

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Learning from
PPO investigations**

Older Prisoners

June 2017

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The role and function of the PPO

The Prisons and Probation Ombudsman (PPO) is appointed by and reports directly to the Secretary of State for Justice. The Ombudsman's office is wholly independent of the services in remit, which include those provided by the National Offender Management Service; the National Probation Service for England and Wales; the Community Rehabilitation companies for England and Wales; Prisoner Escort and Custody Service; the Home Office (Immigration Enforcement); the Youth Justice Board; and those local authorities with secure children's homes. It is also operationally independent of, but sponsored by, the Ministry of Justice (MOJ).

The roles and responsibilities of the PPO are set out in his office's Terms of Reference (ToR). The PPO has three main investigative duties:

- complaints made by prisoners, young people in detention, offenders under probation supervision and immigration detainees
- deaths of prisoners, young people in detention, approved premises' residents and immigration detainees due to any cause
- using the PPO's discretionary powers, the investigation of deaths of recently released prisoners

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity



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Foreword

One of the most marked changes in prisons in recent years has been the increase in the number of older prisoners. This demographic shift has been dramatic, driven largely by increased sentence length and more late-in-life prosecutions for historic sex offences. As a result, the number of prisoners over 60 has tripled in 15 years and the projections are all upwards, with 14,000 prisoners over 50 predicted by June 2020.

The challenge to the Prison and Probation Service is clear: prisons designed for fit, young men must adjust to the largely unexpected and unplanned roles of care home and even hospice. Increasingly, prison staff are having to manage not just ageing prisoners and their age-related conditions, but also the end of prisoners' lives and death itself – usually with limited resources and inadequate training.

Unfortunately, there has been little strategic grip of this sharp demographic change. Prisons and their healthcare partners have been left to respond in a piecemeal fashion. The inevitable result, illustrated in this review, is variable end of life care for prisoners and a continued inability of many prisons to adjust their security arrangements appropriately to the needs of the seriously ill. For example, it is unacceptable that I still find too many cases of prisons unnecessarily and inhumanely shackling the terminally ill – even to the point of death.

However, I have personally seen examples of impressively humane care for the dying by individual prison staff, as well as glimpses of improved social care and the development of some excellent palliative care. Indeed, this review contains some examples of very good practice, but this progress is inconsistent and too slow. I remain astonished that there is still no properly resourced older prisoner strategy, to drive consistent provision across prisons. This is something I have called for repeatedly and without which I fear my office will simply continue to expose unacceptable examples of poor care of the elderly and dying in prison.



This review expands on previous publications from my office, including research into end of life care, dementia and the use of restraints on the elderly or infirm. It focuses on findings and recommendations from investigations into deaths of older prisoners from natural causes between 2013 and 2016 and identifies lessons that need to be learned if the ever increasing numbers of older prisoners, particularly those reaching the end of life, are to be treated appropriately and humanely.

A handwritten signature in black ink, appearing to read 'Nigel Newcomen'. The signature is written in a cursive, slightly stylized font.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

Executive summary

This report is a thematic review of our investigations into naturally-caused deaths of prisoners over 50. It reviews 314 investigations over 2013-2015, and offers 13 lessons on six areas where we frequently make recommendations following investigations into deaths in custody of older prisoners. The six areas it examines in depth are: healthcare and diagnosis; restraints; end of life care; family involvement; early release; and dementia and complex needs. We also offer one good practice case study.

With respect to healthcare and diagnosis, this publication offers lessons on both continuity and coordination of care. We offer case studies that illustrate the importance of health screenings for newly arrived prisoners, following NICE guidelines and, where possible, we suggest that prisoners with ongoing health concerns should see the same doctor.

This publication also includes case studies showing the recommendations we make about restraining old or infirm prisoners, and reiterates much of the guidance we have issued in past publications. Namely, we expect that risk assessments should be proportionate to the actual risk posed by the prisoner, given his or her health condition; that input from healthcare staff should be meaningfully and seriously considered; and that risk assessments should be reviewed in line with changing health conditions.

We also offer lessons about palliative and end of life care – something prisons increasingly have to deal with. Here, we acknowledge it is not only prisoners who are ageing – often our facilities are older and not designed to adequately accommodate disability or palliative care needs. We recommend that prisons try to ensure the terminally ill are treated in a suitable environment. We also identify a lesson to improve healthcare coordination at the end of life, by ensuring that care plans are initiated at an appropriate, and ideally early, stage for those who are diagnosed with a terminal illness.

We offer two lessons with respect to family involvement. We acknowledge that prisoners are not always in contact with their families, nor do their families always want to be in contact with them. In this publication, we recommend that, with the consent of the prisoner and their family, trained family liaison officers involve families in end of life care, and notify next of kin promptly when a prisoner is taken to the hospital. Further, we recommend that family liaison officers are nominated as soon as possible after the prisoner's serious or terminal diagnosis.

We identify two lessons with respect to early release of terminally ill prisoners – one that suggests prisons should appoint an appropriate contact to ensure applications for early release are properly progressed, and another that, similar to our lessons for restraints, recommends risk assessments be contextual and based on the actual risk the prisoner poses, taking into account their current health condition.

Finally, as the older population in prisons increases in both size and proportion, we are finding more cases where the prisoner is diagnosed with, or showing signs of dementia. This is occasionally compounded with other social, mental, or physical needs, which can make these cases particularly complex to deal with. In this section, we elaborate more on this, and offer two lessons that might help prisons to better care for and manage prisoners with dementia and complex needs.

Overall, we hope that these lessons, along with an example of good practice in end of life care in prison, will help prisons deal better with this demographic change.

Lessons

Healthcare and diagnosis

Lesson 1: Prisons should ensure that, in line with PSO 3050, newly arrived prisoners have an appropriate health screen that reviews their medical history and conditions and identifies any outstanding appointments and relevant conditions.

Lesson 2: Prison staff should follow NICE guidelines for diagnosis and treatment of conditions. Furthermore, the person responsible for coordinating healthcare within a prison should ensure that there is adequate continuity of care and that so far as possible prisoners with ongoing health problems are seen by the same doctor.

Restraints

Lesson 3: Restraints should be proportionate to the actual risk posed by the prisoner, given his or her current health condition. Where the prison feels a greater means of restraint is required, the reasons for this should be well-founded and explicitly recorded in writing.

Lesson 4: Healthcare input into a risk assessment for restraining a seriously or terminally ill prisoner should be meaningful and seriously considered. If use of restraints is recommended despite medical objections, reasons for this should be proportionate and explicitly recorded.

Lesson 5: In the case of longer hospital stays, the level or use of restraints should be regularly reviewed and updated if and when the prisoner's condition changes.

Palliative and end of life care

Lesson 6: Prisons should ensure that terminally-ill prisoners who require intensive palliative care are treated in a suitable environment, in consultation with the prisoner.

Lesson 7: Prisons should ensure that end of life and palliative care plans are initiated at an appropriate and ideally early stage for prisoners who are diagnosed with a terminal illness. These plans should include all aspects of a patient's care, including effective pain relief and psychological and emotional support and, where appropriate, should involve the prisoner's family.

Family involvement

Lesson 8: Prisons should ensure that, with the consent of the prisoner and agreement of the family, trained family liaison officers involve families in end of life care, and promptly notify them when the prisoner is taken to hospital.

Lesson 9: Prisons should ensure that, in line with the wishes of both the family and the prisoner, the nominated next of kin of seriously ill prisoners are informed as soon as possible and that a trained family liaison officer (FLO) is appointed to keep families informed about their condition.

Early release

Lesson 10: The process of applying for a prisoner's release on compassionate grounds should be timely and given the appropriate priority. To adequately facilitate this, prisons should appoint a relevant contact to progress the application, once the process has begun.

Lesson 11: Risk assessments associated with applications for compassionate release should be contextual, and based on an assessment of actual risk given the prisoner's current health condition.

Dementia and complex needs

Lesson 12: Prisons should ensure that patients with complex health needs have personalised care plans in place, and that both primary physical health and mental health care teams effectively share information to ensure a coordinated approach to care.

Lesson 13: Risk assessments for in-possession medication should take account of a prisoner's history, and should be regularly reviewed if the prisoner presents with reduced cognitive function, such as symptoms of dementia.

1. Introduction

As the number of older people in our prisons increases, both proportionately and in absolute terms, the number of deaths we see in prisons will inevitably follow suit. In the last decade, the number of naturally-caused deaths of prisoners over 50 has more than doubled. The substantial increase of older people dying in prison has meant that the Prison Service increasingly has to grapple with risks and procedures they were not previously forced to consider, when prisons in England and Wales were more likely to hold fit young men.

The Care Act¹ clarified that Local Authorities are responsible for assessing the care needs of older prisoners and providing support. This legislation, along with the national and international expectations that require prisoners to be able to access a level of care equal to that in the community,² are significant and positive developments for health and social care in prisons. However, faced with an increase in the population of older prisoners and without a properly resourced and coordinated strategy for this group, prisons still face a number of challenges associated with ageing populations. This publication elaborates on a number of the challenges. It uses representative case studies throughout to illustrate common themes and findings. We offer a case study here to illustrate a broader point: the case of Mr E shows that the challenges confronting prisons in light of an ageing population are frequently of a different kind than those confronting the community.

Mr E was suffering from a very painful, but non-life threatening autoimmune disease for which he had to attend hospital. His disease meant that he was covered in weeping sores and shedding skin. He was assessed as a low security risk, but despite this, and despite his painful medical condition, he was restrained by way of escort chain for all but medical treatment for the duration of his stay. It was clear the cuff from the escort chain was causing him further pain – he had blisters as a result, which were bandaged by healthcare staff. While in the hospital, Mr E collapsed due to a pulmonary embolism while using the bathroom. He was still chained to the escort officer at the time of his death.

The case of Mr E, and others that are illustrated within this publication, represent our natural causes investigations, but also suggest a broader conclusion with respect to ageing and dying in prison. Ultimately, aspects of the challenges we have identified are prison-specific and we need more prison-specific research and evidence-based approaches to tackle the issues surrounding ageing and dying in prisons; evidence from the community is often not analogous.

As will become clear in the course of this publication, ageing in prisons and the concerns that accompany this demographic shift, raise specific challenges for the Prison Service.

These challenges are distinct from those experienced in the community, and play out very differently behind bars. For example, in the community, the use of restraints is rare, employed very occasionally for clinical or safety purposes. In prison it is more commonplace, given the necessity of security considerations. However, in prison, we nonetheless expect a well-reasoned and proportionate risk assessment that considers the prisoner's health and its impact on the risk that otherwise governs the way in which they are managed and their liberty routinely constrained. Similar tensions occur in a number of other situations that are associated with ageing and dying in prison: how do we, if at all, involve the family in a prisoner's care, when the next of kin may have been victimised by the prisoner? What are relevant factors to consider, to balance security and dignity, when deciding to release a terminally ill prisoner early? Furthermore, many of the factors that compound the negative effects of ageing are further exacerbated in prison: loneliness, loss of routine, or loss of independence, for example.

We will revisit Mr E in more detail, later in this publication. Additionally, the following pages include 13 further case studies providing lessons that prisons can learn from our investigations into naturally-caused deaths of prisoners over 50. The case studies are chosen based on their representativeness of our frequent recommendations; they are neither unique nor extreme in their failings. Most importantly, these case studies, in addition to illustrating lessons, tell the stories of 14 men and women held in the care of the state; they give us a sense of the impact of serious illness and health conditions on prisoners, and the challenges of delivering effective care with humanity while balancing concerns about risk and security.

This publication also uses descriptive statistics to provide context to our lessons, and to identify some of the issues that arise in the course of Prison and Probation Ombudsman (PPO) investigations. It takes a closer look at these scenarios, and outlines a number of lessons establishments can learn from collective analysis of our investigations. In terms of subject matter, we elaborate on findings about: restraints, healthcare and diagnosis, palliative care, early release, family involvement, and dementia and complex needs. We will also include an example of good practice.

The findings fall under three overarching themes. First, a number of our lessons mandate that prison staff should make **proportionate decisions in context**. This is the case with our recommendations about restraints risk assessments, determining when and how to involve families, or assessing applications for compassionate leave, for example. We often see assessments undertaken either using outdated or irrelevant evidence, or assessments that do not account for relevant factors in a meaningful way. The first group of lessons aims to address this.

The second broad theme that shapes our lessons calls for prisons to **have a coordinated approach to the care and management** of older prisoners. We have found that some processes or situations can lack coordination. This is particularly the case where a prisoner's condition is complex, or where multiple organisations, teams, or individuals are involved in the prisoner's care or management. These lessons aim to address these scenarios.

Finally, the third grouping of lessons asks that prison and healthcare staff be aware of and ensure their actions **conform to local and national policies**. In many investigations, recommendations could have been avoided if, for example, prison or healthcare staff had adhered to Prison Service Orders (PSO) or had been aware of NICE guidelines. While it seems obvious, this group of lessons emphasises the importance of prisons following their own instructions and policies, and underscores how necessary it is that frontline staff properly understand them.

Overall, we hope the lessons this publication identifies assist prisons to better cope with the changes ahead, and provide an evidence base that will contribute to an effective older prisoners' strategy.

2. Ageing prison populations

2.1 Changing prison demographics

The proportion of older prisoners has been growing over the past decade and a half. In absolute terms,

the numbers of prisoners over the age of 50 has nearly trebled, from more than 4,800 in 2002, to nearly 12,600 in 2016.³

Figure 1: Total number of prisoners by age group

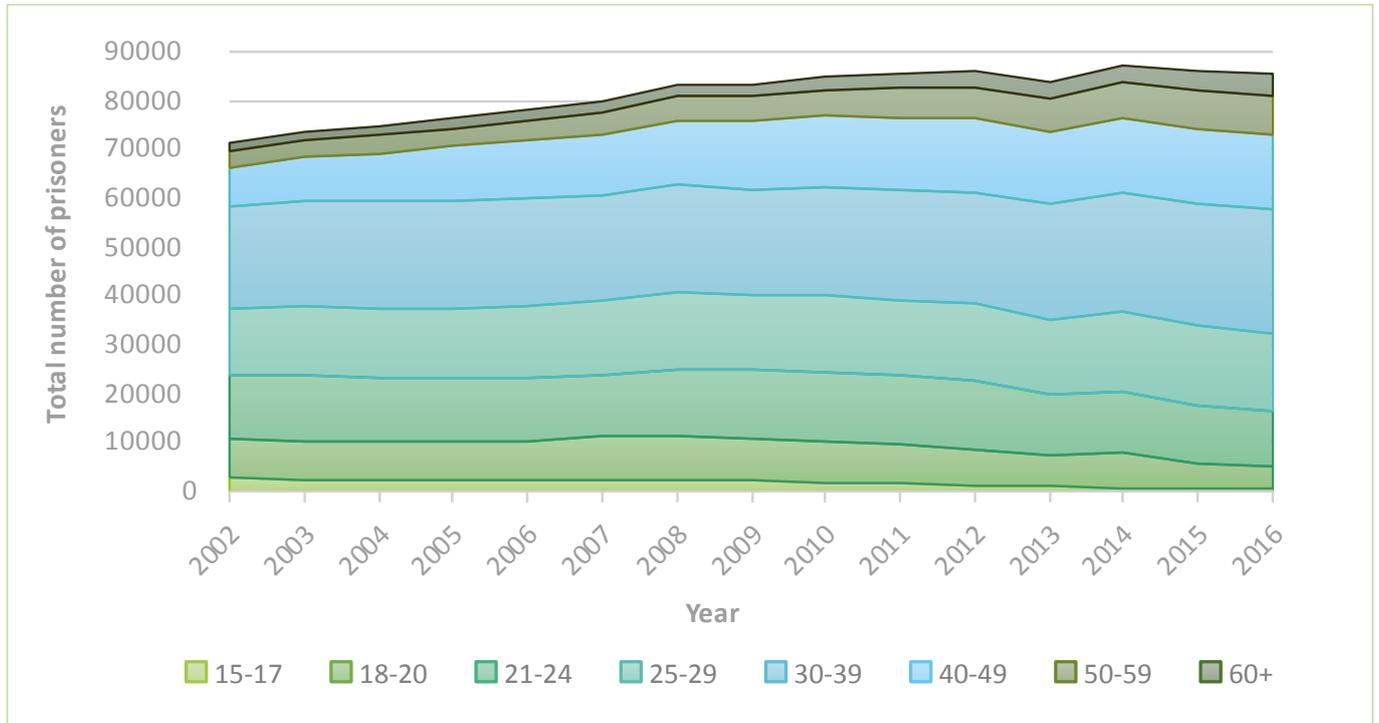
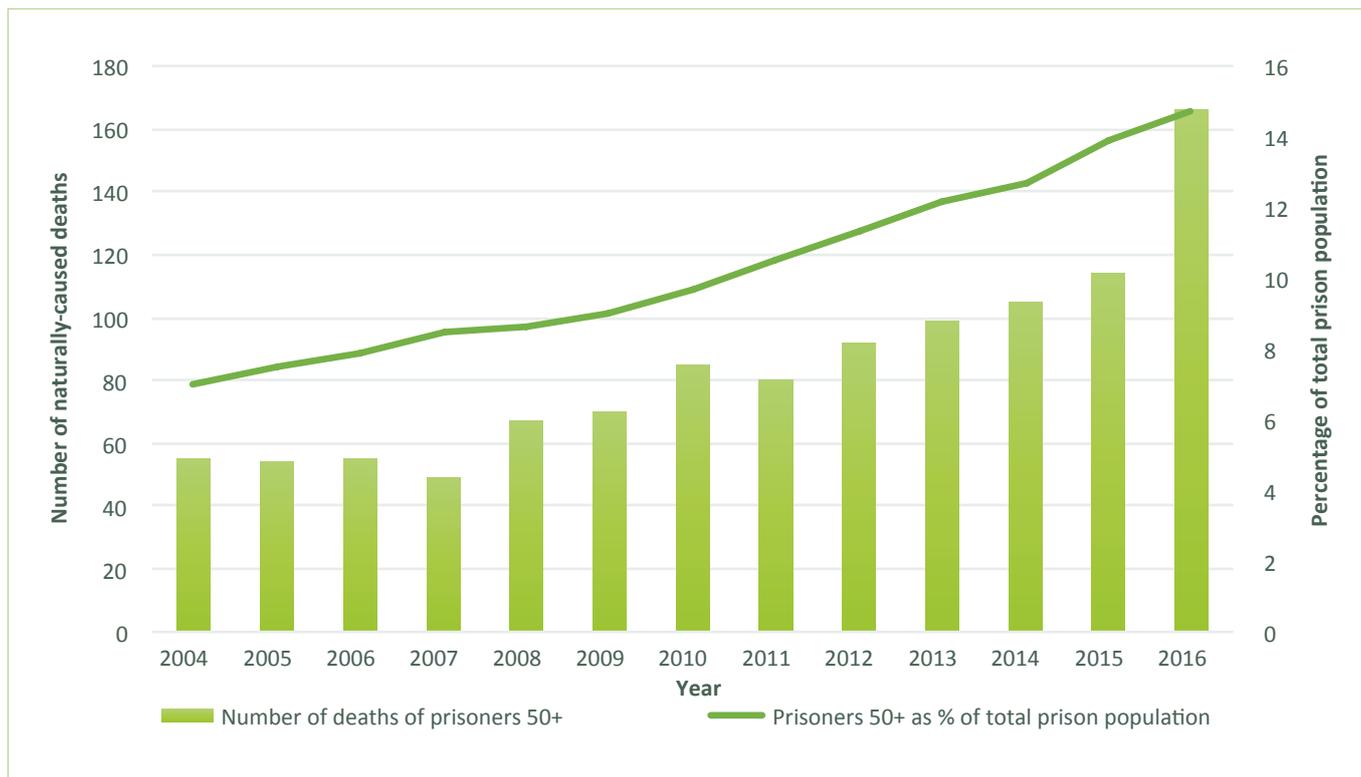


Figure 2: Number of naturally-caused deaths of prisoners over 50 and prisoners over 50 as a percentage of total prison population, 2004-2016



As demonstrated in figure 2, the populations of prisoners aged 50 and older are expected to rise over the next 15 years, both in terms of absolute numbers and the overall proportion. The over 50 population is projected to grow from 12,700 (as of 30 June 2016) to 13,900 by the end of June 2020 – an increase of nearly 10%. This change is even more marked with respect to the prison population over 70, where projections anticipate a 35% increase.⁴

The age profile of the general population in England and Wales is shifting, with expected increases in the median age over the coming decades.⁵ These shifts are reflected in prisons too, though to a much greater degree. The overall demographic shift and increase in life expectancy contribute to an ageing prison population as, quite simply, even if patterns of criminal activity remain the same, there will be a greater number of people over 50 to commit crimes. Given this, we would expect an increase in older people receiving custodial sentences. However, further factors drive the ageing prison population in addition to normal demographic changes.

Changes in sentencing practices toward longer custodial sentences mean that more people are growing older in prison.⁶ Indeed, figure 1 shows a marked increase in the proportion of prisoners over 50 from 2012, which correlates to the imposition

of longer sentences mandated by the Legal Aid, Sentencing, and Punishment of Offenders Act, 2012 (LASPO). Finally, there is evidence that changes in the offence mix will result in a greater proportion of prisoners over 50. This is particularly the case given the upsurge in prosecution and incarceration of sex offenders, often for historic crimes, as these offenders tend to be relatively older.⁷

In this publication, we demarcate those 50 and above as ‘older’ prisoners, and do so for several reasons. Practically, we adopt this cut-off point to keep consistent with other relevant organisations.⁸ This allows us to better set our research in the broader context of work now conducted about the ageing prison population. Substantively, we demarcate those 50 and above as ‘older’, as there is evidence prisoners experience an earlier onset of certain health problems than do older people within the community.⁹ Designating prisoners ‘older’ by similar means as we would those in the community (say, by designating retirement age as a relevant cut off) would assume prisoners experience old age in prison much the same way others would in the community. While prisons strive for equivalence in healthcare, we have numerous examples that the experience of ageing in prisons is very different and adopting a higher cut-off point for ‘older’ prisoners would not acknowledge this.

2.2 PPO cases

This thematic review focuses on lessons learned from PPO fatal incident investigations into the deaths of older prisoners. The data used for this publication includes all naturally-caused deaths of prisoners aged 50 or older that occurred between 2013 and 2015 inclusive, where the investigation was complete at the beginning of the analysis period. This publication focuses on our natural causes death in custody investigations only, and excludes our investigations of self-inflicted deaths, homicides or those whose cause of death was classified as ‘other non-natural’.¹⁰ Moreover, this sample includes deaths in prisons only, and not deaths that have occurred in other establishments within the PPO’s remit (Immigration Removal Centres, for example). This sample includes 314 investigations. The youngest person included in the data was 50 at the time of death, and the oldest was 94 at the time of death.

The PPO sample of naturally-caused deaths shows a much higher proportion of sexual offences and other serious offences, when compared with the broader prison population.¹¹ Of those included in the PPO sample, 60% were convicted of sexual offences.¹² This is a much higher proportion than the broader prison population, where only 16% of those under immediate custodial sentence were for sexual offences.

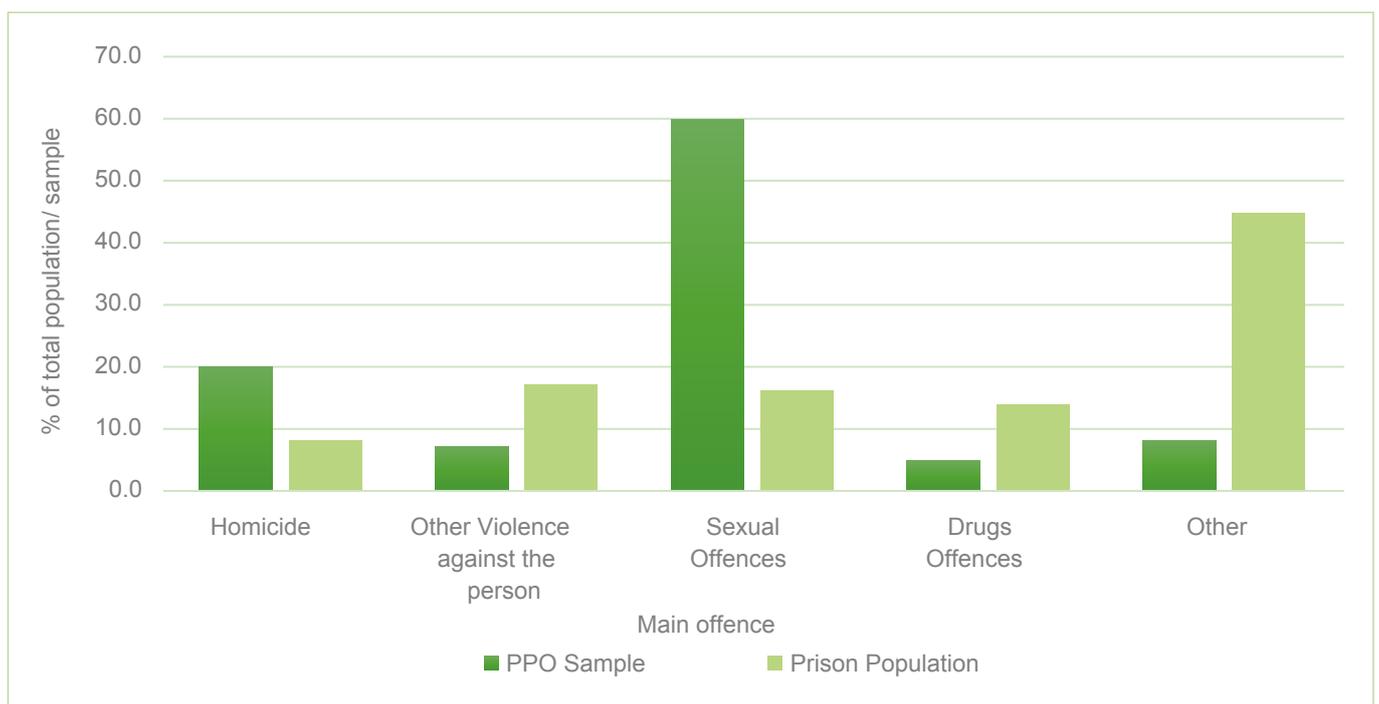
The next most common offence in the sample was homicide, accounting for 20% of the sample, compared with 8% of the prison population. Other offences against the person accounted for 7% of the sample, as compared to 17% of the prison population. In the sample, 5% of those who died in prison of natural causes were convicted of a drugs offence, whereas

this represents 14% of the broader prison population. In the broader prison population, 44% of prisoners were convicted of offences with shorter sentences, such as robbery, theft, or public order offences. These cases made up only 8% of the sample for this publication. This reaffirms one of the demographic drivers discussed above: that older prisoners are more likely to be serving longer sentences for serious crimes, particularly sexual offences.

We also collect data on the security category of those who have died in custody, as shown in figure 4. Prisoners are assigned security categories based on their risk of escape and risk to the public. In men, these categories range from category A (for those who are considered most dangerous to the public or to national security, should they escape) to category D, who are low risk prisoners often in ‘open’ prisons. In between are category B prisoners, who do not require maximum security conditions, but could still pose a risk to the public upon escape; and category C prisoners, who are unlikely to escape, though cannot yet be trusted in ‘open’ conditions.¹³

We discuss security category here for context, as it arises throughout this publication, particularly when we talk about risk assessments for prisoners. It is important to note that the location of a prisoner is determined by more than just their security category. The allocation process also considers a number of factors relevant to older prisoners, for example, healthcare requirements, vulnerability of the prisoner, or family issues.¹⁴

Figure 3: Main offence committed by those in the PPO sample compared with the prison population

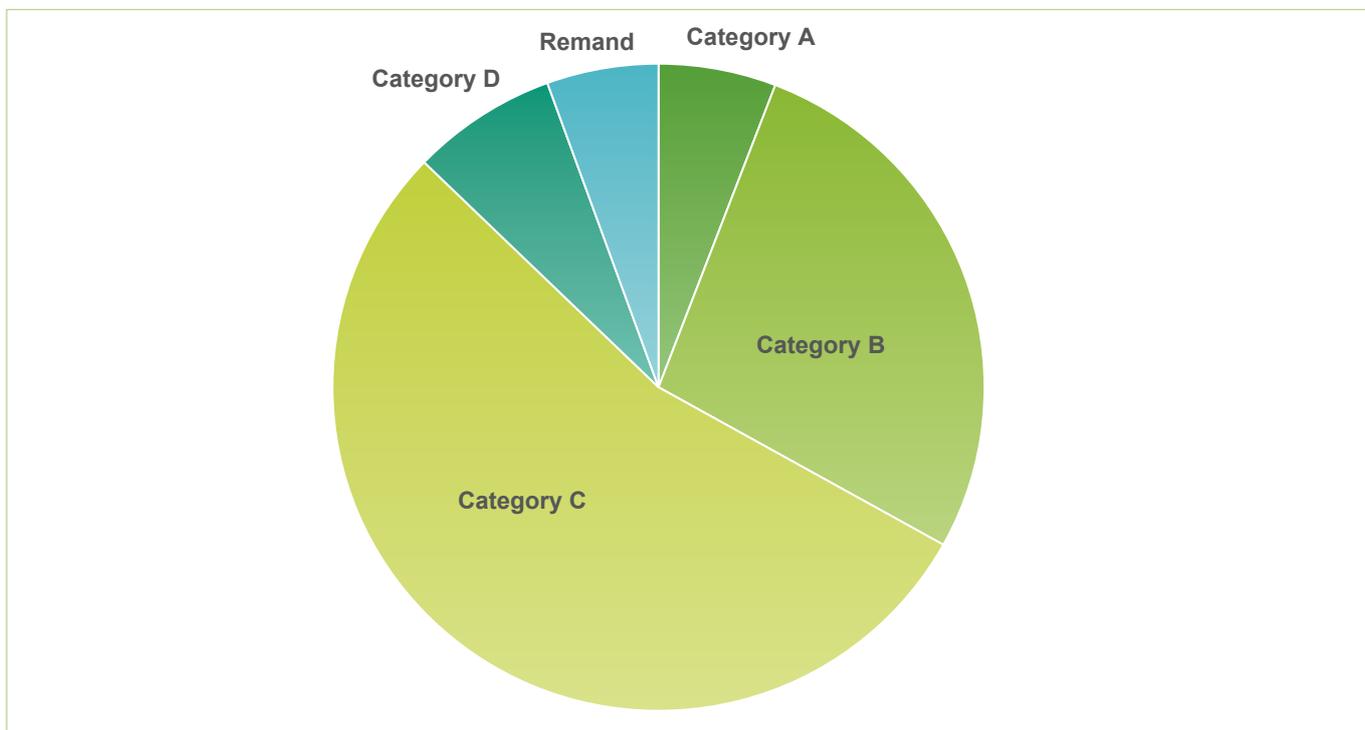


Location is relevant to the treatment of older prisoners because certain prisons will be more capable of caring for elderly prisoners than others – this is particularly the case where prisons have a large, existing population of older prisoners. For this reason, it is possible and even likely, that we might find older, lower security prisoners in a higher security establishment. This is relevant to the topic at hand because those who work at higher security prisons are necessarily more familiar with higher category security protocol. Several times throughout this publication, we identify lessons that prisons can learn with respect to making risk assessments based on individual circumstances, and identify instances where these risk assessments have been approached

as box-ticking exercises. Remediating this routine approach can be more difficult where interactions with lower security, terminally ill, disabled, or vulnerable, prisoners are the exception rather than the norm. This is an issue that deserves further consideration and one that will be of particular interest in the development of an older prisoners' strategy.

In the sample of investigations considered by this publication, the majority of prisoners were classified as either category C at the time of their death (54%) or category B (27%). Prisoners designated categories D and A made up 7 and 6 per cent of the sample, respectively. Six per cent of prisoners were on remand at the time of their death.

Figure 4: Prisoners in the sample by security category (proportion of total sample)



The majority of the prisoners in the data were male (308 of the 314 cases), representing 98% of the sample. This is above the national average for 2015, where those identifying as male make up 95% of the prison population.¹⁵

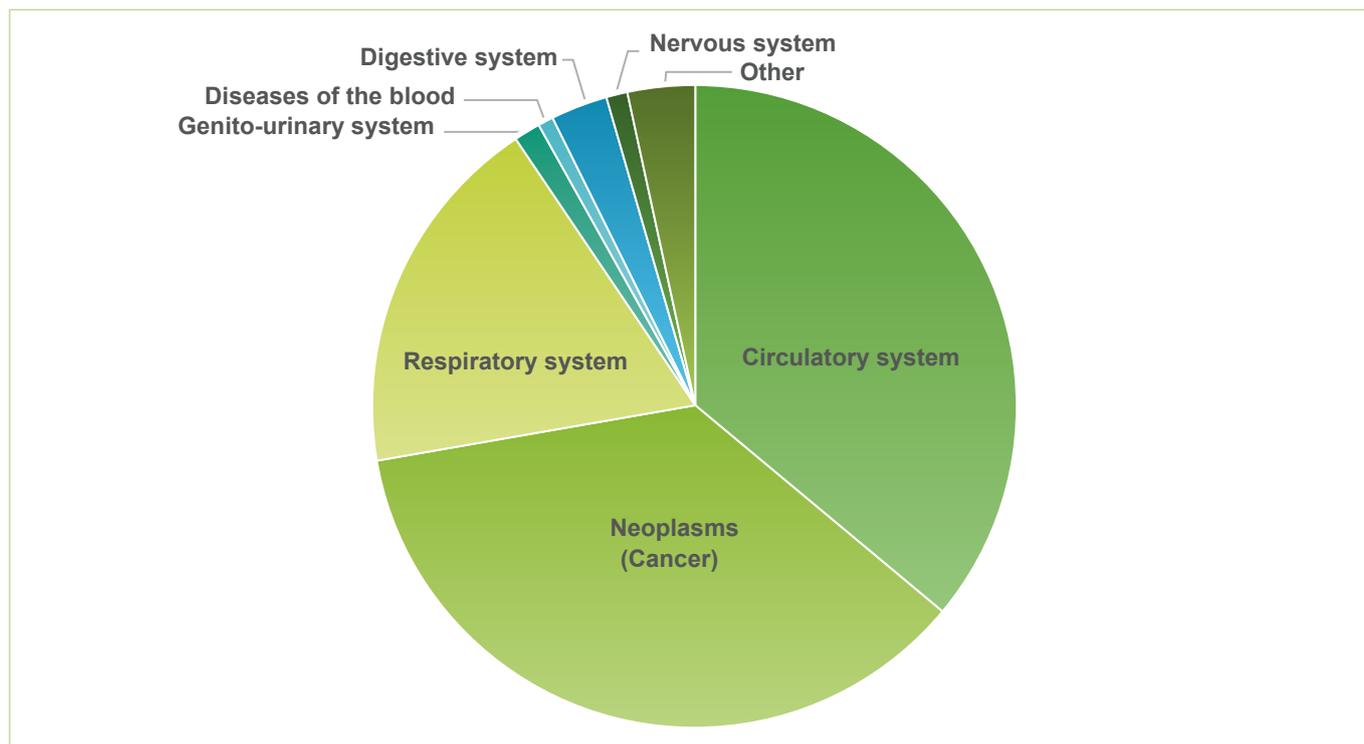
Ethno-nationally, 90% of these prisoners were recorded as both white and British. This is a higher proportion than is found more broadly in England and Wales, with 80.5% identifying as both white and British in the population as a whole.¹⁶ In the sample, 5% was recorded as either as white and Irish or white and another nationality. Less than 5% of the sample was recorded as minority ethnic – 1.5% are recorded as black or black British, and 2% as Asian or Asian British. Also, as we might expect, more than a quarter of our investigations involved prisoners with a physical disability.

This publication identifies several lessons relevant to prisoners with protected characteristics – particularly with respect to disability. These underscore that ‘one size fits all’ can no longer apply to the Prison Service, and that policies need to be multidisciplinary and

context-driven, to account for the multiple levels of need or disadvantage that shape the circumstances leading up to a prisoner’s death. As with location issues, this could be a fruitful area for further research, and further coordination by way of an older prisoner strategy.

The PPO collects data on the primary identified cause of death, as identified in the post mortem. Data for this sample is shown in figure 5.¹⁷ Tied for the most common cause of death within the sample are cancer and circulatory system conditions, such as heart attacks. These causes represent 36% of the sample each. The third most common condition is respiratory system failure, which is the main cause of death in 18% of the sample. Beyond these three categories, other main causes of death are less common. Conditions affecting the digestive system claimed three per cent of the sample, as did ‘other’ causes. Conditions of the nervous system, genitourinary system, and diseases of the blood represent approximately one per cent of the sample each.

Figure 5: Prisoners in the sample by the main condition identified as causing death (proportion of total sample)



3. Healthcare and diagnosis

An ageing prison population is accompanied by rising pressures on healthcare staff and resources. This is true for prisons, as it is true for the community. Furthermore, there is evidence that older prisoners display higher and earlier rates of chronic illness than we see in the community.¹⁸ A greater proportion of prisoners are classified as disabled compared to the broader population.¹⁹ The frequency and extent of these conditions within the prison population means that resources will be increasingly stretched as the population ages, and makes it all the more pressing that prisons have in place effective policies and processes that will allow them to ably care for ill and disabled prisoners.

When the PPO investigates a death in custody, either NHS England or Health Inspectorate Wales commissions a clinical reviewer (a relevant healthcare professional who reviews any clinical care the prisoner may have received during their sentence) and determines whether the care the prisoner received was equivalent to what he or she could have expected to receive if they were still in the community. In determining this, the clinical reviewer will examine a number of factors, foremost, whether the relevant Prison Service Orders (PSOs) and/or National Institute for Health and Care Excellence (NICE) guidelines were followed.

Concerns about the quality of healthcare or diagnosis of prisoners frequently underpin recommendations resulting from our investigations. In particular, we often see cases where hospital referrals are not made in a timely manner (relevant recommendations in 15% of cases in the sample), where hospital appointments are missed (recommendations in 16% of the sample), or where healthcare is poorly co-ordinated and continuity of care is not maintained (recommendations in 6% of the sample).

Many of the healthcare-related policies within prisons are governed by PSO 3050, which mandates that prisoners are entitled to the same level of care they could expect in the community.²⁰ It provides for continuity of care, saying that prisons should make every effort to retrieve information from the prisoner's GP or the most recent health service he or she has seen. It also mandates that prisoners must have an initial health assessment within the first week of their reception to custody.

The case of Mr A, below, is an example of a situation where several aspects of the prison's care fell below expectations.

Case study A

Mr A was 61 at the time of his death. Throughout the first years of Mr A's sentence, he suffered from a number of conditions, including frequent indigestion, an inflamed oesophagus, and an enlarged prostate. Four years into his sentence, a doctor discovered a large gallstone, and Mr A was referred to a consultant for possible surgery. Before he could have this appointment, he was transferred to another prison, and referred to another hospital, but a GP did not assess him on arrival, and his hospital appointment did not happen. Mr A was feeling persistently ill and asked to see a doctor several weeks after his transfer, but this did not happen until nearly two months after his arrival. The doctor attributed his symptoms to his gallstone. Over the next month, Mr A continued to suffer stomach pains, had dizzy spells, lost weight, and collapsed several times. Doctors did not fully examine him.

Three months after his arrival, and after persistent abdominal pain and nausea, Mr A was taken to hospital. Tests showed that he had pancreatic cancer and his life expectancy was estimated between six and twelve months. Several months later, Mr A was transferred to a prison that was better able to look after his needs and where he was closer to his family. Here, they implemented an effective palliative care plan. We consider he received a good standard of care at his final establishment, but care fell short at his previous location. Mr A received no effective healthcare assessment upon arrival, his symptoms were ineffectively monitored, and no one reviewed his care plan as his condition changed. We made recommendations to remedy these shortcomings.

In the above case, Mr A received no effective assessment upon arrival – a duty mandated by PSO 3050. While an initial health assessment and a more timely examination of his symptoms would not have prevented death, an earlier diagnosis could have provided some relief of his symptoms and made the last year of his life more comfortable. Mr A's case makes clear the need for continuity of care in cases of location transfer, and underscores the need for initial health assessments upon arrival, even if the prisoner is not arriving from the community. We identify the following lesson.

Lessons to be learned

Lesson 1

Prisons should ensure that, in line with PSO 3050, newly arrived prisoners have an appropriate health screen that reviews their medical history and conditions and identifies any outstanding appointments and relevant conditions.

The case of Mr A illustrated one of our more frequent healthcare-related findings: the fact that prisoners' symptoms were not as thoroughly or proactively investigated as they would be in the community. With respect to Mr A, additional symptoms were attributed to an existing gallstone problem, without further investigation. This failing is even more apparent with respect to Mr B, below. Here, Mr B's symptoms were ascribed to a previous diagnosis of irritable bowel syndrome and, though his symptoms were worsening and varying, healthcare staff did not conduct a routine examination that would have helped identify his cancer.

Case study B

Mr B was recalled to prison for breach of licence conditions. Four years later, he complained of abdominal pain and was referred to the prison GP. The GP saw him 10 days later and referred him for an ultrasound scan, which took place more than a month later. A doctor diagnosed irritable bowel syndrome and gave advice as to how to manage this condition through diet. Mr B continued to have severe abdominal pain multiple times over the next two months and a prison doctor requested a blood test, the results of which turned out to be abnormal, and made a referral to the gastroenterology department at the local hospital. There was no evidence that the hospital received this referral letter. A month later, prison officers were concerned that Mr B appeared to be in pain and had a distended stomach. He was admitted into hospital that evening and, after more than a week, diagnosed with widespread colorectal cancer. He remained in hospital until his death, at age 60, two weeks after diagnosis.

Our investigation found that differing healthcare staff at the prison saw Mr B at least 14 times for abdominal pain without conducting a rectal examination. The clinical reviewer noted that such an examination would have been standard given his symptoms. The clinical reviewer concluded that the standard of care Mr B received while in prison fell below that which he could expect in the community. We made recommendations about referral to hospital, continuity of care, and medical examinations.

Despite the fact that Mr B had persistent and escalating symptoms for which a member of the healthcare team saw him at least 14 times, they did not conduct the standard examination that could have diagnosed his cancer. The clinical reviewer for this case considered this fell short of NICE guidelines for the diagnosis and treatment of his symptoms. Furthermore, we considered there was a lack of continuity of care between healthcare professionals, and that this materially contributed to the lack of adequate investigation of Mr B's symptoms, which resulted in the delayed diagnosis.

Lessons to be learned

Lesson 2

Prison staff should follow NICE guidelines for diagnosis and treatment of conditions. Furthermore, the person responsible for co-ordinating healthcare within a prison should ensure that there is adequate continuity of care and that so far as possible prisoners with ongoing health problems are seen by the same doctor.

4. Restraints

The most frequent recommendation our office makes concerns the use of restraints for ill or dying prisoners. We acknowledge that restraining prisoners who are attending outside hospital appointments is normal practice. What is newer, and what our investigations find prisons cope less well with, is understanding when it is appropriate to restrain the elderly and infirm.

In the deaths in custody cases we investigate, we usually see one of three means of restraining a prisoner when they are outside the establishment.²¹ The first, and most immobilising, means of restraint is double cuffing. This entails the prisoner having their hands cuffed in front of them, with another set of cuffs attached from one of the prisoner's wrists to the wrist of an escorting officer. This is usually recommended for moving category A or B prisoners in good health²² – those who are most likely to escape or those who pose the greatest risk to the public. The second method is single cuffing. Here, a single set of handcuffs is used to attach one of the prisoner's wrists to one of the escorting officer's. The third method of restraining a prisoner is by way of escort chain. This is a long chain with a cuff at either end, one of which is attached to the prisoner's wrist, the other is attached to the escorting officer.

Our expectations, guided by the law of the land, as to how prisoners are restrained when they are not on prison grounds are based on the High Court judgement in *R (Graham) v. Secretary of State for Justice*.²³ This case criticised routine restraint of prisoners on hospital visits without any prior risk assessment, suggesting such restraint was capable of infringing Article 3 of the European Convention on Human Rights, which prevents inhumane or degrading treatment. This judgement requires an individual risk assessment of the prisoner – one that takes into account the crime for which the prisoner was convicted, a prisoner's previous history, a prisoner's category, prison records and a prisoner's current fitness. As a result, when the PPO investigates a death in custody, we look to see if risk assessments for prisoner restraints are in place, whether they are proportionate, and whether they include meaningful input from healthcare staff.

We frequently recommend that the prison's Governor should ensure that staff who undertake risk assessments for the use of restraints understand the legal requirements in the *Graham* judgement (outlined below), and that these assessments are based on the *actual* risk the prisoner poses at the time, critically taking full account of the health of the prisoner.²⁴

Within the sample of 314 cases used for this publication we made this recommendation in nearly 60% of cases in both 2013 and 2014, and nearly 50% of cases in 2015. Given the frequency with which we make this recommendation, we have collected lessons on this theme in previous publications – for example, see our Learning Lessons Bulletin, titled *Restraints*,²⁵ and the restraints section of our *End of Life Care* thematic review.²⁶

It is remarkable then, against this background, that we frequently investigate deaths where we find the level of restraint used is inappropriate. The prevalence of instances where older prisoners, who have been diagnosed with a terminal or otherwise serious illness, have been unduly restrained is particularly noteworthy, as their medical conditions are highly likely to impact on their assessed level of risk as their health fails. This is one of the most typical failings of the risk assessment processes we have evaluated.

This year marks the 10th in which the *Graham* judgement has stood. In the intervening years, the Prison Service has incorporated *Graham*'s findings into relevant guidance. For example, the National Security Framework on External Escorts²⁷ gives advice on the restraint of terminally ill patients who are not category A prisoners.²⁸ It mandates several instances where handcuffing will not normally be employed, including instances where the prisoner's medical condition, advanced age, or physical impairment severely limits the prisoner's mobility. It is unacceptable that we should have to make such recommendations in more than half of the cases sampled for this analysis, in cases where prisoners were terminally ill, in extreme pain, had severely limited mobility or sometimes up to the point of death.

The case of Mr C, below, is one such instance. This case is a representative example of an instance where the perceived risk of the prisoner did not appear to warrant the degree of restraint applied. It is striking that the prison admitted that this degree of restraint for a prisoner like Mr C was common practice rather than a one-off occurrence.

Case study C

Mr C was serving an indeterminate sentence for public protection (IPP). He had severe kidney disease, high blood pressure, and a circulatory disorder that limited his mobility. Mr C attended hospital regularly for dialysis treatment as well as treatment for his other ailments. Four months before his death, his condition deteriorated further and he was transferred to a prison that was better able to offer 24 hour care. At his new location, Mr C continued to attend the hospital as an outpatient. In his final months, Mr C's health was very poor, he could not walk and used a wheelchair. He was a category C prisoner and 65 years of age. Risk assessments rated him a medium risk to the public and a low risk of escape, but recommended the use of double cuffing at all times. This was amended by another prison manager to suggest escorting officers could use an escort chain during treatment or when Mr C was using the toilet.

Mr C attended several appointments over the next few months and risk assessments nearly always recommended double cuffing, with an escort chain during treatment. Indeed, when interviewed, a security manager told us that normal procedure for transporting a category C prisoner was double cuffing. We expect, in line with Prison Service Instruction (PSI) 33/2015, when double cuffing is used on a category C prisoner like Mr C, reasons for doing so are explicitly recorded in writing. This did not happen here. We did not consider that the prison adhered to the guidance in the *Graham* decision in this case, and made recommendations to this effect.

Mr C had seriously limited mobility, was in poor health, and was a category C prisoner only assessed as a low risk of escape and a medium risk to the public. We could see no reason that he required the same level of restraint usually used for higher risk prisoners in good health. We frequently see prisoners restrained disproportionately to the risk they pose; we are less commonly told that this is routine procedure. We consider that prisons can more broadly learn lessons about proportionality and record keeping from this case and propose the following lesson, which accords with the law and the Prison Service's own instructions:

Lessons to be learned

Lesson 3

Restraints should be proportionate to the actual risk posed by the prisoner, given his or her current health condition. Where the prison feels a greater means of restraint is required, the reasons for this should be well-founded and explicitly recorded in writing.

In addition to proportionality and record keeping, we commonly find that risk assessments have inadequate input from healthcare professionals. Healthcare input is explicitly required in the case of prisoners with terminal or otherwise serious illnesses, as the *Graham* decision requires assessments be based on the actual risk the prisoner poses, fully accounting for his or her health. We often find that input of this nature is a cursory 'tick-box exercise', and consultation with healthcare professionals was limited to a member of staff circling a statement that notes no objection.

Still more concerning are instances where healthcare input is meaningful, but where it is ignored by the person undertaking the risk assessment without recording explicit reasons as to why. The case of Ms D below illustrates both of these points as, in the first instance, medical input into the level of her restraints was cursory and, in the second instance, it was either ignored or overruled without explanation.

Case study D

Ms D was sentenced to six years in prison. She was a heavy smoker, and had multiple sclerosis and osteoarthritis of his hip and used a wheelchair to facilitate mobility. Three and a half years after her reception into prison, she began coughing up blood and was taken to hospital for tests. Risk assessments concluded she was a 'medium' risk to the public and of escape, though a 'low' risk of receiving outside help, and recommended she be escorted to appointments by two staff, and restrained by single cuffs (though, in actuality, an escort chain was used). Input from healthcare staff as to the level of restraint was brief, simply noting no objections, and no reasons were recorded as to why this level of restraint was used.

Eventually medical assessment revealed Ms D had lung cancer. Two weeks after diagnosis, the prison moved her to their inpatient unit. Two weeks after this, Ms D collapsed in her cell and the prison called an ambulance. This time, the medical section of the risk assessment stated that healthcare staff objected to the use of restraints given Ms D's condition. Despite this,

use of restraints was recommended for transport. This recommendation was only rescinded when it became clear Ms D was dying. Ms D passed away in the ambulance on the way to the hospital. She was 66 years old. We were not satisfied that Ms D's medical conditions were adequately factored into the prison's risk assessments. Furthermore, it appeared healthcare input into the risk assessments was either cursory or ignored. We recommended the prison's restraints practice better reflect the requirements of the *Graham* judgement.

Ms D's case is one that displays the PPO's concerns about ensuring healthcare professionals have effective input into risk assessments for restraints. In the first instance, healthcare input was cursory and lacked meaningful detail. In the second instance, healthcare input objected to the use of restraints due to Ms D's failing health. Regardless, the prison decided to use restraints for transport, without noting why they had not heeded objections of healthcare staff. In response to this case and the many others like it, we consider that the following lesson can be learned.

Lessons to be learned

Lesson 4

Healthcare input into a risk assessment for restraining a seriously or terminally ill prisoner should be meaningful and seriously considered. If use of restraints is recommended despite medical objections, reasons for this should be proportionate and explicitly recorded.

The more distressing cases of restraint that we see involve prisoners who are restrained at the point of death, still attached to the escorting officer. This is not only upsetting for the prisoner, but also for the escorting officer. The case of Mr E, below, is one such case. It is included because, in addition to reiterating the importance of the previous two lessons about restraints, it also brings attention to the impact of changing circumstances – shifts in pain levels, health conditions, and risk – and illustrates why the use of restraints should be reviewed in line with these changing conditions. Even where input from healthcare staff is included in the initial assessment (and that is not the case with Mr E), chronic or fatal health conditions are infrequently static – the prisoner's condition, and thus their risk, is liable to change. We recommend that the level and use of restraints should be reviewed and updated accordingly.

Case study E

Mr E was 51, a category C prisoner being considered for category D (lowest security risk), on recall for breach of licence. He had a non-life threatening but extremely painful auto-immune disease, for which he had to go to the hospital. The risk assessment for restraints recommended an escort chain was used, but authorised double cuffing if the escort officers had security concerns. Mr E was in extreme pain, covered in weeping sores, and shedding large areas of skin as a result of his illness. While, at one point, healthcare staff put a bandage under the cuff, it was clear they were giving him blisters and causing him additional pain. An escort officer asked for permission to remove the cuff so the prisoner could take a bath, and this was refused as it was not a medical treatment. At one point, Mr E asked to use the toilet, and did so still chained to the escort officer. Mr E collapsed on the toilet due to a pulmonary embolism. Resuscitation was unsuccessful.

We did not consider that there was sufficient healthcare input into the risk assessment, nor did we consider that the level of restraints used was proportionate to the degree of risk posed by the prisoner. The prison had previously received the standard restraints recommendation, and accepted it – we reiterated this recommendation.

In the case of Mr E, while death was not expected, it became apparent the prisoner was in poor condition, was in a great deal of pain, and that the restraints were exacerbating this. Escorting staff asked a manager for permission to remove restraints at least once. Furthermore, hospital staff had to take additional measures to alleviate discomfort caused by the restraints, given his condition. There is evidence that, given double cuffing was authorised, the risk Mr E posed was over-estimated. Even if this was not the case, Mr E's health was worsening and his pain increasing. However, despite all this, there was no evidence that the use or level of restraint was reviewed at any time during his hospital stay. We identify the following lesson.

Lessons to be learned

Lesson 5

In the case of longer hospital stays, the level or use of restraints should be regularly reviewed and updated if and as the prisoner's condition changes.

5. Palliative and end of life care

In many of the cases the PPO investigates concerning older prisoners, the prisoner was suffering from an incurable or terminal disease. In these instances, prisons are required to provide end of life care, or send the prisoner somewhere more able to provide palliative care. Palliative care and end of life care are different, though related, concepts.²⁹ End of life care includes palliative care. End of life care involves supporting those in the last months of life to live as well as possible and die with dignity. Palliative care is usually given to someone with a serious illness. Its aim is not to cure the individual, but to prevent or treat pain and other symptoms. Palliative care can be given to those prior to a terminal diagnosis, while they are receiving other treatments. Having such services available is increasingly essential in many prisons as they adapt to the demographic shift they are experiencing.

Our thematic review on *End of Life Care*³⁰ goes into more detail about the local policies, initiatives, and pathways for palliative care but, as some of the policies and recommendations have changed since its publication, we briefly summarise expectations for end of life care.³¹ NICE sets out 18 quality statements that govern expectations for end of life care for adults in the UK. Broadly, the quality standards suggest that healthcare facilities must have processes in place for the identification and assessment of those approaching end of life, that the support given to these individuals is holistic, that staff be appropriately trained, and that this care does not stop at death – it continues to offer support to families and other loved ones in times of bereavement.³²

Quality statement four, governing the physical and psychological support of those at the end of life, states that service providers should ensure services are available and systems are in place to meet the needs of those approaching the end of life. This includes access to medicines and equipment. Tied to the issue of access to appropriate equipment, is the issue of appropriate location and facilities for those at the end of life. Many of the prisons in England and Wales are older facilities, built well before the current demographic shift, when most of the prisoners they housed were younger, able-bodied men. As a result, it can be difficult to find suitable accommodation at the end of life for prisoners who suffer from decreased mobility, or require large healthcare equipment to facilitate their treatment. The case of Mr F below illustrates this point.

Case study F

Mr F was in the first year of an 18 year sentence when he was referred to hospital for shortness of breath. He had an x-ray and a biopsy at two separate hospitals, the results of which showed he had widespread cancer. He received a prognosis that suggested he had 6-12 months to live, and began chemotherapy. He outlived this estimate by a year, passing away at 65 years of age.

The prison healthcare staff discussed his illness and treatment options with him. Mr F preferred to remain on the wing as he wanted to be closer to friends. Medical records show that he had frequent contact with healthcare staff. When it was clear he was in the final months of his life, the prison put a palliative care plan in place, and enlisted the help of palliative care specialists for additional support. Mr F was also moved from his location on the wing to the healthcare unit at this time.

Our investigation found that staff at the prison supported Mr F very well in the last year of his life; however, we considered the prison's on-wing facilities were inadequate to provide end of life care and made it more difficult for healthcare staff to care for him. For example, as Mr F's mobility decreased, healthcare staff required a hoist to move him, but this would not fit in the cell. We recommended that prisoners requiring intensive palliative care are treated in a suitable environment.

For the most part, we found that the standard of Mr F's palliative care was good, however, the wings were not set up for the equipment necessary to facilitate the level of care that Mr F required. While we understand that he wanted to stay on the wing to be close to friends, cells on the wing were too small to facilitate adequate care of Mr F, putting undue stress on both the prisoner and healthcare staff.

We acknowledge that it can be difficult to balance suitability of location with honouring the wishes of prisoners, where this tension arises. Prisoners who have been on the same wing, with the same people, for a number of years – as is often the case with older sex offenders – may be reluctant to move. We understand when prisons try to honour these wishes; however, the benefit gained by keeping the prisoner in a familiar place should be balanced by detriment to the prisoner's quality of healthcare, and staff's ability to adequately care for the prisoner.

In addition to moving prisoners within an establishment, it is also possible to effect a move to another, better-equipped establishment. As we discuss in the 'Good practice' section, a number of prisons now have specialised wings that focus on palliative care, able to provide constant treatment for prisoners in their last months. In many cases we have investigated, prisons with no such facilities often move prisoners at the end of life to these specialised wings so their symptoms can be better managed. Overall, the location of the prisoner will impact the quality of care he or she receives, and we note that there are lessons to be learned in response.

Lessons to be learned

Lesson 6

Prisons should ensure that terminally-ill prisoners who require intensive palliative care are treated in a suitable environment, in consultation with the prisoner.

The NICE guidelines on end of life care for adults also stipulate the need for personalised care plans that are revised in response to the changing needs and preferences of the patient.³³ Assessments and care plans should involve the prisoner and, where possible, their family. Such care plans allow for co-ordinated care of the prisoner, allowing them to formalise their preferences and needs with respect to their physical, social, psychological, and spiritual support in the final months of their life.

Based on these guidelines, we would expect that prisoners who have been given a terminal diagnosis are consulted on a palliative care plan. A palliative care plan was put in place for Mr F, above, but this is not always the case, as is illustrated with respect to Mr G, below.

Case study G

Mr G was sentenced to life imprisonment. Twenty years into his sentence, he reported recurring back pain. After several visits, his condition had not improved and a nurse referred him for a blood test, which identified abnormalities. Further testing confirmed Mr G had an incurable form of bone cancer that affected blood plasma cells. Over the next year, Mr G had chemotherapy and a bone marrow transplant. Mr G's condition was relatively stable over the next 11 months. Nearly a year after the transplant, Mr G started experiencing increased pain, shortness of breath and swollen ankles. Further treatment was likely to come with significant side effects, including the possibility of death, so he opted to forego any more intervention. He continued to have problems with

pain management. Five months later, Mr G was admitted to hospital, and a month after this he passed away at age 62.

While we were satisfied that the care Mr G received was equivalent to that he could have expected in the community, we were concerned that no formal palliative or end of life care plan was put in place, either upon first diagnosis, or in the five months between when Mr G ceased treatment for his cancer and entered hospital. We consider having a care plan may have helped manage his symptoms better by involving experts. Furthermore, having such a plan in place would have better facilitated family involvement in Mr G's final years, given we found several deficiencies with respect to family involvement in this case.

Mr G's care was not poor, but could have been coordinated more effectively with a care plan. Furthermore, a care plan would have ensured that his wishes for his last months of life were recorded and his psychological and emotional needs were better met. We suggest that the following lesson can be learned with respect to implementation of end of life care plans for prisoners.

Lessons to be learned

Lesson 7

Prisons should ensure that end of life and palliative care plans are initiated at an appropriate and ideally early stage for prisoners who are diagnosed with a terminal illness. These plans should include all aspects of a patient's care, including effective pain relief and psychological and emotional support and, where appropriate, should involve the prisoner's family.

6. Family involvement

As outlined in the NICE guidelines, and reiterated in Prison Service guidance for Governors and Managers, involving families is an important part of providing quality end of life care.³⁴ This should happen at the earliest stage possible, ideally shortly after a prisoner receives a diagnosis of a terminal or otherwise serious condition. In the majority of cases in the sample, we had no concerns about prisons' family liaison services; we only made recommendations regarding family involvement and communication with next of kin in 15% of cases.

Given that not all prisoners are in contact with family, it is important the prison consults the prisoner and the family to determine whether both would like the other involved. Involving family can be particularly important when a prisoner's needs are complex, or the prisoner has behavioural issues, in order to facilitate more effective treatment. For example, PSI 64/2011 says that, when a prisoner is refusing treatment, it is important to involve the prisoner's family in ongoing support of the prisoner (subject to their consent).³⁵ Such was the case with Ms H, below.

Case study H

Ms H suffered a heart attack and collapsed lung just a year into a six year sentence, and had to be on 24-hour health cover. To facilitate this, she was transferred to another women's establishment that was better able to meet her needs. After three months, Ms H was transferred back to her original prison. At this time, she had poor mobility, and the prison arranged a prisoner carer to help with daily tasks. In the year before her death, Ms H often refused medication and to attend medical appointments. A week before her death, at age 59, Ms H collapsed and was taken to hospital, where she was diagnosed with end-stage heart failure.

Despite the fact that Ms H was refusing treatment, there was no evidence the prison involved her partner in her ongoing care, save encouraging him to attend one hospital appointment that Ms H later refused to attend. Furthermore, when Ms H entered the hospital for the last time, her health condition was serious. The prison did not contact her partner until her condition became critical, and he arrived at the hospital only 20 minutes before her death. We found the prison's family liaison function was inadequate in this case, and made recommendations to this effect.

Ms H refused to both attend medical appointments and take medication. This appeared to make the management of her condition more difficult. It is possible that, if Ms H's partner was involved at an earlier stage, he could have encouraged her to cooperate with healthcare staff. Furthermore, if he was contacted earlier, he could have had more time with Ms H at the end of her life.

Lessons to be learned

Lesson 8

Prisons should ensure that, with the consent of the prisoner and agreement of the family, trained family liaison officers involve families in end of life care, and promptly notify them when the prisoner is taken to hospital.

Our investigations frequently reveal shortcomings by prison family liaison services in involving families in a timely manner. Family engagement should ideally happen shortly after the prisoner is diagnosed with a serious or terminal illness. The failure to do so can have a negative impact on the social and emotional wellbeing of the prisoner at the end of life, but can also negatively impact the relationship the prison has with the prisoner's next of kin, making them suspicious of the establishment and the care their relative received. In cases where a prisoner is diagnosed with a terminal or otherwise serious illness, we would expect a family liaison officer (FLO) to be appointed shortly after diagnosis, where possible.

Timely involvement of family did not happen in the case of Mr I, a foreign national offender, which ultimately resulted in distress for the prisoner and distrust on the part of his family.

Case study I

Mr I was a foreign national serving a four year and four month sentence. He had no family in the UK and his wife lived overseas. Five months into his sentence, he saw a nurse about a urinary infection, and told her he had noticed a lump in his anus. A GP examined him five days later and made an emergency referral to a hospital for suspected cancer. A subsequent biopsy confirmed Mr I had bowel cancer. He was 55 years of age. Over the next three weeks his condition deteriorated quickly. It was not until three days before Mr I passed away that he was able to speak with his wife on the telephone and inform her of the extent of his condition.

As per PSI 64/2011 and Prison Rule 22(1), we would have expected the prison to appoint a FLO and contact the prisoner's family when he received his serious diagnosis. This did not happen. Mr I was only able to speak with his brother and wife several weeks after receiving his diagnosis, after his condition had deteriorated significantly. A FLO was only appointed after Mr I's death. This was particularly concerning in Mr I's case, given his status as a foreign national without any family support within the UK.

Nearly a month elapsed between the time of Mr I's diagnosis, and the time he was able to speak with his wife, which was only three days before his death. Prior to this last contact, communication between the two was infrequent. We consider that Mr I could have been better socially and emotionally supported by facilitating family involvement at an earlier stage of his care.

Lessons to be learned

Lesson 9

Prisons should ensure that, in line with the wishes of both the family and the prisoner, the nominated next of kin of seriously ill prisoners are informed as soon as possible and that a trained FLO is appointed to keep families informed about their condition.

7. Early release

In cases where death is imminent or where prisoners have conditions that are difficult to treat in prison, it is possible for some prisoners to be released before their sentence is spent. This can either be on a release on temporary licence (ROTL), as per Prison Service Order (PSO) 6300,³⁶ or early release on compassionate grounds, guided by PSO 6000³⁷ for prisoners with determinate sentences, or PSO 4700³⁸ for those with indeterminate sentences.

Old age alone and illness are not themselves sufficient grounds for early release from prison. When considering release on compassionate medical grounds, several criteria must be met. First, the prisoner must be either bedridden or similarly incapacitated, or suffering from a terminal illness with not long to live. PSO 6000 and PSO 4700 do not set a time limit. A clear medical opinion as to life expectancy is required, with three months regarded as reasonable. Second, the risk of reoffending should be minimal. This is particularly the case with offenders whose crimes are of a violent or sexual nature. Third, further imprisonment should be thought to reduce the prisoner's life expectancy. Fourth, there must be adequate arrangements in place for the prisoner's care and treatment outside the prison. Finally, the prisoner's early release must bring some significant benefit to the prisoner or his or her family.

When a prisoner receives a terminal diagnosis with a clear estimate as to life expectancy, someone from the Prison Service will often initiate an application for compassionate release. This involves collecting information as to the prisoner's medical condition, and evidence as to the prisoner's risk to the public should he or she be released. This assessment should be contextual, given the prisoner's actual risk at the time and taking their current medical condition into account. The Governor of the prison will either support or refuse the application for compassionate release, and forward this to the Public Protection Casework Section (PPCS) in HMPPS headquarters for a final decision. Because the final decision does not lie with the prison, we understand that the control prisons have over this situation is significantly curtailed. However, we offer two lessons here that might facilitate a smoother application process.

We made recommendations with respect to compassionate release or ROTL in 6% of our cases in the sample. While this is a relatively small number, it is nonetheless an important area for analysis – as the prison population gets older, it will be increasingly important to get applications for compassionate release or ROTL right.

There are two main recommendations or areas for improvement that the PPO has identified with respect to applications for compassionate release for prisoners over 50, one procedural, one more substantive.

The first is largely administrative – we often find that the application process is disorganised, and there was a lack of clarity as to who was managing the process or taking forward the application. Such was the case with Mr J, below.

The second area where we see room for improvement is similar to the issues we see in relation to restraints: frequently, risk assessments associated with applications for compassionate or temporary release are judged based on the risk the offender would have posed when healthy, not the actual risk the prisoner poses based on current health condition. This is illustrated in the case of Mr K, and is the most frequent recommendation we make in relation to such applications.

The case of Mr J, illustrates the need for a timely and coordinated approach to progressing a compassionate leave application.

Case study J

Mr J was serving a sentence of two years and three months. A year into his sentence, after two chest infections, Mr J was diagnosed with chronic lung disease. One month after this diagnosis, Mr J was taken to hospital with a suspected stroke. Both his condition and mobility deteriorated and Mr J was kept in hospital. Ten days after his hospital admission, doctors informed Mr J he had lung cancer that spread to his spine, and his condition was terminal with a life expectancy of approximately two months. This same day, a nurse spoke with the prison's offender management unit about the possibility of compassionate release. Neither the prison GP nor the probation officer began their sections of the application until nearly two weeks after the process began, and neither had up-to-date medical reports for Mr J. Mr J passed away at age 61, two weeks after being told his condition was terminal, with the application for compassionate release left incomplete.

We were concerned that the application process was poorly managed and lacked coordination. Furthermore, there was no evidence that the prospect of compassionate release was discussed with Mr J. While it was not clear that Mr J would have met the criteria for compassionate release, we nonetheless considered that the application was not given sufficient priority and made a recommendation to improve the timeliness and coordination of such applications in future.

While we do not see issues related to early release as often as other areas cited in this report, when we do, poor organisation of the compassionate release process is one of the main failings we identify.

Compassionate release was only considered in 36% of the sample for this publication. However, in 43% of these cases, an application was still under consideration at the time of death. While not all of these instances were the result of a disorganised process, this is still a comparatively large number. As such, there is evidence that this process could be more timely and coordinated, and we note the following lesson.

Lessons to be learned

Lesson 10

The process of applying for a prisoner's release on compassionate grounds should be timely and given the appropriate priority. To adequately facilitate this, prisons should appoint a relevant contact to progress the application, once the process has begun.

The case of Mr K below, is an example of the prisoner being evaluated on his risk when fit, not his risk with respect to his current health condition.

Case study K

Mr K was serving a 19 year sentence. Prior to his conviction, he was diagnosed with kidney and lymph node cancer and one of his kidneys and spleen were removed. While in prison, he remained under hospital care. Several months after his sentencing, a scan showed the cancer had spread to his remaining kidney and grown in his lungs. Oncologists continued to monitor Mr K, and he took oral chemotherapy hoping to slow the growth of the cancer. However, a year later, Mr K was informed that the cancer had spread to his liver. An oncologist suggested that he had 12-24 months left to live. Mr K was moved to a prison better equipped to deal with his care needs, and an end of life care plan was put in place. Over the next year, Mr K's condition

deteriorated significantly – the cancer spread to his bladder and he was rendered virtually immobile. Mr K passed away at age 77.

Six months before his death, the prison's family liaison officer spoke with Mr K about the possibility of compassionate release. Mr K said that he was in the process of appealing against his conviction and wanted to see this process through before applying for compassionate release. Five months later, the prison GP informed Mr K he only had weeks to live. The prison started an application for compassionate leave shortly thereafter. The prison Governor contacted the Public Protection Casework Section (PPCS) and explained he did not support the application as he considered Mr K posed a high risk of harm to children. PPCS said that without the Governor's support, they would not progress the application.

While the application may not have succeeded, the PPO investigator was not satisfied the Governor's assessment of risk was objective, and based on Mr K's condition at the time. The fact he was bedridden with no hope of recovery made it likely the risk of his re-offending had passed. We made a recommendation to this effect.

Ultimately, it is important the risk assessments that make up part of the application for compassionate or temporary release distinguish between the risks posed by the prisoner when fit, and the risks posed by the prisoner when suffering from a terminal condition. This was not the case for Mr K and others like him, and we identify the following lesson.

Lessons to be learned

Lesson 11

Risk assessments associated with applications for compassionate release should be contextual, and based on an assessment of actual risk given the prisoner's current health condition.

8. Dementia and complex needs

Last year, the PPO released a bulletin detailing lessons learned from death in custody cases where the prisoner was diagnosed with dementia.³⁹ In this publication we made a number of recommendations, many of which acknowledged dementia can make the factors involved in caring for dying prisoners – such as restraint, family liaison, or caring for physical needs – all the more complex. Since then, we have seen several other cases that can offer learning points to prisons caring for prisoners with dementia. In particular, the case in this chapter illustrates the way in which dementia symptoms can exacerbate the complexity of prisoner care in an already complex case.

In our sample, only 4% of cases noted the deceased had a dementia diagnosis. However, as our bulletin on dementia issues notes, this likely undercounts the number of prisoners who actually had dementia, as our reports will only mention the condition if it is relevant to the investigation. Indeed, it could also be under-representative of the number of prisoners with dementia as there is evidence that, as with other mental health concerns, dementia is under-diagnosed in prisons.⁴⁰

While awareness of dementia is growing within the Prison Service, knowledge of the condition and how best to manage prisoners diagnosed with it are less widespread. In 2013, The National Offender Management Service (NOMS, now Her Majesty's Prison and Probation Service, HMPPS) issued guidance to prison staff as to how to recognise the symptoms of dementia and what to do to get the prisoner diagnosed.⁴¹ With respect to the care and support needs of older prisoners, for which local authorities are responsible, PSI 03/2016 on Adult Social Care⁴² sets out the procedure for caring for prisoners with physical and mental health needs. While this guidance does not mention dementia specifically, it does acknowledge the increase in age-related disabilities and needs that accompany an ageing prison population.

Dementia can also make a prisoner's treatment more complex, resulting in the need for healthcare staff to delicately balance treating the prisoner's mental health needs – which can often present as more demanding – and their physical health condition. We have previously noted in our thematic review on *Prisoner Mental Health*,⁴³ that communication between primary physical health services can be poor or uncoordinated and that, as a result, physical ailments can be overlooked when there are more pressing

mental health symptoms (or vice versa, if physical symptoms are more prevalent). While not a common occurrence, we do continue to see cases where this happens, including the case of Mr L, below.

Case study L

Mr L had several existing conditions when he was remanded to prison, among them, hypertension, diabetes, and possible dementia. He was also profoundly deaf and preferred to use British Sign Language to communicate. Staff did not use an interpreter for his initial health screen nor his mental health assessment, and it took several days for them to request his community health records. In the community, Mr L was assessed as lacking the mental capacity to make decisions about his care and treatment, and was receiving frequent help from family, outside carers, and an advocate. Mr L's daughter expressed concern that her father's emotional and physical health needs were not being met, and a nurse arranged a move to the prison's mental health in-reach unit. Over the next two months, Mr L had frequent appointments with healthcare and mental health staff; however, interpreting services were rarely used and communication was an issue unless his daughter attended these appointments. Mr L's conditions deteriorated rapidly and he was found unresponsive in his cell only four months after he was remanded to prison. Resuscitation was unsuccessful. He was 61.

Overall, we considered the prison prioritised Mr L's mental healthcare treatment over his physical health, treating the behavioural symptoms associated with his dementia rather than his chronic physical conditions. There was limited sharing of information between the mental healthcare and primary health teams, no personalised care plan in place, irregular monitoring of his blood sugar levels, and no clinician responsible for coordinating his care. We do not consider that his chronic physical conditions were managed to the degree Mr L could have expected in the community. In light of this, we made recommendations about the management of complex healthcare needs.

The case of Mr L is an example of an investigation where we found the prison was prioritising mental health or behavioural issues over treating the prisoner's physical needs. Mr L had complex care needs, including likely dementia, and we understand it would not have been easy to treat him. However, this makes it all the more necessary to have a clear and co-ordinated plan in place, in order to ensure the prisoner's care is equal to what they would have received in the community. We suggest that the following lesson can be learned in relation to treating prisoners with complex needs.

Lessons to be learned

Lesson 12

Prisons should ensure that patients with complex health needs have personalised care plans in place, and that both primary physical health and mental health care teams effectively share information to ensure a coordinated approach to care.

Our next lesson with respect to prisoners with a diagnosis of, or those suspected of, dementia, is very similar to other lessons about assessing risk. Specifically, those performing risk assessments should be responsive to changing conditions and review their decisions as a result. Specifically, staff performing assessments should be aware that dementia can be degenerative, or that the nature or severity of symptoms can change day-to-day, and the nature of this condition means that risk assessments need to be monitored and revised accordingly. This is particularly so with risk assessments for in-cell medication, as was the case with Mr M, below. Dementia can affect memory, decision-making, concentration, problem-solving, communication, and motor skills.⁴⁴ Many of these symptoms impair the cognitive function required to manage medication accurately and effectively, and could possibly lead to either missed doses or overdoses – the former was the case with Mr M.

Case study M

Mr M was sentenced to 10 years imprisonment. When he arrived at prison, he had a number of health problems, including high blood pressure, high cholesterol, diabetes, and a fatty liver. A year after beginning his sentence, he was transferred to another prison. Here, Mr M was also diagnosed with diabetes. Mr M was on a number of medications for these conditions. Shortly after his diabetes diagnosis, Mr M became increasingly confused. The prison referred him for a series of tests to understand the reason for this confusion. One month later, Mr M was transferred back to his original location. At induction, he signed a form allowing him to keep medication in his cell.

A few months later, an elderly care consultant asked a pharmacist to review and explain Mr M's medications to him. There is no evidence that Mr M's medications, or the risks of him keeping them in his cell, were reviewed at any other time.

Mr M's ability to perform day-to-day tasks deteriorated. Several months later, Mr M was moved to an in-patient care unit after a nurse found that he could not answer simple questions. Once Mr M was moved, a nurse went to retrieve his medications, and found a number of them unused. While at the in-patient unit, staff there decided Mr M could not look after his own medication. A GP examined him and thought his confusion might be due to dementia, though this diagnosis could not be confirmed before his death, at age 54 due to pneumonia.

Mr M became increasingly confused throughout his sentence. Despite this, there was no evidence the prison reviewed Mr M's risk of having his medication in-cell, and relying on him to monitor his doses. While it is possible that a review may not have removed Mr M's ability to look after his medication at an earlier time, this review should nonetheless have taken place in light of Mr M's worsening symptoms. We identify the following lesson.

Lessons to be learned

Lesson 13

Risk assessments for in-possession medication should take account of a prisoner's history, and should be regularly reviewed if the prisoner presents with reduced cognitive function, such as symptoms of dementia.

9. Good practice

Providing end of life care and managing older prisoners on the scale required by the demographic changes to our prisons is new territory for prisons. Policies and procedures are still being written and best practice is still being developed and disseminated. As a result of this, and because of the PPO's responsibility to identify lessons that need to be learned, our reports and publications frequently focus on the things that went wrong in aspects of prisoner care and management, identifying failings and making recommendations to correct these. However, not all of our investigations identify failings. More and more, as prisons come to grips with the issues associated with caring for older prisoners, PPO investigations make fewer recommendations with respect to naturally-caused deaths in custody. Moreover, we occasionally identify instances of good practice. We share one of these cases here.

One of the more recent developments from within the Prison Service is the creation of palliative care suites. These are specially-designated wings or rooms meant to house prisoners who have been given a diagnosis of a terminal or otherwise serious illness, and require greater access to healthcare staff or equipment. In this way, prisoners are able to spend their final months within the prison, while receiving a similar level of attention that they might expect in a hospice.

We highlight the case of Mr N, who spent his final months in a specialised palliative care suite and received what we considered was an exemplary level of care.

Case study N

Mr N arrived in prison with pancreatitis and had type-2 diabetes, along with several health conditions related to chronic alcoholism. Mr N was sent to hospital several times to investigate possible prostate cancer after suspicious blood tests. The tests performed at the hospital confirmed a benign tumour in Mr N's prostate. Mr N was discharged to another prison, where he was given a ground floor cell as his mobility was now poor. However, he was shortly moved back to his original prison, which had a palliative care suite, and was able to better provide the 24 hour care he needed. Mr N's condition continued to deteriorate. He often appeared confused and occasionally vomited and complained of stomach pains. After a further abnormal blood test, he was sent to hospital by emergency ambulance and he was diagnosed with bronchopneumonia and, after further testing, cancer of the liver, brain, and kidney. Doctors estimated he only had weeks to live.

Throughout his last months, we considered Mr N received a very good level of care, and was supported physically, emotionally, and socially. His location in the palliative care suite meant healthcare staff had access to the equipment and resources necessary to adequately care for him. His door was left open, and staff had unrestricted access. The care plans in place were clear and comprehensive, and the FLO kept his next of kin informed. We had no recommendations to make and commended staff for their caring and respectful approach to end of life care.

We understand that not all establishments are, at the moment, able to create these specialised facilities. However, we have found that, in a number of cases, where compassionate release was not an option, prisons without adequate facilities appropriately initiated transfers to prisons who had these specialised units.

10. Conclusion

This thematic review has explored examples of the most common recommendations we make at the end of investigations into naturally-caused deaths of prisoners over 50 and identified 13 lessons prisons can learn. While each lesson is tailored to the situation it addresses, there are some overarching themes we can identify from these lessons.

First, those caring for ageing prisoners need to **make proportionate decisions in context**. It can be difficult to separate the idea of the prisoner as an ageing person who needs care, from the crimes they committed in the community. Often, these offences were committed when the prisoner was younger and fitter, as it is increasingly the case that older prisoners are sentenced for historic crimes. There are a number of situations in which prison staff are required to assess the risk of the prisoner. In too many instances, we find that risk assessments are formulaic or merely procedural – they are not sufficiently responsive to rapid changes in circumstances and, in consequence, do not adequately address the prisoner’s current, individual circumstances. A serious health condition can materialise, develop, and change quickly, significantly affecting the prisoner’s physical capacity, materially impacting on actual risk. This requires a more flexible, contextual approach to risk assessment. As we have seen in some of the foregoing cases, the failure to do so can result in inhumane treatment of prisoners – and, we should not forget the impact on staff who, in extreme situations, may be chained to their charges as they die.

Second, the lessons we set out call for prisons to **have a coordinated approach** to the care and management of older prisoners. This is evident in the recommendations we make with respect to continuity of care or for holistic care plans, particularly following a terminal diagnosis. The care and management of older prisoners ought usually to be a multi-disciplinary exercise, calling upon multiple different organisations, teams, or individuals all at once, to achieve its ends. Coordination and organisation in this respect can mean the difference between care that is equivalent to that of the community, and care that falls short.

Third, many of the lessons in this thematic review ask prison staff to ensure their actions **conform to local and national policies**. While this appears to be obvious, too often we have to recommend that prisons simply follow their own and national policies. Having a policy or instruction is not enough – establishments must also ensure accountability, management assurance and policy awareness among front-line staff.

Some of the pressures of an ageing prison population are similar to those that confront community health and care services faced with an ageing UK population, particularly how to resource rising demand. However, many of the challenges faced by prisons are quite different. For example, prisons must consider what dying with dignity means in a setting where security is paramount – when and how to restrain, to involve family, or consider early release. The changes required to make the Prison Service fit to deal with its ageing population are a difference of *kind* as well as *degree*. We hope this review will add to the prison-specific evidence base needed to adequately tackle these concerns.

Overall, we hope those working with older prisoners find this thematic review a helpful resource to guide their practice. It should also act as a further prompt to the Ministry of Justice and HM Prison and Probation Service (HMPPS) to deliver a much needed, properly resourced older prisoner strategy that enables an effective and humane response to the rapidly ageing prison population.

Endnotes

- ¹ The Care Act 2014, c. 23. Online at: <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>
- ² See, for example, United Nations Organisation (UNO), 'Basic principles for the treatment of prisoners', Resolution 45/111, 14 December, 1990. Online at: <http://www.un.org/documents/ga/res/45/a45r111.htm>. This principle is also nationally integrated in the UK context. See, for example, Prison Service Order (PSO) 3050, 'Continuity of healthcare for prisoners', 10 February, 2006.
- ³ Data taken from Allen, G. and Dempsey, N. (2016) 'Prison Population Statistics', House of Commons Library Briefing Paper SN/SG/04334. Full report online at: <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN04334#fullreport>
- ⁴ Ministry of Justice (2006) 'Prison Population Projections 2016-2021, England and Wales', *Ministry of Justice Statistics Bulletin*. Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/548044/prison-population-projections-2016-2021_FINAL.pdf
- ⁵ ONS projections show the median age in 2014 was 40. This is expected to rise to 40.9 years in mid 2024, and to 42.9 years by 2039. See ONS (2014) *National Population Projections: 2014-based statistical bulletin*. Online at: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalpopulationprojections/2015-10-29#changing-age-structure>
- ⁶ Howse, K. (2011) *Growing Old in Prison: A scoping study on Older Prisoners*, Prison Reform Trust. Online at: http://www.prisonreformtrust.org.uk/uploads/documents/Growing.Old.Book_-_small.pdf
- ⁷ Ministry of Justice (2006) 'Prison Population Projections 2016-2021, England and Wales', *Ministry of Justice Statistics Bulletin*. Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/548044/prison-population-projections-2016-2021_FINAL.pdf
- ⁸ For example, Her Majesty's Inspectorate of Prisons (HMIP), as well as NHS England and third sector organisations working in this area, such as Age UK adopt these parameters. See: House of Commons Justice Committee (2013) *Older Prisoners: Fifth Report of Session 2013-14, Volume 1*, 12 September 2013
- ⁹ *Ibid.*
- ¹⁰ Our 'Other non natural' category includes drug-related deaths, accidents, and deaths where post mortem and toxicology reports have been unable to establish a cause of death. As such, they are difficult to classify as either 'natural' or 'self-inflicted' deaths.
- ¹¹ Statistics for the broader prison population are from Ministry of Justice (2016) Prison population: June 2002 to June 2016. Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/541235/population-2016.xlsx. Numbers shown are a snapshot for June 2015 rather than the most recent statistics to keep as comparative as possible with the time period of the sample. These numbers represent those under immediate custodial sentence.
- ¹² To make the sample comparable to the Ministry of Justice data, only those under immediate custodial sentence are included in this figure – those on remand were excluded.
- ¹³ See Prison Service Instructions (PSI) 40/2011 Categorisation and recategorisation of adult male prisoner at section 2.1 for precise definitions. For more information, refer to House of Commons (2015) *Categorisation of prisoners in the UK*, Briefing Paper 07439, 29 December 2015. Note that female prisoners are not classified into security categories in this way, having their own classification system. As a result, the figures given in this section represent proportions for male offenders only.
- ¹⁴ *Ibid.* at Part 4.
- ¹⁵ Statistics for the broader prison population are from Ministry of Justice (2016) Prison population: June 2002 to June 2016. Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/541235/population-2016.xlsx

- ¹⁶ ONS (2012) Ethnicity and National Identity in England and Wales: 2011. Data taken from the last published census. Online at: <https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/>
- ¹⁷ The PPO does not determine official cause of death and classifies deaths based on the information that is available up until the point that the initial report is issued.
- ¹⁸ See Fazel et al. (2001) 'Health of elderly male prisoners: worse than the general population, worse than younger prisoners,' Age and Ageing 2001: 30 403-407; as well as evidence submitted by HMIP to the House of Commons Justice Committee's inquiry into older prisoners (Evidence 41).
- ¹⁹ HMIP (2009) *Disabled Prisoners: A short thematic review on the care and support of prisoners with a disability*, March 2009. Note that the definition of 'disabled' used in this publication includes both physical and mental disabilities.
- ²⁰ PSO 3050, Continuity of healthcare for prisoners. Online at: https://www.justice.gov.uk/downloads/offenders/psipso/ps0/PSO_3050_continuity_of_healthcare_for_prisoners.doc
- ²¹ Prison Service Instruction (PSI) 33/2015, National Security Framework – External Escorts, Issued 9 December 2015. Online at: <https://www.justice.gov.uk/downloads/offenders/psipso/psi-2015/psi-33-2015-external-prisoner-movement.pdf>. This PSI also gives another method – the 'body belt' – but stipulates that this is only to be used in exceptional circumstances, must be removed upon arrival, and requires additional paperwork for approval for use of this method of restraint. As a result, we rarely see this in the cases we investigate.
- ²² *Ibid.* at s. 5.5.
- ²³ *R (on the application of Graham) v Secretary of State for Justice* [2007] All ER (D) 383 (Nov).
- ²⁴ The Graham judgement and guidance on restraints is summarised in a learning bulletin for prison staff. See NOMS Equality, Rights and Decency Group (2016) 'Emergency Response and the Use of Restraints', *Safer Custody Learning Bulletin*, April 2016, Issue 8.
- ²⁵ Prisons and Probation Ombudsman (2013) Restraints. Online at: http://www.ppo.gov.uk/wp-content/uploads/2014/07/LLB_FII_Restraints_web_version.pdf#view=FitH
- ²⁶ Prisons and Probation Ombudsman (2013) End of Life Care. Online at: http://www.ppo.gov.uk/wp-content/uploads/2014/07/Learning_from_PPO_investigations_-_End_of_life_care_final_web.pdf
- ²⁷ See PSI 33/2015 at ss. 6.17-6.19.
- ²⁸ The external movement of Category A prisoners is governed by Prison Service Instruction (PSI) 9/2015, the Management and Security of Category A Prisoners – External Movement, online at: <https://www.justice.gov.uk/downloads/offenders/psipso/psi-2015/psi-09-2015.pdf>
- ²⁹ The NHS provides a good explanation and overview. See NHS (2015) End of Life Care. Online at: <http://www.nhs.uk/Planners/end-of-life-care/Pages/what-it-involves-and-when-it-starts.aspx>
- ³⁰ Prisons and Probation Ombudsman (2013) End of Life Care, online at: http://www.ppo.gov.uk/wp-content/uploads/2014/07/Learning_from_PPO_investigations_-_End_of_life_care_final_web.pdf
- ³¹ The Guidance in place at the time of publication for the End of Life Care thematic review was the Liverpool Care Pathway. This has since been replaced with the NICE Quality Standard for End of Life Care for Adults (QS13), available online at: <https://www.nice.org.uk/guidance/qs13>
- ³² *Ibid.*
- ³³ *Ibid.*
- ³⁴ HMPPS issues guidance on the family liaison function for both Governors and Managers. See Safer Custody and Public Protection Group (n.d.) *The Role of the Family Liaison Officer: A Guide for Governors*, London: HMPPS; and Safer Custody and Public Protection Group (n.d.) *The Role of the Family Liaison Officer: A Guide for Managers*, London: HMPPS.
- ³⁵ National Offender Management Service (2013) 'PSI 64/2011: Management of prisoners at risk of harm to self, to others, and from others (Safer Custody,' London: Ministry of Justice (Updated 09 September 2013).
- ³⁶ PSO 6300, Release on Temporary Licence. Available online at: <http://www.justice.gov.uk/downloads/offenders/psipso/ps0/ps0-6300-rotl.doc>
- ³⁷ PSO 6000 'Parole Release and Recall. Available online at: <http://www.justice.gov.uk/downloads/offenders/psipso/ps0/ps0-6000.pdf>

- ³⁸ PSO 4700 Indeterminate Sentence Manual. Available online at: <https://www.justice.gov.uk/offenders/psos/ps0-4700-indeterminate-sentence-manual>
- ³⁹ Prisons and Probation Ombudsman (2015) Dementia. Available online at: http://www.ppo.gov.uk/wp-content/uploads/2016/07/PPO-Learning-Lessons-Bulletins_fatal-incident-investigations_issue-11_Dementia_WEB_Final.pdf
- ⁴⁰ Kingston et al. (2011) 'Psychiatric morbidity in older prisoners: unrecognized and undertreated,' *International Psychogeriatrics*, 23:8, 1354-1360.
- ⁴¹ National Offender Management Service (2013) Hidden Disabilities: Dementia (Essential Guide for Prison Officers).
- ⁴² National Offender Management Service (2016) 'PSI 03/2016: Adult Social Care,' London: Ministry of Justice.
- ⁴³ Prisons and Probation Ombudsman (2016) Prisoner Mental Health. Available online at: <http://www.ppo.gov.uk/wp-content/uploads/2016/01/PPO-thematic-prisoners-mental-health-web-final.pdf>
- ⁴⁴ Moll, A. (2013) *Losing Track of Time: Dementia and the ageing prison population*. London: Mental Health Foundation. Online at: <https://www.mentalhealth.org.uk/sites/default/files/losing-track-of-time-2013.pdf>

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