Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Reginald Swinscoe a prisoner at HMP Thameside on 6 July 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 Reginald Swinscoe died of lung cancer on 6 July 2018 while a prisoner at HMP Thameside. He was 77 years old. I offer my condolences to his family and friends.

The investigation found that the healthcare that Mr Swinscoe received at Thameside was of a good standard and equivalent to that which he could have expected to receive in the community.

However, it is important that terminally ill prisoners not only receive the correct medical treatment, but that all aspects of their wellbeing are considered so that, within the constraints of their status, prisoners are able to die with dignity.

I am concerned that Mr Swinscoe was restrained during his final admission to hospital six weeks before he died. The use of restraints was not justified by a fully considered risk assessment which took into account his age, his limited mobility, his very poor health and that he was receiving end of life care.

I am concerned that Mr Swinscoe's family were only allowed to visit him in the prison inpatient unit once a week during the last few weeks of his life, and I consider that the Director should have used his discretion to allow more frequent visits.

Mr Swinscoe's family were at the prison when he died but were denied the opportunity to view his body. I would have expected staff to have approached the Coroner to see whether this might have been possible, and I am concerned that this did not happen.

Although prison and healthcare staff did liaise with Mr Swinscoe's family, I am concerned that a family liaison officer was not appointed until after Mr Swinscoe had died. I consider that a suitably trained family liaison officer would have been able to provide better support to Mr Swinscoe and his family and might have helped the prison avoid some of the mistakes it made.

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 CB
Prisons and Probation Ombudsman **February 2019**

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Summary

Events

1. On 9 May 2017, Mr Reginald Swinscoe was remanded to HMP Thameside, charged with sexual offences. In 2016, he had been diagnosed with lung cancer and had had radiotherapy. When he arrived at prison, the cancer was stable and staff referred him to hospital to monitor his condition.
2. On 19 June, Mr Swinscoe was sentenced to four years in prison, and returned to Thameside.
3. In September 2017, Mr Swinscoe was told that the lung cancer had got worse. He started radiotherapy in October and had five sessions. The cancer was not cured but was stable, and healthcare staff at Thameside continued to monitor his health and manage his symptoms.
4. In May 2018, Mr Swinscoe's health declined significantly and he spent just under three weeks in hospital. He was initially restrained with a single cuff which was reduced to an escort chain two days later. The restraints were finally removed four days later as he was terminally ill and immobile.
5. A hospital doctor recommended that Mr Swinscoe be discharged from hospital to a hospice, but prison staff did not consider this was possible. On 14 June, he returned to Thameside where he was given end of life care and staff focused on managing his pain. He died on 6 July 2018.

Findings

Clinical care

6. The clinical reviewer concluded that the care that Mr Swinscoe received at HMP Thameside was equivalent to that which he could have expected to receive in the community. He received continuity of care, treatment and specialist care for his lung cancer, and received appropriate end of life care. Healthcare staff used a multidisciplinary approach to manage his health needs, and also met his social care needs.

Restraints

7. Prison managers authorised the use of restraints during Mr Swinscoe's final admission to hospital in May/June 2018. When staff assessed Mr Swinscoe's security risk they failed to take into account his low risk of escape and the impact of his poor health and very limited mobility, as they should have done.

Family liaison

8. Mr Swinscoe's family were unhappy that they were only allowed to visit Mr Swinscoe once a week when he was in the prison inpatient unit during the last three weeks of his life. Prison Service Instruction (PSI) 64/2011 says that prisoners who have a terminal illness must be encouraged to engage with their families and we consider that the Director should have exercised his discretion to

allow Mr Swinscoe's family to visit him more frequently as he was near the end of his life.

9. Although prison and healthcare staff did liaise with Mr Swinscoe's family during his final months, we consider that the prison should have appointed a family liaison officer before Mr Swinscoe died. A trained family liaison officer could have provided a single point of contact for the family, could have arranged extra visits and should have understood the procedures for compassionate release and ROTL.

10. Mr Swinscoe's family were at the prison waiting to visit him when he died and wanted to view his body, but were not allowed to. We consider that the prison should have approached the Coroner to see if this might have been possible.

Early compassionate release

11. Hospital and prison healthcare assessed that Mr Swinscoe should receive end of life care in a hospice but did not apply for Mr Swinscoe to be released early on compassionate grounds, as they should have done.

Recommendations

- The Director should ensure that all staff undertaking and reviewing risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take in to account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Director and Head of Healthcare should ensure that they exercise discretion to allow the families of terminally ill prisoners in the prison's inpatient unit to visit frequently, and as far as possible, in line with the family's wishes.
- The Director and Head of Healthcare should ensure that applications for early release on compassionate grounds are completed at the earliest possible opportunity and are progressed without delay.
- The Director should ensure that a prison family liaison officer is appointed at the time of diagnosis (rather than after the prisoner's death) to be the key point of contact for the family during the prisoner's final months and weeks.
- The Director should ensure that if the family of a deceased prisoner asks to view the body, staff approach the Coroner to see if this might be possible, and that the Serco Custodial Safety Strategy is updated to reflect this.

The Investigation Process

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

2. The investigator obtained copies of relevant extracts from Mr Swinscoe's prison and medical records. She interviewed two members of staff at HMP Thameside on 20 September 2018.

3. NHS England commissioned a clinical reviewer to review Mr Swinscoe's clinical care at the prison. He joined the investigator for interviews on 20 September 2018.

4. We informed HM Coroner for Inner South London of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

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

6. We have assessed the main issues involved in Mr Swinscoe'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 early compassionate release was considered.

7. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HM Prison Thameside

9. HMP Thameside is a local prison which holds up to 1,232 male prisoners who have either been convicted or are on remand. It is managed by Serco. Healthcare is provided by Oxleas NHS Trust. A dedicated healthcare unit has inpatient facilities for 18 prisoners.

HM Inspectorate of Prisons

8. The most recent inspection of HMP Thameside was in May 2017. Inspectors reported that overall, HMP Thameside was a relatively good prison, and they identified an unusually high number of good practice points from which other establishments could learn. However, they noted significant staff shortages that had affected the delivery of health services, particularly in primary care. They found that the prison regime and inefficiencies with the booking system delayed prisoners' access to healthcare. They noted that there was an appropriate range of primary care services, but some waiting times were too long, especially to see a GP. Inspectors found that the inpatient unit provided reasonably good care. They noted that some patients experienced delays in receiving their medication, and this led to potentially serious gaps in treatment. They found that prison staff's supervision of medicine queues was variable, which led to delays in administration and a lack of confidentiality.

Independent Monitoring Board

9. 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 2018, the IMB reported that Oxleas NHS Trust struggled to deliver the expected standard consistently, though there had been improvements during the reporting year (such as health screens for newly arrived prisoners).

10. The IMB noted that transfers of patients to hospital required escort staff employed by Serco. The IMB reported that Oxleas NHS Trust had asked for a review to increase escort capacity because the current resourcing meant that prisoners' hospital treatment was sometimes postponed. The review would be subject to commercial negotiations.

Previous deaths at HMP Thameside

11. Mr Swinscoe was the ninth person to die at HMP Thameside since July 2015, and the sixth from natural causes. Following a previous investigation into a prisoner's death in 2016, HMP Thameside agreed to implement our recommendation to address the inappropriate use of restraints.

Findings

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

12. In June 2016, Mr Swinscoe was diagnosed with lung cancer while in the community. He had radiotherapy in July, and in January 2017 a CT scan (a scan that uses x-rays to create detailed computerised images of the body) showed that the lung cancer had responded well to the treatment. In March, an oncologist saw Mr Swinscoe and assessed that his condition was stable.

13. On 9 May 2017, Mr Swinscoe was remanded to HMP Thameside for sexual offences.

14. When he arrived, a nurse assessed him and noted his complex medical issues including Type 2 diabetes, severe heart failure, peripheral neuropathy (damage to the nerves in hands and feet), chronic obstructive pulmonary disease (a chronic inflammatory lung disease that obstructs airflow from the lungs) and osteoarthritis (a condition that causes the joints to become painful and stiff). He also had a history of blood clots on his lungs, gout (a form of arthritis), a leg ulcer and asbestos exposure. She referred Mr Swinscoe to a prison GP due to his health issues.

15. That day, a prison GP examined Mr Swinscoe, and noted his medical issues and that he used a frame to help him walk. He admitted Mr Swinscoe to the prison healthcare unit and prescribed medication to manage his conditions.

16. On 3 July, a prison GP saw Mr Swinscoe as he was complaining of persistent hoarseness and referred him to a hospital specialist under the two-week pathway for patients with suspected cancer. On 19 July and16 August he was seen by specialists who arranged CT scans. On 27 September 2017, hospital doctors confirmed that the cancer had spread within his lung and recommended radiotherapy.

17. We are satisfied that healthcare staff identified Mr Swinscoe's medical problems promptly and appropriately referred him for ongoing specialist treatment.

Clinical care

18. Mr Swinscoe had five sessions of radiotherapy at Guy's Hospital between 30 October and 3 November. A nurse told us that the radiotherapy helped to manage Mr Swinscoe's symptoms and make him more comfortable.

19. On 22 November, Mr Swinscoe attended QEH. A consultant clinical oncologist told him that it would not be possible for him to have chemotherapy as he had a heart condition.

20. Healthcare staff at Thameside monitored Mr Swinscoe's health and managed his symptoms. He needed help with some activities of daily living but remained relatively independent.

21. On 23 February 2018, a nurse saw Mr Swinscoe and they discussed his health at length. She noted that Mr Swinscoe accepted his diagnosis.

22. A nurse told us that, as Mr Swinscoe had lung cancer, he was more prone to chest infections so healthcare staff monitored his vital signs carefully.

23. On 27 May, a nurse examined Mr Swinscoe. He sent him to hospital as an emergency after a significant drop in his blood pressure and oxygen saturation levels.

24. On admission, doctors assessed that he had hours to live and needed end of life care. However, Mr Swinscoe's health improved unexpectedly and plans were made for him to be discharged.

25. On 11 June, a multidisciplinary meeting was held at QEH to discuss his needs before he was discharged. The hospital consultant assessed that Mr Swinscoe would mostly be confined to his bed and would need a constant supply of oxygen. It was agreed that once Thameside had oxygen and specialist equipment for him, Mr Swinscoe would be discharged. The consultant said that he could not determine Mr Swinscoe's prognosis.

26. Mr Swinscoe signed an order to say that attempts should not be made to resuscitate him if his heart or breathing stopped.

27. On 14 June, Mr Swinscoe returned to the healthcare unit at Thameside, with the specialist equipment in place. A nurse said his condition had deteriorated dramatically since his hospital admission. He was increasingly confined to bed and required help with all activities of daily living. His package of support was increased to meet his needs. A prison GP told us that the priority was to keep Mr Swinscoe comfortable and to manage his pain.

28. On 5 July, the prison GP examined Mr Swinscoe as he had low oxygen saturation levels. He found that Mr Swinscoe had a chest infection and prescribed antibiotics and a higher dose of oxygen. He noted that it was obvious that Mr Swinscoe's general health was deteriorating and he appeared to be near the end of his life, but was not in pain. He recommended stopping Mr Swinscoe's oral medication and liaising with the palliative care team to consider starting end of life treatment.

29. At 11.16am on 6 July, a prison GP noted that he had seen Mr Swinscoe and that he looked peaceful.

30. At 11.55am, a social care worker noticed that Mr Swinscoe had stopped breathing and called a healthcare assistant. She immediately called two nurses and an officer to Mr Swinscoe's cell. One of the nurses checked for a pulse but did not find one.

31. Healthcare staff did not try to resuscitate Mr Swinscoe as he had previously signed an order not to be resuscitated. They called a code blue emergency, indicating that a prisoner is not breathing, and the control room called an ambulance.

32. Paramedics arrived at 12.11pm and completed an electrocardiogram (a test used to check the heart's rhythm and electrical activity) which confirmed that Mr Swinscoe's heart had stopped. A prison GP who was not in the inpatient unit at the time, returned and confirmed Mr Swinscoe's death at 12.20pm.

33. The post-mortem report found that Mr Swinscoe had died of bronchial carcinoma (lung cancer) of the left lung and a chest infection, with chronic obstructive pulmonary disease a contributory factor.

34. The clinical reviewer found that healthcare staff referred Mr Swinscoe to the oncology department at QEH in May 2017. When his lung cancer got worse, healthcare staff facilitated his radiotherapy treatment as an outpatient and facilitated specialist care.

35. The clinical reviewer found that the healthcare team monitored Mr Swinscoe's health closely in the healthcare unit and frequently completed observations and checked his vital signs. He considered that the healthcare team provided continuity of care for Mr Swinscoe's long-term conditions.

36. The clinical reviewer identified that the healthcare team appropriately sought specialist advice, held multidisciplinary case conferences, including while he was a patient at QEH, and that meetings included a number of professionals and agencies.

37. Mr Swinscoe needed help with some of his daily living tasks but was mostly independent until he went to hospital on 27 May 2018. When he returned from hospital on 14 June, his needs had increased significantly and his support was increased. Healthcare staff ensured that Mr Swinscoe's social care needs were met.

38. Before Mr Swinscoe's discharge from hospital on 14 June, healthcare staff liaised with the hospital to plan his return to Thameside and liaised with the community palliative care team to provide end of life care. The clinical reviewer found that the healthcare team provided appropriate end of life care for Mr Swinscoe.

Emergency response

39. Prison Service Instruction (PSI) 03/2013 on medical emergency response codes states that an emergency code should be called in a medical emergency. It says that if a code blue is called (when a prisoner is unconscious, choking, fitting or concussed, has difficulty breathing, chest pain, a severe allergic reaction or suspected of having a stroke), an ambulance should be called immediately.

40. A nurse told us that they called a code blue when Mr Swinscoe died, in line with prison policy.

41. The clinical reviewer considered that a code blue should not have been called when Mr Swinscoe was found unresponsive as he had an order in place not to be resuscitated, paramedics were not needed to confirm death and it was a waste of the National Health Service's emergency resources. Thameside does not have a policy to cover whether or not a code blue should be called if there is an order in place not to resuscitate. Since Mr Swinscoe's death, Serco and Oxleas NHS Trust have agreed to develop a policy by December 2018 on whether to call a code blue in such circumstances.

Mr Swinscoe's location

42. When Mr Swinscoe arrived at Thameside on 9 May 2017, a prison GP assessed that he was unlikely to cope well on a standard wing due to his medical issues. The peripheral neuropathy affected his mobility and he used a frame for walking and was vulnerable to falls. He was therefore given a single cell for disabled prisoners in the in-patient unit which appropriately took account of his needs.

43. On 1 June 2018, a nurse visited Mr Swinscoe in hospital and spoke to a doctor who said that Mr Swinscoe would need to go to a hospice. They agreed that the hospital would discuss discharge plans with the prison and prison healthcare team to ensure that they were able to look after him safely if he was not able to go to a hospice.

44. The nurse told us that Mr Swinscoe was content to go to a hospice but that, if it was not possible, he said he would prefer to return to the inpatient unit at Thameside as the nurses were very supportive.

45. On 8 June, a multidisciplinary meeting was held at Thameside. It was noted that the preferred option to meet Mr Swinscoe's needs was a hospice and the prison GP agreed that Thameside was not the right place to meet Mr Swinscoe's needs. It was noted that the prison's senior management team was progressing an application for Mr Swinscoe to be released early on compassionate grounds, which would allow him to go to a hospice. An application for downgrading Mr Swinscoe's security category was also planned to enable Mr Swinscoe to transfer to an open prison with a palliative care unit if the application for early compassionate release was turned down.

46. The PPCS confirmed that they did not receive an application from Thameside for Mr Swinscoe's early release on compassionate grounds.

47. The Offender Management Unit Service Manager confirmed that on 13 June, Mr Swinscoe was re-categorised from a Category C to a Category D prisoner. The justification for this was based on Mr Swinscoe's ill-health and the reduction to his risk of reoffending or escape.

48. On 14 June, Mr Swinscoe was discharged from hospital to the inpatient unit at Thameside. He died before he was able to be transferred to an open prison with a palliative care unit, as was planned.

Restraints, security and escorts

49. 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 in to 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 he has a serious medical condition. The judgment indicated that medical opinion about a prisoner's ability to escape must be considered as part of the assessment process and reviewed as circumstances change.

50. Mr Swinscoe was restrained with a single cuff when he was transferred to hospital as an emergency on 27 May. There were no medical objections to the use of restraints in the escort risk assessment. It was noted that Mr Swinscoe posed a medium level of risk to the public and a low level of risk of hostage taking, potential to escape and of external assistance. A prison manager concluded that because there were no medical objections to the use of restraints and Mr Swinscoe was a Category C prisoner, two officers should escort him, using a single-cuff restraint (which meant that he was handcuffed by one arm to an officer).

51. Two days later, an Assistant Director reviewed the use of restraints and reduced Mr Swinscoe's restraints to an 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). She authorised a one-person escort. As she is on maternity leave, we have not been able to ask her what criteria she relied on when deciding that Mr Swinscoe should continue to be restrained. We also note that her decision to reduce the escort to one officer was contrary to PSI 33/2015 on external escorts, which requires a minimum of two escort officers when prisoners are escorted outside a prison, irrespective of whether restraints are applied.

52. The Deputy Director reviewed the use of restraints on 31 May and authorised the removal of Mr Swinscoe's restraints as he was terminally ill and immobile. An officer continued to monitor him.

53. We are concerned that the approach some prison managers applied to the use of restraints was inconsistent with the provisions of the High Court judgement and with basic principles of dignity. The Prison Service has a responsibility to protect the public but security must be balanced with humanity. Mr Swinscoe used a frame to walk and was in very poor health when he was transferred to hospital as an emergency. This clearly impacted on his ability to escape. It was two days before the use of restraints was reviewed and, even though Mr Swinscoe was seriously unwell and thought to be at the end of his life, the use of restraints was still approved. Too much weight was given to his original offences without considering his actual risk at the time. It is good to see that when this was reviewed again two days later, the Deputy Director considered Mr Swinscoe's health and mobility and appropriately authorised the removal of the restraints. We make the following recommendation:

The Director should ensure that all staff undertaking and reviewing risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take in to account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Swinscoe's family

54. Mr Swinscoe's next of kin was one of his daughters. He was in frequent contact with his family and had their support.

55. An inpatient manager at Serco, and an inpatient manager at Oxleas NHS Trust, liaised with Mr Swinscoe's family during his illness. They kept the family informed about his health and location, and facilitated visits and their attendance at healthcare meetings.

56. On 6 July, Mr Swinscoe's family planned to visit him and attend a healthcare meeting at the prison. They had arrived early and they were waiting nearby when he died. An inpatient manager at Serco arranged for them to be escorted to the Director's office, where she and a Reverend informed them of his death.

57. After Mr Swinscoe's death, the prison appointed a prison manager as the family liaison officer. He telephoned Mr Swinscoe's next of kin to introduce himself. He noted that Mr Swinscoe's daughter was upset and angry that she had only been allowed to visit her father four times a month and had not been allowed to see her father's body while she was at the prison. The family liaison officer arranged to visit her at home after the weekend.

58. On 9 July, the family liaison officer and a prison officer visited Mr Swinscoe's daughter to offer their condolences and support.

59. Mr Swinscoe's family arranged his funeral which took place on 27 July. Thameside contributed to the costs of the funeral, in line with national instructions.

60. PSI 16/2011 on prison visits says that prisoners are entitled to receive at least two, one-hour social visits in every four-week period. In addition to any entitlement to visits, it gives Directors the discretion to allow special visits when a family member is seriously ill. PSI 64/2011 on safer custody says that prisoners who have a terminal illness must be encouraged to engage with their families where it is appropriate to do so.

61. A prison manager contacted the inpatient manager at Serco on our behalf and said that when Mr Swinscoe received a diagnosis, family visits were put in place. She said that the family were allowed to visit once a week and chose Sunday afternoons. She said that an inpatient manager at Serco had approved this.

62. We recognise that the prison took Mr Swinscoe's poor health into account and allowed his family to visit him once a week, which is more frequent than usual. However, Mr Swinscoe was seriously ill and at the end of his life. We are concerned that the prison did not exercise their discretion in these circumstances to allow his family to visit him more frequently than once a week. Involving families in the end of life care process is a key part of an end of life pathway and should ideally happen at the earliest stage in a prisoner's terminal diagnosis. Strong support from families and friends can make an enormous difference to a prisoner's quality of life in its final stages.

63. We are also concerned that Thameside did not appoint a family liaison officer until after Mr Swinscoe had died.

64. In cases where a prisoner is terminally ill, PSI 64/2011 says that prisons must appoint a member of staff to keep families informed of their relative's condition and offer them support. It also says it is good practice for a log of the contact with the family to be maintained.

65. PPO investigations have repeatedly recommended that prisons should appoint a family liaison officer at the time that a terminal diagnosis is made, as opposed to after death. Although prison and healthcare staff did liaise with Mr Swinscoe's family, we consider that it would have been preferable for the family to have had

a single point of contact in the form of a family liaison officer trained to deal with end of life situations in prison. Family liaison officers are usually the best people to organise extra visits and liaise with a hospital or hospice, and a trained family liaison officer should also be aware of the procedures for compassionate release and ROTL.

66. We make the following recommendations:

The Director and Head of Healthcare should ensure that they exercise discretion to allow the families of terminally ill prisoners in the prison's inpatient unit to visit frequently and as far as possible, in line with the family's wishes.

The Director should ensure that a prison family liaison officer is appointed at the time of diagnosis (rather than after the prisoner's death) and should be the key point of contact for the family during the prisoner's final months and weeks.

67. A prison manager said that Mr Swinscoe's family were told that they were not allowed to see his body as the prison was waiting for the Coroner to arrive. The Serco Custodial Security Strategy (SCSS) states that cells must be sealed after a death in custody until the police arrive.

68. The police attended Thameside at 2.50am the next morning, and the Coroner attended at 5.05am.

69. A prison GP had pronounced that Mr Swinscoe had died. He was a terminally ill man in the prison's inpatient unit. He was being monitored closely by the healthcare team as he was at the end of his life. The circumstances of his death were not suspicious. Although we cannot say for certain whether it would have been approved, prison staff should have contacted the Coroner to seek approval for the family to view Mr Swinscoe's body. This did not happen, and we are concerned that the family's wishes were again not met. We make the following recommendation:

The Director should ensure that if the family of a deceased prisoner asks to view the body, staff approach the Coroner to see if this might be possible, and that the Serco Custodial Safety Strategy is updated to reflect this.

Compassionate release

70. 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 (PSO) 6000. 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) of the Her Majesty's Prisons and Probation Service (HMPPS).

Although Mr Swinscoe did not have a definitive diagnosis, it was clear by the time of the MDT meeting on 11 June, that he was coming to the end of his life. It was noted that the prison's senior management team was progressing an application for Mr Swinscoe to be released early on compassionate grounds. However, we are concerned that this application was not submitted before Mr Swinscoe died on 6 July.

71. We make the following recommendation:

The Director and Head of Healthcare should ensure that applications for early compassionate release are completed at the earliest possible opportunity and are progressed without delay.

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