PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in October 2014, while a prisoner at HMP Long Lartin.

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of the man in October 2014, while a prisoner at HMP Long Lartin. The man had been suffering from cancer of the liver and died from abdominal bleeding. He was 56 years old. I offer my condolences to the man's family and friends.

The investigator carried out the investigation. A clinical reviewer reviewed the clinical care the man received at Long Lartin. The prison cooperated fully with the investigation.

The man had been at Long Lartin since July 2010. He had a history of hepatitis C and liver disease, caused by alcohol and substance misuse. In September 2013, the man began to receive treatment for oesophageal varices (enlarged veins in the gullet). In September 2014, doctors diagnosed liver cancer, which could not be treated. On 19 October, the man was taken to hospital after he began to vomit blood. He died in hospital the next day.

The clinical reviewer considered that, while aspects of the healthcare the man received in prison were good, there was still areas of concern. In particular, there was no clear care plan to advise healthcare staff about his medication and how to manage the risk of bleeding, and he missed important MRI scans and other appointments, because there were insufficient officers to take him to hospital.

I am particularly concerned that stringent security checks delayed ambulance staff reaching the man and there was a further significant delay allowing the ambulance to leave the prison and take him to hospital. Long Lartin is a high security prison and security is the priority, but this level of delay in a life-threatening emergency is unacceptable and the Governor needs to ensure that such delays are minimised. I am also concerned that despite his very serious condition, staff used handcuffs to restrain the man when taking him to hospital. I have raised the issue of unnecessary and unjustified use of restraints with Long Lartin before.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2015**

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SUMMARY

1. On 16 October 2008, the man was remanded to HMP Hewell charged with murder and arson with intent to endanger life. He was sentenced to life imprisonment on 24 August 2009. The man's reception health screen at HMP Hewell had identified that he had liver disease, a result of hepatitis C caused by substance misuse and excessive alcohol consumption. In November 2009, the man was admitted to hospital for a long course of antiviral treatment.

2. The man moved to Long Lartin in July 2010, after he had completed his hospital treatment. He had regular routine blood tests and ultrasounds to check for cirrhosis, a common and serious complication of long-term liver disease. In 2011, the man refused to continue with active treatment for hepatitis C, but healthcare staff regularly monitored his condition.

3. In September 2013, investigations showed oesophageal varices (enlarged veins in the gullet). Doctors prescribed medication to reduce the risk of bleeding. In April 2014, a prison doctor referred the man for urgent tests because of ascites – a build-up of fluid in his abdomen. Five months later, an MRI scan confirmed liver cancer. The cancer was too advanced for active treatment.

4. On 7 October, the man complained of vomiting blood. A nurse did not send him to hospital as he appeared well otherwise and his clinical observations were normal. On 9 October, at a hospital appointment for an endoscopy, doctors carried out a procedure to reduce the risk of the varices bleeding. He was due to have another endoscopy four weeks later. Doctors prescribed medication to reduce the abdominal swelling.

5. At 5.10pm on 19 October, an officer called healthcare staff after the man had vomited blood. A nurse attended and requested an emergency ambulance, which the control room called at 5.22pm. The nurse took the man to the prison's healthcare centre. Paramedics arrived and treated the man before taking him to hospital. The man continued to vomit blood and hospital doctors moved him to an intensive care unit later that evening. The prison informed his sister at 11.40pm and she was with him when he died at 12.20pm the next day.

6. Although the clinical reviewer concluded that the man's overall care was equivalent to that he could have expected in the community, the investigation identified a number of concerns, which the prison will need to address. There was no care plan to inform healthcare staff about his medication and how to manage the risks of his condition. The man missed an important scan twice because of a shortage of officers to escort him. We are concerned that security checks hindered ambulance staff reaching the man quickly and further delayed him getting to hospital. Staff restrained the man when he went to hospital, without a fully considered risk assessment. We make six recommendations.

INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at Long Lartin informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She interviewed six members of staff at Long Lartin in December and interviewed two members of staff by telephone.

9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

10. We informed HM Coroner for Worcestershire District of the investigation who provided the post-mortem report. We have sent the coroner a copy of this investigation report.

11. One of the Ombudsman's family liaison officers contacted the man's sister to explain the investigation process. She did not have any specific issues for the investigation to consider.

12. The man's family received a copy of the draft report. They did not make any comments. The prison also received a copy of the draft report and the response to the recommendations has been added to the end of the report.

HMP LONG LARTIN

13. HMP Long Lartin is a high security prison holding up to 625 men who have been sentenced to at least four years imprisonment. Worcester Health and Care NHS Trust is the healthcare provider. There is a small impatient unit.

HM Inspectorate of Prisons

14. The most recent inspection of Long Lartin in October 2014, found that the healthcare service was reasonably good, but was too reliant on locum GPs, which potentially affected the delivery of appropriate care. Inspectors found that the role of the prison's healthcare inpatient unit was not well defined and prisoners there received poor care. There was generally good access to a range of clinics but inspectors were concerned that prisoners missed hospital appointments because of a shortage of officers to escort them.

Independent Monitoring Board

15. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. It its most recently published annual report for the year to January 2014 the IMB noted that the loss of some experienced staff had had a substantial effect on the day-to-day work of healthcare during part of the past year.

Previous deaths at Long Lartin

16. Since 2012, there have been eight deaths at Long Lartin, including the man. There have been two deaths subsequently. We have raised the issue of the unjustified use of restraints for hospital escorts before.

KEY EVENTS

17. On 16 October 2008, the man was remanded to HMP Hewell for offences of murder and arson with intent to endanger life. He received a life sentence on 24 August 2009.

18. A reception health screen at HMP Hewell identified that the man had liver disease, a result of hepatitis C, excessive alcohol consumption and substance abuse. He had had previous psychiatric treatment for anxiety, depression, and personality disorders. In November 2009, the man attended Worcestershire Royal Hospital as an outpatient for a twenty-four week course of antiviral treatment. The treatment appeared to be successful and on 9 July 2010, he was discharged from hospital to HMP Long Lartin.

19. In October 2010, the man had a routine blood test to check his liver function. The results showed a mildly abnormal liver function, a low platelet count, and a recurrence of the hepatitis virus. A consultant in infectious diseases examined the man at the prison and referred him for an ultrasound examination to check for cirrhosis, a common and serious complication of long-term liver disease. The ultrasound showed that the man had gallstones but there was no evidence of cirrhosis. Doctors did not consider surgery was necessary for the gallstones, as the man did not have any pain.

20. A specialist discussed a further course of hepatitis C treatment with the man, who was reluctant to continue as he had suffered depression as a side effect of the first course. The specialist agreed to monitor the man's liver disease with six-monthly blood tests (including one for liver cancer, which measures alpha-fetoprotein (AFP) levels) and ultrasound examinations.

21. In June 2011, the man's liver function tests were stable and the AFP blood test was normal. In July, the specialist discussed hepatitis C treatment with the man again. He agreed to try it but felt generally unwell after the first injection and immediately discontinued the treatment. As new treatments with potentially fewer side effects were being developed, the specialist agreed he should wait. Meanwhile the specialist arranged for his condition to be monitored with regular blood tests and scans.

22. A year later, in July 2012, an ultrasound showed a slightly enlarged spleen but no evidence of cirrhosis. Blood tests in January 2013 showed a slight deterioration in liver function and, in April 2013, the man's AFP levels started to rise. Initially, this suggested advanced liver disease and a prison GP enquired about a more specialist scan to diagnose cirrhosis (a fibroscan). This was not available in the area at the time.

23. On 15 July 2013, a prison GP arranged another ultrasound scan and an endoscopy (a thin flexible tube with a camera to look inside the body), a routine investigation for patients with liver disease. The ultrasound showed fatty deposits in the man's liver and some signs of fibrosis, which suggested he was developing cirrhosis.

24. On 16 September, the endoscopy confirmed oesophageal varices (enlarged veins in the gullet, between the throat and the stomach). Doctors prescribed the man propranolol to reduce the pressure in the swollen veins and the risk of bleeding. In October, blood tests showed a slight deterioration in his liver function and a small rise in the AFP level, both of which were consistent with cirrhosis and active hepatitis C.

25. On 5 November, the man told a locum GP, that propranolol made him feel unwell. The doctor changed the medication to atenolol but did not discuss the change with the hospital consultant. The clinical reviewer said that although atenolol is in the same class of drugs as propranolol, it would not have had the desired effect of reducing the pressure in oesophageal varices.

26. In April 2014, further routine blood tests showed that the man's AFP level was worryingly high. A visiting specialist in infectious diseases reviewed the man, as it was clear his liver disease was deteriorating significantly. He had a swollen abdomen due to a build-up of fluid in the abdominal cavity (ascites). The specialist requested a liver ultrasound and an endoscopy.

27. On 4 July, an ultrasound did not show any new changes. However, The specialist remained concerned and requested an urgent MRI scan of the liver, and changed the man's medication to reduce the pressure in the oesophageal varices. The man missed the first appointment for the MRI scan on 14 July, apparently because the prison did not receive the appointment letter in time. The hospital rescheduled appointments on 21 July and 28 July, but the prison GP had to cancel both appointments, because there were no officers available to escort the man.

28. On 5 August, blood tests showed a very high AFP level, indicating likely liver cancer and a doctor asked the hospital for another MRI appointment urgently. On 12 September, an administrator recorded that the hospital had brought the MRI forward but there was no date at the time. On 17 September, a community health nurse, requested another emergency MRI and noted the appointment must not be cancelled. The man had the MRI scan on 26 September. The scan showed a large cancerous mass in the right side of the man's liver.

29. On 7 October, a nurse saw the man who reported that he had been vomiting blood. The nurse noted no signs of blood and recorded his pulse, blood pressure and other routine clinical observations as normal. She noted he seemed well and decided not to send him to hospital.

30. On 9 October, the man had an endoscopy at Worcestershire Hospital, and doctors banded the oesophageal varices. (A procedure to apply tight bands to the swollen veins to help reduce the risk of bleeding.)

31. Doctors scheduled another endoscopy four weeks later to check the progress of the treatment. They prescribed medication to reduce abdominal swelling and advised the prison GPs to send the man to hospital as an emergency if he had any further bleeding.

32. On 15 October, the man attended Queen Elizabeth Hospital, Birmingham for a follow-up appointment after his MRI scan. Specialists told him the liver cancer was too advanced for treatment. When he got back to the prison, healthcare staff admitted him to the prison's inpatient department but he discharged himself the next day, as he preferred to be with his friends on the wing. On 17 October, the man attended a multidisciplinary team meeting to discuss his end of life care.

Events on 19 October

33. At 5.10pm on 19 October, an officer responded to the man's cell bell and found him vomiting blood. He phoned the healthcare department and a nurse attended and asked for an ambulance. Control room staff requested this at 5.22pm. The nurse took the man to the healthcare department to wait for the ambulance to arrive as access for the ambulance would be easier and there was more room for paramedics to administer treatment.

34. A paramedic first responder arrived at the prison at 5.36pm, but it took nine minutes to reach the man due to security procedures. An ambulance arrived at 5.54pm and took eight minutes to get through prison security and the gates to reach the man. The man's blood pressure had dropped and the paramedics inserted a cannula (tube) into his throat and gave him intravenous fluids. The man was jaundiced and continued to vomit blood.

35. The man left the prison for hospital at 6.44pm, 50 minutes after the ambulance arrived at the prison. Part of this time is accounted for while paramedics tried to stabilise him. However, a paramedic was concerned that prison security procedures and risk assessments delayed the transfer too long and told prison security staff that the man was seriously unwell and needed to get to hospital immediately.

36. The ambulance took the man to the Alexandra Hospital, Redditch arriving at 7.14pm. The man continued to vomit blood and doctors admitted him to the Intensive Care Unit at 11.15pm. He died at 12.20pm the following day.

Notifying the man's next of kin

37. At 11.30pm, the prison appointed a family liaison officer. At 11.40pm, he telephoned the man's sister, his nominated next of kin, to let her know that he was seriously ill in hospital. Another prison family liaison officer, met with the man's sister at the hospital the next day to offer support. Members of his family were with the man when he died.

38. The man's funeral took place on 31 October and the prison contributed to the costs in line with national guidance. The prison held a memorial service in the prison chapel on 5 November.

Support for staff and prisoners

39. The prison issued notices to prisoners and staff informing them of the man's death and offered support to anyone affected. Staff reviewed prisoners assessed as at risk of suicide or self-harm, in case they had been adversely affected by the news of the man's death. There is no record that managers debriefed the staff involved in the emergency response to review what had happened and to support them.

Post-mortem

40. A post-mortem examination concluded that the man died of acute gastrointestinal haemorrhage and oesophageal varices, caused by micronodular cirrhosis due to hepatitis C infection. The report said that while the cancer was not the direct cause of death it had increased the risk of bleeding.

ISSUES

Clinical Care

41. The clinical reviewer noted that the man had died from blood loss due to bleeding from his oesophageal varices. This is a common complication of cirrhosis of the liver. Doctors prescribed appropriate medication but in November 2013, the man said it made him unwell. The clinical reviewer was concerned that a locum GP changed the medication without referring to his specialist, as the alternative medication prescribed would not have had the desired effect of reducing the pressure on the man's oesophageal varices. Six month later, the specialist prescribed more effective medication. The clinical reviewer considered that the doctor should not have changed the medication without advice from the specialist. It is impossible to tell if the change in medication in November 2013, contributed to the serious bleeding the man suffered in October 2014.

42. On 6 October 2014, a nurse decided not to refer the man to hospital, when he first reported vomiting blood. She based this decision on her clinical observations, which were normal, and the man's presentation. The clinical reviewer considered that the risk of a serious bleed was high at this time and the nurse should have arranged for the man to go to hospital urgently.

43. Overall, the clinical reviewer found that the man's general standard of care was satisfactory and that the care he received for his hepatitis treatment exceeded that which most patients would be able to get in the community. She was impressed by the ability of prison GPs to contact specialists and take advice by email of telephone. However, there was no clinical care plan to advise staff about his medication and the risk of serious bleeds and what action to take. We make the following recommendation:

    The Head of Healthcare should ensure that there are care plans for all prisoners with chronic or serious conditions to inform and direct healthcare staff about appropriate treatment.

Cancelled appointments

44. In July 2014, the specialist requested an MRI scan for the man, yet this did not happen until September 2014. The man missed the first scan, as the prison did not receive the appointment letter in time. The hospital rearranged the scan but prison GPs had to cancel it twice more because there were insufficient prison officers to escort him.

45. The Head of Healthcare said that Long Lartin provided escort staff for only one patient to attend hospital appointments in the morning and one in the afternoon each day. This means that prison GPs have to use their clinical judgement about priorities and decide who goes out for appointments.

46. The specialist requested another endoscopy in June 2014, but appointments in July and early September were cancelled because of a lack of escort staff.

The man was unable to attend a further appointment in September because he was ill and eventually had one in October. The clinical reviewer says that noted that an earlier endoscopy would have resulted in earlier banding of the varices, but as this was done before his fatal bleed, the delay is unlikely to have affected the eventual outcome. .

47. It is concerning that; such a seriously ill man should have had important hospital appointments cancelled because of the lack of officers for escorts. We note that HM Inspectorate of Prisons also identified this as a concern at its recent inspection of Long Lartin. Providing escorts for only two appointments a day requires prison doctors to make invidious choices about relative priorities, places prisoners' health in jeopardy and is wasteful of NHS resources when appointments have to be cancelled and rescheduled at short notice. We make the following recommendation:

The Governor should ensure that prisoners are taken to all urgent hospital appointments unless there are overriding fully justified and documented reasons and there is no detriment to the prisoner's health.

Emergency response

48. Prison Service Instruction (PSI) 03/2013 requires governors to have a medical emergency response code protocol based on the instruction. This should instruct staff how to communicate the nature of a medical emergency using agreed emergency codes and ensure that the control room calls an ambulance automatically as soon as an emergency code is called.

49. When the officer found that the man was vomiting blood on 19 October, he did not call an emergency code but asked a nurse to attend. The officer told the investigator that he did not use an emergency code because the man was vomiting only a small amount of blood at the time. We accept that this was a judgement call and it would have been difficult for the officer to have identified this as a life-threatening situation, especially as a nurse had not done so in similar circumstances on 7 October. A nurse attended quickly and there was little delay calling an emergency ambulance.

50. We are concerned that it took the first response paramedic nine minutes to reach the man because of security checks and the need to get through six vehicle gates. It took the ambulance eight minutes to get through for the same reason. This is too long in a life-threatening emergency. There were further unacceptable delays taking the man to hospital, which led to one of the paramedics raising concerns about the length of time it took to arrange an escort. She told prison security staff that the man was acutely unwell and needed to go to hospital as soon as possible as there was a risk of cardiac arrest.

51. The Head of Security at the prison told the investigator that he considered that the emergency response turnaround was quick, taken into account the number of vehicle gates. He did not accept that there had been any significant delay in completing risk assessments or preparing escort staff. He

said that staff needed to be briefed and collect equipment, which would impact on getting the prisoner out of the prison quickly.

52. While we accept the need for effective security, particularly in a high security prison, preservation of life in an emergency should be paramount. PSI 03/2013 has a mandatory requirement that prisons should have protocols to ensure there are no unnecessary delays in ambulances getting to prisoners and leaving prisons to take prisoners to hospital. We do not consider that Long Lartin met this standard. Prison staff should have started planning the arrangements for the escort as soon as they called an emergency ambulance at 5.22pm and should have been in a position to leave as soon as the paramedics were ready. We make the following recommendation:

The Governor should ensure that staff arrange and brief escorts immediately they call an emergency ambulance and that there is no unnecessary delay in ambulances reaching a prisoner and taking them to hospital.

Restraints, security and escorts

53. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgement indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

54. The written risk assessment for the man to be taken to hospital on 19 October was authorised by an operational manager, who concluded that officers should restrain him with double cuffs. Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. The manager told us that in fact officers used 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). The records we have examined all clearly refer to double cuffs. Subsequently, it appears that an escort chain was used in hospital.

55. When the man went to hospital, he was vomiting large amounts of blood and was acutely unwell. He had terminal liver cancer and just two days before a multidisciplinary meeting, which included security staff, had discussed his end of life care. A manager assessed him as a medium risk to the public and a low risk of escape. The healthcare section on the risk assessment was not completed. The man remained restrained in hospital throughout the night and

restraints were not removed until the next morning at 7.49am on 20 October. The man died at 12.20pm that day.

56. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account, and balanced against the security risks. We are concerned that despite the man's serious condition there is no evidence of healthcare input into the risk assessment as the court judgment requires. While there is a lack of clarity about the level of restraint used and when, the use of any level of restraint had not been justified by an appropriately considered risk assessment. We have raised this matter with Long Lartin before. We make the following recommendation:

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

Notifying next of kin

57. The man was acutely unwell when he left the prison. The hospital admitted him at 7.14pm but the prison did not inform his sister, his nominated next of kin, until 11.40pm, a delay of over three hours.

58. The prison told us that the prison does not usually inform families straight away when prisoners go to hospital. She said that families usually have to travel long distances and often the prisoner is back in prison before they arrive. She said that she had waited for the results of tests, which confirmed significant blood loss, before deciding that they should inform the man's sister.

59. Prison Rule 22 says that if a prisoner becomes seriously ill, the Governor should "at once inform the prisoner's spouse or next of kin." The man had already been diagnosed as terminally ill and paramedics had informed security staff that he was acutely unwell. There is little doubt that the man was seriously ill at the time he was taken to hospital. We consider that the prison should have informed the man's sister immediately he was admitted to hospital in line with Prison Rules. This might have allowed his family to spend more time with him before he died. We make the following recommendation:

The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.

Support for staff

60. Prison Service Instruction (PSI) 64/2011 Safer Custody, requires a manager to hold a debrief after a prisoner's death, for all staff involved, including healthcare staff. The purpose is to offer support, allow staff to support each other and to discuss any lessons from how the emergency was handled. No

one debriefed the staff involved in the emergency response on 19 October. We make the following recommendation:

The Governor should ensure that a debrief is held promptly after the death of a prisoner and that all staff involved are offered effective support.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that there are care plans for all prisoners with chronic or serious conditions to inform and direct healthcare staff about appropriate treatment.

2. The Governor should ensure that prisoners are taken to all urgent hospital appointments unless there are overriding fully justified and documented reasons and there is no detriment to the prisoner's health.

3. The Governor should ensure that staff arrange and brief escorts immediately they call an emergency ambulance and that there is no unnecessary delay in ambulances reaching a prisoner and taking them to hospital.

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

5. The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.

6. The Governor should ensure that a debrief is held promptly after the death of a prisoner and that all staff involved are offered effective support.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Head of Healthcare should ensure that there are care plans for all prisoners with chronic or serious conditions to inform and direct healthcare staff about appropriate treatment.	Accepted	The Head of Healthcare will conduct an audit to ensure that all prisoners with chronic or serious conditions have an appropriate care plan in place.	31 May 2015 Head of Healthcare
2	The Governor should ensure that prisoners are taken to all urgent hospital appointments unless there are overriding fully justified and documented reasons and there is no detriment to the prisoner's health.	Accepted	Prisoners will continue to be taken to all hospital appointments that are identified as being urgent by Healthcare staff. Urgent in this context is taken to mean circumstances where non-attendance would have life-threatening or long-term serious consequences to the health of the prisoner.	Completed Governor
3	The Governor should ensure that staff arrange and brief escorts immediately they call an emergency ambulance and that there is no unnecessary delay in ambulances reaching a prisoner and taking them to hospital.	Accepted	A Governor's Order will be issued to ensure that staff arrange and brief escorts appropriately once they have called an emergency ambulance and prevent any unnecessary delays in ambulances reaching the prisoner.	31 March 2015 Governor
4	The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that	Accepted	Risk assessments for prisoners taken to outside hospital will be carried out at HMP Long Lartin in line with the *Graham* judgement and based on a consideration of the individual's circumstances/current condition and the actual risk that they present at the time of transfer.	Completed Head of Security

	assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.			
5	The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.	Accepted	The Duty Governor at HMP Long Lartin will authorise the Family Liaison Officer (FLO) to contact the next of kin of seriously ill prisoners as soon as the seriousness of their condition is confirmed by Healthcare staff.	Completed Governor
6	The Governor should ensure that a debrief is held promptly after the death of a prisoner and that all staff involved are offered effective support.	Accepted	Local contingency plans will be reviewed to ensure that debriefs take place and support is offered to the staff involved following all deaths in custody, including instances where prisoners die in hospital following emergency response treatment at the prison.	30 April 2015 Head of Safety and Equality