Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Doig, on 11 March 2024, following his release from HMP/YOI Norwich.

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.

3. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

4. Mr Ian Doig (also known as Mr John Smith) died of heart disease on 11 March 2024, following his release from HMP Norwich. He was 70 years old. We offer our condolences to those who knew him.

5. The clinical reviewer concluded that the clinical care Mr Doig received at Norwich was of a good standard and equivalent to what he could have expected to receive in the community. The clinical reviewer made no recommendations.

6. We found an issue of concern relating to Mr Doig's End of Custody Supervised Licence (ECSL) release planning.

Recommendations

- The Governor and the Head of Suffolk Probation Delivery Unit should ensure that all staff are aware of their responsibility and the importance of sharing relevant information when conducting pre-release planning.

- The Head of Suffolk Probation Delivery Unit should ensure that all staff are aware of their responsibilities when conducting pre-release address checks, including verifying an address with the occupant, to ensure people on probation have a stable and suitable place to live.

The Investigation Process

7. HMPPS notified us of Mr Doig's death on 26 March 2024.

8. The PPO investigator obtained copies of relevant extracts from Mr Doig's prison and probation records.

9. The investigator interviewed Mr Doig's prison offender manager and the senior probation officer at Lowestoft probation office.

10. NHS England commissioned an independent clinical reviewer to review Mr Doig's clinical care at Norwich.

11. The investigator and clinical reviewer conducted a joint interview with the Head of Healthcare at HMP Norwich.

12. We informed HM Coroner for Suffolk of the investigation. He gave us the results of the post-mortem examination. The Coroner informed us that they were not holding an inquest. We have sent the Coroner a copy of this report.

13. The Ombudsman's office contacted Mr Doig's family to explain the investigation and to ask if they had any matters they wanted us to consider. The family asked questions about Mr Doig's conviction and sentence, the management of his mental and physical health, release planning and the lack of support following Mr Doig's death. We have answered the family's questions in our report and the clinical review.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

15. Mr Doig's family received a copy of the draft report. They pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. Mr Doig's family also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. Mr Doig's family said they did not feel like they were supported following Mr Doig's death.

Background Information

HMP Norwich

16. HMP Norwich is a multifunctional local prison which holds male prisoners who have either been convicted or are on remand. It is managed by HMPPS.

Probation Service

17. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervise people throughout their licence period and post-sentence supervision.

Key Events

18. On 15 December 2023, Mr Ian Doig was convicted of harassment offences and was sentenced to eight months in prison. He was sent to HMP Norwich. Mr Doig was due to be released in April 2024.

19. Between 2013 and 2022, Mr Doig's community GP saw him several times after he complained of chest pain. In February and March 2022, the community GP offered to refer Mr Doig to a cardiology specialist, but he declined on both occasions.

20. Mr Doig had pre-existing medical conditions including chronic kidney disease, high cholesterol, pre-diabetes and epilepsy. He also had significant mental health needs and was diagnosed with anxiety, depression and Emotionally Unstable Personality Disorder (EUPD - a borderline personality disorder which affects how a person thinks, feels and interacts with other people).

21. During the reception health screen, a nurse noted that Mr Doig's Person Escort Record (PER) said that Mr Doig had manic depression and severe mental impairment. His clinical observations were satisfactory and no concerns about his health were raised. He was prescribed medication for his conditions.

22. On 16 December, Mr Doig was moved from the induction wing to the healthcare wing. In interview, the Head of Healthcare told the investigator that there were no specific medical reasons why Mr Doig was on this wing; it seemed most likely it was age related and for bed management reasons.

23. On 26 December, a nurse saw Mr Doig in the long-terms conditions clinic. She created a care plan for his chronic kidney disease, and discussed this with him and gave him pre-diabetes advice.

24. On 31 December, the mental health team conducted an initial psychiatric assessment. It was considered that Mr Doig was struggling to adapt to the prison regime, and he was referred to the prison's mental health day care unit for additional support.

25. On 4 January 2024, Mr Doig attended an appointment with the prison substance misuse team. He did not disclose a history of substance misuse or excessive alcohol use. He declined any further support from the service.

26. On 9 January, Mr Doig was moved from the healthcare wing to the social care wing. He was accommodated here mainly due to his age, rather than him having any medical or social care needs.

27. On 22 January, the mental health team reviewed Mr Doig's referral. They discharged Mr Doig from the primary mental health team as he was receiving support from the day care support services.

28. On 13 February, the wellbeing Improving Access to Psychological Therapies (IAPT) team conducted an initial assessment with Mr Doig. They signposted him to a mental health support group in his local area, which he could access following his release from prison.

29. On 16 February, the wellbeing IAPT team saw Mr Doig. They noted that he was irate and demonstrated poor emotional regulation. Mr Doig did not engage during the appointment and walked out. They discharged Mr Doig from IAPT and said that the day care unit would be more suitable for him.

30. On 22 February, a nurse created an older persons care plan for Mr Doig. It was noted that he was completely independent and did not require assistance.

Pre-release planning

31. On 21 December 2023, Mr Doig was allocated a prison offender manager (POM).

32. On 3 January 2024, the POM emailed Mr Doig's community offender manager (COM) to discuss Mr Doig's release planning. The POM said Mr Doig wished to return to his home address, but she told him this may not be possible as the victim of his offences lived next door. She also said that Mr Doig had told her that he was planning to sell his property.

33. The next day, the COM responded to the POM's email. He confirmed that Mr Doig's property was up for sale, and he suggested that due to Mr Doig's repeat offending against the victim, he would consider referring him to an Approved Premises (accommodates offenders released from prison on licence and those directed to live there by the courts as a condition of bail). He said that he would contact Mr Doig in March to discuss his release plan and accommodation.

34. On 5 February, a resettlement worker saw Mr Doig. Mr Doig said that he had been diagnosed with a mental impairment, personality disorder, anxiety and depression, and that he was on medication for these conditions. He said that upon his release from prison, he planned to live with his son until he could sell his own property and find somewhere to rent. He did not have support in the community and agreed to be referred to the mentoring service. The resettlement worker emailed the COM to ask him to complete the referral.

35. On 7 March, the prison offender management unit (OMU) notified the POM that Mr Doig met the criteria for early release on End of Custody Supervised Licence (ECSL, a scheme introduced in 2023 which allows some determinate sentenced prisoners to be released before their conditional release date, to ease overcrowding in prisons). She emailed the COM and a Senior Probation Officer (SPO) to say that Mr Doig was now due to be released on 27 March instead of 14 April. She attached an exemption panel referral form (Annexe D) to the email in the event the Probation Service had any concerns to share with the prison about Mr Doig being released from prison early.

36. Later that day, OMU told the POM that the ECSL policy had changed, and that the early release had now been extended from 18 days to 35 days. They told her that Mr Doig's new release date was 11 March (in four days' time). She emailed the COM and the SPO to inform them of the new release date.

37. The COM was on leave from work, so his manager allocated Mr Doig's case to a duty COM to conduct pre-release checks and to complete Mr Doig's licence.

38. The duty COM called the POM to discuss Mr Doig's ECSL release. She noted that Mr Doig's plan was to reside with his son, and asked the POM for the son's contact number so this could be verified. The POM said she would get the number from the resettlement team and get back to her. The duty COM considered additional licence conditions and returned Mr Doig's licence to the prison with appropriate additional conditions.

39. On 8 March, the duty COM completed an address check on Mr Doig's son's address with the local police and a safeguarding check with social services. Both checks were returned with no concerns raised.

40. That day, Mr Doig was told that he was due to be released early under the new ECSL scheme and his release date would be 11 March. Prison records note that Mr Doig was very upset by this, and he was anxious that he had not been able to contact his son to plan transport for his release.

41. On 11 March, Mr Doig was discharged from the prison healthcare service. Mr Doig declined support to register with a GP in the community, so healthcare staff gave him a month's prescription for his medication to take with him when he registered with a new GP. They issued him with discharge documents and noted that he was fit for discharge as there were no healthcare concerns.

Post-release management

42. At 11.30am on 11 March, Mr Doig attended Lowestoft probation office for his induction appointment. His COM was on leave, so a duty COM saw him. Mr Doig told the duty COM that he would be staying with his son for a few weeks until he sorted out his own accommodation. The duty COM gave Mr Doig his next appointment in writing for 15 March, as he said he did not have a mobile phone.

Circumstances of Mr Doig's death

43. Mr Doig's family told us that following his probation induction appointment, Mr Doig visited his son's address. His son was at work, so he was called to come home. They described that Mr Doig was distressed, struggling to breath, and felt unwell. Mr Doig said he had nowhere to go. They told us that Mr Doig and his son had a disagreement. Mr Doig left and walked into Southwold, and whilst walking past a hotel he saw an old family friend. Mr Doig and the friend went into the hotel for a cup of tea, and then the friend booked a room for Mr Doig at the hotel as he told him that he had nowhere to go. They told us that Mr Doig then left the hotel to get some food, and when he returned to the hotel staff became concerned about him. After a few minutes, Mr Doig slumped from the chair he was sitting in, to the ground.

44. The police told us that after his probation induction appointment, Mr Doig met a friend of his son's and spent some time with him before returning to his hotel. While in the hotel, Mr Doig collapsed. Hotel staff called an ambulance and Mr Doig was pronounced dead at 6.19pm.

45. On 13 March, Mr Doig's son informed HMPPS that Mr Doig had died.

46. The SPO told us that he contacted Mr Doig's son to offer condolences, explain that there would be a PPO investigation and to answer any questions and continued support.

47. Mr Doig's family told us that they contacted Probation after a few days, as they were told they would receive support.

Post-mortem report

48. The post-mortem report concluded that Mr Doig died of ischemic heart disease, caused by severe coronary artery atheroma (a fatty material that builds up inside the arteries).

Support for staff

49. Mr Doig's POM said she did not feel supported by the prison following Mr Doig's death. She said she was not asked how she was feeling following his death, but said she was aware of the support available.

50. The SPO for Mr Doig's allocated COM confirmed that support was offered to the allocated COM. He confirmed that the COM was offered support during supervision and the COM was reminded of the MOJ's external support sources such as counselling.

Findings

Clinical care

51. The clinical reviewer concluded that the clinical care Mr Doig received at Norwich was of a good standard and equivalent to what he could have expected to receive in the community. The clinical reviewer made no recommendations.

52. Mr Doig was assessed by healthcare staff prior to his release and was deemed fit for discharge and no health related concerns were raised. Mr Doig was never diagnosed with ischemic heart disease in the community or in prison.

Release planning

Information sharing

53. The End of Custody Supervised Licence (ECSL) scheme was introduced in October 2023. The scheme allows certain determinate sentenced prisoners to be released prior to their Conditional Release Date (CRD), to ease overcrowding in prisons. When it was initially introduced, prisoners could be released a maximum of 18 days prior to their CRD. This increased to a maximum of 35 days on 8 March 2024, and then further increased to a maximum of 70 days on 23 May 2024.

54. The OMU department in the prison notified Mr Doig's POM that he was eligible for ECSL on 7 March, meaning he would be released 18 days before his CRD. However later that day, the policy changed, meaning Mr Doig would now be released 35 days early.

55. Mr Doig's POM notified probation of Mr Doig's new release date in a timely manner, however we found that there was a lack of sufficient information sharing. The POM did not share relevant information relating to Mr Doig's health with probation staff. She told us that she did not have access to Mr Doig's medical records and would not request this information from healthcare in the prison unless probation staff specifically requested it.

56. The Head of Healthcare at Norwich told us that healthcare staff are notified of which prisoners are due to be released under the ECSL scheme, but do not share medical information with probation staff. He said that if healthcare staff had concerns that someone was medically unfit to leave the prison, they would share this information with OMU. The SPO told us that if probation had been made aware of Mr Doig's health conditions, including his mental health diagnosis, they would have completed more appropriate pre-release checks and referrals.

57. Despite having a discussion with Mr Doig's allocated COM in January regarding accommodation and a possible Approved Premises referral, his POM did not share this information with the duty COM who was completing Mr Doig's ECSL pre-release checks. The duty COM called Mr Doig's POM to ask for a contact number for Mr Doig's son, so she could verify that he was happy to accommodate Mr Doig. There is no evidence that the contact number was shared with probation before Mr Doig's release on 11 March.

58. The POM told us that at the time of Mr Doig's release the ECSL scheme included an exemption panel referral form (Annexe D), which probation could complete to share their objections for early release. She told us that since Mr Doig's death, they have introduced a new request for information form for the COM to share information with the prison to either confirm that they are preparing for release or to request an exemption to the early release. However, there is no form that the POM completes to share information with probation staff about the prisoner, including information about their healthcare needs.

59. Given the short notice probation staff often have to prepare for ECSL releases, we consider it is important that vital information is shared between the POM and COM to ensure suitable release planning for the prisoner. We make the following recommendation.

The Governor and the Head of Suffolk Probation Delivery Unit should ensure that all staff are aware of their responsibility and the importance of sharing relevant information when conducting pre-release planning.

Address Checks

60. During Mr Doig's appointment with the resettlement worker on 5 February, he said that he planned to stay with his son upon release. Mr Doig provided his son's address but no contact number.

61. On 8 March, the duty COM completed a police check on the address and a safeguarding check regarding the children residing at the address. Both checks came back with no concerns. The probation SPO told us that the duty COM was unable to speak to Mr Doig's son to check he still lived at the property and was happy for his father to stay there as they did not have a phone number for him.

62. When Mr Doig attended his probation induction appointment on 11 March, he was seen by a different duty COM. Mr Doig told the COM that he would be residing with his son, and again provided his son's address. The duty COM did not make any further enquires with Mr Doig to obtain further information (namely his son's contact number) to confirm that his son still lived at the address, and he agreed for his father to live there.

63. We consider that due to a lack of information sharing and communication, the address Mr Doig provided was not verified with the occupant (his son). Had the address been verified, Probation would have been aware that Mr Doig's son had not agreed to accommodate him, and that Mr Doig had no intention of staying at the address provided. Therefore, we recommend:

The Head of Suffolk Probation Delivery Unit should ensure that all staff are aware of their responsibilities when conducting pre-release address checks, including verifying an address with the occupant, to ensure people on probation have a stable and suitable place to live.

Adrian Usher
Prisons and Probation Ombudsman **February 2025**

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