Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Eral Morgan, a prisoner at HMP Oakwood, on 17 February 2021

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Eral Morgan died from the toxic effects of psychoactive substances (PS) on 17 February 2021 at HMP Oakwood. He was 25 years old. I offer my condolences to Mr Morgan's family and friends.

The investigation found that the care Mr Morgan received at Oakwood for his mental health and substance misuse issues was equivalent to that which he could have expected to receive in the community. However, the emergency response when Mr Morgan was discovered unconscious was extremely poor. The prison investigated and took disciplinary action against the staff involved and a nurse has been referred to the Nursing and Midwifery Council.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **August 2022**

Contents

Summary

Events

1. Mr Eral Morgan was recalled to prison on 29 September 2020. He was moved to HMP Oakwood on 12 February 2021.

2. Mr Morgan had a long history of substance misuse. During his time in custody, he engaged with substance misuse services and seemed motivated to address his drug use. However, he frequently relapsed into taking drugs, usually psychoactive substances (PS).

3. At around 8.45pm on 17 February, while completing a roll check, an officer saw Mr Morgan lying on the floor of his cell. He fetched another officer who called the Night Orderly Officer (the senior officer in charge of the prison at that time). She said she would attend with healthcare staff. Staff did not enter the cell for 13 minutes and then it took another six minutes before they started cardiopulmonary resuscitation (CPR). Paramedics arrived at 9.20pm and continued resuscitation but at 10.12pm, they declared that Mr Morgan had died.

4. The post-mortem report concluded that Mr Morgan died from the toxic effects of PS.

Findings

5. We are concerned Mr Morgan had access to PS. However, we are satisfied the prison is taking steps to tackle drugs supply. It has a drugs strategy in place, which was reviewed in August 2021.

6. Officers failed to call a medical emergency code when they saw Mr Morgan lying on the floor of his cell, which resulted in a delay requesting an ambulance. There was also an unacceptable delay before staff entered Mr Morgan's cell. The prison undertook disciplinary investigations into the actions of the staff involved. One officer resigned and another was dismissed.

7. The clinical reviewer found that the resuscitation was handled very poorly, and the care Mr Morgan received was not equivalent to the care he could have expected to receive in the community. Practice Plus Group, the healthcare provider, conducted an investigation, which found that while the nurse and healthcare assistant involved had had immediate life support training through their employing agency, it was not accredited by the Resuscitation Council. Attempts to engage the nurse in a supervised development plan failed, and she has since been referred to the Nursing and Midwifery Council.

8. The clinical reviewer concluded that the care Mr Morgan received for his mental health and substance misuse issues was equivalent to that which he could have expected to receive in the community.

Recommendations

- Practice Plus Group and NHS England and Improvement should undertake further enquiries to ensure that healthcare agencies which provide staff to prisons are appropriately trained, competent and are practising safely, and Practice Plus Group should:

    - undertake a clinical audit examining the effectiveness of learning following any significant incident and governance managers need to assure themselves that this learning has been embedded; and

    - undertake a clinical audit of records made following an emergency response (after Mr Morgan's death) to assess the quality of record keeping.

The Investigation Process

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

10. The investigator obtained copies of relevant extracts from Mr Morgan's prison and medical records.

11. We suspended our investigation in March 2021, pending the outcome of a police investigation. We resumed it in February 2022, when Staffordshire Police told us that no criminal charges would be brought.

12. NHS England commissioned a clinical reviewer to review Mr Morgan's clinical care at the prison. The investigator, together with the clinical reviewer, interviewed five senior managers, including the Director, on 17 February 2022. On 10 March they interviewed the clinical lead in post at the time of Mr Morgan's death.

13. We informed HM Coroner for Staffordshire South of the investigation. We have sent the Coroner a copy of this report.

14. The PPO's family liaison officer contacted Mr Morgan's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Morgan's family wanted to know why he had a bruised face and cracked skull, which they believed was as a result of an assault. This has been addressed in the report.

15. Mr Morgan's family received a copy of the initial report. They did not identify any factual inaccuracies.

16. The prison also received a copy of the report and did not identify any factual inaccuracies.

Background Information

HMP Oakwood

17. HMP Oakwood is managed by G4S and is one of the largest prisons in England and Wales, providing places for around 2,100 male prisoners. Practice Plus Group (PPG) provides the healthcare services, which include a daily GP clinic, some specialist services and out-of-hours GPs. Mental health and substance misuse services are provided by the Midlands Partnership Foundation Trust (MPFT).

HM Inspectorate of Prisons

18. The most recent inspection of Oakwood was in May 2021. Inspectors reported that prisoners were treated with respect and safety was good. Healthcare services were found to be effective and well-led. Mental health and substance misuse services were well integrated, although mental health support had been limited due to COVID-19 restrictions.

19. Inspectors reported that when a concern was identified, a 'keep safe' referral was made and shared with unit managers and the safer custody team, who liaised with the security department. All referrals were discussed at the following keep safe meeting, which was held twice a week. This multidisciplinary team decided what violence reduction measures would be implemented.

20. Inspectors found there was a comprehensive drug strategy and good collaborative work between the security department and drug use services, and action was discussed at a well-attended monthly meeting. The prison had numerous measures in place to tackle the availability of illicit drugs, including a drug recovery unit and a robust approach to the use of the body scanner. However, inspectors noted the availability of illicit substances was a concern.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recent annual report for the year March 2021, the IMB reported that the impact of a 23-hour lock-down regime, with limited exercise and association, for some prisoners was traumatic and increased frustration and anxiety but that levels of violence and the availability of illicit substances had decreased.

Previous deaths at HMP Oakwood

22. Mr Morgan was the 13th prisoner to die at Oakwood since February 2019. Of the previous deaths, 11 were from natural causes and one was due to accidental burns.

Psychoactive substances (PS)

23. Psychoactive substances (PS - formerly known as 'new psychoactive substances' (NPS) or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways, including increasing

heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for PS to precipitate or exacerbate the deterioration of mental health, and they are linked to suicide or self-harm.

24. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time, NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

Key Events

25. In April 2018, Mr Eral Morgan (known as Jack) was sentenced to 52 months in prison for burglary and dangerous driving. He was released on licence on 31 July 2020 but was recalled to prison on 29 September after committing further burglary offences. He was taken to HMP Hewell.

HMP Hewell

26. Mr Morgan had attention deficit hyperactivity disorder (ADHD) and anxiety and depression. He had a history of self-harm (food and fluid refusal, swallowing glass, cutting) and a long history of substance misuse both in prison and the community. Although at times he was motivated to address his substance misuse and worked with addiction services, he often relapsed. He was supported in the community and in prison by the mental health team.

27. Mr Morgan was supported using suicide and self-harm prevention measures (known as ACCT) between 19 and 23 November after he cut his arm. He told staff he had been using psychoactive substances (PS), had accrued drug debts and wanted help. Staff referred Mr Morgan to the mental health team and supported him using a Challenge, Support and Intervention Plan (CSIP – used to manage perpetrators of violence and to support victims of violence).

28. On 29 November, a prison chaplain told Mr Morgan that his mother had died the previous day of a drug overdose. Staff reopened the ACCT.

29. On 2 December, staff placed Mr Morgan on a disciplinary charge after he climbed onto the security netting. Mr Morgan said he wanted to move wings as he was being tempted by drugs on the wing. Staff moved Mr Morgan to a different wing.

30. The chaplaincy continued to support Mr Morgan until after his mother's funeral, which was held on 24 December. This was a public health funeral, arranged by the local authority, which meant there was no ceremony, but Mr Morgan attended the chapel to light a candle. He was told that the prison chaplain who had been supporting him had sadly died, but the chaplaincy team continued to offer him their support.

31. On 29 December, Mr Morgan cut his arm and inserted a screw into the wound. He told staff that he was frustrated being locked up and only being allowed out from his cell for 30 minutes a day. Staff closed his ACCT the next day. Staff continued to support Mr Morgan using CSIP until 19 January 2021.

32. Mr Morgan was much more settled over the next few weeks. He started work and was also helping other prisoners who were struggling.

HMP Oakwood

33. On 12 February 2021, Mr Morgan was moved to HMP Oakwood as part of his sentence progression.

34. At the initial healthscreen, the reception nurse noted Mr Morgan's extensive history of drug use, specifically the use of PS, and that he had previously self-harmed. Mr

Morgan declined to be referred to the substance misuse service but was referred to the mental health team.

35. On 14 February, a nurse assessed Mr Morgan's mental health. She did not identify any immediate mental health needs but noted that Mr Morgan was concerned about his safety at Oakwood because of historic drug debts. She added Mr Morgan for discussion at the referrals meeting, to consider if he was appropriate to be added to the integrated mental health services and she contacted the safer custody team to alert them to the concerns about his debts.

36. On 15 February, Mr Morgan was discussed at the integrated mental health and substance misuse team meeting, attended by the team leader, mental health nurses, psychosocial and recovery workers. They concluded that because Mr Morgan did not have a severe or enduring mental illness, he would not be added to their caseload, but would continue to be supported by the prison doctor.

37. On 16 February at 10.46am, a First Line Manager (FLM) recorded in Mr Morgan's prison record that the safer custody team had flagged concerns about his safety and possible debts. The FLM and a colleague spoke to Mr Morgan who said there were other prisoners at Oakwood that he had stolen a substantial amount of money from some years earlier, but he did not give any names. Mr Morgan told staff that he felt safe on the induction unit but thought he would soon be recognised. The FLM recorded that Mr Morgan had requested a transfer out of Oakwood and that he had said if it was not considered his behaviour would potentially dictate it.

38. The FLM completed a keep safe referral which meant that Mr Morgan would be considered for support using CSIP procedures, but there was no time to complete a full assessment of his risks and needs or discussion at the keep safe meeting before he died. This is the last entry in Mr Morgan's prison record.

17 February

39. CCTV shows that at around 5.08pm on 17 February, a prisoner stopped outside Mr Morgan's cell and passed what appears to be a small piece of paper through the cell door. At 5.49pm on 17 February, an officer locked Mr Morgan in his cell for the night after he had collected his food. CCTV shows that at 7.11pm, a prisoner, who was a wing cleaner, went to Mr Morgan's cell and was then laughing and joking with the occupant of the cell next door. He appeared to do an impression of Mr Morgan lying back with his arms above his head. A few minutes later, another prisoner, also a cleaner, arrived at Mr Morgan's cell. He looked into the cell and then closed the cell hatch.

40. Officer A started the roll check at 8.44pm and arrived at Mr Morgan's cell just over a minute later. He used a torch to look into the cell, then kicked the door and around a minute later moved on to continue checking the other cells. At 8.48pm, he returned to Mr Morgan's cell with Officer B. Officer B radioed the FLM, the Night Orderly Officer who was in charge of the prison at that time, and asked her to attend the wing as soon as possible because Mr Morgan appeared to be unconscious. He told her that Mr Morgan appeared to be unconscious on his cell floor and she told him she was on her way with healthcare staff.

41. At 8.55pm, Officer B (who was now wearing PPE), returned to Mr Morgan's cell with Officer C. They were joined by Officer A (also wearing PPE), and they remained outside the cell; a short while later another officer joined them, then all four walked away.

42. At 8.57pm, Officers A and B returned to Mr Morgan's cell. A nurse and a healthcare assistant (HCA) arrived soon after and looked through Mr Morgan's observation panel. At 8.58pm, the FLM arrived with Officer C, and they opened Mr Morgan's cell door. The FLM activated her body worn video camera (BWVC), which captured events when they entered, and she requested an ambulance.

43. Mr Morgan was lying on his back, with blood and vomit around his mouth and was described as cyanosed (a blueish tinge to skin caused by a lack of oxygen). Mr Morgan was placed in the recovery position while the nurse tried to obtain a pulse and she requested oxygen. Six minutes after staff entered the cell, they started cardiopulmonary resuscitation (CPR).

44. The nurse started CPR, but the HCA took over after a short while and asked for the defibrillator. (As officers had not called a medical emergency code blue indicating the prisoner was unconscious, healthcare staff had not taken a defibrillator with them.) The HCA stopped administering CPR for a few seconds while he told an officer where he could find a defibrillator machine. A defibrillator was brought to the cell about four minutes later but was placed on Mr Morgan's bed and was never used.

45. West Midlands Ambulance Service records show an ambulance was requested at 8.58pm. Paramedics arrived at Mr Morgan's cell at 9.20pm; they questioned why the defibrillator had not been used. Paramedics continued resuscitation attempts, but, at 10.12pm, declared that Mr Morgan had died. Paramedics noted that on their arrival, they observed CPR was ineffective, there was no airway inserted and oxygen was not being used; they also recorded that the defibrillator in Mr Morgan's cell had not been attached.

46. When Mr Morgan's cell was searched after his death, a broken vape pipe and white paper were found in his bin, which later tested positive for PS.

Contact with Mr Morgan's family

47. Oakwood appointed a family liaison officer (FLO) and a deputy. Under normal circumstances next of kin should, wherever possible, be informed of a death in person by a FLO. However, the guidance was changed during the COVID-19 pandemic to say that telephone contact could be made instead. The FLO therefore informed Mr Morgan's grandmother of his death by telephone. She offered her condolences and ongoing support. In line with Prison Service instructions, the prison contributed towards the costs of Mr Morgan's funeral, which was held on 22 March.

Support for prisoners and staff

48. After Mr Morgan's death a prison manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any

immediate issues and to offer support. The staff care team also attended and offered their support.

49. The prison posted notices informing prisoners of Mr Morgan's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Morgan's death.

Post-mortem report

50. Toxicology tests showed that Mr Morgan had used PS before he died, and the pathologist gave the cause of death as synthetic cannabinoids (PS) toxicity.

51. Mr Morgan's grandmother said that Mr Morgan had injuries to his head and face. The post-mortem concluded there was no evidence of injury or assault

Findings

Oakwood's Drug Strategy

52. Mr Morgan died from the effects of PS. He had a history of misusing substances but when he arrived at Oakwood, Mr Morgan declined to be referred to substance misuse services.

53. Oakwood has a comprehensive Drug Strategy, which is reviewed and updated annually. It sets out the objectives to prevent supply of, and reduce the demand for, illicit substances. A drug supply reduction action plan is completed and reviewed each month and sets out the targets for cell searches, visitor and staff searching and the process for referring those found under the influence of illicit substances to substance misuse services. Oakwood reviewed the strategy in August 2021. We are satisfied that Oakwood keeps its Drug Strategy under regular review and we do not make a recommendation.

Emergency response

54. We found the emergency response was extremely poor by both prison and healthcare staff. Staff did not call a medical emergency code as they should have done when they saw Mr Morgan unconscious on his cell floor. It then took staff 13 minutes to enter Mr Morgan's cell and an ambulance was not called until the Night Orderly Officer arrived.

55. The prison undertook disciplinary investigations into the actions of the four officers who delayed going into Mr Morgan's cell. Officer A resigned and Officer B was dismissed on 4 May 2021. Officer C received a Written Warning on 25 May 2021 (which stays on his record for 12 months). No action was taken against the fourth officer. As Oakwood has already taken disciplinary action, we do not make a recommendation.

56. The Head of Safer Custody told us that staff had been reminded of the need to enter a cell as soon as possible and to call the correct code in a medical emergency. She said all staff now carry a card to remind them of how to respond in a medical emergency and notices have been reissued. Given Oakwood has taken steps to address these issues, we do not make a recommendation.

Resuscitation

57. Staff did not start CPR until over six minutes after the cell was opened. BWVC footage shows the clinical assessment of Mr Morgan was poor and that CPR was not delivered effectively, which was also noted by paramedics when they arrived. There was no defibrillator in the emergency medical bag, as is required, and when one was brought to the cell, it was never attached to Mr Morgan. The clinical notes made by the nurse following Mr Morgan's death were limited. The HCA did not record his account in the medical records. The clinical reviewer found that the resuscitation was handled poorly and was not equivalent to the care Mr Morgan could have expected to receive in the community.

Clinical investigation into emergency response

58. On 2 March 2021, Practice Plus Group (PPG), which provides healthcare services at Oakwood in conjunction with Midlands Partnership NHS Trust, held a Clinical Case Review because of the poor emergency response. The HCA attended the meeting, but the nurse did not. The clinical reviewer is satisfied that the HCA has completed necessary training, via his employing agency, as a result of this meeting.

59. The Director of Nursing & Quality for PPG told us that she had contacted the nurse and the agency she worked for and invited them to work with PPG to develop a plan for restricted and supervised practice until a decision had been made regarding referral to the NMC. The initial agreement was that the nurse would work at a different prison during this time but would not carry the emergency response radio until additional training had been undertaken and competency assured. However, the nurse did not engage with either PPG or the agency, so they were unable to implement the support and risk mitigation plan.

60. PPG undertook a Patient Safety Incident Investigation and subsequently referred the nurse to the Nursing and Midwifery Council (NMC - the regulator for nursing and midwifery professions in the UK) who are investigating.

61. Given that PPG has already referred the nurse to the NMC, we do not make a recommendation.

Practice Plus Group (healthcare provider)

62. The nurse and the HCA had completed Immediate Life Support (ILS) training delivered by their agency, but this was not delivered by an accredited Resuscitation Council UK instructor.

63. The clinical reviewer concluded that PPG did not ensure agency staff were trained and competent to provide an emergency medical response, or that the agency have the required clinical governance checks in place to ensure staff are competent and practising safely. The investigation is limited to the care Mr Morgan received at Oakwood and does not extend to the agency, so we make the following recommendation:

Practice Plus Group and NHS England and Improvement should undertake further enquiries to ensure that healthcare agencies who provide staff to prisons are appropriately trained, competent and are practising safely, and Practice Plus Group should:

- **undertake a clinical audit examining the effectiveness of learning following any significant incident and governance managers need to assure themselves that this learning has been embedded; and**

- **undertake a clinical audit of records made following an emergency response (after Mr Morgan's death) to assess the quality of record keeping.**

Clinical Care

64. The clinical reviewer found that the care Mr Morgan received for his mental health and substance misuse issues was equivalent to that which he could have expected to receive in the community.

Inquest

65. The inquest into Mr Morgan's death concluded in December 2024. Mr Morgan's death was drug related (synthetic cannabinoids toxicity).

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