Prison Healthcare Study

Study protocol

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Introduction

The House of Commons Health and Social Care Committee report 'Prison Health', published in 2018 reported that the Government was failing in its duty of care towards people detained in England's prisons.[1] '*Too many prisoners die in custody or shortly after release; so-called 'natural' cause deaths, the highest cause of mortality in prison, too often reflect serious lapses in care'*. The Select Committee recommended that the National Prison Healthcare Board work with stakeholders to agree a definition of equivalent care, and indicators to measure health inequalities between people in prison and the general population, which should then be reduced. This has yet to happen.[2]

Between 2000 and 2019, 2,365 people died in prison, from deaths attributed to 'natural' causes, of which 13% were under 40 years and 52% were under 60 years of age. In addition, 259 deaths were classified as 'other non-natural'[3,4] such as accidental poisoning from an adverse reaction to prescribed medication. The Prison and Probation Ombudsman currently states the number of people dying from 'natural' deaths is largely explained by the increase in older prisoners and associated age-related conditions.[3] Whilst the increasing elderly population would account for many deaths, review of the people who died under the age of 60, would provide the opportunity to highlight and address serious health inequalities which are already known to be part of the cycle of disadvantage faced by people in prison. No one is sentenced to worsened health but, largely because of overstretched staff, overcrowding and poor facilities, it is too often the outcome.[1]

All people in prison have been NHS patients since 2006. NHS England Health and Justice is responsible for commissioning healthcare in prisons via 10 Health and Justice Teams across four regions (North, Midlands, London and South).

The NHS England Health and Justice website states teams commission to the '*principle of equivalence'* which means that the health needs of a population constrained by their circumstances are not compromised and that they are afforded provision of and access to appropriate services or treatment and that this is considered to be at least consistent in range and quality (availability, accessibility and acceptability) with that available to the wider community, in order to achieve equitable health outcomes and to reduce health inequalities between people in prison and in the wider community. However, there is no supporting evidence base for this statement.[1]

NHS England Health and Justice commissioning promotes effective links with Clinical Commissioning Groups (CCGs) and Local Authorities to support the delivery of social care within prisons and the continuity of care as individuals move in and out of them. However, a prisoner's daily contact is with operational prison staff who act as gatekeepers to prison healthcare professionals, thus front-line prison staff have a key role in facilitating access to healthcare. Likewise, healthcare staff should share clinical information on a 'need-to-know basis' if safe and effective continuity of care is to occur. However, the need for medical confidentiality can be used as a reason not to do this, with the potential to make care unsafe. Good prison operational staff-prisoner interaction can be a considerable challenge as it has been reported by 23% of prisoners that they usually spend less than two hours out of their cell on a typical weekday, preventing regular engagement with officers who might be able to help if they are unwell.[5] Furthermore, such limited time afforded outside of their cell can contribute to/create health issues.

Review of the current literature highlights the fact that there is currently no collective review or oversight of deaths in prison. There has only been one prevalence study of physical health of people in prison, and that was conducted by the Office for National Statistics in 1995.[6] The

Prisons and Probation Ombudsman (PPO) does carry out independent individual Fatal Incident Investigations (FII) into deaths in custody, but there are limitations to these, for example:

- They are single reviews of individual deaths which makes the identification of common themes and lessons learnt difficult.
- Only prison healthcare interventions are investigated as NHS primary or secondary care services are outside their remit.
- Identified healthcare issues may often not be discussed beyond an individual prison thus failing to implement widely any lessons that could be learnt from an individual death
- NHS secondary care providers may be unaware death has occurred so that serious incident (SI) reviews do not take place.
- The final report compiled by the PPO FII team, is not undertaken by anyone with clinical expertise.
- The FII reports are often published before the inquest for whom they provide evidence and are not amended in the light of inquest findings.

Whilst the HM Chief Inspector of Prisons (HMCIP) inspects prison health services jointly with the Care Quality Commission (CQC), the latest annual report made little reference to healthcare in prison.[5] Although it did describe poor governance of medicines management, with many prisons lacking on-site pharmacists to provide oversight of medicines. It also highlighted that several prisons had poor resuscitation equipment.[5]

'*Deaths in prison: a national scandal*', was recently published by the charity INQUEST[7.] It details repeated previously highlighted safety failures, including consistently poor mental and physical healthcare. INQUEST state there are a high proportion of premature and highly preventable deaths in which inadequate healthcare provision was a significant factor and that applying the term 'natural' is extremely problematic.

'Avoidable natural deaths in prison custody: putting things right' was published in 2020 by the Independent Advisory Panel on Deaths in Custody (IAPDC) and looked at the increase in non-self-inflicted deaths over the last ten years.[8]

Dr Miranda Davies and colleagues at Nuffield Trust, recently published '*Locked out? Prisoners' use of hospital care*'.[9] It reported that prisoners had 24% fewer inpatient admissions and outpatient appointments in 2017/18 than the equivalent age and sex demographic in the wider population, and 45% fewer attendances at emergency departments. Their literature review found no mention of circulatory disease (heart attack and stroke) being a major risk factor for patient hospital episodes. This was surprising as circulatory disease is the commonest cause of prison 'natural' deaths (43%).[10] Dr Davies stated *"the biggest worry for me is the lack of publicly available information about the health of people in prison and all the gaps in knowledge the report highlights".*[11]

In 2021, Hospice UK produced a report called *'Dying Behind Bars'*[12] which revealed that prisoners are missing out on adequate care at the end of their lives.

In contrast to the absence of reviews into 'natural' deaths, there has been frequent analyses of self-inflicted deaths by people in prison over the last 25 years, by academics[13,14] and prison multidisciplinary operational reviews.[15,16] Research outcomes from these may have led to improvements in the care of those at risk of suicide within prison. Since 1997, the proportion of people dying from 'natural' deaths in prison has been higher than from suicide.[3,4]

Aims and objectives

Overall aim

To identify remediable factors in the clinical and organisation of healthcare for people who died from a 'natural' or 'other non-natural' death whilst detained in prison or were transferred to an acute NHS hospital or hospice, whilst detained.

Objectives - organisational

To review:

- The healthcare provision available
- Networks of care/healthcare pathways
- Access to acute NHS hospitals
- Processes/ standards/ systems and impact of transfers between prisons
- Multidisciplinary team working
- The commissioning of services
- Adherence to national clinical guidelines/quality standards relevant to the organisation of services for the medical conditions being treated (e.g. NICE guidelines and quality standards)
- The use of local policies and protocols
- Training for healthcare related matters
- Healthcare commissioning arrangements.
- Interface between healthcare and operational staff
- Professional structures, networks and support for prison doctors
- Examples of good practice

Objectives - clinical

To review:

- The cause of death
- Whether death was thought to be avoidable or premature
- The quality, nature and timeliness of healthcare provision and delivery, including 'out of hours' care
- Recognition and treatment of acute medical emergencies and deteriorating clinical conditions
- The quality of multidisciplinary healthcare delivered
- Evidence of healthcare reviews for individuals
- Prescribing and medicines reconciliation by pharmacists
- Adherence to national clinical guidelines/quality standards relevant to the medical conditions being treated (e.g. NICE guidelines and quality standards)
- The quality of drug and alcohol detoxification, including an assessment of dependence
- The content and quality of the NHS commissioned independent clinical review
- PPOs' judgment of whether healthcare received was commensurate with that expected in the community.

Method

Study advisory group

A multidisciplinary group of relevant stakeholders (listed on the first page) comprising commissioners, prison governors, experts in the field, healthcare professionals, a former prisoner and third sector organisations has convened to finalise the areas of care that should

be reviewed, the method to be undertaken and the inclusion criteria. This group will also provide oversight of the report recommendations at the end of the study.

Inclusion criteria – *data relating to the identification and clinical care of prisoners who died*

All adults aged 18 years or over, who died in prison custody, from a death categorised as 'natural' or other 'non-natural', from 1st January 2018 to 31st December 2020 inclusive. This will include some COVID-19 deaths.

All deaths categorised as 'natural' or other 'non-natural' deaths for the study inclusion period will be identified from the PPO. Only deaths with a published PPO report at the time of sampling will be included in the study population.

Exclusions

Causes of death by suicides, homicides or other self-harm related deaths.
People wo died while in an Immigration Removal Centre.

Participating providers of healthcare

Patient-level data - all relevant prisons with one or more death categorised as 'natural' or other 'non-natural', in the study period. In addition, all acute hospitals where one or more of the identified people who died, died in hospital.

Organisational data - all public and private prisons and all acute hospitals in England and Wales.

Study promotion

NCEPOD has liaised with the head of communications at Her Majesty's Prison and Probation Service (HMPPS) who will communicate the initial details of the study and the requirements for participation to all relevant prisons. NCEPOD has also been invited to join the Director of the Prison Service, Prison Governors meeting to summarise the study. NHSE will communicate details of the study to all providers of healthcare within prisons. The study will also be promoted to relevant stakeholders, patient groups, third sector organisations, NCEPOD Local Reporters (sending the study poster on to the relevant departments), via any study contacts recruited, and via the relevant colleges and associations.

Data collection

There will be four main ways of collecting data for the study:

1. Anonymous surveys and from this consented interviews/focus groups

These data will not link to any of the detailed case reviews described below and do not require HRA-CAG S251 support

Prisoner and family views

The initial survey will gather data on prisoner and family views of the healthcare provided to them/a family member in prison. The data will not be linked to any other aspects of data collection. Participants will be invited to attend one-to-one interviews or focus groups and we will work with relevant charities (e.g. Pact, Prison Reform Trust and INQUEST) for support and to encourage involvement.

Prison healthcare professional views

The survey will gather data on prison healthcare professional views of the services that are available for them to provide to patients in prison. The data will not be linked to any other

aspects of data collection. We will work with HMPPS/Royal college specialist groups (e.g. nursing, GPs) to encourage involvement from clinicians.

On-line prison* operational staff *survey

The survey will gather data on operational staff views of the support/training/services that are available for them to recognise healthcare problems and obtain healthcare input when needed. The data will not be linked to any other aspects of data collection. We will work with HMPPS to encourage involvement from prison governors, officers, operational support grade staff and safer custody group leads.

2. Organisational questionnaires

These data will not link to any of the detailed case reviews described below and do not require HRA-CAG S251 support

Prison organisational questionnaire

Data collected will include information on the organisation of healthcare services within prisons. The healthcare provision available, networks of care/healthcare pathways, access to acute NHS hospitals, multidisciplinary team working, the commissioning of services, adherence to national clinical guidelines, the use of local policies and protocols.

Acute hospitals organisational questionnaire

Data collected will include information on local arrangements for admitting prisoners for acute care and the outpatient management of long-term conditions.

Prison healthcare providers organisational questionnaire

Data collected will include information on the provision of healthcare services in prisons.

3. Clinician questionnaires

These data will contain patient identifiable information and HRA-CAG S.251 support has been requested

Prison clinician questionnaire

A short questionnaire will be sent to the prison GP/healthcare team who were responsible for the healthcare of each person included in the study sample. If an included patient died in hospital or received care in hospital prior to death in prison, a questionnaire will also be sent to the consultant responsible for their care in hospital. The prison clinician questionnaire will be sent directly to the prison healthcare team for completion via an online questionnaire system.

Hospital clinician questionnaire

The hospital clinician questionnaires will be sent to the NCEPOD Local Reporter for dissemination to clinicians involved in the care of the patient via and online questionnaire system.

4. Clinical case data collection for peer review

These data will contain patient identifiable information and HRA-CAG S.251 support has been requested

The PPO fatal incident reports, NHS commissioned clinical review reports, SystmOne™ notes, hospital case notes and coroners reports where applicable, will be reviewed by a multidisciplinary group of clinicians from prison, acute and community healthcare settings. Clinical notes for each included person will be requested for the 12 months leading up to the death so information on the ongoing management of any long-term conditions can be reviewed.

All SystmOne™ notes for the 12 months leading up to the death, including but not limited to:

- Clinical annotations
- Clinic letters
- Electronic prescribing
- Test results
- Physical health observations/early warning scores (NEWS2)
- Healthcare provider Initial review/ 72-hour review report
- Task messages requested
- Handover and daily checks record
- Treatment escalation plans

Hospital notes for any acute admissions and outpatient appointments in the 12 months leading up to the death, including, but not limited to:

- Ambulance notes/Ambulance Service Patient Report Form (PRF)
- Emergency Department clerking proforma/Emergency Department records
- All inpatient annotations/medical notes
- Nursing notes
- Allied health professional notes
- Operation notes
- Consent forms
- Anaesthetic charts
- Imaging reports
- Observation charts
- Fluid balance charts
- Haematology/biochemistry results
- Microbiology reports
- Drug charts
- Out patient follow up clinic notes and letters
- Autopsy report if applicable
- Treatment escalation decisions/ DNACPR forms
- Discharge letter/summary

Upon receipt at NCEPOD the clinical notes will be redacted if not already done so prior to sending.

Peer reviewer assessment form

A multidisciplinary group of reviewers (detailed below) will be recruited to assess the clinical notes and questionnaires and provide their opinion on the care each person received while in custody and hospital (if applicable).

Table 1 summarises the data sources for significant points along the pathway

Area of enquiry	**Method of data collection**	**Confidentiality**
Prison healthcare	SystmOne notes, NHSE clinical reviews, PPO reports, organisational questionnaire	Identifiable
	Online surveys	Anonymous
Acute secondary healthcare	Clinical notes, organisational questionnaires	Identifiable

Expected data returns

Based on number of deaths, number of prisons, and number of acute hospitals, the maximum data returns are displayed in Table 2. The number of surveys is unknown, so a cautious estimate has been included.

Table 2. Estimated sample size for each data source

Data source	*Target number*
Population of deaths to review	Up to 300
Associated documents	Up to 300
Organisational questionnaire - prisons	117
Organisational questionnaire - acute hospitals	200
Organisational questionnaire - Providers	17
Prisoner survey/interview	Approximately 20-30
Prison operational staff survey	Approximately 40-50
Prison healthcare staff survey	Approximately 40-50

Study method test

The data collection methods and data collection tools will be tested to ensure they are robust before the full study is run

Analysis and review of data

Peer reviewers

A multidisciplinary group of reviewers will be recruited to assess the clinical notes and NHS commissioned clinical reviews. As well as extracting information from the documents they will provide their opinion on various aspects of care each prisoner received. The reviewer group will comprise nurses; general practitioners; acute physicians working in prisons, acute hospitals and the community.

A case reviewer advert will be sent to the prison GP network, RCN secure group and Local Reporters to disseminate throughout the relevant hospital departments. It will also be placed on the NCEPOD website. Successful applicants will be asked to attend a training day where they will each assess the same two cases to ensure consistent assessment. A number of meeting dates will be arranged, and each reviewer will then be asked to attend a minimum of a further 4 meetings. NCEPOD staff will ensure there is a mix of healthcare staff with prison experience and acute specialists at each meeting from across England and Wales. Each meeting will be chaired by an NCEPOD clinical coordinator who will lead discussion around the cases under review. The meetings will either be held in person in the NCEPOD office, or over Microsoft Teams with secure and temporary access to the clinical notes for review. Towards the end of the study the reviewers will be invited to attend a meeting where the data will be presented to and discussed with them. The reviewers will also be sent two copies of the draft report for their comment as this is developed.

Confidentiality and data protection

All electronic data are held in password protected files and all paper documents in locked filing cabinets. As soon as possible after receipt of data NCEPOD will encrypt electronic identifiers and anonymise paper documents. Section 251 approval has been obtained to perform this study without the use of patient consent in England and Wales.

Study outputs

On completion of the study a report will be published and widely disseminated to all stakeholders to encourage local quality improvement (QI) (further details available in the

communication plan). In addition to the report, supporting tools will be made available including:

- A summary report and summary sheet
- Infographics
- The recommendation checklist
- An audit tool
- A slide set
- A guide for commissioners
- Fishbone diagrams
- An anonymous organisation data comparison table

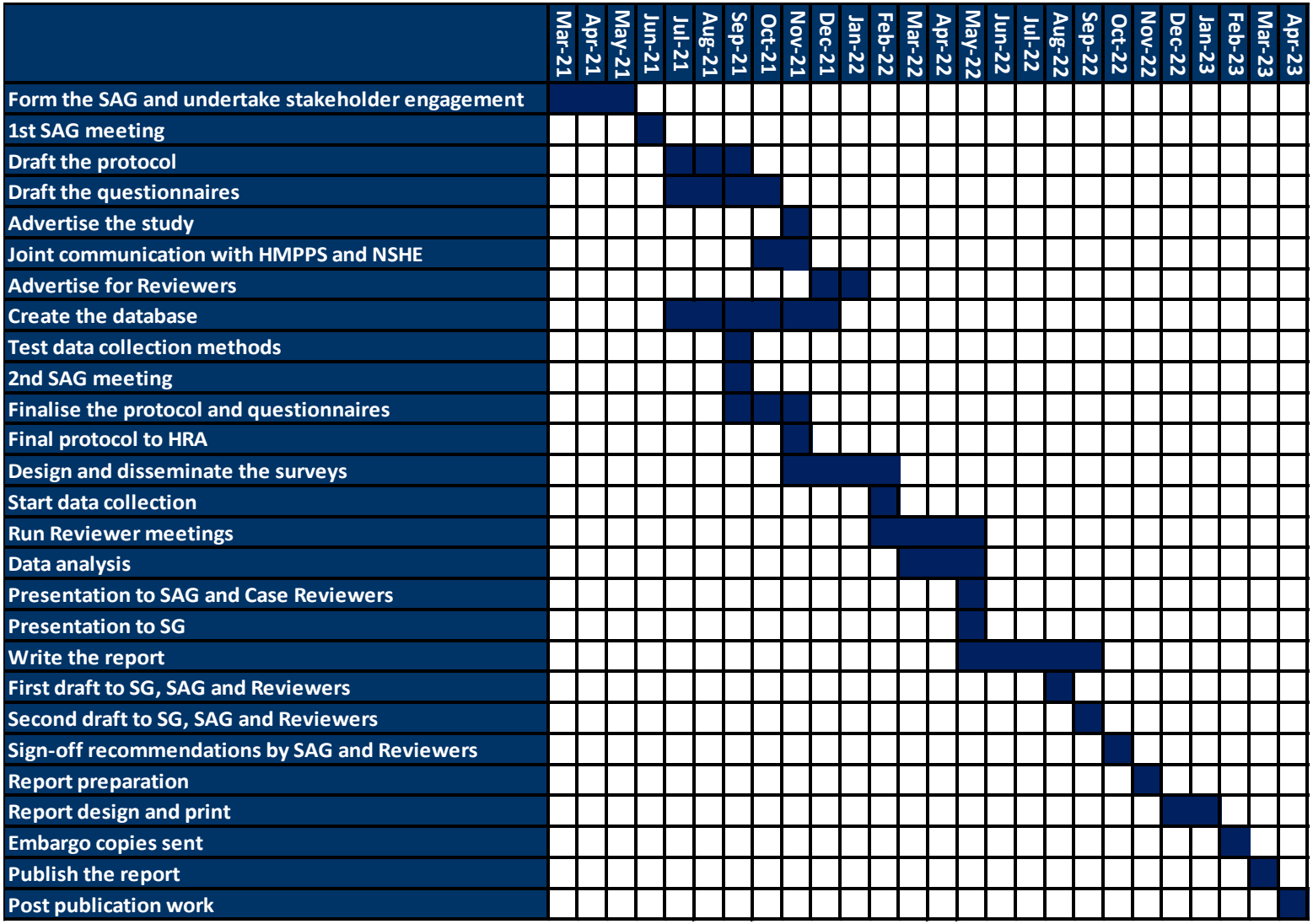
Examples of good practice will be shared, and additional QI tools will be developed where appropriate. Key messages from the report will be shared via social media.

Following publication, the report findings will be shared at national and local conferences, study days and other events; and papers submitted to journal for consideration for publication.

Data sharing

Post publication of the study there is the potential to share anonymised data sets with interested parties working in the same field. This will be undertaken following a strict data sharing process and will ensure the data does not become identifiable in their nature due to small numbers.

Project plan



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