
A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in October 2012 at
hospital, while in the custody of HMP Parc**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a man, a prisoner at HMP Parc. He died at hospital in October 2012 of pneumonia as a result of a brain tumour. He was 48 years old. I offer my condolences to his family and friends.

The investigator was appointed and the local PCT conducted a review of the man's clinical care in custody.

In 2007, the man was sentenced to twelve years imprisonment. While he was at HMP Wandsworth in 2009, he began to suffer seizures and falls and was diagnosed with a brain tumour. On 14 February 2012, he fell during a seizure and hit his head, resulting in a brain injury. He was taken to hospital for surgery and, although his condition improved over the following months, he remained confused and agitated. He spent much of his time in the hospital's specialist rehabilitation unit. In September, he developed a chest infection which turned into pneumonia. His condition deteriorated and he died in October.

While communication between Wandsworth and Parc regarding the man could have been better, the investigation found that he received a high standard of care at Parc which was equivalent to that he could have expected to receive in the community. There was an unnecessary delay in considering his application for early release on compassionate grounds, but he had been released on temporary licence for some time before he died. The use of restraints was generally managed appropriately and with sensitivity. His family was well supported by Parc both before and after his death.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man was sentenced to 12 years imprisonment at Crown Court on 13 June 2007. At HMP Wandsworth in November 2008, he began to suffer seizures and frequent falls. A scan revealed that he had a brain tumour which was slow-growing, but likely to be fatal. He was prescribed medication to manage the seizures.
2. The man transferred to Parc on 20 October 2011. Initially this was a temporary arrangement to enable family visits, but he was allowed to stay to be nearer his family. At first he chose to live on a general wing but he moved to a wing for those with chronic medical conditions after a number of falls. On 14 February 2012, he hit his head during one of these falls. He was taken by emergency ambulance to hospital and had surgery to remove the bulk of his tumour and a blood clot. After more surgery on 14 March he moved to a specialist rehabilitation unit and his condition stabilised.
3. An application for early release on compassionate grounds (ERCG) was submitted in February 2012, but was rejected in June as the man had no definite prognosis. After his condition deteriorated in October, the application was re-submitted. This coincided with a parole review, so it was decided to wait for the outcome of this review, due on 12 October. He died in October before his parole application was considered. At the time of his death, he was released on temporary licence and not subject to restraints or a prison escort.
4. Parc appointed a family liaison officer when the man was admitted to hospital in February 2012. When he died she went directly to the hospital to support his sister, who was with him, and later informed his son, who was his nominated next of kin.
5. We agree with the PCT's conclusion that the man's treatment and care at Parc was equivalent to that he might have expected in the community. Although this was not a factor in his death the PCT was concerned that his health records did not accompany him when he transferred from Wandsworth to Parc to allow appropriate continuity of care. We have made a recommendation about this and about the need for timely decisions about compassionate release.

THE INVESTIGATION PROCESS

6. The Ombudsman was notified of the man's death on 8 October 2012. The investigator issued notices to staff and prisoners at Parc informing them of the investigation and asking anyone with relevant information to contact her. No responses were received.
7. The investigator visited Parc on 11 October and obtained the man's records. She spoke to a range of relevant staff and two prisoners. At the end of the visit, she met the Director to give preliminary feedback, which was confirmed in writing on 7 November.
8. The local PCT conducted a review of the man's clinical care and had copies of the available medical records. His medical records from Wandsworth were not received until 16 January 2013. The final clinical review was received on 4 February.
9. HM Coroner for the County Borough of Neath Port Talbot was informed of the investigation. A copy of the investigation report has been sent to the Coroner.
10. One of the Ombudsman's family liaison officers contacted the man's son and sister on 26 October to explain the purpose of the investigation. He also spoke to the man's ex-wife during the course of the investigation. His family did not have any specific concerns for the investigation to consider.
11. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.
12. The man's family received a copy of the draft report as part of the consultation period. His son raised a number of additional questions. His sister commented she had found the draft report distressing to read and welcomed the recommendations made. Although the comments made by the family have led to no changes in the investigation report, the investigator sought to address the issues raised in separate correspondence to them.

HMP PARC

13. HMP & YOI Parc, which opened in 1997, is run by G4S. It holds more than 1,400 convicted male adult prisoners and young adults on remand or convicted. It also has a unit for up to 60 young people under 18.
14. There are 24 hour primary general and mental healthcare services at Parc provided by G4S. The healthcare centre has a 14 bed unit for older prisoners and those with increased health needs where the man lived when he was at the prison.

HM Inspectorate of Prisons (HMIP)

15. HMIP last completed a full unannounced inspection of Parc in September 2010. HMIP found that prisoners were mostly positive about their relationships with staff. However, support for prisoners with disabilities was weak, with no clear assessment of individual needs or care plans. HMIP reported that, at the time, healthcare services were not delivered to an acceptable standard. G4S was about to take over the provision of healthcare services when the inspection occurred. The prison has not been re-inspected since.

Independent Monitoring Board (IMB)

16. Each prison in England and Wales has an Independent Monitoring Board, made up of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. The last report published by the IMB for Parc, covering the period March 2011 – February 2012, noted that the prison was a well-run and safe prison. Some problems with prisoners being made aware of medical appointments were noted.

Previous deaths at Parc

17. There were three investigations completed into deaths at Parc in the year before the man died, all of which were due to natural causes. There were no direct similarities in the circumstances of these deaths.

ISSUES

18. On 17 October 2006, the man appeared at Magistrates' Court and was remanded to HMP Cardiff. At his initial health screen, he had no mental or physical health issues. He transferred to Parc on 2 March 2007 and, following his conviction on 25 April 2007, he was sentenced to 12 years at Crown Court on 13 June 2007.

The diagnosis of the man's terminal illness

19. On 30 July 2008, the man transferred to HMP Wandsworth. When he arrived, he appeared fit and well, but he began to experience seizures and falls in November 2008.
20. A consultant neurologist at hospital examined the man in July 2009 and referred him for an MRI (magnetic resonance image - a type of scan that is often used to diagnose health conditions that affect organs, tissue and bone) and an EEG (Electroencephalography - a technique that records the brain's electrical activity). The neurology department at the hospital wrote to the prison healthcare department on 8 December 2009:

“The MRI scan has shown quite an extensive abnormality in the left frontotemporal region consistent with glioma...which is consistent with a type of malignant brain tumour ... the range of outcomes from gliomas can be anything from a few months to many years, and although the radiologist felt this was probably towards the more severe end of the spectrum, it is difficult to be more certain at this stage.”

21. The man was diagnosed with a brain tumour, but he was not considered terminally ill. He remained at Wandsworth and a consultant neurologist oversaw his care.
22. The man transferred to Parc on 20 October 2011 so he could use accumulated visiting orders to spend time with his family. On 14 February 2012, he collapsed and hit his head as he fell, sustaining a significant brain injury. Healthcare staff and the prison doctor quickly attended and he was taken by ambulance to hospital. He had surgery to remove some of his tumour and a blood clot. Two days later he had more surgery to remove another blood clot and, on 22 February, he had a tracheostomy (a tube inserted into the neck to assist breathing). On 27 March, he had a ventriculoperitoneal shunt fitted (to drain excess fluid in the brain and reduce pressure within the skull).
23. The man's condition stabilised, and he transferred to another hospital on 12 May for neuro-rehabilitation. He understood simple commands, but remained confused. On 17 August, he moved to another hospital and the shunt was replaced the next day.
24. After this operation, the man required 24 hour care and assistance. Although it was known that ultimately his condition would prove fatal, there was no

definite prognosis. In September he developed a chest infection. He was treated with antibiotics, but did not respond and subsequently developed pneumonia. On 5 October, hospital staff informed Parc that his condition was terminal and he was not likely to survive the infection.

25. The PCT concludes, and we agree, that the diagnosis of the man's condition was appropriate.

Informing the man about his condition and treatment

26. On 8 December 2009, hospital staff told the man that the MRI scan had shown that he had a type of malignant brain tumour. He was advised that a precise prognosis was not possible but that he would be prescribed medication for his seizures. At his request the doctor informed his sister of his diagnosis.
27. The PCT writes:

“The neurosurgeon at the hospital in London had personally written to the man explaining the biopsy result and the nature of his illness and the management plan for the future. There is evidence that the doctors in HMP Wandsworth had also discussed with him about his management plans at the hospital...discussion between him and the doctors in HMP Parc is also documented.”

He was offered and provided support by mental health nurses at both prisons.

28. After his fall on 14 February 2012, the man was aware of his condition and the treatment plan. After his surgery to remove a blood clot he was in a coma for a period of time. When he awoke from his coma, he was severely confused and therefore not able to contribute meaningfully to his care and treatment plan.
29. We are satisfied that hospital and healthcare staff ensured that the man was fully informed about his condition and treatment.

The man's medical appointments and treatment

Appointments

30. The PCT was concerned that, on some occasions at Wandsworth, the man missed appointments for MRI scans and the reasons were not explained in the records. The clinical review notes a general lack of information about his hospital appointments during his time at Wandsworth. We therefore make the following recommendation:

The Governor and Head of Healthcare at HMP Wandsworth should ensure that prisoners do not miss important hospital appointments and that reasons for non-attendance are fully recorded.

31. Parc ensured that the man was able to attend all his scheduled hospital appointments while he was at the prison. When an appointment for an MRI scan on 17 January 2012 was cancelled because the consultant was sick, Parc wrote to the neurology department outlining the urgency of the appointment and ensured a further appointment was arranged for 16 February. (He was unable to attend after his fall on 14 February.) The PCT notes:

“There were concerns raised by the neurology department at the hospital that the man missed his MRI/ neurology appointment and it was stressed the importance of attending these as they were the primary method of monitoring the progression of his tumour ... In HMP Parc all his treatments and appointments were conducted appropriately and in a timely fashion. There were numerous detailed referral letters, requests to make appointments and requests to give urgency for follow up appointments.”

32. We agree with the PCT that the man’s appointments were well managed at Parc.

Treatment

33. When the man transferred from Wandsworth back to Parc in October 2011 there was no contact between the two healthcare departments about the extent of his medical condition or his care and treatment plans. His medical records did not transfer with him. Prison Service Order (PSO) 3050 Continuity of Healthcare for Prisoners, requires:

“Current healthcare needs are assessed and continuity of care ensured when prisoners are transferred between establishments, from establishments to outside NHS hospitals for inpatient care, or released into the community... Ensuring information on continuing care is conveyed to other establishments on transfer and to NHS hospitals for outpatient and in/outpatient appointments.”

34. On 27 October 2011, a doctor at Parc asked the healthcare department to request the man’s medical records from Wandsworth. On 1 November an administrator recorded that he would be returning to Wandsworth on 20 November, so there was no need to obtain these records. In fact, he never returned to Wandsworth. Regardless of how long he was meant to be at Parc, his healthcare records should have accompanied him. There was no communication between the prisons, and his medical records from Wandsworth were never sent to Parc. The failure to transfer his records to Parc led to further problems in obtaining them for this investigation. The records were requested in October, but not supplied by Wandsworth until 16 January 2013, which was an unacceptable delay.

The Heads of Healthcare at HMP Wandsworth and HMP Parc should ensure that medical records accompany prisoners when they transfer, especially where there is a pre-existing serious condition.

35. The man did not always take his medication at the prescribed time, which worsened his seizures. While at Parc, his medication was reviewed and altered as necessary and in accordance with the treatment plan from the neurology consultant.
36. The man was assessed by a consultant on 30 August 2012, who suggested a course of radiotherapy might help alleviate his symptoms, but on 22 September the oncology team decided that no benefit would be derived from such treatment.
37. The man's treatment options were limited to managing his symptoms. We agree with the PCT that his treatment was appropriate for his condition.

The man's pain relief and medication

38. The man was prescribed all the medications in prison directed by the hospital consultant, although at Wandsworth the dosage was not always increased as advised. He was prescribed sodium valproate and lamotrigine (both anticonvulsants), and paracetamol and ibuprofen to manage his pain.
39. The clinical review states:

“In HMP Wandsworth when there was a question of patient compliance with the medication, (it was vital that he took his medication appropriately), the medication was taken from in his possession and changed to being dispensed regularly to ensure his compliance. In addition, blood tests were taken to measure the level of the drug in his blood to look for compliance and this was subsequently repeated.”
40. During his time in hospital, the man was made as comfortable as possible and his pain managed according to his needs. On 5 October, his pain was managed via a syringe driver (a battery operated pump that delivers medication at regular intervals).
41. We are satisfied that appropriate steps were taken to encourage him to take his medication as prescribed. In the light of the PCT's findings, we conclude that the management of the man's medication and pain relief was appropriate to meet the needs of his condition.

Palliative care

42. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. It helps carers to plan when and how care will be delivered, and helps patients make choices about how they are cared for towards the end of their lives.

43. On 20 September 2012, a cancer specialist concluded that palliative radiotherapy was not likely to improve the man's condition and referred him to the hospital's palliative care team. On 27 September, the hospital palliative care team assessed him for possible transfer to a hospice but concluded that he should remain at hospital and only receive pain relief.
44. Parc held regular case review meetings to discuss the man's ongoing and changing needs. In addition to his physical care, his emotional needs were also well considered, evidenced by the decision to allow him to remain at Parc in 2011 and the facilitation of contact with his family. In the clinical review, the PCT comments:

"There were numerous care plans in the notes from HMP Parc and these were being reviewed regularly. These were appropriate and set out the guidance to the staff as to how to respond in certain situations if and when they developed."
45. We conclude that officers and healthcare staff provided a high standard of care with attention to both the man's physical and emotional needs while he was at Parc. After his admission to hospital he had specialist palliative care.

The man's location

46. After he had been diagnosed with a brain tumour, the man preferred to stay in his cell on a second floor landing at Wandsworth and he continued to work. Officers became increasingly concerned about his safety and his frequent seizures and wanted him to move to a shared cell on the ground floor. He did not want to move and, on 10 October 2010, he signed a disclaimer to that effect.
47. The man went to Parc on 20 October 2011 to facilitate family visits. On 21 November 2011, he deliberately cut his arm as he did not want to return to Wandsworth. After a review of his medical condition on 24 November, he was told that he could remain at Parc to be close to his family. He was originally located in a single cell on the second floor at Parc. Despite concerns by staff about his safety, he signed a disclaimer on 11 December stating that, against medical advice, he did not want to move to the ground floor. After a number of falls, he was persuaded to move to a cell on the ground floor on 19 December. After another fall on 4 January 2012, he initially refused to move to X wing, the older prisoners unit, but eventually agreed and soon settled there. He had a larger than standard single cell on the ground floor, which was adapted for his needs. The wing was quieter and close to healthcare facilities.
48. The man was admitted to hospital in February 2012 and his care and location were the responsibility of a consultant. The consultant arranged for him to be transferred to the neuro-rehabilitation unit at another hospital on 22 June 2012. In a report dated 19 July, the consultant concluded that he could not return to Parc, and that consideration of his location and needs should be

reviewed. After he developed pneumonia, the consultant concluded that the most appropriate location was for him to remain at hospital.

49. We consider that the man's location was properly considered and his wishes respected as far as possible.

Compassionate release

Early release on compassionate grounds (ERCG)

50. Early release on compassionate grounds (ERCG) is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 1600 and prisoners are usually expected to have less than three months to live. The criteria include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within the National Offender Management Service (NOMS).
51. On 21 February 2012, an application for ERCG was submitted by Parc. PPCS required further medical evidence of the man's condition and prognosis and for an assessment from the probation service regarding release arrangements. The Offender Management Unit at Parc pursued the additional information, but there was a significant delay in obtaining the consultant's opinion about his medical condition. The consultant eventually assessed him in May and provided his report the following month.
52. On 7 June the man's application was refused stating:

"I have carefully considered your application and whilst I am sympathetic to the situation, I regret to inform you that the Secretary of State is not going to grant your early release at this time. Your treating doctor expects you to continue to make further progress and therefore it is not possible to assess your level of risk at the current time. Your response to planned neuro-rehabilitation treatment should provide further insight into the long-term impact of the illness and also help determine suitable release arrangements. I have asked the Governor to keep your case under review and to apply again if your circumstances change."
53. The man's parole eligibility date (the earliest date at which he could be released) was 13 November 2012. His application for his first parole review was submitted on 19 July and considered on 6 September. The Parole Board deferred the decision, pending more information about his prognosis and proposed accommodation to ensure that his risk would be adequately managed.

54. A second ERCG application was submitted by Parc on 4 October to PPCS. A report prepared by probation staff noted the man was unlikely to survive more than a few weeks, but did not support release on parole as they did not consider there was an appropriate release plan in place. A date for an oral hearing (when a panel consider if parole should be granted) was set for 12 October, and the decision regarding ERCG was postponed until the outcome of this hearing. He died before his case was considered.
55. We are concerned that a decision about compassionate release was inappropriately postponed on 4 October when it was evident that the man had little time left to live. At that stage, he had been in hospital for some months, had been released on temporary licence since 14 September (see below) and was unlikely ever to leave hospital. Any difficulties over a release plan could have been overcome by regarding the hospital as a suitable release address.

The Director at Parc and the Head of the Public Protection Casework Unit at NOMS headquarters should ensure that appropriate priority is given to dealing with applications for compassionate release for terminally ill prisoners and that decisions are not unnecessarily delayed.

Release on temporary licence (ROTL)

56. The man was considered for release on temporary licence following his initial admission to hospital on 14 February (ROTL - in certain circumstances, a prisoner may be allowed to leave prison on a temporary licence). Risk assessments were completed and he was released on special purpose licence on 23 February, so there was no escort from the prison. On 21 April, the escort risk assessment was reviewed due to his abusive behaviour towards hospital nurses. An operational manager adjusted the arrangements and one escort officer accompanied him, but he was still technically subject to ROTL. He remained on ROTL until 18 May when the risk assessment was again reviewed, following concerns raised by hospital and prison staff about his aggression and inappropriate sexualised behaviour. ROTL was withdrawn.
57. After a deterioration in his condition, the man was released on temporary licence again on 14 September. Although no officers were with him, Parc maintained regular telephone contact with the hospital.
58. The man was released on temporary licence, and prison staff were present when assessed as necessary to monitor and assess any change in risk. There is evidence that the risk assessment was reviewed regularly, and there was regular and proportionate contact between the prison and the hospitals. Although he was not formally released from his sentence he was able to die with dignity, without restraints and without the need for prison officers to guard him.

Liaison with the man's family

59. Prison Rule 22 says that:

“If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of a mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed.”

60. The co-ordinating prison chaplain was appointed as the family liaison officer on 14 February, after the man's admission to hospital. His nominated next of kin was his son, but there were some initial difficulties in contacting him. The chaplain obtained his sister's contact details from prison records and telephoned her. Later, she spoke to his son to explain the circumstances of his admission to hospital. Parc arranged for transport to take his sister to the hospital.

61. Over the next few months, the chaplain kept in contact with the man's sister and his son, providing transport when necessary and meeting them at the hospital to support them. In September, when he developed a chest infection, transport was arranged again so that his family could be with him. His sister was with him when he died and, as agreed, the chaplain telephoned his son to inform him of his father's death. The chaplain went directly to the hospital to support his family.

62. The chaplain and the Director of Parc visited the man's sister and son on 9 October. Funeral expenses were offered and his property was returned to his son. A memorial service was held at Parc on 15 October for all those that wished to pay their respects. The funeral was arranged for 24 October and conducted by the chaplain.

63. We consider family liaison was sensitive and appropriately managed throughout the man's hospital admission and after.

Restraints, security and bed watch

64. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was

degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

65. The man was taken by ambulance to hospital after his fall on 14 February 2012. He was not conscious when he left the prison. Although the Head of Security assured the investigator that he was not subject to restraints when he left Parc, the written risk assessment concluded that an escort chain was required (a two metre long escort chain with a cuff at either end). Later the same day, the risk assessment was reviewed by the deputy Director, and it clearly records that no restraints were to be used and the escort was reduced to two PCOs to one. Parc said that the original risk assessment was a mistake and the prison was clear that he was not restrained when he went to hospital. We accept this assurance but remind the prison of the need to ensure that written risk assessment take fully into account prisoners' health and mobility and how this impacts on their risk.
66. After his condition improved, hospital nurses and officers recorded regular aggressive outbursts and sexualised behaviour, and the man frequently tried to leave his room and enter other patients' rooms. As a result the escort risk assessment was reviewed. Initially this difficult behaviour was managed by having an escort of two PCOs, but his behaviour remained a concern.
67. On 29 May, escort officers contacted Parc and spoke with the Security and Operations Manager about the man's continuing aggressive and inappropriate behaviour and that nurses had no objection to restraints being applied. His risk was revised from medium to high risk to the public. The manager authorised the use of an escort chain at 11.35pm, to be removed for medical treatment, physiotherapy and showering. On 27 June, hospital staff asked officers to remove the escort chain to allow him to eat with other patients (as part of his rehabilitation programme), and the manager agreed. Restraints were never reapplied after that date.
68. A case conference took place between the prison and hospital to review the man's care and risk on 29 June. The Security and Operations Manager confirmed that although he was no longer restrained, two PCOs would remain at the hospital which would be reviewed and reduced to one if he continued to pose no further threat to staff or nurses. The escort was reduced to one officer on 3 July.
69. The escort risk assessment was regularly reviewed and medical opinion sought regarding the man's level of mobility and physical condition. Parc tried to manage an increased risk by having a two person escort, but this was not sufficiently robust. We recognise the officers' overriding concern at the time was to protect hospital and prison staff, other patients and their relatives. We therefore conclude that, in the circumstances, the decision to apply restraints was not unreasonable.

RECOMMENDATIONS

1. The Governor and Head of Healthcare at HMP Wandsworth should ensure that prisoners do not miss important hospital appointments and that reasons for non-attendance are fully recorded.

Accepted: *Review of all process related to hospital appointments and implementation of any necessary actions to improve.*

*Processes have been reviewed and improvements made as required.
Process:*

- *Daily check of all external appointments from previous day to be made directly with central detail and Repat by healthcare Administrator.*
- *Referring clinician and duty doctor alerted if appointment was not attended*
- *If patient declined to attend appointment disclaimer obtained and scanned onto patient record*
- *Details logged on SystmOne patient record*
- *Hospital contacted by healthcare Administrator to rebook appointment.*

To be implemented by 26.3.13:

Details of all non attendance of external appointments cancelled by prison to be collated and distributed to relevant healthcare and prison staff for weekly Governors briefing meeting.

2. The Director at Parc and the Head of the Public Protection Casework Unit at NOMS headquarters should ensure that appropriate priority is given to dealing with applications for compassionate release for terminally ill prisoners and that decisions are not unnecessarily delayed.

HMP Parc Response:

Accepted - *Parc accepts the recommendation and will always submit compassionate release applications in a timely manner. However, the decision on this occasion to not review his compassionate release on early parole was made by the Parole Board. The Director of HMP Parc does not have the authority to tell the Parole Board when to hold a hearing.*

HMP Parc now holds clinically vulnerable prisoner meetings on a weekly basis where this is a standing agenda item.

Public Protection Casework Unit at NOMS headquarters Response:

Accepted - *Applications for release on compassionate grounds are always prioritised. It is normal practice, in accordance with PSO 6000 to seek the Parole Board's advice where appropriate and if there is time to do so.*