Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Milne a prisoner at HMP Doncaster on 7 September 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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 Edward Milne died on 7 September of a heart attack while in hospital suffering with terminal liver failure, while a prisoner at HMP Doncaster. He was 82 years old. I offer my condolences to Mr Milne's family and friends.

Hospital doctors diagnosed Mr Milne with terminal liver failure in August 2016 and prison healthcare staff implemented care plans and saw him frequently after this date. However, the clinical reviewer found that there were significant features of Mr Milne's care that were inconsistent and, therefore, it was not equivalent to that he could have expected to receive in the community. In particular, staff made some care decisions without fully understanding Mr Milne's disease progression and, in his last weeks Mr Milne was in considerable pain and distress, which the prison did not manage effectively.

I am also concerned this dying man was kept in a cell with a broken window for some time, meaning he was unduly cold. This was unacceptable and preventable.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2017**

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Summary

Events

1. In November 2015, Mr Edward Milne was sentenced to 14 years in prison for sexual offences and was sent to HMP Doncaster. Mr Milne was 82 years old and had a number of chronic health conditions, including heart disease, high blood pressure, angina and limited mobility. Healthcare staff managed his conditions with medication and reviewed him frequently.

2. In January 2016, after Mr Milne suffered a suspected angina attack, he was admitted to hospital and discharged back to prison the same day.

3. Over the next seven months, healthcare staff saw Mr Milne frequently, treating him for a chest infection, hypertension and the symptoms of kidney failure, as well as his ongoing heart disease. From June, he began to complain of an itchy rash, which although treated with cream, continued to cause him discomfort.

4. On 15 August, a doctor was concerned about Mr Milne's clinical observations and ongoing rash so sent him to hospital for investigations. Mr Milne discharged himself the same day and returned to Doncaster where he told a nurse that hospital doctors had diagnosed terminal liver failure. Staff created a nursing and social care plan, and Mr Milne said he would not go to hospital again. He also refused to be admitted to the prison's social care unit.

5. Mr Milne continued to deteriorate and healthcare staff implemented a care plan, which included frequent observations, care and support. Mr Milne began vomiting and suffered abdominal pain. Despite anti-sickness medication and some pain relief, Mr Milne continued to vomit and was in considerable pain. On 26 August, a doctor sent Mr Milne to hospital for a review and management of his pain. Mr Milne discharged himself four days later and returned to the prison. By 2 September, Mr Milne was very distressed and in pain. He agreed to be re-admitted to hospital and hospital staff implemented an end of life care plan.

6. On 7 September, the officer escorting Mr Milne noticed he was not breathing and called a nurse. A hospital clinician confirmed that Mr Milne had died.

Findings

7. The clinical reviewer found that the care Mr Milne received at Doncaster was not equivalent to that he could have expected to receive in the community. Some aspects of his care were good; healthcare staff monitored him frequently and he was well assisted with his social and personal care. However, the clinical reviewer considered there were significant features of Mr Milne's care that were inconsistent. Healthcare staff made some care decisions without fully understanding his disease progression, and there was no evidence that Mr Milne's chronic conditions were managed in line with national guidelines. The clinical reviewer was also concerned that healthcare staff did not manage Mr Milne's pain or vomiting appropriately, which caused him considerable distress.

8. We are also concerned that healthcare staff missed various opportunities to review and explain the use of medication to treat Mr Milne's cardiac conditions.

However, we agree with the clinical reviewer that given Mr Milne's numerous, significant cardiac risk factors, failing to review his medication was unlikely to have affected the outcome for Mr Milne.

9. We are concerned that a broken window in Mr Milne's cell was not repaired for some time, meaning that he was cold. This was unacceptable and preventable.

Recommendations

- The Head of Healthcare should ensure that clinicians consider a prisoner's overall symptoms in a holistic manner, so that any indicators of disease progression are quickly acted upon.
- The Head of Healthcare should ensure that there is appropriate, documented follow-up with a hospital when further information is required after a prisoner is discharged, particularly in relation to a serious diagnosis and treatment.
- The Head of Healthcare should ensure that prisoners with chronic conditions have detailed care plans, planned interventions and monitoring, and regular reviews of medication in line with National Institute for Health and Care Excellence (NICE) guidelines.
- The Head of Healthcare should ensure that there is an effective process in place to obtain essential palliative care medications without delay when required.
- The Governor should ensure that urgent repairs are carried out without delay, particularly when this impacts on the wellbeing of a prisoner.

The Investigation Process

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

11. The investigator obtained copies of relevant extracts from Mr Milne's prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Milne's clinical care at the prison.

13. We informed HM Coroner for South Yorkshire East of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

14. One of the Ombudsman's managers wrote to Mr Milne's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

15. The investigation has assessed the main issues involved in Mr Milne's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

16. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Doncaster

17. HMP Doncaster is a local prison, operated by Serco, which holds up to 1,145 remanded and sentenced men and young male offenders. Nottingham Healthcare NHS Foundation Trust provides physical and mental health services, and substance misuse services

HM Inspectorate of Prisons

18. The most recent inspection of HMP Doncaster was in October 2015. The Inspectorate found that prisoners were negative about their experience of healthcare and there was evidence of deterioration in provision, mainly owing to staff shortages. They found that prisoners had reasonable access to an appropriate range of primary care services, though the management of prisoners with long-term conditions was underdeveloped. Some prisoners had experienced delays in receiving their medication and too many external hospital appointments were cancelled because of a lack of escort staff.

19. Inspectors also noted that cell conditions throughout the prison were very poor, as they were dirty and many had missing windows.

Independent Monitoring Board

20. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year to September 2015, the IMB noted that a shortage of nursing staff meant doctors were taking on nursing duties which had caused delays with appointments to see a doctor. The Board commented that the increase in older prisoners meant there were more complex and chronic health problems to manage. More prisoners were having outpatient appointments and the Board acknowledged the challenge of providing escorts for such visits.

Previous deaths at HMP Doncaster

21. Mr Milne was the fourth prisoner to die from natural causes at Doncaster since January 2015. There has been one subsequent death. We have made a previous recommendation about the need to follow national guidelines for the management of chronic medical conditions.

Findings

The diagnosis of Mr Milne's terminal illness and informing him of his condition

22. On 30 November 2015, Mr Edward Milne received a 14 year prison sentence for sexual offences and was sent to HMP Doncaster.

23. Mr Milne had a medical history of ischemic heart disease, high blood pressure, angina, hearing and memory loss, and limited mobility. He was also a very heavy smoker and continued to smoke, despite advice and treatment to help him give up. He lived in a cell on a wing for vulnerable prisoners with easy access to healthcare facilities.

24. On 8 January 2016, Mr Milne suffered a suspected angina attack and was taken to hospital. Hospital doctors examined him, diagnosed stable angina and discharged him back to Doncaster on the same day.

25. On 4 February, Mr Milne attended an older person's health review and a nurse recorded his ten year cardiovascular risk score at 54.92% (a high risk). Mr Milne declined any assistance to give up smoking. Six days later, Mr Milne asked healthcare staff to replace his glyceryl trinitrate spray (GTN spray – used to treat angina), though there was no record that they discussed his usage of the spray or the circumstances when he needed to use it.

26. On 15 February, a prison GP examined Mr Milne. The GP diagnosed a chest infection and prescribed an antibiotic. Again, there was no record that the GP discussed Mr Milne's usage of GTN spray during the appointment.

27. Four days later, the prison GP referred Mr Milne for a chest X-ray which showed some enlargement of the heart but no sign of heart failure. It also showed that Mr Milne's lungs were clear.

28. On 1 April, a nurse saw Mr Milne after he had fallen in his cell. She noted no obvious injuries and recorded his pulse at 63 beats per minute (bpm) (normal) and his blood pressure at 160/80 (high). Mr Milne said he had woken with chest pains that morning. She advised him to rest and arranged for him to have antacid medication and a falls assessment.

29. Three days later, a prison GP reviewed Mr Milne. A urine test indicated abnormal protein levels (which can be an indicator of renal damage and is associated with stroke and heart disease). The doctor prescribed medication for high blood pressure and requested a repeat urine test in two weeks. A blood test was also abnormal and an appointment was made for Mr Milne to attend to the cardiovascular and hypertension clinic on 29 April (which he attended).

30. On 25 June, a nurse saw Mr Milne, who was complaining of an itchy rash and swollen feet (both of which can be a sign of multi-organ failure). The nurse made an appointment for Mr Milne to see a GP. A prison GP saw Mr Milne two days later and prescribed a cream to treat the rash.

31. On 15 and 18 July, nurses saw Mr Milne, who was distressed by being constantly itchy. They prescribed further medicated creams. However, on 7 August, a nurse saw Mr Milne, who said he was upset and fed up with the ongoing rash.

She noted several large blistered areas on his arms and legs. She arranged for Mr Milne to see a GP.

32. On 10 August, a health professional saw Mr Milne who said he was tired and fed up with the ongoing rash. She noted his pulse at 110bpm, blood pressure at 140/90 and oxygen saturation at 97%, all outside normal ranges. She noted a GP appointment had been booked.

33. Five days later, a prison GP saw Mr Milne and was concerned about his combined symptoms, including the constant rash and itching. He sent him to hospital, where he was admitted for observation and tests. Mr Milne discharged himself later that day.

34. On 16 August, a nurse saw Mr Milne, who said that hospital doctors had told him he had terminal liver failure. She noted that the hospital said they would be prepared to re-admit Mr Milne, but he refused hospital or healthcare admission saying he preferred to stay on the wing with his friends. The discharge letter contained no summary and no diagnosis or findings. Healthcare staff contacted the laboratory directly to obtain the blood test results taken at the hospital. These showed indicators of severe liver disease, damage or failure. There is no record that anyone contacted the hospital for further information.

35. The clinical reviewer noted that, although Mr Milne was terminally ill due to liver and probable kidney failure, this was not formally documented in his prison medical record. Nor was there any documented prognosis from a treating physician.

36. The clinical reviewer also noted that, from June 2016, Mr Milne complained of an itchy rash, which with his deteriorating kidney function tests should have indicated to clinicians the risk of multi-organ failure. This conclusion was not reached until mid-August when a prison GP sent him to hospital. We are concerned that clinicians did not look at Mr Milne's overall symptoms sufficiently holistically. Had they done so, they may have sent him to hospital for earlier investigations, though we recognise that the clinical reviewer said this would have been unlikely to have affected the outcome for Mr Milne.

37. The clinical reviewer also noted that healthcare staff missed various opportunities to review and monitor Mr Milne's usage of GTN spray or clarify the circumstances in which he used it. These would have been a useful indication of how often Mr Milne was experiencing chest pain and angina. By failing to review his medication, this aspect of his cardiac care was not equivalent to that he could have expected to receive in the community, although his numerous, significant cardiac risk factors meant that this failure was unlikely to have affected the outcome for Mr Milne. We make the following recommendations:

The Head of Healthcare should ensure that clinicians consider a prisoner's overall symptoms in a holistic manner, so that any indicators of disease progression are quickly acted upon.

The Head of Healthcare should ensure that there is appropriate, documented follow-up with a hospital when further information is required

after a prisoner is discharged, particularly in relation to a serious diagnosis and treatment.

Mr Milne's clinical care

38. On 17 August, the healthcare team held a multi-disciplinary meeting to discuss Mr Milne's ongoing care. Staff spoke to Mr Milne about returning to hospital but he refused and signed a disclaimer to this effect. Mr Milne also refused to be admitted to the prison's social care unit because he could not smoke there. The healthcare team created a care plan with a nurse as Mr Milne's named nurse. The plan arranged for Mr Milne to receive six hourly observations alongside a social care package. The plan also recorded that he should be offered hospital admission if his condition required it.

39. Between 17 and 26 August, records show frequent observation, care treatment and support for Mr Milne.

40. On 19 August, a prison GP and Mr Milne discussed his wishes regarding resuscitation if his heart or breathing stopped. Mr Milne said he did not want to be resuscitated and the GP recorded this. The GP also assessed Mr Milne's mental capacity and was satisfied Mr Milne was able to make decisions about his healthcare.

41. On 20 August, healthcare staff attended to Mr Milne after wing staff found that he had vomited. A nurse found that Mr Milne's pulse was irregular so gave him anti-sickness medication and made him comfortable.

42. On 21 August, a nurse implemented an end of life nursing plan and noted Mr Milne was prescribed a fluid dietary food supplement to support his nutrition. He was also provided with a new mattress to make him more comfortable.

43. Mr Milne continued to deteriorate. Nursing staff saw him regularly to provide social and nursing care. He had repeated bouts of sickness with some abdominal pain. Doctors prescribed paracetamol, both in tablet and liquid form. Records show that Mr Milne became increasingly distressed and said no one cared for him. On 25 August, after continued vomiting and abdominal pain, healthcare staff suggested Mr Milne go to hospital, but he declined.

44. The following day, blood results showed deteriorating liver and renal function so a prison GP referred Mr Milne to hospital for a review and management of his pain. Mr Milne remained in hospital and clinicians investigated his vomiting and abdominal pain, which doctors suspected was caused by a gastric ulcer. However, on 30 August, Mr Milne discharged himself against medical advice and returned to Doncaster.

45. During the evening of 31 August, a nurse noted that Mr Milne was "screaming with pain" so she prescribed him codeine (stronger pain relief).

46. Mr Milne remained in considerable pain and, around 6.00pm on 2 September, he agreed to go back to hospital. A non-emergency ambulance was requested at 6.30pm, although it had not arrived by 11.00pm so the control room requested an emergency ambulance. Paramedics took Mr Milne to hospital and doctors diagnosed him with multi-organ failure. Three days later, the hospital

implemented an end of life care pathway. Mr Milne's condition continued to deteriorate and a doctor confirmed that he had died at 10.30am on 7 September.

47. Although Mr Milne was suffering multi-organ failure, the coroner confirmed that he died from a heart attack caused by ongoing heart disease.

48. The clinical reviewer noted that there were good aspects of Mr Milne's care. Healthcare staff saw him frequently and monitored his condition after he discharged from hospital on 15 August. Healthcare staff assisted Mr Milne with his social and personal care.

49. However, the clinical reviewer said there were significant features of Mr Milne's care that were inconsistent so his care was not equivalent to that he could have expected to receive in the community. She considered that healthcare staff made some care decisions without fully understanding his disease progression. There was also insufficient information in Mr Milne's prison medical record about his serious conditions or whether any information for appropriate specialists had been sought. There was little evidence that healthcare staff adhered to the relevant National Institute for Care and Health Excellence (NICE) guidelines in relation to Mr Milne's chronic conditions of kidney disease and hypertension.

50. The clinical reviewer also considered that healthcare staff did not manage Mr Milne's pain or vomiting appropriately. Although his medical record said that anti-sickness medication should be given regularly and preventatively, there was no evidence to show this actually happened. Additionally, Mr Milne's pain relief was poorly managed, as at times staff noted Mr Milne screaming in pain. The clinical reviewer noted that a failing liver and kidneys can affect the metabolism of drugs and there was some concern about drug toxicity. It is difficult to understand why there was not a better understanding and management of his pain in line with national guidelines. We make the following recommendations:

The Head of Healthcare should ensure that prisoners with chronic conditions have detailed care plans, planned interventions and monitoring, and regular reviews of medication in line with National Institute for Health and Care Excellence (NICE) guidelines.

The Head of Healthcare should ensure that there is an effective process in place to obtain essential palliative care medications without delay when required.

Mr Milne's location

51. Mr Milne consistently refused to move to the social care unit and frequently refused hospital admission. He wished to remain on the wing with his friends and where he could smoke. Healthcare staff continued to see him regularly on the wing throughout his illness.

52. On 19 August, a member of healthcare staff noted that Mr Milne was cold to the touch and he said he would rather sit out on the wing than in his cell, as a broken window meant that it was very cold. Although staff asked for the window to be repaired urgently, there was no record of whether this happened. We agree with the clinical reviewer that the impact of this on Mr Milne's deteriorating health was

unacceptable and avoidable. On 23 August, Mr Milne agreed to move to an area of the prison with enhanced care facilities.

53. While we are satisfied that Mr Milne was appropriately located during his illness in line with his wishes, we are concerned that this very sick man was in a cell with a broken window which meant he was very cold. We also note that HM Inspectorate of Prisons had similar concerns ten months earlier. We make the following recommendation:

The Governor should ensure that urgent repairs are carried out without delay, particularly when this impacts on the wellbeing of a prisoner.

Restraints, security and escorts

54. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

55. We note and agree with the decisions taken so that Mr Milne was not restrained at any time in hospital, but was instead escorted and supported by a single officer.

Liaison with Mr Milne's family

56. Mr Milne had consistently refused to allow anyone to inform his family of his illness. The prison appointed an officer as the family liaison officer and she spoke to Mr Milne on 23 August 2016. He eventually agreed that she could tell his daughter about his condition.

57. On 26 August, the officer visited Mr Milne's daughter, discussed her father's failing health and offered her support. She made arrangements for Mr Milne's daughter and granddaughter to visit him in the prison.

58. At 10.40am on 7 September, Mr Milne's granddaughter telephoned the officer to tell her that the hospital had informed them that Mr Milne had died.

59. At 3.30pm, the officer and a prison chaplain attended the hospital to see Mr Milne's daughter and support her at the chapel of rest. They offered their support and condolences.

60. Mr Milne's funeral was on 14 September. The prison contributed to the costs in line with national policy.

61. We are satisfied that the prison appropriately informed and supported Mr Milne's family when he became seriously ill and after his death.

Compassionate release

62. Prisoners can be released before their sentence has expired on compassionate grounds, for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

63. The prison started gathering information for a compassionate release application on 31 August and submitted it two days later. Sadly, no decision was made before Mr Milne's death.

64. We are satisfied that the prison appropriately considered and applied for compassionate release for Mr Milne.

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