Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Archie Morrison a prisoner at HMP Swaleside on 9 June 2017

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*

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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.

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

Mr Archie Morrison died in hospital on 9 June 2017 of blood poisoning caused by pancreatitis while a prisoner at HMP Swaleside. His hepatitis C infection was also a contributory factor. Mr Morrison was 45 years old. We offer our condolences to Mr Morrison's family and friends.

Our investigation found that some aspects of the healthcare Mr Morrison received at Swaleside fell short of the standard he could have expected in the community. Healthcare staff at Swaleside failed to identify that Mr Morrison had a chronic hepatitis C infection when he arrived and he was not referred to a specialist hepatitis C nurse until he himself requested a referral almost one year later. There was also a potential delay in Mr Morrison's hospital admission after prison staff failed to recognise the seriousness of Mr Morrison's condition when he became unwell.

It is very disappointing that when Mr Morrison was taken to hospital on 26 May he was double cuffed and that he remained restrained in hospital even after he was moved to intensive care. We are not satisfied that managers properly considered his medical condition and how this affected his risk of escape, and we consider that the use of restraints failed to address established case law and was disproportionate. We have raised the inappropriate use of restraints with Swaleside previously and draw this serious and continuing failure to the attention of the Executive Director for Long Term and High Security prisons.

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 **January 2018**

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 5

Findings 8

Summary

Events

1. Mr Archie Morrison arrived at HMP Swaleside on 9 June 2016, having spent time at a number of prisons. He had a history of drug and alcohol abuse and was infected with hepatitis C, which had been diagnosed in the community around 2000 and for which he had received some treatment in prison in 2015. Healthcare staff at Swaleside did not identify that Mr Morrison had a chronic hepatitis C infection and he was not referred to a specialist hepatitis C nurse until 7 April 2017, when Mr Morrison asked for a referral.

2. On 22 May, Mr Morrison told a prison officer that he felt sick and dizzy and was going to his cell to try to sleep it off. On 26 May, Mr Morrison asked to see healthcare because he felt very weak. A prison officer made a same day medical appointment for him for that morning but Mr Morrison was too weak to attend. At around 5.35pm, a senior officer telephoned healthcare and asked them to see Mr Morrison in his cell. A nurse arrived at roughly 8.00pm. She found him pale in colour and clammy. He had not eaten for four days and had abdominal pain.

3. Mr Morrison was taken to hospital at 9.15pm under escort and was restrained with double handcuffs. Mr Morrison's handcuffs were replaced with an escort chain on 28 May.

4. Mr Morrison was moved to intensive care on the evening of 4 June. He remained restrained by an escort chain until 6 June when a prison manager authorised its removal. Mr Morrison died at 4.22pm on 9 June. The post-mortem report shows that Mr Morrison died from blood poisoning caused by pancreatitis. His hepatitis C infection was a contributory factor.

Findings

5. We found that some aspects of Mr Morrison's clinical care were not equivalent to that which he could have expected to receive in the community. Current NICE (National Institute for Health and Care Excellence) guidance states that all patients with hepatitis C should be offered specialist care and treatment, regular review, information and support. This did not happen when Mr Morrison arrived at Swaleside.

6. We consider there may have been a delay in Mr Morrison's hospital admission. Although we were told that staff checked on Mr Morrison's wellbeing between 22 and 26 May, this was not documented in the medical records or on his prison file. When Mr Morrison was too weak to attend his medical appointment on the morning of 26 May, there was a delay in notifying healthcare, who did not see Mr Morrison until that evening.

7. Mr Morrison was restrained, double cuffed, during his escort to hospital on 26 May and he was restrained in hospital until 6 June, including during a period when he was in intensive care. We are not satisfied that managers properly considered his medical condition at the time and how this affected his risk of escape. We consider that the use of restraints was disproportionate.

Recommendations

- The Head of Healthcare should ensure that a suitably qualified clinician reviews a prisoner’s medical history on arrival to ensure safe transfer of healthcare between establishments.
- The Governor should ensure that prison officers monitor and record all meaningful interactions with prisoners who are unwell for an extended period in the wing observation book and/ or the prisoner’s NOMIS record.
- The Governor should ensure that prison officers contact healthcare urgently if a prisoner is too unwell to attend a healthcare appointment.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of the prisoner and are based on the actual risk the prisoner presents at the time.
- The Executive Director for Long Term and High Security prisons should assure himself that managers at HMP Swaleside properly understand and apply the clear case law relating to the use of restraints during escorted moves outside the prison.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact her. A prisoner at Swaleside responded.

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

10. The investigator interviewed four members of staff and three prisoners at Swaleside on 14 August 2017.

11. NHS England commissioned a clinical reviewer to review Mr Morrison's clinical care at the prison. She conducted a telephone interview with a prison GP on 17 August.

12. We informed HM Coroner for Mid Kent and Medway District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Morrison's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She said that her brother had hepatitis C and asked if he had been taking his medication for this.

14. Mr Morrison's sister received a copy of the initial report. She did not make any comments.

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

Background Information

HMP Swaleside

16. HMP Swaleside, HMP Elmley and HMP Standford Hill form a group of prisons on the Isle of Sheppey. Swaleside is a category B training prison and houses up to 1,112 men. IC24 Integrated Care provides primary healthcare at Swaleside. There is 24-hour nursing cover, which includes a qualified nurse and a healthcare assistant at night. There is a 17 bed inpatient unit. Minster Medical Group provides GP cover from 9.00am to 5.00pm on Monday to Friday, while Medoc provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Swaleside was in April 2016. Inspectors reported that prisoners had access to an appropriate range of primary care services and visiting specialists, although not all long-term conditions clinics ran regularly because staffing was inconsistent. Few of the clinics were led by nurses and none of the nurses were specialists in long-term conditions.

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 30 April 2017, the IMB reported that prisoners had made many complaints about lack of timely healthcare appointments.

Previous deaths at HMP Swaleside

19. Mr Morrison is the tenth prisoner to die at Swaleside since 2015, the fourth from natural causes. We have highlighted the inappropriate use of restraints in four previous cases.

Key Events

20. On 20 May 2008, Mr Archie Morrison was sentenced to four years for wounding with intent to do grievous bodily harm. He was released on licence in February 2010 but his licence was revoked seven months later. On 14 October 2011, after throwing boiling water over a prison officer, Mr Morrison was given an indeterminate sentence for public protection with a tariff of four and a half years.

21. Mr Morrison had a history of drug and alcohol abuse and was hepatitis C positive. He had been diagnosed in the community around 2000 and after various hospital tests, he started treatment while in HMP Lowdham Grange in 2015. However, he stopped taking his medication after a disagreement with a prison nurse. When he attended a hepatitis C clinic subsequently, he was told it was too late to restart treatment and he would be put on a waiting list to start a new treatment programme when it became available.

22. Mr Morrison was moved to HMP Gartree on 30 March 2016 and then to HMP Swaleside on 9 June 2016. As he had transferred to Swaleside from another prison, a nurse completed a change of circumstances interview instead of the normal reception screening. It is unclear if she reviewed Mr Morrison's medical record before this appointment as she recorded in her notes that he did not wish to be screened for hepatitis and that his only medical problem was hypertension (high blood pressure). He then saw a prison GP on 16 June who issued a new prescription for amlopidine, his blood pressure medication.

23. Mr Morrison saw a prison GP on 7 April 2017. He told the GP that he had not seen a hepatitis C specialist for at least two years. The GP referred Mr Morrison to the hepatitis C nurse. There are no further mentions of hepatitis care or monitoring of his liver after this date.

24. A healthcare assistant saw Mr Morrison at 2.20pm on 22 May for a routine blood pressure check. Mr Morrison did not appear unwell or complain of ill health.

25. The same day Mr Morrison spoke to a prison officer saying that he had felt sick and dizzy while at work that day. He was unable to eat his lunch and said that he would try to sleep it off. There are no other entries in Mr Morrison's medical record or in the wing observation book that relate to this illness until 26 May, when Mr Morrison asked the officer if he could see someone from healthcare.

26. The officer telephoned healthcare and made Mr Morrison a 'special sick' (same day) medical appointment for that morning, 26 May. Mr Morrison was unable to attend this appointment as he was too unwell to leave his cell.

27. A senior officer (SO) telephoned healthcare at roughly 5.35pm that afternoon. She told a nurse that an officer had told her that Mr Morrison had not eaten since Monday and, while "it didn't warrant calling a code red or blue, … he did need Healthcare to attend to look at him and to take some obs [observations]". The SO made a note of this call to healthcare on Mr Morrison's prison NOMIS record.

28. A nurse told the SO that she would see Mr Morrison later that evening while doing her rounds. She arrived at Mr Morrison's cell at roughly 8.00pm. She found him pale in colour and clammy. He confirmed that he had not eaten for

four days as he had not been able to keep anything down. He complained of left abdominal pain and had a raised temperature of 38.3 degrees. She suspected that Mr Morrison may have an infection and asked for an ambulance to be called. An ambulance was called straightaway at 8.30pm.

29. Mr Morrison was taken to a hospital by ambulance at 9.15pm. He was double cuffed to a prison officer during the escort. (Double cuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.) Medical opinion was not sought on the appropriateness of restraints for the escort. On arrival Mr Morrison was admitted to hospital and later diagnosed with severe pancreatitis.

30. Mr Morrison's handcuffs were replaced with an escort chain on 28 May. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

31. A hospital nurse told Mr Morrison at 10.30pm on 4 June that he would be moving to the intensive care ward that evening. A prison officer with Mr Morrison contacted a prison manager in the early hours of the next morning to notify him of the move. The prison manager told the officer that the escort chain had to remain on "unless medical intervention was needed…but it should be reapplied at the earliest opportunity".

32. On 5 June, at 9.00pm the prison officers on the hospital bedwatch "contacted ops to see if a management check could look at the cuffing arrangements due to the poor health of Mr Morrison".

33. The following day, on 6 June, prison escort staff noted Mr Morrison was "struggling more and more with his breathing" and "remains in what appears to be a sleepy state laying in his bed". He remained restrained by the escort chain. Mr Morrison had a chest X-ray at 10.30am. A prison manager authorised the escort chain to be temporarily removed during the procedure. Later that morning Mr Morrison's consultant asked the prison officers to remove Mr Morrison's restraints as he was unable to stand unaided.

34. Mr Morrison said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect when the lower part of his lungs collapsed at 3.20pm that day. A hospital consultant confirmed that Mr Morrison was now bedridden and had little chance of recovery. A prison manager authorised the escort chain to be removed at 3.45pm.

35. On 8 June, Mr Morrison asked that his oxygen machine be turned off. The hospital consultant confirmed that he was happy to remove anything that made him uncomfortable.

36. At 3.19am the next morning, on 9 June, prison staff were authorised to sit outside the room to allow Mr Morrison to spend some time with his family. Prison staff checked on him hourly. Mr Morrison was released on temporary licence (ROTL) at 8.00am on 9 June. A prison officer remained at the hospital to provide support. Mr Morrison died at 4.22pm that day.

Contact with Mr Morrison's family

37. The prison family liaison officer contacted Mr Morrison's sister on 27 May, to tell her that her brother was unwell and in hospital. She kept in regular contact and had a meeting with her and her other sister at the hospital on 8 June.

38. Mr Morrison's family was with Mr Morrison when he died on 9 June. Mr Morrison's funeral was on 11 July. The prison contributed to the cost of the funeral in line with national policy.

Support for prisoners and staff

39. After Mr Morrison's death, a prison manager debriefed the prison officer who had been with Mr Morrison at the hospital to ensure he had the opportunity to discuss any issues arising, and to offer support.

40. The prison posted notices informing other prisoners of Mr Morrison'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 Morrison's death.

Post-mortem report

41. The post-mortem report confirmed the cause of death to be purulent ascites (abnormal accumulation of fluid in the abdomen) and septicaemia (blood poisoning) caused by acute necrotizing pancreatitis (swollen pancreas) with abscess formation. Micronodular cirrhosis (liver damage caused by hepatitis C infection) was a contributory factor.

Findings

Clinical Care

Hepatitis C management

42. Mr Morrison had a change of circumstances interview with a nurse when he arrived at HMP Swaleside on 9 June 2016. He then saw a prison GP on 16 June who prescribed his medication. There is no record that either the nurse, prison GP or any other clinician noted that Mr Morrison had a chronic hepatitis C infection. Mr Morrison was not referred to a specialist hepatitis C nurse until he asked for a referral when he saw another prison GP on 7 April 2017.

43. The Head of Healthcare told us at interview that the full medical record from previous prisons is immediately available to healthcare staff when a prisoner is transferred. The information about Mr Morrison's hepatitis C infection was therefore available for all to view. It appears unlikely that the nurse did view his medical records since she had noted that hepatitis screening was declined. This would be clearly irrelevant for someone already infected.

44. NICE (National Institute for Health and Care Excellence) guidance states that all patients with hepatitis C should be offered specialist care and treatment, regular review, information and support in primary care. There is no record that this happened while Mr Morrison was at Swaleside.

45. It is concerning that Mr Morrison's significant past medical history was not identified earlier. The clinical reviewer concluded that it was not possible to say whether earlier referral would have changed the outcome for Mr Morrison.

46. PSO 3050 (Continuity of healthcare) states, 'Current healthcare needs are assessed and continuity of care ensured when prisoners are transferred between establishments, from establishments to outside NHS hospitals for inpatient care, or released into the community'. This did not happen. We are of the opinion that the management of Mr Morrison's hepatitis C infection did not meet the standard expected in the community. We make the following recommendation:

    The Head of Healthcare at HMP Swaleside should ensure that a suitably qualified clinician reviews a prisoner's medical history on arrival to ensure safe transfer of healthcare between establishments.

Mr Morrison's hospital admission

47. An officer confirmed that Mr Morrison had gone to work as normal on Monday 22 May but had started to feel sick during the day. He offered him lunch on the Monday and booked him a doctor's appointment on Friday when he visited him in his cell. He was not on duty for the whole of that week and was therefore unable to say what other support was offered.

48. A senior officer (SO) told us that a daily log would be taken of who collected a meal from the servery. However, because the prisoners on Mr Morrison's wing were able to purchase and then cook their own food using a 'self cook' facility it would not necessarily have caused alarm if someone had not collected their food.

49. Mr Morrison's friend told us that he knew Mr Morrison had not been eating and had offered him food, which he had declined. He saw food in his cell and knew prison officers had been checking on him during the week. He did not realise how unwell his friend was until he went to hospital.

50. The SO is not a wing-based officer. She only became aware of Mr Morrison's ill health and telephoned healthcare when she attended the wing for an unrelated reason. Apart from her entry of 26 May, there is no record in the wing observation book or in Mr Morrison's NOMIS record to say he had been unwell and remained in his cell for almost one week. It is possible, that an opportunity may have been missed to assess his medical condition earlier in the week.

51. Mr Morrison's medical records confirm that a special sick appointment was made at 10.50am on Friday 26 May. There is no record that anyone chased up Mr Morrison's non-attendance that day. The clinical reviewer said, "In the community a friend or relative would usually contact the healthcare provider if a patient is too weak to get out of bed to attend an appointment." The Head of Healthcare confirmed that special sick appointments are always held in the morning. The officers on the wing would have been aware that Mr Morrison had a medical appointment to attend. It is not clear why it took almost six hours for healthcare to be alerted (by a non-wing-based member of staff) that Mr Morrison had been too unwell to attend his appointment that morning.

52. After the SO telephoned healthcare asking that they attend the wing, she put 'a safety net' in place, asking one of the officers to contact healthcare if Mr Morrison had not been seen within the next couple of hours. This was good practice.

53. The clinical reviewer considers that once a nurse arrived at Mr Morrison's cell she made a thorough assessment of his clinical condition and that her decision to transfer him to hospital urgently was entirely appropriate. We agree.

54. Once the SO notified a nurse of Mr Morrison's ill health, he received appropriate care that met the expected standard. However, we are concerned that he was reported to be too unwell to attend his medical appointment in the morning and this was not picked up by the wing officers or by healthcare. This oversight may have led to a significant delay in admission to hospital and poorer prognosis. We make the following recommendations:

The Governor should ensure that prison officers monitor and record all meaningful interactions with prisoners who are unwell for an extended period in the wing observation book and/ or the prisoner's NOMIS record.

The Governor should ensure that prison officers contact healthcare urgently if a prisoner is too unwell to attend a healthcare appointment.

Restraints

55. 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.

56. 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.

57. Mr Morrison was double cuffed during his escort to hospital on 26 May. Medical opinion was not sought on the appropriateness of restraints for the escort. Escort paperwork showed that Mr Morrison was medium risk to the public but gave no other justification for the level of restraint. Double cuffing is usually required for moving category A or category B prisoners in good health. Mr Morrison had not eaten for four days and had been too unwell to attend healthcare that morning. We are not satisfied that managers appropriately considered his condition at the time and how this affected his risk.

58. Mr Morrison remained double cuffed until the morning of 28 May, when the handcuffs were replaced with an escort chain. He remained secured by the escort chain until 3.45pm on 6 June when it was removed at the request of a hospital consultant. Mr Morrison was clearly unwell and should not have been restrained in the first place. It is highly regrettable that it took a request from the hospital consultant, and prompting from prison officers on the hospital escort asking that restraints be reviewed, before managers were prepared to authorise the removal of restraints on 6 June. We are not satisfied that the level of restraint used while in hospital was justified and took into account Mr Morrison's current level of risk. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of the prisoner and are based on the actual risk the prisoner presents at the time.

59. We are very concerned that, despite a very clear legal framework, managers at Swaleside continue to fail to apply the relevant considerations in making decisions on the use of restraints. Despite having accepted recommendations from this office about the need to address this important issue on four separate occasions, they clearly have not. This now requires the urgent attention of senior management within Her Majesty's Prison and Probation Service. We make the following recommendation:

The Executive Director for Long Term and High Security prisons should assure himself that managers at HMP Swaleside properly understand and apply the clear case law relating to the use of restraints during escorted moves outside the prison.

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