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Dying Behind Bars: A Capability Approach to End-of-Life Care in UK Prisons

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Abstract

Background: With a rapidly ageing prison population in the United Kingdom (UK), an increasing number of people in prison are dying from chronic and life-limiting illnesses. **Methods:** A sample of 487 independent investigation reports into deaths from natural causes in UK prisons (2017–2020) was examined to explore palliative care referrals, appropriateness of restraints, applications for early release on compassionate grounds (ERCG), and equitable access to healthcare. **Results:** Most of the reports were based on male prisoners aged 60+, and the leading cause of death was cancer. While care was regarded as 'equivalent' in 83.7% of cases, several reports indicated delayed diagnosis, poor care coordination, and limited access to palliative care, particularly for people with non-malignant diseases. Restraints were regularly criticised as inappropriate or inhumane, and early release was not considered in 42% of cases, often due to delays or procedural issues. When viewed through Nussbaum's Capability Approach, being unable to access healthcare 'when needed' represents a failure to secure the basic capability of bodily health, and reflects a profound restriction on practical agency. **Conclusions:** Delays in diagnosis, treatment, and referral are not merely inefficiencies but constitute structural barriers that constrain individuals' real opportunities to achieve health and well-being. It is anticipated that older people in prison will experience layered capability inequalities, arising from age, health status, and custodial context. These findings suggest that prisons function as sites of punishment and environments in which capability deprivation is intensified towards the end-of-life.

Keywords: prison healthcare; palliative care; end-of-life care; capability approach; compassionate release



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1. Introduction

1.1. Demographics of People in Prison and Policy Landscape

Globally, the prison population is approximately 11 million and continues to rise (Fair and Walmsley 2024). Within Western Europe, the United Kingdom (UK) maintains the highest prison population (Fair and Walmsley 2024). While young men on remand have historically dominated this demographic, UK prisons are facing an unprecedented shift, with the number of people in prison aged 60+ quadrupling since 2002 (Price 2024). Currently, individuals aged 50 and over account for almost one in five (18%) of people

in prison, which the [Ministry of Justice \(2024\)](#) expects to grow by another 15% by 2028. Within the criminal justice system, ‘older people’ are defined at the lower threshold of 50+ due to the early onset of dependency, frailty and disease-related illnesses ([Department of Health and Social Care and Ministry of Justice 2025](#)). The premature ageing effect is driven by a combination of lifestyle factors (i.e., smoking, alcohol, poor diet, and substance use) ([Carlisle 2006](#)) alongside housing insecurity and underutilisation of healthcare services ([Turner and Trotter 2010](#)).

Consequently, dying from natural causes in prison custody is an ever-greater reality ([Department of Health and Social Care and Ministry of Justice 2025](#); [Turner 2026](#)). This shift is compounded by longer prison sentences ([Prison Reform Trust 2018](#)), an increasing number of chronically sick prisoners ([Williams et al. 2014](#)), the ageing prison population ([Van Zyl Smit and Appleton 2019](#)), older people being sentenced for historical crimes ([Bellass et al. 2024](#)) or older people being sentenced to life in prison ([Vannier 2026](#)). Despite the crisis, systemic policy failures prevent timely intervention. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report, *Inside Healthcare*, found that while 44% of those who died from natural causes were identified as palliative or end-of-life and had a care plan, an additional 23.5% of people in prison could have been identified as palliative but were missed. People with a cancer diagnosis were more likely to be identified as end-of-life than those with non-malignant diseases or advanced chronic disease ([NCEPOD 2024](#)). Despite several Prisons and Probation Reports (PPO) making similar recommendations on palliative and end-of-life care (PEOLC), little tangible change in practice has been documented ([Department of Health and Social Care and Ministry of Justice 2025](#)). While these overarching macro-policies and demographic shifts are being reported, the reality of the systemic failure is experienced as a deprivation of human rights by the people in prison.

1.2. The Capability Approach and the Lived Experience

The Capability Approach, developed by [Nussbaum \(2000, 2011\)](#), provides a framework for evaluating justice and well-being by focusing on what people are genuinely able to ‘be’ and ‘do’, rather than focusing on available resources. Central to the approach is the idea that all individuals should have the capability to live with dignity. For people living with advanced illness in prison, institutional rules, stigma, limited family contact and reduced autonomy create compounding layers of restriction that strip away fundamental capabilities ([Nussbaum 2011](#)). Other relevant capabilities include whether the person has adequate access to symptom management, palliative care, or respectful treatment (bodily health and bodily integrity); can maintain family relations, say goodbye, sustain emotional bonds or receive visits (emotions and relationships); and if they can participate in decisions about treatment, resuscitation, hospice transfer or place of death (control over their environment).

Qualitative research involving 14 people with palliative care needs in a French prison demonstrates that the prison environment compromises the capability of bodily health and bodily integrity. People in prison with a terminal diagnosis routinely faced delays in accessing specialists, a lack of essential medical equipment and inadequate support with activities of daily living ([Chassagne et al. 2017](#)). The rigidity of being in prison actively destroys a person’s control over their environment, therefore denying them the autonomy to participate in critical medical decisions, choose a place of death, or opt for a hospice transfer ([Nussbaum 2011](#)). According to international studies exploring palliative care in prisons, the environment inflicts emotional trauma with people forced to witness the distressing, unmitigated deaths of their peers, which fuels intense anxiety about their own impending deaths in prison ([Handtke and Wangmo 2014](#); [Handtke et al. 2017](#); [Loeb et al.](#)

2014). The participants in one study faced social isolation due to reduced social contact, and an unmet wish to die outside of prison (Handtke and Wangmo 2014). When basic capabilities, such as managing pain or sustaining emotional bonds, were restricted, dying in prison was an unwarranted punishment, which inflicted disproportionate suffering, trauma and humiliation (Deaton et al. 2010; Schaefer et al. 2022).

1.3. Operational Barriers

Providing high-quality health and social care in prison requires professional integrity and clinical competence that is often undermined within the prison environment (Coverdale 2021). Central to this is the paradox of care vs. control (Peacock et al. 2017; Roulston et al. 2021). Findings from an international study involving staff delivering palliative care across six Western countries (Turner et al. 2025) reported that locked cells and inflexible regulations created environmental and regulatory barriers to providing palliative care. When healthcare staff request flexible access or unlocked cells, the security procedures need to be prioritised over caregiver–patient privacy, rendering this aspect of dignified care impossible to achieve (Turner et al. 2024, 2025).

According to Peacock et al. (2017), who interviewed 60 males in a UK prison and other key stakeholders regarding the management of ageing and dying people, prison officers recognise the need to provide care, but question if it is their custodial mandate, and state they need further specialist training and resources. When viewed through the lens of care ethics, the prison setting systematically fractures the relational and narrative contexts necessary for compassionate care (Coverdale 2021). These rigid control mechanisms and mechanical restraints compromise the development of therapeutic relationships between people in prison and the health and social care professionals required to provide palliative and end-of-life care.

A landmark judgement in the UK High Court in 2007 made it clear that prison staff need to seek a medical opinion when assessing the need for restraints, as using handcuffs or other restraints on terminally or seriously ill people was inhumane, unless justified by security considerations (Prisons and Probation Ombudsman 2013). More contemporary policy frameworks state that any risk assessment must be clinically informed and proportionate, considering the person's current medical frailty against their genuine escape risk (Ministry of Justice and His Majesty's Prison and Probation Service 2024). Inappropriate restraints contradict core ambitions outlined in the Dying Well in Custody Charter (National Health Service 2018), which states that individual care should promote dignity and respect, maximise comfort and safeguard well-being. Despite this, Klock and Liantonio (2018) reported that some dying prisoners were restrained with handcuffs or remained under guard until they died, illustrating the disconnect between policy and practice. The Prisons and Probation Ombudsman (2022) has repeatedly identified the inappropriate use of restraints during transfers between prison and hospital for severely ill people. According to Pemberton et al. (2024), this means that people transferred to hospital were routinely shackled until their final weeks or days of life, causing unnecessary pain and psychological distress. According to several sources, shackles negatively impact the therapeutic relationship between professionals and their patients (Haber et al. 2022; Turner et al. 2025; Robinson et al. 2021). When explored using Nussbaum's (2011) Capability Approach, the inappropriate or excessive use of restraints acts as a means of institutional trauma that induces fear, humiliation and shame. Furthermore, it has the potential to interfere with family relations or saying goodbye to loved ones with dignity.

Although policies for early release on compassionate grounds (ERCG) exist to enable people to die outside prison (i.e., in a hospice, care home or their own home), the criteria for ERCG are stringent, and the application process is lengthy (Ministry of Justice and His

Majesty's Prison and Probation Service 2024). Medical staff must confirm the person is close to the end of their life (usually less than three months), and the Governor must assess the risks associated with release, before approving applications (Roulston et al. 2021). This means the person may die in prison custody before a final decision is reached (Turner 2026).

Given the increased need for people in prison (Cloyes et al. 2017; Turner 2026), it may be timely to consider relevant tools. These include the 'Surprise Question' (Downar et al. 2017), where healthcare professionals are asked, 'Would I be surprised if this patient died in the next 12 months?' and the Supportive and Palliative Care Indicators Tool (SPICT-4ALL in Prisons). It is used by healthcare staff unfamiliar with specialist palliative care to holistically assess the palliative care needs of adults in prison (University of St Andrews and National Health Service Scotland 2025). Van Wijmen et al. (2020) compared the performance characteristics of both tools with different populations, highlighting the pros and cons. From the body of international literature reviewed, there are clear similarities with the UK in terms of the delivery of palliative and end-of-life care to people in prison.

1.4. *The Impact of Deaths in Custody on Families*

As in many developed countries, every death in custody in the UK is investigated by an independent body. Responsibility for investigations lies with different independent bodies in the four nations of the UK: the Prisons and Probation Ombudsman (PPO) for England and Wales, the Prisoner Ombudsman for Northern Ireland, and the Crown Office and Procurator Fiscal Service in Scotland. According to research by Roulston et al. (2021), grieving family members experience a transformative effect following the death of a relative in prison custody. Families felt marginalised or ignored due to long-term institutional or governmental denial of responsibility; they reported infrequent communication between staff and relatives (Tully 2015) and limited transparency surrounding deaths in custody (Coles and Shaw 2006). Families know that an inquest into the death will not bring their relative back, but they hope lessons are learned to prevent similar mistakes being made in future (Coles and Shaw 2006).

1.5. *Aim and Research Questions*

This study aimed to analyse publicly available reports published by the Ombudsmen in the UK following deaths in prison custody from natural causes (2017–2020). Three research questions were developed in collaboration with the Project Steering Group:

1. Do people diagnosed with life-limiting or chronic illness in UK prisons have 'equivalent' access to prison healthcare?
2. Are people diagnosed with life-limiting illness being referred to palliative care services?
3. How are the family and friends of people dying in prison supported into bereavement?

2. Materials and Methods

This study analysed published reports of independent investigations into deaths in custody between 1 January 2017 and 31 December 2020 in England, Wales, Scotland, and Northern Ireland. These dates were chosen to ensure reports were in the public domain. As the data were publicly available on websites, formal ethical approval was not required. However, although full information about the individuals who died in prison (including names) was published in most reports, a decision was taken by the research team to adopt a more ethical approach and anonymise all study data. A list of reports to be included in data extraction was compiled, and each member of the research team was allocated their own spreadsheet for data collection.

The assessment to determine inclusion was made by an experienced clinician about whether the death was anticipated, and the person had or should have received pallia-

tive care. In a minority of cases, this was unclear, particularly where frailty was noted. Borderline cases were reviewed by two clinical members of the research team and, where appropriate, input was sought from members of the Project Steering Group (PSG). Members included a specialist palliative care doctor, a prison doctor, prison governors, the Prisoner Ombudsmen, members of the EAPC Prison Task Force, professionals from the Healthcare in Prison Team, a Community Palliative Care Team, Patient and Public Involvement representatives, agencies providing support to relatives of people in prison, and researchers. This process, which is in line with Lincoln and Guba's (1985) four-dimensional framework, enhanced the credibility of case selection by ensuring that inclusion decisions were based on clinical expertise and consensus.

2.1. Data Collection

A Microsoft Excel spreadsheet for data collection was created by the research team and discussed with members of the project steering group. Following consultation and testing of the data extraction tool, the spreadsheet was updated; the final version consisted of 30 variables (see Supplementary Materials for Word version of headings used). A guidance document was created to provide detailed information about what to include for each variable and how to record it, to ensure consistency across researchers undertaking data extraction. This process increased the dependability of the data collection process, in line with Lincoln and Guba (1985).

2.2. Data Analysis

Data from the Excel spreadsheets were transferred to IBM SPSS Statistics (Version 29), cleaned, and checked before analysis. All numerical data were analysed using descriptive statistics, and some cross-tabulations were performed. More complex statistical tests, which had originally been planned to determine similarities and differences between the four nations of the UK, were not undertaken because of small numbers of cases in some nations. Some free-text data were coded before analysis, such as place of death, where the limited number of possible places could be converted to numerical data and analysed statistically. Free-text data concerning ERCG, use of restraints, the Ombudsman's judgement about 'equivalent care', and clinical and non-clinical recommendations were subjected to thematic analysis using Braun and Clarke's (2006) framework. This approach was selected because, although the extracted data provided some narrative detail, it was not sufficiently in-depth to warrant a constructivist or interpretivist analysis, which is at the core of Braun and Clarke's more recent work (and that of other researchers). Their 2006 framework, however, provides a structured approach to extracting themes from data, and is particularly useful for researchers working in teams, so it was therefore chosen. The data were copied into a separate Word document and read several times to familiarise the researcher with the data before generating initial codes. Through an iterative process, and in discussion with research team members to resolve any disagreements, codes were grouped into sub-themes and then main themes, which were reviewed and named. Discussion and agreement among the research team enhanced the credibility and confirmability of the analysis by ensuring that coding and theme development were grounded in the data extracted from Ombudsman reports rather than individual researcher interpretation (Lincoln and Guba 1985).

While themes were developed inductively from the data, they were subsequently interpreted through the lens of the Capability Approach (Nussbaum 2000, 2011) to examine the extent to which prison environments and practices enabled or constrained opportunities for people living with advanced illness to maintain dignity and achieve valued aspects of well-being. The analysis therefore considered the experiences described in the Ombudsman reports and how institutional policies, healthcare provision, and prison practices affected

capabilities such as bodily health, bodily integrity, and control over one's environment. The final stage of the [Braun and Clarke \(2006\)](#) framework, interpreting the findings and their significance, is presented in the results section through this theoretical lens. Detailed reporting of the study context, inclusion criteria, data extraction procedures and analytical approach was intended to enable readers to assess the transferability of the findings to other prison and correctional healthcare settings ([Lincoln and Guba 1985](#)).

3. Results

3.1. Characteristics of the Sample

A total of 830 reports on natural cause deaths were reviewed. Of these, 343 were excluded, either because the death was sudden or unexpected, or because the diagnosis was made late and there was no opportunity for the prison to consider palliative care before the death. The remaining 487 deaths were included in the review: 443 from England, 14 from Wales, 28 from Scotland and two from Northern Ireland. Most of the 487 decedents were male (99.2%) and most were aged over 60 (81.6%); the age bands are shown in [Table 1](#). Over a fifth of decedents (21.2%) were aged 80 or over, and 9.2% were aged 85 or over, and thus classed as the 'oldest old' ([Public Health England 2019](#)).

Table 1. Age bands.

Age Band	<i>n</i>	%
20–29	4	0.8
30–39	3	0.6
40–49	23	4.7
50–59	60	12.3
60–69	133	27.3
70–79	147	30.2
80–89	103	21.2
90–99	14	2.9
Total	487	100

3.2. Cause of Death

The main cause of death was cancer (45.2%); almost 80% had more than one healthcare condition, and 29% had more than five different health conditions documented in their medical history. [Table 2](#) shows the main causes of death.

Table 2. Main Causes of Death.

Cause of Death	<i>n</i>	%
Cancer	220	45.2
Heart disease/attack	79	16.2
Pneumonia	63	12.7
COVID-19	19	3.9
Chronic Obstructive Pulmonary Disease (COPD)	18	3.8
Stroke/brain haemorrhage	16	3.3
Sepsis	14	2.9
Multi-organ failure	13	2.7
Old age/frailty/dementia/Parkinson's Disease	13	2.7
Kidney disease/failure	7	1.4

Table 2. *Cont.*

Cause of Death	<i>n</i>	%
Liver disease	6	1.2
Pulmonary embolism	4	0.8
Aortic aneurysm	3	0.6
Peritonitis	3	0.6
Other infection (<i>Clostridioides difficile</i> /viral)	3	0.6
Gastrointestinal bleed	2	0.4
Motor Neurone Disease	2	0.4
Other (epilepsy, peripheral vascular disease, choking)	3	0.6
Total	487	100

3.3. Place of Death

Deaths took place in 83 out of the 142 prisons in the UK (58.5%). Nineteen of these prisons had 10 or more deaths during the study period; these totalled 262 (53.8%) of all included deaths. Almost half of the 83 prisons (46.9%) had only one, two or three deaths. It is important to note that although all decedents (apart from one who had recently been released on compassionate grounds) were in custody at the time of their death, most deaths took place in a hospital (51.1%) or hospice (12.3%), and only 35.8% died in a prison setting. Prison settings include the person's normal cell, inpatient healthcare unit, palliative care unit, older people's unit, social care unit, or disabled unit.

3.4. Equivalence of Care

In England, Wales and Northern Ireland, Ombudsman reports include an assessment by their clinical reviewer of whether the clinical care provided was 'equivalent' to what a person could have expected to receive in the community (this is not reported in Scottish reports). The Mandela Rules for Prison, adopted in 2015, outline the minimum standards for the dignity and safety of people in prison, which include healthcare in prison to meet community standards. In the UK, the [Royal College of General Practitioners \(2018\)](#) has produced a position statement on equivalence of care in secure environments, which states that services or treatment provided to people in prison should be "at least consistent in range and quality with that available to the wider community to achieve equitable health outcomes." It stresses that equivalence does not mean that care provision in prison should be "the same" as that provided in the community. It also acknowledges that there are variations in care provided in community settings. Of the 459 reports that mentioned equivalence, care was considered 'equivalent' in 384 cases (83.7%), and 'partly equivalent' in a further 26 cases (5.7%); in one case (0.2%), it was not possible to determine equivalence. In 48 cases (10.4%), care was considered 'not equivalent'. Of those, 33 (68.75%) were non-cancer and 15 (31.25%) were cancer deaths. Qualitative analysis of the free-text data describing why care was not equivalent in those 48 cases revealed several themes (see Table 3).

Table 3. Main themes, sub-themes and examples of non-equivalent care.

Main Theme	Sub-Theme	Example Data Extract (Record)
Assessment and monitoring	Assessment	Although he was at high risk of falls, an adequate falls risk assessment was not conducted. (209)
	Mental capacity assessment	[There was] a failure to carry out a formal mental capacity assessment when he refused treatment. (165)
	Monitoring	None of the nurses who saw him took his observations or used the National Early Warning Score (NEWS) assessment tool. (83)

Table 3. Cont.

Main Theme	Sub-Theme	Example Data Extract (Record)
Care planning and co-ordination	Care planning	There were no care plans in place to manage Mr X's heart disease or chronic kidney disease. (485)
	Protocols and guidance	Sepsis protocol should have been applied. (80)
	Care co-ordination	Several different prison doctors and hospital consultants were involved in his care, but prison staff failed to coordinate his care in the way that primary care would be expected to do in the community. (111)
Care delivery	Poor care	The clinical reviewer found that the care was variable. Notably, his high blood pressure and heart disease were not managed in line with national guidelines for cardiovascular disease. (454)
	System failures	There were several system failures at [prison] that led to Mr X receiving poor physical and diabetic care. (477)
	Lack of equipment	There were significant delays in providing a pressure-relieving mattress. (480)
	Medication	There were multiple failings, including staff giving incorrect doses of medication. (165)
Care management	Management of care	The clinical reviewer found several weaknesses in Mr X's clinical management, notably no clinical oversight, poor continuity of care, conflicting advice, and a lack of clinical curiosity. (478)
	Inadequate action	[Mr X] was not seen by a prison doctor until three months into his sentence, despite his previous medical history. (213)
	Inadequate follow-up	The Echo Cardio Gram (ECG) results were not followed up promptly or adequately. (331)
	Referrals	He was not referred to a doctor as he should have been. (35)
Communication	Communication with the patient	Prison doctors did not adequately manage his abnormal blood test results or inform him of the need for prompt investigation. (191)
	Communication with family	There was a delay in contacting the family about his admission to the hospital and when he became seriously ill. (259)
	Staff communication	Prison staff did not share information with health and social care staff about his deteriorating health or mobility. (191)
	Documentation	There were concerns regarding the poor quality of recording on patient records, which did not meet the Nursing and Midwifery codes. (429)
Delays	Delayed referrals	When the prisoner presented with concerning symptoms in early December, this should have prompted an urgent referral under the NHS pathway for suspected cancer. (34)
	Delayed admissions	The clinical reviewer considers that nurses should have suspected a stroke much sooner than they did and sent him to the hospital earlier. (418)
	Delayed appointments	Communications between the hospital, the community doctor and the prison were poor, and this delayed appointments. (103)
	Delayed assessments	The Ombudsman shares the clinical reviewer's concerns about delays in obtaining and memory assessment. (81)
	Late diagnosis	Referral to a Haematology specialist was delayed and not made in line with the National Health Service pathway, resulting in a late diagnosis. (95)
	Medical records	Medical records were not obtained until one week after his admission to prison. (331)
	Providing care	Blood tests were requested but not completed until six months later. (213)

Table 3. *Cont.*

Main Theme	Sub-Theme	Example Data Extract (Record)
Palliative care	Poor palliative care	The Ombudsman is also concerned that, following his diagnosis, staff did not put a palliative care plan in place, and there was a two-week delay in administering pain relief. (140)
	Location of care	The clinical reviewer considered that it was not appropriate to transfer him over 370 miles when he had end-stage Motor Neurone's Disease, and staff at [prison] should have attempted to identify a local hospice to provide end-of-life care. (82)

3.5. Referral to Palliative Care Services

Some form of palliative and end-of-life care (PEOLC) planning or delivery was mentioned in 64.7% of reports, although in some cases this was only a brief mention of a 'do not attempt resuscitation' order. In over a third of reports, there was no mention of PEOLC, even though the person was clearly approaching the end of life. Further analysis showed that PEOLC was mentioned in 87.7% of deaths where cancer was the primary cause of death, compared with only 45.7% of deaths from non-cancer causes. Table 4 shows the provision of palliative care in relation to the primary cause of death.

Table 4. Primary Cause of Death and Provision of Palliative Care.

Primary Cause of Death	Palliative Care Mentioned <i>n</i> (%)	Palliative Care Not Mentioned <i>n</i> (%)	Total <i>n</i> (%)
Cancer	193 (87.7)	27 (12.3)	220 (100)
COPD/pneumonia	30 (37.5)	50 (62.5)	80 (100)
Cardiovascular	45 (42.9)	60 (57.1)	105 (100)
Old age, frailty, dementia, Parkinson's Disease	10 (76.9)	3 (23.1)	13 (100)
Other	37 (53.6)	32 (46.4)	69 (100)
All non-cancer	122 (45.7)	145 (54.3)	267 (100)
TOTAL	315 (64.7)	172 (35.3)	487 (100)

3.6. Support for Family and Friends

Some form of contact with family members is mentioned in almost 80% of reports. Families were involved at the end of life in 43.3% of cases; lack of family involvement was usually because of family breakdown and/or the nature of the offence. Family Liaison Officers were involved following the death in 40.9% of cases and provided support until the funeral. The role of the Probation Board and social workers is not mentioned, and bereavement support following the funeral was not mentioned in any reports. It is not the remit of the prison service to provide or the PPO to investigate bereavement support.

3.7. Use of Restraints

Where patients were transferred between care settings at the end of life, restraints were used in 171 cases (35.1%). Different sorts and levels of restraints were used, depending on the circumstances and the risk of escape and reoffending, but the most commonly used restraints were handcuffs and escort chains (where the person is handcuffed to an officer with a length of metal chain connecting them). Individuals were normally escorted by two members of staff. In the 171 cases where restraints were used, the Ombudsman criticised their use in 118 cases (69%). Criticism centred on inappropriate risk assessments that did not adequately account for the current medical condition of the person being escorted but which were based on the risk the person presented at the time of their imprisonment or

original offence. Qualitative analysis of free-text data on the use of restraints identified 15 sub-themes, which were grouped into five main themes. See Table 5 for illustrative data extracts.

Table 5. Thematic Analysis of Restraints.

Theme	Sub-Theme	Example Data Extract (Record Number)
Risk assessments	Poor risk assessment	The Ombudsman considers that the risk assessment failed to take into account his declining health and lack of mobility. (105)
	Medical/health information	Healthcare did not provide sufficient information about the impact of the prisoner's health on his mobility, to enable them to assess the risk. (231)
	Review of risk assessment	An escort chain was used to transfer him to hospital and there is no record of a review of risk so he remained restrained for the nine days he was in hospital. This caused significant swelling and bruising to his wrists. (321)
	Legal requirements	The Ombudsman found that the risk assessment was based on the prison's view of his offence with little consideration of how his health and mobility affected the risk he presented at the time as required by the 2007 High Court judgement. (98)
Use of restraints	Inappropriate use of restraints	For his first chemotherapy appointment an escort chain was used during treatment. The PPO considers the use of restraints inappropriate during medical treatment. (15)
	Patient condition	Prisoner was restrained using single cuff and escort chain and accompanied by two prison officers on his last admission to hospital (5 days prior to his death). This was deemed inappropriate given the health state of the prisoner. (467)
	Inconsistency	The Ombudsman considers the inconsistency in the use of restraints is unjustified. (138)
	Inappropriate level of restraint	The level of restraint was not reviewed in the light of his deteriorating physical presentation and ability to mobilise. (99)
Communication	Use of restraints not approved appropriately	Staff also failed to get approval from a senior manager on one occasion before using restraints. (197)
	Transfer between prisons	There was confusion between Prison A and Prison B about his restraint arrangements. (30)
	Staff communication	The prison manager agreed that restraints should be removed but this was not communicated to the bed watch staff. (290)
	Documentation	The prison also failed to provide the Ombudsman with the risk assessments to cover his admission to hospital on three occasions. (26)
Staff	Risks to officers	An officer asked for permission to remove the chain, but a senior manager refused and the restraints remained in place for another three hours. The Ombudsman is concerned that this delay increased the officers' risk of exposure to C19 (387)
	Staff knowledge and understanding	The Ombudsman is troubled that staff at the prison appear not to understand a fundamental aspect of the High Court judgement—the need for a medically informed assessment. (160)
Prison	Prison-level criticisms	The Ombudsman has made recommendations to HMP Bure about this issue on two previous occasions and will be doing so again in relation to another death in May 2017. Effective action now needs to be taken to implement these recommendations. (51)

3.8. Early Release on Compassionate Grounds

In UK prisons, discussion of ERCG as a person approaches the end of life is considered good practice. There was no mention of ERCG in over 40% of cases. As with palliative care provision, people with cancer were more likely to be considered for ERCG than those whose cause of death was non-cancer. Table 6 shows ERCG in relation to the primary cause of death. ERCG was mentioned in 83.1% of cases where the primary cause of death was cancer, compared with only 37.1% of non-cancer deaths. Qualitative analysis of free-text data on ERCG resulted in 13 sub-themes, grouped into six main themes. See Table 6 for themes and data extracts.

Table 6. Early Release on Compassionate Grounds (ERCG).

Theme	Sub-Theme	Example Data Extract (Record Number)
ERCG was not considered or applied for	Application not made	No evidence to suggest that the prison fully considered ERCG or started the application, which they should have done. (93)
	The application started but was not finished	Written confirmation of diagnosis and prognosis was provided by the hospital and prison staff started the process, but the paperwork was not submitted for consideration. (215)
Prognostication	Uncertain prognosis	Although he was on the Palliative Care register before going to prison, the doctor was unable to give a definitive prognosis. (12)
	Delay in providing prognosis	An application for ERCG was authorised by the Governor and sent to the Public Protection Casework Section of Prison, but a specific prognosis was required and there was a delay in providing this. (68)
Applications	Delayed/late applications	Although he did not have a definitive diagnosis, it was clear by the time of the multi-disciplinary meeting on 11 Jun that he was coming to the end of his life. It was noted then that the prison was progressing an application for ERCG. However, the Ombudsman is concerned that this was not submitted before he died on 6 July. (156)
	Resubmission of applications	When he was admitted to hospital for end-of-life care, the prison did not take proactive steps to resubmit the application in the light of the deterioration in his condition. (84)
	Patient death during application process	The Ombudsman is disappointed that his release was not authorised until 20 March and that his condition deteriorated to such an extent that he died in prison on the date of his proposed release. (390)
	Public Protection Casework Section (PPCS) section	An application was with Public Protection Casework Section for ten days, and no decision was made. (143)
Staff	Staff issues	As prison staff were aware that he had a terminal diagnosis, the Ombudsman considers they should have been more proactive in seeking a prognosis so that the possibility of ERCG could have been considered. (416)
Communication	Communication with patient	An team meeting a month before he died discussed ERCG but there is no evidence that this was then discussed with the prisoner. (10)
	Communication between prisons	Conversations took place at Prison 1 about ERCG but as he was still a prisoner at Prison 2 it was their responsibility to initiate an application. Although conversations took place about compassionate release, it is important that such conversations are documented and communicated to the establishment responsible for making the application. (199)

Table 6. *Cont.*

Theme	Sub-Theme	Example Data Extract (Record Number)
	Documentation	The Ombudsman found shortcomings in recording his wishes about early release on compassionate grounds. (1)
PPO investigation	Investigation process	Despite repeated requests from the Ombudsman, the prison have not explained why they did not respond to Public Protection Casework Section. (169)

3.9. Recommendations from Reports

Analysis of the recommendations (clinical and non-clinical) resulted in the identification of 260 sub-themes grouped into ten main themes (see Table 7). A total of 805 recommendations were made in the 487 PPO reports analysed, with between 1 and 10 recommendations per report (some had multiple recommendations in the same theme).

Table 7. Recommendations by the Ombudsman.

Main Theme	Number of Subthemes
Clinical care (general)	105
Palliative and end-of-life care	54
Communication/documentation	21
Family	20
Restraints	17
Transfers between prisons/for healthcare	13
Early Release on Compassionate Grounds	10
Mental Capacity	9
Well-being of incarcerated individuals	7
Staff support and training	4
Total subthemes	260

4. Discussion

4.1. Novel Approach

The methodology used in this work is novel as it analysed 487 independent Ombudsmen investigations into natural cause deaths in prison during 2017–2020, across all four UK nations. The findings raise concerns about prison healthcare for older, chronically ill, and dying prisoners, which echo concerns regarding the management of older people in prison (Van Zyl Smit and Appleton 2019; Vannier 2026). When the Capability Approach (Nussbaum 2000, 2011) is used to interpret the findings, health inequalities, bodily integrity, and loss of agency become apparent.

4.2. Equivalence of Care

According to the published reports reviewed, Ombudsmen stated that 10.4% of people in prison did not receive healthcare that they would regard as ‘equivalent’ to what people in the community expect. As explained above, the Royal College of General Practitioners (2018) clarifies what ‘equivalent care’ means in prisons and other secure environments, recognising that variations in care exist in part because of the secure environment’s context. In our study, examples of ‘non-equivalent’ care included failure to conduct assessments in line with protocols (i.e., sepsis, falls, mental capacity, cardiovascular disease, diabetic care), following up on test results, and making onward specialist referrals (Table 3). It is important to acknowledge that the Ombudsmen and clinical reviewers make their assessments about equivalence based on clinical care alone, rather than considering the wider aspects of good

quality end-of-life care, such as access to family members, dignity, and involvement in decision-making, and this may account for why care was judged equivalent in the majority of cases reviewed. In contrast, the Dying Well in Custody Charter ([National Health Service 2018](#)) promotes fair access to care that goes beyond clinical needs and maximises comfort and well-being. The Health of People in Prison, on Probation and in the secure NHS estate in England ([Department of Health and Social Care and Ministry of Justice 2025](#)) states the importance of prison staff making onward referrals to specialist clinics or specialist nurses to 'diagnose, assess and manage complex health conditions' (p. 150).

4.3. Cancer vs. Non-Malignant Disease

Although examples of excellent PEOLC provision are reported, many people missed out. Our findings show that most people who received PEOLC were diagnosed with cancer. This echoes findings in a Marie Curie report ([Johansson et al. 2024](#)), which states that the most commonly reported single cause of death was cancer ($n = 318$, 27.0%) (p. 15). The [Department of Health and Social Care and Ministry of Justice \(2025\)](#) report states that patients with cancer were more likely to be identified as end-of-life than those with non-malignant diseases or advanced chronic diseases (p. 161). In our findings, reports for over one-third of deaths made no reference to PEOLC, especially those who died from non-cancer causes, which suggests a systemic failure. Our findings mirror those of [Bellass et al. \(2024\)](#) and [Cloyes et al. \(2017\)](#), where access to palliative care in prisons is patchy and dependent on diagnosis rather than need. Despite having relevant end-of-life care policies for people in prison, the findings of the Ombudsman reports show that standards are not being consistently achieved. The [Department of Health and Social Care and Ministry of Justice \(2025\)](#) also noted that PPO investigations on PEOLC showed little change in practice despite several making similar recommendations.

4.4. Capability Approach

The Capability Approach also contributes theoretically by extending the analysis beyond the concept of healthcare equivalence. Ombudsman investigations primarily assess clinical care against accepted standards, yet the Capability Approach highlights broader dimensions of justice, dignity and humanity. It draws attention to losses of bodily integrity, practical reason, affiliation, and emotional well-being that may occur even when clinical care is judged to be equivalent. This broader perspective provides a richer understanding of inequalities experienced by people who are dying in prison and demonstrates that equivalence and quality of care cannot be evaluated solely through clinical indicators.

4.5. Holistic Care Needs

This could be improved by training staff to use the 'surprise question' (Would you be surprised if this person died within the next year?) ([Gupta et al. 2024](#)) and implementing the Supportive and Palliative Indicators Tool for All in Prison (SPICT-4ALL in prison) ([University of St Andrews and National Health Service Scotland 2025](#)). Furthermore, the Dying Well in Custody Charter ([National Health Service 2018](#)) recommends that each prison should have a palliative care register to identify people and improve access to PEOLC. It is also important to recognise that palliative care involves the active, holistic care of individuals throughout the course of their illness, which includes providing physical, psychological, social, and spiritual support for both the patient and their loved ones ([Taylor et al. 2025](#)). Therefore, we need to look beyond meeting medical needs and consider how psychosocial support can be offered by social workers and other relevant professionals in the multidisciplinary team.

4.6. Inappropriate Use of Restraints

Legislation and general principles that guide decision-making in prisons suggest that restraints should be proportionate to mitigate the risk of a person reoffending, escaping, or harming a member of the public. As outlined in the Dying Well in Custody Charter (National Health Service 2018), a joint assessment of healthcare and security will inform the dynamic risk assessment for restraints. In our analysis of the Ombudsmen reports, restraints were inappropriately applied in over a third of cases. Decisions were based on the risk at the time of sentencing, rather than their health state at the time of being transported, and often without relevant medical input, raising issues of care ethics (Coverdale 2021). The inappropriate use of restraints when transporting people in prison to other settings was reported as inhumane, degrading and disproportionate by others (Klock and Liantonio 2018; Roulston et al. 2021; Turner et al. 2025). This is supported by the capability framework (Nussbaum 2000, 2011), which views inappropriate restraint as a loss of bodily integrity (loss of privacy or loss of control over their own body); loss of agency (communicating their wishes is not important); and loss of social dignity (feeling disrespected or socially devalued). Where the assessed risk is low because of the person's frailty or illness, more dignified and humane transfers could be managed by the presence of one or two prison officers, wearing plain clothes, in hospital and hospice settings.

4.7. Family Involvement and Support

Family involvement at the end of life was reported in 43% of cases. However, some were estranged from their families, or family contact details were inaccurate. Research by Gilbert et al. (2024) and Turner and Peacock (2017) also noted the lack of family involvement at the end-of-life in their respective studies. It could be argued that excluding families from end-of-life care violates Article 8 (the right to private and family life) of the Human Rights Act (Her Majesty's Stationery Office 1998). Some families received support from the Family Liaison Officer until the time of death or funeral, but it is unclear what this entailed. Findings from interviews with bereaved relatives of people who die in prison custody report experiences of the closed world of custody (Coles and Shaw 2006) and institutional secrecy around the death (Vaswani 2023). Such an approach may generate stigma of deaths in prison custody, relationships not being validated, mourners being denied legitimate grief (Vaswani 2023) and overt exclusion or invisibility for griever (Bristowe et al. 2023). Social workers are well placed to offer psychosocial support to people in prison and their families, regardless of the status of their relationship. If they are involved at an early enough point, they may be able to help with communication, reconciliation, visiting permits, advance care planning and advocacy regarding end-of-life care preferences or wishes.

4.8. Barriers to Early Release on Compassionate Grounds (ERCG)

Finally, the study data highlighted complexities around ERCG. Legislation relevant to each nation of the UK allows for ERCG in specific circumstances; in England and Wales, for example, the Secretary of State "may release a serving prisoner at any point in the sentence if they are satisfied that exceptional circumstances exist which justify a prisoner's release on compassionate grounds" (Ministry of Justice 2023, p. 4). This document provides guidance for applications for ERCG due to a person's health and social care needs and identifies cases where "the experience of imprisonment causes suffering greater than the deprivation of liberty intended by the punishment" (p. 9). People in the last few months of life are normally eligible to apply for ERCG if medical advice shows that their needs would be better accommodated in a hospice, hospital, or at home, but it also depends on the nature of their offence, how long they have served, and the anticipated victim impact. Our findings indicated that the ERCG process remains bureaucratically difficult and is

inconsistently applied. Prognostication can be very difficult for non-malignant diseases, which may help to explain why those with cancer were much more likely to be considered for ERCG. The fact that some people were never considered for ERCG or died during the ERCG application process reflects a systemic failure, which has been reported elsewhere (Roulston et al. 2021). The Dying Well in Custody Charter (National Health Service 2018) recommends timely access to a suitable care environment to enable quality palliative and end-of-life care in the preferred and permitted place, which is in line with the capability framework (Nussbaum 2000, 2011), which can be used to shift the focus from managing risks to recognising structural barriers and understanding inequality.

5. Conclusions

5.1. Strengths and Limitations

The first strength is that the analysis draws on data extracted from 487 independently investigated reports of deaths from natural causes in prisons across England, Wales, Scotland, and Northern Ireland. However, the small number of deaths in Northern Ireland made it impossible to make cross-national comparisons.

Secondly, the use of publicly available data from Ombudsmen reports promotes transparency, and adopting a mixed-methods design enhances the depth and breadth of the findings, which provide a more nuanced interpretation of the deaths in prison. However, the authors recognise that the Ombudsman reports do not contain first-person accounts of the lived experiences, which leaves institutional accounts of the deaths. Furthermore, the reports were not written for research purposes, and the quality and consistency of information varied between reports, authors, and jurisdictions.

Thirdly, the study involved the development of a 30-variable data extraction tool, with the application of clear inclusion and exclusion criteria, overseen by a multidisciplinary Project Steering Group, including clinicians, which ensured consistency in data collection. However, interpretation of deaths involving frailty or late diagnoses required clinical judgement, meaning bias in interpretation cannot be entirely ruled out.

Finally, by highlighting structural and ethical issues such as inequitable access to care, inappropriate use of restraints, and barriers to ERCG, the findings will be important for human rights, social justice, and social work. The study is timely, given the rapidly ageing prison population and increased focus on underserved groups.

5.2. Recommendations for Policy, Practice and Research

Those responsible for commissioning and delivering prison health care services in the four nations of the UK need to ensure that there is sufficient access to PEOLC when people in prison need it and that it promotes a holistic approach involving the full range of health professionals, including social workers. Both the complexity of palliative care needs of people in prison and the multiplicity of challenges in providing care in secure settings require a more coordinated system-wide response.

While some good practice is evident at the individual prison level, access to good-quality care appears variable, and opportunities to address structural issues which impact the delivery of care across the whole prison system are being missed. A comprehensive plan to manage anticipated palliative care needs is required as part of a wider national strategy to meet the needs of the ageing prison population. This should include consideration of prison infrastructure, such as the suitability of the current and future prison estate for an ageing population. Such a plan should also drive the development of a comprehensive and targeted education and training package for all prison workforces, including the following issues as a minimum:

1. Identification of palliative care need and timely and appropriate referrals, particularly for non-malignant conditions and frailty, and the widespread use of the “surprise question” or the Supportive and Palliative Indicators Tool for All in Prison (SPICT-4ALL in prisons) (University of St Andrews and National Health Service Scotland 2025).
2. Competent, dynamic, and joint healthcare and security risk assessments to inform the use of restraints during hospital transfers or admissions. Prisons should pilot the plain clothes security escort model for low-risk, frail people who are confined to bed, to maximise patient dignity.
3. Consistent and timely application of the ERCG process, irrespective of diagnosis.
4. Maintaining accurate contact information to allow prompt communication with relatives when a person in prison experiences a significant change in health.
5. Identifying opportunities for social workers to engage with people in prison and their relatives to offer psychosocial support throughout the illness trajectory, including bereavement.

In terms of recommendations for future research, consideration should be given to investigate the efficacy of integrating social workers into the multidisciplinary teams within prisons and measure any changes to family reconciliation, advance care planning conversations and involvement of families in end-of-life care decision-making. Other aspects include the need to investigate the experiences of bereaved relatives navigating the ‘closed world’ of prison custody, the prevalence of disenfranchised grief among bereaved relatives (Doka 2002), and the role of Family Liaison Officers.

Finally, Nussbaum’s Capability Approach could be used to develop a dignity audit tool to measure equivalence that goes beyond clinical care and aims to protect a dying person’s bodily integrity, affiliation and control over their environment.

5.3. Summary

This study adds to the growing evidence highlighting concerns about ageing and dying in prison and suggests that structural inequities, ethical tensions, and potential human rights issues may shape the delivery of end-of-life care in custodial settings. As the prison population continues to age, the demand for prison end-of-life care is expected to increase. These findings underscore the importance of considering policy and practice changes that support equitable resource allocation and enable health and social care professionals to provide dignified, coordinated, and person-centred care for this underserved population.

Supplementary Materials: The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/socsci15080514/s1>, Table S1: Headings of Data Extraction Table.

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Abbreviations

The following abbreviations are used in this manuscript:

ERCG	Early Release on Compassionate Grounds
EAPC	European Association of Palliative Care
NEWS	National Early Warning Score
NHS	National Health Service
PEOLC	Palliative and End-of-Life Care
PPO	Prisons and Probation Ombudsman
PSG	Project Steering Group
SPICT-4ALL	Supportive and Palliative Care Indicators Tool
UK	United Kingdom

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