Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bernard Morton a prisoner at HMP Wakefield on 15 June 2018

A report by the Prisons and Probation Ombudsman

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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*

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.

The Ombudsman's 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 Bernard Morton died in hospital on 15 June 2018 of pneumonia and heart failure while a prisoner at HMP Wakefield. He was 63 years old. I offer my condolences to Mr Morton's family and friends.

Mr Morton received a good standard of care at Wakefield. The day to day management of his conditions was of a good standard and prison healthcare staff worked closely with hospital staff to ensure his health needs were met.

However, Mr Morton's next of kin were not notified of his hospital admission on 6 June and the prison did not contact them until after his death. Mr Morton's condition was serious when he was admitted to hospital, and the prison should have made attempts to contact his next of kin sooner to enable them to see him before he died if they wished. I raised a similar concern earlier this year following an investigation into the death of another prisoner at Wakefield and we expect the Governor to take action to ensure this does not happen in future.

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 **March 2019**

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Summary

Events

1. Mr Bernard Morton was serving a 13-year sentence for sexual offences. He was moved to HMP Wakefield on 7 February 2014.

2. Mr Morton had several pre-existing medical conditions. Healthcare staff regularly monitored Mr Morton, put in place comprehensive care plans to manage his conditions and referred him to secondary care providers when necessary.

3. On 8 May 2018, a routine CT scan showed Mr Morton had developed a large build-up of fluid in his abdomen. A prison GP at Wakefield reviewed the results of the scan the same day and referred him for an urgent CT scan of his urinary tract.

4. A CT scan on 5 June showed Mr Morton had developed a large cyst causing a blockage to his bladder. He was admitted to hospital by emergency ambulance the next day. Hospital staff treated his symptoms, but he developed an infection and his condition deteriorated. Mr Morton died at 6.30am on 15 June.

5. The post-mortem examination showed Mr Morton died from pneumonia and heart failure.

Findings

6. The clinical reviewer found that Mr Morton received a good standard of clinical care at Wakefield. Healthcare staff appropriately assessed his clinical needs and sought advice from secondary care providers. We are satisfied that Mr Morton's care was equivalent to that which he could have expected to receive in the community.

7. When Mr Morton was taken to hospital on 6 June, he was extremely unwell and his condition was noted as being possibly life threatening. There is no evidence that the prison made attempts to inform his next of kin of his admission to hospital as they should have done. The prison did not appoint a family liaison officer until after Mr Morton's death on 15 June, nine days after his admission to hospital.

Recommendations

- The Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that prison staff inform the next of kin of seriously ill prisoners immediately of their admission to hospital, to allow the opportunity to visit if they wish to do so.

The Investigation Process

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

9. The investigator obtained copies of relevant extracts from Mr Morton's prison and medical records.

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

11. We informed HM Coroner for the County of West Yorkshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. The investigator wrote to Mr Morton's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. We did not receive a response.

13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies. The action plan has been annexed to this report.

Background Information

HM Prison Wakefield

14. HMP Wakefield is a high security prison and holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (a small unit aiming to provide a supportive, safe, structured and consistent environment for some of the most challenging offenders).

15. Care UK took over all healthcare provision at Wakefield on 1 April 2016. They provide primary healthcare services during normal working hours and overnight and weekend care in the inpatient unit for prisoners with physical health problems. There is a dedicated palliative care suite in the healthcare unit.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Wakefield was in July 2014. Inspectors noted health services were good overall but some parts of the healthcare environment required improvement. Primary care services were very good and had an appropriate emphasis on the care of patients with long-term conditions.

Independent Monitoring Board

17. 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 30 April 2017, the IMB noted the difficulties and challenges presented by the change of healthcare provider. However, they also noted there had been noticeable improvements within the new team.

18. The IMB was also pleased to note the new initiatives being put in place by the Head of Healthcare in an attempt to lessen the need to send prisoners to hospital. It noted that nurses would be trained to enable them to administer intravenous drugs and that, a review would be carried out following every case in which an emergency ambulance was requested, in an attempt to learn lessons and to assess if any alternative treatments could be put in place.

Previous deaths at HMP Wakefield

19. Mr Morton was the 20th man to die while a prisoner at HMP Wakefield since June 2015. All the deaths were from natural causes. There have been two further deaths since, both from natural causes. We have raised the issue of lack of contact with the families of prisoners following their admission to hospital in a previous case of a prisoner who died in December 2017.

Key Events

20. On 28 September 2011, Mr Bernard Morton was remanded into custody for sexual offences and sent to HMP Woodhill. On 21 November, he was sentenced to 13 years in prison.

21. Mr Morton arrived with several pre-existing medical conditions. He had a history of cirrhosis of the liver, caused by alcoholism, oesophageal varices (dilated veins found in the lower part of the oesophagus prone to bleeding, a condition often developed by sufferers of cirrhosis) and gastric ulcers. Healthcare staff regularly monitored Mr Morton and devised care plans to manage his conditions. A prison GP prescribed medication to treat his medical conditions and referred him to the Gastroenterology Unit at Milton Keynes Hospital for review.

22. Mr Morton underwent a gastroscopy (a thin flexible camera inserted into the throat via the mouth), which confirmed the presence of gastritis (a condition in which the lining of the stomach becomes inflamed and irritated), a duodenal ulcer (eroded lining of the stomach) and varices. Hospital staff subsequently took the decision to use gastric bands in an attempt to relieve Mr Morton's symptoms.

23. In the months that followed, both healthcare and hospital staff continued to monitor and review Mr Morton regularly.

24. On 7 February 2014, Mr Morton was transferred to HMP Wakefield. Healthcare staff carried out an initial health screen, noted his pre-existing conditions and updated his care plans. A prison GP reviewed Mr Morton the same day. She made a referral to the Gastroenterology Unit at Pinderfields Hospital, Wakefield, to ensure the continuity of Mr Morton's care.

25. Mr Morton saw healthcare staff daily for medications and frequently for review and he remained under the care of the Gastroenterology Unit at Pinderfields Hospital. His care was in line with NICE guidelines (National Institute for Clinical Excellence).

26. On 20 January 2017, a nurse reviewed Mr Morton. She noted he was complaining of pain in his abdomen which had been increasing since early December. She examined him and considered he may have developed ascites (a build-up of excess fluid between the lining of the abdomen and internal organs). She referred him to a prison GP for review.

27. A prison GP carried out a review of Mr Morton on 23 January. He told her his pain had been steadily increasing, and when he experienced the pain it came in waves. He told the GP he had regularly vomited his food but was drinking normally. She noted he did not have any signs of a raised temperature but he did appear mildly jaundiced (a symptom of liver disease). She agreed with the nurse's diagnosis and took the decision to carry out blood tests. She referred him to another GP at the prison, for a second opinion.

28. A prison GP reviewed Mr Morton the next day. He agreed with the previous GP's diagnosis and made a referral to the Hepatology Department at St James Hospital, Wakefield. An appointment was scheduled for 21 February, but Mr Morton was unwell and could not attend.

29. Hospital staff reviewed Mr Morton on 15 March. During the review they carried out an ultrasound scan. Following the scan, they removed excess fluid from his abdomen, a procedure carried out by inserting a drain through the stomach wall.

30. Mr Morton continued to receive regular reviews from the specialist nurse-led clinic at the Hepatology Department, which included routine CT scans of his abdomen (computerised tomography scans create two dimensional scans of the body). In addition, prison GPs carried out monthly reviews of Mr Morton to ensure all actions advised by the Hepatology Department were completed.

31. On 8 May 2018, the results of a routine CT scan indicated that Mr Morton had again developed a large ascites and acute right side hydronephrosis (a condition in which the kidney becomes stretched and swollen as a result of a build-up of urine).

32. A prison GP reviewed the results of the CT scan with Mr Morton the same day. He told her he had had issues passing urine for the past month and had also seen blood in his urine but had not told healthcare staff. She discussed the results, and what Mr Morton had told her during her review, with the urology staff at Pinderfields Hospital. They took the decision to refer him for a CT urogram (a scan of the urinary tract, including the bladder, kidneys and ureters (the tubes that carry urine from the kidney to the bladder)).

33. The CT scan was carried out on 5 June. The results showed Mr Morton had developed a large mesenteric cyst (a large mass in the tissues which attach the intestines to the wall of the abdomen) which was pressing on the part of the bladder which passes urine to the kidney, causing an obstruction.

34. The following day, a prison GP discussed the results of the tests with a consultant urologist at Pinderfields Hospital. They took the decision to admit Mr Morton to hospital for further assessment and to drain fluid from the cyst to relieve the pressure on his bladder. He was taken to hospital by emergency ambulance later that day. He was accompanied by two prison officers and restrained with an escort chain (a length of chain with a handcuff at each end).

35. When Mr Morton arrived at hospital, he refused to comply with any instructions given to him either by prison or hospital staff, often becoming aggressive and trying to interfere with the treatment being given to him. Despite repeated explanations as to why his treatment was so important, his behaviour did not improve. As a result, he remained on an escort chain while in hospital.

36. The following day, Mr Morton underwent a surgical procedure to drain fluid from the cyst. Hospital staff continued to regularly monitor Mr Morton following the procedure and regular CT and ultrasound scans were carried out to ensure the cyst did not increase in size.

37. Despite repeated attempts by the prison staff accompanying Mr Morton to explain the need for his cooperation with his treatment, his behaviour did not improve.

38. On 14 June, prison staff noticed Mr Morton appeared to have vomited in his sleep. Despite attempts to rouse him, he was unresponsive. They removed the escort chain and alerted hospital staff who carried out cardiopulmonary

resuscitation (CPR). Hospital staff resuscitated Mr Morton and diagnosed that his right lung had collapsed and that he had developed an infection. They took the decision to sedate him in an attempt to make him comfortable and allow them to treat his symptoms.

39. However, at 6.00am on 15 June, prison staff noticed Mr Morton's breathing had become shallow and laboured, and they alerted hospital staff. His condition continued to deteriorate and at 6.15am Mr Morton died. At 6.30am, a hospital doctor confirmed Mr Morton's death.

Contact with Mr Morton's Family

40. At 7.40am, the Safer Prisons Administrator at Wakefield appointed a family liaison officer (FLO) and asked her to contact Mr Morton's next of kin.

41. At 10.00am, the FLO, accompanied by an officer, left the prison to visit the home address held on record for Mr Morton's sister, who he had named as his next of kin.

42. However, while they were en route, they received information from a police officer attached to HMP Wakefield, that Mr Morton's sister no longer lived at the address. By chance, the police officer was able to obtain a current address for his next of kin from a relative of Mr Morton's who happened to work at Wakefield Police Headquarters.

43. However, before the FLO could make her way to the address, she received a telephone call from Mr Morton's sister. She had already been informed of her brother's death by the individual who had supplied the updated contact details. The FLO apologised for not breaking the news of his death in person and asked if the family would like her to stay in touch with them by telephone. Mr Morton's sister told her she would prefer that to a visit in person.

44. After Mr Morton's death, the FLO provided on-going support to his sister. In line with national guidance, the prison offered a financial contribution to Mr Morton's funeral, which was held on 18 July.

Support for prisoners and staff

45. After Mr Morton's death, a prison manager debriefed the staff who were accompanying Mr Morton in hospital when he died, to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

46. The prison posted notices informing other prisoners of Mr Morton'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 Morton's death.

Post-mortem report

47. The post-mortem report shows that Mr Morton died from pneumonia and failure of the left ventricle in his heart caused by the hardening of the arteries. Other factors listed in the post-mortem report which did not contribute to the cause of death are alcoholic cirrhosis of the liver and a collapsed lung.

Findings

Clinical care

48. Mr Morton had several chronic conditions for which he took appropriate medication. Prison healthcare staff reviewed him regularly and appropriately referred him to secondary services for review and specialist advice and treatment.

49. The clinical reviewer considered that healthcare staff at Wakefield responded appropriately to deteriorations in Mr Morton's physical health and ensured that he attended all outpatient appointments. They sought appropriate advice and support from outside agencies to ensure that his healthcare needs were met. It is evident from Mr Morton's medical records that all actions requested by secondary care providers were completed in a timely manner by healthcare staff at Wakefield.

50. The clinical reviewer concluded that the clinical care Mr Morton received while at Wakefield was equivalent to that which he could have expected to receive in the community.

Contact with Mr Morton's Family

51. Prison Rule 22 says that when a prisoner becomes seriously ill, the governor should "at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed". This is reflected in Prison Service Instruction (PSI) 64/2011, which requires prisons to contact the next of kin of prisoners who are seriously ill.

52. Mr Morton was taken to hospital by emergency ambulance at 5.09pm on 6 June 2018. He was extremely unwell and his condition was noted as being possibly life threatening. There is no evidence that the prison made attempts to inform his next of kin of his admission to hospital. The prison did not appoint a family liaison officer until after Mr Morton's death on 15 June, nine days after his admission to hospital. We make the following recommendation:

    The Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that prison staff inform the next of kin of seriously ill prisoners immediately of their admission to hospital, to allow the opportunity to visit if they wish to do so.

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