Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Baldwin a prisoner at HMP Littlehey on 6 August 2018

A report by the Prisons and Probation Ombudsman

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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*

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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.

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

Mr James Baldwin died on 6 August 2018, of a blood clot in his lungs, at HMP Littlehey. He was 81 years old. I offer my condolences to Mr Baldwin's family and friends.

Mr Baldwin had a number of health issues, all of which were managed appropriately. Mr Baldwin's diagnosis of terminal blood cancer was explained to him properly, and he was supported well by healthcare staff who created, followed, and regularly updated his palliative care plan. We are satisfied that the care Mr Baldwin received was equivalent to that which he could have expected to receive in the community.

However, I am concerned that there was poor communication between healthcare and prison staff about the frequency of welfare checks.

I am also concerned that Mr Baldwin was restrained unnecessarily when he was taken to hospital for treatment, and I am very concerned that he was left lying naked on the floor of his cell for two long periods in the hour before he died.

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

Sue McAllister
Prisons and Probation Ombudsman **December 2018**

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Summary

Events

1. Mr Baldwin was serving a 15 year prison sentence for sexual offences and had been at HMP Littlehey since 8 January 2016. Mr Baldwin had a medical history of bladder cancer, cardiovascular disease, triple heart bypass and back pain.

2. In June 2016, Mr Baldwin was found to be anaemic and a prison GP referred him urgently to a specialist under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. After tests, hospital doctors said that there were no abnormalities in his gastrointestinal tract and that this was not the cause of his anaemia. He was treated with medication for iron deficiency and prison healthcare staff carried out regular blood tests to monitor his iron levels.

3. In November 2016, Mr Baldwin had a bowel cancer screen and the results were normal.

4. In July 2016, Mr Baldwin's blood tests showed abnormal results, so his iron deficiency treatment was restarted. In September he was referred to the haematology clinic at Hinchingbrooke Hospital because there had been no improvement in his iron levels. He underwent tests and on 11 December 2017, hospital doctors told him that he had myelodysplastic syndrome, an incurable form of blood cancer. Littlehey appointed a nurse and doctor to monitor Mr Baldwin's care.

5. Mr Baldwin's health started to deteriorate over the months that followed. On 19 June 2018, Mr Baldwin said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order.

6. On 17 July, Mr Baldwin told healthcare staff that he did not want any more blood transfusions or hospital treatment as he was getting little benefit. Two days later, he told staff that he did not want to be released and he wanted to die in prison with his friends, in a hospice or hospital. On 25 July, Mr Baldwin's health had deteriorated further and he signed an Advanced Decision to Refuse Treatment agreement. He remained on a standard wing throughout at his request.

7. At 5.30am on 6 August, an officer found that Mr Baldwin had fallen out of bed. Prison officers put him back in bed. At 6.15am, an officer found that he had fallen out of bed again. At 6.25am, staff called an emergency code blue because Mr Baldwin had stopped breathing. An ambulance was called immediately. Staff did not perform cardiopulmonary resuscitation (CPR) because Mr Baldwin had a DNACPR order in place.

8. At 7.15am, a paramedic confirmed that Mr Baldwin had died.

9. The post-mortem report gave the cause of death as a blood clot in the lungs with myelodysplastic syndrome and heart disease as contributory factors.

Findings

10. The clinical reviewer concluded that the care provided was of a high standard and commended both prison and healthcare staff for the care and compassion shown to Mr Baldwin. We agree with the clinical reviewer that the care Mr Baldwin received at Littlehey was equivalent to that which he could have expected to receive in the community.

11. However, the investigation found that on one occasion, shortly before Mr Baldwin's death, there was poor communication between healthcare and prison staff about how frequently he should be checked by staff. We are also concerned that healthcare staff did not give prison staff guidance on what to do if Mr Baldwin deteriorated at night when healthcare staff were not on site.

12. We are concerned that the risk assessments undertaken by the prison when Mr Baldwin went to hospital were not informed by medical information. We do not consider that it was appropriate or proportionate to use single cuffs and an escort chain, given that Mr Baldwin was in very poor health and was assessed as presenting a low risk of escape.

13. We are very concerned that Mr Baldwin was left lying naked on the floor of his cell for two long periods in the hour before he died. We consider that the officer who found him should have entered the cell and done what she could to make Mr Baldwin comfortable before other staff arrived.

Recommendations

- **The Head of Healthcare should ensure that healthcare staff provide prison staff with clear, written guidance on the management of prisoners who are seriously ill, including when they should seek out-of-hours medical advice.**

- **The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency, subject to a risk assessment, in order to help preserve the life of a prisoner.**

- **The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

- **The Governor should revise the prison's escort risk assessment form to ensure that it requires:**

    - **healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and**

    - **prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.**

The Investigation Process

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

15. The investigator obtained copies of relevant extracts from Mr Baldwin's prison and medical records. She interviewed one member of staff over the phone on 7 November 2018.

16. NHS England commissioned a clinical reviewer to review Mr Baldwin's clinical care at the prison.

17. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. The investigator wrote to Mr Baldwin's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

19. The investigation has assessed the main issues involved in Mr Baldwin's 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.

Background Information

HMP Littlehey

20. HMP Littlehey in Cambridgeshire is a medium security prison housing approximately 1,200 men. A high proportion of the prison's population are men who have been convicted of sexual offences.

21. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services at Littlehey. The prison healthcare centre is open from 7.30am to 7.30pm Monday to Friday, and from 8.00am to 5.30pm at weekends. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Littlehey was conducted in March 2015. Inspectors reported that a small group of GPs who regularly attended the prison had significantly improved patient care. Lifelong conditions were identified effectively and there was an appropriate range of clinics, led by specialist nurses. Hospital appointments for prisoners were rarely cancelled but risk assessments for keeping medications in-possession were not always reviewed and recorded correctly.

Independent Monitoring Board

23. 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 January 2018, the IMB reported that the prison's working relationship with the local hospice was positive, enabling men to opt for end of life care where they could be surrounded by family and friends. The IMB had concerns about the number of trained Family Liaison Officers being sufficient to deal with the large numbers of deaths in custody. It reported that the End of Life Suite, completed in 2013, continued to be unused due to a lack of funding.

Previous deaths at HMP Littlehey

24. Mr Baldwin's is the eighteenth death from natural causes at Littlehey in the last two years. This is the second time this year we have made a recommendation about the unjustified use of restraints at Littlehey.

Findings

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

25. Mr Baldwin was serving a 15 year prison sentence for sexual offences and had been at HMP Littlehey since 8 January 2016. Mr Baldwin had a medical history of bladder cancer, diagnosed in 1998, cardiovascular disease, triple heart bypass in 2007 and a long history of back pain.

26. On 16 June 2016, a prison GP saw Mr Baldwin because he reported a change in bowel habit and anaemia. The GP made an urgent referral to the colorectal clinic at hospital, under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

27. On 22 June, Mr Baldwin went to the hospital's gastrointestinal clinic for investigations. On 17 August, Mr Baldwin returned to the clinic and was told there were no abnormalities in his gastrointestinal tract and that this was not the cause of his anaemia. Mr Baldwin's anaemia was treated with iron deficiency medication. His bloods were monitored regularly by healthcare staff to track his reaction to the medication.

28. On 10 November, Mr Baldwin had a bowel cancer screen and the results were normal.

29. On 29 March 2017, a prison GP reviewed Mr Baldwin. His iron medication was stopped because his iron levels had improved but his bloods continued to be monitored in case this changed. On 24 July, Mr Baldwin's blood tests showed abnormal results, so his iron deficiency treatment was restarted.

30. On 4 September, Mr Baldwin was referred to the haematology clinic at hospital because there had been no improvement in his iron levels after a course of iron treatment. Mr Baldwin continued to be tested and reviewed by the consultant haematologist. He underwent a bone marrow biopsy on 20 November.

31. On 11 December, Mr Baldwin went to the haematology clinic. He was told that he had myelodysplastic syndrome, an incurable form of blood cancer.

32. On 15 January 2018, a prison GP reviewed Mr Baldwin and discussed his blood cancer. Mr Baldwin understood his illness and had no questions for the doctor. A nurse was appointed to monitor Mr Baldwin, with oversight and occasional appointments with the prison GP.

33. We are satisfied that healthcare staff appropriately investigated Mr Baldwin's symptoms, made timely referrals to secondary care providers and discussed his diagnosis with him.

Mr Baldwin's clinical care

34. On 19 February and 23 April 2018, Mr Baldwin was reviewed by the haematology clinic. There was no change in the management of his illness. On both occasions Mr Baldwin was escorted by two officers and restrained. On the first visit he was restrained using an escort chain and on the second visit, single cuffs were used.

35. On 23 May, a nurse saw Mr Baldwin at the prison's clinic because he reported feeling unwell. His pulse was outside the normal range so he was taken to hospital. Mr Baldwin was escorted by two officers and was restrained using single cuffs. Mr Baldwin was admitted to hospital and treated for an infection with a seven-day course of antibiotics and a blood transfusion. The restraints were removed at 2.15pm the following day due to his poor health. Mr Baldwin was discharged from hospital on 25 May, and was transferred back to Littlehey.

36. On 8 June, Mr Baldwin was admitted to hospital and was treated for white blood cell sepsis. Later the same day, in response to his increasing ill health, a palliative care plan was created.

37. On 11 June, a nurse emailed the safer custody team to recommend that a family liaison officer (FLO) be appointed and for staff to start the compassionate release process. The next day, an officer was appointed as the FLO. However, the compassionate release application could not be completed because there was no confirmation from Mr Baldwin's consultant that he had less than three months to live.

19. On 19 June, Mr Baldwin told healthcare staff that he did not want anyone to resuscitate him if his heart or breathing stopped, and signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made).

20. On 10 July, Mr Baldwin was feeling unwell. He was examined by a nurse who found that his pulse and oxygen saturations were outside of the normal range. Mr Baldwin was sent to hospital by emergency ambulance and received a blood transfusion. He was not restrained. He was discharged from hospital to Littlehey the same day.

21. On 16 July, Mr Baldwin was taken to hospital to have his blood tested. He was offered a blood transfusion but he refused.

22. On 17 July, prison staff started the compassionate release process. Mr Baldwin told a prison GP that he wanted to stay at Littlehey until he became bedridden or until the nurses were unable to support him. He also said that he no longer wanted any blood transfusions or hospital treatment as he was getting little benefit. Two days later, Mr Baldwin told staff that he did not want to be released and wanted to die in prison with his friends, or in a hospice or hospital if his care needs became too great to be managed in prison. Staff respected Mr Baldwin's wishes and stopped the compassionate release process.

23. On 25 July, the palliative care consultant reviewed Mr Baldwin. Mr Baldwin's health had deteriorated further and he signed an Advanced Decision to Refuse Treatment agreement. Mr Baldwin was prescribed buprenorphine and oromorph to help manage his pain. This was reviewed on 30 July, and Mr Baldwin confirmed he had been pain free since 25 July.

24. From 31 July, it was noted daily in the wing observation book that prison staff should conduct a welfare check on Mr Baldwin every two hours. A Custodial Manager (CM) told the investigator that this decision was made because staff recognised that Mr Baldwin was becoming increasingly unwell.

25. On 2 August, a prison GP saw Mr Baldwin. She reviewed his medication and discussed his location. Mr Baldwin confirmed that he would prefer to remain on the wing with his friends. She recorded that she ‘handed over to officers on the wing – hourly checks in place’ but she did not record how she relayed this information or who she relayed it to. It is not clear whether this instruction reached prison staff correctly, or whether the information was incorrectly recorded, because the level of checks was not increased.

26. The ongoing record of checks show that prison staff checked Mr Baldwin at least every two hours, but often completed additional ad hoc checks. We are concerned that there was poor communication between healthcare and prison staff as an instruction given by a GP was not actioned by prison staff. Although increased welfare checks would not have prevented Mr Baldwin’s death, they might be critical in future cases. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff provide prison staff with clear, written guidance on the management of prisoners who are seriously ill, including when they should seek out-of-hours medical advice.

27. On 3 August, a nurse noted that Mr Baldwin was lethargic and very frail. He was sitting up in bed and told her he was not in any pain. The following day, a nurse noted that Mr Baldwin appeared brighter. She reminded him to keep using his oromorph to maintain his pain relief. On 5 August, Mr Baldwin was noted to be slightly drowsy and lethargic but free from pain.

28. At 5.30am, on 6 August, an officer checked on Mr Baldwin and found him out of bed, lying on the floor, naked. He was conscious and kept saying ’hello’ over and over again. She said she went to the office to phone for assistance. She stayed outside Mr Baldwin’s door and spoke to him through the observation panel while she waited for other officers to arrive.

29. After about 15 mins, three officers and a Temporary Custodial Manager (TCM) arrived and entered Mr Baldwin’s cell. The officer who had found Mr Baldwin, said she stood outside for decency reasons.

30. In his witness statement, the TCM said that Mr Baldwin was conscious but struggling to communicate verbally. He had urinated on himself. The TCM said that he communicated with Mr Baldwin by speaking to him and Mr Baldwin responded by putting his thumbs up or down. Mr Baldwin confirmed he was not in any pain. The three officers covered Mr Baldwin, lifted him back into bed, and adjusted his bedding and pillows to make him comfortable. The TCM told Mr Baldwin that the night officer would continue to check on him and that healthcare staff would visit him as soon as they started their shift. Mr Baldwin gave the thumbs up. The TCM said he believed that Mr Baldwin understood what was being said to him.

31. At 6.15am, an officer checked on Mr Baldwin. She saw that he had fallen out of bed again and was lying on the floor. She told the investigator that she could see that Mr Baldwin was breathing, his eyes were open but he was not looking at her. She went to the office to phone for assistance and while waiting, she stayed outside of Mr Baldwin’s cell and kept talking to him. After about ten minutes, she noticed that Mr Baldwin’s breathing slowed and he appeared to stop breathing.

The officer said she went to the office and used the phone to call a code blue emergency (indicating that a prisoner is unconscious, not breathing or is having breathing problems). She did not enter the cell. She said that it took about five minutes for the TCM and another officer to arrive and enter Mr Baldwin's cell.

32. The TCM checked Mr Baldwin for signs of life but found none. (All Senior Officers are first aid trained at Littlehey.) He did not start CPR because they knew that Mr Baldwin had a DNACPR in place.

33. At approximately 7.05am paramedics arrived to check Mr Baldwin for signs of life. At 7.15am, a senior paramedic confirmed that Mr Baldwin had died.

Mr Baldwin's location

34. Mr Baldwin was located on I wing, a residential wing, designated for older prisoners. He was offered a move to the healthcare suite on A wing twice, where there were more facilities to help manage his care (such as hospital beds, pressure relieving mattress and walk-in showers). On both occasions, Mr Baldwin refused to move and said that he wanted to stay on I wing with his friends. Although the residential wing was not an appropriate location for Mr Baldwin, due to his deteriorating health, staff respected his wishes and he remained on I wing until he died.

35. We are satisfied that the prison respected Mr Baldwin's wishes while still delivering a good standard of care. Healthcare staff visited him in his cell to support his daily needs and provide appropriate medication as his discomfort increased and as he neared the end of his life.

36. However, Littlehey does not have 24-hour healthcare and we are concerned that healthcare staff gave prison staff no advice about what they should do if Mr Baldwin's condition deteriorated during the night. Although Mr Baldwin had signed a DNACPR order, prison staff still needed to know when it might be necessary for them to seek advice from an out-of-hours doctor.

37. We also share the IMB's concern that the End of Life Suite at Littlehey cannot be used because of funding issues. This would have been a better location for Mr Baldwin if it had been in use.

Emergency response

38. We are very concerned that in the hour before he died, Mr Baldwin was left lying on the floor alone in his cell for at least 15 minutes, and that he had been lying on the floor alone in his cell again for at least 10 minutes when he died. On both occasions he was found, the officer called for assistance and then stood outside the door of the cell observing Mr Baldwin through the panel in the cell door until other staff arrived.

39. Prison Service Instruction (PSI) 24/2011 gives national instructions for entering cells at night. The PSI says that under normal circumstances, the night orderly officer (NOO) must give authority to unlock a cell at night and a cell should be opened with a minimum number of staff (according to local risk guidelines) present. However, the PSI goes on to say that the preservation of life must take precedence over this. Where there is, or appears to be, a threat to life, staff may

open and enter cells on their own if they feel safe to do so, having performed a dynamic risk assessment and informed the control room.

40. Littlehey's local instructions about opening a cell during the night say that entry must be authorised by the NOO, and a minimum of two/three staff should be present, one being the NOO. However, if a member of staff finds a prisoner in a cell where the prisoner's life is in immediate danger they must consider entering the cell, but they should not take any action that they feel would put themselves or other in unnecessary danger.

41. The officer who found Mr Baldwin told the investigator that she did not normally work on Mr Baldwin's wing and did not know him. She said that when she started her shift, she was told in the handover that Mr Baldwin was 'fine' but that she should conduct 'random checks' on him because he was 'not very well'. She said she checked him every couple of hours.

42. The officer said that as a lone female on a male sex offender wing she did not feel safe going into the cell on her own and that, for her own safety and to avoid false allegations, she would never enter a cell by herself when she was alone on a wing. She also said that she was not medically trained and could not, therefore, have done anything to help Mr Baldwin if she had entered the cell.

43. We are concerned that the officer was not briefed at the start of her shift that Mr Baldwin was terminally ill, very frail and nearing the end of his life. The prison had chosen to keep Mr Baldwin on a normal wing in response to his wishes and should have taken steps to ensure that staff who might have contact with him were aware of his situation, especially at night when healthcare staff were not on duty. If the officer had known how ill Mr Baldwin was, we consider that she should have entered the cell the first time she found him on the floor instead of leaving him there on his own for 15 minutes until other staff arrived.

44. We are also concerned that, after responding to Mr Baldwin's needs the first time, the TCM should have given the officer clear guidance on what to do, including entering the cell, if there were any further problems.

45. However, even without guidance, when the officer found Mr Baldwin on the floor the second time, she had seen for herself how frail he was and we consider that she should have entered the cell and called a code blue on her radio. It is particularly difficult to understand why she did not enter the cell when she thought that Mr Baldwin had stopped breathing. We appreciate that the officer was not first aid trained and that Mr Baldwin had a DNACPR order in place, but she might have been able to make Mr Baldwin more comfortable and allow him to die with more dignity.

46. We recommend that:

The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency, subject to a risk assessment, in order to help preserve the life of a prisoner.

Restraints, security and escorts

47. 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 judgment 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.

48. After Mr Baldwin's diagnosis in December 2017, he went to hospital six times and was escorted by two officers on each occasion. On the first three visits Mr Baldwin was restrained using either an escort chain or a single cuff. All three risk assessments recorded that Mr Baldwin was a Category C prisoner, that he was a wheelchair user and that there were no medical objections to the use of restraints. Mr Baldwin was assessed as a low risk of escape and a medium risk to the public.

49. We are concerned that restraints were used. We do not consider that this was proportionate to the risks he posed, over and above the control already available through the escorting officers, given that he was 81, his health was clearly deteriorating and he had poor mobility.

50. It is the Governor's responsibility to ensure that the risk assessment process is managed properly, and all prison managers need to show a clear justification for any use of restraints in carrying out the risk assessment. Healthcare staff also need to understand their role in assessing the impact the prisoner's current state of health has on his mobility. We are concerned that the prison's escort risk assessment form does not make this sufficiently clear.

51. We do recognise that Mr Baldwin was not restrained on his final three hospital visits because of his age and ill health. We are satisfied that the prison's risk assessment on this occasion fully considered the medical implications for use of restraints. We make the following recommendations:

    The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

    The Governor should revise the prison's escort risk assessment form to ensure that it requires:

    - **healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and**
    - **prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.**

Liaison with Mr Baldwin's family

52. On 11 June 2018, an officer was appointed as the family liaison officer (FLO) for Mr Baldwin, a member of the chaplaincy team was the Deputy FLO. Mr Baldwin had named his daughter as his next of kin, but contact was not appropriate as she and her children were the victims of Mr Baldwin's offences. The FLO contacted Mr Baldwin's probation officer and told them about his ill health, and they informed the victim liaison officer (VLO) for Mr Baldwin's daughter.

53. Initially, Mr Baldwin's daughter decided that she did not want to be contacted directly by the FLO, and that any information about Mr Baldwin should be given to her via her VLO. On 17 July, the VLO contacted the FLO and told him that Mr Baldwin's daughter wanted to visit Mr Baldwin.

54. On 25 July, Mr Baldwin met with his daughter at Littlehey. The deputy FLO and another member of staff were present and Mr Baldwin's daughter was accompanied by her husband. The deputy FLO told the investigator that the meeting was difficult at times, but positive overall. Mr Baldwin's daughter later told the FLO that when Mr Baldwin died she wanted her husband to be informed by telephone. On 6 August, the deputy FLO phoned Mr Baldwin's daughter's husband, to tell him that Mr Baldwin had died. He later told the deputy FLO that neither he nor Mr Baldwin's daughter would be attending the funeral.

55. Mr Baldwin's funeral was held on 25 September and was conducted by the deputy FLO. No family members attended. The prison contributed to the funeral costs in line with national policy.

Compassionate release

56. Prisoners can be released from custody on compassionate grounds before their sentence has expired for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

57. In July 2018, prison staff started a compassionate release application but stopped the process after Mr Baldwin said that he wanted to stay in the prison. He felt that leaving prison would be too stressful and he wanted to remain with his friends and under the care of healthcare staff who knew him.

58. We are satisfied that the prison appropriately considered compassionate release.

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