

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr David Morton, a prisoner at HMP Littlehey, on 12 November 2021**

**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

**OGL**

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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 David Morton died of heart failure as a result of ischaemic heart disease on 12 November 2021 while a prisoner at HMP Littlehey. He had also had a stroke which contributed to but did not cause his death. He was 79 years old. I offer my condolences to his family and friends.

The clinical reviewer found that the clinical care that Mr Morton received at Littlehey was equivalent to that which he could have expected to receive in the community. However, she found no evidence that care plans were created to manage his high blood pressure and heart failure.

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**

**September 2022**

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# Summary

## Events

1. In 2009, Mr David Morton received an indeterminate sentence for public protection for sex offences, with a minimum tariff to serve of 15 years. In 2014, he was transferred to HMP Littlehey. Mr Morton had ischaemic heart disease, atrial fibrillation (an abnormal heart rhythm) and high blood pressure. He had also had a heart attack in 2014.
2. On 24 December, Mr Morton had a heart attack and was sent to hospital, where doctors fitted a coronary stent (a procedure to widen blocked or narrow coronary arteries).
3. On 5 March 2018, a hospital doctor concluded that Mr Morton had impaired heart valve function (which affects the flow of blood through the heart). A consultant cardiologist planned for him to have annual reviews to monitor his heart disease.
4. On 12 August 2021, healthcare staff sent Mr Morton to hospital because he had angina pain. Hospital staff found that he had atrial fibrillation.
5. On 16 September, Mr Morton had chest pain. A nurse thought that he may have internal bleeding and sent him to hospital, where he was diagnosed with heart failure.
6. At about 10.30am on 9 November, an officer went to Mr Morton's cell to give him his canteen. Mr Morton asked to see healthcare staff. Two nurses went to his cell and found him semi-conscious, with left-sided facial weakness. A nurse noted that Mr Morton's National Early Warning Score (NEWS, a tool to detect and respond to clinical deterioration) was 8 which indicated a high clinical risk. She sent him urgently to hospital.
7. On 12 November, Mr Morton died in hospital.

## Findings

8. The clinical reviewer concluded that the clinical care that Mr Morton received at Littlehey was of a reasonable standard and was equivalent to that which he could have expected to receive in the community.
9. However, the clinical reviewer found no evidence that care plans were created to manage Mr Morton's high blood pressure and heart failure.
10. The clinical reviewer made a recommendation which is not directly related to Mr Morton's death but which the Head of Healthcare will need to address.

## Recommendations

- The Head of Healthcare should ensure that care plans are created for the management of a prisoner's long-term health conditions.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Littlehey informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Morton's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Morton's clinical care at the prison.
14. We informed HM Coroner for Cambridgeshire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
15. The Ombudsman's family liaison officer wrote to Mr Morton's wife to explain our investigation. She did not respond.
16. We shared the initial report with the Prison Service. There were no factual inaccuracies. Their action plan has been appended to the report.

## Background Information

### HMP Littlehey

17. HMP Littlehey is a medium security prison, housing approximately 1,200 prisoners. A high proportion of the prison's population are men convicted of sexual offences. There is a substantial elderly population.
18. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services at the prison. The prison healthcare centre is open on weekdays from 7.30am to 7.30pm, and at weekends from 8.00am to 5.30pm. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

### HM Inspectorate of Prisons

19. The most recent full inspection of HMP Littlehey was in August 2019. Inspectors reported that the healthcare team provided prompt access to a range of primary care clinics, and referrals to secondary care were well managed. They said that the patient records that they sampled were informative and demonstrated patients' involvement in their care. The records also demonstrated good care plans for long-term conditions. They said there was good health promotion at the prison.
20. Inspectors carried out a short scrutiny visit of HMP Littlehey in June 2020, focussing on key issues for prisoners during the COVID-19 pandemic. Inspectors reported that Littlehey had been declared an official COVID-19 outbreak site in March 2020 and that the prison, in conjunction with Public Health England, took swift action to control the spread of the virus. They found a strong emphasis on shielding vulnerable prisoners.

### Independent Monitoring Board

21. 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 January 2021, the IMB reported that Littlehey continued to be a safe and secure prison. The IMB reported that the COVID-19 pandemic had significantly impacted on the health and wellbeing needs of the prisoners and that the prison had managed the challenges provided by the pandemic well, with protocols to protect all prisoners.

### Previous deaths at HMP Littlehey

22. In the two years before Mr Morton's death, 27 prisoners died from natural causes at Littlehey, nine as a result of COVID-19. There was also one self-inflicted death in the same period. One prisoner has died from natural causes at Littlehey since Mr Morton's death. There are no significant similarities between our findings in this investigation and those of the other deaths.

## Key Events

23. In 2009, Mr David Morton received an indeterminate sentence for public protection for sex offences, with a minimum tariff to serve of 15 years. In 2014, he was transferred to HMP Littlehey.
24. Mr Morton had chronic kidney disease, ischaemic heart disease, atrial fibrillation and high blood pressure. He had had a heart attack in 2014 and kidney cancer in 2015.
25. On 11 June 2014, a nurse saw Mr Morton to review his blood pressure because he had had chronically high readings for three years but he refused treatment. Mr Morton's blood pressure remained high. The nurse found that he was at high risk of having a stroke or a heart attack within ten years.
26. On 8 July, a nurse saw Mr Morton after he agreed to have treatment for his high blood pressure. On 17 July, a prison GP saw Mr Morton and prescribed him amlodipine and simvastatin for blood pressure and to prevent a future stroke and heart attack.
27. On 24 December, Mr Morton went to hospital because he was having a heart attack. Hospital doctors fitted a coronary stent.
28. Healthcare staff regularly reviewed Mr Morton for cardiovascular disease and blood pressure, for which he also regularly attended hospital appointments.
29. On 5 March 2018, a hospital doctor diagnosed Mr Morton with impaired heart valve function and annual reviews were arranged to monitor this.
30. On 20 May 2020, after an angiogram (a test that looks at the heart's blood supply, and valves), a consultant cardiac surgeon concluded that he would not benefit from surgery.
31. On 20 November, a palliative care consultant saw Mr Morton who decided that he did not want to be resuscitated if his heart or breathing stopped. He signed an order to that effect.
32. On 12 August 2021, Mr Morton had angina pain and was sent to hospital, where he was diagnosed with atrial fibrillation. Mr Morton returned to Littlehey that day.
33. On 16 September, Mr Morton had chest pain and a nurse sent him to hospital because she thought that he may have internal bleeding. Hospital staff diagnosed heart failure. He was sent back to Littlehey.
34. Healthcare staff took Mr Morton's observations twice a day. They remained normal.
35. On 11 October, a hospital consultant cardiologist, reviewed Mr Morton. They decided that surgery was not appropriate for him but that he should continue with his medication which was limited due to his kidney failure. The hospital consultant cardiologist referred him for an echocardiogram (a scan of the heart).
36. At about 10.30am on 9 November, an officer went to Mr Morton's cell to give him his canteen. He said that Mr Morton was lying on his bed, watching television and

had asked to see healthcare staff. The officer said that he asked him why but he did not answer, which he said was not unusual. The officer said that he was not concerned for Mr Morton's wellbeing and that he did not look more unwell than usual. He telephoned healthcare staff who agreed to see Mr Morton.

37. Two nurses went to Mr Morton's cell and found him semi-conscious, with left-sided facial weakness. A nurse noted that Mr Morton's National Early Warning Score was 8 which indicated a high clinical risk. She sent him unrestrained to hospital as an emergency.
38. On 11 November, a business administrator in the Offender Management Unit, started an application for him to be released from prison on temporary licence. The application was not completed as Mr Morton died in hospital the next day.

### **Contact with Mr Morton's family**

39. On 9 November 2021, the Head of Safer Custody appointed an officer as the family liaison officer (FLO) and as the deputy family liaison officer. The FLO telephoned Mr Morton's wife and told her that he was seriously ill in hospital. When Mr Morton died on 12 November, he called her again but she did not answer. A Custodial Manager (CM) telephoned Mr Morton's son and broke the news of Mr Morton's death. On 15 November, the FLO telephoned Mr Morton's wife and son and offered his condolences. Mr Morton's funeral took place on 8 December. The prison contributed to its cost in line with national instructions.

### **Support for prisoners and staff**

40. After Mr Morton's death, the Head of Residence debriefed the staff at the hospital to discuss any concerns and to offer support. The staff care team also offered support.
41. The Governor 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**

42. A post-mortem examination established that Mr Morton died of decompensated cardiac failure (deterioration of heart failure). This was caused by ischaemic heart disease (narrowed heart arteries). He had also had an old stroke which contributed to but did not cause his death.

# Findings

## Clinical care

43. The clinical reviewer concluded that the clinical care that Mr Morton received at Littlehey was of a reasonable standard and was equivalent to that which he could have expected to receive in the community.
44. The clinical reviewer found that while Mr Morton was appropriately managed for his long-term conditions and appropriately transferred to hospital when clinically indicated, he found that care plans were not created to manage his high blood pressure and heart failure. We therefore recommend:

**The Head of Healthcare should ensure that care plans are created for the management of a prisoner's long-term health conditions.**

45. The clinical reviewer also made a recommendation which is not directly related to Mr Morton's death but which the Head of Healthcare will need to address

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