NHS England

Health and Justice Commissioning for Prisons and IRC in Oxford

Deaths in Custody April 2013 to July 2016

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The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Health and Justice Commissioning

1. Context

Any death that occurs in a prison or IRC is investigated by the Prisons and Probation Ombudsman (PPO). The Ombudsman is appointed by the Secretary of State for Justice and is independent of the National Offender Management Service (covering Prisons and Probation Services), Youth Justice Board and Home Office. As part of the PPO investigation, clinical issues relevant to any death in custody are required to be examined.

NHS Teams have commissioning responsibility for all the healthcare services in all prisons and immigration facilities in England. A death in custody is regarded as a Serious Incident (SI) in line with similar incidents in relation to community NHS funded services, and as such is subject to an investigation. All Serious Incidents are logged by NHS England and the providers carry out a 72 hour review and an internal investigation within 60 days of the incident occurring. These reports are reviewed by the commissioner and the Nursing and Quality team.

In addition the Secretary of State for Health agreed that NHS England Teams will take the lead in investigating the clinical issues relating to deaths in custody. Therefore the local Area Team (or equivalent) in respect of all prisons and immigration facilities, has the lead responsibility for arranging an independent investigation of the clinical care provided, including whether referrals to secondary healthcare were made appropriately. The clinical review forms part of the PPO investigation and subsequent PPO report.

The health care provider is expected to complete an action plan addressing all the recommendations that emerge from the independent clinical review and the internal investigations. The action plan is monitored regularly and reviewed at the quarterly Health and Social Care partnership boards.

2. Deaths in Custody in Oxfordshire

Since April 2013 when NHS England took over the commissioning of healthcare in to prisons there have been 13 deaths in HMP Bullingdon and one in HMP Huntercombe. There have been no deaths in IRC Campsfield.

Prison	**2013/14**	**2014/15**	**2015/16**	**2016/17 (to July 2016)**
HMP Bullingdon	**3**	**1**	**7**	**2**
HMP Huntercombe	**0**	**0**	**0**	**1**

Of the deaths in HMP Bullingdon two were expected deaths, the other 11 were unexpected. The death in HMP Huntercombe was unexpected. The majority of unexpected deaths were deemed to be self-inflicted.

3. National Picture

Ministry of Justice figures show that deaths in prisons increased in 2015. There is an increase in the number of deaths through natural causes as the prison population becomes older but the number of self-inflicted deaths stayed the same in 2014 and 2015.

The Government and PPO are alert to the increase in the number of deaths in custody, the House of Commons Justice Committee recently examined the Government's response to the increase and noted the report of an Independent Review into Self-inflicted Deaths in Custody of 18–24 year olds, led by Lord Toby Harris, known as the Harris Review, was published in July 2015.

NHS England centrally receives all PPO reports and independent clinical reviews and the PPO regularly produce 'lessons learned' thematic reports. Locally, lessons learned are discussed at a quarterly Quality and Safety Seminars which cover Thames Valley and Wessex and good practice is shared amongst both healthcare and prison staff.