Stakeholder Hearing 25
Health Inspectorate Wales
Represented by Lisa Bresner - Investigation Manager for Deaths in Custody and
Jane Mackenzie MSc, RN (G), RMN – (Recently retired) Clinical Reviewer for Health Inspectorate Wales

5 February 2015, 102 Petty France, London

Background on who/organisation

Lisa Bresner (LB) is an Investigation Manager employed by the Health Inspectorate Wales her area of responsibility is investigating deaths in custody.

Jane Mackenzie (JM) was the Head of Clinical Governance and Deputy Director of Nursing at Broadmoor Hospital, she then worked for the Mental Health Act Commission (MHAC) for England and Wales and is now one of a number of Clinical Reviewers undertaking Deaths in Custody Reviews for Health in Wales.

Health Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. HIW has a signed Memorandum of Understanding with HM Inspectorate of Prisons (http://www.hiw.org.uk/opendoc/234134), which outlines their respective duties when inspecting health care facilities/services within custodial establishments.

SELF-INFLICTED DEATHS

HIW said that their strongest recommendation to the Review, to reduce the number of self-inflicted deaths of 18 – 24 year olds, is to have more mental health services and more drug and alcohol services in the community and prisons, this would reduce the number of young people in prisons. A further big issue to tackle is around record keeping and sharing of information to provide a holistic approach to the young person.

STAFF AND CULTURE IN PRISONS

Health care in prisons in Wales is changing and service has improved through the support of the Health Care Boards. JM and LB think that there are not enough mental health services in prison and the services that are available could be better co-ordinated. In Broadmoor staff all belong to the health services but are also members of the Prison Officers Association which means that they are not as separate from operational staff as is the case in prisons. In prisons the healthcare staff and the operational prison officer grades are totally separate and information falls through the gap between them.

Prison works well in HMP Swansea because the prison is small the staff are local and where prisoners are recidivist offenders the staff get to know them, chaplains will often know the families.

HIW thought that Usk prison has a good record with YOIs, they have a very low rate of self-inflicted death they focus on rehabilitation, activities, developing life-skills, prison officers have good relationships with prisoners and get to know them very well; although security is strong there is a more therapeutic approach. HMP Parc also focuses on rehabilitation and has really good drug and alcohol services. These services are provided by a mixture of Third Sector providers, CARATS and mental health in-reach teams.

The loss of the Personal Officer scheme over the last few years has had a huge impact. The loss for prisoners has been that they no longer have one person identified who they can go to who they know will help them. Mental Health training should be mandatory for the role.

ACCT

Risk assessment should be better, asking someone if they feel suicidal and accepting a 'yes' or 'no' 'tick as appropriate' answer is not good enough. This is particularly important as someone who is quite determined to take their own life will not suggest there is a problem but will just get on and do it.

Ideally Healthcare staff (although not essential) should be included in a multi-agency/multi-disciplinary team of staff professionals at ACCT reviews, alongside whoever has had involvement with the prisoner, for example this could also include a CARAT worker or chaplain. Where this is not the case this is both a resource and good practice issue, healthcare staff don't get asked to take part and it is not in their job plan to attend ACCT reviews. It should be built into the practice for both parties so that healthcare are invited to and attend ACCT reviews.

HIW have not come across any cost based decisions around opening an ACCT, but health and mental health are not enough of a priority in terms of the prison agenda.

HEALTH AND MENTAL HEALTH

Some aspects of healthcare in Welsh prisons are different, the healthcare is not commissioned but determined by the local health board according to need.

There is too much of a tick box approach to health assessments, nurses may have to do thirty assessments in an afternoon and so it is impossible to assess someone in any depth.

Getting sufficient health care information at Reception is a challenge, staff don't automatically ask for the prisoner's previous health record.

Mental Health care is improving in prisons but there is not enough of it and it is not joined up. 'Mental health services should get bigger then prisons could get smaller.'

FAMILY ENGAGEMENT

Following a death the Clinical Review is shared with the family and a 28 day consultation period is allowed. The Clinical Reviewer will have the family in mind

when they write the report and will make sure they include anything nice about the prisoner. The PPO will ask the family if they have been treated in a sensitive and supportive way, if not, this will be reflected in the PPO recommendations. Any recommendations and the final Clinical Review will go to the PPO and they will write their report before it goes to all relevant stakeholders.

FOLLOWING A SELF-INFLICTED DEATH

Clinical Reviews are commissioned from HIW by the PPO, HIW act as a co-ordinator to ask the relevant clinicians to carry out the reviews on their behalf. Any recommendations that concern health issues, particularly if the same issue comes up over and over again will feed into a Prison Forum set up between prisons and Healthcare teams, where findings, recommendations and learning points from deaths in custody are shared. This Forum would be ideally placed to develop a suicide prevention strategy for Wales. The investigative approach of the Clinical Reviews is a root cause analysis, they look at all the prison records not just health records before they interview staff. The PPO will include families if they have the contacts and this will be on a case by case basis.

HIW have 10 weeks to prepare the Clinical Reviews and this has just been extended to 12 weeks, it is common for it to take a year before the inquest follows this.

HIW are involved in inquests at the discretion of the Coroner and so will not automatically see the Coroner's report and inquest findings, they have no role in checking whether recommendations have been complied with.