Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Apperley, a prisoner at HMP Long Lartin, on 7 August 2023

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. 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.

3. Mr Mark Apperley died in a care home on 8 August 2023, while a prisoner at HMP Long Lartin. He died from the respiratory complications of tetraplegia (paralysis that affects all four limbs, plus the torso) caused by a post-traumatic cervical paraspinal abscess. Mr Apperley was 52 years old. We offer our condolences to his family and friends.

4. The clinical reviewers concluded that the clinical care Mr Apperley received at Long Lartin was equivalent to that which he could have expected to receive in the community. They made four recommendations which were not relevant to Mr Apperley's death but which the Head of Healthcare will need to address.

5. One of the clinical reviewers made a recommendation to NHS England's health commissioners about the lack of facilities in the prison estate for prisoners with complex health needs. Mr Apperley did not meet the criteria for release on temporary licence (ROTL) or early release on compassionate grounds (ERCG). While his condition did not require him to remain in hospital indefinitely, his medical needs were complex and required specialist care and equipment. As his needs could not be met in the prison estate, Mr Apperley lived in a nursing home.

6. We did not identify any significant non-clinical learning.

Recommendation

The Director General of HMPPS should work with NHS England and the Association of Directors of Adult Social Services with the aim of developing a strategy to meet the needs of prisoners not suitable for release but who need an adapted environment and specialist nursing and social care.

The Investigation Process

7. HMPPS notified us of Mr Apperley's death on 7 August 2023.

8. NHS England commissioned two independent clinical reviewers, to review Mr Apperley's clinical and mental health care at HMP Long Lartin. The clinical reviewers' report is attached as Annex 1.

9. The PPO investigator investigated the non-clinical issues relating to Mr Apperley's care. She obtained copies of relevant extracts from Mr Apperley's prison and medical records.

10. The investigator visited Long Lartin on 22 and 23 November 2023 and interviewed six members of staff with the clinical reviewers.

11. The investigator carried out an interview on 10 November and conducted a further three interviews with one of the clinical reviewers on 20 December and 16 January 2024. The investigator and the other clinical reviewer also interviewed one member of staff on 1 December.

12. We informed HM Coroner for Worcestershire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of the report.

13. The PPO wrote to Mr Apperley's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. However, following feedback from HMPPS a change was made to the wording of the recommendation.

15. Mr Apperley's mother received a copy of the draft report. She did not make any comments

Previous deaths at HMP Long Lartin

16. Mr Apperley was the eleventh prisoner to die at Long Lartin since 8 August 2020. Of the previous deaths, eight were from natural causes and two were self-inflicted. There are no similarities between our findings in these cases and those in our investigation into Mr Apperley's death.

Key Events

17. On 17 March 1997, Mr Mark Apperley was sentenced to life imprisonment for murder, with a minimum term of 15 years. He was diagnosed with antisocial and borderline personality disorders, with features of paranoid personality disorder.

18. On 1 July 2021, Mr Apperley was transferred from HMP Swaleside to Long Lartin. He lived in the segregation unit due to aggressive and abusive behaviour.

19. On 10 November, Nurse A saw Mr Apperley to give him his medications. She recorded that he had blood on his forehead from what looked like an old wound and his hand was bleeding. An officer told her that he had been annoyed earlier and had head butted and punched the door in frustration.

20. On 23 November, Nurse B saw Mr Apperley to give him his medication. He told her that he had collapsed earlier as his body felt numb. Nurse B told Mr Apperley a doctor would see him the next day.

21. At 1.35pm on 24 November, Dr A, a GP operating at Long Lartin, examined Mr Apperley in his cell. Mr Apperley told him that he was unable to use his arms and legs and he had had a migraine for some time. Dr A noted that he saw Mr Apperley move his arms. Because of Mr Apperley's history of headbanging, Dr A consulted the hospital and sent Mr Apperley to hospital.

22. Following tests, Mr Apperley was discharged from hospital and returned to Long Lartin at 11.49pm. Officer A, an escort officer, told the investigator that Mr Apperley was unable to walk or use his arms and had used a wheelchair to travel to the prison van. He said that when they arrived at Long Lartin, they had to carry him back to his cell. Nurse C saw Mr Apperley in reception when he returned to Long Lartin. He told the investigator that the officers helped Mr Apperley off the van into a wheelchair and then into his cell and onto his bed.

23. On 25 November, Officer B completed the escort debrief form. He stated that Mr Apperley had been compliant, that he had said he could not use his arms and legs and a CT scan had been completed. He had noted that when Mr Apperley was discharged from hospital and returned to Long Lartin, he had jumped off the van and walked unaided. He said that a concern had been raised about whether he was feigning his symptoms. However, Officer B told the investigator that although he had accompanied Mr Apperley to hospital, he had handed over the escort to Officer A later that day and had not escorted Mr Apperley when he returned to prison. He told the investigator that it was the escort officer's responsibility to complete the escort debrief. He confirmed that he had completed the debrief form but could not recall why he had done this or who had told him that Mr Apperley had jumped down from the van.

24. On 25 November, Mr Apperley was placed on the escape list based on the information provided following his escort.

25. At approximately 9.55am on 25 November, Nurse D and Nurse E visited Mr Apperley in his cell. They saw that he looked pale and was hot to touch. They carried out physical observations and calculated a NEWS2 score of thirteen. (NEWS2 is a tool to detect and respond to clinical deterioration). A score of thirteen meant that Mr Apperley was at a high risk of clinical deterioration/sepsis and an emergency assessment by a critical care team was needed. Paramedics were called and took Mr Apperley to hospital at 12.20pm. (His name was removed from the escape list before he went to hospital.)

26. On 26 November, the hospital told the prison that Mr Apperley had been taken to another hospital, that he had a spinal cord compression and was undergoing surgery. Later that day, a neurosurgeon told the prison that Mr Apperley was very unwell and may die. Despite the surgery Mr Apperley was left with paralysis that affected his arms and his legs (tetraplegia) and he was placed on a ventilator and admitted to the intensive care unit.

27. On 3 December, a multidisciplinary (MDT) meeting at Long Lartin discussed whether Mr Apperley could be released on temporary licence (ROTL) or released early on compassionate grounds (ERCG).

28. On 31 January 2022, an ERCG application was submitted to HMPPS' Public Protection Casework Team (PPCS, a specialist casework team). The application was incomplete and the prison was asked to provide further evidence.

29. On 25 March, Mr Apperley's application for early release was refused because he did not meet the criteria. (He did not have a terminal illness and although he was severely disabled, his prognosis was unclear. There was no evidence that further imprisonment would reduce his life expectancy and the Secretary of State did not consider that, on balance, his risk of reoffending was minimal.)

30. On 4 October 2022, an MDT meeting took place, with attendees from different disciplines, including staff from HMPPS headquarters, the long-term high security estate, HMPPS social care and strategic health partnerships, senior managers from Long Lartin and HMPPS' social care team. They considered Mr Apperley's clinical needs and his current and future accommodation needs. They noted that a return to Long Lartin was not possible as they did not have a room large enough to accommodate all the healthcare equipment needed and they did not have a working lift. They also noted that there were no nursing home facilities in the prison estate and the only viable options were to try to place Mr Apperley in a different prison in the long-term and high security estate or in a category B prison. In the meantime, they agreed that NHS England would continue to look for a nursing home in the community as a short-term measure. Regular meetings between stakeholders to progress finding suitable accommodation for Mr Apperley continued during October.

31. On 24 November, a nursing home confirmed that they had a bed available for Mr Apperley. In November and December, regular MDT meetings took place to facilitate Mr Apperley's move to the nursing home due to the specialist care he needed. During this period, Mr Apperley developed infections which needed hospital treatment so was unfit to be discharged.

32. On 12 January 2023, Mr Apperley was discharged from hospital to the nursing home. Mr Apperley had two officers with him at all times.

33. Between February and May 2023, Mr Apperley was re-admitted to hospital on three occasions due to medical complications. Following his paralysis, Mr Apperley's behaviour continued to be anti-social. On occasions, he was verbally abusive to hospital staff and visitors and spat at nursing staff.

34. On 8 February, an MDT meeting took place at HMP Five Wells. Staff from HMPPS headquarters, NHS England and prison and healthcare staff from Five Wells attended. An occupational therapist completed a suitability assessment which was shared on 22 February. It concluded that Mr Apperley did not meet the criteria for the prison and the accommodation could not be modified to meet his needs.

35. On 23 February, an MDT meeting took place with staff from the social care and strategic health partnerships, the social care team, the long-term and high security estate and NHS England. They agreed to explore a new ERCG application. They noted that Mr Apperley needed a specialist nursing home, with mental healthcare provision. They recorded that although Mr Apperley was already in a nursing home, it was conditional on him remaining a serving prisoner.

36. In the following months, there were a number of MDT meetings which discussed the ERCG application and whether any other prisons were viable options. Consideration of the ERCG application included discussion about how to manage Mr Apperley's risks (because of his outbursts and spitting) and whether a care home or nursing home was appropriate.

37. On 7 June, Mr Apperley was taken to hospital as staff had noticed blood in his urine.

38. On 3 July, a suitability assessment was carried out at HMP Stafford.

39. On 13 July, an MDT took place. Staff from the social care and strategic health partnerships, the social care team, NHS England and Long Lartin attended. They discussed the suitability assessment which had concluded that HMP Stafford was not suitable for Mr Apperley due to his complex health needs. They agreed a letter would be sent to the Executive Directors of HMPPS and NHS England, outlining the current situation and acknowledging that a prison space was needed to meet his environmental needs and where specialist services could be brought in to meet his medical needs.

40. On 28 July, Mr Apperley was discharged from hospital and he returned to the nursing home.

41. At 4.44am on 7 August, a nurse at the nursing home checked on Mr Apperley and found that he had died. An order was in place not to resuscitate him if his heart or breathing stopped so no resuscitation attempt was made.

Post-mortem report

42. The post-mortem report concluded that Mr Apperley died from the respiratory complications of tetraplegia caused by a post-traumatic cervical paraspinal abscess.

43. In his report the pathologist set out his consideration of the findings from the toxicology report, in regards to the presence of mono-acetyl morphine (a substance which the body produces following heroin use) and the level of morphine identified, and how he reached his conclusion.

Inquest into the death of Mr Apperley

44. The inquest into Mr Apperley's death was held on 27 January 2025 and a verdict of natural causes was recorded.

45. The coroner concluded that Mr Apperley's death was due to respiratory complications of tetraplegia caused by a cervical paraspinal abscess (treated).

Clinical Findings

46. The clinical reviewers concluded that the clinical care Mr Apperley received was equivalent to what he could have expected to receive in the community. They made four recommendations which were not relevant to his death but which the Head of Healthcare at Long Lartin will need to address.

47. However, the clinical review also identified a lack of facilities in the prison estate for prisoners who do not meet the ROTL/ERCG criteria due to their complex health and treatment needs.

48. Mr Apperley's circumstances were complex and challenging. He was severely disabled and needed 24-hour specialist nursing care and specialist equipment to maintain his health. Although he needed nursing care, he did not always need a hospital bed.

49. Mr Apperley also had an antisocial and borderline personality disorder, with features of paranoid personality disorder and a history of anti-social and aggressive behaviour. Following his paralysis, Mr Apperley's behaviour continued to be anti-social. On occasion, he had been verbally abusive to hospital staff and visitors and spat at nursing staff. Mr Apperley had been in prison since 1997 serving a life sentence, with a minimum tariff of fifteen years. Due to his offence, Mr Apperley was subject to the parole process and he could not be considered for ROTL.

50. An ERCG application was submitted in January 2022, but was refused on the basis that Mr Apperley did not meet the criteria: his prognosis was unclear; he was in hospital (so imprisonment was not reducing his life expectancy) and there was still a risk of re-offending (as he had not undertaken risk reduction work since 2004). While it later became clear that Mr Apperley's condition was not going to improve, the other two criteria remained unresolved.

51. We note that the various stakeholders involved in Mr Apperley's case considered making a second ERCG application but this was not progressed because a suitable alternative placement for Mr Apperley had not been identified (as he could not have remained in the nursing home) and his risk of reoffending remained a concern, even though it was reduced due to his physical condition.

52. The various stakeholders in HMPPS and NHS England met regularly to discuss Mr Apperley's situation and a number of alternative locations within the prison estate were explored. However, they were unable to identify a prison which could cater for Mr Apperley's custodial requirements, as well as his environmental and medical needs.

53. While Mr Apperley was outside the prison estate, he was not accessing the parts of the regime that would have allowed him to participate in risk reduction work and he was not receiving support to address his antisocial/borderline personality disorder. Without progress in these areas, Mr Apperley was unlikely to succeed in any application for parole or ERCG. Given this, it was in his best interests to remain in the prison estate.

54. We appreciate the clear tensions between looking after an elderly, frail or severely disabled prisoners and holding them in secure conditions when they are not suitable for release. It seems inevitable that HMPPS will need to consider the option of establishing what would amount to a secure care home, but appreciate the resources and complications that would be involved, and therefore that progress is likely to be slow. We therefore make the following recommendation:

The Director General of HMPPS should work with NHS England and the Association of Directors of Adult Social Services with the aim of developing a strategy to meet the needs of prisoners not suitable for release but who need an adapted environment and specialist nursing and social care.

Governor to note

55. The officer who escorted Mr Apperley back to the prison did not complete the appropriate escort form and the information contained in the form was incorrect. Staff completing forms should make it clear if they are completing documents on behalf of a colleague.

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

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