Investigation into the circumstances surrounding the death of a man in an Infirmary in February 2010 whilst in the custody of HMP Long Lartin

Report by the Prisons and Probation Ombudsman for England and Wales

April 2011

This is the report of an investigation into the death of a man. He was a prisoner at HMP Long Lartin and he died in February 2010 at hospital. He had harmed himself by cutting his wrists three days earlier and was taken to hospital for treatment. The doctors discovered that he had an unusual type of leukaemia and he died of complications of the disease. He was 68 years old.

I extend my condolences to the man's family and friends and hope that my investigation helps them to better understand the circumstances surrounding his death. I apologise for the delay in issuing this report and any further distress it may have caused.

The investigation was carried out by my colleagues. A clinical review was commissioned from the local Primary Care Trust which was carried out by two clinical reviewers.

I am grateful to the Governor and his staff for their co-operation and assistance during this investigation. In particular, I thank the liaison officer for arranging the investigation programme.

I am told that the man could be a difficult prisoner, and he often showed his frustration with healthcare staff. On certain occasions, he started hunger strikes as a protest.

In his final few days in Long Lartin, he complained repeatedly about being in pain and was treated for a chest infection. However, he continued to complain and eventually, on 3 February, cut his wrists. At this point, he was transferred to hospital where it was found that he was suffering from acute myeloid leukaemia. I am mindful of the fact that he was in so much pain that he seemingly felt that the only way to get treatment was to harm himself. I have heard from other prisoners who were concerned about the healthcare given to older prisoners.

However, in clinical matters, I rely on the opinion of the clinical reviewers. They judge that the man's last illness was managed appropriately, and that both the diagnoses and treatments given were reasonable given the way that he presented. In particular, I note that he was being treated for pneumonia, which proved to be the eventual cause of death. It is unfortunate that he also had another underlying and undiagnosed illness that caused severe pain.

I make four recommendations to the Governor and Head of Healthcare. They concern cancelled hospital appointments, in-possession medication, opening the suicide monitoring procedures and displaying the Ombudsman's notices. I also comment on his statement to a nurse a few days before he died that he "would not be there" by the weekend, which was not interpreted as meaning that he would go on to harm himself.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **April 2011**

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SUMMARY

1. The man was remanded into HMP Woodhill in November 2003 and received a 20 year sentence in November 2004. This was not his first experience of prison although his previous sentence was some years previously. He was transferred to HMP Long Lartin in June 2006.

2. Whilst at Woodhill, he had treatment for bowel problems and attended a number of other healthcare appointments. He also had an ongoing problem with his right shoulder. Some hospital appointments were cancelled without his knowledge and so he wrote a number of complaint letters to prison staff and his solicitor. He complained to this office in 2004. He wrote of a delay in his medical treatment for a dislocated shoulder.

3. He became increasingly frustrated with his perceived lack of healthcare intervention and responded by refusing food. The longest period he did this for was eight weeks. In December 2004, he was assessed by a psychiatrist who said that he was capable of making his own decisions and understood the potential effects of not eating food. At no point was he assessed as feeling suicidal.

4. When the man was transferred to Long Lartin he had ongoing issues with his health and was treated for angina and hypertension. He was also seen by other specialists and treated for prostatism, although again he was not always satisfied with his medical treatment. He continued to write letters about his treatment and wing staff noted that he complied with the regime when he was satisfied that his health needs were being taken seriously. If not, he was described as very argumentative with staff.

5. He did not engage with sentence planning, saying that he was too old and ill to do so. He thought that his health problems were more of a priority.

6. On 1 February, the man was seen by a prison doctor who thought that he had a respiratory tract infection. He said he would see him in a couple of days and would probably refer him for further investigation. Other prisoners interviewed as part of this investigation who saw him in the days leading up to his admission to hospital said that he looked ill.

7. Two days later, on 3 February, the man was found in his cell having cut his arms. He was taken to hospital where he was then diagnosed with leukaemia. He died there three days later. The clinical reviewers said that this type of leukaemia is not always easily detectable and is more common in older people.

8. He died in hospital in February. The prison family liaison officer contacted his next of kin and the Royal Society for the Protection of Birds (RSPB), who he had named as executors to his will, to inform them of his death.

9. I make four recommendations as a result of this investigation. They concern cancelled hospital appointments, in-possession medication, opening of ACCTs and displaying the Ombudsman's notices

THE INVESTIGATION PROCESS

10. The man died in hospital. Terms of reference and notices were issued to staff and prisoners at Long Lartin telling them that an investigation would be taking place and inviting those who wished to see the investigator to make themselves known. The investigator requested copies of his core record, clinical record and other documentation relevant to his time in custody and his death.

11. The investigator also contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report.

12. She visited Long Lartin on 16 February, 16 March and 20 April 2010 to interview staff. A number of prisoners asked to meet with her, although did not consent to taped interviews. An Assistant Ombudsman was present during these interviews. One member of staff, a nurse, was unavailable for interview, and provided a written statement instead. The investigator visited Perrie Wing and met staff and prisoners who knew the man. She also met the Governor.

13. A clinical review of the man's clinical care was commissioned from the local Primary Care Trust and undertaken by two clinical reviewers. Their comprehensive review appears as an annex to this report.

14. The Family Liaison Officer for the Ombudsman contacted the man's friend, who he had nominated as his next of kin. The friend thanked her for contacting him, asked to be told about the outcome of the investigation and the cause of death, but did not wish contribute any further.

HMP LONG LARTIN

15. HMP Long Lartin is a high security establishment, accommodating prisoners with a sentence of over four years including those serving a life sentence. It also accommodates high security remand prisoners. During the past year, the prison has increased its maximum capacity from 454 prisoners to 622.

16. There have been three self-inflicted and two natural cause deaths at Long Lartin since my office assumed responsibility for investigating deaths in custody. None of the issues raised in the previous investigations have any relevance to the death of the man.

Independent Monitoring Board (IMB)

17. All prisons in England and Wales have an Independent Monitoring Board which is staffed by volunteers from the local community. The IMB has access to every area of the prison, including attending meetings, adjudications and segregation reviews. Members answer prisoner's queries and investigate complaints. The IMB also publishes an annual report.

18. The IMB report for the period of 1 February 2009 to 31 January 2010 acknowledged the challenges the prison faced in dealing with the significant increase in the population at Long Lartin and specifically the increase in older prisoners.

HM Inspectorate of Prisons

19. An announced inspection of Long Lartin was held in July 2008 by the then Chief Inspector of Prisons. Her report following the inspection praised Long Lartin for successfully managing the increase in the population.

20. The report described the primary healthcare services as good with a broad range of nurse led clinics and visiting consultants. The recent increase in the population had not been matched with an increase in healthcare staff although a nurse had been appointed as an elderly care specialist. The inspection team noted that there were no delays in prisoner access to secondary health services.

Bedwatch logs

21. Bedwatch logs are completed by prison staff who are with the prisoner in hospital. They must be completed at set intervals and record the prisoner's activity and progress throughout the stay in hospital.

Categorisation of prisoners

22. All prisoners are risk assessed and are given a category based on their offence and the risk they pose to the public should they escape. There are four levels – A, B, C and D. Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult.

Cell sharing risk assessment (CSRA)

23. In order to make sure that unsuitable prisoners do not share cells, a cell sharing risk assessment is completed by reception staff when a prisoner first arrives at the prison.

Emergency codes

24. Emergency codes are used to summon staff to deal with a particular situation. A code red refers to life threatening situations such as hanging, severe blood loss, cardiac arrest. Such emergency situation requires immediate attention from healthcare staff and the prisoner cannot normally be escorted to the healthcare centre for treatment.

Hot debrief

25. A hot debrief takes place after a serious incident. It gives the staff the opportunity to raise immediate issues and help normalise the reactions that some people experience after a traumatic incident. Benefits include being able to discuss their experiences in a safe and confidential environment.

Incentives and Earned Privileges (IEP)

26. The IEP scheme encourages and rewards good behaviour by prisoners. There are three levels: basic, standard and enhanced. Incentives include access to in-cell television, more private cash to spend, being able to wear their own clothes, more time out of cell and access to extra and enhanced visits. Each prison sets its own criteria to obtain each level.

Listeners

27. Listeners are prisoners trained by the Samaritans to provide a confidential service for other prisoners. They do not offer counselling but offer support, particularly for prisoners at risk of self harm.

Person Escort Record (PER)

28. The police, courts, escort and prison services have an agreed procedure for sharing information about prisoners as they are moved between their establishments. It is essential that, when a prisoner is moved from police station, court or prison to court, prison, hospital or other destination, those responsible are aware of any risks or vulnerabilities. In particular it is essential that known risks of escape, assault, suicide/self harm or harassment are communicated to others into whose custody the prisoner is passed; to protect prisoners, staff and the public. It is also essential that any new risks that develop during a movement are recorded and flagged up for others. The PER is the means of ensuring that information about the risks is available to those responsible for their custody.

Prostatism

29. Prostatism is a condition affecting men. Symptoms, which are caused by an enlarged prostate gland, include difficulty with urination.

Roll check

30. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur on a number of specified occasions during the day and night, and staff sign that the roll is correct.

Suicide and self harm monitoring

31. Assessment, Care in Custody and Teamwork (ACCT) procedures aim to help and monitor prisoners at risk of harming themselves. The key aims of ACCT are to create a safe and caring environment, identify prisoners' individual needs, and provide individualised care and support before, during and after a period of crisis. Once an ACCT is closed a post closure review must take place within seven days.

KEY EVENTS

Events at HMP Woodhill

32. The man was remanded into HMP Woodhill on 12 November 2003. On 20 November, an 'Identification of Potential Life Sentence Prisoner' document was completed which noted that, if he was found guilty, he thought it unlikely that he would leave prison due to his age and health.

33. Whilst still on remand, he complained of a shoulder injury and was seen by healthcare staff. However, his records show that he was not satisfied with the treatment he received. His prison personal records say that he was polite to the staff on the unit but was angry with healthcare for not treating his shoulder problem. He wrote to his solicitor complaining about his lack of treatment and he also became more abusive to wing staff.

34. In October 2004, the man started to refuse food due to his frustration with having a hospital appointment cancelled. He wrote a letter to his trial Judge saying that he was on hunger strike and would not be attending court. He also wrote to his solicitor setting out his concerns. The prison records include these letters and the subsequent replies from the Head of Healthcare to both the man and his solicitors. His prison personal records say that he decided to start eating again on 26 October.

35. In the event, he did attend court and, on 1 November, received a 20 year sentence. He returned to Woodhill and his records note that he started refusing food again in mid-November. He thought the prison had "an agenda against him" and said he would be "leaving in a box". However, there is no record of whether he was assessed as being at risk of self harm or suicide at this point.

36. On 30 December, the man had a mental health assessment by a psychiatrist as he continued to refuse to eat. The assessment concluded that he was not detainable under the Mental Health Act as he appeared fully rational and understood the nature and potential affects of his actions.

37. By the beginning of 2005, he had started to eat food again. A few days later, he was examined by a doctor who referred him to an outside hospital with a suspected twisted bowel. He underwent an operation and, on return to the prison, was given a special diet to meet his medical needs. In April, he attended a follow up outpatient's appointment at which the consultant added him to a waiting list for a reversal of the operation. This operation took place in August 2005.

38. Throughout 2005, the man was seen by healthcare about his ongoing medical conditions. He wrote to various staff members complaining of his treatment and threatened to go on another hunger strike in July as a hospital appointment had been cancelled. However, he changed his mind once he was told that the appointment had been rebooked. His records say that he his behaviour changed towards the end of the year in that he worked very hard on the wing and was polite to staff.

Events at HMP Long Lartin

39. The man transferred to HMP Long Lartin on 8 February 2006. The PER and the CSRA both note he had a medical condition. He was assessed as low risk of harm to others and was allocated a single cell.

40. The reception screening document noted that he had angina, a Hartmann's procedure (the surgical procedure used to correct his twisted bowel) with reversal, and tinnitus. It was also noted that he had a history of self harm with "hunger strike 8 weeks" written in the comments box. There was no reference to this being followed up. The document also said he was to be referred to a dentist but the investigator found no record as to whether this happened.

41. Whilst the man was at Long Lartin, he was reluctant to engage in sentence planning (to help address his offender behaviour). At a Risk Assessment and Management (RAM) review meeting in 2006, he was asked about the risk that he would reoffend in the future. His reply was that it was "unlikely" as he fully expected "to leave prison in a wooden box" or alternatively he would stay in prison for a long time and present little risk due to his age. His sentence planning documents assessed him as unmotivated to engage in education and behaviour programmes. He was happy to watch television and look after the bird that he was allowed to keep in his cell. There was no concern raised about him being at risk of harming himself in these documents.

42. Throughout 2006, he attended healthcare appointments on several occasions and was referred onto other healthcare teams, such as the dentist, audiologist (to treat hearing loss) and an optician. He was also seen at the Wellman Clinic. He had an IEP level review on 14 November which noted that he had occasionally been argumentative with staff and had been given a written warning as a consequence.

43. Entries in the man's personal prison record in 2007 say that he complied with the prison regime, although he remained unmotivated to engage in sentence planning due to his age and health. An entry in his record on 11 July recorded that he had talked to his personal officer about a friend who was dealing with his money and would look after his funeral arrangements in due course. There is nothing in his records to suggest that he was suicidal at this point. His records say he exercised on a regular basis and looked after his bird.

44. The man also wrote a letter to a staff member complaining that he had been waiting for over two and half years for an ear problem to be resolved and was also waiting to see a dentist. He said that whether he lived until he was older or left the prison in "a wooden box", he wanted respect

45. His personal prison records in 2008 show that he did not cause any problems on the wing but complained about healthcare. He had an IEP level review in May and remained as a standard prisoner as he had not completed the targets set by the RAM board in 2007.

46. Also in 2008, the man had further health issues having teeth extracted and was seen on numerous occasions for toothache. In July, he attended the Wellman/older person's clinic and also saw a doctor for a prostatism problem. He missed two appointments for follow up blood tests which were eventually taken in December.

47. On 12 August, he was referred to see an audiologist. He had been referred in 2006 but no appointment took place. This was explained to him and healthcare apologised for the mistake. He wrote to his personal officer saying that two audiologist appointments had been cancelled and although he was grateful for his personal officer's help, he did not trust healthcare due to his experiences at both Woodhill and Long Lartin. An entry in his personal prison record on 15 August recorded that he said he would write to his solicitor and begin a hunger strike if he did not get any satisfaction with his medical problems.

48. The man was given an audiologist appointment for 11 September, but was not seen until a week later. He wrote to the Head of Healthcare complaining about this. The Head of Healthcare apologised, informing him that the administration system for booking visiting consultants had now been changed.

49. In April 2009, he wrote to the doctor saying his prostate problem was getting worse. The doctor saw him later that month. On 29 April, a doctor noted that he would refer him to urology and continue his medication. He was prescribed finasteride 5mg for his problem with prostatism. However, there seem to be occasions when the medication does not seem to have been prescribed to him. A plan was agreed that he should continue with the medication and he was given a supply of 28 tablets which were to be taken once a day. Although this medication was meant to be held in his possession, he complained that the tablets were not available to him. The tablets arrived at some point during the month and were then given to him.

50. The man was referred on 20 May to the hospital, but he was not seen by the urologist until 4 September. (Letters on his medical records show that the appointment was changed three times in that period. He asked to change one of the appointments and was given a new date of 7 August. He again asked for another appointment date and received confirmation that this had been put back until 21 August. No further information is available about why these appointments were changed, apart from him requesting so on two occasions.)

51. The clinical reviewer noted that given that although the finasteride tablets were to be taken daily, the prescription seems to have been erratic. The tablets were prescribed in batches of 28 on 29 April, 35 days later on 3 June, 54 days later on 27 July and 36 days later on 1 September. On 4 September, it was recorded in the man's medical records that he was not responding to this medication, and an alternative was prescribed by a prison doctor and endorsed by a consultant urologist.

52. On 4 September, a prison doctor prescribed a supply of 30 tamsulosin 400mg tablets for the prostatism and he was to take one tablet daily. However, the next prescription for 30 tablets was 63 days later on 6 November, then 31 days later

on 7 December and 28 days later on 4 January. The clinical reviewer notes that, although it is not certain whether he took the finasteride tablets every day, there does not appear to have been any systematic process to ensure that the supply of in-possession medicine was monitored and maintained.

53. Entries in the man's prisoner personal records note that his behaviour to wing staff changed in May. He distanced himself from staff, only talking when he needed to and being rude on occasion. However, he continued to exercise and engage with other prisoners. A sentence planning review board took place in May to which he was invited, but declined to attend. The documents from that meeting note that he was not complying with his sentence planning and would remain a category B prisoner.

54. In September, staff undertook a cell search and found screws, broken furniture and paper clippings with racial comments in his cell. A security information report (SIR) and racist incident report form were completed. A cell sharing risk assessment review was also completed which raised his risk to medium due to the paper clippings found in his cell. There is a hand written note in his prison records which appears to have been written by him. The note relates to two incidents in September, one when an officer allegedly refused to listen to him and the other about a meeting with a governor. The note said "Thurs 17.9.09pm in his office meeting with (wing gov) – a waste of time, all inmates are liars".

55. In the early hours of 28 January 2010, a healthcare assistant was called to the wing as the man had pain around his ribcage. She called for an ambulance. Paramedic staff attended, gave him further pain relief and suggested that he might have a urinary tract or chest infection. Later that day, he was seen by Nurse A and said that he had been in pain for the previous four days. The nurse discussed this with the doctor who prescribed the painkiller, tramadol.

56. The man saw Nurse B the following day. The nurse described him as 'articulate and lucid' and said he would 'continue to monitor' him. He had an outpatient's appointment, which he did not attend, but was then seen by Prison Doctor A on the wing. The doctor examined him and was concerned that he might have an early chest infection. The doctor advised that he should take fluids for 24 hours and the nurses should monitor him over the weekend.

57. Healthcare staff did monitor the man over the next couple of days and, on 31 January, Nurse B saw him after being called to the wing by staff. The medical record states that he was complaining of pain, said that his prescribed medicine was ineffective and he wanted to go immediately to outside hospital.

58. Later that morning the man was seen by Nurse C who described him as 'sarcastic and hostile'. She did not think that he appeared unwell at that point and noted that the doctor was due to see him the following day.

59. That same day, he handed a note to staff saying that he was going on a hunger strike as he was not happy with the treatment he was getting from the healthcare department. His records indicate that healthcare and the duty governor were informed and the appropriate paperwork was raised.

60. The man was seen by Nurse D later that morning as he was refusing food. The nurse checked his temperature and advised him to start eating again and drink fluids. It was noted in his medical records that he was argumentative and wanted to be sent to an outside hospital.

61. The following day, he was seen by Prison Doctor B, who thought he 'looked reasonably ok for somebody with chest infection'. The doctor was concerned as the man had coughed up blood in his phlegm which he thought could be due to a respiratory tract infection. He prescribed tramadol and noted that he should be reviewed in two days.

62. The investigator saw a copy of some diary sheets that appear to have been written by the man. An entry for 28 January suggests that he slept in a chair as he was in too much pain to sleep in the bed.

63. On 2 February, he was seen by Nurse E. She said that he questioned the effectiveness of his medication and then became very challenging towards her. He wanted to go to outside hospital but she offered admission to the prison healthcare unit if it was assessed as clinically appropriate. He declined this offer, saying 'I won't be here by the weekend'.

64. Nurse E was unavailable for interview for this investigation but she did supply a written statement for this investigation. She wrote that it was clear to her that the man wanted to go to outside hospital and was in a lot of pain but she had no reason to believe he was expressing any suicidal intentions. It was her professional opinion that he was "attempting to address the seriousness of what he was experiencing by asking for outside help and nutritional supplements". She contacted a doctor, who agreed to follow up her concerns, although her statement does not say which specific concerns she is relating to. (There is no record of the concerns being followed through by a doctor.)

65. Later that afternoon, Nurse F responded to a call from the wing about the man. When she asked him what was wrong, he said that she should know. She asked him to say what was wrong at that particular time and he responded by swearing at her. Officer A was also there and she told the investigator that, after he swore, she gave him an IEP warning. She did not think that he was displaying any signs of intending to harm himself and said that she would have opened the ACCT support procedures if she had thought otherwise.

66. That same day, the man spoke to Prisoner A. The prisoner told the investigator that the man had told him on three occasions that he intended to kill himself. The prisoner thought that he said this because he wanted to go to hospital as he was in so much pain. It is not clear whether the prisoner spoke about this with any members of staff as there was no record of any conversations about this matter.

67. At approximately 06.45am on 3 February, a routine roll check on Perrie wing was carried out by an Operation Support Grade (OSG). (There had been no alerts from the man's cell during the night and a cell bell print out shows that he had not pressed his bell prior to the roll check. He was located in a single cell.) The

officer looked through the observation panel and could see him lying on his bed, covered in dried blood. He raised an emergency call.

68. Nurse A responded to the code red emergency call. He took the emergency bag with him and, on arriving at the man's cell, found him lying on his bed covered in dried blood and blood clots with fairly deep cuts to both elbows and one on his wrist. He appeared to be conscious but only responded by blinking a lot when the nurse talked to him. The nurse noticed a razor blade (it is common practice for prisoners to be allowed access to razor blades for shaving) on the floor of the cell along with a loose pile of antibiotics and an empty strip of eight paracetamol tablets.

69. An ambulance was called whilst Nurse A tended to the man. Paramedics arrived at the cell approximately 20 minutes after being called. The ACCT procedures were opened because he had harmed himself by cutting his arm. Basic details about the incident were recorded with a case review set for the following day. He was taken from the prison to the emergency department at hospital at 6.42am and one of the escort staff informed the prison of their arrival at 7.09am. At this stage, restraints were used.

70. Later in the afternoon of 3 February, the Clinical Team Manager contacted the hospital and was advised the man was in the coronary care unit and his condition was 'far from stable'. The healthcare department remained in contact with the hospital over the next few days.

71. On 4 February, one of the prison escort staff was told by the consultant haematologist that the man had been diagnosed with leukaemia and might be moved to another hospital. One of the bedwatch officers telephoned the healthcare department to inform them of this news. An entry in the bedwatch log noted that a doctor had asked for next of kin details.

72. The same day, the ACCT review was completed by the bedwatch staff at the hospital. Although the man was present, he was heavily medicated and was unable to contribute to the review. The review noted that he was still talking to staff and had said that he harmed himself because of the pain he was suffering. A review date was set for the following day and the ACCT document was updated as required.

73. The following day, a governor visited the man in hospital. The bedwatch records note that he spoke 'rationally about his fears and his current situation'. He said that he had made a Will in 1995 giving his estate to the RSPB. Entries in his ACCT document record that he had eaten some food and appeared to be in 'slightly better spirits'. He agreed to accept treatment for his illness. Later that evening, he was transferred to an Infirmary. He had periods of restlessness which subsided when he was given more medication.

74. The following day a risk assessment was completed and the restraints were removed due to the seriousness of his condition. One of the hospital doctors also asked for the man's next of kin details. Later that day, the prison's family liaison officer contacted the friend who he had nominated as his next of kin. She asked

for his address, explaining that she had some difficult news but instead he asked to be told over the telephone. She told him that the man was in hospital and had asked staff to contact him. The friend thanked her for contacting him and asked to be kept informed.

75. The man talked to the bedwatch staff and watched television that day. Later in the evening, he became more distressed and was breathing heavily. He was given further medication by the nursing staff. Some time later, staff noticed he did not seem to be breathing and called for the medical staff. He died that evening at 11.10pm. One of the bedwatch staff immediately telephoned the prison to inform them. The duty governor was then notified and said she would go to the hospital. The Independent Monitoring Board, chaplain and police were informed.

76. Prisoner B, one of the prisoners interviewed as part of this investigation, said that a senior officer told him about the man's death and asked him to tell other prisoners on 7 February. He said that a chaplain was available for a short time that day. He also said that the notice advising prisoners of the Ombudsman's investigation was placed out of sight behind a door until he complained that it was not visible.

77. The prison's family liaison officer telephoned the man's friend again on 7 February to tell him of his death. He was offered a visit from staff but declined. She telephoned him on several other occasions. She also contacted the senior legacy advisor at the RSPB, the executors of his Will, and also contacted his sister and an ex-partner.

78. The post-mortem report concluded that the man died from pneumonia and acute myeloid leukaemia.

79. A representative from the RSPB collected his belongings from the prison in accordance with his wishes. They took some items, asked for some to be donated to charity (which the prison gave to SCOPE, a charity for children and adults with cerebal palsy) and some items were destroyed as they were in a poor state. They also arranged his funeral, which was held at the crematorium on 5 March. The liaison officer and the Deputy Governor attended, along with the RSPB representative. The RSPB declined to scatter the man's ashes, so these were passed to a friend.

ISSUES

Medical Care

80. The clinical review was undertaken by two clinical reviewers on behalf of the local Primary Care Trust. Their review was based on prison and medical records including the PCT's clinical review report. With the investigator they also interviewed prisoners and staff at the prison.

81. The reviewers have found that overall the man's illnesses were generally managed appropriately by healthcare staff at Long Lartin. There was evidence of organised chronic disease management and that Wellman clinics were conducted. He was also referred appropriately to other specialists, including an audiologist, dentist and optician. However, the reviewers raised concerns about some of the delays in these referrals, which resulted in him having to wait longer than necessary for his appointments.

82. A number of the man's appointments were cancelled at both Woodhill and Long Lartin, sometimes at his own request. He was not always informed about other cancellations which resulted in him becoming increasingly frustrated. His experiences at Woodhill seem to have given him a negative view of healthcare which does not appear to have been alleviated by his experiences at Long Lartin. It would appear that he held the view that threatening or actually carrying out a hunger strike would solve his problems. Both the investigator and the clinical reviewers have since been informed that prisoners are notified when clinics are cancelled.

The Head of Healthcare should ensure that procedures are in place so that the number of cancelled appointments is kept to a minimum and, if an appointment is cancelled, the prisoner is informed as soon as possible. The number of cancelled appointments should be regularly monitored.

83. Like the reviewers, I am concerned about the apparent shortcomings providing the man with the prescribed doses of his medication. The supply seems, at the very least, to have been erratic. As well there does not seem to have been a systematic process to monitor and maintain prisoners' compliance with their in-possession medication. Subsequent to these findings, I understand that steps have already been taken to address this issue.

The local PCT and the Head of Healthcare should ensure that a policy for in-possession medication is written and adhered to. The policy should ensure that prisoners are given the correct dose of their prescribed medication and are monitored to ensure that they take it correctly.

84. The investigator spoke with several prisoners when she visited the prison and also received letters from two prisoners. The prisoners raised concerns that the man looked ill before he died and they felt that there was not enough care for him. Two of the prisoners said that a few prisoners on Perrie wing look after the more frail prisoners, collecting their meals and cleaning their cells alleging that this is because healthcare staff do not look after them. One prisoner also said

that some prisoners collect medication for others because there is no healthcare support. The prisoners expressed grave concern about the standard of healthcare at the prison, and care for older prisoners in general.

85. The investigator asked the Head of Healthcare about these concerns and she said that there was no system in place for prisoners to collect other prisoner's medication. She said that there is a consultation system in place for prisoners to raise any concerns about healthcare and that she hoped to improve these systems. Although the prisoners did not give specific examples of any mistreatment, they all spoke of the pain that the man had endured, and the poor treatment he received from healthcare.

86. I have taken the concerns of the prisoners very seriously. Indeed, an Assistant Ombudsman was present during the interviews conducted by the investigator, and was aware of the issues raised. With regard to the specific concerns raised about the care provided for the man, the investigation has not found any evidence to substantiate their concerns. Although it is clear that he was in great pain on 2 February, the clinical reviewers believe that the treatment he was given and the diagnoses made were appropriate and reasonable. I hope this allays the concerns of the prisoners. However, I draw the attention of the Governor to the concerns for him to look further into the issues raised.

Risk of self harm

87. There is no record of the man cutting himself before he did so on 2 February. There are records of him saying and writing that he thought he would leave prison in a 'wooden box' but no issues were raised about him being at risk of harming himself or suicide at that time. In relation to his episodes of refusing food, the self harm/suicide procedures (such as starting an ACCT) were instigated which may have been because he began to eat again very shortly after saying he would go on hunger strike.

88. The man made a comment to Nurse E a few days before he was taken to hospital about not being there by the weekend. She did not interpret this as meaning that he was planning to harm himself but instead that he was trying to get to an outside hospital. She said that she would follow up his concerns with the doctor, but there is no record whether this happened.

89. As mentioned above, the clinical reviewers judge that the man's last illness was dealt with appropriately. He had been in pain for some time and was being treated for what was thought to be a chest infection. Nevertheless the pain did not subside which, it appears, led him to harm himself. It is regrettable that a prisoner should be in such a state that he should cut his wrists, telling another prisoner that he had done so in order to be admitted to hospital. In the event, he achieved what he wanted and his admission to hospital was because he had harmed himself. The reviewers believe that he would have been referred within a couple of days if his symptoms had continued. The reviewers advise that the onset of this type of leukaemia (acute myeloid leukaemia) can be sudden and it is not a disease with obvious symptoms. Indeed, I understand that the symptoms of the disease are often not noticed until two or three weeks before death.

90. The investigator and clinical reviewers believe that the man's comment to Nurse E was made as he was in so much pain. The investigator and clinical reviewers have since been told that the Head of Healthcare has ensured that this is a learning point for staff. However, he made a comment that could have been interpreted in two ways, and I believe that action should have been taken to ascertain what he meant by his remarks.

The Head of Healthcare should review the learning from the man's death and ensure that consideration is given to the risk of self harm when a prisoner is treated by healthcare staff.

Use of restraints

91. I have reviewed the risk assessment paperwork and bedwatch logs completed by the officers. The logs show that hourly checks on the man's mood were recorded and the staff updated the prison at four hourly intervals. In addition to this, staff also recorded that restraints were checked hourly. I am satisfied that sending him to hospital under restraint was in accordance with the prison's security policies and procedures and also that the restraints were removed at the appropriate point when his condition deteriorated.

Debrief for staff

92. The investigator found no evidence of a hot debrief (or critical debrief) after the man's death. At the time of his death, Prison Service Order 8150 gave instruction about post-incident care for staff, although this was replaced in March 2010 by a prison service instruction, PSI 08/2010. Following this guidance, Governors should arrange for a debrief to be held following a 'potentially traumatic incident'. Given that he had harmed himself before being taken to hospital, and that the cause of his death was unclear at the time this office was notified, his death might well be deemed to fall into this category. It is for the Governor to decide whether to hold a debrief and, on this occasion, no members of staff have expressed any concerns about their support following his death.

Ombudsman's notices

93. Some of the prisoners interviewed said that the Ombudsman's notice announcing this investigation was placed behind a door and out of general view. The notices are issued to ensure that prisoners and staff are aware of my investigation and know how to access the investigator. This is imperative for an open and transparent investigation to take place. The notices should be displayed around the prison to ensure they are in full view for all staff and prisoners.

The Governor should ensure that the Ombudsman's notices are prominently displayed to prisoners and staff.

CONCLUSION

94. It is clear from the investigation that the man was a demanding prisoner who had a low opinion of healthcare. He complained regularly and threatened to harm himself in protest and to gain further medical intervention.

95. The clinical reviewers note that his final illness, acute myeloid leukaemia, can be difficult to diagnose. They believe that the prison doctor's diagnosis of either intercostal muscle strain or a chest infection was reasonable. They conclude that an earlier admission to hospital would not have changed the outcome.

96. The clinical reviewers also highlight problems associated with the prescribing and dispensing of medication. These include delays in prescribing, failure to monitor in-possession drugs and delays in the delivery and subsequent dispensing of drugs to him. They also found that some referrals had been delayed and appointments missed. In the latter case, this was because he had asked for them to be rescheduled.

97. Whilst content that the man's symptoms were being managed by healthcare staff and doctors in his last days at Long Lartin, I am concerned that he seems to have continued to be in pain. I understand that this particular illness is difficult to diagnose. Nevertheless I do not think it appropriate for any prisoner, whether one who complains or not, to say to a friend that he had cut his arms as a means of getting hospital treatment. He had clearly been suspicious of healthcare intentions for many years. I wonder how a more compliant prisoner would have been looked after. I trust that no other prisoners are apparently in such discomfort that they harm themselves in this way.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that procedures are in place so that the number of cancelled appointments is kept to a minimum and, if an appointment is cancelled, the prisoner is informed as soon as possible. The number of cancelled appointments should be regularly monitored.

   The Prison Service has accepted this recommendation.

2. The local PCT and the Head of Healthcare should ensure that a policy for in-possession medication is written and adhered to. The policy should ensure that prisoners are given the correct dose of their prescribed medication and are monitored to ensure that they take it correctly.

   The Prison Service has accepted this recommendation.

3. The Head of Healthcare should review the learning from the man's death and ensure that consideration is given to the risk of self harm when a prisoner is treated by healthcare staff.

   The Prison Service has accepted this recommendation.

4. The Governor should ensure that the Ombudsman's notices are prominently displayed to prisoners and staff.

   The Prison Service has partially accepted this recommendation. The prison said that on the day of the man's death a notice was placed under the door of every prisoner on the wing.