Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Morris, a prisoner at HMP Frankland, on 12 June 2025

A report by the Prisons and Probation Ombudsman

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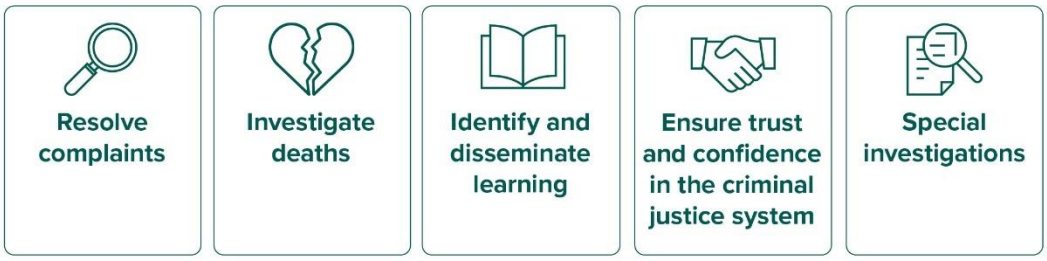
OUR VISION

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

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. In September 2020, Mr David Morris was sentenced to 10 years in prison for wounding or inflicting grievous bodily harm. He died of metastatic diffuse gastric adenocarcinoma (form of cancer that has spread from the stomach to other parts of the body), on 12 June 2025, at HMP Frankland. He was 40 years old. We offer our condolences to Mr Morris' family and friends.

4. The Ombudsman's office wrote to Mr Morris' next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She asked for a copy of our report and had questions about Mr Morris' treatment in prison. Her concerns have been addressed in the clinical review.

5. The PPO investigator investigated the non-clinical issues relating to Mr Morris' care. We did not find any significant non-clinical issues of concern.

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

7. The clinical reviewer concluded that the clinical care Mr Morris received at Frankland was partially equivalent to that which he could have expected to receive in the community. She found that there was a delay in Mr Morris attending for a fast-track hospital appointment as the earliest date that the prison healthcare administration team could accommodate was 28 days from the referral. She also found no evidence of an end-of-life care plan. We make the following recommendations:

    - **The Head of Healthcare should ensure that a care plan is implemented for patients with an end-of-life diagnosis.**

    - **The Head of Healthcare should ensure that there is an escalation process for breaches in fast-track referrals.**

    - **The Head of Healthcare should ensure that patients presenting with red flag symptoms, such as weight loss and increased contact with healthcare, are referred for discussion at complex care meetings.**

Head of Healthcare to note

8. Custodial Manager A asked the healthcare department to request a consultant report from the hospital for Mr Morris' Early Release on Compassionate Grounds (ERCG) application on 14 May 2025. The healthcare department told us that they actioned this request promptly, but were unable to provide evidence of this. We are

unable to determine whether healthcare missed Mr A's request. The consultant report was not received until 10 June, after the ERCG application had been submitted. The healthcare department are aware that consultant reports should be routinely requested for ERCG applications. We are satisfied that this is not a systemic issue and if it was missed on this occasion it was due to human error. Consequently, we do not make a recommendation.

Good practice

9. The family liaison officer arranged for, and the Governor approved, eight members of Mr Morris' family to visit him so that he could break the news of his diagnosis to his family in person. Frankland then facilitated daily visits for his family in the lead up to his death.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and Spectrum Community Health's action plan is annexed to this report.

11. Mr Morris' family received a copy of the draft report. They did not make any comments.

12. At an inquest held on 16 January 2026, the Coroner concluded that Mr Morris died of natural causes.

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

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