Mendas

Deaths in Custody: The Impact of Coroners' Rule 43 Reports on Organisational Learning

A research study

Authors:
Justin Spray CPsychol AFBPsS
Dr Simon Draycott CPsychol
Claire Taylor CPsychol

Mendas Ltd
Brownlow House 50-51 High
Holborn, London WC1V 6ER
t: 020 7611 0860
enquiries@mendas.com
www.mendas.com

October 2012

Contents

Appendices

1. Executive Summary

The Independent Advisory Panel on Deaths in Custody[1] (IAP) commissioned Mendas to:

- Identify the action that has been taken by the individual custodial sector in response to (Coroner) Rule 43 reports
- Determine the impact Rule 43 reports are having in terms of sharing learning and contributing to the prevention of future deaths

The purpose of this report is to provide suggestions for improvement for the IAP. The IAP will in turn take forward those suggestions it chooses to pursue by making recommendations to the Ministerial Board.

We hope that the report will also serve as a useful learning resource for organisations to refer to as they develop their evidence-based approach to tackling deaths in custody.

The research followed two lines of enquiry:

- Interviews with stakeholders
- Examination of individual cases

These two lines of enquiry pursued examples of deaths of detainees across the custodial sectors of prison, police custody and hospital/healthcare.

The issuing of Rule 43 reports offers a powerful mechanism for reducing the number of deaths in custody. It is clear that this potential is currently not being realised.

There is significant potential to further improve current practice and integrate it with learning from other investigations, especially given that there is a desire to reduce the risk of future deaths on the part of the organisations implicated.

What follows sets out what needs to improve and how this might be undertaken.

The receipt of a Rule 43 report is unlikely to trigger a sequence of events that result in organisational change. Whilst it is generally clear what is expected of the recipient, this is rarely accompanied by a rationale for the requests being made by Coroners. The receipt of a Rule 43 report is frequently perceived as a punishment, rather than as an opportunity to learn. The primary response is to focus upon what action has already been taken as a result of investigations conducted many months and years before a Rule 43 report is issued. It is typically these investigations that trigger changes and not the Rule 43 report. We have uncovered several examples of learning and effective practice being undertaken by those responsible and across the custodial sectors as a result of these investigations.

Recipients frequently focus on responding with reasons why suggested actions have not been taken and they sometimes challenge the Coroner's conclusions.

Significant delays after the death and before a Rule 43 report is issued contribute significantly to Rule 43 reports having reduced impact. In the majority of cases, Rule 43 reports have not prompted action that would not have otherwise occurred through other existing mechanisms.

Requests made by Coroners in Rule 43 reports focus more upon solutions than outcomes. For example, Coroners may request the delivery of more extensive training in response to a death as opposed to asking recipients to seek to understand whether the training itself is being effective.

The changes implemented following a death in custody are rarely informed by organisational learning and behaviour change research, and we found little evidence that Coroners or the agents of change within organisations are aware of evidence-based approaches to facilitating change.

The changes that are implemented consequently tend to lack an evidence base for the interventions, focus on solutions rather than outcomes, and have little impact on improving organisational learning more generally. Specifically, responses to Rule 43 reports typically focus upon the circulation of information, training and the amendment of existing procedures, rather than institutions seeking to understand why what is currently in place has failed, and thus promote a culture of organisational learning. With this in mind, there is little evidence that those charged with making custody safer have been provided with development opportunities to improve their expertise in organisational learning and behaviour change.

There are significant inconsistencies in coronial practice as to when and how Rule 43 reports are written. These inconsistencies extend to proclivity to issue a report, report recipient(s), report length, number of issues raised and the nature of action expected from recipients. Whilst training in the writing of Rule 43 reports is offered by the Coroners' Society, this is not obligatory and does not currently facilitate Coroners in writing Rule 43 reports that focus upon outcomes, improving organisational effectiveness and tools for behavioural change. This compromises the ability for Rule 43 reports to produce lasting change.

Inadequate information is available within the custodial sectors about Rule 43 reports and the responses to them. The IT systems available to facilitate learning are poorly used which hampers the prioritisation of learning. For example, there is currently very limited capacity in the current system for identifying and acting upon trends emerging from Rule 43 reports and thus improve organisational effectiveness in this way.

Coroners' variable interpretation of their role in sharing information contributes to the lack of availability and transparency of the Rule 43 report process. Some Coroners refuse to share information with individuals who fall outside a very narrow definition of an 'interested party'. This restricted flow of information presents a barrier to organisational learning.

There is insufficient openness and accountability in the system to establish whether the actions suggested in the Rule 43 report are implemented, and that their impact is monitored and evaluated. Action taken as a result of a Rule 43 report, whilst satisfying the needs of the coronial system, may do little to actually improve organisational learning and effectiveness in preventing deaths in custody.

Coroners are part of a complex system that seeks to address deaths in custody. Where they identify that changes in the system are required, their power to issue Rule 43 reports affords them the opportunity to be significant agents of change. However, the nature of this change role is poorly defined and consequently the impact that Coroners have on the system is limited.

The appointment of the Chief Coroner provides an opportunity to raise standards and ensure that Coroners maximise the impact they have on the custodial sectors. This would involve the Chief Coroner exercising its powers to mandate training in the creation of effective Rule 43 reports.

Whilst there are some examples of good practice, very little cross-sector learning following a death in custody or the issuing of a Rule 43 report was found. There are few mechanisms for sharing learning across sectors which is undoubtedly a contributory factor.

2. Areas for improvement

The following areas for improvement have been designed to create and promoting a learning culture across the custodial sectors in order to achieve a more effective response to deaths in custody:

1. Those involved in learning following a death in custody should avail themselves of the evidence base presented here as a means of better understanding relevant learning and change mechanisms. Doing so should improve the impact their activity has on reducing deaths in custody.

2. Organisations with responsibility for responding to Rule 43s and learning from deaths in custody should examine the extent to which their own processes and behaviour incorporate the findings of learning research.

3. A fully searchable database of all Rule 43 reports should be created, containing all the relevant information that is needed to identify themes and trends in the data. A process could subsequently be implemented that requires Coroners to submit a quarterly return detailing their activity with respect to Rule 43 reports.

4. NOMS could consider how the work they undertake in creating responses to Rule 43 reports might be directed more clearly towards facilitating learning, rather than the process of creating a response.

5. Mandatory training could be provided to all Coroners that sets out when and how they might write a Rule 43 report with a view to maximising the chance of changing behaviour and instilling a learning culture across the custodial sectors. Mindful of the workload of Coroners, we anticipate that appropriate training could be achieved in less than two hours, and could be delivered on-line.

6. Organisations in the custodial sectors identify potential early adopters of change. This group should be provided with tools, advice and learning opportunities.

7. The IAP could identify and provide opportunities by which the group of early adopters come together to share issues and solutions.

8. Dialogue between recipients of Rule 43 reports and Coroners could be promoted to improve the understanding of the issue being reported and the quality of subsequent Rule 43 reports.

9. The Chief Coroner could adopt the role of quality assuring reports and their responses.

10. The IAP raises in early conversation with the Chief Coroner the role of individual Coroners as agents of change.

11. The IAP could sponsor or facilitate the arrangement of regional meetings with custodial organisations to address cross sector learning from deaths in custody.

12. IAP identifies a group of cross sector organisations that it believes should always be considered interested parties from a learning perspective and should receive copies of all Rule 43 reports and responses relevant to their organisation.

13. The IAP consults Coroners and other organisations that might be relevant interested parties in deaths in custody with a view to identifying the barriers to sharing Rule 43 reports and responses, and implementing a tool that makes the Rule 43 reports and responses available to the public.

3. Introduction

The Independent Advisory Panel on Deaths in Custody (IAP) reported that there were 5,998 deaths in custody recorded from January 1, 2000 to December 31, 2010 [2].

Rule 43 of the Coroners Rules [3] provides a Coroner with the power to issue a report to a person or organisation where they believe that action should be taken to prevent future deaths.

This research study, commissioned by the IAP sought to:

- Identify the action that has been taken by the individual custodial sector in response to Rule 43 reports
- Determine the impact Rule 43 reports are having in terms of sharing learning and contributing to the prevention of future deaths. A description of this impact is provided once we have first set out research underpinning perspectives on learning, and the policy and legal context in which Rule 43 reports sit

The concern that promoted this research is that more could and should be done to prevent deaths in custody and the Rule 43 report is one of the tools that may contribute to the prevention of further deaths. The importance of ensuring that every opportunity to learn from a death is maximised cannot be overstated. While deaths in custody are infrequent, they are signal events within a system that will also encounter:

- Errors
- Unsafe acts
- Procedure violations
- Glitches
- Near-misses
- Accidents
- Injury

While the above do not result in death they are warnings of lapses in the system which may precede the ultimate tragedy of a death in custody.

The inquest and the valuable work of the Coroner provides a rare opportunity for public scrutiny of the custodial sectors. While minor errors, glitches and near-misses may be subject to internal audit mechanisms and performance management systems, they will not receive the same level of external attention.

The Rule 43 report offers a real opportunity to improve custodial care. We hope that in some small but significant way this research contributes to this endeavour.

4. Research study methodology

The research study combined interviews with stakeholders and recipients of Rule 43 reports, complemented with an analysis of Rule 43 reports and the responses to these reports. Interviews took place between November 2011 and June 2012.

A database was created from data provided by the Secretariat for the IAP. The database contained 182 cases of deaths in custody for which a Rule 43 report had been written between the years of 2000 and 2010. This database was not a complete record. The Secretariat has had to follow up missing cases with the Ministry of Justice. The database has been made available to the research sponsors.

Stakeholders were identified for interview who represented the Independent Advisory Panel on Deaths in Custody (IAP), the Ministry of Justice (MoJ), Department of Health (DH), HM Inspectorate of Constabularies (HMIC), HM Inspectorate of Prisons (HMIP), the Independent Police Complaints Commission (IPCC), Prison and Probation Ombudsman (PPO), National Offender Management Service (NOMS), the Association of Chief Police Officers (ACPO), INQUEST, Coroners, lawyers and a family member.

A sample of 30 cases was extracted from the database using a proportional sampling technique[4] which has ensured that the cases being researched are representative of the whole database. For example, male cases accounted for 87% of the cases in the database. This was then proportionally represented in the sample. Similarly ethnicity, custodial setting where the death occurred, the cause of death, and theme related to the cause of death was proportionally represented. With this sample in place, part of this report looks at how Coroners wrote these reports, and how organisations, in turn, responded to what the Coroner had to say.

Table 1 details the custodial setting of the cases examined:

Custodial Setting	No. of cases examined
Prison	15
Mental Health	6
Police Custody	5
Young Offender Institution	2
Court Cell	1
Approved Premises	1

Table 1: Breakdown of cases by custodial setting

Any cases for which the Rule 43 report was written before November 2007 were excluded from the sample to increase the likelihood of actions taken in response to the Rule 43 report being relevant and representative of current practice.

The Rule 43 reports and responses were obtained for each of these 30 cases and interviews were sought with individuals involved in these cases to establish the veracity of the documentary evidence. Interviews were obtained that covered 14 of these cases (see Table 2).

Custodial Setting	No. of cases where interviews took place to support documentary evidence
Prison	7
Mental Health	3
Police Custody	2
Young Offender Institution	1
Court Cell	0
Approved Premises	1

Table 2: Breakdown of interviews undertaken by custodial setting

The interview followed a semi-structured format and sought to:

- Identify the action that had been taken by individual custodial sectors in response to Rule 43 reports
- Determine the impact that Rule 43 reports are having in terms of sharing learning and contributing to the prevention of future deaths

A copy of the interview schedule may be found in Appendix 1.

The following individuals contributed to this research. We would like to take this opportunity to thank them for their valuable input.

Name	Job Title & Location
Sarah Anderson	Offender Safety, Rights & Responsibilities Group, NOMS
William Armstrong	Her Majesty's Coroner for Norfolk
KrzystofAtraszkiewicz	Inspector, Force Custody Services Unit, West Yorkshire Police
Alice Balaquidan	Secretariat for the Ministerial Council on Deaths in Custody
Jane Bailey	Former Head of Safety at HMP Brinsford
Judith Bernstein	Head of Coroners, Burials, Cremations & Inquiries Team, Ministry of Justice
Sir Norman Bettison	Chief Constable of West Yorkshire Police
Fiona Borrill	Head of the Civil Liberties Department, Lester Morrill Solicitors
Ruth Bundey	Partner, Harrison Bundey Solicitors
Sue Clements	Offender Health Development Lead, Care UK
Deborah Coles	Co-Director, INQUEST
Paul Davies	Inspector, HM Inspectorate of Constabularies
Dr Peter Dean	IAP Panel Member and HM Coroner for Suffolk and South East Essex
Dexter Dias QC	QC, Garden Court Chambers
Mike Franklin	Commissioner, IPCC
Sarah Green	Commissioner, IPCC
Jan Goldsmith	Professional Advisor, Education, NMC

Helene Harvey	Office of the Force Solicitor, West Yorkshire Police
Lindsay Harvey	Policy Project Officer, IPCC
Lynette Hill	Training and Bereavement Manager, Access to Justice, Justice Policy Group, Ministry of Justice
David Hinchliffe	Her Majesty's Coroner for County of West Yorkshire (Eastern District)
Helen Hobday	Head of PALS, Complaints and Legal Services, Manchester Mental Health and Social Care Trust
Karen Jones	Senior Policy Projects Manager, Patient Safety Branch, Department of Health
Sean Langley	Approved Premises Team, NOMS
Michael Lozano	Patient Safety & Complaints Lead, Norfolk and Suffolk NHS Foundation Trust
Selena Lynch	Her Majesty's Assistant Deputy Coroner for Inner South District of Greater London
Daniel Machover	Partner, Civil Litigation Department, Hickman and Rose
Zoe Markham	Head of National Safer Custody Managers & Learning Team, NOMS
Laura Mccaughan	Head of Secretariat, Ministerial Council on Deaths in Custody
Anne McDonald	Deputy Director, Mental Health Care Pathways, Department of Health
Debbie Mead	National Operations Manager, Mental Health Act, Care Quality Commission
Nigel Meadows	Her Majesty's Coroner for Manchester (City) District
Loma Moyo	Sister of Godfrey Moyo who died in HMP Belmarsh in January 2005
Andrew Parker	Chief Constable, Warwickshire Police
John Parkinson	Deputy Chief Constable, West Yorkshire Police
Dave Pate	ACPO National Custody Lead-Programme Manager (until June 2012) & Chief Inspector at Kent Police
Jenny Rees	Head of Safer Custody Casework, Offender Safety, Rights and Responsibilities Group, NOMS
Kellie Reeve	Inspector, HM Inspectorate of Prisons
Nicholas Rheinberg	Her Majesty's Coroner for Cheshire
David Rollinson	Legal Services Manager, Norfolk and Suffolk NHS Foundation Trust
Tony Sperry	Offender Safety, Rights & Responsibilities Group, NOMS
Jacqueline Townley	Offender Safety Rights & Responsibilities Group, NOMS
Andrew Tweddle	Her Majesty's Coroner for North and South Districts of Durham and Darlington
Andrew Walker	Her Majesty's Coroner for Northern District of Greater London
Thea Walton	Acting Deputy Ombudsman, Fatal Incidents Investigations, Prisons and Probation Ombudsman
Tom Wilson	National Safer Custody Manager, NOMS
Derek Winter	HM Coroner for the City of Sunderland, Archivist for the Coroners' Society
Sarah Witton	HMP Dartmoor

5. Perspectives on learning

Before we present our research findings, we think it is important to set out what is understood by the term 'learning' and draw from the existing evidence base to describe a number of different perspectives on learning.

Our rationale is that the findings that follow point to significant opportunities for improvement about what constitutes effective learning and how this might be developed. Development in this area starts with understanding the evidence base.

5.1 What do we mean by learning?

Central to the issue of how organisations learn from a death in custody is the question of what we mean by learning. Three dictionary definitions are useful for our discussion:

1. Knowledge acquired by systematic study
2. The modification of behaviour through practice, training, or experience
3. The act or process of acquiring knowledge or skill

The first definition emphasizes how learning can be about knowing something. Pursuing this kind of learning ensures that an issue is explored and a conclusion is reached but nothing may be done as a result of the learning. In the context of Rule 43 reports, this knowledge is the outcome of the inquest: necessary if any change is to take place, but not sufficient to ensure change.

By contrast the second, more psychologically-derived definition places emphasis on the outcome of learning and in particular the change in behaviour that results from the learning. In the context of deaths in custody this would draw our attention to the outcomes of the Rule 43 reports. We would extend this to emphasise the need for relatively permanent change in behaviour.

The third definition demands particular attention as its impact is potentially greater than the other perspectives. It focuses on the act of learning rather than an outcome. In the context of this research, we would be looking at how a Rule 43 report may influence the process by which the sectors learn. By examining and improving the process of learning there is the potential for any interventions to have a greater impact than simply addressing a specific, local issue. Indeed, by influencing how learning takes place, a Rule 43 report may contribute to change that has nothing to do with the specific issue detailed in the report. This is in line with the Coroners (Amendment) Rules 2008[5] which provides that Coroners have a remit to write reports to prevent any future death rather than simply similar deaths. Expressed another way, this means that Coroners are given a mandate to attempt to influence learning behaviour across the sectors and not just correct a local error by pronouncing specific corrective action.

In examining the impact of Rule 43 reports upon learning we have therefore adopted the following as the focus of our study:

To examine the extent to which Coroners' Rule 43 reports contribute to sustained behavioural change and the development of effective behavioural change mechanisms within and across the custodial sectors to reduce the risk of future deaths occurring.

In examining this area we have sought to identify effective practice so that this can be encouraged and built upon. We have also identified shortcomings so that these can be addressed. In doing so, it is important that we set out a benchmark against which we can assess current activities. In this section we will therefore draw from the existing evidence base into what constitutes effective organisational learning and behaviour change. In subsequent sections we will use the models that we outline here to reflect on the findings of our research into specific death in custody cases.

As we summarise the evidence base in this area, it is worth noting that what is presented here is neither controversial nor 'cutting edge' in the field of learning and behaviour change. As we undertook the current research study it became evident that those who are tasked with implementing learning across the custodial sector were largely unaware of this existing evidence base and there was certainly no evidence of individuals being supported to use it as a tool.

This is the first area identified for improvement.

Those involved in learning following a death in custody should avail themselves of the evidence base presented here as a means of better understanding relevant learning and change mechanisms. Doing so should improve the impact their activity has on reducing deaths in custody.

A number of perspectives on learning are presented below, each drawing from and supported by existing research findings.

5.2 Complexity of the system

When a death occurs in custody, the tragic event triggers various forms of investigation to find out what happened and why. The traditional approach in such investigations, as is the case in investigations into accidents and serious incidents across industry, is to trace back the incident until it is possible to identify the chief errors that led to the final tragedy. In doing so we adopt a view that the behaviour of such-and-such a person at some particular point in the history of the event led to the next event which in turn led to the next event and so on, until the incident under examination occurred. Change the behaviour of the key individuals and the outcome would have been very different.

Such an explanation of error, often referred to as Heinrich's Domino Theory[6] , places key people at the centre of the causes for the incident with the result that blame and subsequent recommendations for change also focus on these key people. The field of accident research has established that while seeking to influence the behaviour of these key stakeholders (through mechanisms such as reward and punishments, monitoring and evaluation) will lead to some improvements, the changes resulting from singular person-centred solutions do not yield the reduction in accidents that would be considered acceptable[7].

What is missing in this approach is recognition of the multi-layered complexity of the situation being examined. We will refer to this as the system. In this context the term 'system' is being used to refer to all the variables that make up the work context and have an impact on behaviour and outcomes.

If we were merely considering learning in a single organisation we would still be dealing with a dynamic system of interactions between variables such as employees, management, incentives, environment and clients. It is evident that even the simplest organisation presents us with a complex system. The domain of death in custody presents us with a far greater challenge. An examination of the list of contributing stakeholders to this study alone reveals that we are dealing with dozens of organizations across at least three sectors as well as investigatory organizations such as the PPO and the policy-making roles of organizations such as MoJ (NOMS), DH, and the Home Office. We must also acknowledge the role of the family of the deceased and the public as important stakeholders with an influence on the system.

Given this inherent complexity, it would be naive not to acknowledge that a Rule 43 report issued by a Coroner is but one tool among many that may impact on the system by facilitating, encouraging or mandating learning following a death in custody. Rule 43 reports cannot be the key determinant of success or failure. A functioning Rule 43 regime may guide the system in a positive direction but effective learning will require engagement of all the stakeholders referred to in this report.

Whilst the focus of this research study is upon the impact of Rule 43 reports, we should point out that there is a case for further research to be undertaken that is broader in scope and which adopts a systems approach. Such an approach has created a great deal of attention within the area of safeguarding children where it is being used with success in Serious Case Reviews[8].

This report provides a framework for organisations involved in deaths in custody to examine their role in learning.

We therefore suggest that organisations with responsibility for responding to Rule 43s and learning from deaths in custody should examine the extent to which their own processes and behaviour incorporate the findings of learning research.

5.3 Understanding the current situation

Before learning can take place it is necessary to have a full grasp of the current situation. In evaluating the effectiveness of any initiative to implement learning, we should therefore firstly identify the extent to which the current situation is understood. In the context of death in custody this extends to an understanding of themes that have emerged as a result of inquests and the context within which learning is taking place.

While studying the current situation, note should be taken of the extent to which learning takes place in response to something going wrong or as a means to seeking continual improvement.

5.4 Stakeholder engagement

For change to take place there must be a compelling justification built on an understanding of the current situation. The case for change does not need to come from any particular quarter for it to be effective. For example, organisational leaders may provide a vision for an improved state; alternatively, groups of employees may demand change from within an organisation. Regardless of the source of the impetus for change, the more people are committed to the change, the greater the likelihood of it being implemented. Learning initiatives that are successful will therefore seek to influence the desire for change and enlist the support of a wide range of stakeholders.

Once the support of stakeholders is gained, these stakeholders must then be empowered to take control of their learning. In a complex system in particular, it is important not to rely on top-down learning alone. It is folly to assert that the right way to address a situation may only be identified by a central or senior authority. Flexibility and shared responsibility will encourage people to learn from one another. An evaluation of effective learning should therefore consider the extent to which hierarchical command-and-control based structures are enforced or whether flattened, shared responsibility structures should be encouraged in order to improve the likelihood of initiating and sustaining learning.

Linked to the issue of engagement is identification and mobilization of people within the organisations who are likely to become early adopters of the change. If these key practitioners have been identified, what emphasis has been placed on influencing and developing them?

Developing a case for change also involves establishing the associated risks that may be causing individuals to resist it. Neutralising resistance may be as powerful as garnering support.

The discussion of engagement presupposes that someone is doing the engaging. Who is identifying early adopters and ensuring they are developed? Who is identifying the risks associated with change and addressing them? Personal responsibility and accountability are therefore fundamental to the successful implementation of all of the learning mechanisms identified here.

5.5 Resources available to change

Change requires time and resources to achieve the desired outcome. This does not necessarily mean that extensive resources need to be assigned to a change initiative but it would be unrealistic to expect individuals to attend to changes when they are stretched to deliver what is already required of them.

Calls for change will be more successful if they are mindful of these constraints. With this in mind, we have attempted to suggest changes that require only minimal resources to implement.

5.6 Environmental and cultural considerations

A key feature of the systems approach to the examination of instances of effective and ineffective practice is the idea that individuals who are part of the system are not entirely free to make choices about how effectively they operate within the system.

The system is made up of processes and tools, accepted routines and ingrained thought patterns. All of these steer the practitioner along certain paths of behaviour.

To improve the performance of individuals we must therefore also seek to influence the environment within which they are operating, making it more difficult to do the task badly. The desired behaviours become the default behaviours. For example, if a form needs to be completed about an individual and shared with a colleague so that risk can be identified, the system should be designed so that an individual is not able to complete their work unless they comply with this system. This may extend to not enabling them to complete the next task they want to undertake. An example of this is not being able to save on-line case records until all relevant fields have been populated.

5.7 Attention to mental models

Mental models comprise assumptions, generalisations, concepts and images of how we view our world and react to it. Put another way, they are the lens through which we see the world.

The facilitation of learning occurs when one is able to understand how these mental models influence behaviour. If we understand the impact of mental models we may be able to adapt them so that learning is facilitated.

For example, an investigation prompted by the committing of an error may be perceived as a challenge and a risk, or as an opportunity to learn. If the former, individuals are likely to provide minimal information to avoid the risk of being perceived negatively. This lack of candid disclosure will limit learning.

5.8 Single solution focussed learning vs. double-loop outcome focussed learning

We recognise that the concept of single and double-loop learning articulated by Argyris[9] may be an unfamiliar concept that is difficult to grasp but its understanding is so central to the findings presented here that we urge the reader to give it due consideration.

In single-loop learning individuals, groups, or organizations incrementally modify their actions according to the difference between what they expect to happen and what actually happens. For example, training is implemented that an organisation expects will equip individuals with certain skills to tackle particular tasks. The organisation subsequently finds that individuals do not tackle the tasks as they expected. The response might then be to provide more of the training with the belief that training leads to change and so more training must lead to more successful change.

By contrast double-loop learning involves questioning the values and assumptions and policies that led to the actions in the first place. Put another way, those involved seek to learn about the way they learn. For example when an organisation identifies that training did not lead to the desired outcome they may reflect on how decisions were reached to develop the training in the manner it was.

Another way of grasping this approach to learning in the context of Rule 43 reports is that single-loop learning focuses on providing a solution to address the specific circumstances that have arisen, whereas double-loop learning focuses on identifying a desirable outcome. For example, a Coroner might suggest that a death was a result of a failure to share information between two teams in an organisation. A solution focussed recommendation would be to suggest that they create a form to pass between the two groups with the information written on it. An outcome focussed suggestion

might be to highlight that the failures in sharing of information between the two groups contributed to the death and to request that the organisation identify specific, concrete mechanisms by which they can improve the communication between the groups. The outcome is improved communication but how they achieve this is left to the organisation to explore and identify.

The benefit of this approach is that it leads to changes that have a wider and deeper impact by reflecting on practice rather than immediately reinforcing existing guidance which may not be working. For example, an examination of how training is developed may lead to all training being improved, whereas the implementation of extra training to tackle a skills gap may at best only lead to addressing the specific issue, and will more likely lead to the repetition of the outcome that has already been experienced.

These benefits were highlighted in 2000 as part of the wide-ranging Department of Health commissioned report into learning in the NHS[10]. The report, "An organisation with memory", drawing from the Safety literature, identified the need to move from a focus on short-term, individual error and blame to a systems approach that emphasises sustained risk reduction by identifying hazards through a blame-free reporting process. It is noteworthy that the report identified that as a prerequisite to learning there needed to be improved reporting mechanisms.

The decade that followed witnessed improved reporting mechanisms and an increase in Reflective Practice[11].

Reflective Practice is a set of processes underpinned by a philosophy of continual learning that leads to practitioners becoming mindful of their behaviour and reflecting on how it might be improved. This might involve reflecting on the experience after the event or during an event. The aim of developing Reflective Practice is to create an environment within which reflection becomes a way of being for practitioners[12].

While the benefits of developing the NHS as a learning organisation are generally accepted, there is some debate about how achievable this is. Commenting in 2006 on the journey that the NHS was taking, Sheaff and Pilgrim[13] contrasted the approach that a single organisation might take to make it more competitive than its less reflective competitors with the approach that a whole market might take. They concluded that the marketization of the NHS inevitably leads to competition and consequently hinders sharing of learning across the sector. They also state that the changes have been more effective in "acute care with its relatively well-specified outcomes and working practices than in socially-oriented areas such as mental health care, where the opposite conditions apply".

Attending to the part of the feedback loop that ensures that wider lessons are translated into real behavioural change has been the focus of a National Institute for Health Research initiative 'collaborations for leadership in applied health research and care' (CLAHRC) in Leicestershire Northamptonshire and Rutland (LNR)[14].

Three years into a five year study, they report that a degree of success has been achieved through a concerted effort to promote inter-professional education. This is a process whereby professions learn from and about each other. This has been achieved through the appointment of specialist staff tasked with linking academic staff with NHS staff to deliver multidisciplinary teams and by identifying "fellows" who assist end-users in incorporating research evidence in their policies and procedures. While the programme still has two years to run before it may be evaluated fully, they are confident that the initiative is informing commissioning decisions and improving service delivery.

5.9 Capacity and capability

New behaviours are likely to need new skills. Any evaluation of learning should therefore attend to how new skills are developed.

In the context of implementing changes identified through Rule 43 reports this extends to those who create the reports, the Coroners. To what extent are they equipped to create Rule 43 reports that facilitate learning?

5.10 Embedding changes

The aim of a learning initiative is to embed behavioural change so that it is sustained. Learning initiatives start with the externalization of the desired changes in training programmes, manuals, memos and similar tools. But such initiatives are only the beginning of the learning process.

The changes only become embedded and sustained when they become internalised by employees who demonstrate the behaviour as a matter of course, without needing to be reminded and without needing to refer to manuals and rule books.

Effective learning initiatives will attend to embedding learning as well as initiating learning. Whilst research shows one of the most effective ways to embed learning is through practice[15], in the context of Rule 43 reports it is important to recognize that the context may provide few opportunities to do this, itself leading to increased risk of human error. For many, the need to respond to emergency events on a regular basis, for example, is rare. In cases such as these, rather than simply providing refresher training or reminding staff of a policy, consideration needs to be given to how individuals can learn and be trained more effectively to ensure that this training really does embed the necessary learning or knowledge. For example, scenario-based training is more effective than lectures/computer-based learning to deal with emergency events[16], and so this may be a more appropriate method of training delivery.

Two of the most important tools for embedding change are monitoring and evaluation.

Monitoring and evaluating change have a two-fold effect on learning. They motivate individuals to implement change and enable those involved to identify if learning is successful. By identifying success and failure, initiatives and learning mechanisms may be adapted or abandoned.

Consideration of how behaviours are rewarded and punished should also be considered when evaluating the effectiveness of learning. Punishment and the threat of punishment can undermine a learning environment but can motivate the change of a particular set of behaviours. Research indicates that learning is optimal when we punish only when necessary and reward modestly[17]. Even small rewards such as acknowledgement of change can have a significant effect.

We are not advocating that there is a “no blame” approach but rather that an emphasis should be placed on an “open and fair culture” which “requires a much more thoughtful and supportive response to error and harm when they do occur”[18].

Having set out a number of perspectives on learning, the following section moves on to describe the policy and legal context in which Rule 43 reports sit.

6. Policy and legal context

An explanation for the current practice of Coroners issuing Rule 43 reports may be best understood by tracing the current system's development over the last three decades.

Article 2 of The European Convention on Human Rights (ECHR) establishes that everyone's right to life shall be protected by law.

In 1984 this was incorporated into the Coroners Rules[19] as providing a Coroner with the power to issue a report to a person or organisation where they believed that action should be taken to prevent future deaths. It is important to note that at this point the Coroner had the power to issue such a report but no obligation.

Since 1984, there has been a series of policy reviews and legal judgments, which have highlighted and brought about significant change.

The Luce Review[20] (2001 – 2003) was a crucial part of this process. It identified "critical weaknesses of the death certification and coronial processes".

Among its findings of relevance to this research study were:

- The systems were internally fragmented and not concerned with the identification of patterns or trends
- The coronial system lacks leadership, accountability and quality assurance
- The death certification and coronial systems are isolated from each other, from the mainstream healthcare and justice systems, and from other public health and safety agencies
- There was a lack of consistent training for Coroners, Coroners' Officers and other professionals working in the death certification and investigation systems
- There was no full-time leadership in the coronial system and most Coroners themselves work part-time
- Complex and contentious inquests are inadequately resourced and there is a lack of clarity in the relationship between inquests and other formal death investigation processes

This review, as well as lobbying from organisations such as INQUEST and legal judgements, led to the publication of the Coroners Bill for consultation in 2006.

Important cases that highlighted the need for change were Edwards[21], which placed a duty on the state to conduct an effective investigation following any death in state custody, and Middeleton[22] which requires an inquest to return verdicts which properly reflect:

- Whether a person takes their own life in part because the dangers of their doing so were not recognised by the authorities
- Whether appropriate precautions could have been taken to prevent the death

During the consultation process for the Bill, Coroners' powers to make reports were discussed extensively and feedback from the consultation suggested that the public protection role for Coroners could be further strengthened. Consequently, there were proposals to amend Rule 43 (of the Coroners' Rules) to increase the impact of the reports issued and address a number of the concerns raised in the Luce review.

As a result of the amendment, Coroners were able to report issues to prevent any deaths even if those issues were peripheral to the specific death with which they were dealing.

Coroners were also required to share reports and responses with interested parties to the particular inquest as well as the Lord Chancellor. Coroners could also share reports and responses with other interested organisations and stakeholders such as relevant regulatory bodies.

The amendment effectively made it obligatory for Coroners to issue a report when it is appropriate to do so rather than a discretionary power.

Organisations receiving the reports would be required to respond in writing within 56 days detailing the action taken in response to the report or alternatively why no action had been proposed.

As a means of establishing compliance with the requirement to respond, a role was established within MoJ to compile and report when Rule 43 letters had been issued and responded to.

While it was acknowledged that the new regime for tracking who received reports and how they responded to them would not address all of the concerns raised by Luce, it was seen as a significant improvement on the practice at the time and an important step forward, while a significant overhaul of the coronial system was being considered. This was set out in the Coroners and Justice Act 2009, including the role of Chief Coroner.

Claridge, Cook and Hale (2009) wrote with hope about what they believed to be imminent reform of the Coroners service suggesting it would "make the Rule 43 reports more effective"[23]. They recommended that as part of the changes "the role of these reports should be explored at national level and standardized tools developed in order to achieve consistency in its application".

However, the office of Chief Coroner was added to the Public Bodies Bill and considered for abolition. Following significant lobbying from the Royal British Legion and INQUEST, the role was taken out of the Public Bodies Bill in November 2011 and Peter Thornton QC was appointed in May 2012 to commence in September.

While it is important to recognise that the many demands placed on the Chief Coroner will make it unrealistic to expect that all the issues set out in this report could be implemented, there is a unique opportunity to make a real, evidence based, difference to the way that Rule 43 reports are used to minimize deaths in custody.

Another important piece of legislation that must be considered is the Corporate Manslaughter Act. From September 1 2011, the Act applied to the management of custody. The Act states that an organisation is guilty of an offence if the way in which its activities are managed or organised by its senior management is a substantial element in the cause of a person's death or amounts to a gross breach of a relevant duty of care.

Later in this report we will reflect on how this Act may impact on the way Rule 43 reports are received.

In addition to the changes to the coronial system, efforts to reduce deaths in custody are brought together in the Ministerial Council on Deaths in Custody, which was implemented in 2009. The body comprises a Ministerial Board on Deaths in Custody and the Independent Advisory Panel on Deaths in Custody.

The Board brings together decision-makers responsible for policy and issues related to deaths in custody in the Ministry of Justice, Home Office and Department of Health. The Independent Advisory Panel on Deaths in Custody (IAP) is the principal source of advice to the Ministerial Board. In 2012 the decision was made to retain this structure for a further three years.

Thus we find ourselves with the current imperfect but evolving system with the shared aims of reducing deaths in custody.

Rather than call for new legislation or simply state the need for custodial organisations to respond appropriately to Rule 43 reports, we have sought to identify how the currently emerging framework may be best used to influence behaviour.

7. How do organisations respond to a Rule 43 Report?

Before we examine how effectively organisations adapt and learn following a Rule 43 report, it is important to refer to an overview of the evidence we found from interviews with stakeholders about the actions that take place as a result of the letter. The most important point to recognise is the lack of consistency between organisations in the way in which they respond to Rule 43 reports. Please see Appendix 2 for details.

Inconsistency in approach is not necessarily problematic for ensuring learning. However it is important to be aware of the inconsistencies so that the context of a Rule 43 report is understood before suggestions for change are made.

7.1 Research findings and recommendations

These research findings expand on the high level findings reported in the executive summary by looking at how Coroners write Rule 43 reports, how organisations respond to these reports, and what organisational learning takes place.

Our research uncovered numerous examples of learning and effective practice being undertaken by dedicated and motivated staff. It would be neither accurate nor helpful to suggest for one moment that these staff are not contributing to the reduction in the number of deaths in custody. However, we identified several shortcomings that make learning difficult and in some instances virtually impossible. We will detail these shortcomings and suggest remedies.

Most notable, however, is the lack of evidence of learning mechanisms being systematically implemented. Throughout the following findings we have made suggestions and observations that are often based on no evidence of the behaviours we were seeking.

The simple observation that learning is incomplete leads us to conclude that there is a role for any tool that facilitates learning. While there are many ways that the system could be influenced to learn more effectively, our remit is to focus on Rule 43 reports and so as we explore how learning is undertaken we will restrict our comments to interventions that link these reports to improved organisational behaviour. So for example, we have not researched the efficacy of PPO investigations but we will comment on how a Coroner might wish to ensure that the findings of any investigation are implemented. When reading this report, therefore, it is important not to forget that Rule 43 reports are one small part of the system. We are neither saying that the rest of the system is working in an optimal fashion nor are we saying that Rule 43 reports can be the sole mechanism by which positive change takes place.

In terms of the Rule 43 reports and responses, as detailed above, we took a proportional sample of 30 from the original 182 cases and reviewed the content of the reports from Coroners and responses to the reports (see Table 1).

Our aim was to evaluate the content of the reports from Coroners and establish how recipients respond to them.

As we describe the contents of the reports and responses below, we will use percentages to illustrate how effectively they are being written. As these reports were selected through a thorough sampling we can be reasonably confident that the findings reflect what we would have found if we had analysed the whole dataset. However we are referring to only 30 cases when we provide statistics. These statistics should therefore be treated with a degree of caution. It would be inappropriate, for example, to assign any particular meaning to differences of only a few percentage points. However, as an appropriate sampling process was employed when selecting cases for further review we can be reasonably confident that the findings do illustrate what we would have concluded had we attended to the entire sample of 182 cases.

When looking at the responses to Rule 43 reports, we were cognizant of the possibility that respondents may have written something but done something entirely different. We therefore interviewed individuals involved in responding to a report in an attempt to establish if the response did reflect the reality of the actions. It was as important to establish if organisations had undertaken more than they had indicated in their reports as it was to establish if they had done less.

It is plausible that activities were undertaken, but as the Coroner did not ask about them, respondents did not mention these in their Rule 43 responses. We were not able to speak to individuals involved in every case but we looked in detail at approximately half of the cases. We were able to interview multiple stakeholders involved in several of the cases. We were not able to conclusively confirm that all the actions detailed in the responses actually took place but there was no compelling evidence that they had not. We were confident, however, that the respondents did not under-report activities undertaken as a result of receiving a Rule 43 report.

7.2 Circulation and access to Rule 43 reports and responses

The Luce Review highlighted the need to establish trends and themes in Rule 43 reports in 2003.

On embarking on this research, we expected to find a database of reports that would enable us to establish what is being written about and how organisations are responding. We thought that this would be the starting point from which a fuller analysis of the situation would be possible.

Such a database does not currently exist.

When a Rule 43 report is issued, the Coroner is required to send a copy of the report and response to the Lord Chancellor, at the Ministry of Justice (MoJ). These reports and responses are logged onto a spreadsheet-based system. This data gathering mechanism was designed so that it would be possible to establish the speed of responses. It is not a searchable database. This system was set up as an interim measure in response to the 2008 Rule 43 amendment.

It is the MoJ's intention to have a full record of Rule 43 reports and responses but the current system simply requires Coroners to send them if they exist. There is no process of submitting, for example, a quarterly return detailing Rule 43 reports including an option for a nil return. The MoJ are confident that the current system ensures that they are likely to receive all of the Rule 43 reports issued by Coroners but it is more likely that they will not receive all the responses to Coroners. However, the MoJ periodically liaise with the Coroners' Society which holds an archive of Rule 43 reports and responses to establish if there are any reports or responses that have not been sent directly to them.

The Coroners' Society created this archive of unredacted Rule 43 reports and responses several years ago. It is only accessible to Coroners online through the Society website. This is not funded or sponsored by central government. It is currently maintained by HM Coroner for the City of Sunderland on a voluntary basis.

This was an initiative that the Society identified would make an important contribution to the sharing of knowledge and learning. It may be used to assist a Coroner when they are considering whether an issue has previously been the subject of a Rule 43 report. In interviews, Coroners conceded that they are frequently pushed for time and so may not inspect the archive unless they are presented with a particularly complicated case. Indeed, in the sample of Rule 43 reports analysed, we found reference to other Rule 43 reports in only 13% of cases despite the fact that reports cover issues that have been raised by Coroners in other Rule 43 reports. For example, inadequate risk assessment is cited 26 times in our dataset of 182 cases, access to medical records 16 times and information not being correctly recorded 21 times.

The efficacy of the archive itself is also dependent on Coroner action. It is for a Coroner to determine to whom copies of a Rule 43 report should go. Coroners are encouraged to submit Rule 43 reports and responses to the Society but they are under no obligation to do so. Some Coroners do this and some do not. Consequently the archive is incomplete.

The Coroners' Society archive provides a sound basis from which to develop a complete resource for the collation and research of Rule 43 reports. It is more useful than the spreadsheet of data collated by the MoJ as it is searchable and accessible by all Coroners in the Coroners' Society via an online portal. However more needs to be done to ensure its completeness. The archive will remain incomplete if submission of data is voluntary. It was not possible to establish clear reasons why all Coroners do not submit Rule 43 reports to the database. One reason proposed was that it is not appropriate to share such information.

The incompleteness of the current archive is not its only shortcoming. Whilst the archive is searchable in that individual reports are categorized and scanned documents may be accessed, the manner in which the data is stored means that there is limited scope for qualitatively or quantitatively analysing the content. In effect the data is stored as photos of the reports making it impossible to search for individual words or themes. It is not possible, for example, to track issues over several years.

Every six months the MoJ produces "A Summary of Coroners Reports to Prevent Future Deaths"[24]. This report includes reference to Deaths in Custody and seeks to identify themes. The MoJ liaises with the Coroners' Society to ensure accuracy of the information. Over the last few years identifying themes has been the task of one member of staff, and this was a small part of the individual's role. However, the individual has left the organisation, and there has been a loss of expertise and memory as a result. The job has recently been taken on by another member of staff and we believe that responsibility is likely to be transferred to the Chief Coroner's office. Wherever responsibility sits, individuals will require tools to assist them in developing an understanding of themes and issues because the tools currently available do not either enable the examination nor the exploration of the data.

When we consider that Rule 43 reports do not just cover deaths in custody but a plethora of cases that come before a Coroner, it is possible to appreciate the value of a tool that would enable analysing the rich seam of information being collated.

We advocate adopting the double-loop learning approach described above and as this function may be the responsibility of the Chief Coroner's office in the near future we suggest that his office should consider the value of implementing a searchable database of Rule 43 reports to encourage identification of themes and to provide a learning resource for a range of stakeholder.

As part of this research study, we pulled together recent Rule 43 reports into a database for use by the IAP, which was vital for undertaking the sampling of cases. The database was relatively simple to create and a more sophisticated version with greater capacity for all Rule 43s could be designed and implemented by the Chief Coroner. A technically qualified member of staff could be seconded from within the department or another government department to complete the work and to keep the costs to a minimum. This would then enable the MoJ to undertake meaningful, potentially life-saving thematic analyses.

If the Chief Coroner agrees to its development, we suggest that a fully searchable database of all Rule 43 reports be created, containing all the relevant information that is needed to identify themes and trends in the data. A process could subsequently be implemented that requires Coroners to submit a quarterly return detailing their activity with respect to Rule 43 reports.

We argue that there needs to be a very strong case against developing such a database for the limited resources not to be made available for its creation.

7.3 Timeliness of Rule 43 reports

The commitment expressed by the most senior politicians to reducing deaths in custody is unequivocal. In a recent press release the Minister for Prisons, Crispin Blunt, said:

> *"Every death in prison is a tragedy, and affects families, staff and other prisoners deeply...the Government remains fully committed to reducing deaths in custody."* [25]

This is echoed by those running the custodial organisations. For example, Michael Spurr, Chief Executive Officer of the National Offender Management Service (NOMS), said:

> *"Reducing the number of self-inflicted deaths and occasions of self-harm continues to be a key priority for staff of all disciplines working in prisons. Staff work diligently and with immense professionalism to ensure vulnerable prisoners are held safely in custody."*

Unsurprisingly our interviews did not uncover a single instance of individuals explicitly not caring about a death in custody. How then might the Rule 43 support, enhance or encourage the engagement of individuals so that their desire for change is translated into action?

One impediment to engaging individuals is the length of time between a death and a Rule 43 report being issued. Our analysis of the 172 cases provided to us by the IAP for which we had date information found that the mean length of time from the date of death to the date of the Rule 43 report is 866 days. In 13% of cases there was a lag of over 4 years from the death to the Rule 43 report. 10% of Rule 43 reports were written within a year of the date of death.

Feedback is most effective when it follows immediately after an action. It is unsurprising that the lengthy delays identified here mean that by the time that a Rule 43 report is issued, many of those involved in the case, the individuals most likely to be motivated to address the issues, will have moved on. This was certainly the situation as we sought to identify individuals involved in the cases in our sample.

Interviewees made comments such as:

> ***"by the time we received the Rule 43 report what it suggested was useless"***
>
> Quote 1

> ***"Years had passed since the death. If we hadn't already spotted and rectified the issues identified by the Coroner it would have been ridiculous."***
>
> Quote 2

It should be noted that this does not contradict the observation that we are dealing with a complex system and that the system needs to be addressed. While this still holds true, we should not ignore the role of the individual who is an important component in the system.

It is beyond the scope of this report to identify how to speed up the coronial system and we are aware that the IAP is pursuing recommendations aimed at addressing this. We would simply like to add the issue of improved learning to the list of reasons for speeding up the system.

7.4 Consistency of approach

Coroners are reasonably consistent in the way that they introduce the Rule 43 report, providing an explanation of Rule 43 (93%) and making it clear to whom the report has been circulated (77%). It is here that the consistency ends. In length, reports range from as few as 111 words to a dozen pages. The number of issues that Coroners reported on ranged from 1 to 18, the average number being 3.4. (Incidentally almost everyone we interviewed recognised the Rule 43 reports as recommendations even if this is not their technical definition.)

While the way that Rule 43 reports are written may lead to damaging inconsistencies, of more importance is the fact that there is inconsistency in when they are written. Interviewees observed that some Coroners appear to write Rule 43 reports as a matter of course following every inquest and some never produce a Rule 43 report. One interview observed that when their role moved a few miles from one jurisdiction to another, they were confronted with the situation that their new Coroner frequently issued Rule 43 reports whereas the previous Coroner had written only one report in 13 years.

7.5 Provision of a rationale for recommendations made

Although most reports made it clear what they expected the recipient to do, only 33% of Coroners attempted to provide a rationale as to why they believed that there was a risk of other deaths in similar circumstances. This is key because a number of interviewees spoke of their confusion over receiving a recommendation that appeared to have no bearing on the death that had been investigated. Many interviewees were also unaware that the Coroner may write a Rule 43 report where it is believed a risk of death has been identified even when that risk did not contribute to the death in question.

7.6 Recipients' perception of Rule 43 reports

A majority of interviewees spoke of the Rule 43 report being perceived as a punishment to be avoided rather than an opportunity to learn. It is more likely that the content of a report will be received defensively if it is considered to be a punishment and so we were keen to establish the tone of the reports.

In 27% of the reports, the efforts and progress made to date by the recipient organisation were acknowledged. It was rare for a report to focus on admonishing the organisation (10%). Most reports were either neutral in tone (43%) or focussed on the possibility of learning (47%).

Nevertheless we find that 33% of responses focussed on either excusing themselves from taking the actions that are identified in the report or challenging the Coroner's conclusions without suggesting a dialogue to address the root of the concerns. Here are two examples highlighting this:

> ***"No changes are proposed to written and computer generated documentation created and utilised by XXX. Documentation is normally accurate and complete. Although on this occasion documentation was not to usual standards this was because focus shifted to caring for XXX. I am satisfied that the manner in which the documentation was completed had no bearing on communication between the custody officers in the custody suite on the day in question."***
>
> Quote 3

> ***"Whilst we would agree that psychiatric nurses should have a basic knowledge of physical illnesses we would not necessarily agree with you that this would be best enabled 'by a period of attachment to an acute medical ward'."***
>
> Quote 4

This indicates that the reports are far from being a tool for opening up a discussion about how the organisation might learn.

Indeed in 63% of cases the responses indicated that the report had not prompted any action that would not have occurred otherwise. Rather, the response reported what action had been taken as a direct result of reflections after the death or as a result of other investigations

The Reflective Practitioner literature highlights that the negative feelings and anxiety that precede reflection make it natural for individuals to distort, rationalise or even deny the situation that causes these emotions. For learning to be effective, it is important to challenge the practitioners' mental model.

One way of achieving this is to allow individuals (who are being asked to implement practical changes following a death) to work through the negative feelings with support from professionals so that that the individual can move on to channelling their energies into improving the situation rather than minimising it.

We found no evidence of this approach being adopted.

7.7 Nature of requests being made by Coroners

In 80% of the reports we found advice that specifically addressed the incident in a single-loop learning (see Section 5.8) manner, such as:

> ***"...leads me to the conclusion that uniformed Prison Officers should have appropriate first aid training to ensure that they have the skills needed to take swift and effective action to preserve life should a ligature incident be encountered. The specific recommendations were:***
>
> ***(1) That the personality disorder assessment and liaison team at XXX amend the referral form to negate any confusion caused within the stated referral criteria.***
>
> ***(2) That the personality disorder assessment and liaison team at XXX review and amend the referral chart and include timescales for an assessment to be carried out and a timescale for a decision regarding the outcome of the assessment."***
>
> Quote 5

> ***"You consider undertaking an audit of the prison staff's awareness of the heightened risk of suicide for those withdrawing or suspected to be withdrawing from drugs to ensure that all staff are fully aware of the risk in future."***
>
> Quote 6

This type of recommendation focuses on providing a solution. The solution may be the incorrect one, in which case it is challenged or ignored or it might prompt the organisation to take specific actions without attending to the core issue.

Coroners requested a review in 50% of reports but without specifically pointing the recipient in the direction of double-loop learning. A review may lead to double-loop learning but does not necessarily do so. The request for an unspecified review may also be perceived as too broad to be of practical use, as is the case with the following examples:

> ***"My recommendation is in the following terms...that [the Chief Constable] arrange for a full review of the Policies Practices and Procedures carried out in all custody suites within the XXX area to ascertain if the involved personnel are fit for purpose and to take such action as he deems appropriate and that he advise me of the outcome of this exercise."***
>
> Quote 7

> ***"...urgent steps need to be taken in my opinion to improve the whole ACCT review process to address the points listed above."***
>
> Quote 8

Coroners suggest double-loop learning in 7% of cases. In these cases, the Coroner is focussing more on the outcome they desire and is suggesting that the processes and culture are examined so that changes are made to achieve the outcome.

> ***"I understand that the form of the PER has or is being changed. However, whilst the new form was not the same subject of scrutiny in this case as was the old form it strikes me forcibly that the issue is not so much the design of a form, but a common understanding of its function and how it should be used and that this common understanding should extend across all relevant agencies and within them. It is not a problem which can be cured by the individual agencies working independently but needs a coordinated approach to the education of all staff using the form."***
>
> Quote 9

63% of reports were directed at specific institutions, although in the case of NOMS the response would always be from a central team regardless of where the report was directed. The strength of this approach is that the Rule 43 report may receive the attention of a team with a national perspective that can ensure that learning is shared across the estate. However, we found a number of examples of when this opportunity was not maximised. For example, the responses frequently state the national policy regarding the issue without instigating any efforts to learn. While it is important that the team creating responses fulfils the organisation's legal requirement to respond to the Coroner's letter, much more could be done to integrate their efforts to learn from other investigations into the deaths with the findings in Rule 43 reports.

We suggest that NOMS could consider how the work they undertake in creating responses to Rule 43 reports might be directed more clearly towards facilitating learning, rather than the process of creating a response.

One operational staff member we spoke to in a prison thought all the effort they had made to deal with the issues raised by the Coroner were not sufficiently reported back in the response to the Coroner because it was written by someone who was not close to the case.

The responses from organisations reflected the nature of the reports from Coroners. 67% of responses focussed on single-loop learning such as:

> ***"HMP XXX has confirmed that the guidance contained in Prison Service Order (PSO) 2700 "Suicide Prevention and Self Harm Management", Annex 6B, relating to the use of shared cells is reinforced."***
>
> Quote 10

and

> ***"May I please direct you to Standard 05 page 3 and the guidelines to good practice page 5. These two paragraphs show that actions, which address your concerns, have been implemented.***
>
> ***Standard 05. All Patients detained under the Mental Health Act will be escorted to A&E/acute hospital by a member of the nursing team and appropriate Section Leave Forms will be completed."***
>
> Quote 11

The following example (Quote 12) given in response to the request above (Quote 5) to ensure that Prison Officers are appropriately trained in first aid procedures is typical of a type of response that simply states what the policy is, without addressing the core of the request from the Coroner. In this case, the Coroner was clearly concerned about the outcomes of whatever training had taken place. However, the response simply re-stated national policy i.e. that individuals should be trained, without any reflection on the appropriateness or quality of the training.

> ***"National policy contained within Prison Service Order (PSO) 3801 "Health and Safety Policy Statement" contains a mandatory requirement which sets out that:***
>
> ***"Governing Governors must carry out an assessment to identify the number of first aiders required by their establishment and ensure that a sufficient number of***

trained first aiders are available at all times. This assessment must take account of holidays, sickness absence and the shift patterns operating in the establishment".

Colleagues at XXX confirmed that in the last three years, fifty staff have completed first aid training courses."

Quote 12

Only 10% of responses focussed on double-loop learning. The example of a request for double-loop learning detailed above (Quote 9) prompted responses from the police force, NOMS, a private escort provider and a health provider. A cross sector working party was convened to review the process and various training and evaluation processes were implemented to embed the change. Only 13% of reports suggested cross-sector initiatives but the response to this report indicates how powerful such a request may be in ensuring cross-sector learning.

Quote 3 in which a recommendation is challenged highlights a further danger of making specific suggestions because these may be incorrect. Where this is the case, it is difficult for the recipient to divorce the prompt for learning from the specific advice, and so the opportunity to learn may be lost entirely.

Double-loop learning suggestions should also be attractive to Coroners as they are less likely to suggest inappropriate solutions and consequently the risk to their credibility is reduced.

7.8 Nature of responses made to Rule 43 report requests

The responses detail a limited set of activities that had been undertaken as a result of the death. Note that the following figures do not add up to 100% as some responses indicated multiple activities. It should also be noted that many of these activities were not prompted by the Rule 43 report but the recipient considered it appropriate to respond to the report with activities that they had undertaken following the death as a result of other investigations, but prior to the inquest. This corroborates our finding that respondents do not under-report activity. Rather, they are inclined to tell the Coroner about all the activity that has taken place in response to the death whether or not the Coroner referred to it in their Rule 43 report.

Reported activities undertaken as a result a death in custody were:

Provision of a new/revised rule	23%
Refresher training	37%
New system	40%
System to minimise human error/non-compliance	30%
Circulation of reminders of existing rules and guidelines	37%

It is encouraging that initiatives are taking place that seek to change the system or reduce human error. One such initiative was the development of the IT system used when individuals are brought into a police custody suite. By creating fields that were required to be completed before the individual could be processed, it was possible to minimise the chance of the data not being recorded.

However, the reliance on circulation of rules and refresher training appears to ignore the fact that the original circulation of the rules and the initial training failed to produce the results expected, so why would it produce a different outcome when repeated? Such an over-reliance on single-loop learning initiatives underlines the need for efforts to instil a culture of true learning rather than one where local issues are addressed while the system remains in need of attention.

Organisations should also seek a much wider set of tools to embed change.

We found no cases (0%) where the Coroner had indicated that monitoring and evaluation should be undertaken to ensure that the change was embedded. We found 10% of respondents indicating that monitoring had taken place and 13% said that they had evaluated the impact of the change.

In only one case did the report from the Coroner request for an individual or a particular role to be identified to take responsibility for the suggested changes and in only 17% of responses did recipients indicate that individuals had taken individual responsibility.

In summary, we find that in the majority of cases, the Rule 43 report does not prompt changes and the issues raised in the reports have already been addressed by organisations.

Organisations typically respond to deaths in custody and to Rule 43 reports by implementing local, single-loop learning initiatives. Whilst this may be having some impact in the prevention of deaths in custody, If the learning is to be more effective, there must be a greater focus on double-loop learning, cross-sector issues must be brought to the fore and initiatives must be monitored and evaluated.

As these are the kinds of changes that are not typically implemented as a result of a death in custody, Coroners have a unique perspective on the failings that take place which lead to deaths in custody and therefore have a significant opportunity to facilitate learning by addressing these issues in their Rule 43 reports.

7.9 Reward and punishment

Reward and punishment have a long pedigree as agents of behavioural change. In this report we have attempted to highlight other mechanisms that will promote organisational learning, but it is worth addressing the extent to which these two tools are used effectively by Coroners.

In Section 7.6, we highlighted how recipients may perceive a Rule 43 report as a punishment while the tone of the Coroner is more likely to be neutral or focus on learning. It is evident therefore that much could be done to improve the mental model of Rule 43 reports as positive learning opportunities. It is important to address this because where an individual's mental model persistently provokes negative feelings; it is less likely that learning will take place as the recipient may avoid the mental exertion of tackling the issue.

It is difficult for Coroners to have a significant impact on the recipient's mental model of the circumstances; a small but significant step would be for Coroners to acknowledge receipt of a response to a Rule 43 report. Several interviewees indicated disappointment that they heard nothing from the Coroner when they replied. It may seem trivial but it would help organisations to build a constructive relationship and dialogue with the Coroner.

Several interviewees also observed that the Corporate Manslaughter Act (2007)[26] may have a powerful influence on organisational behaviour.

Our focus is the role of Rule 43 reports so we have reflected on how Coroners may harness the influence of the Act.

Interviewed by the Guardian Newspaper, John Coppen, the Police Federation representative for Custody Sergeants, summed up how the Act may influence senior managers:

> ***"This will mean the people at the top who actually control the buildings and the budgets have to think about their responsibilities. In future if someone was to hang themselves from a ligature in a cell not only would the Custody Sergeant be questioned but the authorities would look at the way the building was designed, whether there were any obvious ligature points that had not been removed and the force could be held responsible."***[27]
>
> Quote 13

Coppen makes the same link between an incident and the design of the system that we have detailed throughout this report. As he points out, failure to attend to the design of the system may lead to prosecution. This may be extended to any failure to implement appropriate learning mechanisms.

It is also encouraging that within NOMS, Prison Service Instruction 64/2011 (replacing PSO 2700 Suicide and Self-Harm, PSO 2750 Violence Reduction, and PSO 2710 Follow up to Deaths in Custody from April 2012) there is an explicit statement that:

> ***"Prisons must have procedures in place to facilitate and disseminate learning from incidents of self harm, violence and deaths in custody to prevent future occurrences and improve local delivery of safer custody."***
>
> Quote 14

This provides Coroners with a carrot and a stick. If a Rule 43 report truly facilitates improvements to the system they are likely to be received more positively. Organisations that ignore a Rule 43 report that suggests modifications to the system leave themselves more exposed to potential prosecution.

7.10 Coroner capacity and capability

If we are to look at how a Rule 43 report may become an agent of change, we must look at the capability and capacity of Coroners.

Inspection of the reports written by Coroners leads us to conclude that they have little expertise in the tools of behavioural change. This is not surprising given that this forms just a small part of an extensive role and that they currently receive no training in this area.

The Coroners' Society in collaboration with the MoJ offers training in Rule 43 reports, which covers the circumstances in which the reports should be written and provision of a template to Coroners. Our inspection of reports suggests that a number of Coroners do make use of this and it has been helpful in ensuring that Coroners explain the context of the law correctly. However, this template does not touch on how to write a report for maximum effect.

Training designed and provided through the Coroners' Training Group is currently not obligatory and a number of Coroners have not taken up the opportunity to be trained in Rule 43 reports.

The Coroners and Justice Act 2009[28] can change this. The Act states that:

> *The Chief Coroner may, with the agreement of the Lord Chancellor, make regulations about the training of—*
> *(a)senior Coroners, area Coroners and assistant Coroners;*
> *(b)the Coroner for Treasure and Assistant Coroners for Treasure;*
> *(c)Coroners' officers and other staff assisting persons within paragraph (a) or (b).*
> *(2)The regulations may (in particular) make provision as to—*
> *(a)the kind of training to be undertaken;*
> *(b)the amount of training to be undertaken;*
> *(c)the frequency with which it is to be undertaken.*

We suggest that mandatory training could be provided to all Coroners that sets out when and how they might write a Rule 43 report with a view to maximising the chance of changing behaviour and instilling a learning culture across the custodial sectors. Mindful of the workload of Coroners, we anticipate that appropriate training could be achieved in less than two hours, and could be delivered on-line.

Online learning platforms are widely available and inexpensive to purchase and implement.

This would promote consistency about how and when to write a Rule 43 report. If individuals are concerned about their views being scrutinised and criticised as one interviewee suggested, providing training should allay some of these concerns and increase confidence amongst Coroners.

Such training should also cover the culture and governance arrangements of the custodial settings and other relevant organisations that investigate and regulate them. We read reports that indicated

that some Coroners are unaware, for example, of the structure of government departments. For example, letters were addressed to the Home Secretary rather than the Lord Chancellor, NHS London rather than Department of Health. It appears that not all Coroners are aware of the remit of the Rule 43 report; in one instance the Coroner wrote about consideration as to whether an individual should be prosecuted rather than suggesting changes.

If the training focuses on the use of double-loop learning, cross-sector issues and evaluation, Coroners will also be less exposed to making suggestions that are inappropriate or reveal an ignorance of the cultural and political context of an organisation. For example, if they ask how the organisation receiving the report has ensured that the lessons learnt have been shared with other organisations they will encourage this issue to be looked at without prescribing how this is achieved.

7.11 Capacity and capability elsewhere in the system

The second group of individuals that would benefit from investment is more difficult to define, but equally important. It is evident that across the custodial sectors there are individuals who have been assigned the task of making custody safer. For example, in the case of prisons, there are individuals assigned to safer custody in each establishment and they meet regionally to share good practice. NOMS HQ has a group called Offender Safety, Rights and Responsibilities – which leads on policy and national safer custody management issues

Within the Police setting a focus may be placed on the Custody Officer.

Further research is needed before we can identify the equivalent individuals within mental health settings.

These individuals are likely to be influential early adopters of change. With limited resources available, this group provides a cost effective route towards sustained change.

There is little evidence that these individuals have been provided with development opportunities to improve their expertise in organisational learning and behaviour change.

As a framework for this, it strikes us that there is great opportunity for all sectors to learn from the sort of initiatives currently being implemented in parts of the NHS as detailed in section 5.8.

We suggest that organisations in the custodial sectors identify potential early adopters of change. This group should be provided with tools, advice and learning opportunities.

The IAP could identify and provide opportunities by which the group of early adopters come together to share issues and solutions.

7.12 Accountability, implementation and assurance

The issue of accountability arose repeatedly as we conducted our interviews and analysed reports.

Once a Rule 43 report is written, there is currently nobody responsible for judging whether or not the responses are appropriate and no consistent mechanism for establishing if the actions detailed in the responses have taken place. The issue of accountability stretches across the entire investigatory process following a death. We searched for accountability, with the Coroners, PPO, IPCC, CQC, NPIA, MoJ, NOMS, ACPO and DH. While all of these organisations are part of the system of accountability no organisation actually seeks to establish if the responses to a Rule 43 report are appropriate or if any actions have taken place as a consequence of the letter. Our conclusion is that nobody outside of the organisation where the death occurred takes responsibility for ensuring that a Rule 43 report has an impact.

An argument that was presented to us is that it is the responsibility of the individual organisation to deal with the issue appropriately and if they do not, and a similar death occurs where they have not taken the appropriate action, they may face criminal proceedings. As such it is not necessary to have anyone outside the organisation evaluate whether action has taken place. This argument presupposes that such a threat is enough to prompt action.

If left to the individual organisation, it is also very unlikely that effective intra-sector or cross-sector learning will take place as this would require individuals with oversight of the criminal justice system and mental health settings.

We suggest that responsibility for ensuring that Rule 43 reports are attended to could be assigned to a central body. The remit of this body would be to ensure that Rule 43 responses are appropriate and that actions are indeed being undertaken as described in the response. Any suggestions of additional work not already being undertaken must rightly be considered in the context of the current strain on resources. What we are advocating here is not an examination of every case. Even a small sample of a handful of cases would send a clear message that responses are being considered and the evaluation would facilitate learning both for the organisations receiving the report and the Coroners writing them.

Where should this responsibility lie? The two candidates that we have identified are the IAP and the Chief Coroner.

The IAP plays a significant role in promoting learning about death in custody but it currently neither has the remit nor the resource to take on a casework approach to individual deaths in custody. Significant investment and potential changes to legislation would be needed to enable it to take on this role.

As well as it being outside the scope of their rules, a compelling case against this responsibility resting with the Coroner is presented by Bridget Nolan in her report looking at hyponatraemia-related deaths[29].

> ***"It should not be or become the role of a Coroner to write policy or procedures for other organisations. Such matters are outside a Coroner's expertise and the decision as to whether action needs to be taken may depend on many factors of which the Coroner is wholly unaware."***
>
> Quote 15

It is reasonable to assume that Rule 43 reports were designed to be useful in reducing further deaths. Where they are deemed not to be, a dialogue between the Coroner and the recipient would improve learning from that case and increase the chances of the next report being useful. It is of note that a dialogue, either informal or formal, is not currently common practice. In the sample we inspected in only 3% of cases did a Coroner offer to engage in a dialogue and only 7% of recipients suggested a dialogue with the Coroner. Where dialogue does take place, recipients of Rule 43 reports deem it to be useful.

The Youth Justice Board attest to this view. They have adopted a proactive approach to inquests and now ensure that they provide sufficiently up to date evidence to Coroners about how policies have changed since the death. They believe that this has led to more targeted, appropriately pitched, Rule 43 report.

We therefore suggest that dialogue between recipients of Rule 43 reports and Coroners could be promoted to improve the understanding of the issue being reported and the quality of subsequent Rule 43 reports.

If dialogue can minimize the chance of inappropriate Rule 43 reports being written, the Coroner's view on the quality of the response is valid.

We therefore suggest that the Chief Coroner adopts the role of quality assuring reports and their responses.

The law currently requires that the recipient of a Rule 43 report responds within 56 days. The only sanction for non-compliance is that organisations are named in the 6-monthly report by the MoJ. Even with such a trivial sanction, organisations tend to comply and devote considerable resources

to responding to the report. The Chief Coroner could have a role in regularly looking at a sample of Rule 43 reports and the responses to identify missed opportunities for learning and to promote good practice across the coronial system.

This would be a useful quality assurance process that requires few resources and no changes to existing powers.

The issue of accountability raises the fundamental question of roles of the various stakeholders in the system.

Stakeholders such as NOMS, PPO, ACPO, MoJ, and DH all have different aims and concerns. While they might agree that the overall aim of reducing deaths in custody is a shared goal, given their differing agendas, it is unsurprising that the role of maximising the learning from Rule 43 reports has been to a large extent overlooked as individuals seek to achieve their own aims. Meanwhile, in the absence of a Chief Coroner there has been no clear steer to Coroners.

By providing the Coroner with powers to write a Rule 43 report, they have been afforded the role of an agent of change in the system. The finding that some Coroners never write Rule 43 reports suggests that not all Coroners are keen to exploit such a role.

It would be helpful, therefore, to clearly establish what is expected of the Coroner.

Room[30] sets out a framework that describes the different ways in which such an agent may interact with the system. While his model set out to describe complex system change in public policy, it is useful to consider it in relation to the role of each individual Coroner.

> Tuner – The Tuner attempts to "Steer the trajectory of the system" by continually encouraging adjustments towards a desired goal. While the ultimate goal may be clear, the exact path towards that goal will not be. The Tuner does not attempt to impose a specific solution or structure but does identify opportunities for moving the system towards or away from transitions points.
>
> Energiser – The Energiser attempts to enable the individuals in the system to self organise to improve the system. Rather than impose their preferred order they encourage, agitate and facilitate so that those involved in the system develop the capacity to self organise and identify their own vision of their preferred system.
>
> Steward – The Steward attempts to impose a structure and system that they consider the most appropriate. Stewards believe that the system will not self organise but that there must be an architect and builder of the system.

As the role of the Chief Coroner is established, its part as either the Energiser or Steward is likely to be influenced to some extent by the resources available to it: imposing a structure successfully requires significantly greater investment than enabling others in the system to self-organise. If the role of Energiser were to sit with the IAP, it would be important to establish how current aims and responsibilities overlap.

With regard to individual Coroners, we observe that the role of Tuner is the most appropriate. However, we suggest that the IAP raises in early conversation with the Chief Coroner the role of individual Coroners as agents of change. This in turn will go some way towards developing more consistency in the application of their powers and greater clarity for other constituents of the system.

In considering these different roles it should be noted that the clear implication is that the complexity of the system means that it is unrealistic to expect that any one agent can have complete control over the system. Actions and interventions will produce unexpected results but that does not mean that the agents of change will have no impact. Nor does it mean that any one intervention is without value.

7.13 Cross-sector learning

One of the primary objectives of this research was to establish the extent to which cross sector learning is taking place.

Our analysis of the responses to Rule 43 reports found only one case where there was evidence of implementation of shared learning across sectors:

> ***"You will have noted in this letter that I have asked for your permission to share all of these documents with the NPIA and I have asked you to remit some issue to the Ministry of Justice. I am also content for this report to be made public. The enforced silence up to and during the inquest has left the impression in the mind of some commentators that XXX Police have been defensive heartless and oblivious to the lessons to be learned following the tragic death of XXX."***
>
> Quote 16

In 10% of cases there was evidence of implementing shared learning across their own sector that is, for example, from one force to another or within the prison estate. Clearly much more could be done to facilitate learning across organisations and the sectors.

Interviewees consistently reported that they would only learn lessons from outside their sector by happenstance. Many interviewees reported that they were completely unaware of any learning or initiatives outside their own sector. Where there were instances of cross sector learning, this was on a regional basis where individuals from other sectors attended local meetings set up to share information.

Recently, however, Regional Safer Custody Groups, have been set up by NOMS and individuals from other sectors (e.g. NHS) are invited to their meetings. The group in the South West has been a particularly effective vehicle for sharing learning in the area.

It has also been reported that police forces are beginning to share lessons learned with other sectors by circulating their internal memos that address deaths in custody.

The role of the IAP in this respect should not be underestimated. Its annual conference brings together practitioners and stakeholders from across the sectors who share an interest in deaths in custody. Running such events or meetings more frequently with a specific group of stakeholders could have a significant effect on cross-sector learning and strengthen relationships.

The IAP could sponsor or facilitate the arrangement of regional meetings with custodial organisations to address cross sector learning from deaths in custody.

7.14 Sharing of Rule 43 reports

In addressing cross-sector learning, we must once more return to the issue of how information about Rule 43 reports is shared.

We have already discussed the need to create a database of information so that themes and issues can be identified across time and across sectors. We must now address the issue of who has access to this data.

The current situation is that interested parties such as the IPCC find it very difficult to gain access to Rule 43 reports. The IPCC reported that some Coroners send reports to police forces but not the IPCC and suggest that they are not a relevant interested party. Obtaining Rule 43 reports addressing issues in other sectors is even more problematic. This is addressed to some extent by developing a relationship with each Coroner but some Coroners state that the organisation is not an interested party and refuse to share a report.

The law currently states that the Coroner may decide who is an interested party as a Rule 43 report is issued.

We suggest that IAP identifies a group of cross sector organisations that it believes should always be considered interested parties from a learning perspective and should receive copies of all Rule 43 reports and responses relevant to their organisation.

There is considerable debate regarding how widely Rule 43 reports and responses should be shared. Some interviewees believe that the reports should be available to the public via a fully searchable website. Indeed some Coroners believe it is appropriate to publish each of their Rule 43 reports on their own website. Other interviewees suggested that the sensitivity of the information makes it inappropriate to share the information. The feelings of family members was/were cited as a reason not to publish the report but it is more often than not that the family are keen for lessons to be shared as widely as possible.

If a centrally held database is created we believe that making Rule 43 report information widely available would increase accountability and facilitate learning. Given the strong feeling among some Coroners regarding this issue, it would be inappropriate to suggest sharing reports with the public without undertaking a wider consultation.

We therefore suggest that the IAP consults Coroners and organisations that might be relevant interested parties in deaths in custody with a view to identifying the barriers to sharing Rule 43 reports and responses, and implementing a tool that makes the Rule 43 reports and responses available to the public.

8. Concluding comments

This report has placed a spotlight on the complex and challenging environment within which Rule 43 letters are written and responded to. This involves dedicated professionals across a wide range of sectors seeking to minimise the occurrence of deaths in custody. The beam of our spotlight was never going to be wide enough to shed light on the whole myriad of variables that contribute to a death in custody or its prevention.

What is clear to us, however, is that there is an opportunity to use the psychological evidence base to complement any initiatives to change the system or the law. In particular we have promoted the importance of influencing mental models so that actors in this complex system identify more opportunities to learn.

Among these opportunities is the possibility of promoting a Rule 43 report as a vehicle for learning rather than punishment and encouraging respondents to consider how a Rule 43 report can promote sustained learning rather than short term fixes.

Developing an effective learning culture within and across sectors to address death in custody requires tackling the issues on many fronts, and integrating learning points arising from all sources, such as investigations as well as inquests. We hope that the suggestions contained in this report enhance the chances that these initiatives will be a success.

9. References

[1] The role of the IAP http://iapdeathsincustody.independent.gov.uk/

[2] Independent Advisory Panel on Deaths in Custody Statistical Analysis of all recorded deaths of individuals detained in state custody between 1 January 2000 and 31 December 2010http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/10/IAP-Statistical-Analysis-of-All-Recorded-Deaths-in-State-Custody-Between-2000-and-2010.pdf

[3] Ministry of Justice Guidance for Coroners
http://www.justice.gov.uk/downloads/burials-and-Coroners/Coroners-reports-future-deaths.pdf

[4] Patton, M. (1990) Qualitative evaluation and research methods pp 169-186. Beverley Hills CA: Sage

[5] Ministry of Justice Guidance for Coroners
http://www.justice.gov.uk/downloads/burials-and-Coroners/Coroners-reports-future-deaths.pdf

[6] Reason, J. T. (1990). Human Error. Cambridge University Press

[7] Rasmussen, J. (1990) The role of error in organizing behaviour, Ergonomics, vol 33, pp 1185-99

[8] Fish, S., Munro, E. and Bairstow, S. (2008) Learning together to safeguard children: developing a multi-agency systems approach for case reviews, Social Care Institute for Excellence (SCIE)

[9] Argyris, C. (2002) Double-Loop Learning, Teaching and Research. Academy of Management Learning & Education Vol 1, No. 2, p206-218

[10] An organisation with a memory (2000) Chief Medical Officer, Chair,
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4065086.pdf

[11] Greenwood, J. (online 2003) The role of reflection in single and double loop learning, Journal of Advanced Nursing, vol 27, Issue 5 pp 1048-1053

[12] John, C., (2009) Becoming a Reflective Practitioner, Wiley-Blackwell

[13] Sheaff, R., Pilgrim, D. (2006) Can Learning organizations survive in the newer NHS? Implementation Science 1:27

[14] Sinfield, P., Donoghue, K., Horobin, A., Anderson, E.,(2012) Placing interprofessional learning at the heart of improving practice: the activities and achievements of CLAHRC in Leicestershire, Northamptonshire and Rutland. Quality in Primary Care Vol. 20 pp. 191-198

[15] Ericsson, K., Krampe, R., Tesch-Römer, C. (1993) The role of deliberate practice in the acquisition of expert performance., Psychological Review, Vol 100(3), pp 363-406

[16] Blickensderfer, E.L., Strally, S., Doherty, S., (2012) The Effects of Scenario-Based Training on Pilots' Use of an Emergency Whole-Plane Parachute. International Journal of Aviation Psychology, Vol. 22 Issue 2, p184-202

[17] Arvey, D., Icancevich, J., (1980) Punishment in Organizations: A Review, Propositions, and Research Suggestions, The Academy of Management Review, Vol. 5, No. 1, 123-132

[18] Vincent, C. (2006) Patient Safety, London: Elsevier

[19] Ministry of Justice Guidance for Coroners
http://www.justice.gov.uk/downloads/burials-and-Coroners/Coroners-reports-future-deaths.pdf

[20] Fundamental Review of Death Certification and Investigation, (2001–2003) Tom Luce CB, Chair, http://www.archive2.official-documents.co.uk/document/cm58/5831/5831.pdf

[21] Edwards v UK (2002) 35 EHRR 19

[22] R v HM Coroner for the Western District of Somerset ex parte Middleton (2004) UKHL 10

[23] Claridge, T., Cook, G., Hale, R. (2008) Organizational learning and patient safety in the NHS: an exploration of the organizational learning that occurs following a Coroner's report under Rule 43, Clinical Risk 14: 8-13

[24] MoJ Summary of Coroners Reports to Prevent Future Deaths. http://www.justice.gov.uk/downloads/publications/moj/summary-rule-43.pdf

[25] MoJ Press release http://www.justice.gov.uk/news/press-releases/MoJ/newsrelease010112

[26] Corporate Manslaughter Act. http://www.legislation.gov.uk/ukpga/2007/19/pdfs/ukpga_20070019_en.pdf
http://www.nio.gov.uk/corp_mans_leaflet_web_revised.pdf_9_oct_07-3.pdf

[27] Guardian, 28 August 2011 John Coppen article http://www.guardian.co.uk/uk/2011/aug/28/corporate-homicide-law-prison-police

[28] Coroners and Justice Act 2009 http://www.legislation.gov.uk/ukpga/2009/25/contents

[29] Dolan, B., (2011) Report to the Inquiry into Hyponatraemia-Related Deaths, http://www.ihrdni.org/dolan-report-19-04-11.pdf

[30] Room, G., (2011) Complexity, Institutions and Public Policy, Cheltenham, UK: Edward Elgar

Appendix 1

Areas covered in research interview

- Clarify their role and responsibilities in the context of Rule 43 reports/narrative verdicts
- Ask for their general views on the topic; what do they think about what we're being asked to do
- Do they know what a rule 43 is/has it been shared with them
- Explore their response to the Rule 43 report (where appropriate).
- Are there action plans in respect of deaths and post investigation and inquest findings/are these revised/audited etc
- What do they think needs to be changed if anything? Why?
- What is the process by which information/a report is shared in the organisation/sector/between sectors thereby leading to new understanding?
- How is the information stored for future use?
- How does that knowledge flow around the organisation/sector/between sectors? Who has access to it?
- What monitoring, if any, takes place?
- What support structures are in place to facilitate learning in the organisation/sector/between sectors (Technology, training, skill development etc)? How effective are these?
- What is the process by which distributed information is given one or more commonly understood interpretations? (i.e. How is the report translated into practical, concrete activity)
- What is the process by which the learning is actively implemented rather than simply left to be taken up by staff?
- In the context of implementing learning, what has worked / not worked in the past and why?
- What value does the organisation/sectors impart on the learning? How does that manifest itself?
- What value do the organisations/sectors put on input of individuals in the learning process?
- What attitudes do individuals have as a result of the verdicts?
- What is the understanding of the issues as a result of the communication of the verdict in the organisation/sector/between sectors?
- What behavioural changes have taken place as a result of the communication of the verdict? How has performance changed following the communication of the verdict?
- How does management enable time for learning and reflection in the organisation/sector/between sectors?
- How are organizational boundaries broken down to enable learning?

Appendix 2

How do organisations respond to a Rule 43 Report?

The descriptions detailed here cover only how organisations respond to Rule 43 reports and not learning from other investigations – unless this is integrated with responses to Rule 43 reports. [Note that processes for the Youth Justice Board and UKBA have not been covered because our sample contained no such cases.]

1.1 How NOMS typically responds to a Rule 43 report about a death in prison

A Coroner will typically send a Rule 43 report to the establishment where the death occurred, although Coroners do on occasion send a report directly to NOMS. As with cases across the different sectors, it should be noted that the letter will be received after internal and PPO investigations have taken place. In rare circumstances, the inquest may take place before the PPO report has been issued but in any case the establishment will already have been examining what happened and whether anything needs to change.

Rule 43 reports are usually addressed to the Governor of the establishment. The report is typically forwarded to NOMS where a central team responds to it. The role of the team at NOMS is to fulfil the statutory requirement of responding to the report in 56 days. The role of this team is not to implement or facilitate learning although they work closely with the National Safer Custody Managers and Learning Team, with whom they discuss relevant learning. There is scope for improved integration of these functions, which we address in the main body of the report.

The team responding to the Rule 43 report will gather information they believe is necessary to respond to the report. This may include gathering information from the establishment where the death occurred, although not always. For example, if a Coroner reports on an issue which NOMS believes is already covered in a national policy; they will provide information about the policy. The response to the Coroner is in the form of a letter. We found no evidence that NOMS attempt to liaise with the Coroner in the process of writing the response. If the content of the Coroner's report is not clear, NOMS will seek to provide an answer that it believes best addresses the issue.

When input is needed from the establishment, NOMS will contact the Governor of the establishment who will delegate responsibility to someone in the prison. This individual provides details of how the organisation is addressing the issues highlighted in the report. This might include providing action plans but will typically be in the form of a letter or telephone conversation to gather the information needed to respond. NOMS keep records of electronic transactions regarding Rule 43 reports and responses.We were unable to gather any evidence of any member of the NOMS team visiting establishments, or of seeking to establish whether the activities identified took place. The responsibility for this rests with the establishment where the death occurred. However, there is significant activity in the National Safer Custody Managers team, to look at key issues arising from early reports of deaths and PPO investigations and to work with individual prisons on implementation of action plans. Within each establishment, individuals are assigned to addressing safer custody and implementing recommendations from other investigations (i.e. PPO). Typically it will be these individuals who contribute to a response. These individuals meet regionally and share information about Rule 43 reports.

The National Safer Custody Managers team are the interface between NOMS headquarters, safer custody teams and regional offices. They make sure policies are fulfilled and learning is shared/acted on. They do this through one day national learning events three times per year which are usually themed. They ask Governors to nominate staff to attend and invite other stakeholders (for example, UKBA and HMIP). At these events they explain why policies have changed. The aim is to have national discussions and share national learning.

The National Safer Custody Managers team also send out Quick Time Learning Bulletins. These bulletins are sent out to all staff, Safer Custody Leads, and the Coroners' Society, amongst others. They typically receive a large amount of feedback to these bulletins.

Regional Safer custody meetings are also held quarterly by the National Safer Custody Managers Team. They are held in each region and attended by each prison, the Operations Manager from the regional office, and normally a guest speaker. Sometimes Coroners attend. In these meetings the team checks that the QuickTime Learning Bulletins are being distributed and have been posted, and they ask the Safer Custody Leads what they want to see in future. The team typically receives a large amount of feedback from the prisons but not from the wider stakeholder group.

When considered appropriate, responding to Rule 43 reports will include discussions with individuals responsible for national policy in a range of teams in NOMS headquarters.

Any policy changes that need to be conveyed to establishments will be issued using formal mechanisms and publication of a revised Prison Service Instruction. Thematic issues arising from deaths in custody – which are mainly drawn from PPO investigations and the NCSM team observations – are also communicated to practitioners through Quick Time Learning Bulletins. These are the chief mechanism by which information flows around the system and is available for future use. The local safer custody leads are usually responsible for local implementation.

Some Coroners copy Rule 43 reports to HMIP. HMIP sometimes receives them from the MoJ Coroners Policy team. HMIP has started to undertake analysis to identify themes and patterns in Rule 43 reports and NOMS responses. Themes are used to inform the inspection criteria for specific prisons. The Chief Inspector is briefed on these themes at the end of the year.

HMIP report difficulties with accessing Rule 43 reports, and particularly the responses from NOMS. NOMS has apparently informed HMIP that Data Protection issues prevent this.

In summary, our research established that the primary focus of a response to a Rule 43 report within NOMS is ensuring that the statutory obligation of replying in 56 days is adhered to. The focus is not upon attempting to influence learning specifically as a result of Rule 43 reports although there is significant activity on learning from deaths in general.

1.2 How police forces and ACPO typically responds to a Rule 43 report about a death in or following police custody

A Coroner will typically send a Rule 43 report to the Chief Constable responsible for the force where the death occurred and to the Association of Chief Police Officers (ACPO). As with cases in other sectors, it should be noted that the Rule 43 report would be received after other investigations have already taken place, particularly by the IPCC. In rare circumstance, the IPCC report may not have been issued by the time of the inquest. In any case, the force will already have been examining what happened and whether anything needs to change through its own internal investigation(s).

In the forces we interviewed, the Chief Constable's office typically took the lead on providing a Rule 43 response to the Coroner. On occasion, the Chief Constable asked for a meeting with the Coroner to discuss the Rule 43 report and their satisfaction with the response but our research indicates that this is the exception rather than the rule. The response will take into account what was put in place to remedy the shortcomings that led to the death before the inquest.

We found evidence of good practice in police forces where a number of measures were put in place in response to a death in custody. It should be noted that these were in response to the death, not the Rule 43 report.

For example, 'dip sampling' has been undertaken to help monitor that actions following a death in custody have had the desired effect. This dip sampling involves sampling custody records and cross-referencing these with CCTV footage. Press cuttings have also been distributed within a force to show the impact of their actions on public perception. 'Thematic visits' have also been put in place which involve police officers and the constabulary's Professional Standards department checking that procedures are being followed. We found evidence of double-loop learning in the encouragement of officers to provide 'in-the-moment' feedback on how well procedures are working with a view to improving these. Through an analysis of trends, it was also found that some basic

issues were not being attended to. These issues were then traced back to the nature of the training being offered. The training was subsequently modified, placing more emphasis on examples to help drive home key messages. Finally, 'near miss' reporting and the use of Independent Custody Visitors i.e. lay people have both proved to be useful learning mechanisms from a monitoring and checking perspective.

It is not always the case that the ACPO Custody and Movement of Prisoners lead will be sighted on Rule 43 report actions and it is usual for the individual Force involved to action any requirements. It is only when the Coroner specifically requires a comment or action from the ACPO Custody lead that the 'national' aspect comes in. On receipt of a Rule 43 report ACPO contacts the relevant forces for their input before responding to the Rule 43 report. A response is not always received from the force, in which case ACPO formulates its own response to the Coroner without the force's input. The response to the Coroner is in the form of a letter. ACPO also copies Rule 43 reports to the relevant force when they do not seem to have been copied by the Coroner. While ACPO will ensure that a Rule 43 report is responded to, there is a lack of clarity as to what the official process for the sending of and responding to Rule 43 reports is. ACPO deals with and responds to cases involving the interpretation of Safer Detention and Handling of Persons in Custody Guidance. ACPO consults with the National Police Improvement Agency (NPIA) in some cases and see it as NPIA's role to share learning from a particular case nationally. NPIA were not available to be interviewed and so no comment is made on their contribution/actions in response to Rule 43 reports. Responses to Rule 43 reports from ACPO often describe actions taken. ACPO attach documents referring to current or proposed guidelines for staff to their responses. ACPO keep records of electronic and paper transactions regarding Rule 43 reports. ACPO do not analyze Rule 43 reports they receive to identify themes arising from them, although learning from specific cases might be raised by ACPO at the National Custody Forum which is held quarterly. The ACPO lead for Custody changed in June 2012 – the previous lead ensured that the National Custody Forum would discuss any relevant and key Rule 43 reports. The regional leads would be expected to cascade the learning points to the forces in their regions. Learning is promulgated by way of a letter/guidance to ACPO members and/or via NPIA who may amend guidance or add to training packages to develop this as 'learning the lessons'.

HMIP and HMIC conduct joint inspections of police custody, although these are led by HMIP. Rule 43 reports may be copied to HMIP by the Coroner. When HMIP receive Rule 43 reports regarding police custody, they send them on to HMIC. No analysis is conducted on these reports by HMIC, although they are used to check that the inspection criteria already covers the areas raised in the reports, and they provide reassurance for evidence triangulation purposes. No reference is explicitly made to Rule 43 reports in inspection reports.

The implications of this approach are addressed in the main body of this report.

1.3 How the Department of Health and Trusts typically responds to a Rule 43 report about a death of a detained patient

We found no evidence that the Department of Health (DH) or Trusts classify or process Rule 43 reports pertaining to deaths in custody differently to other Rule 43 reports they receive.

A Coroner will typically send a Rule 43 report to the Secretary of State for Health. The Secretary of State for Health will then forward the report to the DH policy unit to manage the response. The Secretary of State for Health may also require DH officials to provide the Coroner with on-going updates of action being taken in regard to issue(s) raised by a death.

Depending on the issues raised, the Rule 43 report may also be copied to the respective NHS Trust or associated bodies. Those taking responsibility for Rule 43 responses at the Trust level vary – some are led by the Head of Patient advice and Liaison Service (PALS). If a Rule 43 report is received by a Trust, they inform CQC and Monitor. Associated bodies to which a Rule 43 report might be forwarded include the Nursing and Midwifery Council (NMC).

If a Rule 43 report goes to both the DH policy unit and the Trust where the death occurred, separate responses would be submitted to the Coroner. Although both parties may be in communication with

each other prior to a response being sent, we found no evidence that co-ordinated responses were submitted.

Depending on the issues raised by the Rule 43 report, the DH policy unit may choose to involve a range of stakeholders to help in the formulation of its response. Examples included the Royal College of Nursing, Royal College of Psychiatrists, Chief Nursing Officer and National Patient Safety Agency (NPSA), Care Quality Commission, and organisations employing medical specialists. Communication with these stakeholders will be conducted on both a formal or informal basis depending on the information and advice being sought.

Although we are not aware of dedicated DH policy unit resources being tasked with identifying trends in Rule 43 report findings, such trends are nonetheless observed and action taken as a result. Similarly, a Rule 43 report may form another piece of evidence amongst many that help formulate the case for change in a specific policy area.

Although there is no requirement for them to do so, some professional bodies e.g. Royal College of Physicians, who have an interest in the issues raised by the Rule 43 report, may choose to keep the Coroner updated with changes in practice that are being put in place.

To ensure that action is taken and learning takes place, deaths of detained patients and other serious incidents are reported to Strategic Health Authorities and the steps outlined by the National Patient Safety Agency (NPSA) guidance on investigations should be followed.

Patients Safety Boards are also in place to help ensure that learning takes place following serious incidents. The NPSA holds a database of local incidents that have been referred to them. Part of this agency's remit is to identify trends in serious incidents and report these back to respective NHS Trusts and other institutions.

The NPSA has also developed a national framework for serious incidents in the NHS. This framework is a step towards developing a consolidated Serious Incident Management System and to help standardise procedures and promote learning across the healthcare system.

NHS Trusts are also required to report serious incidents to the Care Quality Commission, whose role is as regulator, and for monitoring implementation of the Mental Health Act. There is a statutory requirement for all Trusts to report deaths of detained patients.

Actions taken by the DH policy team as a result of receiving a Rule 43 report might include an instruction to cascade relevant information to NHS Trusts. This cascade of information may be used to reaffirm existing DH policy at a national level. It is less likely that a Rule 43 report will lead to the generation of new DH policies or to the amendment to existing DH policies.

Where the communication of information is an action identified and prompted by a Rule 43 report, pre-existing communication channels are identified and utilised.

A Coroner's Rule 43 report recommendations may be challenged in cases where it is felt that actions have already been put in place following a death in custody. These actions that have already taken place will be described in the Rule 43 report response as a means of reassuring the Coroner.

Mendas Ltd
Brownlow House 50-51 High Holborn
London WC1V 6ER

t: 020 7611 0860

enquiries@mendas.com www.mendas.com