offender healthcare
unlocking potential + positive change

15-16 Queens Square
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30 October 2014

To the Secretariat of the Harris Review

I am submitting responses to the call for submission from Lord Harris for the Harris Review.

At the meeting on 2 October Lord Harris requested that if there are further submissions then he would accept them and to send them through the secretariat.

The following is my submission from SAFE Offender Healthcare. Accompanying this submission is a brief of SAFE Offender Healthcare credentials outlining who SAFE are and therefore our credibility in responding to the review.

The following responses answer the headings from the call for submissions brief that we feel we can add value.

1

a. Not fully mature, away from known family/care systems, without familiar peers or adults, susceptible to bullying from others or bullying of others borne out of a position of fear and insecurity, poor social skills
b. Gangs, lack of joint working with families, lack of visits, no friends in prison, learning disabilities, fear and anxiety, no one to speak to, not sure what is happening, lack of control over their lives, cultural and language difficulties, sexuality, isolation

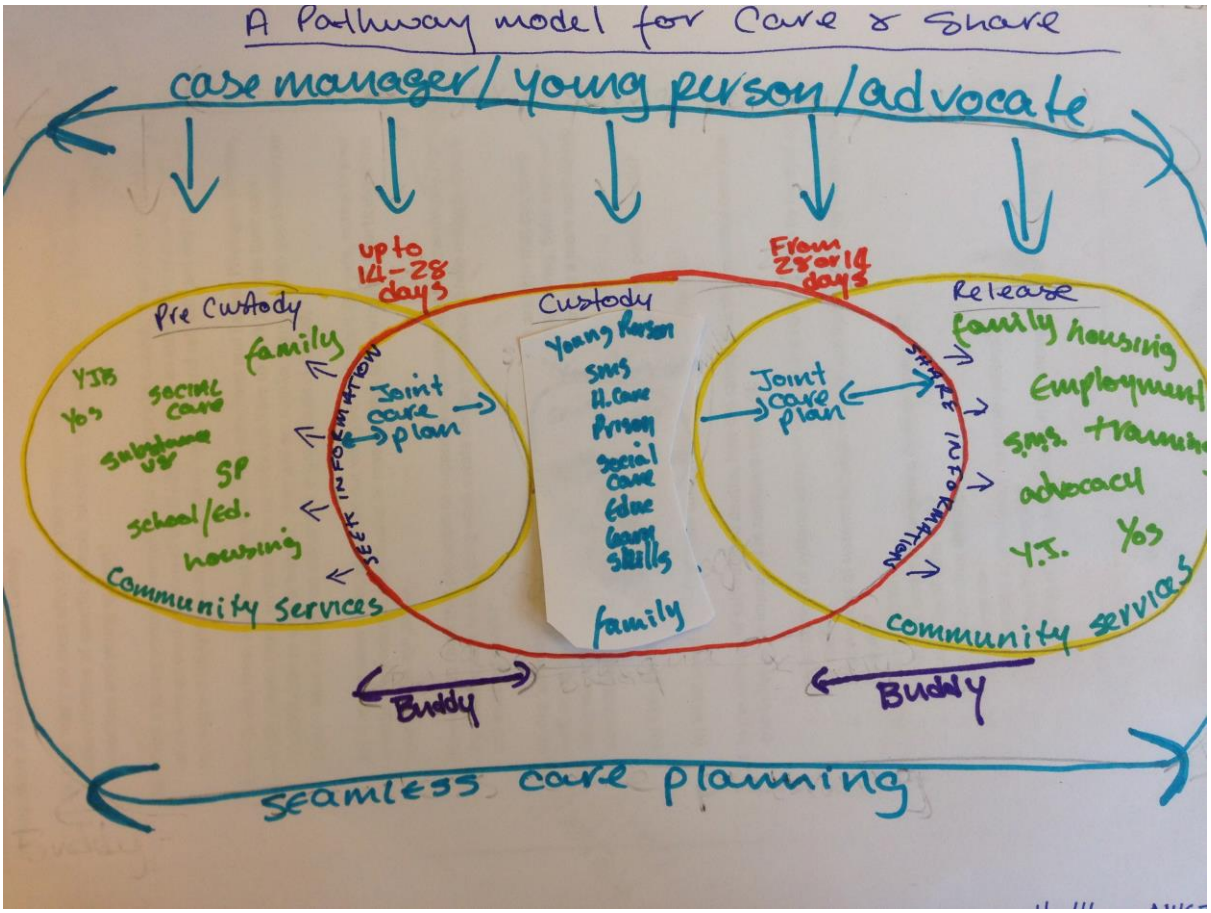
2

a. Locate the budget for custody of a young person with their local authority and see the community options available to sentencing judge expand.
b. Genuine care, housing, work with young people with their families OR significant others, community sentences and
c. As alternative to 'custody-as-we-know-it', all evidence would suggest smaller institutions designed to the needs of rehabilitation achieves best outcomes. I would like to see architecturally driven small community secure houses/units within all communities/cities…where a young person would be 'sentenced' to rehabilitation within the community, that focuses on care and safety, near significant others, with community services working with the young person that will continue support after release, that where when young peoples health/safety is stabilised they can 'go out to work' (WE HAVE PLANS WE CAN SHARE OF WHAT THIS MIGHT LOOK LIKE)

3 Arrest, sentence and first 14 days in custody, flash points through custody e.g. when family visits don't happen or when bullied, and, discharge to the same old same old with limited 'hand over' to community support

4 The following provides a draft of a model (from my memory) worked up for commissioners of substance misuse services by multiple provider agencies in HMYOI Wetherby led by Leeds Community Healthcare NHS Trust in 2011 or 12. I have

developed on this model to include buddy's, the yp and case manager/advocate holding or leading the care. This model offers a pathways approach to a young persons journey that would provide significant opportunities for identifying vulnerability as it arises.



DRAFT NOT FOR REPRODUCTION WITHOUT SUITABLE PERMISSIONS I have contacted NHS Trust to request a copy of their original model for use should the review require it. I am offering this drawing for understanding of the model.

The key focus of the model is that the first 14-28 days in prison are outward facing where custody teams work with the yp/case manager to seek as much information as possible from their community. At the same time they are undertaking assessments, safeguarding and providing the yp with a trusted buddy (much like an adult listener scheme) to support the yp into their sentence. During custody this seamless care plan continues through sentence into the discharge period. Discharge period will be outward facing where prison/case manager sharing the information with the community services. A buddy will be allocated from the community who will support the yp through release.

A further issue that fundamentally blocks opportunities to identify vulnerability is the lack of confidential space in which to see young people when they are in prisons. There are few private spaces that a young person can talk openly to a professional or peer to get support. Interactions often take place on the wing with other prisoners and staff around. The environment is often noisy and is not conducive to disclosure. *For information, SAFE are collaborating with an architect, prison and health staff to produce a confidential, mobile, therapeutic pod, that is designed to infection control, security and fire standards that will be located and evaluated within a prison in 2015.*

5 I would consider that all young people in prison have experienced trauma of one form or another by the very nature of being young and in prison. If we treated all yp's as having experienced trauma we would make significant changes to their care.

6 *Time* to make appropriate assessment by *skilled* people, asking the *right questions* and *listening* then *skilled* in knowing how to formulate this into a *care plan led* by the *yp/advocate*

7 Yes – the more unskilled people on low wages that are employed with little training and lack of experience in prisons the more attitudes and behaviours will contribute.

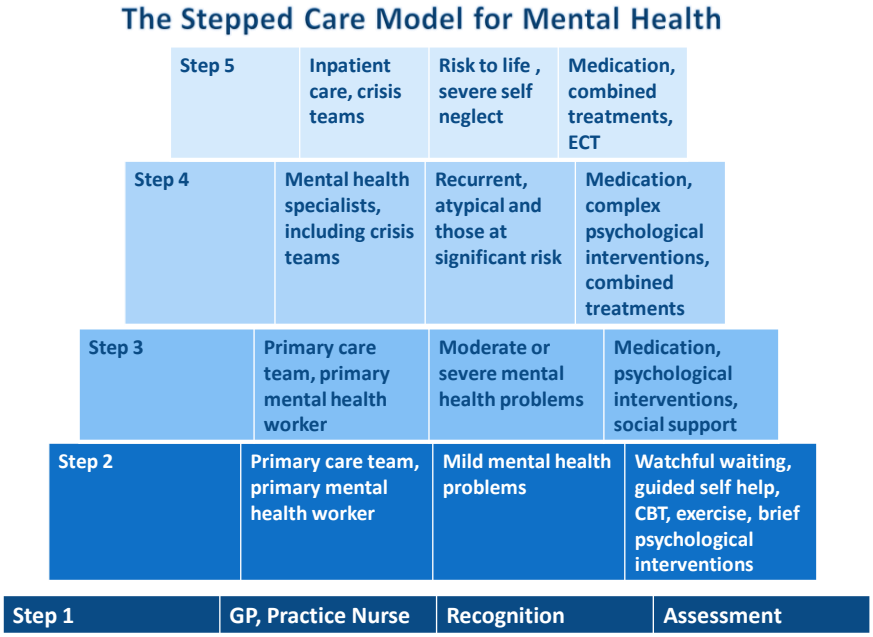
8

a. Time and assumptions
   Silo commissioning of services and not pathway commissioning
   So many electronic record systems where information is gathered about a yp, that do not connect to each other
   All agencies gather significant amounts of information that is not passed on
   Lack of staff who are; experienced, trained, know the yp, know others on the wing and regularly working on the same wing

b. Case manager/advocate system paid by the young person's local authority that is responsible for the yp throughout their time in the CJS. That will continue to work with the YP wherever they are located in the country attending all reviews, advocating for the yp. If this exists already then it is not suitably resourced, as it does not work.

9. As above

10. From my reviews in 7 prisons in 2014, there is little primary care mental health provision in prisons. The following is the stepped care approach that could be adopted with steps 2 and 3 'stepped' up.



11. Good practice from any estate can be interrogated for transferability into another estate. Where good practice that demonstrates reduced deaths in custody and improved patient/prisoner safety is transferable, the essence of this can be captured in a national audit format and used across the country in individual prisons, to identify where good practice is embedded and where services have room to improve. This audit tool can be reviewed systematically using learning from reviews into deaths in custody, to keep it current.

    As General Manager of a cluster of prisons healthcare services in my previous post, we reduced deaths in the adult estate by 78% in my first year leading the service, maintained over a five-year period from 2007 to 2013. In 2010 we developed a 'patient safety audit tool' from our learning that we used across the three prisons. This approach won the organisation the Health Service Journal and Nursing Times 2013 Patient Safety National Award.

12.

13 Safety in prisons has come along way however with the recent reduction in officers on the wings, weaknesses have been exposed in the management and effectiveness of ACCTs.

14.

15 No – I would suggest a review of the ACCT process led by a team that understands the need for a review of this sort to engage widely with operational teams that includes ALL partners in the care of offenders including healthcare

16. 17. 18. Roles and responsibilities are not adequately understood. In a recent clinical review I undertook, the mental health team attended all acct reviews, however they did not have a clear role and did NOT consider that they were in the review to make a mental health assessment. They did not read the ACCT document prior to attending the review. The other members of the ACCT review believed that the MH team were there to make mental health assessment using all the information available to them. It would not be appropriate for mental health teams to attend all ACCT reviews but clarity on roles and responsibilities is essential. DO Not QUOTE THIS EXAMPLE PLEASE AS IT IS YET TO GO TO CORONERS

19

20 Significant others are important re visits and support. Young people should be located in their communities to support and encourage contact. *See 2 c for a humanitarian model for community custody*

Where bullying is not an issues I would also suggest young people are kept and cared for on their wing unless absolutely no alternative exists but to move them. In one instance where a young person who was significantly troubled was moved from wing to wing and through health care and out in revolving circles his mental health deteriorated on each move. Units like the Keppel are set up to manage young people and can do a lot to keep yp safe.

Developing relationships on the wings/house blocks with regular skilled staff that are able to spot changes in a person's demeanour is important.

21

22 Pre visit (?), buddy YP with a prisoner in adult estate, have the case worker/advocate manage the transfer – all just ideas – though I think the Review could ask young people what was important for them.

23

24 Other: Getting people out of their cell and interacting with other either professional or peers (dependent on health status). Day unit for mental health or for vulnerability can run groups.

25 Yes I think so in general

26

27 I would like to add a crucial and missing element of investigation.

Every person who comes into prison becomes a patient of healthcare. Article Two is critical where it comes to health; as a prisoner with health issues including anxiety and depression, must rely on health services being accessible, sharing appropriate information, following up concerns, making the right assessments, providing treatment and referral.

Every death in custody therefore has some element of health input and should therefore healthcare must examine itself at its earliest opportunity to check that its; systems and process are effective, staff are delivering appropriate care, multiagency teams are working effectively along a care pathways, that there are no gaps in service.

Article 2 requires an independent investigation. It can be argued that the clinical reviewer on behalf of the PPO provides this however, a serious incident investigation should also be undertaken and monitored through NHS England Commissioning Teams and this is not routinely happening. There are no NHS guidelines for investigations in prison and there is limited understanding within prison health services of their responsibility – particularly in the case of a patient who is seeing multiple health agencies.

I would also suggest that there is good argument for another step. Between 48-72 hours after a death a review of the death should be initiated where the internal healthcare teams, across the multi-agencies, undertake a rapid review of the clinical notes. The purpose of this immediate review is to manage immediate risks in a multidisciplinary way and to begin to define the scope of the following SI investigation.

I absolutely believe from my experience in HMP Leeds from 2008 – 2013 that this rigorous investigation process that we embedded, the protocol that we developed with prison, police, other health providers that commenced with a 48 hour review through to completion of Coroner case, and how we managed learning across the prisons, and the developed audit, was the significant contribution healthcare made to reduction of deaths in Leeds.

In not one of the six prisons healthcare departments I have worked in within the last year could I find evidence of a robust, investigatory, transparent, learning process for deaths in custody.

NHS England is set up to deliver a single model of healthcare into prisons. This configuration provides NHS Health and Justice a unique and exceptional opportunity to develop a single model for learning from deaths in custody.

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30 see 27 and audit see question 11

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