Session 3: Common themes arising from deaths in state custody

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Introduction

This is the third of our three sessions on behalf of the Nursing in Justice and Forensic Health Care Forum:

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 themes that we see arising in inquests and some detailed case studies

Common Themes

We often see common themes arising from deaths in mental health settings including:

- Where a patient has absconded from a unit because they were not observed properly
- Where a patient is granted section 17 leave without being properly risk assessed
- Self inflicted deaths due to a failure to remove prohibited items
- Failure to identify ligature points
- Failures in properly assessing their risk level or through issues with frequency or quality of observations.
- Issues with medication, for example inappropriate prescriptions or use of illicit substances.
- Deaths arising as a result of another patient's conduct or violence.

Case Study 1

Nurse A was a mental health nurse. He was on duty with 3 HCAs working a night shift. He believed the shift was quiet so told the HCAs they could take a 2-hour break each.

Throughout the night, the patients had to have observations taken. The HCAs and the nurse documented in all the patient records that they were asleep and added in some extra details (seen on side, seen breathing etc).

In the morning, Nurse A went into the patient's room and found him unconscious on the floor. Blood was over the patient bed and in the patient sink. He was clearly deceased and it turned out subsequently this was due to an upper gastrointestinal haemorrhage. However, the HCAs and the Nurse in the patient records had recorded the patient was sleeping up until 7am.

1. What issues can you identify in this scenario which would concern the Coroner?
2. What forms of evidence do you think the Coroner would be most interested in?
3. What do you think the consequences were for Nurse A?

Common Themes

Common themes we see in prison inquests include:

- Failure to have sight of the Prison Escort Record or Self Harm and Suicide form during the reception screening.
- Failure to record key consultations on SystmOne
- Failure to open an ACCT – known as an Assessment, Care in Custody and Teamwork Process.
- Failure to refer to the Mental Health Team or the substance misuse team
- Failure to transfer a prisoner out to hospital when their physical health deteriorates.
- Issues with improper restraint
- Issues with timely emergency response

Case Study 2

Nurse B worked in a prison. She was asked to assess a prisoner's suitability for segregation following what had been recorded as a "dirty protest". She delegated the task to a nurse who had just joined the prison, who refused to sign off on the move as she had not been trained in making this type of assessment. Nurse B signed off on the move without seeing the prisoner or consulting his medical records.

A Nursing Associate learned that this prisoner had been moved to the segregation unit and went to check on him as this was out of character. She was very concerned with his presentation (cold, confused, dehydrated, raised breathing and heart rate, unable to communicate and covered in faeces) and asked Nurse B to see him. Nurse B carried out an assessment but was unable to obtain an oxygen saturation level. She moved the prisoner to the wellbeing unit for observation.

The Nursing Associate remained concerned that the prisoner's incontinence was due to him being seriously unwell. Another nurse assessed the prisoner and called an ambulance.

Paramedics obtained an oxygen saturation reading, which fluctuated between 64% and 78%. The prisoner was transferred to hospital, where he died with covid-19 pneumonia and a grade 3 acute kidney injury caused by extreme dehydration.

The prisoner had tested positive for covid-19 ten days before his death. This had been recorded in his NOMIS records six days before his death.

Case Study 3

Nurse A worked in healthcare in a prison. She was asked to admit Patient M in reception who had arrived from the Magistrates Court, having been remanded in custody charged with GBH.

When Patient M arrived at reception there was no prisoner escort record, no suicide and self-harm form and he had multiple NHS numbers. Nurse A undertook her assessment and Patient M stated he wanted to take his own life and that if he was put in a shared cell he would 'batter' the other person.

Nurse A opened an ACCT and completed the Cell Sharing Risk Assessment advising there was no 'increased risk' of him sharing a cell.

1. What issues can you identify in this scenario?
2. What actions could Nurse A have taken at this time?

Common Themes

Common themes arising from deaths in police custody include:

- Risks of plastic cutlery left in a custody cell
- Turning off the call-bell system
- Inappropriate recording of cell observations
- Inappropriate restraint
- Denial of a detained person’s medication due to communication errors

Case study 4

Patient A was arrested following a domestic incident. Officers were told by paramedics on arrest that Patient A had recently been in hospital for a minor stroke. Patient A said she had been punched in the head by her partner. One of the officers noted that Patient A had recently been sick into a bin.

Patient A told officers she was not drunk nor dependent on alcohol. She did not smell of alcohol and did not appear to be under the influence. On arrival at custody, she was sick, held her head and explained she had a pounding headache.

A HCP assessed Patient A and said she was fit to be detained. She was not aware of the domestic incident. Patient A did not say anything about her minor stroke. She was not aware that the patient had recently been sick nor that she was seen to be holding her head. The HCP did not have access to the summary care records system as she was relatively new.

Patient A was placed on level one observations with cell checks every 30 minutes. The CCTV in the woman's cell had been obscured by a previous detainee. This meant CCTV did not show Patient A at any stage of her detention.

Patient A asked for paracetamol which she was given. She was interviewed and had a seizure shortly after returning to her cell. Two HCPs attended and an ambulance was called. She died the following day.

1. What concerns would the Coroner have about the above?

Identifying themes and trends

- No system for identifying recurring trends but same local Coroner is likely to recall previous failings, and this may set the tone for the inquest
- Preventable Deaths Tracker has been created by Dr Georgia Richards at Kings College London which is the first centralized surveillance tool of coroner's Prevention of Future Deaths Reports
- With over 125,000 avoidable deaths each year in England and Wales, the PDT helps identify risks, support learning and drive accountability. Preventable Deaths Tracker
- INQUEST organisation have called for a National Oversight Mechanism to be collated – an independent body to monitor, collate, analyse and follow up on what action has taken place in response to PFD reports. This has been accepted by Scotland.
- Lampard Inquiry – potential recommendation for deaths in mental health hospitals to have an independent investigation undertaken akin to PPO and Clinical Review

- **Key for professionals** – raise concerns, document them and escalate until a solution has been found. Maintain professional integrity and remain honest and accountable

Any questions?

Thank you for joining us

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