Independent Advisory Panel on Deaths in Custody
The Royal College of Nursing

Avoidable natural deaths in prison custody: putting things right

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About the Independent Advisory Panel on Deaths in Custody

The Ministerial Council on Deaths in Custody

Executive summary

This briefing paper presents the conclusions of an initiative by the Independent Advisory Panel on Deaths in Custody (IAP) and the Royal College of Nursing (RCN) to identify how natural deaths in prison might be prevented, where possible, and end of life care managed with dignity and compassion. These findings are especially relevant as prisons and prison

Introduction and background

1. **The number of natural (i.e. not self-inflicted or homicide) deaths in prison has risen rapidly.** In ten years, numbers have increased from 103 in the year up to June 2009 to 165 in the year up to June 2019, with a high of 195 in the year up to June 2017.[1] Deaths in the 2020 calendar year could be the highest yet, partly due to the challenges presented by the COVID-19 pandemic. Questions arise: are any of these deaths, classified as natural, avoidable? And, if so, what can be done to prevent or reduce natural deaths in custody?

   Table 1: [2]

	June 2009	June 2010	

cause of natural death in prison is disease of the circulatory system (43%) followed by neoplasms (cancer) (32%).[6]

5. **The prison population is getting older**. As of April 2020, there were around 13,700 prisoners over the age of 50 in England and Wales, compared to around 4,800 in 2002.[7] This is partly due to a shift towards longer custodial sentences and an increase in the imprisonment of individuals for historic sex offences. Future changes to sentence lengths, including the proposed increases to the number of offences eligible for life tariffs suggested as part of the new White Paper on sentencing, will have further implications on the age profile and health needs of the prison population.

6. Recognising this, the Justice Select Committee this year relaunched an inquiry into the ageing prison population to establish the specific needs of older prisoners and to make clear recommendations on how they might be cared for. This inquiry reported in July 2020.[8]

7. **However, the high number of natural deaths in prison is not just a reflection of an ageing prison population.** PPO investigations show that 39% of such deaths were of people aged between 35 and 54. The average age of someone dying in custody is just 56 years-old, a significant contrast to almost 81 in the general population.[9]

Table 2: Percentage of prisoner natural cause deaths by age group, England and Wales.

9. A key issue concerns , with the quality of care received closely dependent on age and sentence length. The PPO have found that care is particularly poor for the youngest age groups (15-34 years), with just over half receiving equivalent care compared to that received in the community. It found that 71% of people with physical health conditions who had been in custody for ten years or more had care plans in place, compared with 58% of people who had been in custody for less than twelve months. Overall, only 36% of prisoners received a proper and timely investigation of their symptoms.

10. While the number and proportion of 'natural' deaths that occur in prison is no higher for women than for men, there are different **issues specific to women** and research from the male estate cannot simply be applied to the women's estate. To take just one example: the incidence of cervical cancer is higher for women in prison than for women in the community and they are less likely to have had cervical screening. Guiding principles and standards are set out in 'Gender Specific Standards to Improve Health and Wellbeing for Women in Prison in England'.[11] These should be followed.

11. There is not a disproportionally higher number of natural deaths occurring within the **Black and minority ethnic (BAME) population** in prisons, though specific consideration must be given to the characteristics and needs of this particular group. BAME groups are disadvantaged in their access to healthcare within prisons. The Lammy Review found that BAME individuals experience differential treatment compared to their peers across the prison estate and that BAME men and women report poorer relationships with prison staff.[12] Prisoners from BAME groups are less likely to report ill health and access services and support, because of distrust of services among BAME individuals and a culture of disbelief from healthcare professionals which has sometimes resulted in missed opportunities to identify instances of ill health.[13]

Recommendation: Conduct an in-depth review of the characteristics of natural deaths in and others with protected characteristics and make specific amendments where appropriate.

Towards sustainable solutions

12. This paper presents the conclusions of an initiative by the Independent Advisory Panel on Deaths in Custody (IAP) and the Royal College of Nursing (RCN) to identify **how such**

[11] Public Health England, Gender Specific Standards to Improve Health and Wellbeing for Women in Prison in England. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/687146/Gender_specific_standards_for_women_in_prison_to_improve_health_and_wellbeing.pdf [Accessed 24 August 2020].

[12] Ministry of Justice, The Lammy Review: An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System. 2017. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643001/lammy-review-final-report.pdf [Accessed 7 July 2020]; Ministry of Justice. Black, Asian and Minority Ethnic disproportionality in the Criminal Justice System in England and Wales (2016). Available at: https://www.gov.uk/government/publications/black-asian-and-minority-ethnicdisproportionality-in-the-criminal-justice-system-in-england-and-wales [Accessed 7 July 2020]

[13] Edgar, K. and Tsintsadze, K. Prison Reform Trust, Zahid Mubarek Trust, Tackling Discrimination in Prison: still not a fair response. 2017. Available at: http://www.prisonreformtrust.org.uk/Portals/0/Documents/Tackling%20discrimination.pdf [Accessed 7 July 2020].

deaths might be prevented, where possible, and end of life care managed with dignity and compassion. These findings are especially relevant as prisons and prison health

Recommendation: Develop extended , involving prisoners' families where possible, improving and sharing information in person escort records (PERS) and introducing prisoner 'medical passports' to facilitate a continuation of prescribing.

the need to implement the Quality and Outcomes Framework (QOF), equivalent to its use in the community.[20] Using evidence-based indicators developed by National Institute for Health and Care Excellence (NICE) guidelines, the framework financially rewards general practices which deliver interventions and achieve patient outcomes in accordance with QOF. A study examining QOF implementation in prisons by Dr. Nat Wright, Clinical Research Director at Spectrum Healthcare, found that none of the four prisons sampled had systems to implement the framework, meaning completion tended to be dependent upon an individual 'enthusiast'. High prisoner turnover, time pressures and lack of role legitimacy (i.e. staff not thinking it is their job) were highlighted as significant barriers to fulfilling QOF monitoring.[21]

Recommendation: Implement the across the prison estate, including employing administrators to update records and make summaries and Code diagnoses.

Recommendation: , including through developing:

- secondary care clinics in prisons in major specialities;
- an escort algorithm to prioritise outpatient visits and escorts;
- a contracted out service to conduct escorts as in the court service;
- a halt to, and clear policy guidance on, any unnecessary use of restraints; and
- a more comprehensive use of telemedicine where appropriate.

30. Concerns were raised about a lack of continuity of health care and poor multi-agency working on from prison. As detailed in the NHS England Long Term Plan, the 'RECONNECT: Care after custody' intervention aims to reduce inequalities in this vulnerable patient group by reconnecting this population to community health services, allowing them to take personal responsibility for their own healthcare needs.[24]

31. The delivery of healthcare in prison is already a joint approach between NHS England and HMPPS. However, delivering has its difficulties: one key issue is the efficiency of multi-disciplinary working, and despite theoretical guidance in place, in practice it is difficult to achieve.[25] A comprehensive care pathway should be evidence-based, include an audit cycle, and represent a joint approach between healthcare, prison and external health, social care and housing services with clear and specific guidance for staff and evidence-based healthcare toolkits suitable for all prison establishments.

Recommendation: Implement a across prison healthcare that is evidence based and applies a joint approach across all agencies, departments and services.

32. Prisons are primarily designed for, and traditionally inhabited by, young and able-bodied people. The increasing aging prison population brings with it several challenges including that prisoners:
    a. are frequently held in prisons which, even with reasonable adjustments, are unfit for their needs;
    b. have limited opportunities to remain active and productive if they cannot " no

and securely funded within commissioned services.[31]

38. A national strategy for the provision of care for older prisoners is required that incorporates environmental modifications, provision of appropriate work and leisure activities, and specialist services for dementia and palliative care.

Recommendation: Develop a joint health and justice for the criminal justice system. This should be integrated with local social care plans and provision.

39. The IAP have received a number of anecdotal reports of poor practice of healthcare staff ignoring **do-not-resuscitate decisions** (DNRs) for older terminally ill patients. There appears to be minimal guidance regarding the use of DNRs within the prison healthcare system which could explain the varying practices between prisons. Clear guidance should be developed so that all prison healthcare staff understand the appropriate circumstances to administer cardiopulmonary resuscitation (CPR) to

Ministry of Justice by the NHS show that between 2016 and 2019, 23% of these applications resulted in the prisoner being released on compassionate grounds. The most common disease in compassionate release applications was cancer, usually lung cancer. There have been applications for compassionate release in relation to prisoners who suffer from diseases such as Parkinson's, Alzheimer's and Dementia where death is not necessarily imminent but there is concern about whether prison is the most appropriate, or even suitable, place for the prisoner. There has also been a small number of examples of requests for individuals who are incapacitated due to injuries or self-harm received within the custodial setting. All applications in medical cases are accompanied by medical reports and PPCS will also seek independent medical advice on individual applications where appropriate. In addition, all applications take into account reports by the probation officers assigned to the case and the governor of the prison.

48. The most common reason for refusal is an unclear prognosis, or that death is unlikely to occur within three months. Other reasons for rejection include risk of reoffending or having a release management plan that lacks the care, support or safeguarding checks required. There is no central record made of applications rejected by prison governors under their delegated authority. Information is not available on the time taken to process applications.

49. Byock (2002) and Linder & Meyers (2007) found that prisoners often wish to spend their last days in the community and are often fearful of dying in prison.[35] Handtke et al (2016) found that many prisoners hold the belief that death in prison was not part of their sentence and that impending death should prompt release.[36]

50. Concerns have been raised about the **timeliness and transparency of the compassionate release process**. The PPO found that compassionate release was considered in just 36% of the 314 natural deaths examined.[37] In 43% of these cases an application was still under consideration at the time of death. A prisoner wrote to the IAP:

> *lmate was a much-loved family man. I know this because he was illiterate so I had the job of reading his post to him. He was 67 when I met him - a retired farm labourer. He was suffering from terminal lung cancer and had a painful hernia. He was bedridden*
> *cellmate apply for early release on compassionate grounds. His request was (eventually) turned down. He was never told why at least in terms he could understand.*

51. **Data relating to compassion**

into the category of ‘medically vulnerable’ could apply for emergency temporary sionate release based on health need and safety considerations. It became clear e was limited data available on the number of people in prison who would have o be shielded had they been in the community. Estimates varied between 500 - isoners. Although applications were made, fewer than 60 people have been under this scheme which has proved difficult to administer. Instead it has been additional eligibility criteria and mired in bureaucracy. This has thrown into sharp ny of the gaps and anomalies of the current system for compassionate release.

dation: Review and overhaul the process of from make sure that it is clear, transparent, timely and fair.

Care

on estate has **limited provision for specialist long-term care** and end of life re, although the PPO noted that an increasing number of prisons are building care cells or units for prisoners who require specialist end-of-life care and a of prisoners have died in these specialist units.[38]

g the best possible end of life care in prison can be very complex. Not all prisoners inal chronic illness want compassionate release because they may have little in of social and support networks in the community, and find that their familiarity with nvironment, staff and fellow peers provides stability enabling the management of ss.

AP-RCN roundtable, Gill Scott, Macmillan Palliative Care Lead for North East presented the ‘Dying well in custody’ charter, an intended

.[39] The guidance outlines a set of clinical and operational s based upon best practice. This model should be established in all prisons, as palliative care is delivered on an ad-hoc basis. The need to maintain dignity and f life should be at the forefront of this approach! ╪ eme] le e

Recommendation: Implement the charter across prisons to maintain dignity, better support families and deliver uniform palliative care.

57. Prisons face problems with an **entrenched closed culture** resulting in difficulties instigating positive change, worsened by the current climate of resource limitations. Roundtable delegates highlighted an on-going lack of communication and mutual understanding between prison and NHS systems with disconnect between healthcare and wing staff.[42] One delegate explained that amongst some nursing staff there has been a development of a more security driven behaviours entwined with therapeutic attitudes. Discussion centred on the need for confident leadership from governors and healthcare managers, with an authoritative approach emphasising a 'collective ownership' for providing care.

Workforce and Training

58. Reduced along with retirement of experienced professionals are also contributing to care needs not being met. The number of prison officers leaving the service increased from 596 in 2015/2016 to 1,244 between March 2017-2018.[43] Possible solutions included input from external services to reduce the pressure on prison staff including outsourcing prison escorts to hospital appointments to contracted private companies and utilising out of hours GP services with n the

explored including a leadership academy, with courses delivered by trainers with real-life experience, which would support staff to develop confidence. Building on this it was suggested a 'skills lab' should be developed to allow individuals to practice their skills.[45]

62. Wider nursing workforce plans should be based on a robust , including in prison settings to provide safer and more effective care.

Recommendation: Raise the profile of as a career. Encourage student placements and rotational training schemes across disciplines. Streamline security clearance arrangements. Develop a forensic training academy and skills lab. Establish prison medicine as a sub-speciality.

63. Delegates to the IAP-RCN roundtable indicated that the process of review following deaths and dissemination of findings was . Good models of practice should be shared across establishments and workshops should be run involving Prisons and Probation Ombudsman staff, prison governors and healthcare managers to ensure that often repeated recommendations are considered with solutions found and actioned.

64. The charity INQUEST, which contributed to the IAP's roundtable, has repeatedly highlighted the urgent need to improve standards of investigations and to ensure recommendations made after a death are implemented.[46] Supported by the IAP, INQUEST has called for a national oversight mechanism to monitor the implementation of official recommendations arising from post-death investigations.

Recommendation: Convene regular standing meetings between the PPO %

		7. Develop a joint health and justice for the criminal justice system. This should be integrated with local social care plans and provision.	MoJ, HMPPS, DHSC	IAP, inspectorates, researchers
		8. Develop a across the prison estate including making all prisons dementia friendly, with clear signage, well-lit areas preferably with as much natural light as possible, and consistently plain and levelled flooring.	MoJ, HMPPS, NHS	Dementia Action Alliance, DeCIsion
4		9. Reassess the policy on and their use within the prison healthcare system to make clear at what time and in which situations it is appropriate to administer CPR.	NHSE, HMPPS	
		10. Review and overhaul the process of from custody to make sure that it is clear, transparent, timely and fair.	MoJ, NHSE	IAP, PPO
		11. and for people on release from custody with a view to establishing minimum standards, sharing good practice and identifying poor or unacceptable performance under the Act.	DHSC, NHSE	CQC, ADASS
		12. Implement the charter across prisons to maintain dignity, better support families and deliver uniform palliative care.	NHSE, HMPPS	Macmillan Palliative Care

15. **Imhe[illegible]re**

Appendix: Delegates, RCN-IAP roundtable

Andrea Albutt