The Harris Review

Analysis of the Clinical Reviews

(with inclusion of case summary data)

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1. Introduction

Following a response to an advertisement by the Harris Review, Dr Tovey, Dr Routhu and Dr Aslam were commissioned to conduct a thematic analysis of the Clinical Reviews of the deaths in custody of the cases considered by the Harris Review, supervised by Dr Maganty, who is a consultant Forensic Psychiatrist. All of those involved are qualified forensic psychiatrists with extensive experience in prison settings, and all are members of the Royal College of Psychiatrists. In addition, Dr Maganty is a member of HNHS England National Clinical Reference Group for Health and Justice.

The team were also given access to the case summaries produced by the Harris Review legal team, who had extracted data from the Prison & Probation Ombudsman Reports, Coroner's Inquest Reports, Coroner's Rule 43 Reports, and National Offender Management Service (NOMS) data.

2. Method

There were 87 deaths in custody included in the review, 83 of young adults and 4 of children under 18 years of age. For this reason, we most frequently use the term 'young people' in this report to describe the cases.

We were provided with 66 documents that were ascribed to being Clinical Reviews. On examination, however, one of these was a post-mortem report. We were provided with the case summaries for all 87 deaths in custody.

2.1 Quality of Clinical Reviews

It became apparent very early on that the Clinical Reviews were not conducted in a uniform manner and their quality was felt to vary greatly. It was decided that an audit into their quality would help both to provide context to this paper, and might help improve the consistency and quality of reviews in the future. The quality audit is appended to this report. It should be noted that the clinical review

team felt that the varying quality of the reviews were likely to result in an underestimate of the prevalence of identified themes.

2.2 The Analysis

The clinical reviewers were provided with case summary data prepared by the independent legal advisors for the Harris Review. Data from this summary (such as offence, length of time in custody, length of time in current prison prior to death etc.) that was considered relevant was extracted and commented on.

Finally, the review of the Clinical Reviews, with the corroborative case summary material, was conducted. This was done in a four-step process:

1. One of the clinical review team read all of the Clinical Reviews and case summaries to familiarise himself with the broad issues and to develop a table to populate, where themes could be considered. The table comprised of the following columns to be populated to enable further analysis:
    - Mental & physical healthcare
    - ACCT process & implementation
    - Psychiatric formulation of cause of death
    - Whether the death was felt to be predictable and/or preventable

2. Each of the three remaining reviewers then re-read a third of the cases each, populating the table prior to each reviewer then re-reviewing a different third of cases to ensure consistency.

3. Subsequently, one of the reviewers then read the populated table and extracted themes and constructed a further table for population with the following themes identified:
    - Stressful life events
    - Oppositional behaviour
    - Physical health
    - Vocalisations of self-harm or suicidal intent
    - Previous self-harm or suicide attempts
    - Proximity of self-harm to death
    - Language difficulties
    - Bullying

- ACCT status at death
- The proximity of ACCT closure to death
- Whether the deceased had ever been known to have been managed under the ACCT process
- Whether there were health record communication issues
- Mental health diagnoses
- Whether there was evidence of active mental health illness
- Whether referral had been made to an external healthcare provider
- The proximity of the deceased's most recent mental health review to death
- Whether there were any medication compliance issues
- Drug and/or alcohol withdrawal concerns
- A comment on whether the ACCT process should have been in place at the time of death

4. On constructing this theme table, the reviewer then re-read all Clinical Reviews and case summaries and populated the table. This was followed up by a meeting of the group to discuss and agree on the findings, and to discuss subjective matters of whether or not it was appropriate for the deceased to have been managed under the ACCT process at the time of their death and whether their death was felt to have been predictable and/or preventable. These decisions were made on all available evidence, together with the combined clinical experience of the reviewers.

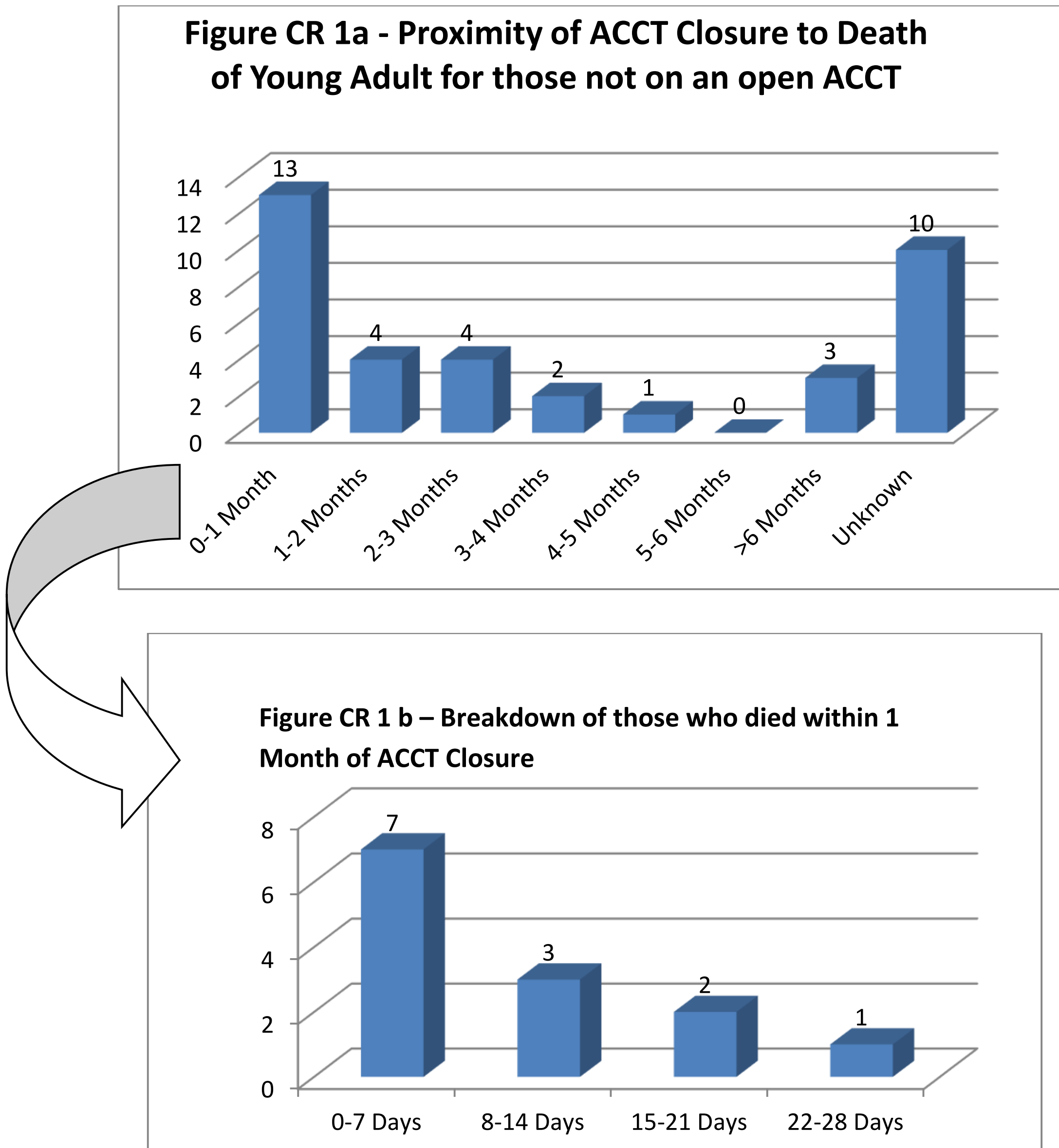
3. Results

3.1 ACCT

In 54 of the total 87 cases (62%) considered by the Harris Review, the young person had been known to have been managed under the ACCT process at some point in their imprisonment (though it could not be determined whether this related to a current period of incarceration or a previous one). Of these 54 cases, 31 (57%) were not on an ACCT at the time of their death.

Of the cases that had not been on an ACCT at the time of their death, but had previously been on an ACCT, many young adults had had the ACCT closed relatively close to their deaths. We did not have data to determine when ten of the 31 cases not on an ACCT at the time of their deaths had been

closed. Thirteen, however, were closed within a month of the death. Figures CR 1 a & b illustrates the breakdown of how close to the deaths the ACCT closures occurred.[1]



In 30 (35%) of the total of the 87 cases considered by the Review, the young person was not known to have ever been managed under the ACCT process. Of these 30 cases, 13 (43%) were known to have previously self-harmed or attempted suicide, and 14 (47%), whilst not having a known history of self-harm or suicide attempts, were determined by the reviews to have a recognisable mental health vulnerability. In the context of this review, the clinical review team used their professional experience and knowledge to define *'vulnerability'* as including having been subjected to a recent

[1] Please note that although 31 individuals were known to not be on ACCT at the time of their deaths, but who previously had been on ACCT, the data in Figure CR-1 refers to 37 ACCTs, as some had ACCTS opened and closed multiple times.

stressful life event, having language difficulties, being bullied, behaving in an oppositional manner, having a mental health diagnosis, having substance withdrawal issues or showing difficulties with medication compliance.

In 3 (almost 3%) of the total of 87 cases considered by the Review, there was insufficient information about the ACCT process to know whether or not the deceased had ever been managed under its processes (in two of these, we know for certain that they were *not* on ACCT at the time of their death, but we don't have sufficient information to know about whether they were ever managed under ACCT).

At the point of death, 23 (26.5%) out of the 87 cases considered by the Review were being managed under the ACCT process. Of these, ACCT status at death was not known in one case. Of the 86 cases on which data was known, 63 (73%) were not being managed under the ACCT process when they died.

Of the 23 cases being managed under the ACCT process at the time of death, 18 (78.3%) had a history of attempting self-harm or suicide, in 2 cases the deceased had threatened, though not attempted, self-harm or suicide previously. In one case, there was no information about their self-harm history.

Of the 63 cases *not* being managed under the ACCT process at the time of their death, 31 (49%) had a history of self-harm or suicide attempts (although this does not mean that these were also on ACCT), and the relationship of their most recent self-harm or suicide attempt to their death is shown in Figures CR 2 a & b below.

Additionally, of those 63 cases not managed under the ACCT process at the time of their death, 14 (22% of the 63 cases) were identified by the clinical review team as having vulnerabilities.

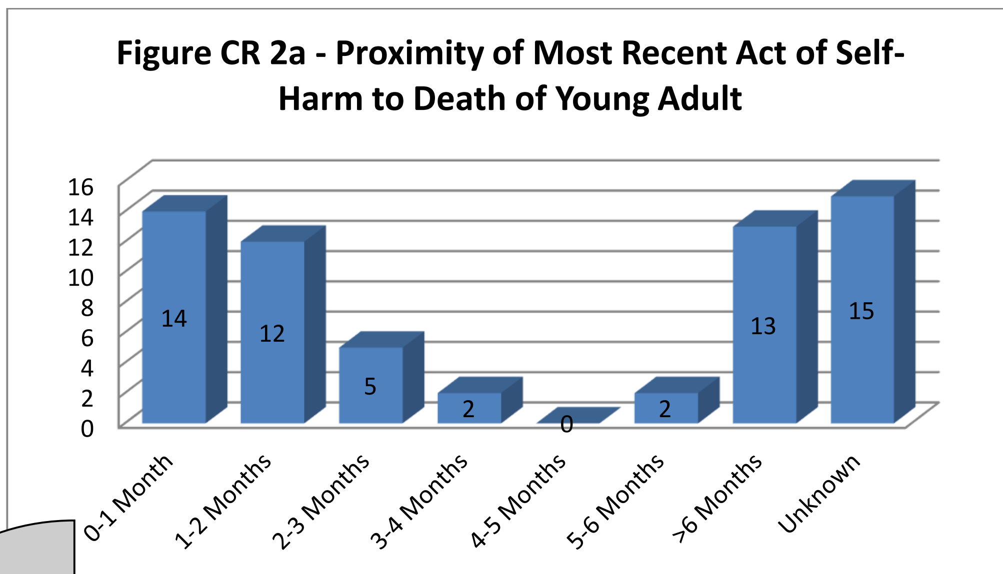
The clinical review team considered that, of the 63 cases who were not being managed under the ACCT process at the time of their death, 36 (57% of the 63 cases) should have had management under the ACCT processes in place. The team considered that in 15 of the 63 cases (24%) there was no evidence to suggest management under the ACCT process was appropriate. In 12 of the 63 cases (19%), the team assessed that insufficient information was present to enable a judgement to be made.

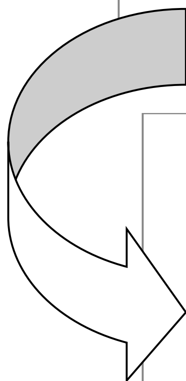
3.2 Self-Harm

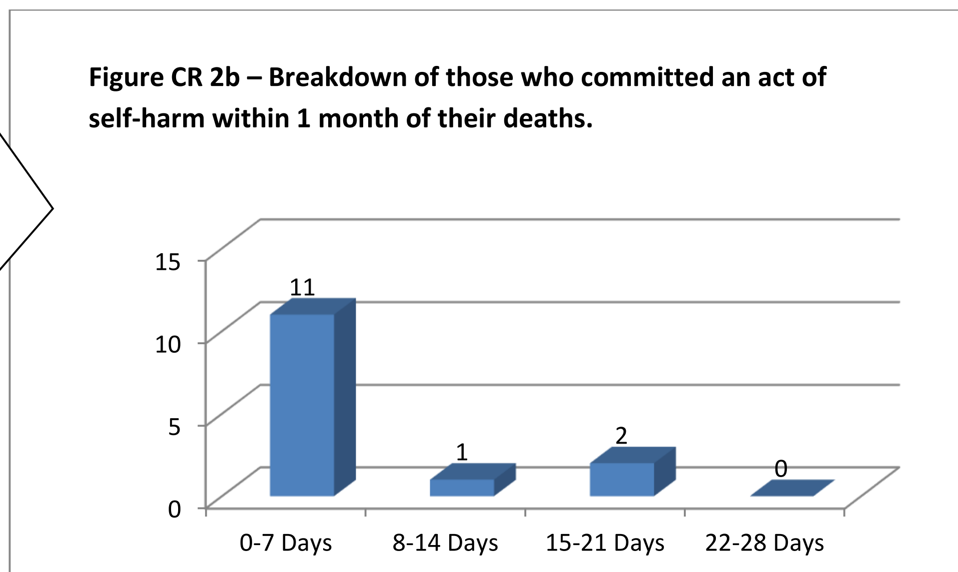
In 40 (46%) of the 87 cases considered by the Harris Review, the clinical review team found evidence that the deceased had a history of communicating (either by verbal or written means) intent to harm

themselves or end their life. Of these 40 cases, 3 had never been known to have actually engaged in suicide attempts or acts of self-harm prior to their deaths. The clinical review team found evidence that for 57 (66%) of the 87 cases, there was a history of engaging in self-harm and/or suicide attempts.

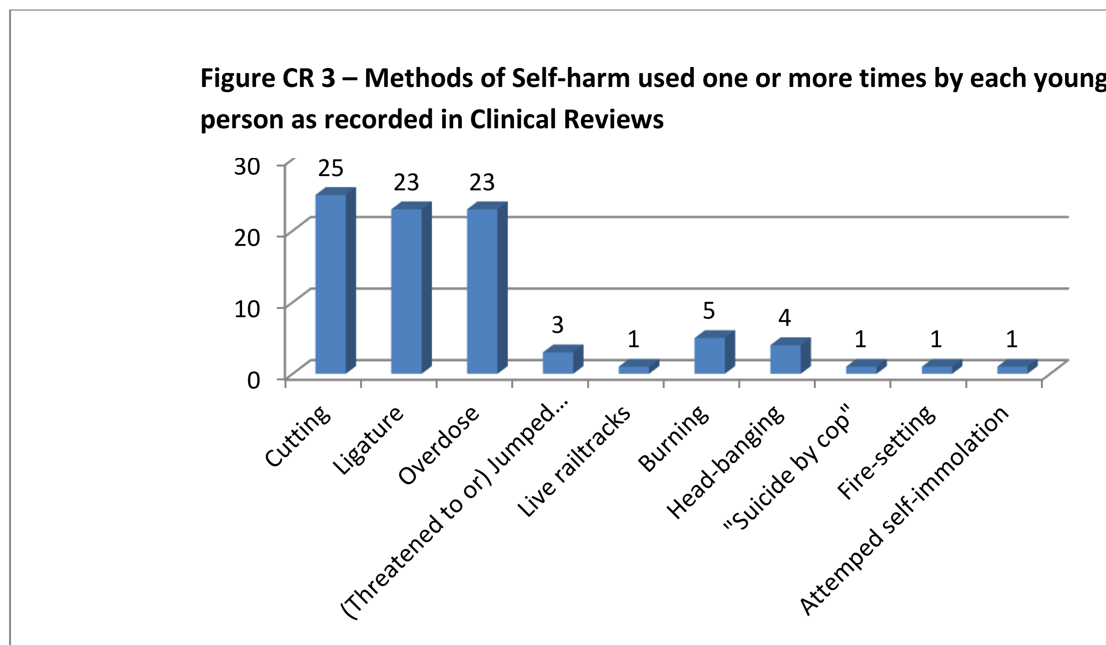
Figures CR 2a & b show that many of these young adults had engaged in an act of self-harm in close proximity to the time of their deaths. Twenty six of those young people for whom data was available had committed an act of self-harm within two months of their deaths, and for 11 of these it was within 7 days of their deaths.







Methods of self-harming identified in the clinical reviews and their relative frequency are shown in Figure CR 3 below. It needs to be noted, however, that in some cases, the young person engaged in multiple methods of self-harm or suicide attempts. Figure Cr 3 captures methods of self-harm that were used one or more times by the young people. Each method is counted only once per person, so the figure does not capture the total number of times each method of self-harm was used. Nonetheless, quite notably, the most frequent methods used were cutting, using ligatures (hanging) and taking an overdose.



3.3 Mental Health

It should be noted that when considering mental health diagnoses, the clinical review team decided that any mention of a diagnosis was to be taken as fact, even where there was no comment as to how the diagnosis was made. Exceptions were made when the team judged that there was evidence to the contrary.

In 38 (44%) of the 87 cases the Harris Review considered, the clinical review team considered that there was evidence of a mental health diagnosis, and in a further 3 cases there was evidence highly suggestive of a mental health disorder. Of these 41 cases, 29 (71% of the 41) had been managed under the ACCT process at some point in their history and 16 (39%) were being managed under the ACCT process at the time of their death.

In 12 (14%) of the 87 cases, there was evidence of 'active' mental illness (overt symptoms of a mental illness in the immediate period prior to death). Of these, only 7 were being managed under the ACCT process.

Within the 38 cases in which the reviewers found evidence of a mental health diagnoses (and not including those with a mental health disorder), the clinical review team identified 55 separate mental health diagnoses (in some individual cases there were multiple diagnoses).

Of the 55 diagnoses, the clinical review team concluded that 24 could be considered severe mental illness, with the following breakdown:

- 12 cases of major depressive disorder
- 5 cases of bipolar affective disorder
- 3 cases of schizophrenia
- 2 cases of anxiety disorders
- 1 case of 'erotomania'
- 1 case of obsessive compulsive disorder

As well as this, the clinical review team concluded there were 30 mental health disorder diagnoses, broken down as follows:

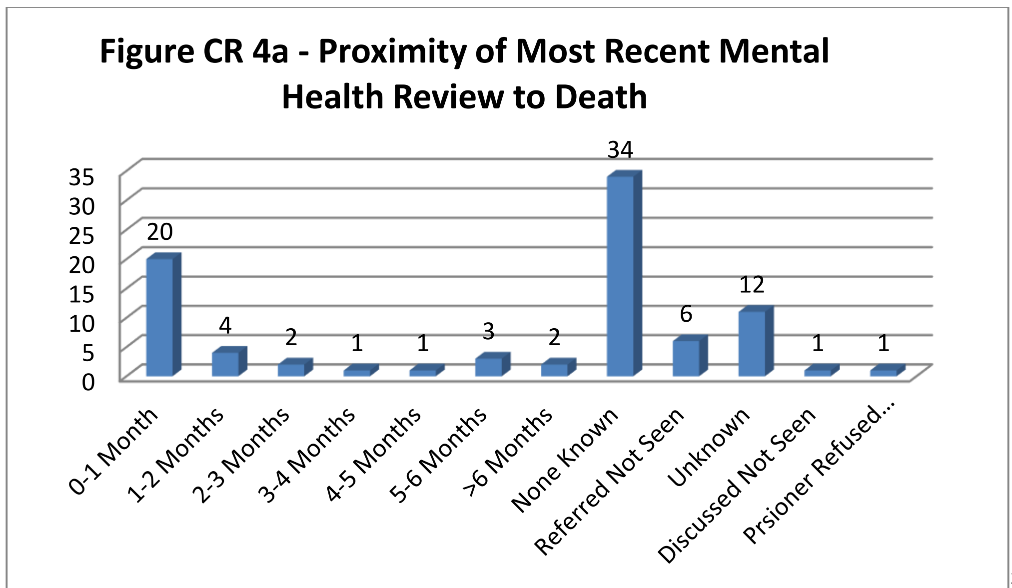
- 10 cases of attention deficit hyperactivity disorder
- 8 cases of emotionally unstable personality disorder
- 6 cases of dissocial personality disorder
- 1 case of narcissistic personality disorder
- 1 case of 'personality disorder'
- 1 case of autistic spectrum disorder
- 1 case of adjustment disorder
- 1 case of psychopathic personality disorder
- 1 case of conduct disorder.

In 1 case there was evidence of an intellectual disability.

The clinical review team felt it was important to highlight that the characteristic of impulsivity was uniquely identified in 1 case, but that when combined with other mental health diagnoses where the characteristic of impulsivity is described as part of the diagnostic criteria (emotionally unstable personality disorder and attention deficit hyperactivity disorder) then this was found in 17 distinct cases. Based on the clinical experience of the team, it was felt that the underlying issue of impulsivity is an example of the type of problem that is not addressed by opening and closing an ACCT on the basis of expressions of intent to self-harm. The underlying problems that might cause a

person to self-harm – in this case potentially impulsivity – are not being adequately deal with by the current system.

The clinical review team looked at how close the most recent mental health review was to the death of the young person. As Figure CR 4a shows, there was evidence that 20 young people were reviewed within 1 month of their deaths, and Figure CR 4b breaks these down further.



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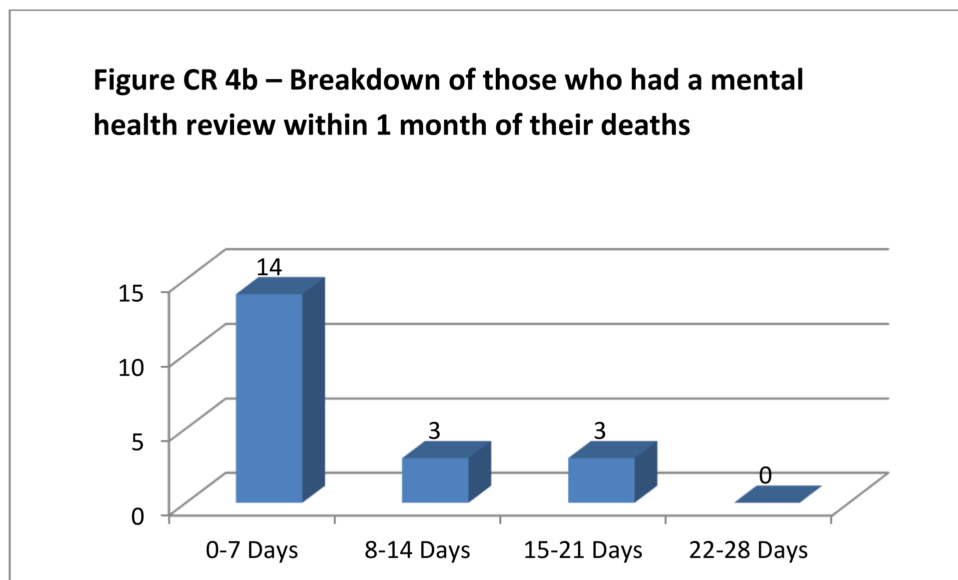


[2] *Note:* in Figure CR 4a, 'referred not seen' means that a referral was made to a mental health professional, but the individual had not yet been seen. 'Discussed not seen' means that a discussion was held about the person, but they had not been seen by a mental health professional. 'None known' means that the case material suggests none were held. 'Unknown' means there was not enough information in case material to say whether or not a review was held.

The clinical review team noted that many of those for whom they could not find evidence that they had ever been seen by the mental health team, had vulnerabilities recognised by the team. 31 of these cases had engaged in previous self-harm, and 16 had at least one mental health diagnosis.

3.4 Stressful Life Circumstances

In the professional view of the clinical review team, it was felt there was evidence in the material they had access to that 33 of the 87 cases considered by the review of significantly stressful life circumstance in the period prior to suicide. Examples of such stressors were having one's children taken into care, receiving a life sentence, being informed that one was subject to deportation, the suicide of one's brother, the murder of one's partner etc. The clinical review team noted that only 7 (21%) of the 33 cases were being managed under the ACCT process at the time of their death.

3.5 Bullying

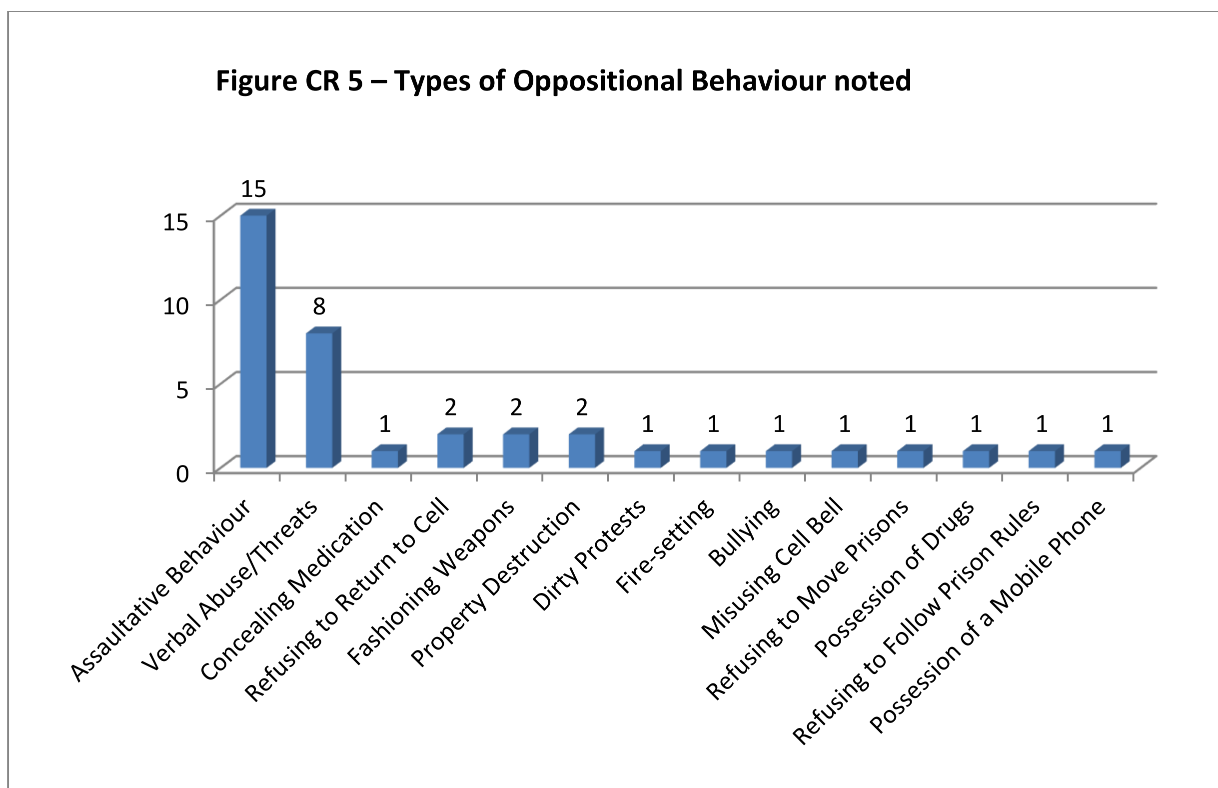
The clinical review team assessed that in 30 of the 87 cases considered by the Review, there was evidence that the young person had been bullied. The method of bullying was identified in 8 of the 30 cases (7 x assault, 1 x preventing deceased from leaving his cell and banging on his door), and the motives identified in 7 of the 30 cases (for medication in 3 cases, for tobacco in 3 cases and in one case, the young person was pressured to convert from Christianity to Islam).

In 16 of the 30 cases where bullying was identified, the young person had a known mental health diagnosis (and in 1 case mental illness was suspected). In 9 of the 30 cases where bullying was identified, the young person was being managed under the ACCT process at the time of their death.

3.5 Oppositional Behaviour

The clinical review team found evidence to identify oppositional behaviour[3] in 27 of the 87 cases considered by the Review. These behaviours, which the reviewers defined as oppositional, are tabulated below (please note that some of the young people engaged in multiple methods of oppositional behaviour). It is interesting to note that many of these cases were assault, which the reviewers felt reflected the difficulties staff would have in managing these behaviours.

[3] The Clinical Review Team described this as behaviour that would be considered a disciplinary offence in a prison.



3.6 Medication Issues

In 17 of the 87 cases, the clinical review team had concerns that related to the young people's medications as follows:

- In 11 cases it was felt there was evidence that the young person was non-compliant with their medications in the lead up to their deaths. Six of these were being managed under the ACCT process at the time of their death;
- In 2 cases, the young person did not have their medication from the community prescribed during their prison stay;
- In 2 cases the deceased requested their medication to be discontinued prior to imprisonment;
- In 1 case the deceased requested their medication to be stopped whilst imprisoned;
- In 1 case, another prisoner was found with the deceased's medications.

3.7 Communication of Medical Information

The clinical review team felt that in 16 of the 87 cases there was evidence of clear communication inadequacies. In these cases, it was felt that if the right information had been available, it might have made a difference to the decision regarding risk and care. The Clinical Review Team felt that

there was evidence about communication problems with a variety of types of information, including healthcare information, ACCT information, police custody information, and PER information.

3.8 Referrals Out of Prison

In 2 of the cases the young person was awaiting a transfer to a medium secure hospital (and 1 of these was returned to custody from a PICU).

In 2 of the 87 cases, the young person was awaiting an assessment by secure mental health services.

3.9 Language Difficulties

The clinical review team identified evidence of language difficulties were identified in 5 of the 87 cases.

3.10 Physical Health Issues

The clinical review team looked for a wide variety of physical health issues, and identified evidence of neuropsychiatric co-morbidity (2 cases of epilepsy, 2 cases of brain damage).

3.11 Substance Withdrawal

The clinical review team found evidence to suggest that:

- In 1 case the young person was assessed and treated for both opiate and alcohol dependence;
- in 2cases, the young person was assessed and treated for alcohol dependence;
- in 1 case, the young person requested detoxification for alcohol dependence but did not attend the appointment;
- in 5 cases, the young person was assessed and treated for opiate dependence. In one of these, however it was felt that despite treatment, they still exhibited features of withdrawal;
- in 1 case, the young person was felt by the clinical reviewer to be sourcing opiates illicitly and was suffering from withdrawal, but was never treated.

4. Discussion

4.1 ACCT Process

The 'Safer Custody' (Prison service Instruction) document states as its desired outcomes of the ACCT process:

- Identify, manage and support prisoners and detainees who are at risk of harm to self, others, and from others;
- Reduce incidents of self-harm and deaths in custody;
- Manage and reduce violence, deal effectively with perpetrators and support victims.

It is clear that the first stage in this process is to identify those with vulnerabilities that lead them to have an increased likelihood of self-harming or suicide. Whilst the evidence considered by the clinical review team suggests that self-harm has already been noted in nearly two thirds of those who go on to take their own life in custody, and it is a very important consideration, the clinical review team feels that a management strategy solely addressing the act of self-harm and not addressing the underlying motivations is likely to have significant shortcomings. Whilst it is not clear that this was the expected utility of the 'Safer Custody' PSI, the evidence considered by the clinical review team suggests that this is in fact how it is being used: that is as a self-harm management strategy only, and not a document used to address and manage wider vulnerabilities that play into the risk of self-inflicted death in young adults and children under 18. This is further supported by the fact that 73% of cases on which data was available were not being managed under the ACCT process at the time of death, yet it was felt that 57% of these should have been.

It is the suggestion of the clinical review team that whilst, in principle, the ACCT document is appropriate, it ought to be reframed as a vulnerability management tool (Vulnerability Assessment, Care in Custody and Teamwork – VACCT), so as to draw staff's attention to the fact it is equally as important to consider a prisoner at risk who is being bullied, who has had a recent bereavement or who has recently self-harmed and how this might interplay with their psychosocial history and thus enable a more complete assessment of one's risk of self-harm or suicide.

Additionally, given the high prevalence of mental health diagnoses and self-harm, it is our assertion that:

1. The 'Safer Custody' process ought to be jointly embedded within both healthcare and prison regimes.

2. On opening an ACCT document, an automatic referral to the mental health team ought to be generated such that a comprehensive psychosocial assessment occurs, conducted by a

suitably qualified member of staff (psychiatrist, psychologist, senior nurse), together with an environmental risk assessment.

Given that the 3 month period following an act of self-harm or ACCT closure encompasses the majority of cases who subsequently go on to complete suicide, any management plan needs to consider this increased time period.

In terms of management under the ACCT process, this should be jointly owned by both prison and healthcare regimes, and as such all ACCT reviews must be multidisciplinary.

Given that the highest risk period following closure of the ACCT is on the subsequent 7 days, a decision to discontinue management under the ACCT process must be taken in a multidisciplinary fashion in conjunction with a member of staff who is suitably trained in risk management (psychiatrist, psychologist or senior mental health nurse with extensive prison experience).

4.2 Self-Harm

Given that self-harm heralds the greatest association with self-inflicted death, it is imperative each self-harm act is considered seriously and scrutiny is given as to whether or not the person should be managed under the ACCT process as outlined above.

In addition, management of self-harm in prison ought to follow the principles outlined in the NICE guideline 'Self-Harm: Longer Term Management'.[4]

4.3 Mental Health

The clinical review team concluded that mental health diagnoses are common amongst young people who died from self-inflicted death (including the 18-24 year olds and the children under 18). The team identified a diagnosis in 44% of the 87 cases. It is therefore imperative that any concerns raised about the possibility of mental illness are acted on expediently. The standard of care in prison ought to be equivalent to that one might expect to receive in the community.[5] In the community, if one were experiencing a mental health crisis, one could be expected to be able to see a psychiatrist 24 hours a day, 7 days a week. It is our assertion, therefore, that there ought to be provision for 'out-of-hours' cover for psychiatric care in prisons. This care ought to be 'consultant-led' in keeping

[4] See https://www.nice.org.uk/guidance/cg133/resources/guidance-selfharm-longerterm-management-pdf.

[5] HM Prison Service & NHS Executive (1999). *The Future Organisation of Prison Health Care.* Report by the Joint Prison Service and National Health Service Executive Working Group. London: Department of Health

with the Academy of Medical Royal College's vision for 7 day consultant-led services[6], and in keeping with the principles of parity of esteem between mental health and physical health care.[7]

It would also be our recommendation that those working in prison healthcare have adequate knowledge and skills in diagnosing and managing ADHD and emotionally unstable personality disorder, and that consideration is given to specific screening for both difficulties on reception into prison.

There is a specific offender personality disorder pathway, described as:

"*The pathway is intended to meet the needs of all offenders who meet the criteria for an assessment using the Offender Assessment System (OASys); and who have a severe personality disorder; and*

- *are assessed as presenting a high likelihood of violent or sexual offence repetition*
- *present a high or very high risk of serious harm to others;*
- *and where there is a clinically justifiable link between their psychological disorder and the risks they pose.*"[8]

However, in the view of the clinical review team, in addition to the offence related work, there needs to be included within the pathway specific work addressing the emotional instability and impulsivity, thus aiming to lessen self-harm and improve psychological well-being.

The Clinical Review team feels, from the experience of the psychiatrists on the team, that prisoner moves and short sentences limit the ability of those with psychological needs to engage in complex psychological treatment to address issues such as self-harm. It has previously been recommended[9] that prisoners requiring psychological input should not be subject to prison moves during therapy, and that those on short-sentences should be enabled to continue their therapy in the community (through work with probation hostels, CMHTs etc.). These issues should be given further consideration.

4.4 Stressful Life Circumstances

The clinical review team found that stressful life circumstances are common amongst the cases considered by the Harris Review. Clearly, it is not possible to prevent such occurrences, but staff working with individuals in prison ought to aim to foster a working relationship that enables the

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[6] For more information see http://www.aomrc.org.uk/doc_view/9532-seven-day-consultant-present-care
[7] For more information see http://www.rcpsych.ac.uk/pdf/OP88.pdf
[8] Consultation on the Offender Personality Disorder Pathway Implementation Plan. Developed in partnership with the Ministry of Justice. http://www.pn.counselling.co.uk/personality_disorder_pathway_feb_11.pdf.

[9] For more information see http://www.rcpsych.ac.uk/pdf/OffendersPositivePracticeGuide2009.pdf.

prisoner to discuss concerns with the staff, and staff on the wing out to have a detailed knowledge of the vulnerabilities of each of the prisoners in their care so as to be aware when further support (for example under the ACCT process) is appropriate.

4.5 Bullying

The data analysed by the clinical review team suggests that bullying was an issue in 30 of the 87 cases considered by the Review (35%).

Despite the 'Safer Custody' document replacing, amongst others, PSO 2750 'Violence Reduction' which contained an anti-bullying strategy, there is no mention of the term 'bullying' in the entirety of the 'Safer Custody' document. It seems clear that there needs to be a system-wide strategy to combat bullying.

4.6 Oppositional Behaviour

Oppositional behaviour was found in 31% of cases (27 out of 87). It may be said that this is unsurprising given the environment. However, it is known that those involved in perpetrating violence are also much more likely to be the victims of violence (Reza, Krug, & Mercy, 2001[10]) and both difficulties are associated with an increased incidence self-harm. It is, therefore, clear that such behaviour needs to be addressed, and not solely punitively, but rather consideration ought to be given to oppositional behaviours as vulnerabilities and appropriate assessment undertaken.

4.7 Medication Issues

The clinical review team identified evidence to suggest that 11 of the 87 cases considered, the young people were not complying with their prescribed medication. The team considered that this might potentially represent a level of hopelessness in the person, and that in some way the cessation of medication is indicative of a suicidal aim. Therefore, we would recommend that where a patient prescribed a medication for mental health reasons becomes non-compliant, that this generates an automatic referral to mental health services for an in depth assessment. It may be that the computerised systems in prisons (such as 'SystemOne') can 'flag' this up.

It may be that a prisoner reasonably wishes to discontinue their psychiatric medication. However, it is essential that if a prisoner makes this decision, it is done in consultation with a mental health professional so that their reasoning can be explored and any risk issues addressed.

[10] Reza A, Krug EG, Mercy JA. (2001). Epidemiology of violent deaths in the world. *Injury Prevention, 7*:104–111

Given that there ought to be equivalence in care between the community and prison, it ought to be the case that medications prescribed to persons in the community are available whilst in prison. Each prison ought to have a medicines' reconciliation policy, such that each new reception into prison receives their usual medications within 24 hours.

4. 8 Communication of Medical Information

The clinical review team felt that there was evidence to suggest that communication of medical information in many of the cases was inadequate. This may be related to individual concerns about breaching confidentiality. The clinical review team suggested that a process be set up whereby on reception to prison a request is made that the prisoner consent to the sharing of their healthcare and prison records between the two systems (where the prisoner has capacity to do so). Where the prisoner refuses to give consent, this issue should be regularly revisited.

Based on their experience and consideration of the case files, the clinical review team concluded that there should be processes to enable sharing of information between community healthcare providers and the prison at the point of reception. It was felt that more consideration needs to be given to obtaining GP medical records, psychiatric records, and possibly requesting expert psychiatric reports where consent is given by both the prisoner, their solicitor and the report's author as these necessarily contain a great deal of information pertaining to the prisoner.

The clinical review team felt that there was evidence of communication difficulties around ACCT process within prisons, and that a computerised version of the process might be considered.

4.9 Referrals out of Prison

Although the number of those requiring referral to outside healthcare providers in the sample considered for the Harris Review is small, it is an important consideration. It is the opinion of the clinical review team that, where it is decided a young person requires an assessment for consideration of admission to a psychiatric hospital, this ought to take place within 14 days of receipt of such a referral. In addition, once decided that admission to a psychiatric hospital is appropriate, this should occur within 14 days of such a decision (inclusive of obtaining a warrant).

4.10 Substance Withdrawal

Whilst the numbers of those showing difficulties as a result of substance withdrawal was small, it is the opinion of the clinical review team that going through a period of substance withdrawal ought to be considered alongside any other vulnerability, as it is likely to be a particularly traumatic time for them.

4.11 Language Difficulties

Once more, whilst the absolute numbers of those with language difficulties was small, there was at least one case of a prisoner who could not engage in his healthcare due to language difficulties and the lack of provision of interpreting services. It seems entirely appropriate that where a prisoner has a language difficulty that consideration is given to housing them with people who speak the same language and that provision is made for regular engagement with interpreters, especially for all healthcare appointments.

4.12 Physical Health

Whilst no association can be drawn between the physical health conditions suffered by those young people who died through self-inflicted death, it was of interest to note that 4 cases suffered with neuropsychiatric conditions, and it ought to be noted that these conditions may add further to the vulnerability of a prisoner.

4. Predictability and Preventability

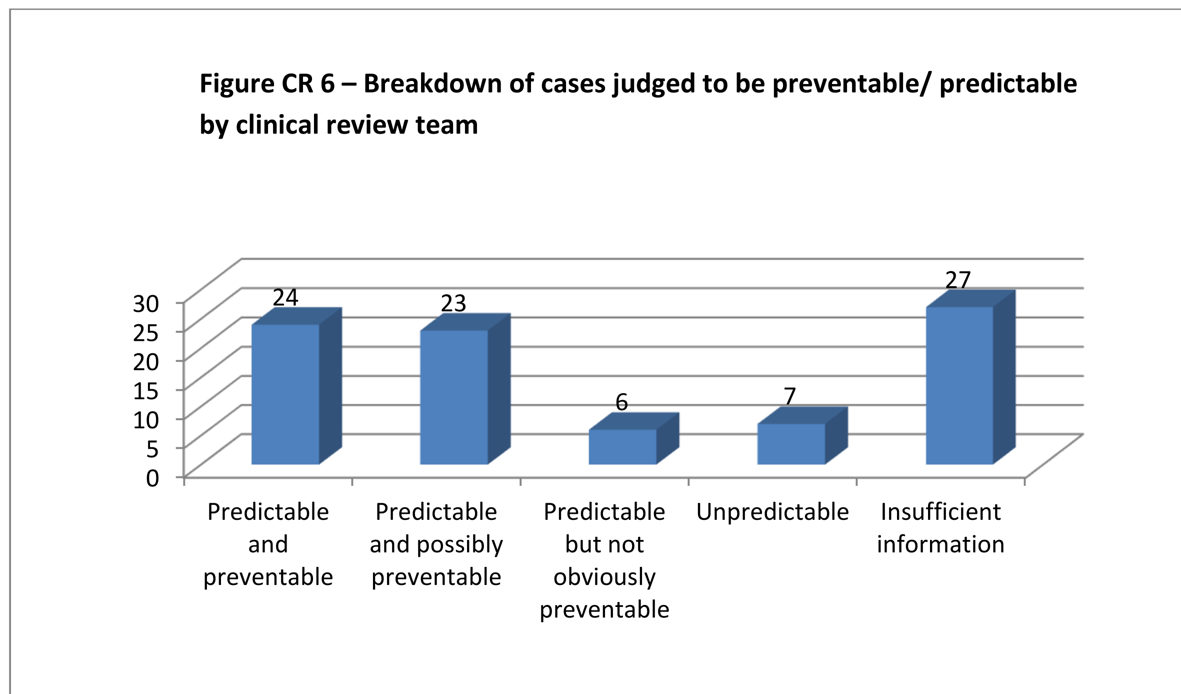
All of the forensic psychiatrists on the clinical review team had independently reviewed the information from the clinical reviews and case summaries of all 87 cases considered by the Harris Review. The team formed views regarding the preventability and predictability of deaths. Although we acknowledge that these views are subjective, they are also based the Reviewers' clinical judgement and experience of working in prison settings. The opinions were broadly categorised into five groups:

- Deaths were predictable and preventable
- Deaths were predictable and possibly preventable
- Deaths were predictable but not obviously preventable
- Deaths were unpredictable
- Insufficient information to comment on predictability and preventability.

A typical example of a death that the team considered both predictable and preventable includes a young adult with a clear history of inpatient psychiatric care, who was on an ACCT in the month before his death after a severe self-harm incident that required hospitalisation. The ACCT was closed without involvement of mental health services, despite concerns about mental illness and compliance with medication.

The independent opinions of each psychiatrist on the team were compared and a concerted team decision was arrived at for each case. Of the 87 cases considered by the Harris Review, 27 cases (31%) did not have sufficient information to arrive at an opinion. The team felt that that many of the cases, however, were found to be predictable with most of them possibly preventable as shown below. It was felt that 24 cases were both predictable and preventable, and a further 23 were predictable and possibly preventable. While this analysis is limited in that it is subjective, it is based on the informed view of experienced psychiatrists and ideally should be explored and researched further.

Figure CR 6 – Breakdown of cases judged to be preventable/ predictable by clinical review team



Appendix 1 - Audit of the Quality of Clinical Reviews

Aim

The aim of the audit was to assess the quality of the Clinical Reviews conducted on the young people who died following self-inflicted deaths that were included in the Harris Review cohort by comparing against the standards set by the National Patient Safety Agency (NPSA, March 2010) and NHS England's Serious Incident Framework (March 2013).

Standards

The standards provide a clear definition of serious incident and set out the underlying principles, clarifies roles and responsibilities. They also draw together legal and regulatory requirements and provide information on time scales. The standards signpost tools and resources that support practice, provides an assurance framework for investigations and encouraged a culture of openness, honesty and trust. The six key principles focus on preventative, outcome focused, personal, open and transparent, collaborative and proportionate reviews.

Audit Tool

An audit tool was prepared using the standards of Serious Incident Framework, consisting of the following questions:

- Were families involved in the review process?
- Was investigation method stated in the clinical review?
- Were lead staff up to date in their training?
- Was the investigative team sufficiently removed from the incident to provide an unbiased report?
- Were there any conflicts of interest for the review team members?
- Were the findings clearly stated?
- Does the investigative team have experience in prison mental health to provide appropriate review and recommendations?
- Were recommendations made targeting Improvements?
- Were there agreed actions with measurable goals?

Results

The audit data was collected from the clinical reviews by 3 reviewers independently and compared to improve the inter-rater reliability. A total of 64 clinical review reports were available for the audit. One of them is a post mortem report submitted as clinical review report and was excluded.

The results showed that:

- there was no documented record of family involvement in any of the 63 clinical review reports considered;
- the investigative method was stated in 58 of the 63 clinical review reports;
- a record of the lead staffs up to date training is recorded in only one of the clinical review reports;
- only one of the clinical review reports had a declaration of conflict of interests;
- the recorded roles and professions of the investigators showed 16 out of 63 clinical reviews were conducted by investigative team sufficiently removed from the investigation;
- only 21 of the 63 clinical review reports were led by investigative team with clear experience in prison and mental health;
- the findings of the clinical reviews were clearly stated in 60 of the clinical review reports;
- 51 of the reports suggested clear recommendations suggesting need for improvements, while 5 made no recommendations;
- of the recommendations made, none had clear agreed actions or time scales for the implementation of the recommendations.

Recommendations

The clinical review team agreed that the need for family involvement throughout the clinical review process was important. It was also important that the lead reviewer should be made responsible for this. It is recommended that the family should be given access to the findings prior to publication for comments. They should be informed of any delay in the process of investigation or publication of the report.

It is also recommended that all team members should submit a declaration of interest statement. It is recommended that the lead reviewer should have knowledge of root cause analysis, expertise in facilitating family involvement, experience in prison healthcare at a senior level, should have responsibility and support for administration and documentation, and should also have a clear

communication strategy and appropriate mechanism to share lessons learnt both locally and nationally. It is also recommended that, to ensure more consistent quality of clinical reviews, the appropriate professionals to lead the clinical reviews would be senior doctors with extensive prison experience and training in root cause analysis by National Patient Safety Agency. This sort of training enables the doctors to carry out the investigation using the best evidence based process for identifying lessons learned. The doctors could be senior general practitioners, consultant forensic psychiatrists or consultant general adult prison psychiatrists, all supported by relevant professionals. It is recommended the recommendations of the clinical reviews should be specific, measurable, agreed upon, realistic and time-based (SMART).