Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jeffrey Long, a prisoner at HMP/YOI Moorland Closed, on 5 July 2024

A report by the Prisons and Probation Ombudsman

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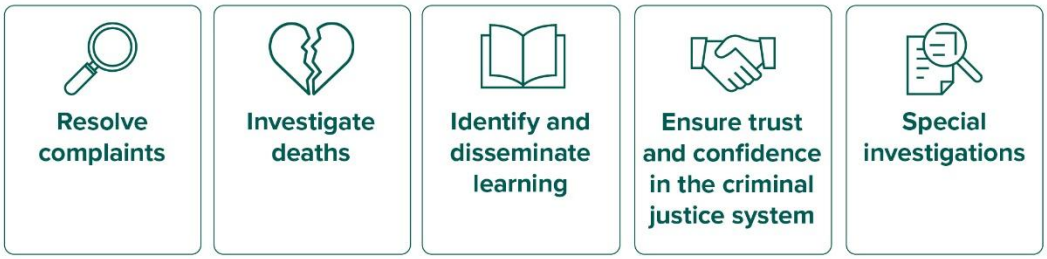
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

1. 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.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. On 6 October 2023, Mr Jeffrey Long was sentenced to four years imprisonment for sexual offences. He died in hospital of bronchopneumonia on 5 July 2024, while a prisoner at HMP Moorland. Ischaemic heart disease, chronic kidney disease and liver cirrhosis contributed to, but did not cause his death. He was 76 years old. We offer our condolences to Mr Long's family and friends.

4. The Ombudsman's office contacted Mr Long's family to explain the investigation and to ask if they had any matters they wanted us to consider. They asked for a copy of our report and asked questions about Mr Long's health. We have answered the family's questions in our report and the clinical review.

5. The PPO investigator investigated the non-clinical issues relating to Mr Long's care. We did not find any non-clinical issues of concern.

6. NHS England commissioned independent clinical reviewers, to review Mr Long's clinical care at HMP Moorland. The clinical reviewers' report is attached as Annex 1.

7. The clinical reviewers concluded that the clinical care Mr Long received at Moorland was not of the required standard and was not equivalent to what he could have expected to receive in the community.

8. They found that Mr Long was not appropriately referred to the long-term conditions nurse when he transferred to Moorland on 7 May 2024. Staff missed opportunities to identify Mr Long as a potentially deteriorating patient in the days leading up to his death, including that his National Early Warning Score 2 (NEWS2- a tool which improves the detection and response to clinical deterioration in adult patients) observations were not calculated or were miscalculated during intervention, and senior nurses did not raise sufficient concern regarding Mr Long's deteriorating health in a multi-agency meeting held on 28 June.

9. The clinical reviewers found that there was a significant delay in Mr Long's assessment and transfer to hospital on 2 July, including that a senior nurse did not attend Mr Long's cell when concerns regarding his deterioration were raised, healthcare staff's failure to call a medical emergency and delays in a senior medical review once Mr Long was moved to the healthcare wing.

10. They also found a significant issue, which the Ambulance Service made a formal complaint about, in the transfer of Mr Long from the healthcare wing to the ambulance resulting in Mr Long having to be transferred on a carry chair despite being in a critical condition.

11. We make the following recommendations:

The Head of Healthcare at HMP/YOI Moorland must implement:

- **a robust process to ensure all relevant staff are aware of prisoners who may be at risk of clinical deterioration.**
- **ensure an individualised care plan is in place so these prisoners have appropriate reviews and a clear escalation plan.**

The Head of Healthcare at HMP/YOI Moorland should ensure that all staff document a full set of physical observations and calculate a NEWS2 score at every encounter with unwell prisoners.

The Head of Healthcare at HMP/YOI Moorland should:

- **undertake a multi-disciplinary training event with all staff involved in Mr Long's care.**
- **detail roles and responsibilities of senior staff to ensure that junior staff are appropriately supported when asking for clinical assistance with unwell prisoners. This should be facilitated with minimal delay.**
- **undertake training on assessment of the clinically unwell prisoners and escalation process at Moorland with all healthcare staff.**

The Head of Healthcare at HMP/YOI Moorland must ensure that when an ambulance is called, healthcare staff inform the prison duty manager of the location where the ambulance is to be received. This is to prevent unnecessary delays in the provision of care.

The Head of Healthcare at HMP/YOI Moorland should ensure that all prisoners living with a long-term condition are referred to the long-term condition nurse at their reception screening. This will ensure an individualised plan of care, follow up, and if required, referral to the MPCCC for the wider MDT.

The Head of Healthcare at HMP/YOI Moorland should ensure that if a clinical concern is raised about a prisoner, there is a robust management plan and the prisoner should be seen and assessed at the earliest opportunity by a member of the healthcare team. This is to identify potentially deteriorating prisoners and ensure they are assessed and reviewed quickly.

The Head of Healthcare at HMP/YOI Moorland should ensure that when prisoners are reviewed at the MPCCC, all relevant clinical information is discussed so senior members of the team are aware of changes in the prisoner's condition.

The Head of Healthcare and Governor at HMP/YOI Moorland should undertake a plan for extricating prisoners from the healthcare department that is safe and does not compromise prisoner care.

12. The clinical reviewers made several other recommendations related to Mr Long's care which the Head of Healthcare will wish to address.

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

14. Mr Long's family received a copy of the draft report. They raised a number of issues/ questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Adrian Usher
Prisons and Probation Ombudsman **July 2025**

Inquest

15. At the inquest held on 6 April 2026, the Coroner concluded that Mr Long died of natural causes.

16. The jury concluded that Mr Long's condition, as presented to healthcare professionals on or before 28 June 2024, should have led to his admission to hospital. They believed that, on the balance of probabilities, Mr Long would not have died if he had been admitted to hospital on or before 28 June 2024.

17. The Coroner found that there was a gross failure to provide or procure basic medical attention for someone in a dependent position, who could not provide for themselves. The Coroner concluded that neglect contributed to Mr Long's death.

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