

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Morgan a prisoner at HMP Cardiff on 12 May 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 Morgan died on 12 May 2016 from restrictions in his small bowel and associated artery, a rare complication of his vascular disease, while a prisoner at HMP Cardiff. He was 77 years old. I offer my condolences to Mr Morgan's family and friends.

I agree with the clinical reviewer, that Mr Morgan's care in prison was equivalent to that he could have expected to receive in the community. His death was caused by an uncommon complication of a pre-existing medical condition and was unexpected. The emergency response was good. However, as a low risk prisoner who had been successfully been released on temporary licence for previous hospital visits, I am surprised that Cardiff did not consider temporary release for Mr Morgan when he went to hospital for the last time.

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

January 2017

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Summary

Events

1. On 10 January 2014, Mr John Morgan was sentenced to five years in prison for theft and was sent to HMP Bullingdon. Mr Morgan had high blood pressure, heart disease (he had a pacemaker fitted), osteoarthritis of the right knee and had a history of problems with blocked arteries in his legs. He received medication for these conditions. Mr Morgan progressed through his sentence and on 9 August 2014, he transferred to HMP Prescoed.
2. Mr Morgan attended hospital appointments with cardiologists to check his pacemaker and with orthopaedics about his right knee, which surgeons noted would need replacing at some point. Doctors prescribed medications to help with these conditions. He was released on temporary licence to attend his appointments.
3. In April 2015, vascular specialists diagnosed Mr Morgan with advanced peripheral vascular disease in both legs (when a build up of fatty deposits in the arteries restricts the blood supply to leg muscles). They recommended that Mr Morgan should take pain relief as necessary and should contact his GP if he had any further problems.
4. In May 2016, Mr Morgan underwent a total knee replacement and was transferred directly from hospital to the inpatient unit at HMP Cardiff. However, within days his health deteriorated and on 11 May, he collapsed. A nurse called an emergency code and the control room called an ambulance immediately. A prison GP attended, she was unable to obtain his blood pressure or oxygen levels, but noted that Mr Morgan's hands were turning blue. Paramedics attended and took Mr Morgan to hospital where he was admitted.
5. Mr Morgan deteriorated further in hospital. He died on 12 May. His family were with him.

Findings

6. Healthcare Inspectorate Wales (HIW) found that the overall care Mr Morgan received was good and equivalent to that he could have expected to receive in the community. Thought was given to the best location for Mr Morgan after his operation and the move to the inpatient unit at Cardiff ensured healthcare staff could monitor him and he could avoid stairs. HIW were concerned that a baseline medical assessment and observations were not recorded when Mr Morgan arrived at Cardiff, but said this did not affect the outcome for him.
7. We are concerned that managers at Cardiff did not proactively seek release on temporary licence for Mr Morgan when he was admitted to hospital. He was a category D prisoner (considered to pose little or no risk of escape) and had previously been released on temporary licence by Prescoed.

Recommendations

- The Head of Healthcare should ensure that a baseline medical assessment and observations are taken for all prisoners returning or arriving at the prison following general surgery or a period in hospital.
- The Governor should ensure that release on temporary licence is considered without delay for seriously ill prisoners in hospital who meet the criteria.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Cardiff informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Morgan's prison and medical records.
10. Healthcare Inspectorate Wales reviewed Mr Morgan's clinical care at the prison.
11. We informed HM Coroner for Cardiff and Vale of Glamorgan District of the investigation, who gave us the cause of death. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers and the investigator met Mr Morgan's family on 24 June 2016, to discuss the investigation. The family had a number of concerns for the investigation to consider, including:
 - When Mr Morgan left hospital, he was unable to use the telephone and his family were not told where he had gone.
 - They wanted to know if information was shared with Cardiff about his complex health issues.
 - They asked whether he should have been admitted to hospital sooner.
 - They wanted to know why there were escorting officers by his bed, even when Mr Morgan was on a ventilator. The family said this was inappropriate and also meant his grandchildren could not visit him (because they were very young and did not understand that he was a prisoner).
13. Mr Morgan's family received a copy of the initial report. They pointed out a factual inaccuracy. This report has been amended accordingly. Mr Morgan's family also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
14. Mr Morgan's family raised issues/questions about HIW's clinical review. The investigator copied the family correspondence to HIW for comment. HIW said that they made two amendments on page 27 due to typing errors and updated the report. HIW said the family comments about page 6 of the review were unchanged as this was the incident context section and not about the care Mr Morgan received.
15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Cardiff

16. HMP Cardiff holds around 800 men, mostly from South East Wales. Many of the prisoners come from local courts on remand. Cardiff and Vale University Health Board is responsible for delivering primary, physical and mental health services at the prison. There is a 22 bed healthcare centre providing 24 hour nursing care and a full time doctor's service between 8.00am and 5.00pm every weekday and a 24 hour on call provision.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Cardiff was in March 2013. Inspectors found that Cardiff was busy and overcrowded, and noted that the population was very transient with many prisoners serving only short sentences. The Inspectorate found waiting times for a GP appointment had improved and were generally less than seven days. Pharmacy services were satisfactory.

Independent Monitoring Board

18. 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 August 2015, the IMB reported that healthcare staffing levels had improved. This meant reduced waiting time for prisoners to see doctors, dentists and mental health specialists.

Previous deaths at HMP Cardiff

19. Mr Morgan was the second prisoner to die from natural causes since January 2014. There were no significant similarities with the circumstances of the previous death.

Key Events

20. On 10 January 2014, Mr John Morgan was sentenced to five years in prison for theft and sent to HMP Bullingdon. He was an older prisoner with several chronic health conditions including high blood pressure, heart disease (he had had a pacemaker fitted), osteoarthritis of the right knee and a history of problems with blocked arteries in his legs. Healthcare staff prescribed medications for these conditions.
21. Mr Morgan progressed through his sentence and, on 19 August 2014, he moved to HMP Prescoed (an open prison). He attended hospital appointments with cardiologists to check his pacemaker and with orthopaedics about his right knee, which surgeons noted would need replacing at some time. Doctors prescribed medications to help with these conditions. The prison released Mr Morgan on temporary licence for his appointments.
22. In April 2015, vascular specialists diagnosed Mr Morgan with advanced peripheral vascular disease in both legs. They recommended that Mr Morgan should take co-codamol (pain relief) when necessary and that he should contact his GP if he had any further problems.
23. On 8 December, orthopaedic surgeons at hospital reviewed Mr Morgan and decided to go ahead with his knee operation in 2016. The hospital originally scheduled the operation for 30 March, but cancelled and rebooked it for May. Surgeons decided that his vascular disease should not prevent his knee operation.
24. On 3 May, surgeons at the hospital replaced Mr Morgan's right knee. Prison managers at Prescoed released him on temporary licence for the period of his hospital admission. Both hospital and prison healthcare staff were concerned at how Mr Morgan would cope with the hilly location at Prescoed after his operation. They discussed this with Mr Morgan and he agreed to arrangements to discharge him directly from hospital to the inpatient unit at HMP Cardiff for his recovery. From 4 May, a nurse and the nurse manager spoke to healthcare staff at Cardiff to update them on Mr Morgan's condition and his care requirements.
25. On 9 May, when he arrived at Cardiff, Mr Morgan told reception staff that he had "bad knees" and a nurse noted that he had mobility issues following surgery. The nurse noted Mr Morgan was in possession of his prescribed medication but did not record any clinical details about Mr Morgan's health conditions or surgery, or take any baseline observations. Mr Morgan's medication was aspirin, atorvastatin (a statin to prevent heart disease), clopidogrel (to inhibit blood clots), ezetimibe (to treat high cholesterol), lansoprazole (reduces stomach acid), lisinopril (to treat high blood pressure) and verapamil (to treat high blood pressure and heart problems).
26. The next morning, a nurse noted that Mr Morgan was settled with no issues or concerns.

Events on 11 May 2016

27. At approximately 8.35am on 11 May, a nurse was helping Mr Morgan to sit up in bed, when Mr Morgan collapsed but did not lose consciousness. The nurse radioed a code blue (an emergency code which indicates that a prisoner is unconscious, not breathing or having breathing difficulties) and applied oxygen. The control room staff called an ambulance immediately. A prison GP attended and noted Mr Morgan was conscious but unable to sit up. She was unable to obtain readings for his blood pressure or oxygen saturation but noted his fingers were cyanosed (had turned blue). She made him comfortable by covering him and trying to keep him warm, until the ambulance arrived at 8.48am. Paramedics took Mr Morgan to hospital at 9.20am. Two officers escorted him but did not restrain him.
28. The hospital admitted Mr Morgan and his condition deteriorated. At 3.30pm, prison managers reduced the escort to one officer. Mr Morgan continued to deteriorate and became unresponsive. He died at 9.40pm on 12 May. His family were with him.

Contact with Mr Morgan's family

29. Mr Morgan was in contact with his family and they were aware of his planned knee operation. When he went into hospital for his operation, on 3 May, his family were able to visit him. Mr Morgan was also able telephone them from the hospital and knew that he was moving to Cardiff when the hospital discharged him.
30. On 11 May, when Mr Morgan was admitted to hospital from Cardiff, a prison manager rang his daughter, his nominated next of kin to inform her. Members of his family arrived at the hospital at 3.30pm to see him and were with him when he died.
31. After Mr Morgan died, the prison appointed an officer as the family liaison officer. At around 10.15am, the morning after Mr Morgan died, the officer telephoned Mr Morgan's daughter to offer his condolences and support. The officer, the deputy governor and a chaplain also visited her to offer condolences and support.
32. Mr Morgan's funeral was on 1 June 2016. The prison contributed to the costs in line with national policy.

Support for prisoners and staff

33. After Mr Morgan's death, a prison manager debriefed the escort staff, offering support and that of the staff care team.
34. The prison posted notices informing staff and 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.

Cause of death

35. The Coroner confirmed that the cause of Mr Morgan's death was a small bowel ischaemia (when the small intestine is starved of blood because of a narrowing of the arterial blood supply) and superior mesenteric artery atherosclerosis (the main artery to the small bowel is restricted by fatty deposits in the vessel wall, reducing blood flow and causing blood clots).

Findings

Clinical care

36. Healthcare Inspectorate Wales (HIW) found that the overall care Mr Morgan received in prison was equivalent to that he could have expected to receive in the community.
37. HIW said that Mr Morgan died of recognised but rare complication of his pre-existing arterial atherosclerosis (vascular disease). HIW said in the early stages this condition is very difficult to diagnose and carries a very high mortality rate. HIW also said that any surgical operation carries risk and this risk is greater when there are existing conditions present. They make two recommendations to the hospital, which NHS Commissioners will need to address, but are outside the scope of this investigation.
38. When Mr Morgan arrived at Cardiff he was recovering from major surgery. HIW commented that he was appropriately admitted to the prison's inpatient unit and healthcare staff closely monitored his progress and wellbeing. There is no evidence that he complained of any adverse symptoms before his collapse on 11 May.
39. However, when Mr Morgan arrived at Cardiff, healthcare staff did not carry out a full baseline assessment or observations as his move there was seen as temporary. While HIW did not consider that the lack of a full medical assessment impacted upon the care that Mr Morgan received, baseline clinical observations enable staff to better assess improvements or deterioration in his condition and this could be significant in other circumstances. Prison Service Order (PSO) 3050, Continuity of Healthcare, emphasises the importance of continuity in the success of clinical interventions and treatment. We make the following recommendation:

The Head of Healthcare should ensure that a baseline medical assessment and observations are taken for all prisoners returning or arriving at the prison following general surgery or a period in hospital.

Restraints, security and escorts

40. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.
41. We are pleased to note that officers did not restrain Mr Morgan when he went to hospital for the final time.

Temporary release

42. Release on temporary licence (ROTL) can be granted for precisely defined and specific activities, which cannot be provided in the prison. A risk assessment is completed to ensure that the prisoner's temporary release does not present

unacceptable risks. The governor of the prison is able to grant the temporary licence and will decide on whether the prisoner is to be accompanied by staff.

43. We asked if managers at Cardiff considered release on temporary licence for Mr Morgan, especially as he was a category D prisoner and this had been achieved at Prescoed. A prison manager said that there was not sufficient time to complete an assessment as Mr Morgan was taken to hospital as an emergency and died the next day. She said that as Mr Morgan was in a serious condition, the prison decided that one escort should remain with him so he was not alone at any time.
44. The prison attempted to act compassionately in deciding to keep an officer with Mr Morgan to stop him being on his own. However, we consider that when his family were present, the need for support was removed and the officer should have left the room. In the future, the Governor should ensure that, in cases where there are no security considerations, the wishes of families for appropriate privacy are met.
45. We consider that ROTL for a category D prisoner with a record of successful temporary release should not have been difficult to achieve. Even in the short time Mr Morgan was at Cardiff, we consider that the Governor should have agreed this with the minimum of delay. Release on temporary licence would have enabled Mr Morgan's grandchildren to see him before he died. We make the following recommendation:

The Governor should ensure that release on temporary licence is considered without delay for seriously ill prisoners in hospital who meet the criteria.

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