Investigation into the circumstances surrounding the death of a man in December 2009, following his release on temporary licence from HMP Spring Hill

Report by the Prisons and Probation Ombudsman for England and Wales

August 2010

This is the report of an investigation into the death of a man, following his release on temporary licence from HMP Spring Hill. He died at hospital in December 2009. He was 67 years old. He spent the last five months of his life as an inpatient in hospital, having suffered a severe stroke in July 2009 which meant he needed 24 hour medical care. The cause of his death was found to be pneumonia and a cerebral vascular accident (stroke). I offer my sincere sympathy and condolences to his family, and to all who have been affected by his loss.

The investigation was carried out by my colleague. A review of the man's medical care in prison was carried out by the clinical reviewer on behalf of the local Primary Care Trust. I am most grateful to him for his assistance. I would also like to thank the Governor and staff of Spring Hill for their full and ready co-operation during the course of the investigation.

The clinical reviewer finds that there were no significant shortcomings in the management of the man's health at Spring Hill. Although he was released on temporary licence, his permanent release had not been approved when he died. Given his medical condition, and the significant reduction in his risk to the public this entailed, this is perhaps surprising. I have sent a copy of my report to the Parole Board and the unit within National Offender Management Service (NOMS) that deals with early release on compassionate grounds.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman **August 2010**

CONTENTS

SUMMARY

The man was sentenced to life imprisonment in 1981. After a heart attack in 2002, he suffered from unstable angina for several years. He underwent a significant operation on his heart in May 2007, five months before transferring to HMP Spring Hill, an open prison. The operation was initially a success and he reported no further angina for around a year.

When his angina returned in April 2008, the man was referred to a cardiologist (heart specialist) at a local hospital. At a consultation with the cardiologist in August, he was put on the waiting list for an angiogram (a scan of the heart). However no appointment was made during the remainder of his time at Spring Hill, nearly a year. I recommend that prison healthcare staff follow up if an appointment is not received within six months of referral to a hospital waiting list.

On 21 July 2009, the man was admitted to hospital after suffering a severe stroke. The stroke left him bedridden and paralysed in his right arm and right leg. His condition only improved slightly in the five months before his death. As a result of his stroke, he was released on temporary licence shortly after he was admitted to hospital. This meant that he could be treated in hospital without being escorted by prison staff or restraints being used. I consider this to be an example of good practice.

The Parole Board met on 30 September to consider whether the man's risk to the public had reduced to the extent that he could be released from custody on a permanent (life licence) basis. The Board determined that the hearing should be deferred for six months for the completion of additional reports, including a more comprehensive medical report. At the same time, an application for early release on compassionate grounds was deferred by the Public Protection Unit of NOMS (National Offender Management Service). The unit also asked for more detailed reports and said the application would be considered further at the reconvened Parole Board hearing.

Given the man's condition, and the expectation that his recovery was likely to be slow and he would continue to have significant disability for the rest of his life, my view is that his risk had reduced to the extent that his release would not have been unreasonable at this time.

The man died in December, shortly after developing a serious chest infection. Although the deferred Parole Board hearing was unlikely to be held for another three and a half months, little progress had been made in preparing the reports requested by the Board. I recommend that a designated individual is assigned the responsibility of co-ordinating all such reports and actions at an early stage.

THE INVESTIGATION PROCESS

1. The investigation was opened on 18 December 2009 when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. No one came forward as a result.

2. The investigator visited Spring Hill on 30 December 2009. During his visit he met with staff who knew the man, including the senior manager responsible for life sentenced prisoners, and Senior Officer (SO), the lifer manager. The investigator was provided with copies of his prison records, including the medical record.

3. A review of the man's medical care in prison was carried out by the clinical reviewer, Professional Executive Committee chairman at the local Primary Care Trust. The investigator also contacted the Public Protection Unit of the National Offender Management Service (NOMS), the Parole Board and Buckinghamshire County Council Social Services during the course of the investigation.

4. The Ombudsman's senior family liaison officer wrote to the man's sister and son on 18 January 2010. She explained the purpose of the investigation and provided the opportunity for them to ask questions or raise any concerns they might have. No reply was received. I hope this report clarifies any issues that might remain unclear for his family and helps them better understand what happened in the time leading to his death.

HMP SPRING HILL

5. HMP Spring Hill is an open prison situated near Aylesbury in Buckinghamshire. Its purpose is to prepare prisoners for release by addressing offending behaviour needs, as well as helping prisoners find accommodation and employment on release. A key part of this process is the 'working out' scheme, which allows prisoners to work in the local community. This is firstly on a voluntary basis and, if successful, in a paid capacity. Spring Hill holds up to 334 prisoners, most of whom are longer sentenced prisoners within the last few years of their sentence.

6. Spring Hill is jointly managed with the neighbouring HMP Grendon. The two prisons share a number of common services, but operate as separate units. Healthcare at Spring Hill consists of an outpatient facility which is staffed by healthcare personnel from Grendon. Prison doctors provide surgeries three days a week. In addition, prisoners have full access to clinic facilities at Grendon.

7. Her Majesty's Chief Inspector of Prisons last inspected Spring Hill in August 2008. She found that, overall, Spring Hill was an effective open prison with a "reasonably good standard of healthcare". However, she went on to say:

> "The management of chronic diseases was generally unsatisfactory and there were no regular nurse-led clinics … [healthcare] staff appeared demoralised and staffing levels were poor. The cross-deployment of staff between Spring Hill and Grendon created a lack of continuity for patients and a lack of ownership for health services staff. The support given by senior prison managers to clinical staff was excellent."

8. This is the first death of a prisoner at Spring Hill since the Ombudsman began investigating all deaths in custody in England and Wales in April 2004.

KEY FINDINGS

9. In February 1981, the man was convicted of murder and sentenced to life imprisonment with a tariff (the minimum time that must be served before eligible for parole) of 13 years. He spent his first 12 years in prison in HMP Wormwood Scrubs, HMP Kingston and HMP Ashwell. In 1993 he moved to his first open prison, HMP Ford. (An open prison is an establishment with no physical barriers to prevent escape. Life sentenced prisoners will usually live in an open prison as the last stage before their release. Prisoners at an open prison often work in the community during the day as part of their resettlement plan.) After returning to Ford under the influence of alcohol, the man was transferred back to a closed prison in 1996.

10. In both 1999 and 2004, the man transferred to another open prison, HMP Hollesley Bay. On both occasions he again returned to closed conditions after being found to have drunk alcohol. On the latter occasion, in September 2005, Mr Islania moved to HMP Highpoint. He lived there for two years before moving to Spring Hill on 26 October 2007.

11. At the time of his move to Spring Hill on 26 October 2007, the man had a number of long standing medical conditions. After a heart attack in 2002 he suffered from unstable angina and, over the following years, was occasionally admitted to hospital with chest pain. As a result, he underwent an operation known as an angioplasty in May 2007. (Angioplasty is a procedure to widen an artery of the heart and therefore increase blood flow, by inserting a small tube known as a stent into the artery so as to hold it open.) The operation was a success and he reported no further angina prior to his arrival at Spring Hill.

12. In addition to his heart condition, the man was diabetic and had high blood pressure. He also experienced occasional back pain following an operation on his spine in 1991. As a result of his conditions, he took a variety of medication. They included bisoprolol, clopidogrel and aspirin (all used to prevent heart attacks), irbesartan (to treat high blood pressure), simvastatin (to lower cholesterol) and amlodipine (to treat high blood pressure and prevent angina). He was allowed to keep these medicines in his possession at Spring Hill.

13. The man settled well into life at Spring Hill. He began working in the prison's kitchens, where he helped prepare meals for those with special dietary needs. After reporting some pain in his right wrist in late November, he was assessed in hospital and minor degenerative changes were found. He was prescribed a course of diclofenac (an anti-inflammatory medication used to treat arthritis).

14. In January 2008, the man visited hospital for an annual diabetic review. The consultant concluded that his diabetes management was satisfactory and no further action was required. He reported no further significant concerns about his health in the first quarter of 2008.

15. The man saw a prison doctor on 29 April. He told the doctor that he felt dizzy and had pins and needles over his heart and left arm. He used his GTN spray (a spray used to ease angina pains), which helped. The doctor doubled his dose of amlodipine and, on 2 May, referred him to a cardiologist at hospital. On account of this episode, his hours in the kitchen were reduced.

16. As he had settled satisfactorily into life at Spring Hill, the man was allowed to start weekly visits to a local town in July 2008. These visits were part of his resettlement plan, with the aim of helping him to re-adjust to life outside prison by the time of his release.

17. On 4 August, the man saw the cardiologist at hospital. He said he had experienced pain in the left side of his chest, which felt like angina. After assessing him, the cardiologist thought his symptoms might suggest coronary artery disease (the build up of plaque in the arteries of the heart, meaning less blood reaches the heart and resulting in angina or a heart attack). He was put on a waiting list for an angiogram (a scan of the heart). No changes were made to his medication. It does not appear that he had the angiogram during the remainder of his time at Spring Hill.

18. The next stage in the man's resettlement plan began in September, when he first visited Ealing Approved Premises. (An approved premises, formerly known as probation hostels, is a residential establishment whose aim is to provide an advanced level of supervision in the community.) He visited the hostel in Ealing each month, staying for three to five nights at a time.

19. In November, the man began a part time community work placement at an Age Concern shop in Oxford. The manager of the shop was reportedly happy with his contribution. However, after around three months, the man decided to stop working at the shop. His reasons were firstly that, at 66, he had passed the retirement age, and, secondly, he was unhappy that he had to take a packed lunch with him and was not allowed to buy hot food whilst he was out. After his resignation, he continued to work part time in the prison's kitchen.

20. The man saw the prison doctor on 9 December as he had noticed blood in his faeces for the past three days. The doctor thought he had piles and decided no further action was necessary. The man also said that he had recently felt unsteady when walking. The doctor considered whether this might be caused by diabetic neuropathy (a disease of the nervous system sometimes suffered by diabetics) and also considered whether he might have experienced mini strokes (symptoms similar to a stroke but which last for just a short period of time). The doctor concluded that he could do nothing to help other than offer him a walking stick or frame, which he declined.

21. Two months later, on 10 February 2009, the man saw the prison doctor again and said he was now “swaying” from side to side more than previously. He thought this might be due to a problem with his vision and the doctor asked that an appointment be made with an optician.

22. Around five weeks later, the man attended hospital for a diabetic retinal screening. (Diabetes can cause blindness or inhibited sight due to a condition called retinopathy. This is a complication of diabetes where blood vessels in the retina can become blocked.) The tests found some background retinopathy in his left eye. He was advised to return in a year to check for any further deterioration.

23. The man reported feeling unwell on the morning of 21 July and was seen by a nurse. He said he could not remember when he last had a drink. He also said he had not attended roll check that morning as he felt too ill. The nurse took his blood pressure, temperature and pulse, all of which were within normal ranges. She encouraged him to drink water and rest and said she would return to check on him that afternoon. In the meantime, another prisoner volunteered to watch over him and help him fetch his meals and drinks.

24. At around 12.00 noon, the man went to the healthcare centre and reported that he was feeling worse. The nurse returned to see him with a second prison doctor. His speech was now slurred and his right arm was “heavy”. The doctor suspected that he might have suffered a stroke and an emergency ambulance was therefore requested. He left the prison in the ambulance shortly afterwards and was taken to hospital.

25. After being assessed following his arrival at hospital, the man was diagnosed with a stroke in the left side of his brain. As a result, he was partially paralysed in the right side of his body. He was admitted to hospital as an inpatient. The following day he had a scan of his brain, which showed the presence of a large blood clot. He was mostly unconscious at the time, although he regained consciousness the following day and was able to sit up in bed.

26. As a result of his condition, the man was released from prison on a temporary licence on the evening of 21 July. This allowed him to be treated in hospital without having a prison officer present all the time. The licence was renewed each week or fortnight throughout his time in hospital.

27. The man was visited by his sister on 29 July. The following day, his consultant was asked to write a letter setting out his condition and prognosis for an application for early release on compassionate grounds. (This is a full and permanent release, unlike the temporary licence which he was released on which could be cancelled at any time.) The consultant replied on 5 August. He described the man’s condition as follows:

> "The man remains very unwell in hospital having developed a severe pneumonia following his stroke. His prognosis is uncertain and he is likely to require continuing hospital care for a number of weeks. After hospital treatment it is at present unlikely he will return to any significant independence and therefore will require ongoing care … At present it seems likely that this care would need to be provided in a nursing home but an accurate forecast cannot be given at this point."

28. The senior manager responsible for life sentence prisoners led a meeting at Spring Hill on 19 August to discuss the man's case. Also present were the lifer manager, the lifer clerk, the prison's offender supervisor and the man's solicitor. It was agreed that they should continue to progress the application for early release on compassionate grounds and go ahead with the next scheduled Parole Board review, which was due on 30 September.

29. A parole assessment report was completed on 21 August by the man's offender manager in the community. (This is a report produced in advance of a Parole Board review with the purpose of advising the Board of the risk posed by a prisoner and any work they had done to reduce that risk.) She noted that he had successfully stayed at an approved premises on nine occasions in the past year and had completed courses to tackle his alcohol consumption. She thought that, given his age and state of health, his risk was "significantly lower". She concluded that the Board could consider releasing him to a nursing home.

30. In addition to his earlier letter, the consultant completed the medical section of the application for early release on compassionate grounds on 2 September. He wrote that the man's prognosis was currently "limited" and might be up to five years "if he survives his current illness". His health at the time was described by the consultant as follows:

> "The man has suffered a serious stroke as a consequence of which he is drowsy, poorly communicative and paralysed on the right side. He cannot swallow and he is fed by a stomach tube. He has two serious chest infections and remains very frail. He is nursed in bed and has no independent mobility."

31. The lifer manager completed the lifer manager's report for the application for early release. Her section is not dated, but would have been completed in early September. She wrote that the man had successfully completed a number of temporary releases from prison. His main risk revolved around drinking alcohol although she reported that his medical condition would limit his capability to cause harm to the public.

32. On 4 September, the man was reported to have improved slightly and he was now able to sit out of bed, although he had to be lifted in and out of bed by hospital staff using a hoist. Two weeks later he was able to sit out in his chair for longer and was reported to be "progressing slowly" and "more vocal".

33. The Governor of Spring Hill completed the governor's report for the early release application on 16 September. He wrote that, whilst the man's prognosis was uncertain, medical opinion was that he would require ongoing care. The Governor added that his deteriorating health meant that his risk to the public had diminished. The application was sent to the Public Protection Unit where it was received on 21 September.

34. An application for the man's transfer to the healthcare unit for older prisoners at HMP Norwich was submitted in September. (This is a specialist unit designed and equipped to enable older and less able prisoners to be supported and cared for within the confines of the prison environment.) He was put on their waiting list.

35. The healthcare manager at Spring Hill visited the man in hospital on 17 September. By now he was able to move his right leg to some extent, although it was still weak. His right arm remained stiff and mostly paralysed. He said he was not happy at the prospect of being transferred to Norwich.

36. On the same day, a senior physiotherapist wrote a report regarding the man's progress in his rehabilitation. The physiotherapist wrote that he still had no independent mobility and required a hoist to transfer to a wheelchair, where he was able to sit for a few hours each day. His personal care was provided in full by nursing staff. However, following recent botox injections to his right leg, work had begun on helping him to stand up and move to his wheelchair independently.

37. A week later, the consultant wrote to the lifer clerk with an update on the man's condition ahead of the Parole Board hearing on 30 September. The consultant wrote that the man had made some progress with his rehabilitation and was now able to sit in a wheelchair and take part in physiotherapy. He went on to say:

> "The man continues to have major right arm and leg weakness and considerable pain in his right arm. He is still being fed by a tube … In summary, he is still requiring 24 hour nursing care. Over the past three weeks he has made a certain amount of progress but he remains significantly disabled."

38. The consultant also commented on the man's prognosis and future care needs:

> "He has had a major stroke and is likely to have significant residual disability. The exact extent of this is difficult to accurately predict at this time in the light of his recent stroke but at present he continues to require 24 hour nursing care. His life expectancy will be affected by his risk of recurrent stroke. This can be modified but not avoided by medical intervention. If he does not have another stroke then he could survive for up to ten years but accurate forecasting is not possible."

39. The Parole Board hearing went ahead as planned on 30 September. Amongst the evidence the panel considered to reach their decision was a submission on behalf of the then Secretary of State for Justice. (The submissions are written by the Public Protection Casework Section in NOMS.) It firstly addressed the man's offending behaviour, particularly his history of alcohol abuse. The submission expressed concern that he had refused to participate in the Offender Substance Abuse Programme (OSAP), a course designed for prisoners with a history of alcohol misuse. It went on to say that there appeared to be a "continued lack of insight into the underlying reasons for his offence and alcohol misuse". The submission therefore concluded that he could not be released to the community on licence until he had engaged in the OSAP course and demonstrated further that he had reduced his risk.

40. The submission on behalf of the Secretary of State also considered the man's current medical condition in his submission to the Parole Board. He concluded that he was unable to make a further recommendation until full medical assessments were undertaken.

41. The Parole Board panel made a decision on the man's case on 5 October. They considered the consultant's comments regarding his condition and prognosis, highlighted in paragraphs 39 to 40, above. The Board also considered reports submitted by the offender manager and the offender supervisor before the man's stroke. These recommended that he was not suitable for release as his refusal to attend the OSAP course meant he had not fully addressed his risk of re-offending. The panel noted that this would be a factor were his health to recover sufficiently.

42. The panel determined that the hearing should be deferred for six months. They asked that a comprehensive medical report be completed for the hearing, to provide an opinion on the man's ability to live independently at the time and in the future. They also requested an additional report from the offender manager to take into account his behaviour in hospital. These reports had not been completed by the time of his death two months later.

43. Also on 5 October, the Public Protection Unit contacted Spring Hill to tell them that they were, at present, unable to proceed with the application for early release on compassionate grounds. Similarly to the Parole Board, the Public Protection Unit also requested further information about the man's prognosis before they could make a decision. They added that they would ask the Parole Board to consider the application for compassionate release at the reconvened hearing, should the medical information be forthcoming.

44. The healthcare manager visited the man in hospital on 21 October. She noted that he still required a hoist to get him out of bed, but was now able to stand during therapy. His speech had also improved, and she recorded that he looked well.

45. Two weeks later the man's condition was much the same and he still required 24 hour care. On 10 November, the healthcare manager spoke to the healthcare manager at HMP Woodhill, a prison near Milton Keynes, to see if they might be able to care for him in their inpatient healthcare facility. Woodhill were unable to help as their two cells for disabled prisoners were currently occupied and likely to be for some time.

46. Towards the end of November, the man was able to feed himself with his left hand. However, he still needed 24 hour nursing care and required a hoist to move him into his wheelchair. He was unable to bear his weight and therefore could not stand up. His right arm and leg were still virtually paralysed.

47. On 26 November, the senior manager and offender supervisor met a manager in older people's services for the County Council. They determined that a clear resettlement plan, including an agreed place in suitable accommodation, was needed so the Parole Board could release the man at the deferred hearing if they deemed it appropriate. The offender supervisor subsequently contacted the offender manager in the community. He asked her to provide details of the man's risk to the public, so the manager could locate and approach a suitable residence. This report had not been provided before his death.

48. The man developed a chest infection in December. His condition deteriorated and he died. The cause of death was recorded as pneumonia and a further stroke. His family was informed of his death by hospital staff. The funeral was held on 24 December. The investigation found that the prison's contribution to the funeral costs was in accordance with PSO 2710 (the Prison Service Order that sets out the actions to be taken following a death in custody).

ISSUES

Medical care in prison

49. The man moved to Spring Hill in October 2007, a few months after undergoing an angioplasty to resolve the angina he experienced intermittently following a heart attack five years earlier. He was also diabetic and had high blood pressure. He took a variety of medications, including those listed in paragraph 12.

50. The clinical reviewer makes the following comments about the overall standard of medical care received by the man in prison:

> "I find no cause to be concerned about the treatment he received in prison. He was reviewed regularly and monitored appropriately. His blood pressure and cholesterol levels were managed to target and his medication regime was appropriate for his condition. He had extensive coronary artery disease and was a smoker. He was therefore at high risk of further vascular disease and was already taking aspirin as a [preventative] measure. I feel the care he received in prison was of an acceptable standard."

51. After experiencing angina in summer 2008, the man saw a cardiologist at hospital on 4 August. The cardiologist arranged for him to be put on a waiting list for an angiogram. This procedure did not go ahead before his hospital admission, nearly a year later. The clinical reviewer comments on the waiting time as follows:

> "If the [prison doctor] understood the patient was on a waiting list and the patient's condition was reasonably stable, then it might be several months before the [prison doctor] could be expected to contact the hospital to establish the position. It really is the hospital's responsibility."

52. Nevertheless, 11 months is a considerable time to wait and hear nothing of a prospective date for such a procedure. A prisoner is not in a position to pursue such matters with the hospital themselves. In addition, for security reasons, prisoners are not notified in advance of forthcoming hospital appointments. My view is that prison healthcare staff could contact local hospitals intermittently if prisoners do not hear about outstanding appointments for several months.

    The healthcare manager should ensure that outstanding hospital appointments are followed up if an appointment is not provided within six months of referral to a waiting list.

53. The man reported bloody stools for three days in December 2008. The clinical reviewer comments that this episode was "managed appropriately as the history was short and an identified cause was found". At the same consultation, the man said he felt unsteady when walking. He raised

similar concerns at a second consultation two months later, when he said he was now "swaying" more than previously. The clinical reviewer comments as follows:

> "There are one or two references to gait disturbance but these are most likely to be the result of diabetic neuropathy and mini strokes would be an unlikely cause. He was on the appropriate treatment to reduce the risk of vascular disease and his blood pressure was well controlled. A neurology referral was not necessary."

54. He concludes that "there were no significant shortcomings in the man's management".

Potential release from custody

55. The man was released on temporary licence on 21 July, shortly after being admitted to hospital having suffered a severe stroke. This is a form of release usually used to enable prisoners to participate in activities outside the establishment that directly contribute to their resettlement into the community. (For example, he was earlier released on temporary licence for a day or period of days to allow him to work in the community or stay at the Ealing Approved Premises.) In this case, he was released on a special purpose licence on medical grounds. This meant that he could be treated in hospital without having a prison officer accompany him. He was released on temporary licence throughout his time in hospital. I consider this to be an example of good practice.

56. In addition to his release on temporary licence, the man could potentially have been released from custody on a permanent basis. There were two ways in which this could occur: firstly, following a Parole Board review and, secondly, through early release on compassionate grounds.

57. All life sentence prisoners whose tariff has expired are eligible for release from custody. It is the responsibility of the Parole Board to determine whether such prisoners are suitable for release, by considering whether their imprisonment is still necessary for the protection of the public. A life sentenced prisoner who is released under the direction of the Parole Board is subject to a 'life licence' which is in force for the rest of the individual's life. This means that the release may be revoked at any time if it is determined that the individual no longer represents a safe enough risk to remain in the community.

58. The Parole Board met on 30 September 2009 to discuss the man's case. They considered a number of reports, including one from his offender manager, and a submission from the Public Protection Casework Section on behalf of the then Secretary of State for Justice. Also considered was a medical report from the consultant in charge of the man's care at hospital. The panel determined that his hearing should be deferred for six months, subject to the completion of additional reports, including a "comprehensive medical report". These reports would help the Board to

take a view on whether his risk to the public had reduced to an acceptable level for him to be released.

59. The criteria for early compassionate release on medical grounds for life sentenced prisoners are set out in Prison Service Order (PSO) 4700:

    - "the prisoner is suffering from a terminal illness and death is likely to occur very shortly (although there are no set time limits, three months may be considered an appropriate period for an application), or the prisoner is bedridden or similarly incapacitated, for example, those paralysed or suffering from a severe stroke; and

    - "the risk of re-offending (particularly of a violent or sexual nature) is minimal; and

    - "further imprisonment would reduce the prisoner's life expectancy; and

    - "there are adequate arrangements for the prisoner's care and treatment outside prison; and

    - "early release will bring some significant benefit to the prisoner or his/her family."

60. An application for early release on compassionate grounds was completed by the Governor of Spring Hill and his staff, and submitted to the Public Protection Unit of NOMS on 21 September 2009. Two weeks later, the Public Protection Unit told Spring Hill that they were unable to proceed with the application without further information about the man's prognosis. They added that they would ask the Parole Board to consider the request for early release at the deferred hearing, should this further information be forthcoming.

61. The Parole Board met on 30 September. They had to determine whether the man's medical condition and resettlement work had reduced his risk to the extent that he was no longer a threat to the public. Although he had not completed the OSAP course, he had been on numerous successful community visits, including overnight stays, over the previous year without breaching the conditions of his licence (including not consuming any alcohol).

62. At the time of the Parole Board hearing, the consultant was unable to provide a definitive prognosis to accurately predict the man's life expectancy. However, he had suffered a major stroke and was bedridden with paralysis in his right arm and leg and had very limited mobility. He could only leave his bed with the help of a hoist, and then his time out of bed consisted only of sitting in a wheelchair for a few hours a day. The consultant's view of his future prospects was that he was likely to have "significant residual disability". Given these circumstances, it could be argued that he met the condition set out in the first bullet point of the criteria for early release on compassionate grounds.

63. Whilst I understand the caution expressed by the Parole Board and Public Protection Unit, my view is that the man's diagnosis and future prospects meant that his risk had reduced significantly to allow his release. I do not think it would have been unreasonable to agree to his release at this point and am surprised that this decision was not made. Indeed, he was in effect 'released' already, in that his stay in the hospital was without handcuffs or an officer's presence.

Preparation for deferred hearing

64. Once it was clear that the man would not be released following the Parole Board review of 30 September, various arrangements had to be made before the reconvened hearing. Firstly, the additional reports requested by the Parole Board had to be prepared. Secondly, suitable onward accommodation had to be found for when he was ready to leave hospital.

65. Little progress was made in the weeks following the Parole Board hearing in addressing these matters. A meeting was then held on 26 November at hospital, attended by prison staff and representatives of the County Council. It was at this point that work began in earnest to determine a future plan for the man.

66. At the time of the man's death in December, the reports requested by the Parole Board were still outstanding. A team manager in Adults and Family Wellbeing at the County Council told the investigator that it was still not clear at this stage who would be responsible for finding suitable accommodation. This would depend on whether or not the man was eligible for continuing care funding. She added that they were still awaiting information on his risk from his offender manager, to help determine what type of accommodation was suitable.

67. The deferred Parole Board hearing was still, theoretically, three and a half months away when the man died. Although his solicitor requested that the hearing be brought forward, a caseworker in the Post Panel Team at the Parole Board told the investigator that the hearing could not be arranged until the requested reports were received. She went on to say that, even if the reports were received early, it was unlikely that it would be possible to fit the hearing in before the six months was up.

68. Although it might have been unlikely that the man's case would have been heard sooner than six months, it would have been helpful to have the reports ready early so that his deferred hearing could go ahead as soon as possible. In similar future circumstances it would be beneficial to appoint at an early stage a designated individual with responsibility to co-ordinate the writing of necessary reports and any further actions required.

When a prisoner is seriously ill in hospital, a designated individual at the prison should be appointed to ensure that all necessary parole

and medical reports and all other actions are commenced at an early stage.

Breaking the news of the man's death to his family.

69. The news of the man's death was broken to his family by staff at hospital. The family liaison officer appointed at Spring Hill had intended to break the news to his family in person. Once she discovered that hospital staff had already done so, she sought further advice from the then Safer Custody and Offender Policy Group (a unit in National Offender Management Services who are responsible for national policy on the aftermath of a death in custody). She was advised to initially contact the family by telephone, which she duly did.

70. Prison Service Order 2710, which provides instructions for the aftermath of a death in custody, says that Governors must:

> "Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner, giving an accurate factual account of what has happened."

71. The accompanying Family Liaison Officer (FLO) Guidance recommends that:

> "The family should be informed face to face as soon as possible after the death. Wherever possible this should be done by a dedicated Family Liaison Officer working alongside the Chaplain, or Governor or most senior individual available together with the Chaplain.
>
> "The prison should demonstrate its duty of care and show that it is taking the death seriously by making a personal visit."

72. Although national policy recommends that news of a death is broken face to face by a prison family liaison officer, there is room for discretion based on the nature of the circumstances. In this situation, hospital staff were able to provide more detail of the circumstances of the man's death as they had been caring for him for five months, whereas there was no prison presence at the hospital other than regular visits. However, the Governor may wish to consider establishing a protocol with the hospital so that it is clear in future situations who has responsibility for breaking the news of a death.

CONCLUSION

73. When he arrived at Spring Hill in October 2007, the man suffered from a number of long standing medical conditions, most notably heart disease. I have found that his medical care was managed appropriately at Spring Hill. Unfortunately he suffered a severe stroke on 21 July 2009, which left him bedridden in hospital with significant paralysis in his right hand side. He lived in hospital for the remainder of his life.

74. He was released on temporary licence shortly after his stroke. Although he improved only slightly in the following months, the Parole Board chose to defer a hearing that might have determined his release. At the same time, a decision on whether to release him early on compassionate grounds was also deferred. Although I accept that such bodies would want the fullest possible information before making such a decision, I am surprised that his diagnosis and prognosis did not warrant release at an earlier stage, particularly given that he had already progressed successfully to an open prison.

RECOMMENDATIONS

1. The healthcare manager should ensure that outstanding hospital appointments are followed up if an appointment is not provided within six months of referral to a waiting list.

   Accepted – the healthcare manager will ensure that procedures are in place to follow up outstanding hospital appointments. Further to this, the healthcare manager will ensure that if appointments are not provided within the six month period of referral to a waiting list that such outstanding appointments are followed up and an audit trail maintained.

2. When a prisoner is seriously ill in hospital, a designated individual at the prison should be appointed to ensure that all necessary parole and medical reports and all other actions are commenced at an early stage.

   Accepted – when a prisoner is determined as being seriously ill in hospital a decision will be taken in consultation with relevant senior managers on whether the parole process should be commenced. This being the case, the most senior manager on duty at Spring Hill on the day in question will be required to start the process and to ensure that it is seen through to a satisfactory conclusion. That person will be the responsible manager and will be expected to brief all senior managers on progress. A notice to senior managers will be drafted and distributed explaining the responsibility of the designated manager.

GOOD PRACTICE

1. The man was released on temporary licence when he was admitted to hospital following his stroke.