Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Morgan, a prisoner at HMP Woodhill, on 29 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 Morgan died on 29 August 2021 at HMP Woodhill. The cause of his death was unascertained. The pathologist provided three potential causes for Mr Morgan's death: epilepsy, a sudden unexpected cardiac arrest and asphyxia. Mr Morgan was 47 years old. I offer my condolences to those who knew him.

Between May 2021 and August 2021, Mr Morgan was monitored under suicide and self-harm prevention procedures (known as ACCT). I am concerned that there was no consistency in managing Mr Morgan's ACCT case reviews. I am also concerned that the ACCT procedures were closed four days before Mr Morgan died despite recent evidence that he was at high risk of suicide and self-harm.

Staff also continued with life support, even when it was clear that Mr Morgan had been dead for some time.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **February 2023**

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Summary

Events

1. In April 1995, Mr David Morgan was sentenced to life in prison for arson, affray, threats to kill and perverting the course of justice. On 15 January 2020, he was transferred to HMP Woodhill.

2. Mr Morgan had dwarfism. He was diagnosed with urethral stricture (a narrowing of the tube that carries urine out of the body) and had a catheter fitted. Mr Morgan was also diagnosed with factitious disorder (a mental health condition in which the individual deceives others by appearing or purposely getting sick) and a history of substance misuse.

3. On 7 April 2021, healthcare staff offered Mr Morgan an NHS health check, but he declined.

4. On 25 May, prison staff started ACCT procedures when Mr Morgan said that he had made a ligature and intended to take his life. He said that he was concerned about his pending parole hearing and because his mental health keyworker no longer worked at the prison.

5. On two occasions in June, staff removed ligatures from Mr Morgan's cell. On two further occasions, he threatened to or said that he intended to take his life.

6. On 14 August, Mr Morgan made a ligature, which he said he had "plans to use".

7. On 20 August, a custodial manager ended ACCT procedures because Mr Morgan's prison offender manager was in the process of completing a referral to a medium secure psychiatric hospital, which Mr Morgan was "happy" about. She also recorded that Mr Morgan was also happy that his parole hearing was upcoming (on 27 September).

8. On 23 August, prison staff restarted ACCT procedures, as Mr Morgan was in a "very low" mood and "threatened to tie ligatures".

9. On 24 August, a supervising officer (SO) ended the ACCT procedures and recorded that a support plan would be a better means of helping Mr Morgan rather than ACCT procedures. It is unclear if a support plan was completed before Mr Morgan died.

10. At around 9.14am on 29 August, an officer unlocked Mr Morgan's cell. Mr Morgan did not respond. The officer fetched a colleague, who identified that Mr Morgan was not breathing. They radioed a medical emergency. The nurse who responded began cardiopulmonary resuscitation, despite indications of rigor mortis. Paramedics were called, who confirmed that Mr Morgan had died.

11. A post-mortem examination found that the cause of Mr Morgan's death was unascertained. The pathologist identified three potential causes of death: a sudden unexpected death in epilepsy, sudden cardiac arrhythmic death, or asphyxia (a lack of oxygen). The pathologist suggested that there may have been an element of positional asphyxia (where someone's body position prevents them from breathing

normally) or that Mr Morgan had used a torn bed sheet as a ligature. He noted that the absence of a ligature mark on the neck did not exclude the action of a ligature.

Findings

Managing the risk of suicide and self-harm

12. There was a lack of consistency in care planning and risk management. Eleven different members of staff chaired ACCT case reviews and it was very rare that the same person chaired consecutive case reviews.

13. It is concerning that the ACCT procedures were ended less than a week after Mr Morgan had made a ligature, described a suicide plan and been assessed as at high risk of suicide and self-harm. The ACCT procedures were appropriately restarted three days later, but we are again concerned that they were ended the next day, to be replaced with a 'support plan'. We have seen no evidence that a support plan was completed before Mr Morgan died.

Resuscitation

14. Prison and healthcare staff continued to try to resuscitate Mr Morgan, even though a prison GP found signs of rigor mortis and believed that he had been dead for several hours.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
    - a case co-ordinator is appointed at the first case review, who should lead all subsequent case reviews whenever possible;
    - healthcare staff attend all case reviews for all patients on the mental health team's caseload, with the patient's keyworker attending all case reviews, whenever possible; and
    - ACCT procedures are only ended when the risk of harm is no longer raised, and all outstanding support actions have been completed.
- The Governor and the Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council Guidelines.

The Investigation Process

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

16. The investigator obtained copies of relevant extracts from Mr Morgan's prison and medical records. He interviewed a member of staff by video link on 10 November 2021.

17. NHS England commissioned a clinical reviewer to review Mr Morgan's clinical care at the prison. The investigator and clinical reviewer jointly interviewed six members of staff by telephone and video link on 15 December.

18. The investigator interviewed three further members of staff in July 2022.

19. We informed HM Coroner for Milton Keynes of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

20. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Woodhill

21. HMP Woodhill is a training prison for long-term Category B prisoners serving sentences of at least four years. Woodhill also holds a small number of Category A prisoners on remand and attending trial. Central and North-West London NHS Foundation Trust provides health services at the prison. The Clinical Assessment Unit (CAU) is a 12-bed inpatient unit at Woodhill, which provides mental and physical healthcare. The Compass Unit opened in May 2021, with an aim to support prisoners who struggle to cope in standard wings.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Woodhill was in September 2021. Inspectors reported that, despite some positive changes in response to PPO recommendations, levels of self-harm remained high.

23. Inspectors reported that health services were well-led by a strong clinical management team. Regular nurse-led clinics were held for long-term conditions and the clinical assessment unit provided good care. The mental health service was stretched but delivered an impressive range of support.

24. Inspectors found that the Compass Unit provided a supportive, non-clinical environment in which vulnerable prisoners could receive support and prepare to reintegrate into prison life.

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 31 May 2021, the IMB reported that healthcare services operated well despite the severe difficulties caused by the COVID-19 restrictions, staffing and resource restraints and the disruption caused by relocating prisoners temporarily to other premises during building works. They found that there was good evidence of strong multidisciplinary working among the mental health team.

Previous deaths at HMP Woodhill

26. There were two deaths at Woodhill in the two years before Mr Morgan's death, both of which were self-inflicted. There are no significant similarities between our findings in this investigation and those of the other deaths. There have been two further self-inflicted deaths at Woodhill since Mr Morgan's death.

Assessment, Care in Custody and Teamwork (ACCT)

27. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk,

how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

28. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key Events

29. In April 1995, Mr David Morgan was sentenced to life in prison for arson, affray, threats to kill and perverting the course of justice. On 15 January 2020, he was transferred to HMP Woodhill.

30. Mr Morgan had dwarfism. He was diagnosed with urethral stricture (a narrowing of the urethra) and had a catheter fitted. Mr Morgan was also diagnosed with factitious disorder (a mental disorder in which an individual deceives others by appearing sick, by purposely getting sick or by self-injury). Mr Morgan misused drugs, including heroin, psychoactive substances (PS) and alcohol. Healthcare staff created care plans for dwarfism and urethral stricture. Prison staff monitored Mr Morgan under ACCT procedures on several occasions during his time in custody, including a period of constant supervision when he first moved to Woodhill.

31. On 26 January 2021, Mr Morgan told healthcare staff that he was fed up and had used PS.

32. On 7 April, healthcare staff offered Mr Morgan an NHS health check, but he declined.

33. On 29 April, Mr Morgan moved to the Compass Unit. He lived in a cell adapted for a prisoner with physical disabilities.

34. On 25 May, prison staff started ACCT procedures because Mr Morgan was concerned about his pending parole hearing and because his mental health keyworker no longer worked at the prison. Mr Morgan said that he had made a ligature and felt like taking his own life.

35. Over the following three months, prison staff held 33 ACCT case reviews. A Supervising Officer (SO) was named as ACCT case manager (later ACCT case co-ordinator when Woodhill introduced the revised version of ACCT in July) but attended just five of the case reviews. (This SO has since left the Prison Service and we were not therefore able to interview him.) Several different members of staff chaired case reviews but rarely did anyone chair consecutive case reviews. From 25 June, SO 1 chaired or attended just over half of the case reviews.

36. Healthcare staff attended most case reviews but there was little consistency in attendance. The same member of healthcare staff only attended three consecutive case reviews.

37. On two occasions in June, staff removed ligatures from Mr Morgan's cell. On two further occasions, he threatened to or said that he intended to take his life. On each occasion, prison staff held impromptu ACCT case reviews and appropriately increased the frequency of ACCT observations.

38. On 3 June, Mr Morgan told prison staff that he was using PS every day.

39. On 3 August, Mr Morgan told an officer that he had relapsed and had used PS. On 18 August, she offered Mr Morgan an appointment with the drug recovery service, but he told her that he was "not up for the session".

40. On 14 August, Mr Morgan made a ligature, which he said he had "plans to use". Mr Morgan said that this was in response to a letter he had received from the Parole Board and also that he had had flashbacks to previous abuse. Mr Morgan said that he had a "specific plan" to take his life, which he described. A SO recorded that Mr Morgan was at high risk of suicide and self-harm and increased the frequency of his ACCT observations.

41. On 20 August, a Custodial Manager (CM) chaired an ACCT case review. She recorded that she was now the case co-ordinator. She recorded that Mr Morgan's prison offender manager was in the process of completing a referral to a medium-secure psychiatric hospital, which Mr Morgan was "happy" about. She also recorded that Mr Morgan's parole hearing was due to take place on 27 September, which Mr Morgan was also happy about. She ended the ACCT procedures and said that at that time, Mr Morgan was happy with his situation.

42. On 23 August, prison staff restarted ACCT procedures because Mr Morgan felt "very low" and had "threatened to tie ligatures".

43. On 24 August, SO 1 chaired a case review. She recorded that Mr Morgan was much better and that issues that he had had with catheter supplies had been resolved. She ended the ACCT procedures. She said that Mr Morgan had not harmed himself, that his mood had improved and that his caremap had been completed. She recorded that a support plan would be a better means of helping Mr Morgan rather than ACCT procedures, which Mr Morgan "seemed to be on board with". She told us that a support plan was managed by the Safer Custody department and contained an individual support plan, which meant that Mr Morgan would still have individual meetings and structured support. She said that ACCT procedures were aimed at a prisoner in crisis, whereas a support plan was for a prisoner who needed extra support. She said that Mr Morgan would have been in the ACCT post-closure phase for six days so would still have been subject to ACCT checks. She also said that she understood that Mr Morgan's prison offender manager was telephoning him daily by in-cell telephone as part of the support plan.

44. On 26 August, a clinical psychologist saw Mr Morgan, who told her that he did not have any thoughts of self-harm. Mr Morgan said that he was anxious about his pending parole hearing and the possibility of being released from prison.

45. Between 8.45pm and 9.15pm on 28 August, Officer A carried out a count of prisoners living in the Clinical Assessment Unit and Compass Unit. He looked into Mr Morgan's cell and saw him lying on his bed, watching television.

Events of 29 August 2021

46. At about 5.00am, on 29 August, Officer A carried out a further roll count and saw Mr Morgan lying on his bed, asleep. He recorded that he had no concerns about Mr Morgan's wellbeing as he looked, "sound asleep in his bed".

47. At about 7.00am, Officer B carried out a further roll count and saw Mr Morgan lying on his bed, facing away from the door. She told us that she could not recall if she saw him move.

48. At about 9.14am, Officer C unlocked Mr Morgan's cell for medication. He said that Mr Morgan did not wake up or respond. He left the door unlocked and went to fetch his colleague, Officer D.

49. At 9.16am, both officers went into Mr Morgan's cell. Officer D went over to Mr Morgan, calling to him. She moved a pillow away from his head and saw that his face was purple. At 9.17am, Officer C radioed a medical emergency code blue.

50. Officer D cut a bed sheet which was tied to the top of the bedframe and, with Officer C, lifted Mr Morgan on the bedsheet onto the floor and placed him in the recovery position.

51. At 9.19am, a nurse went into the cell. He saw that Mr Morgan was not breathing, that he was cold, and had blue lips and mottled skin. He could not find a pulse. He started cardiopulmonary resuscitation (CPR).

52. Three CMs went to Mr Morgan's cell who carried Mr Morgan out of his cell and onto the landing.

53. The nurse applied a defibrillator, which on several occasions advised not to shock Mr Morgan but to continue CPR. Two CMs continued CPR.

54. A prison GP found that Mr Morgan's jaw was clenched, that his lips were cyanosed (a bluish-purple colour) and that he was cold. He was unable to insert an airway, so a nurse inserted an airway into Mr Morgan's nose and gave him oxygen. The GP thought that Mr Morgan had been dead for some time, but prison and healthcare staff continued life support.

55. At 9.40am, ambulance paramedics arrived. At 9.45am, the prison GP and the paramedics confirmed that Mr Morgan had died.

Contact with Mr Morgan's family

56. On 29 August, the Head of Safer Custody appointed a family liaison officer (FLO). After Mr Morgan died, the FLO went to the addresses that Mr Morgan had given for his mother and daughter, but he found that the addresses either did not exist or that his next of kin were not known there. The FLO was unable to locate a next of kin for Mr Morgan. Mr Morgan's funeral took place on 30 September. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

57. After Mr Morgan's death, the Head of Security debriefed the staff who were involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

58. A governor 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' death.

Post-mortem report

59. A post-mortem examination found that the cause of Mr Morgan's death remained unascertained. The consultant histopathologist who carried out the post-mortem examination, gave three possible causes for Mr Morgan's death: a sudden unexpected death in epilepsy, a sudden cardiac arrhythmic death with a morphologically normal heart (a heart attack where the cause cannot be found) or asphyxia (a lack of oxygen). The consultant suggested that there may have been an element of positional asphyxia (where someone's body position prevents them from breathing normally) or that the torn sheet noose had actually been used as a ligature. He noted that the absence of a ligature mark on the neck did not exclude the action of a ligature.

60. Post-mortem toxicology tests detected a small amount of lamotrigine (for epilepsy) and lidocaine (a local anaesthetic used during CPR). Mr Morgan did not have a diagnosis of epilepsy and had not been prescribed lamotrigine. No illicit drugs or alcohol were detected.

Findings

Clinical care

61. The clinical reviewer concluded that the clinical care that Mr Morgan received at Woodhill was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

62. The clinical reviewer found that Mr Morgan's physical health needs were met with care plans in place for dwarfism and urethral stricture. Mr Morgan declined a routine NHS health screen in April 2021.

63. The clinical reviewer also found that Mr Morgan received psychological interventions relevant to his needs. This included psychological support for his substance misuse. Mr Morgan was appropriately offered support from the drug recovery service but declined to work with them.

Managing the risk of suicide and self-harm

64. Prison staff appropriately started ACCT procedures in May 2021, when Mr Morgan made a ligature and spoke about taking his own life. It is apparent that many staff knew him well and some positive, supportive actions were taken. The ACCT case reviews were frequent and multidisciplinary, and observations were appropriately increased when Mr Morgan's risk had clearly risen such as when he made ligatures. However, some of the ACCT procedures were poorly managed and not in line with Prison Service policy.

65. Prison Service Instruction (PSI) 64/2011 on safer custody contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It instructs that a case manager (or case co-ordinator in the revised version of ACCT that was implemented at Woodhill in July 2021) must be appointed at the first case review. The case manager/case co-ordinator should lead all case reviews, where possible, to promote consistency in managing the ACCT plan, assessing risk and care planning.

66. A SO was named as case manager on the front cover of the ACCT document but attended just five of the 33 case reviews held. In total, eleven different members of staff chaired case reviews (albeit some of these as duty manager when an impromptu case review was required following an increase to Mr Morgan's risk) and it was very rare that the same person chaired consecutive case reviews. In these circumstances, it is difficult to maintain consistent care planning and risk assessment.

67. There was healthcare attendance at nearly every case review. While this is positive in itself, attendance was also very inconsistent and there were just three occasions when the same member of healthcare staff attended consecutive case reviews.

68. We are also concerned that the ACCT procedures were ended on 20 August, less than a week after Mr Morgan had made a ligature, described a suicide plan and had been assessed as at high risk of suicide and self-harm. CM 1, who ended the ACCT procedures, recorded that this was her first case review as Mr Morgan's new

case co-ordinator. Much of Mr Morgan's risk related to his upcoming parole hearing and it might have been appropriate to continue ACCT monitoring and support through the parole process.

69. ACCT procedures were appropriately restarted three days later, when Mr Morgan "threatened to tie ligatures". We are concerned that these were ended the next day, to be replaced with a 'support plan'. We have seen no evidence that a support plan was created for Mr Morgan. While a support plan might have had some merits, it should not be used to replace the risk assessment, care planning and monitoring that ACCT procedures provide for prisoners at risk of suicide and self-harm. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- **a case co-ordinator is appointed at the first case review, who should lead all subsequent case reviews whenever possible;**
- **healthcare staff attend all case reviews for all patients on the mental health team caseload, with the patient's keyworker attending all case reviews whenever possible; and**
- **ACCT procedures are only ended when the risk of harm is no longer raised, and all outstanding support actions have been completed.**

Resuscitation

70. In September 2016, the National Medical Director at NHS England wrote to Heads of Healthcare for prisons introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison and was in line with the European Resuscitation Council Guidelines 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". (These guidelines have since been updated but the content remains applicable.)

71. After Mr Morgan was found unresponsive, a prison GP identified a clenched jaw which, in his opinion, suggested that rigor mortis was established. The GP thought that Mr Morgan had been dead for some time (four to five hours). However, prison and healthcare staff continued to perform CPR.

72. The clinical reviewer concluded that the management of the resuscitation attempt was not in line with Resuscitation Council guidelines. While we understand the wish to continue resuscitation until death has been formally recognised, staff should understand that resuscitation is inappropriate when there is clear evidence that it will be futile, such as the presence of rigor mortis. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council Guidelines.

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