Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Morris, a prisoner at HMP Long Lartin, on 20 August 2021

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.

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 David Morris died of heart disease on 20 August 2021 at HMP Long Lartin. He was 59 years old. I offer my condolences to Mr Morris's family and friends.

The clinical reviewer found that the care Mr Morris received at Long Lartin was equivalent to that he could have expected to receive in the community.

I make no recommendations.

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 **May 2022**

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Summary

Events

1. In June 2002, Mr David Morris was convicted of murder and was sentenced to life imprisonment.

2. On 13 February 2005, Mr Morris was moved to HMP Long Lartin.

3. Mr Morris had several long-term health conditions including type 2 diabetes (a condition where the body is unable to regulate blood sugar), angina (chest pain caused by reduced blood flow to the heart) and high blood pressure.

4. At around 7.30am on 20 August 2021, Mr Morris's cell was automatically unlocked so that he could collect his medication.

5. At 7.43am, an officer noticed Mr Morris had not been to the medication hatch. The officer went to his cell and saw Mr Morris was asleep, so he woke him up.

6. At 7.47am, another officer noticed Mr Morris had still not attended the medication hatch, so she went to his cell. Mr Morris was asleep. The officer woke him up and, as she left his cell, Mr Morris began to get out of bed.

7. A few minutes later, Mr Morris left his cell. He was unsteady on his feet and looked pale. Two officers assisted Mr Morris to the medication hatch and told nurses that he did not seem well.

8. At 7.53am, Mr Morris collapsed and started to have a seizure. An officer called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties.) The nurses started giving Mr Morris CPR. An officer collected a defibrillator, and a nurse applied the pads to Mr Morris's chest.

9. At 8.43am, healthcare staff and paramedics agreed CPR should be stopped and Mr Morris was pronounced dead.

10. The post-mortem report concluded that Mr Morris died from heart disease. Diabetes was listed as a contributory factor.

Findings

11. The clinical reviewer concluded that the clinical care Mr Morris received was equivalent to that which he could have expected to receive in the community.

12. We make no recommendations.

The Investigation Process

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

14. NHS England commissioned a clinical reviewer to review Mr Morris's clinical care at the prison. The clinical reviewer conducted joint interviews of prison healthcare staff with the investigator on 7 January 2022.

15. The investigator interviewed one member of prison staff on 14 January.

16. We informed HM Coroner for Worcestershire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Morris's next of kin, his father, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. We received no response from him, but Mr Morris's daughter contacted the PPO asking for a copy of the report. She also asked the investigator how her father's diabetes was managed in prison and whether this was linked to his death. This has been addressed in the report.

18. Mr Morris's family received a copy of the draft report. They did not make any comments.

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

Background Information

HMP Long Lartin

20. HMP Long Lartin is a high security prison in the Vale of Evesham, Worcestershire. It holds approximately 600 men across five main wings and two support wings. All prisoners live in single cells. Practice Plus Group provides the healthcare services at the prison.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Long Lartin was in January 2018. Inspectors reported that Long Lartin was a well-run prison, where prisoners generally spoke positively about staff members. They reported healthcare staff provided a well-run service which was accessible to prisoners.

Independent Monitoring Board

22. 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 December 2020, the IMB reported that Long Lartin was a safe prison and overall, prisoners were treated fairly and humanely, and health and wellbeing needs of prisoners were met, despite the difficulties they faced as a result of the COVID-19 pandemic.

Previous deaths at HMP Long Lartin

23. Mr Morris was the eigth prisoner to die at Long Lartin since August 2019. Of the previous deaths, six were from natural causes and one was self-inflicted.

Key Events

24. In June 2002, Mr David Morris was convicted of murder and was sentenced to life imprisonment.

25. On 13 February 2005, Mr Morris was moved to HMP Long Lartin.

26. Mr Morris had several long-term health conditions including type 2 diabetes (a condition where the body is unable to regulate blood sugar), angina (chest pain caused by reduced blood flow to the heart) and high blood pressure.

27. On 9 July 2021, Mr Morris attended the medication hatch, looking panicked. He asked the prison nurse for GTN spray (glycerol trinitrate - used to relieve chest pain caused by angina). The nurse gave Mr Morris the spray and checked on him later, when he said he was feeling better. The nurse arranged an appointment with the GP and for an ECG (electrocardiogram – used to check the heart's rhythm) to be completed.

28. On 14 July, a prison GP completed a medication review and ECG with Mr Morris following his angina attack. His results did not raise concern.

29. On 11 August, Mr Morris did not attend an appointment with the prison GP to review changes to his medication following his angina attack.

Events of 20 August

30. At around 7.30am on 20 August, Mr Morris's cell was unlocked automatically so that he could collect his medication.

31. At 7.43am, a Prison Custody Officer (PCO) noticed Mr Morris had not come out of his cell. He went to Mr Morris's cell and saw he was asleep, so called his name to wake him up. Mr Morris responded and seemed confused, but the PCO thought this was because he had just woken him. The PCO left the cell, expecting Mr Morris to attend the medication hatch now he was awake.

32. At 7.47am, a PCO noticed that Mr Morris had still not attended the medication hatch. She went to his cell, where she also saw him asleep, so woke him up. Once again, he appeared confused, but she also thought this was due to her waking him up. Mr Morris began to get out of bed as she left his cell.

33. A few minutes later, Mr Morris left his cell. He was unsteady on his feet and looked pale. Two PCOs helped him to the medication hatch. They told the nurses that Mr Morris did not seem well.

34. As Mr Morris was diabetic, a nurse asked him if he had taken his blood sugar reading that morning, to which he said he had not. A PCO collected Mr Morris's blood sugar reading machine from his cell and got a chair for Mr Morris to sit on.

35. At 7.53am, Mr Morris collapsed and started to have a seizure. A PCO called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Staff in the prison's control room called for an ambulance. The nurses left the medication hatch and started giving Mr Morris

CPR. An officer collected a defibrillator, and a nurse applied the pads to Mr Morris's chest.

36. At approximately 8.20am, ambulance paramedics arrived and assisted in giving Mr Morris CPR and first aid.

37. At 8.43am, healthcare staff and paramedics agreed CPR should be stopped and Mr Morris was pronounced dead.

Contact with Mr Morris's family

38. The prison appointed a PCO as the family liaison officer (FLO), which was later changed to another PCO. At 9.35am on 20 August, the PCO contacted HMP Swansea to arrange for members of their staff to notify Mr Morris's next of kin, his father, of his death.

39. At 10.33am, officers attended Mr Morris's father's address. He was unavailable due to poor health, so they spoke with Mr Morris's sister, another point of contact listed for Mr Morris, and made her aware of his death.

40. The prison contributed financially to Mr Morris's funeral in line with national guidance.

Support for prisoners and staff

41. After Mr Morris's death, the Head of Safety & Equalities and the Duty Governor debriefed the prison staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team were present and offered support.

42. The Head of Healthcare conducted a hot-debrief with healthcare staff following the incident.

43. The prison posted notices informing other prisoners of Mr Morris's death, and offering support. The Duty Governor checked and confirmed there were no prisoners with active suicide and self-harm concerns on the wing who may have needed additional support.

Post-mortem report

44. The post-mortem report concluded that Mr Morris died from heart disease. It listed diabetes as a contributory factor.

Findings

Clinical Care

45. The clinical reviewer concluded that the care Mr Morris received was of a good standard and was at least equivalent to that which he could have expected to receive in the community.

46. The clinical reviewer noted that Mr Morris had care plans in place to manage his long-term conditions, including his diabetes. However, he often did not attend his diabetes appointments, despite healthcare staff encouraging him to attend. She found that the emergency response on 20 August was handled very well.

47. We make no recommendations.

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