Session 2: Understanding investigations and how they feed into the inquest process

Introduction

•This is the second of three sessions, we encourage you to sign up to all three:

1. What to expect from an inquest when a death arises in state custody
2. **Incident reviews and inquests**
3. Common themes arising from deaths in state custody

- Today's session will provide you with an overview of the various investigations that follow a death in state custody including:
  - Police investigation and potential criminal proceedings
  - Serious Incident investigations
  - Investigations undertaken by the Prison and Probation Ombudsman & Clinical Review

What are the implications of multiple investigations following a death in state custody

- **For regulated individuals** – NMC Code of Conduct and GMC Good Medical Practice require individuals to engage with any investigation. Failure to do so can have significant consequences

- Information given during each of these investigations **will likely feature in an inquest.** Statements, interview notes, interview transcripts will be shared with the bereaved family and other interested parties.

- **Consistency** – any inconsistences will be picked up in later proceedings and you may be questioned about any changes in your account.

Police investigations and potential criminal proceedings

1. Criminal proceedings are initiated when there is a suspicion of criminal activity related to a death.
2. If a death is the subject of both criminal proceedings and an inquest, then the criminal proceedings take precedence.
3. Does not mean that the Coroner cannot hold a PIRH, case management hearing, to request documents be provided to the Coroner.
4. The reason for the pausing of inquest proceedings is that the criminal proceedings may influence the outcome of the inquest.
5. Sometimes criminal proceedings are not brought at the outset and the inquest proceeds but, during the course of the inquest, evidence is brought to light which causes the Coroner to suspect that a criminal offence may have occurred.

Serious Incident Investigations

1. A structured process for examining events where patient safety or the delivery of healthcare has been significantly affected or where there is a high potential for learning to improve services.
2. The goal is to understand what happened, identify root causes and implement changes to prevent similar incidents in the future.
3. The report will generally have a chronology, a root cause, conclusion, lessons learned and an action plan.
4. Patient and staff member engagement – request for a statement or to attend an interview. Ask to see the medical records before your interview, if possible, to refresh your memory. Acknowledge in the interview if you have not had the opportunity to see them.
5. The report should be shared with you if you contributed to the process and especially if you're then giving evidence at the Inquest. You'll need to know what it says and be able to explain to the Coroner what steps you have taken, if in a position of seniority to disseminate the learning amongst your team, and to explain how processes or systems have subsequently changed.

Prison and Probations Ombudsman and Clinical Review

The Prisons and Probation Ombudsman launches an independent investigation whenever anyone dies in custody in England and Wales. Their aim is to help organisations improve how they work and to give families reassurance about how their loved one was treated.

Will also under investigations for deaths of recently released prisoners that occur within 14 days of release from prison

Covers individuals detained under immigration powers in immigration removal centres

Neonatal deaths and stillbirths that occur in prison or during prison transfer are also investigated by the PPO.

Any questions?

Thank you for joining us

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