

**Prisons &
Probation**

Ombudsman
Independent Investigations

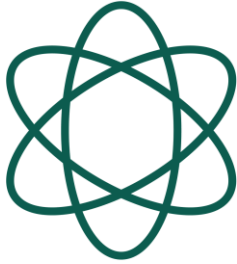
Independent investigation into the death of Mr Kevin Morgan, a prisoner at HMP Liverpool, on 31 January 2023

A report by the Prisons and Probation Ombudsman



Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

OGL

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Summary

1. 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.
2. If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. Mr Kevin Morgan died from advanced oesophageal cancer (cancer of the gullet or food pipe) at HMP Liverpool. He was 61 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Morgan received at Liverpool and HMP Thorn Cross was predominantly equivalent to that which he could have expected to receive in the community.
5. However, the clinical reviewer was concerned that, at the time of Mr Morgan's death, there were no healthcare staff on duty at Liverpool able to verify that he had died and so staff called an ambulance. This is not the most appropriate use of an ambulance resource.
6. The clinical reviewer has made a recommendation which although not directly related to Mr Morgan's death the Head of Healthcare will need to address.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Morgan's clinical care at Thorn Cross and Liverpool.
8. The PPO investigator investigated the non-clinical issues relating to Mr Morgan's care.
9. The PPO family liaison officer wrote to Mr Morgan's brother to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Morgan's brother was concerned that Mr Morgan was transferred to Liverpool four days before he died. He thought that Mr Morgan had been locked in his cell when he died and questioned how staff could have observed Mr Morgan breathing through the observation panel in the cell door. Mr Morgan's brother did not understand why, once at Liverpool, the family was told they could only have limited visits to see Mr Morgan when before his transfer they were told that they could have as many compassionate visits as they were able. We have addressed his concerns in our report.
10. We shared the initial report with the Prison Service. There were no factual inaccuracies.
11. We shared the initial report with Mr Morgan's brother. He did not respond.

Previous deaths at HMP Liverpool

12. In the three years before Mr Morgan's death, ten prisoners died from natural causes at Liverpool, three of which were as a result of COVID-19. There was also a self-inflicted death and an unclassified death in the same period. Two prisoners have died from natural causes at Liverpool since Mr Morgan's death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

13. On 4 May 2018, Mr Kevin Morgan was remanded to HMP Liverpool. On 24 October 2019, he was convicted of conspiracy to supply controlled drugs and a firearm offence and sent to prison for 15 years and six months.
14. On 29 May 2020, Mr Morgan saw a GP at Liverpool, complaining of difficulty in swallowing for three weeks. The GP made an urgent referral to the Gastroenterology Team at Chorley and Ribble District General Hospital under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.
15. On 27 August, Mr Morgan went to the hospital for an oesophago-gastro-duodenoscopy (OGD - a camera which looks at the upper parts of the digestive system) which showed that Mr Morgan had a tumour in the oesophagus (gullet or food pipe). This was confirmed by a PET CT scan on 8 September.
16. On 9 October, a consultant clinical oncologist reviewed Mr Morgan and said that given the extent of the cancer a cure might not be possible but that he could have chemotherapy.
17. On 29 November, Mr Morgan was transferred to HMP Garth.
18. On 15 January 2021, after four cycles of chemotherapy, a consultant and upper gastrointestinal surgeon told Mr Morgan that the tumour was incurable by surgery.
19. On 15 February, Mr Morgan went to hospital where he was fitted with an oesophageal stent (a small tube put into the food pipe to keep the food pipe open).
20. On 23 March, the consultant clinical oncologist reviewed Mr Morgan and confirmed that surgery was no longer an option and that he would now be offered palliative care. He told Mr Morgan that he had a life expectancy of between six months and one year. Mr Morgan had a course of chemotherapy.
21. On 28 May, Mr Morgan was transferred back to Liverpool.
22. On 7 January 2022, Mr Morgan went to hospital where hospital staff replaced the stent. A consultant medical oncologist told Mr Morgan that he had a prognosis of between three and six months and said that he could have a further course of chemotherapy, which he completed.
23. On 23 February, Mr Morgan was transferred to HMP Thorn Cross, an open prison where Mr Morgan was able to drive himself to appointments.
24. On 17 May, the consultant medical oncologist reviewed Mr Morgan and said that, despite three cycles of chemotherapy, the cancer had worsened. He referred Mr Morgan to a consultant in clinical oncology for consideration of palliative radiotherapy.
25. The consultant in clinical oncology reviewed Mr Morgan and agreed that he could have radiotherapy to the lower oesophagus and upper stomach. In June 2022, Mr Morgan completed a course of palliative radiotherapy.

26. In July, the Secretary of State for Justice refused an application for Mr Morgan to be released early from his prison sentence on compassionate grounds.
27. On 27 September, the consultant medical oncologist had a telephone consultation with Mr Morgan. He told Mr Morgan that the cancer had spread to the lymph nodes (small glands which are located in many parts of the body, including the neck, armpit, chest, abdomen and groin) and that he had peritoneal disease (the spread of cancer into the lining of the abdominal cavity).
28. In November 2022, Mr Morgan started a further course of palliative chemotherapy.
29. On 16 January 2023, Mr Morgan went to hospital because he was short of breath and had difficulty swallowing. Hospital staff carried out a CT pulmonary angiogram (CTPA - a special test used primarily to look for the presence of pulmonary embolism (blood clots in the lung)) which showed that the cancer had progressed further. Hospital staff decided that he should have no further active treatment. He was admitted to hospital.
30. On 20 January, the consultant medical oncologist telephoned the healthcare team at Thorn Cross and told them that the cancer was progressing and that treatment options were running out. He said that Mr Morgan's prognosis could be very short, probably weeks to months.
31. In January 2023, the Secretary of State rejected another application for Mr Morgan to be released on compassionate grounds.
32. On 24 January Mr Morgan went back to Thorn Cross.
33. On 25 January, healthcare staff sent Mr Morgan back to hospital because they thought that he may have sepsis (a severe infection). Hospital staff found that Mr Morgan had no acute symptoms, and that they were happy to discharge him. Healthcare staff at Thorn Cross said that because they did not have healthcare provision after 5.00pm, that they were unable to safely meet Mr Morgan's increasing care needs. Healthcare staff had planned that Mr Morgan move to a hospice in Warrington but, at that time, a bed was not available. Mr Morgan was transferred to Liverpool and the 24-hour healthcare facility.
34. On 25 January, healthcare staff created a palliative care plan.
35. On 26 January, healthcare staff held a multi-disciplinary team meeting. A nurse said that, at the meeting, they decided that an open-door policy (when a prisoner requires constant supervision in order to receive concentrated attention designed to reduce the risk of their health deteriorating) was not necessary at that time.
36. On the night of 30 January, a nurse and a Healthcare Assistant (HCA) cared for Mr Morgan. The nurse told the clinical reviewer that she saw Mr Morgan several times during the night.
37. At 5.05am on 31 January, she saw Mr Morgan because he had an increased heart rate. She gave Mr Morgan oxygen, but she was unable to obtain a blood oxygen reading.

38. The HCA told the clinical reviewer that Mr Morgan had an unsettled night. At 7.25am, she checked on him and he was sat upright in bed, breathing, although she said that his colour had changed. She asked an officer to open the cell door and at 7.30am, she assessed Mr Morgan and found that he had died. A nurse requested that an ambulance attend so that a paramedic could confirm that Mr Morgan had died. At 8.15am, ambulance paramedics confirmed that Mr Morgan had died.
39. There was no post-mortem examination. The lead GP at Liverpool said that Mr Morgan died from advanced oesophageal cancer.

Findings

40. The clinical reviewer concluded that the clinical care that Mr Morgan received at Thorn Cross and Liverpool was predominantly equivalent to that which he could have expected to receive in the community.
41. The clinical reviewer has made another recommendation which although not directly related to Mr Morgan's death the Head of Healthcare will need to address.

Governor to note

42. The clinical reviewer found that there were no healthcare staff on duty at Liverpool to verify that Mr Morgan had died was concerned that using an ambulance paramedic to confirm that he had died was not the best use of their resource.
43. The Head of Healthcare told the clinical reviewer that no nurses at Liverpool are trained to certify death. She explained that if a GP is not at the prison, it is current practice for staff to call an ambulance so that a paramedic can verify death, as this was generally quicker than waiting for a GP to attend. She told the investigator that there is no requirement for nurses to be trained to verify death. At the height of the COVID-19 pandemic, she offered the training to the nursing staff at Liverpool, but no one requested the training.
44. The clinical reviewer made the observation that it is not a good use of an ambulance to be called to a prison solely to pronounce life extinct of a prisoner. While there is undeniably a gap in the healthcare service at Liverpool that would address this specific set of circumstances, we recognise that it might not be desirable, or indeed possible, to train healthcare staff to address that gap. The Governor may wish to consider alternatives to the use of an ambulance. Merseyside Police will have in place an agreement with a healthcare provider to meet the health needs of prisoners in police custody. The Governor may wish to explore the possibility of approaching that provider and determining their willingness and capability to provide a life pronounced extinct out of hours service to the prison.
45. Mr Morgan's family were concerned that they were not able to visit him as often as they wanted to once he transferred back to Liverpool. The Head of Safer Custody said that the family had been given incorrect information (we do not know who by) that they could have unlimited visits to Mr Morgan at Liverpool. The Governor will want to consider how to ensure that the families of seriously unwell prisoners are clear about the visits policy to avoid confusion and upset.

Inquest

46. The inquest, heard on 9 February 2023, concluded that Mr Morgan died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman

September 2023

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