

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 formally commenced operation on 1 April 2009 and is jointly sponsored by the Ministry of Justice, the Department of Health and Social Care and the Home Office. The Council consists of three tiers:

- Ministerial Board on Deaths in Custody
- Independent Advisory Panel (IAP)
- Practitioner and Stakeholder Group

The remit of the IAP (and overall of the Council) covers deaths, natural and self-inflicted, which occur in prisons, in or following police custody, immigration detention, the deaths of residents of approved premises and the deaths of those detained under the Mental Health Act (MHA) in hospital. The principles and lessons learned as part of this work also apply to the deaths of those detained under the Mental Capacity Act in hospital.

The role of the IAP, a non-departmental public body, is to provide independent advice and expertise to Ministers, senior officials and the Ministerial Board. It provides guidance on policy and best practice across sectors and makes recommendations to Ministers and operational services. It assists Ministers to meet their human rights obligations to protect life. The IAP's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

Juliet Lyon CBE chairs the IAP. Further information on the IAP can be found on its website: <https://www.iapondeathsincustody.org/>. For more information on this paper – or on the IAP more generally - please contact: Piers Barber, Head of Secretariat (Piers.barber1@justice.gov.uk).

About the Royal College of Nursing

The Royal College of Nursing (RCN) is the world's largest nursing union and professional body. It represents more than 450,000 nurses, student nurses, midwives and nursing support workers in the UK and internationally. It is both a professional body, carrying out work on nursing standards, education and practice, and a trade union.

The RCN's members work in a range of health care specialties and settings in the NHS and independent sectors. It also has members based overseas, and members who are retired. Around 35,000 nursing students are members.

The RCN is governed by an elected Council of 17 members, chaired by Sue Warner, which delegates the running and management of the organisation to our Chief Executive & General Secretary, Donna Kinnair. Its President, Anne Marie Rafferty, is a member of RCN Council.

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 healthcare enter recovery from, and assess the impact of, the immense challenges of the COVID-19 pandemic.

Drawing together insights from an extensive expert roundtable, prisoner consultation and wider research, the analysis in this paper covers primary care and chronic disease management, care of older prisoners, dementia care, social care provision, compassionate release, palliative care, culture, workforce and training.

The IAP and RCN make 15 recommendations, detailed in full from page 19 and grouped into the following categories:

- Improve join-up and information sharing across services and departments
- Implement improvements to primary and secondary care
- Take steps to improve provision and care for specific vulnerable groups
- Improve end of life care across the prison estate
- Enhance the profile of prison healthcare as a career
- Improve learning and investigations

The IAP and RCN recognise the cross-department and agency nature of prison health partnership working, and how this brings both opportunity and challenge. The IAP and RCN will continue to support the delivery, and monitor the implementation of, recommendations made in this report in collaboration with roundtable contributors, other partners, and department and agency leads.

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: Annual prisoner 'natural deaths'²

	June 2009	June 2010	June 2011	June 2012	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018	June 2019
Male	100	110	116	131	113	125	146	187	189	170	160
Female	3	4	4	2	5	7	4	3	6	6	5
Both	103	114	120	133	118	132	150	190	195	176	165

Table 2: Natural deaths and rates per 1000 prisoners for males and females³

	June 2009	June 2010	June 2011	June 2012	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018	June 2019
Male	1.3	1.4	1.4	1.6	1.4	1.5	1.8	2.3	2.3	2.1	2.0
Female	0.7	0.9	1.0	0.5	1.3	1.8	1.0	0.8	1.5	1.5	1.3
Both	1.2	1.3	1.4	1.5	1.4	1.6	1.8	2.2	2.3	2.1	2.0

2. 'Natural cause deaths' are defined by HM Prison and Probation Service (HMPPS) as including "any death of a person as a result of a naturally occurring disease process".⁴
3. **Even though the death may be classed as naturally occurring, investigations by the Prisons and Probation Ombudsman (PPO) and Coroners have revealed that, in some cases, these deaths could have been prevented.** The charity INQUEST has called these types of deaths "far from natural" arguing that they are often premature and avoidable deaths as they stem from a lapse in care.⁵
4. The PPO also categorises 'other non-natural' deaths, in which illicit drugs were thought to be a contributory factor. By 2019 the total 'natural and other natural' deaths per year increased to 231, more than double the 2009 figure. According to the PPO, the leading

¹ Ministry of Justice. Safety in Custody Statistics. Available from: <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-june-2019> [Accessed 11 June 2020]. The number of natural deaths in the 12 months to June 2020 is 179, see https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/905064/safety-in-custody-q1-2020.pdf [Accessed 24 September 2020].

² *Ibid.*

³ *Ibid.*

⁴ Ministry of Justice. Guide to Safety in Custody Statistics: Statistics bulletin. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/843122/safety-custody-statistics-guide-october-2019.pdf [Accessed 24 September 2020].

⁵ INQUEST. INQUEST responds to 'disturbing' statistics on deaths of people in prison and after release. Available from: <https://www.inquest.org.uk/moj-stats-oct2019>. [Accessed 3 February 2020].

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.*¹⁰

Age Group	Natural Cause Deaths	Percentage of total
15-24 years	7	2%
25-34 years	19	5%
35-44 years	63	16%
45-54 years	92	23%
55-64 years	93	23%
65-74 years	97	24%
75-84 years	28	7%
85 years and over	3	1%

8. The increase in natural deaths in custody in the last decade and the spread of deaths across a range of age groups challenges a common assumption that natural deaths only occur in people over 60 years of age and that deaths among this group are to be expected. Instead, evidence suggests that many of these deaths are preventable.

⁶ Prisons and Probation Ombudsman. Learning from PPO investigations: Natural cause deaths in prison custody 2007-2010. Available from:

http://www.ppo.gov.uk/app/uploads/2014/07/learning_from_ppo_investigations-natural_cause_deaths_in_prison_custody.pdf [Accessed 3 February 2020].

⁷ Ministry of Justice. Offender Management Statistics. Available from:

<https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-january-to-march-2020--2>. [Accessed 24 September 2020].

⁸ House of Commons Justice Committee. Ageing prison population, Fifth Report of Session 2019–21. Available from: <https://committees.parliament.uk/publications/2149/documents/19996/default/> [Accessed 24th August 2020].

⁹ IAP-RCN roundtable: can we prevent natural deaths in prison?. 18 November 2019; Prisons and Probation Ombudsman. Learning from PPO investigations: Natural cause deaths in prison custody 2007-2010. Available from:

http://www.ppo.gov.uk/app/uploads/2014/07/learning_from_ppo_investigations-natural_cause_deaths_in_prison_custody.pdf [Accessed 3 February 2020].

¹⁰ *Ibid.*

9. A key issue concerns **prisoner healthcare**, 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 disproportionately 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 **women, BAME individuals** 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-ethnic-disproportionality-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].

natural' 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 healthcare confront the impact of the COVID-19 pandemic.

13. To reach conclusions on how natural deaths can be reduced and end of life care improved, the IAP and RCN:
 - a) convened a roundtable event to examine the scope for preventing natural (non self-inflicted or homicide) deaths in custody;
 - b) invited views from those in prison on how to prevent or reduce natural deaths in custody via a request in *Inside Time*, the national newspaper for prisoners and detainees (correspondence was received under confidential access); and
 - c) incorporated findings and other material, including investigations by the Prisons and Probation Ombudsman, casework by the charity INQUEST, and expert evidence, including from the IAP, given to the Health and Social Care select committee's inquiry into prison health in 2018.

14. The joint IAP and RCN roundtable, convened on 18 November 2019, brought together experts in the field – including academics, inspectors and regulators, and healthcare professionals (see Appendix) – with subsequent roundtable discussions to suggest solutions and interventions to prevent such deaths. Delegates were asked to consider particular themes related to the prevention, or reduction, of deaths in custody:
 - a. Models of Primary Care & Chronic Disease Management
 - b. Social Care & Older Prisoners
 - c. Palliative Care & Compassionate Release
 - d. Models of Primary Care & Chronic Disease Management

15. In line with the IAP's guiding principle to consult people in custody and their families wherever possible, in November 2019 Juliet Lyon, Chair of the IAP, wrote about the issue in *Inside Time* and invited responses to the question: 'how can we prevent or reduce natural deaths in custody?'.¹⁴ Concerns were raised about poor mental and physical health and vulnerability. The impact of the prison environment itself was criticised:

'For most prisoners the combination of poor diet, psychological stress and inactivity results in their leaving prison in a dangerously degraded physical and mental condition'.

'If we are unable to walk to healthcare we can be neglected... Often prisoners with serious medical needs have to rely on other inmates for things like diabetes injections.'

16. Some respondents gave examples of good care. One man wrote:

'Please don't get misled by tales of the many failures of care you will receive from this side of the wire. My experience is that the intense observation, necessary to maintain prison security, saves lives, albeit with a 'piss-poor' bedside manner. I have known several fellow inmates with chronic medical conditions including cancer that were first observed within prison. Some have died but far more have been successfully treated. I have known people who were found dead in their cells, but far more people whose lives have been saved by staff trained to apply CPR.'

17. Combined, the initiative has produced 15 clear recommendations summarised in the conclusion to this document.

¹⁴ Juliet Lyon CBE. Can we prevent natural deaths in prison? *Inside Time*, November 2019. Available from: <https://insidetime.org/can-we-prevent-natural-deaths-in-prison/> [accessed 24 September 2020].

Primary Care and Chronic Disease Management

18. While there is clear evidence of some good practice across the prison estate, the Health and Social Care Committee inquiry into prison healthcare found a number of failings in the quality of care provided by NHS England to prisoners in primary care and secondary care, including:
- a failure to recognise severity of illness and/or deteriorating conditions;
 - poor interdisciplinary working between doctors, nurses and pharmacists;
 - poor attention and adherence to NICE guidelines;
 - discharges to prison with insufficient instructions for effective and safe continuity of care; and
 - patients 'yo-yo' in and out of NHS care.¹⁵
19. **Comprehensive primary care pathways** are vital in reducing the number of preventable natural deaths in custody. According to Dr. Mary Piper, Chair of the RESTORE network, almost all deaths amongst those aged under 40 were avoidable, occurring as a consequence of a failure to recognise an acute medical emergency, either by failure to recognise severity of illness and/or a deteriorating situation. According to her study, problematic trends included:
- issues with inter-disciplinary working;
 - unclear guidance for nurses on how to assess acute symptoms such as chest pain, shortness of breath, headache and loss of consciousness; and
 - insufficient clarity of process whereby the primary health care team are alerted to prisoners' current health symptoms after they have been seen by a member of the nursing team.

Transition into prison

20. The care pathway should begin prior to custody with **efficient, rapid information exchange** between prison, police and courts with rationalisation of IT systems between the community and prison health so that staff have immediate access to community healthcare information. The NHS England Long Term Plan, published in January 2019, provides robust measures to improve digital services within the NHS for its colleagues and patients and details how this will be supported, which includes how this will be funded for the next five years.¹⁶ Where appropriate and with permission, information should be gathered from families, and other external agencies and proportionate information sharing between healthcare and discipline staff.
21. Prisoners should have immediate **access to their community medication** to ensure continuity of treatment. This could come in the form of a medical 'passport' – one copy of which should stay at all times with the prisoner and one with healthcare – containing a log of all conditions and medication prescribed. This would allow prisoner-patients to remain the priority amidst often complex prison and healthcare procedures, whilst also supporting information exchange should there be any emergencies allowing staff to be responsive.

¹⁵ House of Commons Health and Social Care Committee. Prison Health: Twelfth Report of Session 2017-19. Available from: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/963/963.pdf>. [Accessed 11 June 2020].

¹⁶ NHS England. The NHS Long Term Plan. Available from: <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf> [Accessed 20th February 2020].

Recommendation: Develop extended **health information sharing**, 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.

Screening, coding and information transfer

22. **Early identification** of health problems is essential to reducing deaths in custody. Screening and triage should be completed by qualified nurses with the adoption of NEWS (New Early Warning Scoring) to enhance clinical risk assessments and continued monitoring.¹⁷ NEWS is not currently widely used in prison-based assessments and when it is used there is often a lack of understanding of the tool and misapplication. It is widely used in general adult patient care as a detection and response tool to identify clinical deterioration. This tool could be properly and uniformly implemented to support the reduction of natural deaths in custody.
23. The **use of consistent coding systems** for use across prison healthcare departments would lead to practical and efficient implementation. Clinical coding systems are currently used in community settings to ensure standardisation of reporting and data transfer regarding a patient's illness and treatment plan.¹⁸ This would be dependent on colleagues being supported to have the correct resources to implement the national coding template.

Recommendation: Implement clinical coding systems across prison healthcare departments to ensure **standardisation of reporting and data transfer**.

Primary and Secondary Care

24. Problems remain with missed healthcare **appointments** and long waiting times for appointments. Some individuals do not attend their appointments due to fear of bullying. Others were not able to attend due to absence of staff escorts. There is often no follow-up to establish why people did not attend and to encourage future attendance. A recent Nuffield Trust report drawing on an analysis of 110,000 hospital records from 112 prisons in England found that four in 10 hospital appointments made for a prisoner were cancelled or missed in 2017-2018 – at an estimated £2 million cost to the NHS.¹⁹
25. Many prisons lack essential **equipment** or, have only limited access to equipment such as blood pressure or diabetes monitors. There is considerable variation between prisons. This could be standardised by appointing a dedicated individual to monitor and calibrate equipment in each establishment.
26. With regard to **long term conditions** (LTCs), delegates to the IAP's roundtable highlighted

¹⁷ NHS England. National Early Warning Score (NEWS) system. Available from: <https://www.england.nhs.uk/ourwork/clinical-policy/sepsis/nationalearlywarningscore/>. [Accessed 20 February 2020].

¹⁸ Watson, N. Guidelines in Practice. Using clinical coding systems to best effect in electronic records. Available from: <https://www.guidelinesinpractice.co.uk/using-clinical-coding-systems-to-best-effect-in-electronic-records/305085.article>. [Accessed 20 February 2020].

¹⁹ Nuffield Trust. Locked out? Prisoners' use of hospital care: Research Summary. 2020. Available from: <https://www.nuffieldtrust.org.uk/files/2020-02/prisoner-health-report-summary-web.pdf>. [Accessed 6 March 2020]

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 **Quality Outcomes Framework** across the prison estate, including employing administrators to update records and make summaries and Code diagnoses.

27. A better system is required for **escorting** people to hospital appointments. In many prisons a limited number of escorts leads to cancellation of many non-acute appointments, while there is also a lack of prison staff to accompany prisoner patients to external appointments. Solutions could include the development of a prioritisation system, where appropriate greater use of telemedicine, developed in some establishments during the pandemic, and more hospital secondary care specialists delivering clinics in prisons. Some thought that contracting out escorts as for court appearances would be a more cost effective, and less resource intensive, way of ensuring that there are appropriate staff numbers to support these external visits.²²
28. There is a pressing need to review and overhaul policy and practice in regard to the cruel and inappropriate **use of restraints**, from shackles to escort chains, when escorting, or supervising in hospital, people who are frail and seriously ill. Following an earlier report stating that there are: *'still too many cases of prisons unnecessarily and inhumanely shackling seriously and terminally ill prisoners – even to the point of death'*, the PPO confirmed that they are *'still seeing cases of restraints being used even when prisoners are seriously ill, immobile and, often, elderly'*. Healthcare staff have an important role to play in contributing meaningfully to risk assessment and advising on mobility and seriousness of any illness.²³
29. There is also a need to make better use of **'medical holds'** at establishments, to enable continuity of treatment. A medical hold can be requested if a prisoner is undergoing ongoing medical care which might be disturbed should they transfer to a different establishment.

²⁰ IAP-RCN roundtable: can we prevent natural deaths in prison?. 18 November 2019.; British Medical Association. Quality and Outcomes Framework. Available from: <https://www.bma.org.uk/advice-and-support/gp-practices/funding-and-contracts/quality-and-outcomes-framework-qof> [Accessed 24 September 2020].

²¹ Nat Wright et al. Long-term Condition Management for Prisoners: Exploring Prevalence and Compliance with QOF Monitoring. July 2020.

²² IAP-RCN roundtable: can we prevent natural deaths in prison?. 18 November 2019.

²³ Prisons & Probation Ombudsman. Independent Investigations, Learning from PPO Investigations: Older Prisoners. 2017. Available from: https://s3-eu-west-2.amazonaws.com/ppo-dev-storage-4dvijl6iqfyh/uploads/2017/06/6-3460_PPO_Older-Prisoners_WEB.pdf. [Accessed 6 March 2020]

Recommendation: Overhaul secondary care referrals, 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.

Discharge

30. Concerns were raised about a lack of continuity of health care and poor multi-agency working on **discharge** 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 **multi-agency care** 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 **uniform comprehensive care pathway** across prison healthcare that is evidence based and applies a joint approach across all agencies, departments and services.

Care of Older Prisoners

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 participate in the usual prison regime; and
- c. are often released homeless, without sufficient social care support or being registered with a GP.

33. The need for a change in how older prisoners are cared for was reiterated by the HM Chief Inspector of Prisons, Peter Clarke, who stated in July 2018 that:

²⁴ NHS England. The NHS Long Term Plan. Available from: <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf> [Accessed 20 February 2020]

²⁵ Wix, S. Humphreys, M. Multidisciplinary working in Mental Health Care. Elsevier. 2005. 88-89.

“...there needs to be a broader think about what needs to be done for a cohort of prisoners who, although they may need to remain in custody, do not necessarily need the same type of custody.”²⁶

34. In a letter to the IAP, one prisoner raised concerns about older people in prison:

“I work in the healthcare centre for last 26 months. I witness so much and its shocking how the British justice system sending all these older people in prison. There was one who came in four month ago. He was 93 year[s] old and they give him a 12 year prison sentence. Everyone was shocked. He was so weak. He last 2 month and died. Everyone was upset. Then there was one who was 77 year old. He got 12 year. He died last month. And there is Arthur who is 83. He got 15 years. He is dying..... They were never going to get any social care or any treatment. They sleep in a wheelchair. They piss in their cloths. They shit in them. They even cannot eat their food.”

35. There is still no **specific national strategy for older prisoners**, although the 2013 Inquiry by the Justice Committee recommended that one should be developed and in evidence to the Justice Committee earlier in 2020 the Prisons Minister expressed an interest in establishing one.²⁷ HMPPS have developed a ‘Model of Operational Delivery’ toolkit to meet the full needs of older prisoners, though its use and implementation in prisons has so far been limited.²⁸ Good practice does exist and is promoted by bodies such as RECOOP, Clinks and the Older People in Prison Forum, but needs to be universal. Local voluntary sector partnerships can improve coordination between prisons and health and care services.²⁹

36. The ability of HMPPS to look after the aging population was discussed in the House of Commons Justice Committee report ‘Prison Population 2022: Planning for the Future’.³⁰ It found that due to age-related illnesses, prisoners may struggle with the standardised regimes and timetables, while older prisoners frequently ‘slip under the radar’ and experience social isolation, resulting in a further detrimental effect on their wellbeing.

37. Minimal guidance exists to support the implementation of the services required for this vulnerable population. As a result, older prisoners receive **sub-optimal access to appropriate healthcare**. A number of prisons have made good effort in responding to this need with a range of local initiatives; however, these are non-commissioned and as a result not resourced efficiently. Many of these initiatives have not been fully embedded

²⁶ Parliamentary Committee. Prison Healthcare Inquiry. Available from: <https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-and-social-care-committee/inquiries/parliament-2017/prison-healthcare-inquiry-17-19/>. [Accessed 3 February 2020]

²⁷ Ministry of Justice. Government response to the Justice Committee’s Fifth Report of Session 2013–14: Older Prisoners. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/256609/response-older-prisoners.pdf. [Accessed 11 June 2020].

²⁸ HM Prison and Probation Service. Model for Operational Delivery: Older Prisoners. 2018. Available from: https://www.dementiaaction.org.uk/assets/0004/2423/MOD-for-older-prisoners_2_.pdf. [Accessed 20 February 2020].

²⁹ IAP-RCN roundtable: can we prevent natural deaths in prison?. 18 November 2019.

³⁰ House of Commons: Justice Committee. Prison population 2022: planning for the future. Available from: <https://publications.parliament.uk/pa/cm201719/cmselect/cmjust/483/483.pdf>. [Accessed 3 February 2020].

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 **older persons strategy** 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 ensure dignified end of life care.

Recommendation: Reassess the policy on **Do Not Resuscitate decisions** and their use within the prison healthcare system to make clear at what time and in which situations it is appropriate to administer CPR.

Dementia Care

40. Dementia Action Alliance (DAA), the national alliance organisation for dementia, has identified a number of **challenges that affect people with dementia in prisons**. Prison staff and healthcare are not often trained to look for issues relating to cognitive decline, and this can result in conditions such as dementia being missed and therefore not treated in a timely manner. When an individual does manage to receive a dementia diagnosis in prison, there can be further challenges associated with receiving appropriate care.
41. Dr. Jane Senior, Senior Lecturer from The University of Manchester, has estimated, in her DeClision study, the current weighted prevalence of dementia and mild cognitive impairment at 8% within the older prisoner population. The study developed a dementia care pathway and specific guidance on its future implementation. This study will support the development of a future research project which will seek to implement the DeClision care pathway to streamline the assessment and diagnosis process, develop appropriate environmental and living adaptations, and ensure suitable staff and peer support is available.³²
42. A dementia care pathway should be developed across the prison estate. This should include effective training for both healthcare and prison staff to recognise symptoms of dementia. All prisons must also be made 'dementia friendly', with clear signage, well-lit areas with as much natural light as possible, and consistently plain and levelled flooring.

³¹ IAP-RCN roundtable: can we prevent natural deaths in prison?. 18 November 2019.

³² Jane Senior et al. Dementia and mild cognitive impairment in prisoners aged over 50 years in England and Wales: a mixed-methods study. *Health Services and Delivery Research*. June 2020.; IAP-RCN roundtable: can we prevent natural deaths in prison?. 18 November 2019.

Recommendation: Develop a **dementia care pathway** 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.

Social Care Provision

43. The introduction of the Care Act (2014) has placed a number of new social care duties upon local authorities in England. Since April 2015 local authorities with prisons in their catchment area have been responsible for identifying, assessing and meeting the eligible **social care needs of people in custody**. In addition to this, all local authorities are responsible for the continuity of care and support of individuals with social care needs on release into their catchment area. However, there has been a significant variation in compliance and implementation. For example, there are problems with the prison environment, including in suitability for wheelchair users, and variation in the provision of external services such as British Sign Language (BSL) interpreters.
44. There have been difficulties in providing **safe housing on release**. These have been thrown into sharp relief during efforts to achieve the temporary compassionate release of medically vulnerable prisoners under COVID-19.
45. Delegates at the IAP-RCN roundtable expressed concern regarding the care available in prisons compared to that available in the community, highlighting a number of specific cases which should have been referred and reviewed under Section 42 of the Care Act.³³ Section 42 requires that each local authority must make enquiries, if it believes an adult is **experiencing or is at risk of abuse or neglect**.³⁴ However, these cases were not referred or reviewed as the Local Authority did not hold safeguarding responsibility for prisoners.

Recommendation: **Review the application of the Care Act in prisons** 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.

Compassionate Release

46. Compassionate release is a process by which people may be released early from prison for compassionate reasons. In order for a prisoner to be considered for compassionate release an application must be considered initially by the governor of the prison and then by the Public Protection Casework Section (PPCS) in the HMPPS Public Protection Group. Governors can reject applications but must refer cases to the Public Protection Casework Section (PPCS) in the HMPPS Public Protection Group where: 1) the governor supports compassionate release and/or 2) where the medical criteria are met (i.e. irrespective of whether the Governor supports release or not).
47. PPCS receive around 50 applications from governors each year. Figures provided to the

³³ IAP-RCN roundtable: can we prevent natural deaths in prison?. 18 November 2019.

³⁴ Rochdale Borough Safeguarding Adults Board. Factsheet: What is a Section 42 Safeguarding Enquiry? 2016. Available from: <https://www.rbsab.org/UserFiles/Docs/F4%20What%20is%20an%20enquiry.pdf>. [Accessed: 20 February 2020].

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:

'My cellmate 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 on the bottom bunk with a plastic bowl as a toilet...I helped my 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 compassionate release** continues to be unsatisfactory. An urgent review of the process of compassionate release, and subsequent overhaul of the system, is needed. Future developments should look to achieve a greater balance between wellbeing, care needs and risk.

52. In response to the COVID-19 pandemic, the Lord Chancellor announced that prisoners

³⁵ Byock, I. Dying Well in Corrections: Why Should We Care? *Journal of Correctional Health Care*. 2002; 9(2): 107-117; Linder, J. Meyers, F. Palliative care for prison inmates: "Don't let me die in prison". *Journal of the American Medical Association*. 2007; 298: 894-901.

³⁶ Handtke, V. Bretschneider, W. Elger, B. Wangmo, T. The collision of care and punishment: Ageing prisoners' view on compassionate release. *Punishment Society*. 2017; 19(1): 5-22.

³⁷ Prison & Probation Ombudsman: Independent Investigations. Learning from PPO Investigations: Older Prisoners. 2017. Available from: https://s3-eu-west-2.amazonaws.com/ppo-dev-storage-4dvijl6iqfyh/uploads/2017/06/6-3460_PPO_Older-Prisoners_WEB.pdf. [Accessed 6 March 2020]

who fell into the category of ‘medically vulnerable’ could apply for emergency temporary compassionate release based on health need and safety considerations. It became clear that there was limited data available on the number of people in prison who would have needed to be shielded had they been in the community. Estimates varied between 500 - 1,000 prisoners. Although applications were made, fewer than 60 people have been released under this scheme which has proved difficult to administer. Instead it has been beset by additional eligibility criteria and mired in bureaucracy. This has thrown into sharp relief many of the gaps and anomalies of the current system for compassionate release.

Recommendation: Review and overhaul the process of **compassionate release** from custody to make sure that it is clear, transparent, timely and fair.

Palliative Care

53. The prison estate has **limited provision for specialist long-term care** and end of life healthcare, although the PPO noted that an increasing number of prisons are building palliative care cells or units for prisoners who require specialist end-of-life care and a number of prisoners have died in these specialist units.³⁸
54. Providing the best possible end of life care in prison can be very complex. Not all prisoners with terminal chronic illness want compassionate release because they may have little in the way of social and support networks in the community, and find that their familiarity with prison environment, staff and fellow peers provides stability enabling the management of their illness.
55. At the IAP-RCN roundtable, Gill Scott, Macmillan Palliative Care Lead for North East Prisons, presented the ‘Dying well in custody’ charter, an intended **national framework which provides information and guidance on the care and management of prisoners requiring palliative care**.³⁹ The guidance outlines a set of clinical and operational standards based upon best practice. This model should be established in all prisons, as currently palliative care is delivered on an ad-hoc basis. The need to maintain dignity and quality of life should be at the forefront of this approach. Specific recommendations included advance care plans, making provision to better support families, utilising family liaison workers, increasing the number of palliative care suites with appropriate staffing and training with the opportunity for family visits where appropriate.⁴⁰
56. Roundtable delegates instanced **positive examples of end of life** care including the well-established partnership between HMP Dartmoor, St Luke’s Hospice in Plymouth and the local Macmillan living with and beyond cancer project recently recognised by the Burdett Nursing Award.⁴¹

³⁸ Prisons and Probation Ombudsman. Annual Report: 2018-2019. Available from: https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkjhkjmjgw/uploads/2019/10/PPO_Annual-Report-2018-19_WEB-final-1.pdf. [Accessed 11 June 2020]

³⁹ Ambitions for Palliative & End of Life Care Partnership. Dying Well in Custody Charter. Available from: <http://endoflifecareambitions.org.uk/wp-content/uploads/2018/06/Dying-Well-in-Custody-Self-Assessment-Tool-June-2018.pdf>. [Accessed 3 February 2020].

⁴⁰ Macmillan Cancer Support. Available from: <https://www.macmillan.org.uk/about-us/health-professionals/networking-and-awards/networking-opportunities.html> [Accessed 16 July 2020].

⁴¹ IAP-RCN roundtable: can we prevent natural deaths in prison?. 18 November 2019.

Recommendation: Implement the ‘**Dying Well in Custody**’ charter across prisons to maintain dignity, better support families and deliver uniform palliative care.

Culture

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 **staff recruitment and retention** 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 the implementation of a region wide on-call rota of prison GPs.

59. There is a general feeling among nursing staff that healthcare provision in prisons comes with a low status. For students, forensic placements are not considered a core competency. Delegates argued for the need to **increase awareness of the opportunities in prison healthcare**. Recommendations included student placements from all disciplines in prison healthcare and rotation of staff between health services in the community and in prisons. Due to staff shortages, agency staff are often employed but are usually inexperienced in prison healthcare requiring significant on the job induction. Efforts to develop and pilot new ways of training this workforce need to be explored.

60. The **lengthy recruitment process** itself was considered a contributing factor to staffing shortages. Security vetting waiting times can deter people from wanting to work in prisons. Delegates recommended the introduction of a national prison clearance, similar to the Disclosure and Barring Service (DBS) process.⁴⁴

61. **Retention issues** have often led to a higher number of newly trained and inexperienced prison officers creating an unstable environment. Additionally, low levels of pay and few career progression opportunities are deterring people from applying for these roles. Suggested solutions included the development of a national core prison induction and on-going professional development framework for staff. Long term strategies were also

⁴² IAP-RCN roundtable: can we prevent natural deaths in prison?. 18 November 2019.

⁴³ Ministry of Justice. Her Majesty’s Prison and Probation Service (HMPPS) Workforce Statistics Bulletin: December 2019. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/866861/hmppps-workforce-statistics-dec-2019.pdf. [Accessed. 11 June 2020].

⁴⁴ IAP-RCN roundtable: can we prevent natural deaths in prison?. 18 November 2019.

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 **assessment of population needs**, including in prison settings to provide safer and more effective care.

Recommendation: Raise the profile of **prison healthcare** 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.

Inquiry, Review and Dissemination

63. Delegates to the IAP-RCN roundtable indicated that the process of review following deaths and dissemination of findings was **not leading to 'learning at the front line'**. 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, the office of the Chief Coroner, prison governors and healthcare managers to **consider often repeated recommendations with solutions found and actioned**. Create a **national oversight mechanism to monitor deaths in custody**, specifically the implementation of official recommendations arising from post death investigations.

Recommendation: **Improve standards of post-death investigations** so that failures are identified and changes made. Ensure that non self-inflicted deaths are fully investigated by independent specialists.

⁴⁵ IAP-RCN roundtable: can we prevent natural deaths in prison?. 18 November 2019.

⁴⁶ INQUEST Campaigns. Available from: <https://www.inquest.org.uk/pages/category/campaigns> [Accessed 24 September 2020].

Summary and recommendations

Target	Priority actions	Proposed implementation (s)	Proposed advisory role
1	<p>Improve join-up and information sharing across services and departments</p> <p>1. Develop extended health information sharing, 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.</p> <p>2. Implement clinical coding systems across prison healthcare departments to ensure standardisation of reporting and data transfer.</p> <p>3. Implement a uniform comprehensive care pathway across prison healthcare that is evidence based and applies a joint approach across all agencies, departments and services.</p>	<p>NHSE, DHSC, MoJ</p> <p>NHS Primary Care; NHS Digital</p> <p>NHS, MoJ, HMPPS, DHSC</p>	<p>Prisoners' families</p>
2	<p>Implement improvements to primary and secondary care</p> <p>4. Implement the Quality Outcomes Framework (QOF) across the prison estate, including employing administrators to update records and make summaries and Code diagnoses.</p> <p>5. Overhaul secondary care referrals, including through developing:</p> <ul style="list-style-type: none"> ○ 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. 	<p>NHS Primary Care; Royal College of General Practitioners</p> <p>NHS, HMPPS, DHSC</p>	<p>National Institute for Health and Care Excellence; Spectrum Healthcare</p>
3	<p>Take steps to improve provision and care for specific</p> <p>6. Conduct an in-depth review of the characteristics of natural deaths in women and BAME individuals and make specific amendments where appropriate.</p>	<p>MoJ; DHSC</p>	<p>IAP, Offender Health Research Network</p>

	vulnerable cohorts	<p>7. Develop a joint health and justice older persons strategy for the criminal justice system. This should be integrated with local social care plans and provision.</p> <p>8. Develop a dementia care pathway 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.</p>	<p>MoJ, HMPPS, DHSC</p> <p>MoJ, HMPPS, NHS</p>	<p>IAP, inspectorates, researchers</p> <p>Dementia Action Alliance, DeClision</p>
4	Improve end of life care across the prison estate	<p>9. Reassess the policy on Do Not Resuscitate decisions and their use within the prison healthcare system to make clear at what time and in which situations it is appropriate to administer CPR.</p> <p>10. Review and overhaul the process of compassionate release from custody to make sure that it is clear, transparent, timely and fair.</p> <p>11. Review the application of the Care Act in prisons 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.</p> <p>12. Implement the 'Dying Well in Custody' charter across prisons to maintain dignity, better support families and deliver uniform palliative care.</p>	<p>NHSE, HMPPS</p> <p>MoJ, NHSE</p> <p>DHSC, NHSE</p> <p>NHSE, HMPPS</p>	<p>IAP, PPO</p> <p>CQC, ADASS</p> <p>Macmillan Palliative Care</p>
5	Enhance the profile of prison healthcare as a career	<p>13. 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.</p>	<p>NHSE, Chief Nursing Officer for England</p>	<p>Relevant Royal Colleges including RCGP, RCN, RCPsych.</p>
6	Improve learning and investigations	<p>14. Convene regular standing meetings between the Prison and Probation Ombudsman, the office of the Chief Coroner, prison governors and healthcare managers to consider often repeated recommendations with solutions found and actioned. Create a national oversight mechanism to monitor deaths in custody, specifically the implementation of official recommendations arising from post death investigations.</p>	<p>MoJ, HMPPS</p>	<p>IAP, PPO, Coroners Office, NGOs</p>

		15. Improve standards of post-death investigations so that failures are identified and changes made. Ensure that non self-inflicted deaths are fully investigated by independent specialists.	MoJ, HMPPS, PPO, Chief Coroner for England and Wales	IAP, NGOs
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Appendix: Delegates, RCN-IAP roundtable

Andrea Albutt	Prison Governors Association
Dr. Jo Armes	School of Health Sciences, University of Surrey
Dr. Paul Armitage	General Practitioner
Dr. Meng Aw-Yong	Forensic Healthcare Services Metropolitan Police
Chris Barnett-Page	HMPPS
Alison Bernard	Ministry of Justice
Dr. Sarah Bromley	CARE UK
Peter Clarke	HM Inspectorate of Prisons
Deborah Coles	INQUEST / Independent Advisory Panel on Deaths in Custody
Caroline Corby	Parole Board of England and Wales
Katherine Cummings	Royal College of Nursing
Gordon Davison	HMPPS
Jessica Davidson	Royal College of Nursing
Elizabeth Davies	School of Health Sciences, Kings College London
Kate Davies	NHS England
Carolyn Doyle	Royal College of Nursing
Laurence Fiddler	Ministry of Justice
Julie Finch	Spectrum CIC
Jan Fooks-Bale	Care Quality Commission
Bernadette Gardner	Samaritans
Janice Grant	ADASS Care and Justice Network
Carol Gray	St Luke's Hospice
Fiona Grossick	NHS England and NHS Improvement
Paul Hanna	Royal College of Nursing
Ryan Harman	Prison Reform Trust
Leanne Heathcote	Offender Health Research Network, University of Manchester
Kishwar Hyde	Ministry of Justice
Chaplain Trevor Jacquet	HMP Belmarsh
Dame Donna Kinnair	Royal College of Nursing
Deborah Line	HMPPS, Female Prison Estate
Juliet Lyon	Independent Advisory Panel on Deaths in Custody
Sheeylar Macey	North East London Commissioning Support Unit (NEL CSU)
Dr. Annelise Matthews	HMP Littlehey
Sue McAllister	Prisons & Probation Ombudsman
Sheridan McGinlay	HMP Dartmoor
Ann Norman	Royal College of Nursing
Dr. Eamonn O'Moore	Public Health England
Dame Anne Owers	Independent Monitoring Boards
Dr Mary Piper	RESTORE
Nick Poyntz	Ministry of Justice
Rebecca Roberts	INQUEST
Gov. Lynn Sanders	HMP Wymott
Gill Scott	Macmillan Prison Project
Dr. Jane Senior	Offender Health Research Network, University of Manchester Prof.
Jenny Shaw	Independent Advisory Panel on Deaths in Custody
Jenny Talbot	Independent Advisory Panel on Deaths in Custody
Prof. Pamela Taylor	The Royal College of Psychiatrists
Jane Trigg	HMPPS
Debra Vidler	NHS England and NHS Improvement
John Wadham	Independent Advisory Panel on Deaths in Custody
Dr. Stuart Ware	RESTORE
Dr. Caroline Watson	Royal College of General Practitioners
Dr. Sue Wheatcroft	Prisoner Policy Network, Prison Reform Trust
Dr. Nat Wright	Spectrum CIC