Investigation into the circumstances surrounding the death of a man in September 2009, at hospital, whilst released on temporary licence from HMP Altcourse

Report by the Prisons and Probation Ombudsman for England and Wales

May 2011

This report considers the circumstances surrounding the death of a man at HMP Altcourse in September 2009. He died as a result of a brain tumour. He was just 26 years old.

I offer my sincere condolences to the man's family and all those who knew him. I also apologise for the time taken to issue this report and the additional distress which this must have caused.

The investigation was conducted by an investigator on my behalf. I would like to thank the Director of Altcourse and the Controller for their co-operation. I also extend thanks to the liaison for the Ombudsman's office. In addition, I thank the clinical reviewer who conducted a review of the man's clinical care.

The man was sentenced to four years' imprisonment in May 2006, having been remanded to HMP Altcourse in December 2005. He remained there as a sentenced prisoner. Shortly before being released in March 2008, he was diagnosed with a brain tumour and he underwent surgery whilst in the community. He returned to custody in June 2009 after breaching the conditions of his licence. He went to outpatient appointments at hospital, and a new brain tumour was found. A course of radiotherapy was started, but proved ineffective. Although very poorly, he returned to the prison and four days later was released to a hospice before being transferred to a hospital nearer to his family, where he died. It is unfortunate that the hospice place was not arranged whilst he was in hospital and he had to go back to prison for four days.

This is the eighth death from natural causes at Altcourse since 2004, when the Ombudsman's office began investigating all deaths in custody.

I have investigated the man's clinical care, his release on temporary licence and liaison with his family. I believe that the prison healthcare staff gave every attention to his needs, which were complex and unusual. In particular care was taken to release him with a minimal level of restraints and to make sure that his family were enabled to spend time with him. I make no recommendations.

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 **May 2011**

CONTENTS

SUMMARY

1. The man appeared at Magistrates' Court on 15 December 2005, and was remanded to HMP Altcourse. He was convicted at Crown Court on 21 March 2006, and on 5 May the same year, he was sentenced to four years' imprisonment.

2. After being sentenced, he saw a counsellor regularly and had a mental health review on 6 September. He was diagnosed with depression and continued to attend appointments with a counsellor throughout 2006.

3. In January 2007, the man complained of recurrent tension headaches and was prescribed pain relief medication. In April and May, he attended further appointments and reviews about his ongoing depression. He complained of headaches, aching limbs and running eyes and nose in November.

4. He was seen for further appointments in January 2008. He appeared depressed and lethargic and had a poor appetite, and was also very pale. A doctor at Altcourse referred him to a consultant endocrinologist at hospital, because he suspected that he was suffering from hypopituitarism (decreased secretion of hormones from the pituitary gland), specifically testosterone deficiency. This was confirmed in February, and a magnetic resonance imaging (MRI) scan was also carried out.

5. In March, the consultant from the hospital wrote to Altcourse to confirm that the MRI had detected a large brain tumour. The consultant was given the man's home address because he was due to be released from Altcourse.

6. He was released from prison on 14 March 2008. He remained in the community until February 2009, when his licence was revoked after he breached the conditions of his licence. Due to his hospital treatment, he did not return to custody until June. During his time in the community, he underwent surgery to remove his brain tumour. He had scarring to the right side of his head, and parts of his skull were removed. When he returned to prison, he was drowsy, sleepy and suffered from headaches.

7. As a result of his imprisonment, his outpatient care was transferred to a different hospital. He attended appointments at the hospital under escort from prison staff. On 8 July, he had a further MRI scan which revealed a large remnant of the tumour. A six-week course of radiotherapy was recommended.

8. In order to facilitate the radiotherapy, and because of a deterioration in his health, the man was transferred to hospital as an inpatient on 30 July. He remained there for more than two weeks under escort from prison staff. On 13 August, medical staff at Altcourse were informed that all intervention regarding the tumour had ceased as it was proving ineffective. He returned to Altcourse on 18 August but was extremely unwell. The following day, he saw a palliative care consultant, who recommended that he should move to a local

hospice. Rather than being transferred under escort, he was released on temporary licence to a hospice on 21 August.

9. One week later, on 28 August, the man was transferred from the hospice to a hospital which was closer to his family. He died at the hospital in September.

10. I have investigated his clinical care, his release on temporary licence and the prison's liaison with his family and make no recommendations.

THE INVESTIGATION PROCESS

11. One of my senior investigators opened the investigation on 3 September 2009. At HMP Altcourse, he met the PPO's liaison officer. The liaison officer facilitated access to all of the records regarding the man's period in custody, including his clinical record.

12. One of my family liaison officers (FLOs) wrote to the man's mother to explain the purpose of the investigation and offer the opportunity to raise any questions or concerns. The FLO and investigator visited her on 17 November 2009. She said that she had been treated well by Altcourse, and explained that the prison had arranged transport for her to see her son.

13. The local Primary Care Trust (PCT) appointed a clinical reviewer to review the man's clinical care whilst he was in custody. The purpose of the clinical review is to examine the medical care that a prisoner received whilst in custody, which should be of an equivalent standard to what might have been expected in the community. The draft clinical review was sent to my office in October 2010, with the final version following in December. This inevitably delayed the issue of my own report. His findings are summarised in this report and the full clinical review is included as an annex.

14. During the course of the investigation, the investigator consulted the man's prison and medical records, and liaised with the liaison officer about decisions that had been made regarding his release.

HMP ALTCOURSE

15. Altcourse is a prison near Liverpool. It is contracted out by the National Offender Management Service (NOMS) and run by G4S, a private company. It serves the courts in Merseyside, Cheshire and North Wales, and holds up to 1324 sentenced and unsentenced adults and young offenders. There are seven residential units and a separate healthcare unit.

16. Healthcare services at Altcourse are commissioned by the local PCT and delivered by G4S. An outpatients clinic is available every weekday, and the inpatients unit provides 24 hour staffing by nurses. Additionally, doctors are on call 24 hours a day for more serious incidents.

17. This report refers to the man moving from Altcourse to hospital and back again. When prisoners attend hospital appointments, they are escorted by prison officers and are usually restrained using handcuffs. The accompanying prison staff members are known as bedwatch officers.

18. The process of Release on Temporary Licence (ROTL) allows prisoners to be released from prison temporarily, whilst continuing to serve their sentence. Such an arrangement can involve various restrictions, such as a prescribed place of residence.

Performance

19. The Ministry of Justice provides quarterly figures for all prisons in England and Wales. Every establishment is given a rating between 1 and 4 based on 34 agreed performance indicators. During quarter 2 of 2009-2010 (July, August and September 2009), Altcourse received the maximum rating of 4, indicating exceptional performance. The prison maintained its rating during quarter 3 (October, November and December 2009.) The most recently available figures are from quarter 4 of 2009-2010 (January, February and March 2010). For this period, Altcourse received a rating of 3. This indicates good performance, but nevertheless represents a drop in rating from the previous two quarters.

20. The former HM Chief Inspector of Prisons inspected Altcourse on 15-22 January 2010, four months after the man's death. Her report was generally positive, finding that time spent out of cell was "outstanding, and for much of that time prisoners were engaged in purposeful activity". Healthcare staffing was generally good, but some areas of the healthcare unit were run-down or untidy. Inpatients had little structured activity to occupy their time.

Previous deaths at Altcourse

21. The Ombudsman's office has been responsible for investigating deaths in custody since April 2004. Prior to the man's death, seven prisoners have died from natural causes whilst at Altcourse. Two of these deaths were heart-related, four were from cancer, and in one case a cause of death could not be identified.

KEY EVENTS

22. The man appeared at Magistrates' Court on 14 December 2005, and was remanded to HMP Altcourse. On 21 March 2006, he was convicted at Crown Court and returned to Altcourse to await sentencing. He was sentenced to four years' imprisonment on 5 May and returned to Altcourse as a sentenced prisoner.

23. After his sentencing, he saw a counsellor regularly. On 6 September, he was referred to Nurse A, a mental health nurse, and complained of being depressed. The nurse wrote in the clinical record that he presented as "troubled and disorganised". The man wanted to see a doctor regarding medication, and did so five days later. He told Prison Doctor A he was angry that his partner had not visited him in prison. The doctor noted that he was low in mood and had been for several months. He prescribed 20mg of fluoxetine (an anti-depressant drug) daily.

24. The next day, 12 September, the man saw his counsellor, who wrote that he appeared to have had a slight lift in mood. Two days later, he saw Prison Doctor A and complained that he was getting headaches as a result of taking the fluoxetine. He was advised to continue taking the medication.

25. He continued to go to appointments with the counsellor; then on 1 November attended an appointment with Prison Doctor B for a review of his medication. The doctor noted that, whilst the fluoxetine had helped slightly, he was still low in mood with a poor sleep pattern. His medication was increased from 20mg to 40mg daily.

26. On 15 January 2007, the man saw Prison Doctor C and complained of recurrent tension headaches. The doctor wrote in the clinical record that there were no "red flag symptoms" (signs of a serious condition) and advised simple pain relief medication when required. He saw Prison Doctor B on 19 February, when he asked for a repeat prescription for paracetamol. He explained that he used paracetamol for his occipital headaches (towards the back of the head).

27. He saw the counsellor on 23 April and appeared unhappy, which the counsellor thought was due to the death of his grandfather. Four days later, he saw Prison Doctor B and complained of low mood. He said that his grandfather had died suddenly and unexpectedly, and the fluoxetine was no longer relieving his symptoms. He was referred for a review by a mental health nurse, with a view to a possible increase in his medication.

28. Nurse B saw the man for a mental health review on 14 May. He recorded that he thought his problems were mainly social, domestic and relationship based. He encouraged him to continue working with his counsellor, but did not think an increase in medication would be helpful. Over the next few months, he continued to attend appointments with his counsellor, who wrote in the clinical record that he worked "extremely hard both during and outside of sessions".

29. The man saw Nurse C on 15 November 2007, and said he had experienced headaches, running eyes and nose, and aching limbs for four days. He was coughing up green phlegm in the mornings which cleared as the day went on. He was advised to produce a specimen, and he would then be reviewed. The planned review does not appear to have happened, and it is unclear whether this was because he did not produce a specimen, or for some other reason.

30. He saw Nurse B for a mental health assessment on 21 January 2008. The nurse reported that he was low in mood, with a flat voice tone and little eye contact. He wrote that he experienced a lack of appetite and a poor day/night routine which affected his ability to work in the prison. He told the nurse that he had stopped taking his anti-depressants around eight months previously. He was referred to the doctor for a review of his medication, which took place the next day. He told Prison Doctor A that he felt increasingly tired and would often fall asleep between 5.00pm and 9.00pm. He would then be unable to sleep through the night. He was not eating properly and was worried about his release from prison. The doctor noted that he appeared pale and was low in mood. He prescribed 15mg of mirtazapine (an anti-depressant medication) daily. He thought that there was no strong evidence for hypothyroidism (a condition caused by insufficient production of thyroid hormones from the thyroid gland) but asked for an urgent full blood count and thyroid function test.

31. Prison Doctor A next saw the man on 29 January. He wrote in the clinical record that he was very pale, and was not eating or sleeping well. His blood test results were normal. He increased his mirtazapine prescription to 30mg daily.

32. Following the results of the thyroid hormone test, the doctor wrote to a consultant endocrinologist at hospital. In his letter dated 31 January, the doctor described the man's history of depression and also mentioned that he suffered from long-term hoarseness. The doctor thought that he was suffering from hypopituitarism (decreased secretion of hormones from the pituitary gland), specifically testosterone deficiency, and asked the consultant to see him in his clinic at the earliest opportunity.

33. The consultant saw the man on 7 February, and wrote to the doctor on 15 February. In his letter, he agreed that the symptoms suggested hypopituitarism. He recommended a course of hydrocortisone (a steroid hormone) and said that he would arrange for the man to undergo a magnetic resonance imaging (MRI) scan of the hypothalamic pituitary area of his brain.

34. It is unclear when the MRI scan took place, though the consultant wrote to a consultant neurosurgeon on 3 March. In his letter, the consultant explained that the man's MRI scan showed a "large heterogeneously enhancing pituitary adenoma extending into the supra sellar region with compression of the optic chiasm" (a brain tumour). He asked the consultant neurosurgeon to see him in the near future. Four days later, he sent a further letter to the consultant neurosurgeon, explaining that the man would shortly be released from custody, and requesting that the appointment was sent to his home address.

35. The man was released from Altcourse on 14 March. Prisoners are normally released at the halfway point of their sentence, and serve the remainder in the community, subject to a licence. A standard licence has a number of conditions, including a requirement to live at a specified address. Additional conditions can be stipulated. He was subject to an exclusion zone, meaning that he was not allowed to enter a particular geographical area.

36. The man remained in the community until February 2009, when his licence was revoked after he failed to attend three appointments with his probation officer. He was found to have changed his address without informing his supervising officer. He was not required to return immediately to custody because he being treated for the brain tumour and was subsequently hospitalised. In May, however, he was discharged from hospital and went to live at his mother's address. This was in breach of his licence conditions, which did not allow him to live in that area, and he returned to Altcourse on 1 June.

37. Medical assessments completed when he arrived at Altcourse noted that he had been diagnosed with a brain tumour and had undergone surgery as a result. Nurse D wrote in his clinical record that he had scarring to the right side of his head and parts of his skull had been removed. She also noted that he was unsteady on his feet, had slurred speech, and was prescribed significant amounts of medication. He was admitted to the prison's healthcare unit.

38. On 2 June, the man saw Nurse E. He spoke at length about substance misuse, and said that he was prescribed methadone (used to treat dependence on opiates such as heroin). He also saw Prison Doctor D, who noted that he showed no signs of drug withdrawal but had obvious memory problems. There was no further detail given about how his memory had been assessed. Nurse E confirmed that he had been prescribed methadone whilst he was in hospital, and he started the prison's methadone programme.

39. The next day, Prison Doctor D wrote to Altcourse's Director explaining that the man had been receiving treatment at hospital, and that his care had been transferred to another hospital. He explained that the man would be required to go to the hospital every weekday for a six week period.

40. Also on 3 June, Nurse F wrote in the clinical record that the man had made "slow but positive progress". He had made his way with some assistance to the dining area and had eaten his meal.

41. Over the next few days, several entries were made in the man's clinical record. He was consistently described as drowsy, sleepy and suffering from headaches. On 7 June, Prison Doctor B wrote that there had been "little improvement so far" and that he felt very cold and tired much of the time. Later the same day, Nurse G wrote that he appeared much more alert and had been mixing with other prisoners in the television room. However, he had also "been complaining of an excruciating headache that had him sobbing in

pain". As a result of this, the doctor prescribed naproxen, an anti-inflammatory medication commonly used for pain relief.

42. Clinical staff continued to monitor the man over the next few days. He sometimes seemed confused, but showed some improvement, associating with other prisoners and taking time outdoors in the exercise yard.

43. On 11 June, he went to an appointment at hospital, but did not return with any hospital notes and was unable to remember the name of the doctor he had seen. A member of the healthcare staff spoke to one of the officers who accompanied him. The officer said the consultant had informed him that they would be having a meeting about his care, as he would not be able to lie still on a bed for 20 minute periods for radiotherapy.

44. The same day, the consultant neurosurgeon at hospital, wrote to the consultant oncologist who had been responsible for the man's care at another hospital. He wrote that radiotherapy would "pose an extremely difficult logistical challenge" because the man was handcuffed to prison officers and had been told that the handcuffs could not be released. He also mentioned that there were concerns about whether he would be able to remain still for the duration of the radiotherapy sessions, and whether he would be prepared to have a face shell fitted. He said he would arrange for him to undergo an MRI scan.

45. Prison Doctor B wrote to the Director of Altcourse on 15 June, explaining the man's medical condition and emphasising that he would need to be uncuffed for the duration of certain procedures at the hospital. The outcome of this request is unclear, but he later underwent procedures (such as an MRI scan) that would have required the handcuffs to be removed.

46. Throughout the remainder of June, the notes in his clinical record indicated that his condition seemed to remain much the same. He was settled on the healthcare unit, though he slept for long periods of time and often appeared drowsy. He frequently complained of headaches and was prescribed pain relief medication.

47. He underwent an MRI scan on 8 July. Two days later, the consultant neurosurgeon saw him and then wrote to Prison Doctor A with the results. He said that the MRI showed a large remnant of the tumour, and a six week course of radiotherapy was recommended. The consultant said he had tried to explain this to the man but his memory was extremely poor. He noted, however, that he had signed a consent form and understood the side effects of his treatment.

48. Throughout July, his condition appeared much the same. The medical team at Altcourse continued to make regular entries in his clinical record. These were primarily related to his level of alertness, mobility, diet and pain level, and there was little information about his outpatient appointments at hospital.

49. On 30 July, the Release and Recall Section of the Parole Board wrote a review about the man's recall to prison. They considered re-release but did not think it was appropriate. He was not allowed to move back to his mother's house because it was in the exclusion zone, and the Parole Board thought that probation approved premises (hostels) might struggle to manage his medical needs.

50. The same day, Prison Doctor D noted in the clinical record that the man's condition had deteriorated over the preceding few days. The appropriate course of action was to admit him to hospital in order to examine his endocrine system (responsible for the release of hormones into the bloodstream) and commence radiotherapy. He was admitted to hospital the same day.

51. On 31 July, Nurse H spoke to a member of staff at the hospital to ask about the man's condition and whether he was likely to remain in hospital for more than three days. She was told that there had been no change and he was likely to remain in hospital.

52. The next day, a Release on Temporary Licence (ROTL) form was completed in view of the man's poor health. It was acknowledged that he could not be released to his mother's address because of his licence conditions, but the Director agreed that based on "the need to ensure dignity, respect and compassion" he would be accompanied by bedwatch officers but without restraints, such as handcuffs, whilst he was at hospital.

53. The prison's family liaison officer introduced herself to the man's mother and sister on 2 August at the hospital. There was ongoing contact between them from this time until his death one month later, and in the period that followed.

54. The healthcare staff at Altcourse retained some contact with their counterparts at hospital whilst the man was an inpatient. However, this contact did not always seem particularly harmonious. Nurse I wrote in the clinical record on 13 August to suggest that there had been some disagreement about discharging him from hospital. Prison Doctor D was unhappy about this decision being made without any prior notice or consultation especially as it was during the late evening, and was not willing to accept him back on those terms.

55. Nurse I had been advised that the man was now blind, unable to use one of his arms, and extremely unbalanced when trying to walk. He would need one to one care, with a nurse at his bedside 24 hours a day. The hospital had withdrawn all treatment for his cancer as it was ineffective. After 13 August, there was one further entry in his clinical record before his return to Altcourse. It was dated 17 August, and concerned the prison being fully briefed on his medical needs before his return.

56. He returned to Altcourse from the hospital on 18 August. The notes in his clinical record for 18 and 19 August suggest that he was extremely unwell. He slept for long periods, fell on a number of occasions, and struggled to use

the toilet properly. He was given liquidised meals and extra fluids, and his cell door was left open during the night (usually cells are locked at night when staffing levels are reduced).

57. On 19 August, the man was assessed by a Macmillan Consultant in palliative care. He recommended that he should move to a hospice for end of life palliative care. Over the next two days, whilst a hospice place was being arranged, he was given 24 hour care by two members of the healthcare staff.

58. The Macmillan Consultant confirmed on 21 August that a place was available for him at a hospice. A Release on Temporary Licence (ROTL) application was completed and it was agreed that he would be released, unaccompanied by prison staff, to the hospice. The ROTL form was signed on his behalf as he was unable to do so. On the same day, he was released to the hospice.

59. Whilst the man was at the hospice, the prison's family liaison officer made arrangements to provide transport for his mother, so that she could maintain daily visits. She was collected from her home in Macclesfield, and returned there after visiting her son.

60. There were no further entries in the clinical record about his condition whilst he was at the hospice. On 28 August, he was transferred from the hospice to a district hospital, which made it easier for his family to visit him. He died at the hospital six days later.

61. Following the man's death, the prison's family liaison officer remained in contact with his mother whilst funeral arrangements were made. The prison paid for the funeral, which was held on 18 September. A memorial service for him was held at Altcourse three days later.

ISSUES

Clinical care

62. The clinical reviewer was appointed by the local Primary Care Trust (PCT) to review the man's clinical care. He produced a summary of the man's medical appointments, and commented on his admission to Altcourse and his subsequent treatment by healthcare staff. In conclusion, he found no significant shortcomings in how medical care was managed whilst he was at Altcourse.

63. It is the clinical reviewer's view that the palliative care team could have been involved with the man's care from an earlier stage. He was only treated on a palliative basis from August 2009, less than a month before he died, when he was admitted to hospital and treatment for his cancer was withdrawn. Until then active treatment was given and it was only in August that palliative care was deemed necessary.

64. The man returned to Altcourse on 18 August and was seen by a Macmillan Consultant in palliative care the very next day. However, the information in his medical records suggests that he was extremely unwell during this period and that his condition had deteriorated significantly even before his discharge from the hospital. Better communication between Altcourse and the hospital might have resulted in him being assessed by someone from the palliative care team without having to return to the prison. The clinical reviewer observed in his clinical review that it would have been better for him to transfer directly from the hospital to the hospice, rather than returning to Altcourse. However, he concluded that his discharge from the hospital was appropriate.

65. The man received 24 hour nursing care at Altcourse during the four days after he came back from hospital. This is not something which the healthcare centre is ordinarily staffed and equipped to provide but there are no concerns about the quality of his care.

66. However, I question the necessity of the four days he spent in the prison before being released to the hospice. I accept that the hospital wanted to discharge him, though the fact that he went to a hospice four days later suggests that his medical needs were ongoing and complex, and that he was expected to die within a relatively short period of time.

67. Arrangements for his discharge are the responsibility of the hospital, which is outside the Terms of Reference for my investigation, and so I make no recommendations in this regard. I am embarrassed by the delay issuing my report and, some 18 months after his death, does not seem to be the most appropriate time to comment further. I am also conscious that his condition was unusual and that the hospital, although a specialist regional cancer facility, is not the prison's local hospital. I have no doubt that, in the event of similar circumstances in the future, the Director and Head of Healthcare will wish to take every step to improve liaison with the hospital.

68. The possibility of release to a hospice could have been explored by members of staff at Altcourse before the man was discharged. Better planning by the hospital and the prison could have avoided the disruption for him and his family as well as reducing the burden of caring by healthcare staff.

Release on temporary licence (ROTL)

69. The man was admitted to hospital on 30 July. Two days later, in the light of his very poor health, a ROTL application was completed. At the same time, the decision was made that he should be accompanied by prison bedwatch officers, but that he was unlikely to try to escape and did not need to be handcuffed.

70. The arrangements were further reduced when he went to a hospice on 21 August, and his ROTL was amended so that he was no longer accompanied by bedwatch staff. Although still a prisoner, he was able to spend the last two weeks of his life without the indignity of bedwatch officers being present. This is good practice to ensure that prisoners are afforded dignity during their last days. It also means that valuable and scarce prison resources can be used more effectively.

71. Although technically still a prisoner, no entries were made in his prison clinical record after he was taken to hospice on 21 August. He was receiving medical care from the hospice, and later from the district hospital, and was not expected to return to the prison. However, he remained a prisoner under Altcourse's supervision. As such, it would have been good practice for clinical staff at Altcourse to maintain contact with the hospice and the district hospital about his condition and the medical care he was receiving, and to record this in the clinical record.

Family liaison

72. Altcourse's family liaison officer introduced herself to the man's mother and sister on 2 August 2009, when he was in hospital. Ongoing contact was maintained during his illness and after his death.

73. She kept a detailed log of her contact with his mother, and this seemed to be mostly positive. His mother confirmed to my investigator and FLO that the family liaison officer's involvement had been helpful. In particular, she praised the prison for arranging to drive her from Macclesfield to the hospice to visit her son.

Issues raised by the man's family

74. The man's mother told my investigator and FLO that she had experienced difficulty arranging for a piece of her son's artwork to be returned by the prison. This was only rectified after intervention by my own FLO. Whilst I acknowledge that the family liaison was, for the most part, supportive and well-received, I remind the Director of the need to return property to family members promptly.

75. She was also concerned about her son's recall to prison. In February 2009, his offender manager (his probation officer in the community) started proceedings to return him to custody after he failed to attend appointments. However, he was later admitted to hospital and so was not returned to Altcourse until June. His mother explained that his offender manager had visited him in hospital and said that he would find a place for him to live when he was discharged.

76. On 23 June, after his returned to Altcourse, his offender manager completed a report assessing the risks if he were to be released. The section concerning his accommodation needs states:

> "The man's accommodation is problematic in that because of his health needs, he is in high need of support. He is technically homeless. We have liaised with approved premises who would have difficulty accommodating him because of his health needs. His mother has informed us that she is working with the housing department with regard to a transfer away from the area in which the victim resides, in order to accommodate her son. His accommodation is linked to health care. He is currently receiving medical treatment - radiation therapy - at hospital and we understand the hospital is requesting ROTL arrangements for this treatment. If he were to be released immediately he would be homeless which would aggravate his risk to the public as he would be in a state of anxiety. It is hoped that through liaison with his mother/medical services/housing, progress could be made to progress his accommodation situation."

77. Whilst the purpose of this investigation is to consider the circumstances of the man's death, I understand his mother's anxieties about his recall. The evidence from the records is that it was difficult to find suitable accommodation but that the problem had been identified and efforts were being made.

78. On 30 July, which with hindsight was less than a month before the hospital stopped giving active treatment, the Parole Board reviewed his recall to custody, and concluded as follows:

> "The panel noted the length of time during which the man had been supervised in the community under the current licence, and considered the benefits of him addressing his substance misuse problems and offending behaviour within the community. Against this, the panel balanced the seriousness of the index offences and his history of confrontational behaviour towards his mother, together with his history of previous convictions (including violence) and breaches of trust. The panel also took into account the need for supportive accommodation for re-release which is able to deal with his medical requirements, and the lack of confirmation that such accommodation is currently available, and the request of report writers that his case should be reviewed in three months. The assessment of risk is such that it cannot be safely managed within the community at

present. The panel therefore makes no recommendation regarding re-release."

79. As a result of the Parole Board's decision, the man remained in the custody of Altcourse. Had time allowed, at a later date, the Board may well have reached a different decision. Given what was known about his condition in July when the Board met, I believe that their decision took full account of his circumstances and was appropriate.

CONCLUSION

80. This report covers the sad death of a very young man. He was poorly when he was first in prison and then underwent major surgery on release. He breached his licence conditions and was recalled to prison where he lived in the healthcare inpatient's unit. There was evidence of some very good practice by Altcourse, particularly the family liaison arrangements which were put in place when it became clear that his condition was terminal. As well, knowing that the Parole Board had recently refused to release him, the prison applied for Release on Temporary Licence as the best alternative. This meant that no restraints or bedwatch officers were needed. He and his family had privacy and dignity during the last weeks of his life.

81. However, it is a great pity that he had to spend four days from 18 to 21 August 2009 back in prison, when he was clearly so very unwell. His discharge from hospital was a matter for the doctors there. Better communication between the hospital and the prison should have meant greater cooperation. Such a poorly young man should not, to my mind, have been taken back to prison when what he clearly needed was specialist palliative care.