Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Edwards a prisoner at HMP Highpoint on 9 August 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Richard Edwards died on 9 August 2017 of lung cancer while a prisoner at HMP Highpoint. He was 54 years old. We offer our condolences to Mr Edwards' family and friends.

We are satisfied that the care Mr Edwards received while at Highpoint was equivalent to that which he could have expected to receive in the community.

We are concerned that Mr Edwards, who was very ill and posed minimal risk, was restrained while receiving treatment. We have criticised the inappropriate use of restraints at Highpoint before. Despite having agreed to address those criticisms, the prison's risk assessments did not properly consider the case for restraints. The Governor should now take effective action to address this.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **March 2018**

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Summary

Events

1. On 29 September 2011, Mr Richard Edwards was convicted of drug related offences and remanded to HMP Winchester. On 30 September, he was sentenced to 20 years imprisonment. He was transferred to HMP Highpoint in February 2015. Mr Edwards had high blood pressure for which he took medication and healthcare staff reviewed him regularly.

2. On 9 March 2015, Mr Edwards complained of feeling dizzy. He had a blood test to check for any abnormalities. The results of the blood test were normal. Mr Edwards had a further blood test on 27 April to check for any cardiac or cerebral issues as he was still complaining of feeling dizzy and had chest pain. The results came back the same day and showed significant abnormalities. That evening, Mr Edwards was sent to hospital as an emergency.

3. While in hospital, further tests showed Mr Edwards had a brain tumour, secondary to a tumour in his right lung. On 22 May, he had surgery to remove the tumour and the hospital consultant prescribed steroids.

4. Between July 2015 and January 2017, Mr Edwards underwent two courses of radiotherapy treatment and nine courses of chemotherapy treatment. The final course of treatment made Mr Edwards unwell. The hospital oncologist advised Mr Edwards that continuing treatment would not be in his best interests and he was referred to the community palliative care team. Mr Edwards had a poor appetite and his condition slowly deteriorated.

5. On 22 July, Mr Edwards had a seizure in his cell and was admitted to West Suffolk Hospital. Mr Edwards remained on the hospital's Macmillan ward until 7 August when he was moved to a local hospice. He died two days later, on 9 August.

Findings

6. Mr Edwards' symptoms were not indicative of a brain tumour. The prison healthcare team responded promptly to his symptoms of dizziness and referred him for investigative tests, which diagnosed the brain tumour. Mr Edwards received a good level of physical, emotional and dietetic support from the prison healthcare team and his palliative care was exemplary. The clinical reviewer concluded that Mr Edwards' clinical care was comparable to that which he could have expected to receive in the community.

7. We are satisfied that the decision to allow Mr Edwards to remain on his wing and his involvement in decisions about his location were appropriate.

8. The prison, and in particular the head of healthcare, provided a good level of support to Mr Edwards' wife and family who were able to attend hospital appointments. Visits were facilitated regularly.

9. The prison did not take account of Mr Edwards' poor health when considering the use of restraints. The fact that restraints were not removed during treatment is particularly troubling.

10. We are satisfied that the prison completed the compassionate release process appropriately when Mr Edwards' condition was no longer suitable for treatment. However, the Governor did not resubmit the application for review when Mr Edwards' health deteriorated significantly, shortly before he died.

11. We make the following recommendations:

Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understands the legal position and that risk assessments show clear justification for the use of restraints.
- The Governor and Head of Healthcare should ensure that compassionate release applications are kept under review and resubmitted without delay when a prisoner's condition deteriorates significantly.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Highpoint informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Edwards' prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Edwards' clinical care at the prison.

15. We informed HM Coroner for Greater Suffolk of the investigation who informed us of the cause of death. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Edwards' wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. The deceased's wife raised the following issues:

    - the provision of updates on Mr Edwards' condition;
    - family attendance at hospital appointments;
    - Mr Edwards' care during treatment;
    - communication from the prison about Mr Edwards' admissions to hospital;
    - extra resources and dietary support for Mr Edwards;
    - Mr Edwards' location; and
    - the compassionate release process.

17. The investigation has assessed the main issues involved in Mr Edwards' care including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family and whether compassionate release was considered.

18. Mr Edwards' wife received a copy of the initial report. She raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Highpoint

20. HMP Highpoint is a medium security prison on two sites, Highpoint South and Highpoint North, and holds up to 1,319 men. Care UK provides general and mental healthcare services at the prison. The healthcare centre is open from 7.45am to 6.15pm, Monday to Friday, and from 8.00am to 6.00pm at weekends. Care UK delivers the GP Services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

21. The last inspection of HMP Highpoint was in October and November 2015. Inspectors reported that health services were reasonable and continued to improve, with good local partnership arrangements and effective governance processes. Prisoners were treated respectfully and could access an appropriate range of services. Operational leadership was clear and staffing levels appropriate. The skill mix reflected need. Staff had good access to relevant training and development opportunities. There was good access to appointments, both within the prison and externally. External appointments were risk rated to ensure that critical appointments were prioritised. Cancellations were rare and activity was monitored routinely.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2016, the IMB reported that a Board member regularly attended the Healthcare Forums, Governance and Service Delivery and Pharmacy meetings, when they were held. Regular multi-agency meetings ensured prisoners' health needs were met and communicated appropriately. The Board noted that service delivery, as far as possible, mirrored that which could be found in the community. The waiting time to see the GP was 7 days from putting in an application and emergencies were seen the same day.

Previous deaths at HMP Highpoint

23. Mr Edwards was the first death from natural causes since July 2014. We have made recommendations to Highpoint on two occasions about the risk assessment process for the use of restraints.

Findings

The diagnosis of Mr Edwards' terminal illness and informing him of his condition

24. On 29 September 2011, Mr Richard Edwards was convicted of drug related offences and remanded to HMP Winchester. On 30 September, he was sentenced to 20 years imprisonment. Mr Edwards was Jamaican and due to the seriousness of his offences, was liable for deportation to Jamaica at the end of his sentence. He was transferred to HMP Highpoint in February 2015.

25. During Mr Edwards' health screen at Highpoint, he said he was a smoker and had a history of high blood pressure and high cholesterol, for which he was taking medication.

26. On 9 March 2015, Mr Edwards saw Dr A, a prison GP, as he had been feeling dizzy since arriving at Highpoint. Dr A could find no serious cause for the dizziness aside from slightly raised blood pressure and referred him for a full blood test. Mr Edwards had the blood test on 13 April, and the results were normal.

27. On 27 April, Dr B saw Mr Edwards who said he had had daily headaches and chest pain for the last two days. Dr B did an electrocardiogram (ECG - a test to check the heart's rhythm and electrical activity), which was normal. He also requested another blood test to include troponin (a protein released into the blood during a heart attack) and creatine kinase (an enzyme in the blood, which can indicate heart attack, muscle injury or a cerebral event.)

28. The blood results came back that afternoon and showed Mr Edwards' creatine kinase level was abnormally high. Dr B sent Mr Edwards to the Accident and Emergency department at West Suffolk Hospital as an emergency.

29. While in hospital, Mr Edwards had a computerised tomography (CT) scan (an imaging procedure that uses special x-rays to create detailed scans of areas inside the body) and a magnetic resonance imaging (MRI) scan (a scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.) The results showed a tumour in his brain and right lung. The hospital doctors explained the test results to Mr Edwards and his wife but could not give a definitive diagnosis until further specialists had seen him.

30. Ms Z, head of healthcare, visited Mr Edwards in hospital on 6 May to discuss his care needs in preparation for his return to Highpoint. He was able to meet his own care needs and although he had not had a seizure, was at risk due to his condition. Hospital doctors prescribed a steroid to help reduce swelling to his brain.

31. On 9 May, Mr Edwards was discharged from hospital and was sent back to Highpoint. Healthcare staff implemented a care plan to ensure his physical and care needs were met. Due to the steroid treatment, Mr Edwards'

appetite was raised. Prison staff provided extra food at meal times. Ms Z and the prison healthcare staff visited Mr Edwards on the wing daily.

32. On 22 May, Mr Edwards went to the hospital for surgery to remove his brain tumour. The operation was successful and he was returned to Highpoint on 27 May.

33. On 4 June, Mr Edwards attended an appointment with a neurosurgeon as a follow-up to the surgery. The neurosurgeon said that Mr Edwards had a primary cancerous tumour to his right lung and the secondary tumour had been to his brain. The neurosurgeon said that his prognosis should be good. When he returned to Highpoint, Mr Edwards appeared positive when speaking to staff and thanked them for their support.

34. During an appointment with the Macmillan team on 11 June, Mr Edwards was told that his condition was not curable and he had a prognosis of about six to eight months without treatment. Chemotherapy and radiotherapy treatment might give a longer prognosis. The news shocked Mr Edwards and healthcare staff discussed his treatment options and offered him support.

35. Mr Edwards had presented with symptoms of dizziness, which was thought to be due to his blood pressure. Appropriate investigation of his symptoms and admission to hospital revealed a diagnosis of a brain tumour, secondary to a lung tumour. We are satisfied that prison healthcare staff acted in a timely manner, responding appropriately to the symptoms he presented.

Mr Edwards' clinical care

36. Healthcare staff saw Mr Edwards daily to ensure his needs were being met and to discuss how he was feeling. The prison mental health team saw Mr Edwards regularly in his cell to talk to him and offer support. While he was having treatment, the prison kitchen made efforts to provide extra food and ingredients to make bespoke meals. Ms Z purchased extra food for Mr Edwards, such as soups, fish and noodles.

37. On 18 June, Mr Edwards attended an appointment with a hospital consultant along with his wife and Ms Z to discuss his condition and treatment options. Mr Edwards decided to have radiotherapy treatment. He started the treatment on 5 July and completed the course on 22 July. During the course of the treatment, he suffered the side effect of vomiting and a hospital doctor prescribed anti-sickness medication.

38. Mr Edwards had three rounds of chemotherapy between 3 September and 12 October. He did not experience any adverse side effects and a CT scan showed the cancer remained stable but had not reduced. The hospital oncologist advised that Mr Edwards could have three more cycles of chemotherapy treatment.

39. Mr Edwards underwent the chemotherapy and on 28 January 2016, attended an oncology review. The oncologist said the disease remained stable but had not reduced. Mr Edwards decided to undergo a palliative

course of radiotherapy to the lung tumour and lymph nodes in his chest. He completed palliative radiotherapy on 3 March.

40. On 30 May, Mr Edwards was admitted to West Suffolk Hospital as an emergency because he had had a seizure thought to be due to using Spice (a New Psychoactive Substance). He told the hospital and escorting staff that he had taken Spice and there were intelligence reports indicating his use of Spice and cannabis at Highpoint. On 7 June, he was transferred back to Highpoint. During his time in hospital, a physiotherapist completed a needs assessment. She advised Highpoint healthcare staff that he needed assistance mobilising and encouragement to eat and drink.

41. On 9 June, Mr Edwards attended an oncology review. The oncologist said that a recent CT showed the cancer was stable. However, the formal report of the CT scan on 29 June showed that cancer had progressed to Mr Edwards' liver and he was probably not fit enough to have more treatment. The oncologist asked a prison GP to speak to Mr Edwards and his family about the results. It is not clear from the medical records who spoke to Mr Edwards, but he was aware that his condition had progressed and prison healthcare staff continued to offer support.

42. On 7 July, an occupational therapist and social worker assessed Mr Edwards' needs. They advised on the equipment needed to help Mr Edwards maintain independent self-care, which the prison provided.

43. On 19 August, Mr Edwards attended an oncology review. The oncologist discussed the results of the last CT scan, which showed no change in size to the lesion in his lung, but a new lesion in his liver. The consultant advised him to have another scan in a month to check for growth of the liver lesion.

44. On 13 October, Mr Edwards attended a follow-up oncology review. The repeated CT scan showed the cancer had progressed again and the oncologist offered Mr Edwards chemotherapy to his liver, which he accepted.

45. Mr Edwards started the first course of chemotherapy in October which caused toxicity (symptoms such as vomiting, diarrhoea, mouth ulcers and nerve damage.) He had another round of reduced chemotherapy in December, and was able to tolerate it.

46. Mr Edwards started the third course of chemotherapy treatment in January 2017 but it made him feel unwell. On 12 January, an oncologist advised Mr Edwards that further treatment would not be in his best interests and he had a prognosis of about six months. The oncologist referred Mr Edwards to the community palliative care team at the local hospice

47. On 8 March, Dr C, a prison GP, prescribed a long lasting opiate-based pain relief patch, which Mr Edwards said was adequate at relieving his pain. He had a poor appetite and his condition slowly deteriorated.

48. On 18 April, Mr Edwards was sent to the local hospital for treatment for dehydration. On 24 April, he was transferred to the hospice for anti-sickness treatment and pain relief. During a discussion with the palliative

care consultant at the hospice, Mr Edwards said he did not want anyone to resuscitate him if his heart or breathing stopped and signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order. A DNACPR means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided. On 2 May, he was transferred back to Highpoint and healthcare staff implemented an end of life care plan.

49. On 13 July, Mr Edwards was sent to the local hospital suffering from dehydration due to reduced fluid intake. While in hospital, the palliative care team and a dietician assessed Mr Edwards. Despite their intervention, his fluid intake remained poor and he was sent back to Highpoint on 19 July.

50. On 22 July, healthcare staff found Mr Edwards on the floor of his cell after he had had a seizure. He was sent to West Suffolk Hospital. Test results showed his kidney and liver function had deteriorated. At 6.30pm, hospital staff discussed Mr Edwards' condition with him and his family. They agreed that the best option for him was to receive symptom control and supportive care. Mr Edwards was moved to the hospital's Macmillan ward the following morning and the ward staff started a syringe driver (a small battery operated pump that gives continuous medication through a syringe placed under the skin) to keep him comfortable and pain free.

51. Mr Edwards' condition continued to deteriorate and on 7 August, he was moved to the local hospice. He died two days later, on 9 August.

52. Mr Edwards' clinical care at Highpoint was good. There is evidence of appropriate communication with secondary services, which staff documented well in the medical record. Prison and healthcare staff offered Mr Edwards a good level of physical, emotional and dietetic support.

53. The clinical reviewer found that Mr Edwards received pro-active treatment to prolong his life, until it was no longer in his best interests. His palliative care was exemplary and his medication was appropriate at all times. We are satisfied that this was equivalent to that which he could have expected to receive in the community.

Mr Edwards' location

54. Mr Edwards lived on a normal wing. He was located near his carer, who helped him to collect meals and pushed his wheelchair to attend visits or healthcare.

55. On 7 June 2016, after being discharged from hospital, Mr Edwards was moved to a ground floor cell. He was happy on the wing due to the support network he had. Additional resources such as a pressure reliving mattress, foam wedge and wheelchair were provided to enable him to stay on the wing.

56. In February 2017, Mr Edwards said he wanted to be considered for a move to the palliative care wing at HMP Norwich but a bed was not available. Mr Edwards later said he wanted to stay at Highpoint because of his support network and so his family could visit easily.

57. On 22 April, Mr Y, a prison chaplain, visited St Nicholas Hospice with Mr Edwards' wife, which she said she had liked. On 24 April, Mr Edwards was sent to the hospice for a week for assessment and pain relief control. He was then returned to his wing at Highpoint.

58. After a hospital admission following a seizure, Mr Edwards was moved to St Nicholas hospice on 7 August for end of life care.

59. We are satisfied that Mr Edwards' location was appropriate and the prison respected his wishes. Healthcare and prison staff reviewed his needs regularly and appropriate collaboration with local social care services ensured he was able to remain on the wing safely with appropriate additional resources.

Restraints, security and escorts

60. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

61. From 2015, when he had been diagnosed with cancer to August 2017, Mr Edwards attended hospital on many occasions for appointments, treatment and admissions. The risk assessments that the prison provided showed that throughout his illness the information recorded in the risk assessments did not change. This is concerning given that his condition deteriorated significantly in late 2016 and into 2017.

62. The risk assessments referred to intelligence about Mr Edwards' history of drug use, violence and mobile phone possession while at Highpoint and that he was subject to deportation. His security risk to the public, of escape and hostage taking was, though, recorded as low. The only medical information provided was that he was responsive and there were no objections to the use of restraints.

63. There was no healthcare input to the risk assessment that addressed the impact of Mr Edwards' condition on his level of risk. On each occasion, a prison manager authorised the use of a single cuff and escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). There is no evidence that restraints were removed while Mr Edwards received chemotherapy treatment.

64. When Mr Edwards was sent to hospital on 18 April, initial risk assessments show that escorting staff applied a single cuff and escort chain but removed

them the next day because he was frail and not very mobile. The cuffs were not reapplied. In July, though, Mr Edwards was restrained during a hospital admission with a single cuff and escort chain. Although the risk assessment states Mr Edwards was unwell, the escort staff did not remove the restraints at any time.

65. On 22 July, when Mr Edwards was taken to hospital, Prison Manager Ms D authorised the use of a single cuff and escort chain. At 12.30pm, Officer E, one of the escort officers sought permission from Ms D to remove the restraints at the request of hospital staff in case they needed to treat Mr Edwards in an emergency. Officer E said at 1.30pm, he reapplied the restraints in accordance with the prison risk assessment that stated restraints should be applied unless receiving treatment. At 6.50pm, prison manager Mr F gave permission for the restraints to be removed and they were not reapplied.

66. There is insufficient medical information in the risk assessment to inform the consideration of risk required by the High Court judgement. The risk assessments did not change as Mr Edwards' condition deteriorated. We are particularly concerned that restraints remained in place while Mr Edwards was receiving treatment. When Mr Edwards went to hospital on 22 July, Officer E said he was not very responsive. It is difficult to see that the use of restraints was justified in these circumstances. Appropriately, Mr Edwards was not restrained when he was transferred directly from the hospital to the hospice on 7 August.

67. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. The High Court judgement sets out very clearly the conditions, which need to be met to justify the use of restraints. It is the Governor's responsibility to ensure that the process is managed properly, and all prison managers need to show a clear justification for any use of restraints when carrying out the risk assessment.

68. We are concerned that this is the third time we have expressed concern about the inappropriate use of restraints on very infirm prisoners at Highpoint. The prison's response in 2015 said that '…all future risk assessments will evidence the actual risk posed at the time of escort and all risk assessments carried out will be monitored via external and internal audits processes'. There is no evidence from this investigation that this has happened and we make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understands the legal position and that risk assessments show clear justification on the use of restraints

Liaison with Mr Edwards' family

69. When Ms Z visited Mr Edwards in hospital on 6 May, she offered to be the point of contact for his wife. At Mr Edwards' request, Ms Z only shared information with the family that he had previously approved.

70. Ms Z and Mr Y provided on-going support to Mr Edwards' wife and family. His wife was able to attend hospital consultant appointments and multi-disciplinary meetings. If she was not able to attend any appointments, Ms Z attended and updated her accordingly. Mr Edwards' family had direct contact with the community palliative care team. They were also able to attend pastoral visits in the prison chapel. Such restrictions as were put in place were in accordance with prison policy.

71. After Mr Edwards' death, Mr Y went to the hospice to offer support to Mr Edwards' family. Mr Y provided on-going support to Mr Edwards' family and the prison made a financial contribution to the funeral in line with national policy. We are satisfied that the prison gave Mr Edwards' family a good level of support.

Compassionate release

72. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order 6000. Among the criteria is 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) of the Her Majesty's Prisons and Probation Service

73. The prison started Mr Edwards' compassionate release application in December 2016. Mr Edwards' probation officer, Mr X and Ms Z provided a contribution to the application on his risk of re-offending and medical condition, which included correspondence from the oncology consultant, noting his condition was progressive and for palliative care but that there was no information about a definitive prognosis. Both Mr X and Ms Y assessed that his risk of re-offending was low and supported his early release.

74. On 24 February, Mr G, the prison Governor completed the compassionate release application. He said that although Mr Edwards' condition was life threatening, his risk of re-offending had not sufficiently reduced for him to be able to support the application. Mr G submitted the application to PPCS to consider on behalf of the Secretary of State for Justice.

75. On 17 April, PPCS officials wrote to Mr Edwards explaining that his application for compassionate release was refused. The reasons provided

included that the progression of Mr Edwards' condition and prognosis was difficult to predict, he was not receiving end of life care, so did not meet the medical criteria and there was no evidence that at that time that the prison could not adequately meet his care needs. It was also noted that he had seven convictions for offences between 1983 and 2004 and, alongside his index offence, showed a significant escalation in offending behaviour. As Mr Edwards was able to self-care, there was nothing to suggest that his current condition would render him unable to re-engage in offending behaviour.

76. We are satisfied that the prison appropriately considered the initial application for compassionate release and submitted the application for consideration by PPCS. Mr Edwards' condition did not change significantly enough for the prison to reconsider the application for compassionate release prior to his hospital admission on 22 July.

77. However, when Mr Edwards was admitted to hospital on 22 July, the hospital doctor explained that he was entering the end of life stage. The prison did not take any pro-active steps to resubmit the compassionate release application in light of the deterioration in Mr Edwards' condition. We make the following recommendation:

The Governor should ensure that compassionate release applications are kept under review and resubmitted without delay when a prisoner's condition deteriorates significantly.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141