IAPDC

Royal College of General Practitioners

***Independent Advisory Panel on Deaths in Custody***
***Royal College of General Practitioners***

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Thursday 13 January 2022

Dear Chairs of the Ministerial Board on Deaths in Custody,

In response to a request in 2021 by Her Majesty's Prison and Probation Service, the Independent Advisory Panel on Deaths in Custody (IAPDC) and the Royal College of General Practitioners Secure Environments Group (RCGP SEG) have worked together on an initiative to understand the causes of drug and alcohol-related deaths in, and immediately following release from, prison. The resulting report, enclosed with this letter, makes clear evidenced-based recommendations on how such deaths can be prevented and lives protected.

The IAPDC and RCGP welcome the recent prioritisation of measures to reduce the damage caused by substance misuse, particularly in the context of the publication of Dame Carol Black's Independent Review of Drugs in February 2020 which called for a renewed focus on drugs across government. As the new prisons strategy white paper acknowledges, the scale of drug and alcohol misuse in the criminal justice system is significant and both directly and indirectly leads to tragic and avoidable deaths in custody. The urgency of this work has been exacerbated by COVID-19, during which the extreme and restricted regimes imposed to prevent the spread of the virus, have exacerbated feelings of hopelessness, boredom and desperation which can lead to substance misuse and a subsequent risk to life.

This report, *'Protecting lives: a cross-system approach to addressing alcohol and drug-related deaths within the criminal justice system',* brings together expert advice with a specific focus on preventing substance misuse-related deaths. It makes a distinct contribution to the development of wider government work in outlining how the prevention of avoidable deaths must serve as its key driver.

The report's findings are shaped by contributions from an expert roundtable involving coroners, scrutiny bodies, medical practitioners, charities, academics and those with lived experience. We are grateful to the roundtable presenters and attendees for their insightful and constructive contributions and for further consultation and comment provided after the event. We are also grateful to members of the Ministerial Council on Deaths in Custody's

expert Practitioner and Stakeholder Group for their input. A considerable degree of expertise, dedication and experience exists which you should continue to draw on to understand how lives can be protected.

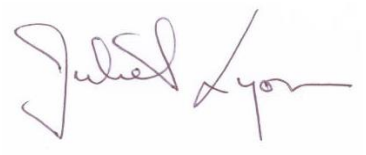
This report highlights the need for a whole-system, cross-organisation approach to tackling substance misuse and aiding recovery through the criminal justice system. Contributors were clear that the harmful impact of alcohol should not be neglected in place of a justified focus on drugs.

The report makes ten evidenced recommendations, appended to this letter. They relate to:

- improving the data associated with substance misuse- related deaths;
- ensuring community drug and alcohol services are adequately resourced to ensure full coverage, reduce waiting times between court sentence and treatment starting and to divert individuals with substance misuse problems away from custodial sentences into treatment in the community;
- increasing the use of newly available opioid substitution therapy to improve continuity of treatment and reduce risk for service users as they move between community and prisons;
- changing the focus of investigations into one which encourages and shares learning and uses suitably experienced clinical reviewers; and
- promoting wider collaboration between prison and community staff to encourage the continuity of treatment, particularly during the transitional period when people are released from prison.

The IAPDC and the RCGP will work with relevant departments and agencies, the cross-government Joint Combating Drugs Unit, and members of the Ministerial Board on Deaths in Custody to progress recommendations and develop further solutions. We are grateful for the initial request from HMPPS to contribute to this work. We would welcome a meeting with you to discuss our findings and recommendations.

As ever,



**Juliet Lyon CBE**
Chair, Independent Advisory Panel on Deaths in Custody

**Dr Jake Hard**
Chair, Royal College of General Practitioners Secure Environments Group

## Protecting lives: a cross-system approach to addressing alcohol and drug-related deaths within the criminal justice system

RECOMMENDATIONS

Evidence base

1. The number of substance misuse-related deaths in the criminal justice system is still unclear. The last dataset analysed for deaths in prison is now five years old. The **Office for National Statistics (ONS)** and **HMPPS** should collaborate again on a review to detail the current size of the problem in prisons, with similar work carried out for deaths on community probation. Understanding who is dying and their characteristics should inform the prioritisation of future work to prevent deaths.

Sentencing

2. While funding has been sourced for the rollout of some Court-based Liaison and Diversion services (L&D) and Community Sentence Treatment Requirements (CSTRs), additional resources are still required to ensure greater coverage. Both initiatives help divert individuals with substance misuse problems away from short custodial sentences into treatment and help prevent deaths. However, for these to be effective, community drug and alcohol services need to be adequately resourced by the **Ministry of Justice, NHS England and NHS Wales** and the **Department of Health and Social Care** to ensure full coverage and reduce the waiting times between court sentence and treatment starting. Courts need to be informed about the availability of treatment in the community and provided with updates on treatment outcomes and evaluation.

Treatment

3. Drug and alcohol misuse is often associated with, or caused by, wider social and economic issues. A streamlined approach which encourages services to be collaborative, and ideally co-located, is required to enable services to work in an integrated way in response to multiple social needs (including housing, employment, mental and physical health, and the effects of prior trauma) and not just achieving abstinence. **HMPPS, Ministry of Justice** and the **Department of Health and Social Care** should consider collaborative commissioning of providers, so they become ‘catch-all’ services rather than providers of a collection of different parts of an individual’s recovery.

4. The increased use of the newly available formulation of prolonged-release buprenorphine as an opioid substitution therapy (OST), given as weekly or monthly injection, would help to reduce risk and improve the continuity of treatment to service users as they move between community and prisons. **Substance misuse commissioners and community providers** should work together to ensure continuity in its use.

5. The use of naloxone as a form of harm-reduction for opioid abuse should be expanded, with training provided to prison staff (and members of the public) to raise awareness of overdose response. The use of naloxone would help prevent deaths associated with opioid overdose in the general public and promote a greater awareness of risks relating to drugs. The rollout of staff training in the use of naloxone is already in place in most Approved Premises. **Relevant substance misuse commissioners and community providers** should work together to encourage its use.

6. **NHS England and NHS Wales, HMPPS** and the **Ministry of Justice** should set out a specific approach to substance misuse for women in the criminal justice system and wider community health to account for the large catchment areas of women's prisons and the specific needs and vulnerabilities of women, for example relating to domestic violence and coercion.

Release from prison

7. People are at particular risk of substance misuse-related death when they transition between prison and the community. The introduction of 'bridging liaison' roles, created jointly by **HMPPS** and **NHS England and NHS Wales**, would reduce the risk of professionals working in silos and ensure continuity in treatment plans. Pre-release work should involve greater outreach from prisons to community services. This has a direct positive impact on an individual's compliance post-release and improves staff awareness of support available in the community.

Learning lessons from a death

8. To enable the learning of lessons by services and establishments following a substance-related death, independent recommendations made by **investigators and scrutiny bodies** should be given to specific owners and made with the clear appreciation as to what changes are realistically possible. Greater attention needs to be paid to communication with, and the respectful involvement of, bereaved families. Recommendations and their responses should be centrally stored by agencies so that they can be easily accessed by both operational and policy staff so future deaths can be prevented. This should include jury verdicts as well as matters of concern raised by coroner-written PFDs. The establishment of a national oversight body would serve to ensure timely compliance with recommendations made by coroners and scrutiny bodies.

9. **Investigators of substance misuse-related deaths** should take into account both the clinical and security factors relevant to the incident. Where possible, scrutiny bodies should identify where there had been missed opportunities for diversion. Staff from the relevant agencies should be supported by their organisations during the investigation process.

10. **NHS England and Health Inspectorate Wales** should work in collaboration with investigators to ensure commissioned independent clinical reviewers who assist in investigations into substance misuse-related deaths are qualified and experienced in the subject area. Experienced reviewers should also be involved in investigations into deaths in Approved Premises, where they are currently not utilised.