

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Morton a prisoner at HMP North Sea Camp on 5 May 2018

A report by the Prisons and Probation Ombudsman

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 Colin Morton died in hospital on 5 May 2018 from a cardiac arrest while a prisoner at HMP North Sea Camp. He was 74 years old. I offer my condolences to Mr Morton's family and friends.

Mr Morton had a number of health issues and in general his healthcare was at least equivalent to that he could have expected to receive in the community.

However, I am concerned that an elderly man with a history of falls, was located in a detached building without a healthcare or social care assessment and without adequate support to ensure he was safe. When Mr Morton fell in his room at night ten days before he died, he had no means of calling for assistance.

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

Sue McAllister CB
Prisons and Probation Ombudsman

November 2019

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	5
Findings.....	8

Summary

Events

1. On 4 January 2010, Mr Colin Morton was given an indeterminate sentence for public protection for a sexual offence. He was moved to HMP North Sea Camp on 23 May 2016.
2. On arrival at North Sea Camp, the reception medical screen identified Mr Morton's health problems, which included Type 2 diabetes, heart disease, high blood pressure and a history of back pain. He was also overweight and used a wheelchair to help him move around. He had a 'buddy' to help him collect his meals and clean his room.
3. Following a number of falls, Mr Morton developed increasing pain in his hips, knees and lower back. He had an X-ray which identified lumbar disc degeneration and was prescribed pain relief medication and referred for physiotherapy.
4. On 29 January 2018, Mr Morton was moved to Jubilee House 1, a detached house, separate from the main prison and designed to help prisoners develop independent living skills.
5. On 25 April, at approximately 10.30pm, Mr Morton fell out of bed. He was found on the floor over an hour later by an officer during a routine roll check. The officer called for assistance and the orderly officer attended. They decided not to attempt to move Mr Morton as they did not know if he was injured, so they kept him warm with blankets and called an ambulance at about midnight.
6. The ambulance arrived at 2.54am and took Mr Morton to hospital just after 4.00am.
7. In hospital Mr Morton was diagnosed with a spinal injury. His health deteriorated and he developed pneumonia. He suffered a cardiac arrest and died on 5 May.

Findings

Clinical care

8. Mr Morton had a number of long term health conditions. The clinical reviewer is satisfied that during Mr Morton's time at North Sea Camp, his conditions were well monitored and care plans were put in place, and that overall, the management of his health conditions was at least equivalent to what he would expect to receive in the community.
9. However, we share the clinical reviewer's concerns that no falls assessments were conducted after Mr Morton suffered falls and no action plan was put in place to help prevent future falls.
10. In addition, there is no evidence that a health or social care assessment was conducted before Mr Morton was moved to live independently in Jubilee House 1. We are very concerned that an elderly man with a history of falls was moved

to a detached building with no means of calling for help if necessary, especially at night.

11. We also share the clinical reviewer's concern that healthcare staff did not consider seeking Mr Morton's consent to share key medical information with prison staff so that they could provide him with optimum support.
12. As a result, prison staff were unable to provide ambulance control with medical information which might have led them to prioritise the ambulance for Mr Morton.
13. Although the ambulance service is outside the Ombudsman's remit, we are concerned that more than four hours elapsed between an ambulance being called and Mr Morton arriving at hospital. The clinical reviewer said that this may have had an effect on his wellbeing.

Recommendations

- The Governor should review the allocation criteria for the Jubilee Units to ensure that prisoners living there are suitable for the environment.
- The Head of Healthcare should ensure that:
 - healthcare staff assess all residents moving into independent living accommodation to identify whether there are any potential safeguarding concerns;
 - if there are any healthcare concerns, prisoners are asked to consent to the sharing of healthcare information to support their safety, particularly at night;
 - where appropriate, prisoners are offered personal emergency alarms of the kind used in the community.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP North Sea Camp informing them of the investigation and asking anyone with relevant information to contact her.
15. The investigator obtained copies of relevant extracts from Mr Morton's prison and medical records.
16. NHS England commissioned a clinical reviewer to review Mr Morton's clinical care at the prison.
17. The investigator and clinical reviewer interviewed four members of staff at HMP North Sea Camp on 21 September 2018.
18. We informed HM Coroner for Lincolnshire (Boston and Spalding) of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
19. The investigator wrote to Mr Morton's partner to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.
20. We shared our initial report with HM Prison and Probation Service (HMPPS). They considered that our description of Jubilee House 1 suggested it was remote from the prison and was factually inaccurate. We do not accept that our description of Jubilee 1, as a detached house separate from the main prison, was factually inaccurate and so we have not amended our report. HMPPS provided an action plan which is annexed to this report.

Background Information

HMP North Sea Camp

21. HMP North Sea Camp is an open (Category D) prison, holding approximately 400 men. Accommodation is provided in five residential units. There are also 66 beds in four detached houses, known as the Jubilee Units, which are used for long-term prisoners living independently.
22. Nottinghamshire Healthcare NHS Foundation Trust provide healthcare services at the prison.

HM Inspectorate of Prisons

23. The most recent inspection of HMP North Sea Camp was conducted in July 2017. Inspectors reported that clinical governance of healthcare was sound and good relationships had been established across the prison. A range of appropriate primary care services were provided and waiting lists for clinics were short, although a significant number of men were waiting too long for routine podiatry care.
24. Inspectors noted that the safer custody and healthcare teams had a complex needs register for prisoners identified as having adult social care needs. This allowed them to track referrals to, and responses from, adult social care. Men were assigned 'buddies' to assist them where appropriate. Men at risk were considered for a single room and a log documented the reason for allocating them one.

Independent Monitoring Board

25. 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 2018, the IMB highlighted the good physical and mental health care provided at North Sea Camp. However, there were some issues with the distance that prisoners had to travel for some treatments, especially those with disabilities.

Previous deaths at HMP North Sea Camp

26. Mr Morton is the first prisoner to die at North Sea Camp since 2017. There was a previous death from natural causes in February 2017, and there have been two further deaths which are still being investigated. There are no similarities between the previous death and that of Mr Morton.

Key Events

27. On 4 January 2010, Mr Colin Morton was given an indeterminate sentence for public protection for a sexual offence. He was moved to HMP North Sea Camp on 23 May 2016.
28. On arrival at North Sea Camp, the reception medical screen identified a number of long-term health problems. These included Type 2 diabetes, ischemic heart disease (IHD), high blood pressure and a history of back pain. He was also overweight. He was prescribed medication for his various conditions. The IHD caused breathlessness, swollen legs and angina and, together with his weight, affected his ability to move around. He used a wheelchair to help him get around.
29. In May 2016, a social needs assessment took place. As a result, Mr Morton was given a 'buddy' to help him clean his room and collect his meals.
30. Also in May 2016, Mr Morton was assessed as having spondylitis (inflammation of the vertebrae) at the top and bottom of his spine and was prescribed painkillers.
31. In June and July 2016 and October 2017, Mr Morton suffered a number of falls. He was not seriously hurt but developed increasing pain in his hips, knees and lower back.
32. He was referred for an X-ray in November 2016 after complaining of acute lower back pain and was found to have lumbar disc degeneration (part of the natural wear and tear of a normal aging spine). He was also referred for physiotherapy and in late 2016/early 2017, he had five sessions, after which he was discharged with exercises to carry out. There is no evidence that he had any further back issues after his physiotherapy sessions had finished.

Move to Jubilee House 1

33. On 29 January 2018, Mr Morton moved to Jubilee House 1, one of the detached houses where prisoners have the opportunity to practice living independently in preparation for release.
34. A multi-disciplinary Release on Temporary Licence (ROTL) assessment was carried out to assess his suitability for a place in the Jubilee Units, but this did not include a health or social care assessment. Mr Morton was given a single room on the ground floor as he had requested.

Events of 25/26 April 2018

35. At approximately 10.30pm on 25 April, Mr Morton fell over after getting out of bed to relieve an episode of cramp. He said he did not recall much afterwards. He called for help but could not be heard by the other prisoners who had rooms upstairs.
36. At approximately 11.45pm, an officer went to Jubilee House 1 to carry out the evening roll check. On arrival, he heard very faint calls for help and found Mr Morton face down on the floor in his room. Mr Morton was very cold and had an

injury to his head. The officer told the investigator that he spoke to Mr Morton but that Mr Morton was very confused.

37. The officer called for assistance and the orderly officer attended. Both officers tried to raise Mr Morton's body temperature by covering him with blankets. He had a bump on his head and was unable to move. He was complaining about pain in his neck, legs and arms. They decided not to move him but to make Mr Morton comfortable as they were unsure what injuries he might have sustained.
38. Ambulance records show that an ambulance was requested by the orderly officer at 11.58pm. As there were no healthcare staff on site at the time, no one had access to Mr Morton's medical notes to provide details for the ambulance control room.
39. The orderly officer told the investigator that he was not aware of Mr Morton's medical conditions, although it would have been helpful to have known so that he could pass them onto the ambulance control room. He said that healthcare staff were reluctant to pass on medical information to officers for reasons of medical confidentiality.
40. Paramedics did not arrive until 2.54am, although the orderly officer chased the ambulance at approximately 1.00am as he felt it was taking a long time to arrive. On arrival, the paramedics stabilised Mr Morton but struggled to get him up off the floor because of his size. The orderly officer told the investigator that Mr Morton did not disclose at the time that he had previous back problems.
41. At 4.08am on 26 April, the ambulance finally left the prison. Mr Morton was taken to Boston Pilgrim Hospital and arrived there at 4.21am. There was a considerable delay between Mr Morton falling and being assessed in hospital, amounting to over six and a half hours.
42. Prison healthcare staff kept in regular contact with hospital staff about Mr Morton's condition and on 30 April they were told that Mr Morton had a spinal injury and would be transferred to a spinal injury centre in Sheffield. This move did not happen before Mr Morton's death.
43. On 2 May, prison healthcare were told that Mr Morton's health had deteriorated. Two days later, Mr Morton contracted pneumonia. On 5 May, Mr Morton died at Boston Pilgrim Hospital after suffering a cardiac arrest.

Post-mortem report

A post-mortem examination concluded that the immediate cause of Mr Morton's death was aspiration of gastric contents, with a cervical spinal cord injury as a contributory factor. The pathologist also noted that Mr Morton suffered a cardiac arrest on 5 May from which it was not possible to revive him.

Contact with Mr Morton's family

44. On 2 May, the prison appointed a family liaison officer (FLO), after Mr Morton's health had deteriorated. Later that afternoon, the FLO and his deputy met Mr Morton and his partner at the hospital. They explained their role and provided their details as the family's points of contact.

45. Mr Morton asked to see five prisoners and a chaplain while he was in hospital, and this was arranged.
46. On 5 May, at approximately 6.55am, the FLO was notified that Mr Morton had died. The FLO was just beginning a bedwatch at another hospital, so the Governor went to see Mr Morton's partner and inform her of Mr Morton's death. Later that day, the FLO called Mr Morton's partner to pass on his condolences and to give her his direct number.
47. On 8 May, the FLO took Mr Morton's partner to see Mr Morton's room in Jubilee House 1. She was able to meet the other residents and was given further information about the procedures and support available following Mr Morton's death.
48. Mr Morton's funeral took place on 31 October 2018. The prison made a financial contribution towards the funeral in line with prison instructions.

Support for prisoners and staff

49. The prison posted notices informing other prisoners and staff of Mr Morton's death, and offering support.

Findings

Clinical care

50. Mr Morton had a number of long term health conditions. The clinical reviewer considered that during Mr Morton's time at North Sea Camp, his conditions, including his lumbar spine degeneration, were well monitored and care plans were put in place. Mr Morton sought help when needed and, overall, the management of Mr Morton's health was at least equivalent to what he would expect to receive in the community.
51. The clinical reviewer did, however, identify some concerns which did not contribute directly to Mr Morton's death. These are set out in the clinical review and are the subject of separate recommendations by the clinical reviewer which the Head of Healthcare will need to address.

Location and falls

52. The clinical reviewer's main concern, which we share, is that Mr Morton was not referred for falls assessments after he suffered falls and no action plans were put in place to reduce his risk of falls. This was not equivalent to the care he could have expected in the community.
53. In addition, although healthcare staff were involved in the multi-disciplinary assessment of Mr Morton's suitability for the Jubilee Units, there is no evidence that any assessment was undertaken to identify any safeguarding concerns. Apart from allocating Mr Morton a downstairs room, no extra provisions were put in place for him.
54. We also share the clinical reviewer's concerns that a failure by healthcare staff to share information about Mr Morton's medical conditions, made him potentially more vulnerable in Jubilee House 1. Although healthcare are bound by patient confidentiality, the clinical reviewer considered that Mr Morton should have been asked whether he would give consent to share some of his medical information so that prison staff could help to ensure his wellbeing.
55. We are very concerned that an elderly man with a history of falls was placed in a detached house with no emergency alarm system. On 25 April, when Mr Morton fell in his room, he had no way of alerting staff. His housemates did not hear his cries for help so he lay on the floor for over an hour before he was found by an officer. If Mr Morton had been in the community and living independently he would have been offered access to emergency call systems.
56. When prison officers called an ambulance, they were unable to provide ambulance control with any information about Mr Morton's health conditions (for example, that he had diabetes and heart disease and that he was prescribed blood thinning medication). The ambulance took nearly three hours to arrive. The clinical reviewer said it is not possible to say whether the ambulance would have been given greater priority if ambulance control had been aware of Mr Morton's medical conditions, but that the lengthy period between Mr Morton falling and being treated in hospital may have had an effect on his wellbeing.

57. We make the following recommendations:

The Governor should review the allocation criteria for the Jubilee Units to ensure that prisoners living there are suitable for the environment.

The Head of Healthcare should ensure that:

- **healthcare staff assess all residents moving into independent living accommodation to identify whether there are any potential safeguarding concerns;**
- **if there are any healthcare concerns, prisoners are asked to consent to the sharing of healthcare information to support their safety, particularly at night;**
- **where appropriate, prisoners are offered personal emergency alarms of the kind used in the community.**

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