

**Investigation into the circumstances surrounding the
death of a man
at HMP Long Lartin in March 2011**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

November 2011

This is the report of the investigation into the circumstances surrounding the death of a man at HMP Long Lartin. The man died of natural causes at HMP Long Lartin on in March 2011. He was 66 years old when he died. I offer my sincere condolences to the man's family and friends.

The investigation was carried out by a senior investigator. I would like to thank the Governor at Long Lartin and his staff for their co-operation with the investigation. I am also grateful to the investigation liaison officer for his work.

Worcestershire Primary Care Trust (PCT) commissioned a clinical reviewer to carry out an independent review of the clinical care the man received at Long Lartin. I am very grateful to him for his contribution to the investigation.

The man was remanded into custody in 1995, aged 50. He had recently been diagnosed with Type 2 adult onset diabetes and was prescribed medication to help manage the condition. Diabetes can lead to a number of complications, including heart disease. In 2007, after complaining of shortness of breath, hospital specialists confirmed that the man had problems with his heart.

In 2009, the man underwent a triple heart bypass and on two occasions was seriously ill in hospital, where he was nursed in the Intensive Therapy Unit. However, he recovered enough to return to prison on both occasions and by all accounts was able to participate in wing life. Staff said that he was a likeable and popular character, although he could be difficult and stubborn at times. On occasions, he refused to co-operate with his treatment and he frequently went against the healthcare advice he was given. The clinical reviewer and I agree that Long Lartin staff worked hard to encourage the man to comply with treatment and did what they could to make his life easier. Although he was known to be unwell, his death came as a shock to staff.

I am pleased to reflect the clinical reviewer's finding that the man received a standard of healthcare equitable to what he could have expected to receive in the community. I make one recommendation as a result of this investigation, which concerns the use of care plans for long term health conditions. I am pleased that the National Offender Management Service (NOMS) has accepted the recommendation.

As part of the investigation, I consider the prison's liaison with the man's next of kin (his niece). It is most unfortunate that it took 11 days to locate her correct contact details when they were in her uncle's prison file all along. Although I make no recommendation in relation to this, I discuss it in some detail. I am grateful to her for considering the report at the draft stage.

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

Thea Walton
Acting Deputy Ombudsman

November 2011

CONTENTS

Summary

The investigation process

HMP Long Lartin

Key events

Issues

Conclusion

Recommendations

SUMMARY

1. The man was charged with murder and remanded into custody in 1995. He was 50 years old at this time and it was not his first time in prison. On his arrival, healthcare staff noted that he had recently been diagnosed with Type 2 adult onset diabetes. Later that year, he was found guilty and sentenced to life imprisonment. He was told he would serve at least 14 years before he could be considered for release.
2. In 2006, the man transferred to Long Lartin. From the outset he had regular contact with healthcare staff, who helped him to manage his diabetes. The man did not always follow the healthy living advice he was given.
3. The man complained of increasing breathlessness and in December 2007 was referred to the local hospital. Specialists there diagnosed him with heart disease (which commonly affects diabetes sufferers). His condition remained stable until January 2009, when he was admitted to hospital. He was diagnosed with a chest infection and serious heart problems. He was very unwell and was nursed in the Intensive Therapy Unit for some time before returning to Long Lartin.
4. In March 2009, the man underwent triple heart bypass surgery, returning to the prison the following month. Healthcare staff continued to monitor and treat his various chronic conditions, with input from hospital specialists. He had to be admitted to hospital again in November 2009, suffering with high potassium levels.
5. At the end of 2009, the man refused to go to hospital, despite raised potassium levels. Staff assessed his mental capacity and decided that he understood the implications of refusing treatment. Eventually, after staff encouragement, the man agreed to be admitted to hospital overnight.
6. A year later, at the end of 2010, the man again began refusing to attend hospital and healthcare appointments. He said that he would not attend if he did not know what the appointment was for. He also said that he did not like having to wear handcuffs while at hospital. Again, prison healthcare staff encouraged him to comply with his treatment.
7. At about 9.00am on the morning of his death, staff unlocking prisoners found the man unresponsive in his cell. On further checking him, they decided that he had been dead for some time and did not attempt to resuscitate him. Nursing staff arrived shortly after and agreed that nothing could be done to help the man. He was pronounced dead by the prison's Medical Director. He was 66 years old when he died.
8. The clinical reviewer concludes that the clinical care the man received at Long Lartin was appropriate and equitable to that he might have received had he been living in the community. He and I make one recommendation about the use of care plans for long term conditions. I also consider the prison's contact with the man's next of kin following his death.

THE INVESTIGATION PROCESS

9. The Ombudsman's office was notified of the man's death on the day he died and the investigation was allocated to a senior investigator, that day. The investigator visited Long Lartin to open the investigation on 17 March. During her first visit to the prison the investigator met the Governor, Head of Healthcare, a representative of the Independent Monitoring Board (IMB) and a member of the Prison Officers Association (POA). She collected relevant paperwork relating to the man's time in prison, including his medical record. The investigator visited Perrie Wing, where the man lived, and the healthcare department.
10. Notices to staff and prisoners were issued, informing them that an investigation would be taking place and inviting those with relevant information to contact the investigator. There was no response to the notices.
11. Worcestershire PCT appointed a clinical reviewer to carry out a review of the clinical care the man received. The clinical reviewer was provided with a copy of the man's clinical record and visited the prison on two occasions to speak to relevant healthcare staff. After an initial delay in his appointment, the clinical reviewer completed the clinical review on 29 July.
12. The investigator contacted HM Coroner for Worcester to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Although the inquest into the man's death has already been held, a copy of this report will be sent to the Coroner for his information.
13. The investigator visited Long Lartin again on 8 June and carried out interviews with staff. Following the interviews, she provided written feedback to the Governor.
14. One of my family liaison officers contacted the man's next of kin, his niece, to explain the purpose of the investigation and invite her to raise any concerns. The man's niece asked why it had taken the prison so long to inform her of her uncle's death. She also asked about some of her uncle's property, which has now been returned to her. I hope this report addresses her questions and gives her a clearer picture of her uncle's time at the prison.

HMP LONG LARTIN

15. HMP Long Lartin is part of the high security prison estate. It holds up to 622 category A and B adult men who have been sentenced to at least four years imprisonment. (Sentenced prisoners are assessed as one of four security categories. Category A prisoners would be highly dangerous to the public, police or national security if they were to escape. Category B prisoners are those for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult. Category C prisoners cannot be trusted in open conditions but are unlikely to make a determined escape attempt. Category D prisons operate open conditions and hold prisoners who can be trusted not to try and escape.) The man was a category B prisoner.
16. Healthcare services are provided by NHS Worcestershire and run along the same lines as a community general practice. In addition, there is a small acute admissions unit for prisoners needing more intensive short term health care.

HM Chief Inspector of Prisons (HMCIP)

17. The last published inspection report by HMCIP concerns the inspection carried out in July 2008. The then Chief Inspector noted that generally relationships between staff and prisoners were good. The personal officer scheme (explained in more detail in the key events section) was effective, with most personal officers showing good understanding and knowledge of the prisoners allocated to them.
18. Primary health services were recognised as being good. Prisoners had good access to nurse-led clinics and community specialists, which enjoyed short waiting lists. HMCIP noted that prisoners experienced no delays in accessing external health services and appointments, such as those at local hospitals, were kept.

Independent Monitoring Board (IMB)

19. Each prison in England and Wales is monitored by an independent board of unpaid members of the local community appointed by the Secretary of State for Justice. The Board's responsibility is to ensure that prisoners are kept in humane and just conditions. It must report annually to the Secretary of State for Justice. The most recent published annual report for Long Lartin covers the period February 2009 to March 2010.
20. The Board noted the issues raised by a growing elderly population, including the increasing need for accessible accommodation. However, it praised the prison healthcare department for continuing to deliver a "high standard of treatment and care".

Previous deaths

21. This man's was the seventh death to occur at Long Lartin since the Ombudsman began investigating all deaths in prison custody in 2004. He was the fourth

prisoner to die of natural causes. There are no apparent similarities between the circumstances of his death or the recommendations I make here and those made in earlier reports.

KEY EVENTS

22. In April 1995, the man was charged with murder and remanded to HMP Wormwood Scrubs. It was his fourth period of imprisonment. He was 50 years of age.
23. On his arrival, healthcare staff noted that he suffered with Type 2 adult onset diabetes (but was not insulin dependent), which had only very recently been diagnosed. (Type 2 diabetes is when the body cannot make enough insulin, or when the insulin that is produced does not work properly. As a result, glucose builds up in the body's cells and cannot be converted to energy. Type 2 diabetes is often managed by healthy eating and exercise, but may also require prescribed medication and insulin.) The man told staff he had a history of heavy alcohol use. He was prescribed medication to help him control his diabetes.
24. On 27 October 1995, the man was convicted of murder and sentenced to life imprisonment, with a tariff of 14 years (meaning that he would serve at least 14 years before he could be considered for release). In January 1996, he transferred to HMP Wakefield.
25. In his first months at Wakefield, healthcare staff recorded that the man was not following the healthy eating advice he had been given. He was given further advice to follow a suitable low cholesterol diet and to stop smoking, but apparently he did not believe it was bad for his health.
26. Over the following years, the man's diabetes was well controlled and he remained on medication. He had regular appointments with healthcare staff who monitored his eyes and feet for diabetes related complications. (Diabetes can cause long term complications such as damage to retinas and to the nerves and muscles and an increased likelihood of suffering with heart disease.) The man complained of pain in his right knee and was also prescribed pain relief medication.
27. The man was monitored regularly and, over time, his blood sugar levels began to rise (a sign that the patient is not sufficiently able to control them without insulin). In 2004, his anti-diabetic medication dose was increased, to see if this helped him to control his blood sugar levels. However, on 20 December, the man was prescribed insulin, which he injected every day. He was given advice on when and where to inject himself.
28. In July 2006, the man complained of breathlessness after walking a short distance. He had an appointment with the doctor, who also noted that the man's ankles were puffy, which might indicate heart failure. The doctor referred the man for a chest x-ray. However, in August, the man requested a transfer to another prison and told healthcare staff that he did not want to have any further appointments at the local hospital.
29. On 29 September 2006, the man transferred to Long Lartin. His medical history was noted and he was referred to the doctor. As well as being prescribed medication for his diabetes (novomix, metformin and gliclazide), he was also

prescribed medication to treat high blood pressure (eprosartan and bendroflumethiazide) and high cholesterol (atorvastatin), iron supplements and an indigestion aid. During an appointment with the doctor the following month, the man was advised to exercise more and try to lose weight.

30. The man complained of worsening breathlessness and in December 2007, prison healthcare staff referred him to outside hospital for further examination. The consultant heart specialist confirmed that the man had mild aortic valve disease (where one of the valves in the heart is not working properly, meaning that blood does not flow through the heart as it should). However, the consultant thought that the condition would not cause the man any problems in the next five years. The consultant advised that because the man suffered with high blood pressure and diabetes, it was quite likely that he had further heart disease.
31. Over the following year, the man complained of ongoing chest problems, including occasional chest pains. One of the prison doctors referred the man back to the hospital cardiology department for a review of the symptoms. No further action was necessary at this time.
32. However, on 13 January 2009, the man complained of breathing problems and was taken to hospital, where he was admitted as an inpatient. He was diagnosed with a chest infection and left ventricular failure. (The left ventricle is one of the four chambers in the heart which help to pump blood around the body.) The man was seriously unwell and had to be ventilated (when a machine regulates the patient's breathing). He spent some time in the Intensive Treatment Unit (ITU) as a result. Because the man was very unwell, the prison made contact with his niece, who was listed as his next of kin. She provided staff with her current contact details.
33. The man was discharged from hospital on 24 February and returned to Long Lartin. The care plans put in place on his return directed that he remain an inpatient in the healthcare unit and be checked four times an hour. Nursing staff were to ensure that the man took his prescribed medication.
34. Less than a week later, on 1 March, staff requested an emergency ambulance when the man complained of chest pains again. He was admitted to hospital and, on 15 April, underwent a triple heart bypass (where three blood vessels around the heart are blocked and blood vessels are taken from another area of the body, typically the leg, and grafted onto the existing heart vessel to divert blood around the blockage and to the heart). On his return to the prison he was monitored regularly by healthcare staff over the following weeks. The man had to be frequently reminded to wear compression socks (which are designed to aid blood circulation) and to keep his feet raised.
35. On 14 November, the man was admitted to hospital once more due to kidney failure and an excess of potassium in his body. He complained of feeling short of breath and generally unwell. In hospital, the man was treated with fluid and insulin dextrose (a recognised treatment for the condition). Kidney specialists at the hospital arranged to continue to monitor his condition. He remained in hospital until 17 November and prison healthcare staff noted that the raised

potassium levels were the result of kidney failure. On his return to prison, the man was offered a bed in the prison inpatients unit, but preferred to return to the wing. He was advised to limit the number of bananas (which are high in potassium) he ate each week.

36. The man's potassium level was found to be high again on 9 December. However, he refused to go to hospital for treatment. In line with the Mental Health Act 2005, healthcare staff arranged for an assessment of his mental capacity. The nurse conducting the assessment concluded that the man understood the implications of refusing treatment and had the mental capacity to make decisions about the care he received. Healthcare staff urged the man to move to the healthcare centre for monitoring. He refused to do so and decided he would go to hospital instead. He was admitted to hospital overnight, returning to Long Lartin on 10 December.
37. On 14 December, the man transferred to HMP Grendon Therapeutic Community for three days, returning to Long Lartin on 17 December. The reason for the brief transfer is not clear.
38. The man's condition was monitored over the following months. On 9 April 2010, he spent one night in hospital after complaining of being short of breath and confused. Three days later, on 12 April, healthcare staff were asked to urgently assess the man after he complained of breathlessness. Staff decided he should be admitted to hospital again because of the potential links between diabetes and heart problems. He was assessed by specialists at the hospital who diagnosed him with anaemia and so he was given a blood transfusion. They noted his "chronic" kidney problems. The man returned to Long Lartin on 15 April.
39. Throughout the remainder of 2010, the man had regular appointments with healthcare staff sometimes for diabetes related check ups and sometimes because he felt short of breath. In early June, he was admitted to hospital again for a few days after blood tests showed problems with his heart. Cardiologists assessed him and amended his prescribed medication. On 15 June, prison healthcare staff made an entry in the man's medical record noting that he was suffering with acute congestive heart failure (when the heart is unable to effectively pump blood around the body).
40. Healthcare staff regularly assessed the man's diabetes and heart failure and his medication was altered as necessary. They noted that he was not managing his diabetes very well because he did not eat regular meals, as advised. On 29 December, blood tests revealed that he might be at risk of an imminent heart attack. As a result, healthcare staff monitored his blood pressure and pulse rate, which were both within satisfactory ranges.
41. In the early weeks of 2011, the man complained of being short of breath on several occasions. He did not need to be taken to hospital as an emergency although he continued to have regular scheduled appointments there.

42. On 22 January, a nurse assessed him in his cell because he was short of breath. The man told the nurse that he did not want to attend hospital appointments if he did not know what the appointment was for. (He had refused to attend two appointments in late 2010 for the same reason, and because he said that he did not like having to be handcuffed to prison staff while at hospital.) He also explained that his shortness of breath after walking made him reluctant to come to appointments in the prison healthcare centre unless he knew exactly why he was being seen. (The man's medical record indicates that, on a number of occasions, healthcare staff went to his wing to see him.) The nurse explained that he had upcoming appointments to monitor his heart and kidneys and he agreed to go to the appointments.
43. The Head of Healthcare at Long Lartin explained that, for security reasons, prisoners are not told of hospital appointments until the day before. It is normally discipline officers (who are responsible for movements into and out of the prison) that tell the prisoner about appointments. The Head of Healthcare explained that discipline staff will not know the reason for the appointment as this is confidential between the prisoner and healthcare staff. However, she said that, if a prisoner is unsure of the reason for the appointment, they can ask a nurse to explain it to them. She said that healthcare staff always told the man what they were referring him to hospital for, and that it was normally related to his ongoing heart problems. She said that because the man had multiple health problems it might have been harder for him to remember what his forthcoming appointments were for.
44. As part of the investigation, three members of wing staff were interviewed, including the man's personal officer. (The personal officer scheme means that each prisoner has an identified member of staff who acts as their first port of call if they have any questions or concerns.) Two prison officers (who found the man on the morning of his death) were also interviewed. All three said that they knew the man quite well because they generally worked on his wing. They described him as a likeable "character" although he could sometimes be difficult and stubborn. One of the officers that found the man on the morning of his death said that he knew he sometimes refused to go to the healthcare centre for appointments and that nursing staff would frequently come and see him in his cell instead.
45. The three staff interviewed were asked whether, to their knowledge, the man had any complaints about the medical care he received at Long Lartin. They agreed that he could sometimes be "grumpy" about his health problems and the service he thought he was receiving. However, they did not think that he had any specific complaints. They agreed that he seemed able to raise concerns directly with staff.
46. The man had an appointment with the hospital heart specialist on 11 February and two further medications were prescribed to him - isosorbide mononitrate, which helps to prevent angina related chest pain and hydralazine, to treat high blood pressure.

The Day of the Man's Death

47. An officer was responsible for carrying out the 6.00am roll check. (During a roll check, staff must check each cell to ensure that the correct number of prisoners is inside. At the 6.00am check staff do not need check the welfare of prisoners or seek any response from them.) Unfortunately, despite attempts to interview this officer and get a written statement from him, the investigator was unable to gather information about the roll check he performed that morning. It has not been possible to establish whether the man was alive at the time of the check.
48. At about 9.00am, two officers were unlocking the cells on Perrie wing. One of the officers unlocked the man's door and looked in on him. The man did not move, but the officer thought that he was asleep. However, as he continued unlocking cells, he began to feel that something was not quite right. He asked his colleague to return to the man's cell with him. The two staff went into the cell and checked the man.
49. The officers said that immediately on checking the man more closely they realised that he had died. The officer who had unlocked the man's door said that he felt the man's neck for a pulse but could not find one. He described the man as feeling cold to the touch and said that rigor mortis (the stiffening of the limbs after death) was already present. The two officers agreed that because of this they should not attempt cardiopulmonary resuscitation (which involves chest compressions and rescue breaths, which can help to keep a person alive until more advanced medical help is available).
50. The officer who was asked to return to the man's cell to check on him by his colleague said that he used his radio, telling staff in the control room that the man had been found dead in his cell. The officer said that a code system is in place at Long Lartin. This means that in an emergency, staff are instructed to use specific words to describe the nature of the emergency. At Long Lartin, the codes are code blue to indicate that a prisoner is not breathing and code red to indicate that a prisoner is bleeding. However, the officer said that in his shock at realising that the man was dead, he did not think to use the code system.
51. At 9.07am, staff in the control room asked the emergency response nurse to go to the man's cell. Two nurses responded, taking the emergency first aid bag with them. They arrived at the man's cell within a few minutes. One nurse went into the cell and checked the man, who was unresponsive and blue in colour. The nurse agreed that rigor mortis had set in and that cardio pulmonary resuscitation should not be attempted. The other nurse telephoned the healthcare department and asked for a doctor to confirm the man's death.
52. The prison's medical director arrived at the cell shortly after 9.15am. She performed further checks and concluded that the man had been dead for some time.

Contact with the man's next of kin

53. At 9.30am on the morning of the man's death, a prison governor was appointed as the prison family liaison officer. She identified the man's next of kin, his niece, from his prison file and found an address and telephone number which she presumed to be correct.
54. Prison Service Order (PSO) 2710, Follow up to deaths in custody includes supplementary guidance covering liaison with a bereaved family. The guidance suggests that, if the next of kin live some distance from the prison, the Governor may wish to ask trained staff from a geographically closer prison to break the news. As the man's niece apparently lived in Middlesex, staff at HMYOI Feltham (a prison in Middlesex) were asked to break the news to her.
55. At 1.30pm, staff from Feltham telephoned the prison's family liaison officer to say that there was no one at home at the given address. They left a note asking the man's niece to contact Long Lartin. The prison's family liaison officer also telephoned the mobile telephone number recorded in the man's file. There was no answer and so she left a message, asking the niece to telephone her.
56. Staff checked the man's file for any other information about his next of kin and telephoned his offender manager in the community (formerly known as a probation officer) to see if they had any additional information. (His niece's correct contact telephone numbers had been emailed to a number of staff, including the prison's family liaison officer, after the man was admitted to hospital in 2009. A printed copy of the email was apparently placed in the man's prison file but was not referred to following his death. This is discussed in more detail in the Issues section.)
57. The following day, the prison's family liaison officer tried the wrong mobile telephone number a second time and left another message. Over the next ten days, the prison continued to telephone the mobile telephone number to no avail. The police liaison officer (a police officer based in the prison) was asked to check police databases for information.
58. Eventually, the Coroner's office provided Long Lartin with the correct contact information for the man's niece, who was upset that it had taken so long for the prison to make contact with her. She told the prison's family liaison officer that she had given the man her new contact details when she visited him in hospital in 2010, and that staff had been present when she did so.
59. In line with PSO 2710, Long Lartin arranged and paid for the man's funeral, on behalf of and in consultation with his niece.

Support for staff and prisoners

60. About an hour after the man's death, a prison governor chaired a hot debrief for the staff involved. (Holding a hot debrief is a requirement of PSO 2710. It is an opportunity for staff involved in a death in custody to talk about the incident and receive reassurance and support.)

61. The officer who had unlocked the man's door and looked in on him explained that the news of the man's death was broken individually to prisoners on Perrie wing. He said that wing staff offered support to those prisoners who were clearly affected by the man's death. A book of remembrance was placed on the man's wing. A notice to prisoners living on other wings was written by the Governor and distributed. Staff were instructed to check all prisoners being monitored under suicide and self harm prevention measures.

Post mortem and inquest

62. The post mortem investigation gave the cause of death as:

- 1a. Acute left ventricular failure
- 1b. Ischaemic heart disease

- 2. Chronic kidney disease, diabetes mellitus

The pathologist commented that the man had "extensive" signs of heart disease, which, despite the triple bypass operation he underwent, had led to scarring of the heart muscle. In his view, this had left the man "at high risk of sudden death".

63. The Coroner held an inquest into the man's death, the verdict of which was natural causes.

ISSUES

Clinical care

64. The clinical reviewer appointed by Worcestershire PCT considered the clinical care provided to the man by Long Lartin. He highlights the man's extensive medical history, noting that he suffered with chronic kidney failure, insulin dependent diabetes and high blood pressure. Within the last three years, the man had undergone coronary artery bypass surgery and had been hospitalised in the intensive care unit on more than one occasion. In the year prior to his death, the man had 76 appointments with healthcare staff.
65. In addition, the clinical reviewer recognises that the man was not always an easy patient. His diabetes was poorly controlled because he did not follow dietary advice. He also began to refuse to attend appointments (both hospital and prison healthcare). He did not like to be handcuffed during outside appointments and said that he would not attend appointments unless he knew what they were for. The clinical reviewer cites evidence of staff keeping the man informed about future treatment. In addition, when he refused to be taken to hospital in December 2009, mental health staff assessed his capacity to refuse treatment. This was a sensible approach to take. However, I am pleased to see that, despite the finding that the man had the capacity to make decisions about his healthcare, staff continued to persuade him to accept treatment.
66. The clinical reviewer notes that aspects of the man's care were managed by hospital specialists. However, prison healthcare staff correctly followed treatment plans. Both prison doctors and nursing staff monitored and reviewed the man's various conditions appropriately. The clinical reviewer concludes that chronic disease management at Long Lartin is "well advanced and comprehensive and offers care that is comparable to primary care in the community".
67. However, the clinical reviewer reviewed the use of care plans to manage the man's numerous medical conditions. He found that the most recent one related to controlling the man's diabetes. The care plan followed guidelines set by the National Institute for Health and Clinical Excellence (NICE) and was written on 3 March 2010 and reviewed on 10 March 2010. The clinical reviewer found no record of the care plan having been updated since. Nor could he find up to date care plans for the other chronic conditions the man suffered. He makes the following recommendation, which I endorse:

The Head of Healthcare should remind primary care staff that:

- **a care plan should be devised for each chronic disease a patient suffers with,**
- **all care plans should include a review date**
- **all care plans should be reviewed in line with documented review dates.**

68. The clinical reviewer concludes, however, that the clinical care the man received at Long Lartin was of an equitable standard to what he might have received had he been living in the community.

The response on the morning of the man's death

69. On realising that the man had not responded when his cell was unlocked, two officers quickly went into his cell and checked him. They told the investigator that it was immediately clear that the man had died and that rigor mortis was present. One of the officers used his radio to tell staff in the control room about the death. Two nurses promptly arrived at the cell and agreed that the man was dead and that no cardiopulmonary resuscitation (CPR) should be attempted. PSO 2700, Suicide prevention and self harm management, directs that staff should always attempt CPR unless rigor mortis has clearly set in. Both the clinical reviewer and I are satisfied that, in the circumstances, staff made an appropriate decision not to attempt to resuscitate the man.

70. The officer who used his radio to tell staff in the control room about the man's death told the investigator that a radio code system is in place at Long Lartin. The code system alerts staff to the nature of the medical emergency and helps healthcare staff to bring the correct equipment to the scene. On this occasion, the officer did not use the code system, instead informing the control room staff that the man had died. Although clearly aware of the code system, the officer said that he was shocked at finding the man dead and did not think to use it. I am satisfied that, in general, Long Lartin staff are familiar with the correct radio procedures and make no recommendation.

Liaison with the man's next of kin

71. Shortly after the man's death, the prison's family liaison officer began trying to contact the man's niece. She referred to the next of kin information the man provided when he first arrived at Long Lartin. Unfortunately, this information was out of date. Despite a number of efforts to locate the man's niece, they were unsuccessful until eleven days after his death and when her correct contact details were provided by the Coroner. The man's niece was upset that it had taken so long for the prison to contact her. She said that she had provided her uncle with her new contact information, in the presence of prison escort staff, when she visited him in hospital in 2009.

72. The prison's family liaison officer told the investigator that it would have been the man's responsibility to inform the prison of his niece's new contact information, and I accept that to be the case. However, an email containing his niece's correct telephone numbers was sent to a number of staff (incidentally including the prison's family liaison officer) on 17 January 2009. A paper copy of the email was placed in the man's file, with the handwritten message "Please record in his file – thanks" written across the top. Clearly, the next of kin information was not updated. Furthermore, when my investigator visited Long Lartin on 17 March, she found the paper copy of the email in the man's file. Knowing that the prison had not yet been able to locate the man's niece, she alerted her liaison officer to

the email and suggested that staff try the telephone numbers listed. It seems that this information was not passed to the prison's family liaison officer.

73. Given that the prison had the correct contact information for the man's niece from the outset, albeit filed in the wrong place, the delay in contacting her is most unfortunate. However, I appreciate that the delay was unintentional and I do not think there is any recommendation that I could usefully make which would prevent such a situation arising again. I am also reassured that, since the man's death, Long Lartin has introduced a new system for checking next of kin details. A notice to staff has been issued instructing all personal officers to check their prisoners' next of kin details on a regular basis. In addition, any prisoner subject to formal suicide and self harm prevention monitoring will be asked to confirm their next of kin details.

CONCLUSION

74. The man had been in prison since 1995 and had suffered ill health for a number of years, including diabetes, heart failure and chronic kidney disease. He had been nursed in hospital intensive care units on more than one occasion in previous years. Staff at Long Lartin who knew the man said that, while he was a likeable character, he could be difficult and stubborn. There is evidence in his prison and medical records to show that he sometimes refused to co-operate with healthcare staff. There is also evidence to show that those staff spent time and effort explaining his treatment to him, and in some cases persuading him that the treatment was in his best interests. I am pleased to endorse the clinical reviewer's finding that the man received an equitable standard of care to that he might have expected in the community.

RECOMMENDATIONS

1. The Head of Healthcare should remind primary care staff that:
 - a care plan should be devised for each chronic disease a patient suffers with,
 - all care plans should include a review date
 - all care plans should be reviewed in line with documented review dates.

This recommendation has been accepted by NOMS.