquest: to find out who the deceased was, the medical cause of death, how, when, where and how/in what circumstances the deceased died.
- Lastly - to come to a conclusion as to the death.
- Only questions that are *relevant* to the inquiry can be asked – each IP can ask questions, but the Coroner can stop any irrelevant questions.
- ***Should*** be questioning, ***not*** cross-examination

CONCLUSIONS

- CC Guidance No 17
- Short-form and narrative conclusions:

  Most likely short-forms are suicide, accident, drug-related and misadventure.
- Need for Article 2 compliance and narrative conclusions – boxes 3 and 4
- Wide variation in how the law is applied
- No determination – from a Coroner or a jury – can be framed in such a way as to determine criminal or civil liability on the part of a named person (section 10(2))

POST-SCRIPT

- The NHS (Performers Lists) (England) Regulations 2013, regulation 4(5)(i) and 9(4)(i), imposes obligations
- 'Is involved in an inquest as a person who has caused or contributed to the death or otherwise had their conduct called into question' must be included in application and inform them after inclusion.
- GMC/NMC/GDC etc – referral process and self-referral

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NETWORKING & LUNCH

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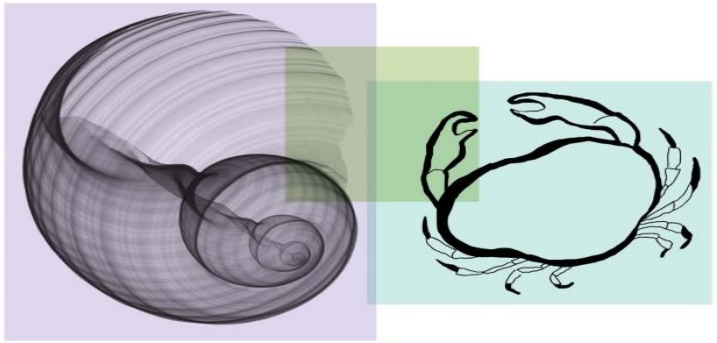
AFTERNOON BREAK, NETWORKING & REFRESHMENTS



Civil claims arising out of deaths in custody

Charlotte Rathbone, Partner

11 July 2022

Types of claims

- Purpose of a civil claim – compensation

- Negligence:
  1) duty of care owed to the patient
  2) breach of the duty of care owed
  3) causation – that breach has caused damage to the claimant

- Human Rights Act 1998 claims – breach of e.g. Article 2 (right to life) ECHR

- Equality Act 2010 claims - discrimination

Compensation payable

- For the patient / their estate
  - pain and suffering
  - losses associated with the death – e.g. funeral expenses
- For the dependents e.g. spouse/ children
  - bereavement award
  - loss of services and income provided to the dependents – fact specific
- HRA award – usually modest, but wider scope

Investigating the claim and time limits

- Inquest process - admissions required before the inquest?
- After the inquest - admissions required or further evidence?
- Expert evidence – was the care reasonable, responsible and logical? Would death have been avoided?
- Possible illegality defence?
- May be multiple defendants
- How long do the family have to bring a claim?
  - 3 years from date of death – estate and dependency claims
  - 1 year – claims under the Human Rights Act 1998

Claims process – what may be required from you?

- Pre-action - Letter of Claim and Letter of Response – comments/interview
- Litigation – formal witness statement
- Trial – called to give evidence. Expensive and risky!
- Conference with a barrister
- Resolution of claims – attendance at ADR
- Sensitive claims and saying sorry
- Importance of supporting staff – claims process can be lengthy

Key issues in defending claims

- Poor record keeping – if it isn't recorded it didn't happen!
- Early disclosure of policies and documentation
- Context is important – change in policy due to pandemic?
- Distinction between purpose of SIs / other investigations and standard of care in civil claim
- Good quality witness statements from key staff are vital
- Consider litigation risks of defending, cost and reputational damage

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THANKS FOR ATTENDING

TRAINING DAY

Learning from Deaths in Custody and the Coroner's Inquest

Deaths in Custody are important events that require thorough investigation in order to learn lessons arising from cases

11th July 2022 - Jurys Inn, Birmingham UK