

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr John Morris a prisoner at HMP Peterborough on 1 February 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr John Morris died on 1 February 2016 of heart failure at HMP Peterborough. He was 67 years old. I offer my condolences to Mr Morris' family and friends.

Healthcare staff at Peterborough looked after Mr Morris well and staff at the prison could not have done anything to prevent his sudden death. I consider that Mr Morris received good care at the prison, equivalent to that he could have expected to receive in the community.

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

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

**August 2016**

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# Summary

## Events

1. On 18 December 2015, Mr John Morris was remanded to HMP Peterborough. He had a medical history of Parkinson's disease, chronic lung disease and asthma. After an initial health assessment, a prison doctor admitted him to the healthcare centre as an inpatient. The prison requested Mr Morris' GP records and details of his specialist treatment for Parkinson's. (There was a delay in the hospital sending the latter.)
2. Healthcare staff managed Mr Morris' health conditions, using appropriate care plans and saw Mr Morris daily to administer medication and monitor him. Mr Morris was incontinent and found it difficult to manage his personal hygiene. The prison arranged a social services assessment and he was waiting for further specialised assessments at the time of his death. He remained an inpatient in the healthcare centre.
3. At 2.10pm on 1 February 2016, a prisoner alerted staff that Mr Morris was unresponsive in his cell. Officers responded very quickly and called for medical assistance and an ambulance.
4. A prison doctor and nurses attended immediately and began to try to resuscitate Mr Morris. Paramedics arrived and took over emergency treatment but Mr Morris did not respond. At 2.45pm, the doctor recorded that Mr Morris had died. A post-mortem examination found that he had died from cardiac failure.

## Findings

5. We are satisfied that Mr Morris received good care at Peterborough, equivalent to that he could have expected to receive in the community. There was nothing staff at the prison could have done to prevent his death.

## The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Peterborough informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
7. The investigator visited Peterborough on 11 February 2016. He obtained copies of relevant extracts from Mr Morris' prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr Morris' clinical care at the prison.
9. We informed HM Coroner for Cambridgeshire and Peterborough District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted Mr Morris' sister and daughter to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Morris' sister said that she was upset about how she had been informed of her brother's death. (The circumstances are explained in the report and we are satisfied that the prison acted appropriately.) His daughter asked to know as much as possible about the circumstances of her father's death.
11. Mr Morris' sister and daughter received a copy of the initial report. They did not make any comments about the factual accuracy.
12. We shared the initial report with the Prison Service and there were no factual inaccuracies.

# Background Information

## HMP Peterborough

13. HMP Peterborough is privately operated by Sodexo Justice Services. It holds up to 916 men and 300 women in separate sides of the prison and has 24-hour health care provision. The men's healthcare unit has a ward with four beds and eight single cells. Cambridge and Peterborough NHS Foundation Trust provides mental health services.

## HM Inspectorate of Prisons

14. The most recent inspection of Peterborough men's prison was in February 2015. Inspectors reported that, overall, Peterborough was an impressive local prison with a positive staff culture, which emphasised decency and professionalism. Healthcare services were reasonably good and effectively governed but initial healthcare screening arrangements required more oversight. An appropriate range of services was delivered and waiting times were generally short. Prisoners had good access to nurse triage clinics and GPs but management of long term conditions and care planning were underdeveloped. The inpatient service delivered effective clinical support.

## Independent Monitoring Board

15. 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 latest annual report, for the year to March 2015, the IMB reported that there was an excellent framework to constantly improve the quality of health services and safeguard high standards of care.

## Previous deaths at HMP Peterborough

16. Mr Morris was the fourth man to die from natural causes at Peterborough since 2014. There were no significant similarities with the circumstances of the other deaths.

## Key Events

17. On 18 December 2015, Mr John Morris was remanded to HMP Peterborough, charged with sexual offences.
18. At an initial health screen, a nurse noted that Mr Morris had Parkinson's, asthma and chronic obstructive pulmonary disease (COPD – the name for a collection of progressive lung diseases including emphysema and bronchitis). He had recently been discharged from hospital after being treated for a chest infection, related to COPD. Mr Morris took a number of medications for Parkinson's, COPD and to lower cholesterol. The nurse referred him to a GP for further assessment.
19. A GP examined Mr Morris and noted clear evidence of self-neglect, non-compliance with medication and incontinence. He re-prescribed Mr Morris' medications and admitted him to the prison's healthcare centre for assessment. Mr Morris continued to live in the healthcare centre until he died.
20. Healthcare staff drew up care plans to monitor Mr Morris' conditions and to help with his mobility, hygiene and nutrition. Mr Morris smoked but refused any help to give up. The prison referred him to social services for a needs assessment and obtained his community GP records. Healthcare staff saw Mr Morris every day to give him his medication and monitor his conditions.
21. On 29 December, a nurse, a social worker and other healthcare staff reviewed Mr Morris' needs. Mr Morris suffered from incontinence and vomiting and had difficulty swallowing. He said he expected to be convicted and was concerned about his continuing treatment for Parkinson's in prison. The social worker agreed to see what services were available to meet his needs and to organise a thorough specialist assessment. The prison contacted a consultant neurologist at the hospital, who had treated Mr Morris for Parkinson's, to ask for more details about his condition and its management.
22. At 4.55pm on 5 January 2016, a prison GP and a nurse went to Mr Morris' cell, as he was choking on his food and could not breathe. Staff called a code blue (which indicates circumstances such as when a prisoner is unresponsive or has breathing difficulties). The control room called an ambulance immediately. The nurse managed to dislodge the food in Mr Morris' throat and his condition improved. Paramedics arrived and took Mr Morris to hospital for assessment, where a doctor examined him. Mr Morris returned to the prison at 8.30pm.
23. On 7 January, a nurse updated Mr Morris' medical records and noted the main issues were managing his incontinence and the continued need to supervise him to make sure he took his medication. The social worker had arranged assessments from a specialist Parkinson's nurse and a speech and language therapist. (Mr Morris had not had these assessments before he died.) Despite repeated requests, healthcare staff had still not received the records from Mr Morris' neurology consultant.
24. That morning, a nurse contacted the hospital to discuss the outstanding records. The consultant's secretary asked for a faxed letter from a prison GP and a

consent form signed by Mr Morris before they would release the records. She faxed the documents later that afternoon.

25. On 11 January, a prison GP noted that Mr Morris' mobility had improved and that he was taking his medication properly. However, the prison had still not received the information requested from his consultant in Wakefield. A nurse called the hospital on 12 January and again on 14 January. The information was eventually received on 18 January.
26. On 20 January, a locum GP examined Mr Morris. He appeared well but said he felt dizzy. The GP asked a nurse to take his blood pressure and a nurse later recorded this as within the normal range.

### **1 February 2016**

27. On 1 February 2016, Mr Morris collected his lunch at approximately 11.45am then went back to his cell. Staff locked all cells for the lunch period.
28. Just after 2.00pm, an officer unlocked Mr Morris' cell and said Mr Morris was standing by the door at the time. He then went back to the staff office in the healthcare unit. Two Senior Officers (SO) were in the office at the time.
29. At approximately 2.10pm, a prisoner came to the office and said Mr Morris was unresponsive in his cell and he thought he was dead. The staff ran to Mr Morris' cell, a short distance away and found Mr Morris slumped on the floor, in a seated position. He had vomit on his clothing and they could not rouse him. They placed Mr Morris in the recovery position and one SO ran to the surgery to get the doctor. The other SO radioed an emergency code blue and the control room called an ambulance immediately.
30. The SO returned with a prison GP in less than a minute. After quickly examining Mr Morris, the GP asked the staff to move him out of the cell so they would have more room to treat him. The GP and other members of the nursing team who had arrived began cardiopulmonary resuscitation (CPR). They attached an automatic defibrillator to Mr Morris but this found no shockable heart rhythm so they continued CPR. At approximately 2.20pm, paramedics arrived and took over emergency treatment. Mr Morris did not respond and, at 2.45pm, all agreed to stop the resuscitation attempt. The GP recorded that Mr Morris had died.

### **Contact with Mr Morris' family**

31. When he first arrived at Peterborough, Mr Morris told staff he had no next of kin and signed a form stating this. Two prison managers acted as the family liaison officers and asked the police to help them find an appropriate family member to inform of his death.
32. The police provided a list of family members but it was difficult to identify the most appropriate person to contact. The Director, in consultation with the police, agreed that they should contact Mr Morris' step-daughter first. He asked the police to make the initial contact because of the nature of Mr Morris' alleged offence.

33. On 1 February, the police told the prison that they had informed Mr Morris' stepdaughter of his death and that she had informed Mr Morris' son, who would be the family contact for the prison. A family liaison officer spoke to Mr Morris' son that day and offered his condolences and support. He also contacted Mr Morris' brother (whose name was on the list provided by the police). He asked him if there were other family members that he wanted the prison to contact but he said he would do this himself.
34. At 9.30am on 2 February, Mr Morris' sister phoned the prison and spoke to the other family liaison officer. Mr Morris' sister said she had spoken to someone on the switchboard the previous evening but no one had returned her call. She said she was upset that the prison had not informed her of her brother's death as she considered herself to be his next of kin. As the prison had not returned her call, she had telephoned the police to get confirmation of his death. We would have expected someone to have spoken to Mr Morris' sister that evening but it does not appear that the message was passed to either family liaison officers. Mr Morris' sister identified other family members, previously unknown to the prison, including a daughter. The family liaison officer explained that Mr Morris had said he had no next of kin and it had been difficult to identify which family member to speak to. At 2.00pm, she had a similar call from Mr Morris' daughter.
35. On 4 February, Mr Morris' sister and daughter visited Mr Morris in the mortuary. Afterwards they attended the prison to see where he had lived and to speak to staff. Both family liaison officers remained in contact with Mr Morris' family.
36. Mr Morris' funeral was on 25 February 2016. The prison contributed towards the costs in line with national policy.

### **Support for prisoners and staff**

37. After Mr Morris' death, the deputy director debriefed the staff involved in the emergency response to offer support.
38. The prison posted notices informing staff and prisoners of Mr Morris' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Morris' death.

### **Post-mortem report**

39. A post-mortem examination indicated the immediate cause of Mr Morris' death was cardiac failure caused by left ventricular hypertrophy (the thickening of the muscle of the left ventricle of the heart), with underlying conditions of emphysema and Parkinson's.

# Findings

## Clinical care

40. The clinical reviewer considered that Mr Morris received appropriate care for his conditions at Peterborough, equivalent to that he could have expected to receive in the community. When he arrived at the prison, healthcare staff identified he was frail and in poor health. A doctor appropriately admitted him to the healthcare centre for assessment and support. He received medication in line with his prescription in the community. Healthcare staff drew up relevant care plans and nurses monitored him each day.
41. The prison contacted relevant outside agencies, including Mr Morris' community GP and the consultant who had treated him for Parkinson's, to inform their treatment. Although there was a delay receiving information from the hospital, we are satisfied that prison healthcare staff did their best to expedite the request. Staff liaised appropriately with social services to assess Mr Morris' needs. Mr Morris had not had the further assessments social services had arranged before he died.
42. The clinical reviewer explained that Mr Morris did not have any recorded symptoms indicative of heart failure and therefore most probably died from an acute (sudden) onset of heart failure rather than chronic (ongoing) heart failure. We are satisfied that Mr Morris received good care at Peterborough and there was nothing staff at the prison could have done to prevent his sudden death.

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