Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Glyn Morgan, a prisoner at HMP Manchester, on 13 January 2018

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

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*

© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Glyn Morgan died in hospital on 13 January 2018 of Sporadic Creutzfeldt-Jakob Disease (CJD)) while a prisoner at HMP Manchester. Mr Morgan was 59 years old. I offer my condolences to Mr Morgan's family and friends.

Sporadic CJD is a rare and fatal disease that affects the brain. There is currently no cure and there was nothing that could have been done to prevent Mr Morgan's rapid decline and death. CJD is difficult to diagnose but I am satisfied that the prison investigated Mr Morgan's mental deterioration appropriately, referred him to hospital for further tests and questioned the hospital's incorrect diagnosis.

I am, however, concerned that Mr Morgan's partner reported that she had great difficulty getting someone from the prison to speak to her when she expressed concerns about his health, including when she informed the prison that he was talking of killing himself. I recognise that there are genuine constraints on the information healthcare staff can give to third parties, including close family members. Nevertheless, I consider that both healthcare and prison staff should have managed the situation better and with more sensitivity.

I am also concerned that Mr Morgan was inappropriately restrained when he was taken to hospital shortly before his death, and that the prison was not able to provide the PPO with all the relevant risk assessments.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **September 2018**

Contents

Summary 1

The Investigation Process.. 3

Background Information.. 4

Key Events.. 5

Findings 11

Summary

Events

1. On 24 March 2017, Mr Glyn Morgan was sentenced to 14 years imprisonment for sexual offences and sent to HMP Manchester. His initial health screen did not raise any serious concerns, although he went on to be treated for high blood pressure and angina.

2. In August 2017, Mr Morgan saw a prison GP, and reported that he was feeling anxious, and was having difficulty sleeping and concentrating. The doctor prescribed an anti-depressant and Mr Morgan subsequently reported that he was feeling much better.

3. On 25 November, Mr Morgan's partner visited him and was alarmed by his confused presentation. She contacted the prison to raise her concerns. She visited Mr Morgan again at the beginning of December and subsequently rang the prison to tell them that Mr Morgan had said that he wanted to end his life. Mr Morgan was reviewed by a nurse the following day at the request of wing staff who were concerned about his presentation. The nurse thought Mr Morgan might have a urinary tract infection, but a test for this was negative.

4. On 19 December, Mr Morgan saw a GP and said that he was struggling with his memory. The GP arranged blood tests and a psychiatric referral. (The psychiatric appointment was later cancelled as it was thought that organic causes should be investigated before psychological ones.) A nurse conducted a mental health assessment later that day and noted that Mr Morgan was confused and distressed.

5. On 22 December, wing staff contacted healthcare to say that Mr Morgan thought he was in Afghanistan, could not find his way to his cell and had been forgetting to collect his lunch. Over the next few days Mr Morgan was seen by a prison GP and various blood tests were done. The test results were normal but Mr Morgan continued to present as highly confused. His partner frequently contacted the prison to report her concerns about him.

6. From 27 December, Mr Morgan was monitored hourly by healthcare staff and on 28 December, a prison GP sent him to hospital for tests and a brain scan. The hospital discharged him the following day with a diagnosis of a 'nervous breakdown'. On his return, he was seen by a prison psychiatrist who contacted the hospital to say that he was concerned that Mr Morgan had a medical condition rather than a mental health issue. Healthcare staff continued to monitor Mr Morgan who was now incontinent and found it increasingly difficult to feed himself or mobilise.

7. On 2 January, a prison GP sent Mr Morgan to hospital, where staff began to explore the possibility of meningitis, encephalitis and Creutzfeldt-Jakob Disease (CJD).

8. Mr Morgan's condition continued to deteriorate and he died on 13 January. The accepted cause of death was Sporadic CJD.

Findings

9. Creutzfeldt-Jakob disease (CJD) is a rare and fatal condition that causes brain damage that worsens rapidly over time. There is currently no cure and there was, therefore, nothing that could have been done to prevent Mr Morgan's rapid decline and death.

10. CJD is difficult to diagnose and we agree with the clinical reviewer that prison healthcare staff investigated Mr Morgan's symptoms appropriately and referred him to hospital where appropriate.

11. However, we are concerned that Mr Morgan's partner had difficulty communicating with the prison during Mr Morgan's illness. We recognise that there are genuine constraints on the information healthcare staff can give to third parties, including close family members. Nevertheless, we consider that the prison could (and should) have managed the situation better and with more sensitivity, for example, by seeking Mr Morgan's consent to share information and/or by inviting Mr Morgan's partner into the prison to discuss his health and care.

12. We are also very concerned that Mr Morgan was restrained when he went to hospital on 2 January, despite the fact that he was extremely unwell, and that healthcare staff do not appear to have contributed to the risk assessment process, as they should have done. The prison was not able to provide the risk assessment paperwork for Mr Morgan's hospital admission on 28 December, but it appears that he may have been inappropriately restrained on that occasion as well.

Recommendations

- The Head of Healthcare should provide written guidance for healthcare staff on the sharing of confidential medical information and the involvement of close relatives when a prisoner is seriously ill. This should include guidance on the importance of treating relatives with sensitivity even if information cannot be shared.
- The Governor should ensure that the prison has mechanisms in place to enable families to raise concerns, that they are treated with courtesy, that details are recorded and that relevant information is quickly acted upon.
- The Governor and the Head of Healthcare should ensure that healthcare staff contribute to risk assessments and that decisions to restrain are based on the risk the prisoner presents at the time.
- The Governor should ensure that, in line with PSI 58/2010, the Prisons and Probation Ombudsman is promptly provided with all requested documents following a death in custody.

The Investigation Process

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

14. NHS England commissioned a clinical reviewer to review Mr Morgan's clinical care at the prison.

15. We informed HM Coroner for City of Manchester District of the investigation. We have sent the coroner a copy of this report.

16. The investigator contacted Mr Morgan's partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She was concerned that the prison did not act on her concerns that Mr Morgan was ill and that, as his next of kin, she was not kept informed of his deterioration.

17. Mr Morgan's partner received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

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

Background Information

HMP Manchester

19. HMP Manchester operates as both a high security prison and as a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 men. Manchester Mental Health and Social Care Trust provides 24-hour nursing care and the healthcare centre includes an inpatient unit.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Manchester was conducted in May 2015. Inspectors reported that health services were reasonably good and most prisoners were satisfied with the quality of healthcare. They also commented that staff on the inpatients' unit provided compassionate care for patients with complex needs.

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 latest annual report, for the year to February 2017, the IMB noted that a lack of prison officers on the healthcare wing sometimes hampered access to prisoners in need of medical assistance. However, the Board commended the "continued dedication of individual prison service and NHS staff in providing excellent medical services to prisoners in difficult circumstances".

Previous deaths at HMP Manchester

22. Mr Morgan was the eighth prisoner to die of natural causes at Manchester since January 2016. There were no significant similarities with the other deaths.

Key Events

23. On 24 March 2017, Mr Glyn Morgan was sentenced to 14 years imprisonment for sexual offences and was sent to HMP Manchester.

24. A nurse conducted Mr Morgan's reception health screen. There were no significant physical or emotional health concerns apart from a high blood pressure reading of 170/60 (normal range is below 140/90), and he was declared fit for normal location.

25. Over the next few months, Mr Morgan's blood pressure readings fluctuated from high to normal. Healthcare staff referred him to a specialist and prescribed medication to treat his high blood pressure, ease angina symptoms and prevent the likelihood of a heart attack.

26. On 8 August 2017, Mr Morgan saw a prison GP and reported that he had a history of anxiety and depression following his return from Afghanistan six years previously where he said he had worked as a personal protection officer. He said that he was currently feeling anxious, flat, and having difficulty sleeping and concentrating. He had also had lost his appetite. The prison GP recorded that there was no evidence that Mr Morgan was experiencing any thought disorder. He prescribed sertraline (an antidepressant) and Mr Morgan said he would contact the chaplaincy for counselling. He noted that the 24-hour ECG results were 'reassuring'. (An electro cardiogram measures cardiac rhythms.)

27. On 29 August, Mr Morgan saw another prison GP and reported that his mood had improved significantly since taking medication. He had had a single counselling session with the chaplain. He noted that the plan was to continue with the sertraline and that he had advised Mr Morgan to contact the chaplaincy about getting more counselling sessions.

28. On 10 October, a prison GP reviewed Mr Morgan and noted he said he was feeling much better, was sleeping and his appetite had improved.

29. Mr Morgan's partner visited him on the morning of 25 November and was surprised that, when he spoke to her on the telephone that afternoon, he had no recollection that he had seen her earlier that day. She spoke to someone in the Chaplaincy who called her back to say they had passed her concerns on to a member of healthcare staff who would arrange for a nurse to see Mr Morgan that day and a doctor the following Monday.

30. On 27 November, a member of the Chaplaincy recorded on NOMIS (the prison's computer system) that Mr Morgan's partner had contacted them. The chaplaincy spoke to a Senior Officer who reported the matter to healthcare who said they would visit Mr Morgan the next day. There are no entries in the medical record to suggest healthcare staff visited Mr Morgan.

31. Mr Morgan's partner told us she contacted the prison again on 29 November, but was told that Mr Morgan's health could not be discussed with her because of the Data Protection Act. Mr Morgan's partner said that she explained that she did not want to discuss his health, as such, but just wanted to explain that there was a problem.

32. Mr Morgan's partner told us she and a friend visited Mr Morgan on 3 December but that she left early as he was so confused it upset her. Their friend stayed for the duration of the visit during which time Mr Morgan said that he wanted to kill himself. Mr Morgan's partner contacted the prison to alert them to this but said that she was told to contact the Safer Custody Team the next day. She said she attempted to contact the Safer Custody Team on 4 December, but was told she had got through to the anti-bullying helpline. She then spoke to someone at the prison who confirmed she had used the right number. She asked if someone would call her back and said she was told 'probably not'. There is nothing in the records to suggest anyone reviewed Mr Morgan as a result of his partner raising concerns about his welfare, or to say what staff did about Mr Morgan expressing suicidal thoughts.

33. On 4 December, a nurse noted that he had received a phone call from wing staff reporting concerns about Mr Morgan's presentation. Mr Morgan's partner had left a visit early because he seemed so confused. Officers had also noticed that he seemed to be having issues with his memory. The nurse wondered if Mr Morgan's confusion might be down to a urinary tract infection and booked him in for a test. The result was noted as normal on the medical record the same day.

34. On 5 December, healthcare staff discussed Mr Morgan at the morning meeting and agreed he should be referred to the primary care mental health team. A nurse noted that he would be seen in due course.

35. Mr Morgan's partner told us that she spoke to Mr Morgan again on 12 December. Mr Morgan was unable to tell her if he had seen a doctor or booked her in for any visits. She contacted the prison and was put through to someone in the Control Room and when she said she wanted to speak to someone about Mr Morgan's health, she was told 'we can't always get what we want'. The member of staff refused to give her name, citing security reasons. She said there was already a note on the system about her concerns and that a chaplain would contact her the following day.

36. On 13 December, Mr Morgan's partner telephoned the reverend to express her concerns about Mr Morgan's health. The reverend said she would email the Head of Healthcare about her concerns, and also advised her to speak to PALS (Patient Advice and Liaison Service). The Head of Healthcare, received the reverend's email and made a referral to the mental health team.

37. On 19 December, a prison GP saw Mr Morgan and conducted a 'mini mental test'. He noted that Mr Morgan was struggling with memory problems, had not done anything dangerous and denied being depressed or anxious. He requested further blood tests and noted that he wanted Mr Morgan to be seen by a psychiatrist.

38. Later that day, a nurse conducted a mental health assessment. She recorded that Mr Morgan was clean and presented with acceptable hygiene standards. Mr Morgan struggled with a number of questions about himself such as his partner's name and where he currently was. She also recorded that he appeared to be distressed and on the verge of tears. She spoke to wing staff to ensure Mr Morgan was eating and drinking as he was unable to confirm this. She noted

that an appointment with a psychiatrist had been booked and blood tests requested to rule out any organic causes.

39. On 20 December, a nurse noted that she had sent a referral to a prison GP that evening about the results of the multi-disciplinary team meeting and that a neurology referral should be considered due to the sudden onset of Mr Morgan's memory problems. (The GP was on leave and did not return to work until 2 January 2018, by which time Mr Morgan had been admitted to hospital.)

40. On 21 December, Mr Morgan's solicitor told his partner that she had visited him and he was confused, unsteady and seemed to have aged. The solicitor said she told a senior officer that she felt he should be in the healthcare unit.

41. The same day, a nurse noted that the psychiatrist's appointment had been cancelled because, a prison GP felt that organic causes should be investigated before psychological ones.

42. On 22 December, a nurse noted that an officer on Mr Morgan's wing had phoned to say that Mr Morgan seemed to think he was in Afghanistan, couldn't find his way to his cell and had been forgetting to collect his lunch. The nurse contacted the administration team to request an urgent GP appointment and was told he already had one scheduled for 28 December. A nurse contacted the wing and updated staff that the mental health in-reach team were due to discuss Mr Morgan on the following Wednesday (27 December), a GP appointment was booked for 28 December and wing staff should contact primary care's 24-hour support service if necessary in the meantime.

43. On 24 December, Mr Morgan was seen by a prison GP after presenting as highly confused at the medicine hatch. She also found him to be confused and arranged for blood tests to be done that day. She also noted that he possibly needed brain scans to determine the cause of his confusion. Mr Morgan was admitted to the healthcare unit's in-patients' department later that day. The blood tests results were normal. He had a fall in the shower and nurses attended to him.

44. On 24 December, a prison chaplain contacted Mr Morgan's partner to let her know that Mr Morgan was in the healthcare unit.

45. On 25 December, a healthcare assistant helped Mr Morgan call his partner, but he seemed confused and ended the call. A prison GP, noted that Mr Morgan had lost 22kg in weight and that, although blood tests were normal, he wanted further tests done for CRP (c-reactive protein levels in the blood can indicate inflammation). He also recorded that Mr Morgan needed a CT (computerised tomography) brain scan and a chest X-ray. Earlier that day, Mr Morgan had flooded his cell.

46. On 26 December, a prison GP reviewed the CRP blood results which were normal. Mr Morgan continued to present as highly confused and he struggled to eat or to remember to eat, although staff gave him prompts and physical assistance. The next day, healthcare staff noted he was crawling around saying he was 'looking for Dave' and that they considered his cell was hazardous for

him because of the painted floor. They also could not get into his cell when only one officer was on duty.

47. Mr Morgan's partner said that when she tried to find out what was happening, an un-named member of healthcare staff told her on 27 and 28 December that they could not provide her with any information because of the Data Protection Act. The Head of Mental Health and Inpatient Care, told her Mr Morgan was going for a CT scan but would not tell her how he was.

48. A member of staff recorded on NOMIS that Mr Morgan's partner had again expressed concerns about his medication and well-being and was frustrated that staff were citing medical confidentiality as a reason to not inform her about his condition. She was aware that members of the chaplaincy were seeing him on daily rounds and asked that they inform her of any changes.

49. On 27 December, a nurse noted that the plan was to monitor Mr Morgan hourly and if his NEWS score remained at 5 or above to transfer him to hospital. (NEWS is the 'National Early Warning Score' system healthcare staff employ to monitor an individual's vital signs.)

50. On 28 December, at 12.21pm, a prison GP noted that he had reviewed Mr Morgan and concluded that his confusion was worsening and he should be transferred to hospital. He contacted the hospital and explained the situation, including the need for blood tests and brain scans. A non-urgent ambulance was arranged which arrived that evening and Mr Morgan was taken to hospital.

51. On 29 December, Mr Morgan was discharged from hospital. He had had a CT scan which was normal, a chest X-ray which was normal, blood results were also normal and there were no signs of any infection. The discharge summary diagnosed a 'nervous breakdown due to being in prison'. Mr Morgan was incontinent when he was returned to the prison and was located in healthcare's enhanced care suite and nursed on an open-door policy. A nurse noted that his hands and wrists were swollen due to cuffs being applied while he was in hospital.

52. A prison psychiatrist, reviewed Mr Morgan that afternoon and noted that he did not think his presentation was consistent with a mental health problem. He was concerned that a medical condition had not been identified and he expressed his concerns to a doctor at the hospital. He agreed to contact the on-call consultant for medical conditions but the consultant did not return his call. Healthcare staff continued to monitor Mr Morgan and he was prescribed lorazepam to ease his agitation.

53. Mr Morgan's partner told us that someone informed her that Mr Morgan had been admitted to the healthcare unit but that she would not be allowed to see him. On 30 December, an un-named member of staff refused to give her any information about his condition. The same day, a prison GP contacted a doctor at a hospital. They discussed the possible need for an MRI scan but, as it was a Bank Holiday, the doctors considered it was unlikely this could happen soon. The doctor advised that Mr Morgan's dose of lorazepam could be increased. Mr Morgan found it increasingly difficult to feed himself, mobilise or remain continent and he became sexually disinhibited.

54. Mr Morgan's partner told us that on 31 December, when she questioned why she had not been given any information about Mr Morgan's condition, an unnamed member of staff told her that the next of kin was only notified where a death had occurred. This person would not give their name for security reasons.

55. On 1 January, Mr Morgan's partner visited him. She said that she had expressed concerns to the prison but felt she had not been taken seriously. A nurse apologised on behalf of the prison and said the Head of Healthcare would keep her informed.

56. On 2 January, a prison GP reviewed Mr Morgan. He agreed with other healthcare staff that, although the hospital had diagnosed Mr Morgan with a nervous breakdown, his presentation was not consistent with a psychological illness. He called paramedics and Mr Morgan was taken to hospital that morning. A nurse faxed records to a doctor at the hospital showing when Mr Morgan had started to deteriorate and how rapid that deterioration had been.

57. Mr Morgan was restrained by single cuffs and two officers escorted him. He left the prison at approximately 11.44am and at 6.10pm, the duty governor authorised the removal of restraints. A senior officer (SO) had conducted another risk assessment following medical advice that Mr Morgan was immobile with no realistic prospect of change in the immediate future.

58. Mr Morgan had a CT scan at the hospital but it was unreadable because he had moved so much during the imaging process. He also had a lumbar puncture and was prescribed antibiotics as a precaution as staff suspected he had meningitis. The result of the lumbar puncture ruled this out and clinicians considered whether encephalitis might be a cause. They planned to do a MRI scan (Magnetic Resonance Imaging) on 4 January but again were unable to because Mr Morgan could not keep still. Mr Morgan was given intravenous steroids in the hope that this might help. On 9 January, a nurse noted that he had been moved to the hospital's acute neurology unit and there was a strong possibility he had Creutzfeldt-Jakob Disease (CJD).

59. On 10 January, a prison GP noted that the security department needed to be informed of Mr Morgan's diagnosis so that restraint measures could be reduced, and that he needed a report from the hospital so that early compassionate release could be considered.

60. On 11 January, a SO authorised escorting staff to move from Mr Morgan's room to outside the door. Mr Morgan continued to deteriorate and was heavily sedated. A hospital doctor confirmed Mr Morgan's death at 4.27pm on 13 January 2018.

Contact with Mr Morgan's family

61. Mr Morgan's named next of kin, his partner, became concerned about his health in November 2017. Although her messages sometimes got through to healthcare staff and investigations were put in train, she has told us about some occasions where it seems they did not.

62. The prison appointed an officer as a family liaison officer (FLO) on 2 January 2018, when Mr Morgan was admitted to hospital. She met Mr Morgan's partner

at the hospital, explained her role and provided her contact details. The FLO and her deputy, stayed in contact with Mr Morgan's partner to offer support and advice.

63. Mr Morgan's partner was by his side when he died on 13 January.

64. Mr Morgan's funeral was held on 1 February. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

65. After Mr Morgan's death, the staff on the escort stayed at the hospital to oversee the formal handover of Mr Morgan's body to the coroner. A custodial manager (CM) went to the hospital to offer care team support and the night orderly officer, briefed the officers on their return to the prison.

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

Post-mortem report

67. A post-mortem report was not carried out. The Senior Coroner's Officer informed the investigation that the Coroner had accepted the cause of death as Sporadic Creutzfeldt-Jakob Disease.

Findings

Clinical Care

68. Sporadic Creutzfeldt-Jakob Disease is a rare and fatal condition. Its cause is unclear but brain proteins undergo an abnormal change and the damage progresses rapidly. It is also very difficult to diagnose and the only way to confirm a diagnosis is after a brain biopsy or post-mortem brain examination.

69. There is currently no cure and nothing could have been done to prevent Mr Morgan's rapid decline and death. The clinical reviewer is content that the clinical care Mr Morgan received in prison was equivalent to that he could have expected to receive in the community. She notes the rarity of the condition and its aggressive nature. Mr Morgan was appropriately referred for investigations, reviewed when necessary and supervised. The prison's healthcare team stayed in contact with the hospital during hospital admission and raised their concerns when he was discharged.

70. After the clinical reviewer had completed her report, the healthcare provider's 72-hour review of Mr Morgan's care was made available to the PPO. We note that it concluded that, if further tests of Mr Morgan's mental functioning had been carried out after the GP's 'mini mental test' on 19 December, they may have provided further evidence of his mental deterioration, but would not have altered the outcome for him.

71. Mr Morgan's partner raised several concerns with the PPO, which have been raised separately with the clinical reviewer. Mr Morgan's partner was critical of the prison's communication with her. Some of these criticisms were aimed specifically at healthcare staff as there were times when she felt she was not kept informed of developments with Mr Morgan's health.

72. The clinical reviewer recognised that there are constraints on what information healthcare staff can give, particularly over the phone. However, she felt that there were occasions where information-sharing could have been successfully managed, for example by inviting Mr Morgan's partner into the prison to discuss his health and care.

73. We asked the Head of Healthcare, what mechanisms exist for families to escalate concerns. He said that families usually contact the Chaplaincy or PALS, but that they could speak to a GP or healthcare manager directly if they asked to.

74. We note that Mr Morgan's partner did speak to healthcare staff directly at times but that she felt they were not forthcoming in trying to help her. We recognise that there are genuine constraints on the information healthcare staff can give to third-parties, including close relatives. We do not criticise staff for taking care what they said. Nevertheless, we understand that seeing Mr Morgan deteriorate so quickly must have been extremely worrying and distressing for his partner, and we share the clinical reviewer's view that healthcare staff could have handled the situation better and with more sensitivity.

75. We make the following recommendation:

The Head of Healthcare should provide written guidance for healthcare staff on the sharing of confidential medical information and the involvement of close relatives when a prisoner is seriously ill. This should include guidance on the importance of treating relatives with sensitivity even if information cannot be shared.

Safer custody concerns

76. Mr Morgan's partner has cited various examples where she received an unhelpful response from prison staff. We are particularly concerned that she did not receive a coordinated, helpful response when she contacted the prison to report that he was talking about taking his life.

77. We asked the Safer Custody Team if there had been an issue with their phone number. An officer told the investigator that when such a call is received, the person operating the helpline should complete the details on a log and on NOMIS (the prison's computer system). Someone should then contact the wing and a staff member should check on the individual and report back to the Safer Custody Team. The officer said that in this case there was no entry on the log about the call.

78. We note that a nurse did check on Mr Morgan the next day, following a call from a member of wing staff, but it is not clear if this was as a result of Mr Morgan's partner's phone call or because wing staff were simultaneously concerned about his presentation.

79. It is not acceptable that when Mr Morgan's partner called to report a serious concern that she was told to call back the next day or that she appears to have been treated with a lack of courtesy. We make the following recommendation:

The Governor should ensure that the prison has mechanisms in place to enable families to raise concerns, that they are treated with courtesy, that details are recorded and that relevant information is quickly acted upon.

Restraints, security and escorts

80. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

81. The prison did not provide the PPO with the paperwork relating to Mr Morgan's hospital admission on 28 December. We do not, therefore, know what level of

restraints was applied or whether this was justified by a considered risk assessment. However, it seems likely that Mr Morgan was restrained because a prison nurse noted that his wrists were swollen because of cuffs when he returned to the prison on 29 December. If Mr Morgan was restrained on 28 December, we are not persuaded that this was necessary or proportionate given how ill he was.

82. Mr Morgan was readmitted to hospital on 2 January and was restrained by single cuffs authorised by the duty governor. The risk assessment paperwork does not reflect any input from medical staff, the need for which is clear from the High Court judgement. Although the restraints were removed within less than seven hours (also authorised by the duty governor), we do not consider that it was necessary or proportionate to have restrained Mr Morgan who was by then seriously ill. We make the following recommendations:

The Governor and the Head of Healthcare should ensure that healthcare staff contribute to risk assessments and that decisions to restrain are based on the risk the prisoner presents at the time.

The Governor should ensure that, in line with PSI 58/2010, the Prisons and Probation Ombudsman is promptly provided with all requested documents following a death in custody.