Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Morgan, a prisoner at HMP/YOI Chelmsford, on 30 August 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.

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 in hospital on 30 August 2018 after becoming ill at HMP Chelmsford on 22 August. A cause of death has not been established. He was 35 years old. I offer my condolences to Mr Morgan's family and friends.

This is an extremely disturbing case. Almost every member of staff involved in Mr Morgan's treatment on 22 August showed a shocking lack of compassion, empathy and concern for his well-being and decency.

Mr Morgan told staff that he had taken an overdose of medication at 9.45am. About an hour later he began to show signs of being unwell. Instead of being properly assessed by clinical staff, he was left in a holding cell for some two and a half hours, becoming increasingly distressed and unwell. His cognition was sufficiently impaired for him to be incapable of coherent speech and unable to prevent himself from repeatedly falling on to the floor and a metal bench. Despite the presence of several staff and the almost constant presence of a nurse, Mr Morgan sustained a broken nose, a broken eye socket and fractures to both his legs during these falls. He eventually lapsed into unconsciousness and was taken to hospital, but he died eight days later.

This is not the first death at Chelmsford that has caused me real concern. I am particularly disturbed by the uncaring and disrespectful culture that appeared to exist among both prison and healthcare staff and to underly the failure to keep Mr Morgan safe.

Although these events occurred two years ago, I have escalated my concerns to the relevant Prison Group Director and to the NHS England Regional Director, who is responsible for commissioning healthcare services at Chelmsford. They will need to satisfy themselves as a matter of priority that the prison now has the strong leadership and positive partnership relationships needed to ensure that the awful treatment accorded to Mr Morgan is never repeated.

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 **September 2022**

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Summary

Events

1. On 15 January 2018, Mr David Morgan was remanded to HMP Chelmsford. On 12 February he was sentenced to two years, three months imprisonment.

2. He was prescribed baclofen (a muscle relaxant) and citalopram (for anxiety) which he was allowed to keep in his cell, and buprenorphine (an opiate substitute) and pregabalin (for nerve pain), which he took under supervision.

3. On 22 August 2018, staff told Mr Morgan he was transferring to HMP Wayland. Mr Morgan said he did not want to transfer because he thought he would not be safe at Wayland. At 9.45am he told an officer that he had taken an overdose of his prescription medication and gave him an empty blister pack. The officer told the wing Supervising Officer (SO) and tried to contact a nurse to come to the wing.

4. Despite the SO and a number of wing staff being aware of the alleged overdose, no one started Prison Service suicide and self-harm monitoring (known as ACCT) and the overdose was not investigated. A nurse did not come to the wing or consult Mr Morgan's medical record to see what medication he had in his possession.

5. Officers told Mr Morgan that he would be examined by a nurse in reception and would be able to speak to the orderly officer in reception there to make his case against his transfer. Mr Morgan was inappropriately restrained and taken to reception in handcuffs.

6. He became unwell in reception during a search and was unable to speak or follow instructions. Staff made the assumption that he had drunk 'hooch', despite being told of the alleged overdose, and a nurse agreed he should be taken to a holding cell to 'sober up'.

7. The nurse remained in reception watching Mr Morgan, although she did not examine him. She was almost continuously accompanied by a number of different members of prison staff. Mr Morgan's condition deteriorated over the next two and half hours. He fell repeatedly in the cell breaking his nose, sustaining significant bruising to his head and face and fractures to both his legs.

8. Eventually he lost consciousness and was taken to hospital. He died eight days later.

Findings

9. There was a comprehensive failure by prison and healthcare staff to discharge their duty of care to Mr Morgan on 22 August 2018.

10. The actions of the nurse present that day fell so far short of what was expected that the clinical reviewer has reported her to the Nursing and Midwifery Council.

11. Mr Morgan was prescribed baclofen without confirmation of his prescription from community medical records. Baclofen is toxic in overdose and is not a suitable medication for prisoners to be allowed in possession.

12. The use of force applied to Mr Morgan on 22 August was unjustified.

13. Information given to the prison by Mr Morgan's mother on 22 August was not followed up as it should have been.

14. Restraints were inappropriately applied to Mr Morgan when he was unconscious during his transfer to hospital.

15. The prison should have told Mr Morgan's next of kin immediately when he was taken to hospital on 22 August.

Recommendations

- The Prison Group Director and the NHS England Regional Director responsible for commissioning healthcare services at Chelmsford should each write to the Ombudsman setting out what action they have taken in response to this report.
- The Governor should investigate whether any of the staff present in reception on 22 August, who witnessed Mr Morgan in the holding cell and who are still employed at Chelmsford, should face disciplinary charges.
- The Governor should arrange for this report to be shared with Officer A and Officer (now CM) B by the Governors of their current prisons.
- The Prison Group Director and Governor should review the culture among prison officers and managers. In particular, they should put measures in place to ensure that staff treat the prisoners in their care with dignity and respect, and to foster a culture in which staff at all grades feel able to raise concerns if they feel something is not right.
- The Governor should apologise personally to Mr Morgan's next of kin for the failure of her staff to exercise their duty of care to him while he was in their custody.
- The Governor should ensure that all the officers present during the events of 22 August and still in post receive ACCT refresher training as a matter of urgency.
- The Head of Healthcare should ensure that policies and procedures are in place to ensure that prescribers and pharmacy work collaboratively to highlight high-risk medications, such as baclofen, which are unsuitable for in-possession administration.
- The Head of Healthcare should immediately ensure that all healthcare staff are aware of and have access to the National Poisons Information Service, either by telephone or via the online Toxbase service, and its use should be mandated in all cases of suspected overdose or poisoning.
- The Head of Healthcare should ensure that evidence-based tools are in place for the immediate recognition of deteriorating health and that this is supported by ongoing competency-based training programme.
- The Head of Healthcare should ensure that all cases of suspected poisoning from alcohol and/or drugs are assessed according to National Guidance, such as NEWS2, thereby facilitating standardised assessment and best practice decision-

making in regard to ongoing observation, escalation to a senior clinician within the prison or for external specialist advice.

- The Head of Healthcare should immediately ensure that staff comply with NMC regulations on making contemporaneous clinical records and individual accountability for record-keeping. The quality of the medical record should be subject to regular clinical audit against national documentation standards as part of the clinical audit plan.
- The current healthcare providers and the NHS Regional Director responsible for commissioning healthcare services at Chelmsford, should review the culture and working practices of healthcare managers and staff. In particular, they should consider how they perceive their role in the healthcare and safeguarding of the prisoners in their care.
- The Head of Healthcare should ensure that all nurses currently working in Chelmsford are provided with a copy of this report and clinical review and that a reflective discussion, facilitated by a nurse, is arranged in order to ensure that the recommendations arising from this report and the learning implications for the professional conduct of nurses are discussed as a team.
- This report should be shared with Essex Partnership University Trust, who was responsible for providing the healthcare services leading up to and at the time of Mr Morgan's death.
- The Governor should ensure that all calls to the main switchboard that indicate a prisoner might be at risk of harm are taken seriously. The subject of the call and the person who dealt with it should be recorded in the prisoner's NOMIS record and the wing observation book.
- The Governor 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 Governor should ensure that:
    - when a prisoner is in hospital in a critical condition, their next of kin is informed at once; and
    - Chelmsford's local policy is revised to reflect Prison Rule 22.

The Investigation Process

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

17. The investigator obtained copies of relevant extracts from Mr Morgan's prison and medical records, CCTV, body-worn camera footage, radio transmissions and PIN-phone calls.

18. Our investigation was suspended at the request of Chelmsford CID between 31 August 2018 and April 2019 while they investigated the circumstances of Mr Morgan's death. The investigation remained suspended while the prison completed an internal investigation and subsequent disciplinary proceedings against three staff. These concluded in September 2019 and we were provided with the records in October 2019. We started interviews at the earliest available date after this, in December 2019.

19. The prison provided the investigator with the records from their internal investigation. We also obtained the healthcare provider's serious incident root cause analysis report, relevant records from Broomfield Hospital and information from the East of England Ambulance Service.

20. The investigator and NHS England agreed that the circumstances surrounding Mr Morgan's death required a panel review rather than a single clinical reviewer. NHS England commissioned a lead clinical reviewer to lead the review of Mr Morgan's clinical care at the prison. Two other medical professionals formed the panel.

21. The investigator and two members of the panel interviewed two members of staff at Chelmsford in December 2019. The investigator interviewed a further 10 staff and one prisoner in December 2019, January, February and March 2020. The clinical review was delayed by the impact of lockdown and COVID-19 on the working patterns of the panel. This further delayed completion of our report.

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

23. The investigator contacted Mr Morgan's next of kin, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Morgan's next of kin had a considerable number of questions about the events of 22 August 2018, and we have answered these in this report and in separate correspondence.

Background Information

HMP Chelmsford

24. HMP Chelmsford is a local prison that takes prisoners directly from the courts. It holds nearly 730 men. At the time Mr Morgan died, Essex Partnership University NHS Foundation Trust (EPUT) was commissioned to provide 24-hour healthcare, which included a range of primary care and secondary mental health services. From 1 April 2019, Castle Rock Group (CRG) Medical took over the contract.

HM Inspectorate of Prisons

25. The most recent full inspection of HMP Chelmsford was in June 2018, and HMIP had concerns in many areas. This resulted in the prison being put under special measures until July 2019. This means that HM Prisons and Probation Service determined that it needed additional, specialist support to improve its performance.

26. HMIP found that some important aspects of health provision were poor, including incident reviews and complaints management, exacerbated by health staffing shortages. They said that many prisoners waited too long for primary care services and some aspects of medications management were unsafe. Partnership working between health and prison managers needed to be stronger to drive improvements. HMIP also recommended that there should be a better focus on the issues raised by the PPO in relation to deaths in custody.

27. In April 2019, HMIP reviewed Chelmsford's progress against the main recommendations. Inspectors found that there had been reasonable progress in the provision of healthcare and that the new healthcare provider had already begun to address many of their concerns. They said that positive partnership working between the new provider and the prison was evident, with several examples of proactive joint strategic and operational work. There was now strong leadership, and the new senior health team was visible to patients and accessible to health and prison staff.

28. HMIP also said that PPO recommendations relating to healthcare were monitored well, and there had been good progress in this area. However, not all the recommendations were actively reviewed to ensure that progress was made or sustained.

Independent Monitoring Board

29. 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 August 2019, the IMB noted that the replacement of EPUT by Castle Rock Group (CRG) had resulted in a much stronger healthcare presence on the wings and closer collaboration with prison managers. Weekly drop-in sessions on the wings were welcome, but staff shortages meant the medical services remained overstretched.

Previous deaths at HMP Chelmsford

30. Mr Morgan's death was the tenth death at Chelmsford since August 2017. Of the previous deaths, two were from natural causes, four were self-inflicted, and three were drug-related.

31. Since Mr Morgan died, there have been nine more deaths at Chelmsford, of which three were from natural causes, four were self-inflicted, one was drug-related, and one is awaiting classification. (Two of these deaths are still under investigation by the PPO.)

32. In our investigations into several deaths at Chelmsford since Mr Morgan's we have expressed concerns about healthcare.

33. In our report into a death in April 2019, we concluded that the healthcare provided was "unacceptably poor" and there had been a catalogue of failings by both healthcare and custodial staff. We found that the death, like Mr Morgan's, was preventable. We also found that the next of kin were not informed that the prisoner had been taken to hospital, and that he had been restrained while unconscious. We repeat serious concerns about these matters in this investigation.

34. In four other deaths (in September and October 2018 and in July and August 2019) we found that aspects of healthcare were not equivalent to that which would have been expected in the community.

Baclofen

35. Baclofen is used to treat spasticity in muscles in disorders such as multiple sclerosis, cerebral palsy, traumatic spinal cord injury and stroke. The entry for baclofen on Toxbase (an online poisons information database providing clinical toxicology advice to healthcare professionals) is headed with an orange warning box titled, "! TOXIC SUBSTANCE'. The first line below it says, "All patients who have been exposed to this product as a result of self-harm should be referred for assessment".

36. Toxbase defines the toxic dose as 2.5mg/kg and says any patient who has taken more than this should be referred for medical assessment. Toxbase also recommends discussion with the National Poisons Information Service (NPIS – a service commissioned by Public Health England to provide expert advice on acute and chronic poisoning).

37. Symptoms of baclofen overdose include:

- agitation;
- confusion;
- hallucinations;
- dizziness;
- gastro-intestinal upset;
- respiratory depression; and
- coma.

Key Events

38. On 15 January 2018, Mr David Morgan was remanded to HMP Chelmsford charged with robbery, assault and theft. He had a history of depression, anxiety, substance misuse and back pain. He had been to prison before. Mr Morgan asked to be treated as a vulnerable prisoner in Chelmsford because he was worried about his safety due to a historic sex offence (which had led to him being seriously assaulted during a previous sentence).

39. Mr Morgan told a nurse at an initial health assessment that he took 30mg baclofen (for muscle spasms and back pain), 150mg venlafaxine (an anti-depressant), 40 mg citalopram (an anti-depressant), 25mg promethazine (for acid reflux), 600mg pregabalin (for anxiety) and 10mg buprenorphine (an opioid substitute used in treatment of opiate withdrawal) daily. He had brought his medication to prison in evidence of this. A prison GP prescribed Mr Morgan 30mg of baclofen, 300 mg of pregabalin and 12mg of buprenorphine without obtaining confirmation from his community GP as he should have done.

40. On 18 January, another prison GP decided Mr Morgan should be allowed his baclofen, promethazine and citalopram in possession. The GP increased Mr Morgan's baclofen from 30mg to 60mg. Mr Morgan received buprenorphine and pregabalin daily under supervision in healthcare.

41. On 12 February, Mr Morgan was sentenced to two years three months in prison. On 28 June, he moved to the vulnerable prisoner's spur on G wing. On 18 July he began a buprenorphine reduction because he wanted to be drug free on release from prison.

42. On 3 and 7 August, Mr Morgan was listed for transfer to HMP Highpoint, but did not go. We do not know why he did not move there. There is no evidence in his record that he received any sanction for refusing to move.

43. On 9 August, Mr Morgan was involved in a fight with another prisoner over vape capsules and was placed on the basic regime of the Incentives and Earned Privileges (IEP) Scheme.

44. The investigator listened to Mr Morgan's prison telephone calls from 1- 21 August. His conversations indicated that he was involved in trafficking drugs into prison. At times he sounded angry, anxious and frustrated, but there was no indication that he wanted to harm himself or that he felt suicidal.

45. On 20 August, Mr Morgan collected a new supply of seven citalopram and 42 baclofen tablets. If he had taken these as prescribed, and we have no reason to think he did not, then Mr Morgan would have had 200 – 240mg of citalopram and 300mg of baclofen in his possession on 22 August.

Events of 22 August 2018

G Wing: 7.00am to 11.00am

46. The following sequence of events has been compiled from CCTV, radio transmissions, documentary evidence and interviews. We have taken the times in this section from the clock on the CCTV. (The cell bell record is two minutes behind the CCTV.)

47. At 7.06am, an officer checked Mr Morgan during the morning roll count. At 8.18am, Officer A walked past Mr Morgan's cell and appeared to be called over by Mr Morgan. The officer said he could not remember what Mr Morgan wanted but said he might have asked him why he had not been unlocked for work with the other prisoners as usual.

48. At 8.22am, Officer B answered Mr Morgan's cell bell. Officer A joined him at Mr Morgan's door carrying property bags. (Both officers were working at Chelmsford on detached duty from HMP Stoke Heath. Although working as an officer at Chelmsford, Officer B had been promoted to Supervising Officer (SO) at HMP Stoke Heath. At the time of writing, he is a Custodial Manager (CM) at HMP Foston Hall. We refer to him as Officer B throughout because that was his role at Chelmsford.)

49. Officer A said he handed out bags to all the prisoners due to transfer that day. He told Mr Morgan he was transferring to HMP Wayland and Mr Morgan replied immediately that he could not go there because they did not have a vulnerable prisoner unit (VPU) and he would be in danger. He said Mr Morgan appeared genuinely distressed at the prospect of transferring to Wayland.

50. Officer A said he would speak to a Supervising Officer (SO) and contact the OCA (the department in prison responsible for transfers) to explain Mr Morgan's case.

51. Officer A said the SO told him that Mr Morgan would "be going anyway". The OCA told him that the nature of Mr Morgan's current offence meant he was not regarded as a vulnerable prisoner for the purposes of transfer.

52. At 8.27am, four wing cleaners, who were friends of Mr Morgan and who were unlocked on the wing, talked to Mr Morgan through his door. CCTV shows that they passed items backwards and forwards to Mr Morgan through the gap between the wall and the side of his door. We interviewed one of these prisoners, who told us that he did not know if anyone passed anything to Mr Morgan that morning.

53. At 8.38am, Mr Morgan called his mother from the prison telephone in his cell but cancelled the call when it went to voicemail. The same four prisoners moved about on the landing outside Mr Morgan's cell.

54. At 8.43am, Officer A spoke to Mr Morgan at his door. He reported what the SO and the OCA had said, and advised Mr Morgan to pack his property and make his case against transferring in reception where he could speak to a CM.

55. Three minutes later Officer C escorted Mr Morgan for his supervised medication (buprenorphine and pregabalin). We did not interview this officer, but we have read

the transcript of his interview for the prison's investigation. The officer said he knew Mr Morgan quite well and got on with him. He said Mr Morgan was upset about transferring to Wayland and became almost tearful talking about it. Mr Morgan took his medication as normal and appeared to feel better about the transfer after the officer told him about the courses available at Wayland. Mr Morgan returned to his cell at 9.05am.

56. At 9.07am, Officer D unlocked Mr Morgan's cell and spoke to him in the doorway for just over one minute. The officer told the investigator that he could not remember exactly what Mr Morgan said to him, but he thought he wanted to talk about his transfer. He said G wing staff were unable to make decisions about transfers so the practice at the time was for prisoners to go to reception where they could explain to a CM why they did not want to transfer. He said this made sense because there was also a nurse based in reception. [In fact, this was no longer the case.] He did not remember what he said to Mr Morgan but said his usual response to prisoners at the time was to encourage them to go to reception where they could see a CM and a nurse.

57. The four wing cleaners continued to talk to Mr Morgan through his door periodically. At 9.33am, he passed a piece of what looked like paper through the side of Mr Morgan's door. (The police told the investigator that they found a piece of paper signed by a prisoner in Mr Morgan's cell in which he claimed that he had "spiked" Mr Morgan with a psychoactive substance.)

58. At 9.37am, Mr Morgan spoke to his mother on his cell telephone. He sounded agitated and asked her to ring the prison and tell them he could not transfer to Wayland because he had issues with prisoners there who were involved in the drug culture outside prison. Mr Morgan's mother said she telephoned the prison and spoke to a female member of staff who said she would look into the matter. We have not been able to identify who this was or what was done.

59. A prisoner told the investigator that Mr Morgan said he had taken all of his medication. He said Mr Morgan was in debt and would be in danger at Wayland because there was no vulnerable prisoner unit there. He said he told landing staff including Officer A, and that another prisoner told a SO.

60. Officer A said that a wing cleaner told him that Mr Morgan had taken some tablets. He went to Mr Morgan's door at 9.45am and saw a number of prisoners standing outside. He unlocked the door and said he asked Mr Morgan why he had taken his tablets. Mr Morgan replied that he did not want to transfer to Wayland. He asked him if he wanted to kill himself and Mr Morgan said "No, I just don't want to transfer", and that the cleaners had told him that if he said he had taken his medication he would not be moved. He said Mr Morgan gave him an empty blister pack, but he did not remember the name of the medication.

61. CCTV showed Mr Morgan also handed Officer A an article of clothing, which he took to another prisoner's cell. As the officer turned back to walk up the wing, he appeared to have a second object in his hand, along with a piece of paper that he arrived with. The investigator reviewed the CCTV footage with the officer, and he confirmed that this was when Mr Morgan gave him the empty blister pack. He said he remembered that Mr Morgan had also asked him to return the clothing to the other prisoner.

62. Officer A said he gave the blister pack to the SO in the wing office and told him that Mr Morgan claimed to have taken all of the tablets. He said the SO looked at the blister pack, remarked that the medication was "out of date" and threw it aside. The SO said he did not remember the officer showing him a blister pack. The officer said he thought two other officers were in the office at the time. One of the officers told the investigator that he remembered seeing a blister pack at some point.

63. Officer A said, as a detached duty officer, he was not given access to NOMIS at Chelmsford and was unable to make entries on Mr Morgan's prison record. At 9.45am, he rang the communications officer to ask the Hotel 6 nurse to come to the wing because Mr Morgan said he had taken an overdose, and he made an entry in the wing observation book (a book kept in the wing office where officers record significant events that other staff need to be aware of) recording this. (Hotel 6 is the radio call sign at Chelmsford of the nurse responsible for responding to incidents on E, F, G wings and the prison gym. Nurse A was Hotel 6 on 22 August. She was an agency nurse and did not work at HMP Chelmsford by the time our interviews took place. We did not speak to her and she was not identified by or spoken to during the prison's investigation.)

64. Officer A said he waited ten minutes for Hotel 6 to call back and then rang the healthcare department. He did not know who he spoke to, but they gave him another number to ring. There was no reply from this number, so he rang the communications officer and asked them to put another call out for Hotel 6 to ring G wing. He told the SO that Hotel 6 would be ringing back, and that they needed to come and see Mr Morgan. He then carried on with his morning duties, which included leaving the wing to collect items from prison stores.

65. The investigator listened to radio transmissions from 22 August, but they are neither timed nor in order. She heard a number of requests from communications for Hotel 6 with no response. The communications officer radioed for Hotel 5 (the call sign for the emergency response nurse), who was Nurse B that day, and also received no response.

66. Hotel 12 (another nurse radio call sign) responded that Hotel 6 was on F wing. The communications officer asked Hotel 12 to go to G wing on behalf of Hotel 6. Hotel 6 then confirmed she was on her way to G wing. A different communications officer also radioed for Hotel 6. Nurse A responded. He told her someone had just called him asking for her and she replied she would return to the office. We have seen no evidence that she went to G wing.

67. At 9.47am and 10.02am, Mr Morgan tried to ring his mother, but both calls went through to voicemail.

68. At 10.07am, Officer B answered Mr Morgan's cell bell and spoke to Mr Morgan at his door for almost three minutes. He said Mr Morgan told him that he had taken an overdose of something that could kill him and that he did not want to die. He said he knew Mr Morgan, and he did not appear to be under the influence of anything. He asked Mr Morgan what he had taken and why. He said Mr Morgan did not tell him the name of the medication.

69. Officer B said he went to the wing office directly after speaking to Mr Morgan and told the SO that Mr Morgan claimed he had taken something that could kill him. He

said the SO showed him the blister pack given to him by Officer A. Officer B described it as a foil package with blue writing on it and said all the tablets were missing. He said he told the SO to look up the medication online. He said he needed to know whether Mr Morgan's claim about the effect of the medication was true.

70. Officer B said he looked at the results of the internet search and saw one of the possible consequences of overdose of the medication from the blister pack was death. He said that the SO appeared shocked by this. He said he told the SO that they needed to get a nurse to see Mr Morgan immediately, make an entry on Mr Morgan's prison record (NOMIS) and start Prison Service suicide and self-harm monitoring procedures (known as ACCT). He said the SO told him he would "sort it". We do not know what happened to the blister pack after this and the prison were unable to provide it to the police.

71. Officer B had also not been given access to NOMIS at Chelmsford. He said he was aware that he could have begun ACCT procedures, but the SO would have had to complete the initial action plan. He said the SO had more time to begin ACCT procedures because he was in the office and the officers were answering cell bells and ensuring the regime ran on the wing. It therefore made sense to him to leave the SO to begin ACCT procedures.

72. Mr Morgan rang his mother at 10.10am and told her that he had taken all his medication and was going to die. He sounded extremely upset and agitated. Mr Morgan asked his mother to ring the Governor because landing staff were not listening to him and he could not transfer to Wayland. Mr Morgan's mother said that she called the prison again and this time spoke to a male senior officer who she believed was on Mr Morgan's wing. He too assured her he would "look into it". We do not know who this was.

73. At 10.24am, Officer B spoke to Mr Morgan at his door for two and a half minutes. He said he went to check Mr Morgan and reassure him. He said he knew Mr Morgan was suspected of trafficking illicit substances and was worried that he might take those too. He reassured Mr Morgan that the SO was aware of the situation and a nurse was coming to see him.

74. At 10.31am, Officer D wrote in the wing observation book that Nurse A rang to ask what the matter with Mr Morgan was. The officer wrote, "I told them he had taken an overdose and what he had taken. They will seek advice and call us back". (At interview the officer said that in fact he did not know what Mr Morgan had taken.) He said the nurse told him she would check Mr Morgan's medical record. There is no evidence that the nurse accessed Mr Morgan's medical record or called G wing back.

75. Officer B said he returned to the office and asked the SO whether he had spoken to healthcare about Mr Morgan. He said the SO told him that healthcare was "not that bothered about it". He said something about the date on the blister pack and that it did not match up with the date Mr Morgan was issued with his medication. The officer said he was under the impression from this that the SO had spoken to healthcare. The SO also told him that Mr Morgan would see a nurse in reception. He said he asked the SO whether he had begun ACCT procedures and the SO said he was "dealing with it".

76. We interviewed the SO several weeks before we spoke to Officer A, during which time the SO left the Prison Service, so we were not able to ask him about the officer's evidence. In his first prison investigation interview on 16 October 2018, the SO said he thought that Officer A had spoken to healthcare to establish whether Mr Morgan had medication in possession and could have taken an overdose. He said he remembered that "healthcare gave it the ok". In his second prison investigation interview on 26 March 2019, the SO said that he did not begin ACCT procedures because wing staff thought that Mr Morgan had only claimed he had taken his medication to avoid transfer.

77. Officer F said he went to G wing from reception to collect Mr Morgan for transfer. When he arrived, officers told him that Mr Morgan had refused to transfer and had said he had taken an overdose.

78. At 10.43am, Officer F, the SO, Officer B, Officer D and Officer E went to Mr Morgan's cell. Officer F unlocked Mr Morgan's door. He said Mr Morgan had a towel around his mouth and told him he had taken an overdose and needed to go to hospital. He said he had not met Mr Morgan before and thought he was very "theatrical" and "over-expressive". He said Mr Morgan did not mention his transfer to Wayland and had not packed any of his property.

79. The SO said he asked Mr Morgan what his problem with Wayland was, and he said that he had issues there. He said he explained to Mr Morgan that every prisoner on the transfer list must attend reception to make their case against transfer. He said he told Mr Morgan that he had known prisoners return from reception after arguing their case successfully.

80. The SO told the investigator that he wanted Mr Morgan to go to reception so he could be checked by a nurse. Mr Morgan agreed to go to reception and began to pack his bags. He said he handed over to Officer F and left to do an ACCT review on another prisoner. CCTV confirmed the SO left Mr Morgan's cell at 10.47am.

81. Officer B went into Mr Morgan's cell while Officer F and Officer E waited outside. He said he reassured Mr Morgan that he would see a nurse in reception and advised him to pack his property so he could go there to be checked.

82. At 10.50am, Mr Morgan left his cell dragging a large bag of property, followed by Officer B with a smaller one. He said goodbye to various prisoners before leaving the wing with Officer F and Officer E. Officer F said Mr Morgan appeared to be moving normally when he left his cell, in contrast to how he had been when he first met him.

83. Officer E said Mr Morgan told him he had taken "more of his medication than he should have" and was worried. He tried to find out what Mr Morgan had taken and how much, but Mr Morgan did not specify what he had taken. He said he thought Mr Morgan should be checked by a nurse and at the time they thought that it would be quicker for him to see one in reception than wait for one to attend G wing.

84. Officer E described Mr Morgan as "bouncing off the walls". He said he was a regular G wing officer and Mr Morgan was usually friendly and polite. It was out of character for him to be aggressive, agitated and angry. He said, on reflection, that it was possible that Mr Morgan had been under the influence of whatever he had

taken. However, one minute he appeared to stumble around the wing and another he appeared to be all right. At the time he felt that Mr Morgan was exaggerating his behaviour.

Events on G wing between CCTV coverage and body-worn camera footage

85. Officer F said that, as they passed the G wing office, he rang reception and told an officer there that he was bringing Mr Morgan over, that he had allegedly taken an overdose and asked her to get a nurse to come to reception to check him.

86. The officer in reception confirmed to the investigator that Officer F had rung her and told her to get a nurse because Mr Morgan had said he had taken an overdose. She said she radioed the communications officer and asked for one. The investigator could not identify the officer's call from the radio transmissions (it is possible that she telephoned them).

87. Officer E said Mr Morgan continued to protest about going to reception as he walked towards the gate with his bags. He complained that the bags his property was in were too flimsy, and the officer gave him some more heavy-duty ones. Mr Morgan asked several times to see a nurse and the officer repeated that one was waiting for him in reception.

88. Officer D said he was in the wing office when he heard Mr Morgan still arguing with Officer F and Officer E about going to reception. Mr Morgan complained that his bags were heavy, so he offered to help carry them. He said Mr Morgan kept repeating that he had taken an overdose of medication and said he felt sick and "not right". He asked Mr Morgan what he had taken, but Mr Morgan did not specify beyond saying tablets and medication. He too told Mr Morgan that a nurse would see him in reception.

89. Officer A arrived back on G wing with the stores trolley and offered it to Mr Morgan to carry his bags. The officers helped him load it.

90. Officer D said he had a good relationship with Mr Morgan and thought that he was unusually agitated. At the time he thought Mr Morgan was very anxious about what would happen to him at Wayland. He tried to explain again to Mr Morgan that he needed to go to reception to make his case against transfer, because wing officers could not make that decision. He said Mr Morgan became more agitated as he got closer to leaving the wing and took his jacket off followed by his t-shirt.

G Wing: use of force 11.00am

91. Officer F switched his body-worn camera on at 10.59am, followed by other officers. Footage showed Mr Morgan standing bare chested by the exit from G wing. He asked Mr Morgan to put his shirt back on. Mr Morgan refused and repeated, "Why are you being like this?" several times. He sounded agitated, upset and argumentative and looked hot.

92. At 11.00am, he appeared to be about to put his shirt back on when Officer F took him to the floor using control and restraint techniques. Officer D and Officer E held Mr Morgan's arms behind his back and applied wrist locks. Mr Morgan shouted repeatedly, "Why are you doing this to me?" and protested that he was not fighting.

93. The SO said he left the ACCT review when he heard shouting. He saw Mr Morgan being restrained on the floor and pressed the general alarm. At 11.01am, body-worn camera audio picked up the alarm bell sounding on the radio network, and just after this Mr Morgan shouted, "I'm out of my nut on medication". He continued shouting and some of the officers attempted to calm him down. Mr Morgan shouted loudly and repeatedly, "Why are you doing this to me?" At 11.02am, the SO handcuffed Mr Morgan's hands behind his back.

94. At 11.04am, Mr Morgan shouted, "Take me to hospital now, I'm out of my nut on medication". The officers managed to get Mr Morgan on to his feet at 11.05am and they left G wing. Another SO spoke to Mr Morgan outside the wing door and he calmed down. (This SO was suspended for unrelated disciplinary reasons and was not interviewed by the prison or by the investigator.)

Journey from G Wing to reception

95. The investigator watched CCTV coverage and body-worn camera footage of Mr Morgan's journey from G wing to reception. At 11.06am, Mr Morgan started walking to reception in a 'guided hold' with his hands cuffed behind his back and an officer each side of him lightly holding him by his arms. Several officers escorted.

96. Radio transmissions indicate that the communications officer first asked Hotel 5 to attend reception, but he was busy, so he next asked for Hotel 6, Nurse A. An officer responded that Nurse A was busy in the gym. A CM radioed that she still required a member of healthcare "to assist this relocation".

97. The communications officer put a call out for Hotel 4 (the radio call sign for the nursing team shift leader) to come to reception, saying, "It's a general alarm and a prisoner needs to be seen by a nurse". Audio from body-worn camera footage confirmed that this call was put out at 11.07am. A nurse who was Hotel 4 on 22 August radioed confirmation.

98. At the same time as the radio call for Hotel 4, an officer's body-worn camera showed that as the party went through the gate to E and F wing exercise yard, Mr Morgan said to the SO, "I've had too much medication, I need to go hospital". The CM joined the escort on the other side of the gate.

99. The CM said another CM, the orderly officer (the operational manager of the prison that day with radio call sign Oscar 1), asked her to attend Mr Morgan's use of force for him. (The first CM left the Prison Service before our investigation started and we did not therefore interview her. We have seen her incident statement of 1 September 2018 and the transcript of her interview for the prison's investigation on 27 September 2018.)

100. She said she arrived as Mr Morgan was being escorted past E and F wing exercise yard on the way to reception. Body-worn camera footage showed the time was 11.07am. She said she was told Mr Morgan had refused to transfer and had damaged his cell. She said that no one told her Mr Morgan had allegedly taken an overdose. She said he was not aggressive or threatening. She was aware there had been a use of force and thought that a nurse should therefore check Mr Morgan (as required by Prison Service policy). She said she radioed the communications officer and asked for a nurse to attend.

101. Audio from Officer G's body-worn camera footage showed that one of the escort officers told the CM that Mr Morgan had refused to transfer. We have not found any evidence that anyone told her that Mr Morgan said he had taken an overdose of his medication. From the point at which the CM arrived, Mr Morgan only repeated that the use of force had been unnecessary and did not mention his overdose. After 11.09am Mr Morgan was only heard breathing heavily and sighing and Officer A told him to hurry up so he could see a nurse.

102. In his interview for the prison investigation, Officer G described Mr Morgan as a little unsteady on his feet and said he seemed a bit tired and was breathing heavily. He was the last officer to turn his camera off and did so at 11.11am when Mr Morgan was in the centre about to enter reception.

103. Officer H said she was by the property desk when Mr Morgan arrived and he said, "Hello Miss, I don't want to transfer". This is the last reported time that Mr Morgan spoke more than a single word intelligibly.

104. Officer H said Nurse C arrived in reception before Mr Morgan and Nurse B arrived after Mr Morgan. Officer H said the nurse B left not long after he had arrived because Nurse C was already there. (Nurse B is an agency nurse and was suspended from Chelmsford at the time of this investigation. We have not spoken to him and he was not interviewed for the prison investigation.)

105. Officer H told the prison investigation that she told Nurse C that Mr Morgan had taken an overdose. She said all the receiving officers in reception were aware of this as well. Officer F said he told a black male nurse (presumed to be Nurse B) standing by the property desk that Mr Morgan had taken an overdose.

Search in reception 11.13am – 11.18am

106. An officer turned on his body-worn camera at 11.13am. Another officer told Mr Morgan that they were going to strip search him and directed him to sit in a small curtained off area. The officer said that Mr Morgan was out of breath and he told him to sit down and have a rest. The SO removed the handcuffs and returned to G wing. He said he noticed Mr Morgan was hot but assumed this was from the restraint.

107. Mr Morgan sat in a chair in the cubicle. Another SO stood to his left and an officer stood to his right. An officer stood in front of him, and another officer stood next to that officer. Mr Morgan looked hot and put his hands to his head several times as if to try to clear it.

108. Mr Morgan looked at whichever officer spoke to him and nodded at what they said but only spoke twice to say a single word - "fuck" - both times. An officer tried to give Mr Morgan a cup of water, and Mr Morgan looked at him and started to cry. He said Mr Morgan did not speak while in the cubicle or, if he did, it was inaudible.

109. The second SO left the Prison Service before our investigation began but we have read the transcripts of his prison investigation interviews on 4 October 2018 and 13 March 2019. He said Mr Morgan was sweating, kept touching his face and seemed tired and out of breath.

110. An officer also left the Prison Service before our investigation. He told the prison investigation on 28 September 2018 that that he knew Mr Morgan from the wing and Mr Morgan had smiled at him when he arrived in reception. He said it looked as if Mr Morgan had been crying. He said Mr Morgan did not speak and did not look like he was aware of what people were saying to him. He said he was only aware that Mr Morgan had come from G wing under restraint for refusing to transfer. He said he was not aware that Mr Morgan had said he had taken an overdose.

111. Officer I asked Mr Morgan to put his top back on. Mr Morgan appeared not to be able to do this and the officers helped him. He leaned forward and made moaning sounds and repeated "fuck". He appeared unable to respond to what the officers said to him.

112. At 11.15am, Officer I said, "Why is it you don't want to go? Come on talk to us. If you talk to us, we can do things. Tell us why you don't want to go." Mr Morgan moaned in response and continued to put his hands up to his head and repeat "fuck". He appeared not fully aware of what was happening. At 11.16am, Officer I said, "Are you saying you have taken something? Is that what you are saying? Are you saying you have taken something you shouldn't have taken?" Mr Morgan did not reply and vomited into the bin.

113. Officer I said immediately, "Drunk – yeah, a bit of hooch". Other officers agreed. Another officer said, "He's pissed, drunk". Officer I told the investigator that, in his experience, the colour, consistency and smell of Mr Morgan's vomit indicated he had consumed hooch. A SO said Mr Morgan's vomit was "orange and smelled of hooch". He said after Mr Morgan was sick, he sweated more heavily and became "unsettled" and "confused". An officer said, after he had been sick, Mr Morgan was completely unresponsive to what he was asked to do and appeared to be unaware of his surroundings.

114. At 11.17am, Nurse C approached the cubicle and said, "He does always look this gormless though". She asked Mr Morgan if he had been drinking. Mr Morgan appeared not to reply. Officer I said, "He's had a bit of the old bubble hooch. It's not good for you that shit."

115. Officer I and Nurse C had a brief conversation outside the cubicle that is not entirely audible on the footage. The officer pointed in the direction of the holding cell and said something including the words "half an hour". The nurse appeared to agree. She did not examine Mr Morgan or ask him any further questions.

116. An officer asked Mr Morgan to remove his trousers. Mr Morgan looked blankly at him. Mr Morgan appeared not to be able to sit or stand without support from officers. Another officer said that Mr Morgan was completely unresponsive to instructions and looked unaware of his surroundings. An officer turned his camera off at 11.18am.

117. Nurse C was suspended from Chelmsford at the time of the investigation and was not interviewed. We have read her written statement of 1 September 2018 and transcripts from her interviews with prison investigators on 10 October 2018 and 28 March 2019. She said she could smell alcohol after Mr Morgan was sick. She said that no one in reception told her that Mr Morgan might have taken an overdose.

118. A CM said she remembered hearing someone say Mr Morgan was drunk or smelled of hooch while he was in the cubicle being searched. She said when Mr Morgan came out of the cubicle his presentation was completely different. She described him as "wobbling" and "swaying". She suggested staff took Mr Morgan to the holding cell nearest the reception desk and she told the escort services that Mr Morgan would not be transferring to Wayland.

119. A SO retired from the Prison Service before our investigation started. We have read the transcript of his prison investigation interview on 2 October 2018. Another SO said that he worked in safer custody and was in reception that morning on an unrelated matter. He said he saw Mr Morgan walking to reception and arrived when Mr Morgan was being searched. He said Mr Morgan appeared to deteriorate very quickly in reception. He said a CM told him that Mr Morgan was drunk and was in the holding cell to sober up.

120. A SO said that Officer I telephoned him to tell him that Mr Morgan was drunk. The SO told him that was not possible. He said Mr Morgan had not appeared to be under the influence of anything on G wing. Officer F, Officer A, Officer D, Officer E and Officer B told the investigator that Mr Morgan had neither appeared drunk nor had they smelled hooch. Officer D and Officer E said they were extremely close to Mr Morgan during the restraint and had not smelled any alcohol.

121. Officer I told the investigator that he did not remember telephoning the SO. Officer E told the investigator that he and other G wing officers had checked CCTV after someone (he could not remember who as he had not spoken to them) from reception rang to say Mr Morgan was drunk. They did not identify any opportunity for Mr Morgan to have accessed hooch on G wing before he left for reception.

CCTV from the holding cell: 11.21am – 12.21pm

122. Mr Morgan's time in the holding cell was recorded on CCTV from a camera inside the cell and a camera outside the cell. The camera inside the cell is set permanently to record, but the screen that it plays to is in an unmanned room in reception and is not routinely checked by staff.

123. There is no clock on the CCTV from the holding cell. By working backwards from 12.21pm, when an officer turned his body-worn camera on, we have calculated that Mr Morgan entered the holding cell at 11.21am.

124. Mr Morgan walked to the holding cell from the search area with the assistance of three officers and a SO. He was unsteady and appeared disorientated. He repeatedly put his hands to his head and paced unsteadily from one end of the cell to the other. He put his hands out in front of him as if to stop himself banging into the walls. At 11.24am, he knelt on the floor and put his head on his arms resting on the bench in the cell. Shortly afterwards Officer F brought him some toast and Mr Morgan started to eat it.

125. At 11.27am, Mr Morgan appeared to retch. He tried to eat the toast but dropped the second piece on the floor. He continued to sway unsteadily and moved his hands repeatedly to his head. At 11.31am, Mr Morgan dropped to one knee and after a minute his head fell forward and his chin hit the bench, causing it to bleed. His

movements appeared jerky and unnatural. At 11.32am, Officer I looked through the cell window. Mr Morgan was sitting on the floor feeling his chin.

126. A CM said he went to reception when he finished dealing with an alarm bell on C wing to arrange a hospital escort for an injured prisoner. He said he heard Mr Morgan "screaming and shouting" and Officer F told him that Mr Morgan had been restrained after refusing to transfer and was in the holding cell. At interview, Officer F confirmed that he did not mention to the CM that Mr Morgan had said he had taken an overdose because he said he had already telephoned that information to reception.

127. The CM said reception staff told him Mr Morgan had walked to reception in handcuffs and they believed he had drunk hooch. He said they told him that Mr Morgan had banged his head "in protest" and kicked the bench and door. (There is no evidence of this on the CCTV.) He said he asked them to begin ACCT procedures if they had not already been started. He said he did not remember exactly who he told to do this and no one we or the prison interviewed said they were asked to do so.

128. At 11.35am, two CMs, Nurse C, a SO and the reception orderly (a prisoner) all looked into the cell. Mr Morgan looked out at them. He looked unsteady, his mouth was open, and his chin was bleeding. The staff remained outside the cell and, at 11.37am, they returned to the reception desk.

129. Ten seconds after the staff returned to the desk, Mr Morgan collapsed to the floor with his legs bent underneath him. He appeared to be in considerable pain. He tried to crawl and rolled on to his back apparently screaming. (A specialist medical report commissioned by the police investigator concluded that Mr Morgan fractured one of his legs at this point.) Nurse C appeared to hear Mr Morgan and she returned to the cell with a CM and the reception orderly. The nurse and the orderly laughed at something. The CM opened the cell door. Mr Morgan was on his back on the floor apparently screaming. After almost 20 seconds the CM shut the cell door and they returned to the reception desk.

130. At 11.38am, Officer H looked into the cell briefly. Mr Morgan was still in the same position on his back in obvious pain. A few seconds later the reception orderly watched Mr Morgan before returning to the reception desk. At 11.39am, a SO looked briefly into the cell. Mr Morgan was sitting on the floor by the bench.

131. Mr Morgan tried unsuccessfully to get up. His head fell forwards and backwards and he appeared unable to keep it up. At 11.42am, his head repeatedly hit the floor and at 11.47am, his face hit the bench. No one was outside the cell.

132. At 11.50am, a CM looked into the cell briefly. Mr Morgan was sitting on the floor making apparently involuntary jerking and rocking movements. Another CM looked at Mr Morgan about 30 seconds later, and Mr Morgan was in the same position. A minute later another officer looked at Mr Morgan and a minute after that, at 11.53am, Nurse C looked at Mr Morgan. Mr Morgan was kneeling on the floor with his hands on the cell bench. His face repeatedly hit the bench with some force. The nurse winced, returned to the desk and demonstrated what Mr Morgan had done to the other staff.

133. At 11.54am, a CM and Officer I entered the cell. Another CM stood in the doorway and Nurse C, a SO and another CM stood behind him watching. Mr Morgan appeared to be unable to sit up on the bench and the CM and Officer I supported him on either side. After a minute, the CM appeared to ask Nurse C if she wanted to check Mr Morgan, and she shook her head. The CM then appeared to suggest that Mr Morgan's face be cleaned, and the SO collected some tissue.

134. The CM told the investigator that Mr Morgan was not aggressive, and he thought it would have been safe for the nurse to check him. He said he would have put any necessary measures in place to allow Nurse C to check Mr Morgan if she had wanted to.

135. At 11.57am, Mr Morgan vomited on the floor. The CM and Officer I tried to get Mr Morgan to stand up, but he did not appear to be able to support his weight. The staff outside the cell laughed. At 11.59am, a SO took over from the CM, who walked back to the desk talking to two other CMs. At noon the SO and a CM put Mr Morgan in the recovery position on the floor and left the cell.

136. One CM said he tried to reassure Mr Morgan that he would not be transferring to Wayland. He said Mr Morgan appeared to be drunk, which accorded with the information already given to him. He looked sweaty and his shirt was wet. The reception orderly brought tissues and they cleaned Mr Morgan's face. Officer I asked for a cup of water. The CM asked for clean clothing for Mr Morgan but said he did not get it because Mr Morgan could not stand and was unable to dress himself.

137. The SO said Mr Morgan was unable to stand up or sit up and could hardly hold his own head up. He said staff put him in the recovery position in case he choked. Mr Morgan was not threatening or aggressive. He said a CM was in charge and everyone was confident that Nurse C was aware of what was going on, although he thought it was odd that she did not go into the cell to assess Mr Morgan or dress his wounds.

138. A CM said he and Nurse C discussed the best course of action. They agreed Mr Morgan was under the influence and they would wait for him to sober up. They decided to leave him in the holding cell because he was unstable on his feet. The CM said he planned to assess Mr Morgan again after lunch. He asked the nurse how best to keep Mr Morgan safe in the meantime and she said she would stay and observe him. He said he then left reception to attend a general alarm.

139. The reception orderly cleaned the blood and vomit up. The SO and Nurse C remained in the doorway of the cell. All three appeared to laugh at Mr Morgan. Mr Morgan lay limply on the floor of the cell. The nurse did not examine him. Between 12.06pm and 12.12pm, Mr Morgan remained on the floor and appeared to be semi-conscious or asleep. The SO and nurse remained standing in or near the open door of the cell watching Mr Morgan.

140. The SO said he was new to Chelmsford and was shadowing another member of staff in reception. He thought another SO was in overall charge of reception, but he had gone off to training at 12.30pm.

141. At 12.12pm, Mr Morgan's head hit the floor repeatedly. The SO entered the cell and tried to hold him up. He attempted to lay Mr Morgan on the floor again before leaving the cell, but Mr Morgan's face and head continued to hit the floor. His movements were jerky and looked involuntary. Nurse C watched from the doorway. The SO walked to the desk and returned with another SO. They both spoke to the nurse. After a minute both SOs returned to the desk. The nurse continued to watch Mr Morgan from the cell doorway.

142. At 12.15pm, Mr Morgan got to his knees and moved towards the bench in the cell. He did not appear to be in control of his movements. As soon as he moved to the bench Nurse C closed and locked the cell door.

143. Nurse C said she decided to stay in reception until she thought Mr Morgan was fit enough to be moved. She said Mr Morgan was aggressive but "not to staff". She saw his facial injuries but said Mr Morgan's unpredictable behaviour meant it was unsafe for her to take his observations.

144. Mr Morgan's fell face forward on to the bench several times. His face was covered in blood and there was a significant amount of blood on the cell floor. Nurse C spoke to Officer I as he passed the cell, and then she moved back to the desk at 12.16pm. Mr Morgan continued to fall heavily on to his face on the cell bench. At 12.18pm he managed to stand up and leaned on the bench for support, but his legs gave way jerkily. Officer J, the reception lunch patrol officer, looked into the cell for the first time shortly afterwards.

145. Officer J said he arrived in reception at about 12.15pm in readiness to begin lunchtime patrol at 12.30pm. Officer I told him that Mr Morgan had refused to transfer, appeared intoxicated and was in the holding room. He said when he first saw Mr Morgan he was lying on the floor and appeared 'very drunk".

146. At 12.19pm, Officer J returned to the cell and watched Mr Morgan fall face first into the bench. He walked back to the desk and appeared to tell other staff what he had seen. While he was away, at 12.20pm, Mr Morgan's legs gave way underneath him and he fell to the floor on bent legs. He looked in considerable pain and appeared to scream. The specialist medical report commissioned by the police investigator concluded that Mr Morgan fractured his other leg at this point.

147. Shortly afterwards, Nurse C walked past the cell from the direction of the desk. She looked in but did not stop. Fifteen seconds later, Officer J returned to the cell with a SO and Officer K. The SO opened the door and he and the officer went in. At 12.21pm, Officer J turned on his body-worn camera.

Body-worn camera footage: 21.21pm – 12.27pm

148. There are two clips of footage from Officer J's camera. In the first clip, between 12.21pm and 12.22pm, Mr Morgan can be seen sitting slumped by the holding room door. His face was covered in blood and he made loud, distressed sounds. Officer K and the SO held him up. Mr Morgan looked floppy and appeared unable to sit up or hold his head up without support. Officer K asked Officer J to see if the nurse was still there and then to see if there was a custodial manager by the front desk.

149. The SO said he and Officer K went into the cell to try to stop Mr Morgan banging his head. He said Mr Morgan did not look like he knew what was going on. He said he was "unpredictable but not aggressive". He said he asked Officer J to contact the CM because Mr Morgan did not appear to be sobering up and he was not sure what to do.

150. Officer K said he went into the cell because Mr Morgan was screaming in pain. Mr Morgan was unable to support himself, so he and the SO held him and tried to stop him hurting his head further.

151. The second clip started at 12.22pm, 30 seconds after the first finished. Officer J returned to the cell accompanied by Officer L, who was using a radio. Officer M joined them. There are two radio calls for Hotel 5 to go to reception from the radio with call sign Tango 8 (a radio usually used by an officer assigned to visits and the video link). Nurse C appeared and asked who was asking for Hotel 5. Officer L said he had not seen her, and the nurse replied, "I've been here for the last hour with this idiot".

152. Officer L asked how Mr Morgan had cut his face and Nurse C said;

> "He's been smacking his face off there. Nothing you can do. You can't stop him. And we can't do nothing until he calms down. He's been doing it constant. So that's why I'm here. And have been."

153. The staff discussed what to do. Nurse C agreed with Officer J that Mr Morgan was "obliterated". The SO told Mr Morgan to "chill out" and "stop behaving like a child". A male voice said they needed a custodial manager to make a decision. Officer K said he asked several times if the CM was coming because he wanted to know what the plan for Mr Morgan was. He said he assumed that the nurse had already checked Mr Morgan. Officer M suggested restraining Mr Morgan and the nurse replied, "Until he sobers up, I can't do nothing".

154. The staff discussed various alternative locations for Mr Morgan but decided none were better than the room he was in. Officer J said, "This can't just be alcohol". Officer M agreed. Officer K mentioned hospital and Officer J said, "They won't take him to hospital, not 'til he sobers up". Officer J walked down to the front desk and appeared to turn his camera off at 12.27pm, at the request of two other officers.

CCTV: 12.28pm – 2.18pm

155. At 12.29pm, Officer N looked into the cell. He swapped places with Officer K briefly, while Officer K changed the gloves he was wearing. A female nurse walked past, and Nurse C and Officer N moved away with her. Officer J returned to the cell and the three officers remained with Mr Morgan. After a minute Nurse C returned. At 12.34pm, a Healthcare Assistant (HCA) arrived carrying two boxes, and he and the nurse moved out of sight.

156. At 12.38pm, Nurse C and the HCA returned and stood outside the cell. The HCA said the nurse had asked him to bring some dressings and gauze to reception. He said when he arrived Mr Morgan was quite aggressive, and they were wary about going in to treat him. He said the nurse was in charge of the situation. He could not remember the substance of any discussion about what to do, but he thought that

the nurse was reluctant to go in. He said he had a vague recollection of someone saying Mr Morgan might have taken an overdose but did not recall this clearly.

157. Officer K and the SO continued to hold Mr Morgan up. At 12.41pm, Officer K and the SO laid Mr Morgan on the floor. Mr Morgan looked floppy, and his head hit the floor as they moved him. The officer and SO held him in place on the floor and tried to stop him moving.

158. At 12.45pm, a CM returned to the cell. CCTV showed he asked Nurse C something and she shook her head. The CM said, in his written statement of September 2018, that he thought Mr Morgan was more intoxicated than he had been earlier and asked the nurse if he needed to go to hospital. She said that he did not. He told the investigator that he was quite concerned about Mr Morgan because it had been a couple of hours and he had not improved, but he deferred to the nurse's opinion as the medically trained person.

159. The CM said he could hear Mr Morgan snoring. He closed the cell door at 12.46pm. He asked Officer N to stay with Officer J over lunchtime so that there would be two officers and Nurse C present. He said that two officers were more than sufficient to open a cell over lunch period if necessary. The two officers could also have formed a hospital escort if the nurse deemed it necessary to send Mr Morgan to hospital.

160. Officer K said the CM asked them to reposition Mr Morgan so he could not hurt himself on the bench. He then asked the officer to escort an officer to hospital who had injured his arm during a restraint.

161. Between 12.46pm and 1.01pm, Mr Morgan remained on the floor hardly moving. Various staff walked past the cell and looked in during this period. The HCA left at 12.48pm. Officer N looked at Mr Morgan every couple of minutes. At 1.01pm, Mr Morgan tried unsuccessfully to get up. At 1.02pm, Officer N looked into the cell. Mr Morgan was still trying to get up, but his head kept falling to the floor and hitting it with increasing force.

162. At 1.04pm, Officer N asked Nurse C to look at Mr Morgan and they both watched him fall to the floor from a sitting position and hit his head hard on the floor. The SO reappeared with latex gloves on, but no one entered the cell and within a minute all three had moved away from the cell.

163. Mr Morgan continued to try to sit up without success. His movements were jerky. He managed to get to his knees and his face hit the floor several times with force. His face and hands were covered in blood. He repeatedly fell face first on to the floor.

164. Another HCA arrived in reception at 1.12pm. She said the other HCA had told her that Nurse C was in reception dealing with a prisoner under the influence so she decided to see if she could help. She said Mr Morgan was lying on the floor covered in blood. The nurse told her that Mr Morgan had drunk hooch on G wing because he was unhappy about transferring. She also told her that Mr Morgan had been acting aggressively and behaving bizarrely. The HCA said she asked the nurse if she had assessed Mr Morgan, and the nurse said it had not been safe to do so.

165. At 1.14pm, the HCA looked into the cell and appeared to relay what Mr Morgan was doing to staff off camera. Officer N looked in and winced. At 1.16pm, Mr Morgan stood up unsteadily and fell to the floor. At 1.17pm, Officer J and Officer N went into the cell and appeared to try to talk to Mr Morgan. Neither of them touched him and after a minute they left the cell, shut the door, and moved away. Mr Morgan continued to fall hitting his head. He appeared unable to sit up or hold his head up for very long and his movements remained jerky and apparently involuntary.

166. At 1.26pm, the HCA looked into the cell again. She tried to get Mr Morgan to respond to her by tapping the glass and then moved out of the picture. At 1.28pm, Mr Morgan's head hit the bench. The HCA said she asked Nurse C if they should call for an ambulance. The nurse said no because if they were not willing to go into the cell, they should not expect paramedics to do so. The HCA said she also asked if officers could restrain him to prevent him injuring himself, but was told no. She said she did not think Mr Morgan's presentation could just be the result of hooch and thought he had probably taken PS or another illicit substance. She said she found it distressing that no one appeared to want to do anything to help Mr Morgan, but she was conscious that she was very low in the pecking order and could not tell the nurse or prison staff what to do. Shortly afterwards, Mr Morgan appeared to lose consciousness and they decided to go into the cell.

167. At 1.29pm, Officer N, the SO and Officer J lifted Mr Morgan on to the cell bench. The HCA and Nurse C cleaned his face. The HCA shone a torch into Mr Morgan's eyes to check his pupil reactions and took his blood pressure. She said Mr Morgan had a broken nose and bruising around his eyes. His right pupil did not react to the light as well as his left eye and his pulse was raised. She suggested to the nurse that they call an ambulance, and the nurse agreed.

168. At 1.32pm, Officer J left the cell and rang the communications officer to ask them to call an ambulance. At 1.33pm, Nurse C left the cell.

169. East of England Ambulance Service recorded the 999 call at 1.34pm. The call was triaged as 'priority red 2' for a traumatic head injury, indicating a target response time of 18-40 minutes.

170. At 1.36pm, the HCA checked Mr Morgan's pupil reaction again. Nurse C returned to the cell at 1.38pm.

171. A minute later a member of staff using radio call sign Oscar 16 (we have been unable to identify this member of staff at the time of writing) joined them and all three discussed what to do. Nurse C shook her head and shrugged during the conversation. At 1.40pm, Oscar 16 left the cell and returned to the desk, followed by the nurse. The HCA and Officer N remained with Mr Morgan. The HCA supported Mr Morgan's head. Mr Morgan appeared to be semi-conscious.

172. The radio traffic from the day included an exchange between Oscar 16, the communications officer and the CM. Oscar 16 radioed communications to ask where the ambulance was. The CM asked communications why an ambulance had been called, and Oscar 16 told communications that he would explain to him.

173. The CM said he heard on his radio that an ambulance was on its way. He said he was annoyed because Officer J had not informed him that he had asked for one, as

he should have done. The CM was in the process of organising the escort for the prisoner that had been injured on the football pitch, so he used that escort for Mr Morgan instead.

174. At 2.00pm, the SO returned with paramedics and they entered the cell. At 2.09pm, one of the paramedics brought a trolley bed to the cell and they put Mr Morgan onto it. At 2.17pm, the paramedics left the cell with Mr Morgan strapped to the ambulance trolley.

Transfer to hospital

175. The person escort record (PER) showed that the ambulance left Chelmsford at 2.30pm with Mr Morgan handcuffed by escort chain to an officer. The ambulance arrived at Broomfield Hospital at 3.00pm, some five and a quarter hours after Mr Morgan first told Officer A he had taken an overdose.

176. At 3.30pm, one of the escorting officers rang prison healthcare to ask what medication Mr Morgan was prescribed. A handwritten note on the PER form lists Subutex, pregabalin, baclofen and citalopram and the doses given. It is not clear whether the hospital was made aware that Mr Morgan had baclofen and citalopram in his possession and therefore had the means to take an overdose.

177. At 3.40pm, the CM gave permission for the escort chain to be removed because Mr Morgan was being sedated for a scan. At 5.00pm, Mr Morgan was admitted to the intensive care unit and placed in a medically induced coma. Restraints were not reapplied.

178. Records obtained from Broomfield Hospital showed that on arrival in Accident and Emergency Mr Morgan was confirmed to be in the deepest level of coma according to the Glasgow Coma Score (GCS). The working diagnosis was that Mr Morgan had taken an overdose of multiple unknown drugs. He had a broken nose, significant bruising to his head and face and fractures to both legs were discovered over the next couple of days.

179. Despite intensive care Mr Morgan, developed multi-organ failure, and died on 30 August 2018..

Contact with Mr Morgan's family

180. Mr Morgan's next of kin were contacted by hospital staff at 5.30pm on 22 August and told he had been admitted to intensive care. The duty governor told escort staff at 6.55pm that Mr Morgan's next of kin should be allowed to visit him.

181. Mr Morgan's mother said that when she arrived at the hospital, one of the escort staff told her that she had seen similar incidents "hundreds of times" and that Mr Morgan would be fine. Mr Morgan's mother said she felt that the officer showed a lack of compassion and sensitivity.

182. The prison appointed a family liaison officer after Mr Morgan died. She visited Mr Morgan's mother at her home and the prison contributed to the cost of Mr Morgan's funeral in line with national guidance.

Support for prisoners and staff

183. The prison posted notices informing other prisoners of Mr Morgan's death, and to offer 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's death.

Post-mortem report

184. The pathologist concluded that the cause of Mr Morgan's death could not be ascertained.

185. He noted that the hospital doctors had concluded that it was likely that Mr Morgan had consumed more than one drug, resulting in deteriorating organ function and collapse. He said that, although he would not disagree with this theory, he could not confirm it because toxicology tests were not possible as the blood samples taken when Mr Morgan was admitted to hospital had not been retained.

Investigations after Mr Morgan's death

Investigation by HMP Chelmsford

186. On 6 September 2018, the Deputy Governor commissioned an investigation into the actions of Officer A, Officer F and a SO on 22 August. The original investigator went on sick leave in November 2018 and another senior manager took over the investigation in December 2018. The senior manager completed his report on 9 May 2019, and it was accepted by the Governor on 24 May. The senior manager concluded that there was sufficient evidence to test charges against all three staff at disciplinary hearing. A copy of the report was shared with us in June 2019.

187. In July 2019, a SO attended a fast-track disciplinary hearing. He accepted two charges that he failed to open an ACCT on Mr Morgan and failed to ensure an ACCT was opened on Mr Morgan on 22 August. The Governor downgraded the SO to the rank of officer, removed him from the field of promotion for a year and gave him a final written warning to remain in place for 18 months.

188. The SO appealed the Governor's decision on the grounds of undue severe penalty and that the disciplinary proceedings were unfair and breached the rules of natural justice. In August 2019, the Prison Group Director for Hertfordshire, Essex and Sussex upheld part of the SO's appeal because of a procedural error in the letter informing him of the allegations against him and the possible penalties. As a result, the SO was not demoted and was not removed from the field of promotion. The final written warning remained in place for 18 months.

189. On 3 September 2019, Officer F attended a fast-track disciplinary hearing and accepted a charge of 'use of unnecessary force on a prisoner' (that is, that the use of force he initiated on Mr Morgan on 22 August was unlawful). The Governor issued the officer with a final written warning for 18 months.

190. On 26 September 2019, Officer A attended a disciplinary hearing and contested a charge that he failed to open an ACCT on Mr Morgan on 22 August 2018. In mitigation the officer referred to Officer B's account that a SO had said he would

"sort it" (open an ACCT). The Governor found the charge proved and issued the officer with a written warning for 12 months.

191. The outcomes of the disciplinary hearings were shared with the investigator in September and October 2019.

Castle Rock Group (CRG) medical services

192. CRG took over provision of healthcare at Chelmsford on 1 April 2019 (seven months after Mr Morgan's death). On 20 June 2019, the contract manager for CRG informed Nurse C that she was suspended from her role pending the results of an investigation into allegations of gross misconduct regarding the events of 22 August 2018. The nurse attended a disciplinary panel in December 2019. CRG dismissed her from their employment in January 2020.

Essex Partnership University NHS Foundation Trust (EPUT)

193. A clinical panel completed a root cause analysis investigation report for EPUT in August 2019. They recommended that Nurse C's skills and competencies should be reviewed. We do not know whether this review took place.

Report to the Nursing and Midwifery Council

194. In November 2019, the clinical reviewer referred Nurse C to the Nursing and Midwifery Council. We understand an investigation is ongoing at the time of writing.

Findings

The conduct of staff at Chelmsford on 22 August

2. This is a shocking case, and we are appalled by the dismissive and disrespectful attitude that underpinned and allowed the utter failure in Mr Morgan's care that day. The treatment he received was nothing short of inhumane and degrading.

3. Mr Morgan's claim to have taken an overdose of his medication was not taken seriously by a SO on the wing and no one attempted to investigate what medication he had access to or open an ACCT. CCTV shows that Mr Morgan was mocked, laughed at, ignored and referred to as "gormless", "this idiot" and "acting like a child" by a nurse and various prison staff when he was barely conscious, seriously injured, covered in blood and screaming in pain. At least three CMs, two SOs, nine officers and two members of healthcare staff witnessed Mr Morgan's distressed state in the holding cell and did not act with sufficient urgency or care to ensure his safety.

4. Only three staff attempted to take Mr Morgan's overdose seriously (Officer A and Officer B on G wing, who were both on detached duty from another prison) or showed compassion to him in the holding cell (the second HCA). Other G wing officers said they were reassured that Mr Morgan would see a nurse in reception.

5. Some staff who witnessed the events in the holding cell looked shocked, but no one took responsibility for ensuring his safety. The conduct of some staff present fell so far short of acceptable that, had they not already left the prison service, we would have recommended that the Governor consider disciplinary investigations into their fitness to work in prison. We are surprised that the original prison investigation concentrated solely on the actions of staff on G wing, including Officer A, who at least took Mr Morgan's overdose seriously and attempted to get a nurse to see him. Although there were failings from 9.45am onwards, the most serious failings in care occurred in reception.

6. We are also concerned that we could not rely on the accuracy of the accounts given by some staff. For example, some staff told us that they did not know Mr Morgan had said he had taken an overdose, when the evidence we have seen suggests this is untrue.

7. Nurse C was present almost throughout and made no effort to discharge any of the requirements of her role or show a duty of care towards Mr Morgan. The clinical reviewer reported her to the Nursing and Midwifery Council during our investigation.

8. We deal with some of the failings in more detail below and make the following overarching recommendations:

   The Prison Group Director and the NHS England Regional Director responsible for commissioning healthcare services at Chelmsford should each write to the Ombudsman setting out what action they have taken in response to this report.

   The Governor should investigate whether any of the staff present in reception on 22 August, who witnessed Mr Morgan in the holding cell and who are still employed at Chelmsford, should face disciplinary charges.

The Governor should arrange for this report to be shared with Officer A and Officer (now CM) B by the Governors of their current prisons.

The Prison Group Director (PGD) and Governor should review the culture among prison officers and managers. In particular they should put measures in place to ensure that staff treat the prisoners in their care with dignity and respect, and to foster a culture in which staff at all grades feel able to raise concerns if they feel something is not right.

The Governor should apologise personally to Mr Morgan's next of kin for the failure of her staff to exercise their duty of care to him while he was in their custody.

An SO

195. The dismissive and cynical response of some staff to Mr Morgan's self-reported overdose was exemplified by an SO. The SO was in charge of G wing on 22 August, and it was his responsibility to ensure that Mr Morgan's overdose was properly investigated. We consider that he should have ensured ACCT procedures were started and kept Mr Morgan on the wing until a nurse had assessed him.

196. Even if he had allowed Mr Morgan to be taken to reception without having seen a nurse, he should have ensured that the information about the overdose was properly handed over. We are very concerned that although he accompanied Mr Morgan to reception and removed his handcuffs there, he did not ensure this happened. When Officer I rang him from reception to tell him Mr Morgan was drunk on hooch, this should have prompted him to make the connection between Mr Morgan's reported state in reception and his claim to have taken medication and to have ensured that staff in reception knew about the alleged overdose.

197. The blister packs of baclofen and citalopram that Mr Morgan was known to have in his possession were not found in his cell after his death. On the balance of evidence, we consider that the SO was given empty blister packs by Officer A and subsequently, at the insistence of Officer B, looked up the effects an overdose of the medication contained in them. He failed to act on this information and his failure to do so had a direct impact on subsequent events.

198. The SO left the Prison Service in February 2020. We can therefore make no recommendation.

A CM

199. A CM was in charge of the operational management of the prison on 22 August. We recognise that he did not receive accurate information from reception staff about Mr Morgan's claimed overdose. He was told that Mr Morgan had drunk hooch and had been placed in the holding cell to sober up. The CM had numerous calls on his time and was in and out of reception that day. We accept that all of this put him at a disadvantage when assessing and responding to the situation.

200. He was also not helped by Nurse C's continued presence, which provided false reassurance that Mr Morgan's wellbeing was being monitored by a healthcare professional.

201. However, regardless of the mitigating circumstances, the CM had overall responsibility for managing Mr Morgan on 22 August. We do not consider that it needed clinical expertise to see that Mr Morgan was not 'sobering up' as one might expect if he had drunk alcohol and that he was in significant distress.

202. The CM said he asked staff to start ACCT monitoring procedures and did not know they had not been started. However, he did not ask to see the ACCT or to make an entry on the ongoing record after his interactions with Mr Morgan, as he should have done. We consider that he had the seniority and opportunity to have taken matters into his own hands and requested a more senior medical opinion or to have asked the duty governor for advice. We are not satisfied that he showed the judgement and leadership expected of a CM that day

The failure to open an ACCT

9. Prison Service Instruction (PSI) 64/2011, which deals with risk assessment and Prison Service suicide and self-harm monitoring procedures (known as ACCT) says:

> "Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form."

10. We consider that every member of staff who was either aware, directly or indirectly, of Mr Morgan's claim that he had taken an overdose or who witnessed the distressing scenes in the holding cell on 22 August should have questioned whether ACCT monitoring had started and completed a concern and keep safe form.

11. We cannot say that it would have guaranteed a different outcome for Mr Morgan if ACCT procedures had been started. He was in effect on constant watch in the holding cell and that did not result in anyone ensuring his safety.

12. However, the key failure was not initiating ACCT procedures on G Wing when Mr Morgan said he had taken an overdose. If ACCT procedures had been initiated on G wing, it would have provided an audit trail of his claimed overdose and might have empowered discipline staff, especially the CM, to take charge rather than defer to Nurse C. It would also have increased the chances that he would have remained on G wing to be properly assessed by a nurse. A proper assessment should have included an investigation of what medication Mr Morgan had access to and what the consequences of overdose were.

13. G wing officers knew Mr Morgan's usual presentation, they were aware of his stated overdose and it was noted in the wing observation book. Therefore, if Mr Morgan had become ill while still on G wing it is likely to have prompted more urgent investigation. By the time Mr Morgan reached reception, the reason for needing a nurse to assess him had become muddled and Mr Morgan had lost the ability to communicate what he had taken.

14. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all the officers and healthcare staff present during the events of 22 August and still in post, receive ACCT refresher training as a matter of urgency.

Clinical care

203. The clinical review was undertaken, at our request, by a panel of clinicians. The reviewers concluded that Mr Morgan's care up to 22 August was broadly equivalent to that which he could have expected in the community, but the care he received on 22 August fell below the expected standard.

204. An expert in emergency medicine calculated that it was likely that Mr Morgan had had a toxic dose of both baclofen and citalopram in his possession on the morning of 22 August, and she concluded that the most likely cause of the signs Mr Morgan exhibited in the holding cell was an overdose of his prescribed medication. She said that if expert advice been taken, it is likely that it would have been to admit Mr Morgan to the local emergency department for further assessment. We cannot say if the outcome for Mr Morgan would have been different if he had been taken to hospital earlier, but it may have been.

Prescription of Baclofen in possession

15. The clinical reviewers concluded that:

- The continuation of Mr Morgan's prescription for baclofen on his first night in Chelmsford, was inappropriate because there was no formal review of his community records.
- The decision to allow baclofen in Mr Morgan's possession was inappropriate because there was no apparent consideration of the risks associated with it.

16. We repeat the following recommendation from the clinical review:

The Head of Healthcare should ensure that policies and procedures are in place to ensure that prescribers and pharmacy work collaboratively to highlight high-risk medications, such as baclofen, which are unsuitable for in-possession administration.

Assessment by the nursing team

17. The clinical reviewers identified a number of failings in nursing care on 22 August including, but not limited to:

- Mr Morgan's self-reported overdose was not assessed.
- There should have been a full enquiry into the type and quantity of the medications that Mr Morgan had access to, and further advice should have been sought from the National Poisons Information Service or online Toxbase service.
- Initial baseline observations of Mr Morgan's vital signs should have been taken as soon as it was obvious that he was not well on arrival at reception.

- Objective evidence should have been obtained regularly in order to assess whether Mr Morgan was improving or deteriorating.
- There is no evidence that Mr Morgan was too aggressive to allow baseline observations to be taken. If he had been, nursing staff could have asked prison staff to restrain him while they took his observations or could have sent him to hospital for assessment.
- There was no effective evaluation of Mr Morgan's condition and no record of a plan for his care.

18. We repeat the following recommendations from the clinical review:

The Head of Healthcare should immediately ensure that all healthcare staff are aware of and have access to the National Poisons Information Service, either by telephone or via the online Toxbase service, and its use should be mandated in all cases of suspected overdose or poisoning.

The Head of Healthcare should ensure that evidence-based tools are in place for the immediate recognition of deteriorating health and that this is supported by an ongoing competency-based training programme.

The Head of Healthcare should ensure that all cases of suspected poisoning from alcohol and/or drugs are assessed according to National Guidance, such as NEWS2, thereby facilitating standardised assessment and best practice decision-making in regard to ongoing observation, escalation to a senior clinician within the prison or for external specialist advice.

The Head of Healthcare should immediately ensure that staff comply with NMC regulations about making contemporaneous clinical records and individual accountability for record-keeping. The quality of the medical record should be subject to regular clinical audit against national documentation standards as part of the clinical audit plan.

Nurse C

19. At interviews for the investigations that took place after Mr Morgan's death, Nurse C said that she did not know that Mr Morgan had self-reported an overdose. However, between 10.50am and 10.59am, Officer F rang reception and asked Officer H to request a nurse to examine Mr Morgan in reception specifically because he had taken an overdose.

20. Officer H gave evidence to the prison investigator that she personally informed Nurse C in reception that Mr Morgan said he had taken an overdose. There is also evidence that some reception staff were aware of the alleged overdose, including Officer I, who asked Mr Morgan if he was saying he had taken an illicit substance.

21. We consider on the balance of probabilities that Nurse C would have known about the alleged overdose.

22. Moreover, we consider that, regardless of whether Nurse C understood that she was required in reception to examine Mr Morgan following a use of force or an overdose, she should have assessed Mr Morgan. If the former, she was required to

check Mr Morgan for injuries and complete the medical section of the use of force paperwork. If the latter, she needed to assess him. She did not do so. She simply agreed with Officer I's assumption that Mr Morgan had drunk hooch and then watched Mr Morgan deteriorate to the point of unconsciousness over the next two hours. The issue of whether Mr Morgan had drunk hooch or taken a psychoactive substance should have become unimportant as soon as he became obviously unwell and did not 'sober up' or improve.

23. The clinical reviewers concluded that:

- There were opportunities for Nurse C to have taken Mr Morgan's baseline observations in reception and the holding cell.
- There was no evidence that Nurse C attempted to protect Mr Morgan's dignity or make any effort to safeguard him from further injury.
- If Nurse C felt that she was unable to protect Mr Morgan or that it was unsafe to treat him, then she should have arranged a transfer to the nearest emergency department.
- Nurse C did not make a contemporaneous record documenting her care plan and decision-making in regard to Mr Morgan's presentation and deterioration.
- Viewing the CCTV footage, you would think that the second HCA, and not Nurse C, was the registered nurse, as she appeared in control of the situation and displayed a calming and compassionate manner.
- Nurse C's poor clinical assessment, disregard for Mr Morgan's dignity and failure to prevent Mr Morgan from sustaining further injury contravened the standards for practice and behaviour of nurses and requires further investigation.

24. The clinical reviewer referred Nurse C to the Nursing and Midwifery Council in November 2019. As she has since been dismissed from Chelmsford, we make no further recommendations.

Nurse A

25. There were clearly competing priorities for Nurse A (and Nurse B, Hotel 5) that morning. A general alarm on C wing was followed by an injury on the football pitch. There may have been other calls on Nurse A's time that we are unaware of. However, Officer D's contemporaneous entry in the wing observation book indicated that he reported that Mr Morgan had taken an overdose, not that he might have, or that some officers were dubious about his claim.

26. We consider that Nurse A should have prioritised investigating whether Mr Morgan had the means to take an overdose by consulting his medical record and taking appropriate advice as necessary, before attending G wing to assess him. Instead, she appears to have prioritised the football injury.

27. We make no recommendation because Nurse A no longer works at Chelmsford.

Healthcare culture at Chelmsford

28. The clinical reviewers concluded that some of the behaviours exhibited by healthcare staff indicated that an exploration of the culture at Chelmsford may be valuable. Several discipline staff told the investigator that nurses did not respond to requests to attend wings when asked and appeared to have a poor attitude to prisoners. One member of healthcare staff referred to bullying by the Healthcare Manager in post at the time of Mr Morgan's death.

29. This is by no means the first investigation in Chelmsford in which we have found serious fault with healthcare staff. We note that HMIP found in April 2019 that the new healthcare providers had begun to address many of the concerns identified in their 2018 inspection. Nevertheless, we are very concerned about the healthcare culture revealed in our investigation and we make the following recommendations:

The current healthcare providers and the NHS Regional Director responsible for commissioning healthcare services at Chelmsford should review the culture and working practices of healthcare managers and staff. In particular they should consider how staff perceive their role in the healthcare and safeguarding of the prisoners in their care.

The Head of Healthcare should ensure that all nurses currently working at Chelmsford are provided with a copy of this report and clinical review and that a reflective discussion, facilitated by a nurse, should be arranged in order to ensure that the recommendations arising from this report and the learning implications for the professional conduct of nurses are discussed as a team.

This report should be shared with Essex Partnership University Trust, who were responsible for providing the healthcare services at the time of Mr Morgan's death.

Use of force

30. The prison's internal investigation concluded that the use of force on Mr Morgan was inappropriate and disproportionate. Mr Morgan was not being aggressive and appeared to be about to put his shirt back on. A number of procedural failures followed.

31. We agree with the conclusions of the prison investigation. We note that Officer F accepted a disciplinary charge that he had used unnecessary force on Mr Morgan and received a final written warning. We consider that, in isolation, this matter has been dealt with appropriately and we make no recommendation. However, the fact that it happened at all lends weight to our overall concerns about the culture at Chelmsford and the treatment of prisoners there at that time.

Contacting the prison

32. Chelmsford's website says that if family or friends have any concerns about a prisoner they should "feel free" to contact the safer custody team helpline, a confidential answerphone. It says that messages are checked daily but that if the

concerns are urgent, you should speak to staff in the visitor's centre or call the main switchboard.

33. Mr Morgan's mother called the main switchboard twice on the morning of 22 August and says she told a senior officer on G Wing that Mr Morgan said he had taken an overdose. Nothing appears to have happened as a result.

34. We are not satisfied that Chelmsford responded appropriately to Mr Morgan's mother's telephone calls. She received reassurance from two different members of staff that her concerns would be followed up. We have not seen any evidence that they were. Calls to the prison's main switchboard are not recorded, and we have not been able to identify who Mr Morgan's mother spoke to. This was another missed opportunity to avert what happened. We make the following recommendation:

The Governor should ensure that all calls to the main switchboard that indicate a prisoner might be at risk of harm are taken seriously. The subject of the call and the person who dealt with it should be recorded in the prisoner's NOMIS record and the wing observation book.

Restraints

35. 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. 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.

36. When Mr Morgan was taken to hospital, he was handcuffed to an officer by escort chain until it was removed when he was taken for a scan over an hour later. We are concerned that restraints were used on Mr Morgan even for this short time. He was losing consciousness in the holding cell and on arrival at hospital was assessed as being in the deepest level of coma. It is difficult to see how Mr Morgan was capable of escaping from an escort of two officers.

The Governor 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.

Informing the next of kin

37. 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". This is reflected in PSI 64/2011, which requires prisons to contact the next of kin of prisoners who are seriously ill.

38. Chelmsford's local policy says that next of kin will be informed by the Security/Duty Manager within 48 hours of a prisoner going to hospital, and that it will be made clear to the next of kin that visitors are not permitted until 72 hours after this unless their condition is critical. The local policy says this gives security time to collate the approved visitors list and check any public protection concerns.

39. We are concerned that the local policy is out of step with the requirements of Prison Rule 22. We consider that it risks families missing crucial time with seriously ill relatives. We are also concerned in Mr Morgan's case that it was the hospital rather than the prison that contacted Mr Morgan's next of kin.

40. We make the following recommendation:

The Governor should ensure that:

- **when a prisoner is in hospital in a critical condition, their next of kin is informed at once; and**
- **Chelmsford's local policy is revised to reflect Prison Rule 22.**

Inquest

The inquest heard on 5 May 2022, concluded that Mr Morgan intentionally took an overdose of his medication to dissuade staff from transferring him to another prison. He had not intended for the overdose to end his life, but in fear for his safety took this course of action. Mr Morgan died as a result of multiple organ failure.

Failings recorded as contributing to Mr Morgan's death included:

- he was wrongly assessed as being suitable to keep his medication in his cell, which probably did contribute to the cause of his death;

- despite Mr Morgan informing staff that he had taken an overdose of his medication, prison and healthcare staff failed to:

    - ensure that a clinician assessed him in his cell; and
    - start ACCT procedures.

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