Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Geoffrey Morris, a prisoner at HMP The Verne, on 10 June 2024

A report by the Prisons and Probation Ombudsman

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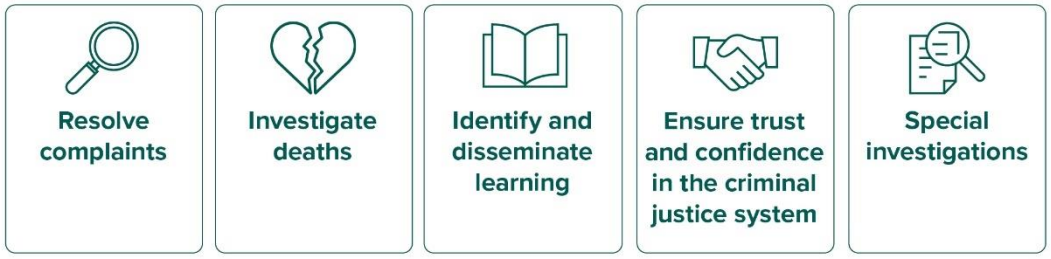
OUR VISION

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

WHAT WE DO



WHAT WE VALUE

Summary

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

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

3. Mr Geoffrey Morris died from ischaemic strokes caused by severe atherosclerosis (the buildup of fats, cholesterol and other substances in and on the artery walls) on 10 June 2024, while a prisoner at HMP The Verne. He was 83 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Morris received at The Verne was of a good standard and equivalent to what he could have expected to receive in the community.

The Investigation Process

5. HMPPS notified us of Mr Morris' death on 10 June 2024.

6. NHS England commissioned an independent clinical reviewer to review Mr Morris' clinical care at HMP The Verne. The clinical review is attached as Annex 1.

7. The PPO investigator investigated the non-clinical issues relating to Mr Morris' care.

8. We issued our initial report in October 2024. Dorset Police subsequently raised concerns about staff actions prior to Mr Morris being found unresponsive on 10 June 2024. We decided to re-open our investigation into the circumstances of Mr Morris' death. The investigator interviewed two members of staff at HMP The Verne on 22 and 28 April 2025.

9. The Ombudsman's office wrote to Mr Morris' next of kin, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP The Verne

11. Mr Morris was the 12th prisoner to die at The Verne since June 2021. Of the previous deaths, 10 were from natural causes and one was self-inflicted. There are no similarities between the findings in our investigation into Mr Morris' death and the findings from our investigations into the previous deaths.

Key Events

12. On 4 December 2018, Mr Geoffrey Morris was remanded to HMP Isle of Wight charged with sexual offences. On 11 January 2019, he was found guilty and sentenced to 17 years imprisonment.

13. Mr Morris had pre-existing medical conditions including diabetes, hypertension, chronic kidney disease and an enlarged prostate. He also had limited mobility and used a walking stick.

14. On 18 October 2021, Mr Morris transferred to The Verne. He was located on Dorset Unit – a unit made up of dormitories used to house prisoners with mobility issues or other social care needs.

15. At Mr Morris' reception health screen, a nurse noted and reviewed his long term medical conditions and referred him for blood tests. Healthcare staff completed a QRISK2 (a cardiovascular risk score to determine a person's risk of having a heart attack in the next ten years) which indicated a score of 74.57%. Mr Morris was not keen on having a statin medication. Healthcare staff added him to the long-term clinic to discuss his options, but this was not followed up. The healthcare team reviewed Mr Morris' long term conditions and medications regularly and adjusted them where appropriate.

16. Mr Morris had frequent risk assessments due to recurrent falls. In 2022, it was noted that he had fallen 12 times in the last year. Mr Morris was given a walker instead of a walking stick.

17. On 17 May 2023, prison staff escorted Mr Morris to hospital as he had a non-surgical procedure to treat an enlarged prostate.

18. On 22 November, a nurse saw Mr Morris after he complained of chest pains. The nurse completed an Electrocardiogram (ECG) and gave him Glyceryl Trinitrate spray (GTN spray – used to help relieve pain that might be coming from the heart). The nurse requested an ambulance and Mr Morris was taken to hospital. He was discharged the following day.

19. Over the following months, prison staff escorted Mr Morris to hospital for several outpatient appointments.

20. On 29 April 2024, prison staff radioed a code blue (an emergency medical code indicating a prisoner is unconscious or is having breathing difficulties) as Mr Morris had fallen in the dining room. Healthcare staff attended and took his clinical observations. Mr Morris said he fell on his left hip and was in pain. Staff called an ambulance and Mr Morris was taken to hospital. Mr Morris had a fractured femur. The following day he had an operation and remained in hospital for rehabilitation.

21. On 14 May, Mr Morris was discharged from hospital to the Dorset Unit at The Verne. Healthcare staff continued to review him.

Events of 10 June 2024

22. At 7.42am on 10 June, two officers completed a routine check on Dorset Unit. During interview, one of the two officers told the investigator that he counted prisoners on the left side of the dormitory, where Mr Morris was located, while the other officer counted prisoners on the right. The first officer told the investigator that he said “good morning” to Mr Morris, and he saw Mr Morris’ foot move, which he took as a response. This officer said he then moved on and submitted the count.

23. At 8.20am, a support care worker conducted a check on Mr Morris. She opened the curtain on Mr Morris’ bedspace and noticed that his eyes were partially open, and his mouth was open. She approached Mr Morris, called his name and tapped his shoulder but he did not respond. She left the dormitory to speak to the social care lead. The care worker told the social care lead that she could not get a response from Mr Morris, and they both went to Mr Morris’ bedspace.

24. The social care lead noted that Mr Morris was lying on his back and was grey and white in colour. She called a code blue and felt for a pulse. She noted that there was no pulse and rigor mortis was present.

25. An officer responded to the code blue. He noted that Mr Morris was lying motionless on his back, with his hands over his stomach. The officer was unable to gain any noticeable signs of life, so he left to go and collect the defibrillator from the wing office. He told the officer who was on the phone to the ambulance that Mr Morris was unresponsive.

26. When the officer returned with the defibrillator, a senior nurse (who also responded to the code blue) had arrived. She examined Mr Morris and assessed that resuscitation was not appropriate as rigor mortis was present. This was communicated to the ambulance service, and the ambulance was stood down.

27. At 9.03am, the prison GP pronounced Mr Morris’ life extinct.

Post-mortem report

28. The post-mortem report gave Mr Morris’ cause of death as ischaemic strokes caused by severe atherosclerosis (the buildup of fats, cholesterol and other substances in and on the artery walls).

Findings

Clinical findings

29. The clinical reviewer concluded that the care Mr Morris received at The Verne was of a good standard and equivalent to what he could have expected to receive in the community. She has made two recommendations about statin medication and escalating the risk of falls to a specialist clinician which the Head of Healthcare will wish to address.

Governor to note

Routine roll checks

30. Routine roll checks are primarily a visual security check to count prisoners to ensure that they are present in their cells, but they are also an opportunity for any concerns about a prisoner's safety to be identified and managed. HMPPS' National Security Framework expects welfare checks to take place at routine checks including that staff are able to see the prisoner's face and satisfy themselves that the prisoner is alive and well.

31. On 10 June, two officer completed the routine roll check in Dormitory 3. During interview, one of the two officers told the investigator that he was satisfied that he saw movement from Mr Morris and therefore submitted the roll count at 7.42am. We consider that it is unlikely Mr Morris moved, as when he was found deceased at 8.20am, rigor mortis was already present (evidence suggests that rigor mortis typically begins within two to six hours after death). In interview, the first of the two officers told us this was his second day on duty. We found no evidence that this is a systemic issue, but bring this to the Governor's attention.

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

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

Inquest

At the inquest held on 20 November 2025, the Coroner concluded that Mr Morris died of natural causes.

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