Ministry of JUSTICE
National Offender Management Service

DH Department of Health

Review of Unclassified Deaths

Ministers have welcomed the Review of Unclassified Deaths and would like to thank Mary McFeely and all those who contributed to her report for their careful and professional approach to this complex issue. The Reviewer looked at a group of 35 deaths in prison over a two year period which, at the time she was commissioned to undertake this work, were not classified within the internal National Offender Management Service classification system. All deaths in custody are a matter of concern to Ministers and the agencies involved, and the purpose of the Review was to examine the deaths and identify any means by which we might reduce their number in future. It should be noted that all deaths in custody will in due course be the subject of a coroner's inquest held before a jury, when the official cause of death will be determined.

The Review contains fourteen recommendations. Four of these are closely related to the deaths; the remaining ten are more general and directed to the management and healthcare of prisoners who are undergoing drug treatment or maintenance regimes, or are involved with drugs illicitly.

The small number of deaths most closely analysed by the Review, where methadone is identified as a factor (17 out of a cohort of 20), must be set in the context of the more than 60,000 prisoners who now access the Integrated Drug Treatment System in a year. Without putting at risk the benefits of IDTS, Ministers recognise that it is important that it remains as fit for purpose as it can be within the prison environment.

Many of the issues raised by the recommendations are complex and will require careful consideration. For this reason we are issuing a preliminary response to the Review at this stage. We will publish a full response and action plan in the Autumn which will be presented for discussion at the Ministerial Board on Deaths in Custody at its next meeting on 9 October.

Summary Response to the Recommendations

The report contains valuable indications of potential problems associated with methadone treatments in the prison setting. Because of the serious issues it raises, the Department of Health (DH) believes that additional exploration of the facts surrounding each tragedy is required and is collecting further clinical information in order to do so. In advance of this further analysis, DH and NOMS have accepted and will be taking forward many of the report's 14 recommendations and has accepted the remainder in principle.

Please note – the responses overleaf apply to English prisons

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	Recommendation	Preliminary Response (Lead Department)
1	**There should be further exploration by Department of Health of the relative merits of both buprenorphine and methadone in prison, recognising that NICE guidance recommends methadone as first line treatment for the clinical management of opiate dependence.**	**Accepted in principle** NICE guidance on buprenorphine and methadone is provided as a technology appraisal, which is a recommendation on medicines and treatments within the NHS in England and Wales. Dept Health does not have the authority to contradict these appraisals, but will work with the National Institute for health & Clinical Excellence (NICE) to review evidence that emerges from the further analysis set out in the summary response.
2	**Guidance for nursing and discipline staff about how to conduct observations (and respond to them) overnight should be reissued and reiterated at regular intervals.**	**Accepted** In the first instance, a joint National Offender Management Service (NOMS) and Department of Health (DH) letter will be issued to all Governing Governors and Heads of Healthcare in prisons. The letter will draw specific attention to the guidance contained in the DH published document *Clinical Management of Drug Dependence in the Adult Prison Setting 2006*. Further consideration will then be given to the best way of ensuring that this information is up to date and visible to healthcare and discipline staff. In particular, DH will review the evidence from the further analysis in the summary response to determine (a) precisely what the recommended guidance should comprise (b) whether the guidance should concentrate on a vulnerable sub-group or groups of patients and (c) the most effective form the guidance should take (training materials, central document, correspondence).
3	**SystmOne should be linked to the NHS "spine"**	**Accepted** This is being pursued as part of the Offender Health IT Programme.
4	**Updated guidance, especially the 2006 Clinical Management of Drug Dependence in the Adult Prison Setting, should incorporate new learning from academia reflecting new**	**Accepted** Offender Health keeps all policy under review in the light of emerging research findings. We are in contact with international colleagues to collect their learning on opioid substitution treatments and toxicity.

	developments in drug treatment and research into drug treatment.	
5	**The Department of Health should issue straightforward guidance about how clinical confidentiality should work in prisons.**	**Accepted** Guidance has been issued by DH in Appendix C of the Prisons Clinical Guidance (DH 2006) and will consult legal colleagues to see if revision is required.
6	**Governors must ensure that health and security departments work closely together to generate a greater flow of information between the two in order to improve the work carried out by both departments.**	**Accepted** Consideration will now be given as to how best information can be routinely shared between security and healthcare staff, including joint attendance at relevant meetings by security and healthcare staff.
7	**Prescribing guidance for the first night in prison should either be revised or reiterated as best practice to achieve greater consistency across the prison estate.**	**Accepted in principle** DH will consult clinical experts to determine what change might be required to current guidance, and suggest methods by which the NHS Commissioning Board should look to achieve consistent adherence.
8	**The scrutiny of the quality of reviews should be part of the contract/commissioned service and therefore part of the contract review process.**	See response to recommendation 7.
9	**NOMS/Offender Health should be clear about governors' responsibilities for healthcare so that governors know what their responsibilities are and what mechanisms they can use if changes need to be made.**	**Accepted** The implementation of the reforms arising from the Health and Social Care Act 2012 provides an opportunity to clarify the responsibility of governors and governance arrangements for commissioning and delivery of healthcare in prisons. NOMS/Offender Health have already committed to revisiting the existing National Partnership Agreement between DH and NOMS in recognition of the health reforms which will provide an opportunity to address.
10	**The regular audit of reviews (i.e. both**	**Accepted**

	process and content) should be part of the contract and commissioned arrangements for healthcare	The National Drug Treatment Monitoring System is currently being rolled out in all prisons in England. It includes audit of 13-week treatment reviews. DH to suggest methods by which the NHS Commissioning Board should look to achieve consistent adherence.
11	**The "dear colleague" letter dated 31.3.10 should be reiterated /reissued**	**Accepted** The "dear colleague" letter dated 31.02.10 is still in force and has been incorporated within section 7 of the prisons clinical guidance. An updated version will be re-issued and further consideration given as to how this should be embedded as accepted practice.
12	**National guidance should be drawn up by NOMS and OH setting out the tasks to be done on the medicine queue, who should do them and how. The work should be "profiled2 as core part of the prison regime.**	**Accepted in principle** NOMS specifications and Instruction System which enable the provision of healthcare in prisons can be reviewed to clarify expectations and responsibilities for enabling the safe distribution and consumption of medicines. However we would wish to promote practice which minimises queuing for medication through joint action between prisons and their healthcare providers. Consideration will be given as to how the medicine queue and the dispensing of medication can be better regulated, including the sharing of information [see recommendation 6].
13	**The NHS commissioning board, as part of its responsibilities for national patient safety, should consider auditing prescribing practice in prisons. Pharmacists with secure environment expertise should be asked to review this data. The corollary of this is that the NHS commissioning board should mandate each outpost/commissioning unit to have a medicines management committee whose job it will be to audit prescribing and**	**Accepted in principle** DH will explore this recommendation with the NHS Commissioning Board and work with the Board to develop robust clinical governance of prescribing and pharmacy practice in prisons.

	medicines; this will require pharmacy expertise.	
14	**NOMS and health should co-commission prison healthcare and a number of issues about which there is an understandable lack of confidence across much of the prison estate and among stakeholders should be built into this. They include:** • **Audit** • **Quality control** • **Training of doctors and nurses** • **The minimum permissible percentage of staff in any contracted service** • **The continued presence of psychosocial interventions now that CARATs are being absorbed into the mainstream drug treatment provision (except in Wales where they remain separate).** • **In their contract with GPs, the PCTs and their replacement bodies should be requiring them to regard requests for documents from prisons as a high priority and delays should not be acceptable.**	**Partly accepted** NOMS will continue to work with the NHS through local, regional and national structures to co-commission healthcare services for prisoners, with the exception of a number of contracted prisons where commissioning arrangements are under review. Influencing flows of information from prisons and places of detention to primary care in the community will be the responsibility of the NHS Commissioning Board which will be responsible for commissioning services in both settings.