Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Craig Miller a prisoner at HMP Liverpool on 4 March 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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 Craig Miller died on 4 March 2016 from complications caused by long-term liver disease, while a prisoner at HMP Liverpool. He was 24 years old. I offer my condolences to Mr Miller's family and friends.

Mr Miller was in very poor health when he arrived at the prison in December 2015. Healthcare staff monitored him regularly and he was admitted to hospital a number of times. I am satisfied that Mr Miller received a good standard of care at Liverpool, equivalent to that he could have expected to receive in the community. There was nothing staff at the prison could have done to prevent his death. There was good liaison with Mr Miller's family after he was taken to hospital in February, but I consider this would have been better, if it had begun at an earlier stage.

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 **October 2016**

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Summary

Events

1. On 7 December 2015, Mr Craig Miller was sentenced to nine months in prison and sent to HMP Liverpool. Mr Miller was in poor health; he had a genetic liver condition and long standing cirrhosis of the liver. He had a history of alcohol abuse and had been warned for some years that if he did not stop drinking his life expectancy would be short. He also had drug and mental health problems.

2. Two days after he arrived at the prison, Mr Miller was admitted to hospital for several days for treatment. He was admitted to hospital a further nine times over the following months, as his condition deteriorated. He developed a brain condition arising from the liver disease, which caused him to be confused and behave erratically. Prison healthcare staff monitored and reviewed him frequently.

3. On 13 February 2016, a nurse found Mr Miller unresponsive in his cell and he was taken to hospital. His level of consciousness was low and hospital staff admitted him to the intensive care unit. Mr Miller's health continued to decline and he died at the hospital on 4 March. His family were with him at the time.

Findings

4. As Mr Miller's complex liver condition deteriorated, prison healthcare staff monitored him frequently and treated him with compassion and dignity. Staff referred him promptly to hospital when necessary. He received very good mental health support. We are satisfied that Mr Miller received an appropriate standard of healthcare in prison, equivalent to that he could have expected to receive in the community.

5. There was good liaison with Mr Miller's family, after he was admitted to hospital on 13 February. However, in view of his serious physical illness and mental health problems, we consider that the prison should have appointed someone to liaise with his family at an earlier stage.

Recommendation

- The Governor should ensure that an appropriate member of staff is appointed promptly to engage with and support families of seriously ill prisoners.

The Investigation Process

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

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

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

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

10. One of the Ombudsman's family liaison officers contacted Mr Miller's family, to explain the investigation. His family did not have any specific matters for the investigation to consider.

11. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

12. Mr Miller's family received a copy of the initial report. They did not make any comments.

Background Information

HMP Liverpool

13. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 1,386 men. Lancashire Care NHS Foundation Trust provides healthcare services. There is 24-hour inpatient care.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Liverpool was in May 2015. Inspectors reported that the new healthcare provider had inherited a failing service. They found the prison and the healthcare provider were working effectively to address the deficiencies. Waiting times for most primary care services, including the GP, were too long and the management of lifelong conditions needed to improve. Inspectors found that prisoners with palliative care needs were identified and discussed at a weekly enhanced care review meeting, but this was not reflected in clinical records or effective care planning

Independent Monitoring Board

15. 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 December 2015, the IMB reported that Lancashire Care NHS Foundation Trust (LCFT) had been successful in securing the prison healthcare contract after Liverpool Community Health NHS Trust had been served notice on its contract. LCFT had implemented many changes and redesigned the service to meet the needs of the health needs assessment and the service specification commissioned by NHS England.

Previous deaths at HMP Liverpool

16. Mr Miller was the third person to die from natural causes at Liverpool since January 2015. There have been four deaths from natural causes since. There were no significant similarities between the circumstances of Mr Miller's death and previous deaths at the prison.

Key Events

17. On 7 December 2015, Mr Craig Miller was sentenced to nine months in prison for burglary, assault and drug offences. He was sent to HMP Liverpool. This was not his first time in prison.

18. Mr Miller had a genetic liver condition, alpha-one antitrypsin, a condition where abnormal protein remains in the liver, gradually damaging the liver, lungs and blood. As a result, he had developed cirrhosis of the liver, which was diagnosed when he was 17. Mr Miller had a history of chronic alcoholism and, in 2011, a hospital consultant warned him that if he did not stop drinking his life expectancy would be short and he would not be considered for a liver transplant. Mr Miller had a blood clotting disorder and ascites (an accumulation of fluid in the abdominal cavity) a consequence of chronic liver disease. He also had mental health problems.

19. On 9 December, a prison GP examined Mr Miller and noted he had a swollen abdomen, an umbilical hernia and yellow sclera (where the white part of the eye is yellow). He noted that these were signs of liver disease and admitted Mr Miller to the prison's inpatient unit for observation.

20. On 10 December, Mr Miller developed a temperature and was admitted to hospital. The hospital diagnosed a bacterial infection of ascites and treated this with antibiotics. On 14 December, the hospital discharged Mr Miller and prescribed long-term antibiotics.

21. On 28 December, a nurse assessed Mr Miller when he could not get out of bed. Mr Miller's pulse and blood pressure were low and he was confused. A prison GP suspected he might have hepatic encephalopathy (loss of brain function due to liver disease) and sent him to hospital. Hospital doctors confirmed this diagnosis.

22. On 3 January 2016, the hospital discharged Mr Miller. When he got back to the prison he threatened to harm himself and said that officers were plotting to kill him. Staff referred him to the mental health team and began suicide and self-harm prevention procedures, which continued for the rest of the time he was in prison. He was confused and disorientated and was admitted to the prison's inpatient unit where nurses observed him four times an hour. The mental health team saw him frequently after this.

23. On 6 January, a prison GP assessed Mr Miller, who was acutely unwell, and sent him to hospital. Later that evening, Mr Miller discharged himself from the hospital, against medical advice.

24. The next day, a nurse recorded that Mr Miller had been verbally aggressive and had thrown furniture around his cell. A prison GP considered that Mr Miller's condition had deteriorated and sent him back to hospital for blood toxicity tests. The GP was unsure whether Mr Miller had the capacity to make appropriate decisions about his treatment due to his confused state. Hospital doctors again diagnosed Mr Miller with hepatic encephalopathy.

25. On 8 January, the hospital discharged Mr Miller. He remained agitated and confused and threw objects and liquids at staff. On 9 January, he refused all medical intervention. An on-call doctor advised that Mr Miller should go back to hospital. Before he left the prison, a nurse noted that she did not consider that Mr Miller had full mental capacity at the time. In hospital, doctors sedated Mr Miller, treated him for hepatic encephalopathy, and referred him to a clinical psychologist. On 14 January, Mr Miller discharged himself from hospital against medical advice.

26. That day, a prison GP reviewed Mr Miller and noted that he had the mental capacity to make his own decisions about his treatment at the time, but this could change if his symptoms deteriorated. The GP prescribed a phosphate enema and lactulose to reduce the symptoms of hepatic encephalopathy.

27. On 15 January, a prison GP prescribed Mr Miller antipsychotic medication. On 18 January, a mental health nurse noted that the mental health team knew Mr Miller from earlier sentences and he had previously been diagnosed with a personality disorder. Mental health nurses reviewed Mr Miller frequently. From 23 January, he refused to take medication, despite advice from various healthcare staff.

28. On 31 January, Mr Miller was taken to hospital by emergency ambulance when he could not be roused. Hospital doctors again diagnosed hepatic encephalopathy and treated him with lactulose, enemas and pabrinex (a vitamin infusion). He remained in hospital until 1 February. On 3 February, a prison GP sent him to hospital again and he stayed in hospital until 10 February. The hospital referred him to a consultant hepatologist at hospital for follow-up treatment.

29. On 12 February, a prison GP sent Mr Miller to hospital after he continued to be disorientated and confused. Hospital staff arranged blood and liver function tests, which were abnormal but expected with his medical condition. He went back to the prison later that day. He was very unsettled during the night, kicked his cell door and threw items onto the landing. He was aggressive and threatening towards staff and nurses were unable to take his clinical observations.

30. Just before 9.30am on 13 February, a nurse checked Mr Miller but found that he was unresponsive and could not be roused. She called an ambulance, which took Mr Miller back to hospital. In hospital, doctors assessed that his level of consciousness was very low. He needed a ventilator to support his breathing. He spent four days sedated in the hospital's intensive care unit, then moved to another ward. Doctors were not certain of the underlying reason for his condition and queried substance misuse, although there was no evidence of this. On 25 February, a prison nurse recorded that Mr Miller had been talking about discharging himself from the hospital, but the doctor looking after him thought he was very confused and delusional; he had been accusing hospital staff of poisoning him.

31. On 3 March, hospital doctors found he had an infection of ascitic fluid. They treated Mr Miller with antibiotics but his condition continued to deteriorate. A hospital consultant decided to withdraw all active treatment and treat Mr Miller palliatively. He died in the hospital on 4 March.

Contact with Mr Miller's family

32. After Mr Miller was admitted to hospital on the morning of 13 February, the prison informed his family. Mr Miller's father visited him the next afternoon and his family continued to visit him frequently until he died. His father and brother were with him when he died.

33. After Mr Miller's death, a prison manager telephoned Mr Miller's mother, who he had named as his next of kin, to offer his support and condolences. On 7 March, a trained family liaison officer took over family liaison. She telephoned Mr Miller's mother and arranged to meet his family at the prison the next day. She and a prison chaplain met Mr Miller's family to offer their condolences and ongoing support.

34. Mr Miller's funeral took place on 21 March. The prison paid funeral costs, in line with national instructions.

Support for prisoners and staff

35. A prison manager debriefed the prison escort officers who were present when Mr Miller died, to offer his support and that of the staff care team.

36. The prison posted notices informing staff and prisoners of Mr Miller's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Miller's death.

Post-mortem report

37. The post-mortem report recorded that Mr Miller had died of hepatic encephalopathy (loss of brain function when the liver is unable to remove toxins from the blood), end stage cirrhosis of the liver and alpha one antitrypsin deficiency.

Findings

Clinical care

38. The clinical reviewer found that Mr Miller received a good standard of care at Liverpool, equivalent to that he could have expected to receive in the community.

39. Mr Miller's behaviour was sometimes very challenging towards healthcare staff. but the clinical reviewer noted that healthcare staff were caring and compassionate towards him throughout his illness and treated him with dignity. Healthcare staff reviewed his condition frequently and made sure he was referred to hospital whenever his condition warranted it. Healthcare staff at the prison liaised well with hospital staff.

40. As well as the care he received for his physical condition, the clinical reviewer considered that Mr Miller received a very good standard of care from the mental health team. The team already knew Mr Miller and had helped find him suitable accommodation after a previous sentence. He had received significant input from the mental health service about coping mechanisms to help him deal with his excessive alcohol consumption and to help control his behaviour.

41. We are satisfied that Mr Miller received a good standard of care at the prison and do not consider that staff at the prison could have done anything to prevent Mr Miller's death.

Use of restraints

42. 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.

43. Mr Miller's behaviour was often threatening, aggressive and violent towards staff. His risk assessments identified him as a high risk to hospital staff and the general public and managers decided that he should be restrained when he was taken to hospital, either by handcuffs or an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). Prison managers frequently reviewed the position and removed restraints when he was sedated. At 4.30am on 3 March, a manager decided that officers should remove the restraints and they were not used again.

44. Mr Miller's behaviour was erratic, difficult and sometimes violent. We are satisfied that restraints were used only when managers considered this was necessary. Managers frequently reviewed the decisions and removed them when Mr Miller neared the end of his life and was no longer a risk.

Support for Mr Miller's family

45. Prison Service Instruction (PSI) 64/2011 states that prisons must have arrangements for an appropriate member of staff to engage with families of prisoners who are either terminally or seriously ill. Mr Miller was very ill from the

time he arrived at the prison on 7 December. At the end of December, hospital doctors diagnosed hepatic encephalopathy, a further very serious complication of his liver disease. We consider that, at least from this point, the prison should have appointed a member of staff to liaise with Mr Miller's family.

46. We note that on 22 January, a member of the safer custody team recorded that Mr Miller's mother had called the prison enquiring how he was. His mother was worried, as she knew that he had been in hospital with cirrhosis of the liver but she had not heard from anyone since before Christmas. The member of staff left a telephone message for Mr Miller's mother but noted that healthcare staff had said they would need Mr Miller's consent before they could pass on any information.

47. We could find no further evidence that anyone from the prison spoke to Mr Miller's family about his deteriorating condition until 13 February. There was then good liaison with Mr Miller's family, but we consider that someone from the prison should have liaised with his family at an earlier stage, to keep them informed of his condition. We make the following recommendation:

The Governor should ensure that an appropriate member of staff is appointed promptly to engage with and support the families of seriously ill prisoners.

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