

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Frank Mills a prisoner at HMP Elmley on 27 May 2017

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*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Frank Mills died on 27 May 2017 of urosepsis and peripheral vascular disease, at HMP Elmley. He was 78 years old. We offer our condolences to Mr Mills' family and friends.

Mr Mills had many chronic health conditions, which healthcare staff managed appropriately. We are satisfied that Mr Mills' care while at Elmley was equivalent to that which he could have expected to receive in the community.

We are, though, very concerned to see that a very ill, elderly and immobile man who posed minimal risk was restrained when he was taken to hospital. Prison managers should properly address the legal requirements of the risk assessment process when considering the use of restraints.

It is remarkable that this happened after we have made recommendations to Elmley about this issue on four previous occasions since January 2016. On each occasion, our recommendations have been accepted and the prison has committed to act on them. Effective action must be taken now.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

January 2018

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Summary

Events

1. On 25 August 2016, Mr Mills was sentenced to six years and eight months imprisonment for sexual offences. He was sent to HMP Elmley. Mr Mills suffered from chronic diseases including diabetes, asthma, Parkinson's disease and heart disease. He was a wheelchair user following a below the knee amputation on his right leg. Healthcare staff reviewed Mr Mills regularly and ensured he was taking his medications appropriately.
2. Mr Mills attended hospital seven times for routine appointments and reviews while at Elmley. On two occasions, he was restrained using an escort chain. The risk assessments did not give any reasons why restraints were required.
3. On his final admission to hospital, Mr Mills remained an inpatient for six weeks, suffering from sepsis and an MRSA infection. When he returned to Elmley, his condition deteriorated significantly and he needed considerable help and support with his care needs from healthcare staff.
4. Mr Mills died at Elmley on 27 May 2017.

Findings

5. Mr Mills received a good standard of clinical care while at Elmley. We are satisfied that this was equivalent to that which he could have expected to receive in the community.
6. Mr Mills was inappropriately restrained on two occasions. The risk assessments for his hospital appointments all contained the same information, that he was wheelchair-bound and elderly. Nevertheless, and despite him being assessed as a low risk of escape or of re-offending, a prison manager authorised the use of an escort chain and two escorting staff. There is no evidence to demonstrate that the risk assessment process took any account of Mr Mills' poor health and limited mobility in justifying the use of an escort chain. Restraints were, though, appropriately not used for all other hospital appointments.

Recommendations

- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that risk assessments show clear justification for the use of restraints.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Mills' prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Mills' clinical care at the prison.
10. We informed HM Coroner for Mid Kent and Medway of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. The investigator wrote to Mr Mills' next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to our letter.
12. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Elmley

13. HMP Elmley is a local prison on the Isle of Sheppey, which serves the courts in Kent. It holds more than 1,200 men in five wings, with a mixture of single, double and triple cells. Integrated Care 24 Ltd (IC24) provides primary healthcare services, with input from Minster Medical Group. The prison's healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Elmley was in November 2015. Inspectors reported that healthcare services at the prison had improved since the last inspection in June 2014 and were generally good. The inpatient unit provided a calm and well run environment with good care for prisoners with the most acute needs. Palliative care pathways were used appropriately and sensitively.

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 1 November 2016, the IMB reported Elmley's outpatient department continued to run efficiently with a very caring team, monitoring and caring for a wide variety of chronically ill prisoners and staff in the prison's inpatient department were commended for their continuing excellent care under sometimes very challenging conditions.

Previous deaths at HMP Elmley

16. Mr Mills was the ninth prisoner to die of natural causes at Elmley since January 2016. We have raised the issue of the unjustified use of restraints four times before.

Key Events

17. On 25 August 2016, Mr Frank Mills was sentenced to six years and eight months imprisonment for sexual offences and was sent to HMP Elmley. Mr Mills had various health problems, including diabetes, asthma, Parkinson's disease and heart disease, for which he took appropriate medications. He was a wheelchair user following a below the knee amputation on his right leg.
18. On 30 October 2016 and 2 February 2017, Mr Mills attended hospital for routine appointments. He was restrained using an escort chain. The risk assessments recorded that he was a low risk of escape, hostage taking and reoffending. The medical section of the report noted he was elderly and in a wheelchair as he had one leg. It did not give any reasons why restraints should be applied.
19. Mr Mills monitored his own blood sugar levels and healthcare staff regularly monitored him and ensured that he took his insulin if his blood sugars were too high. On 20 and 26 March 2017, Mr Mills had two hypoglycaemic episodes (where blood sugars are dangerously high). Healthcare staff responded promptly to administer insulin and on the second occasion, Mr Mills went to hospital for review.
20. On 28 March, healthcare staff admitted Mr Mills to Elmley's healthcare inpatients department for observation after he was doubly incontinent on two occasions. A prison GP reviewed Mr Mills and prescribed antibiotics for a possible urinary tract infection. Mr Mills had a blood test the same day, which showed abnormally low serum sodium (which helps to maintain a normal blood pressure and supports the work of nerves and muscle). He went to hospital for investigations, and a hospital GP stopped one of his blood pressure medications. Mr Mills returned to Elmley on 31 March.
21. On 4 April, Mr Mills fell out of bed. He went to hospital and had intravenous antibiotics and an X-ray taken of his knee. While he was in hospital, the prison ordered additional equipment for Mr Mills, including a hospital bed, chair, cushion and a raised toilet seat, which arrived in good time for his return to Elmley. While in hospital, Mr Mills contracted meticillin-resistant *Staphylococcus aureus* (MRSA, bacteria that is resistant to most antibiotics and can be hard to treat). Hospital staff treated him with several courses of intravenous antibiotics.
22. Hospital doctors felt that Mr Mills needed an operation to his amputation site, to treat sepsis. However on 27 April, it was noted that he was not well enough to survive the operation. Hospital staff informed Mr Mills' family and on 2 May they signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Order on his behalf (in the event of cardiac or respiratory arrest no attempt at resuscitation will be made, all other appropriate treatment and care will continue to be provided.)
23. Mr Mills returned to the inpatients department at Elmley on 16 May. He needed to be turned on his bed hourly and the security department authorised an open door policy to ensure that his medical needs were adequately met. Mr Mills' condition deteriorated slowly but he remained comfortable. On 25 May, a prison GP prescribed a butan patch for Mr Mills (a slow release pain relief).

24. At about 10.00am, on 27 May, a prison GP reviewed Mr Mills, as he was distressed due to the severity of the pain. He prescribed oramorph (an opiate-based pain relief) to be given every four hours for break-through pain. At 10.30am, a prison healthcare assistant completed a routine check on Mr Mills and noticed he was unresponsive to voice or touch. She informed two nurses, who went straight to Mr Mills' cell. A nurse examined Mr Mills and found that he was not breathing and did not have a pulse. He called an emergency code blue (an emergency code indicating that the prisoner is not breathing). A GP arrived and confirmed that Mr Mills had died.

Contact with Mr Mills' family

25. When Mr Mills was admitted to hospital on 4 April, the prison contacted his next of kin, his daughter. Mr Mills' family visited him regularly. On 27 April, Mr Mills' condition worsened. The prison appointed a chaplain as the family liaison officer who contacted Mr Mills' daughter to inform her of Mr Mills' condition and to offer support.
26. At around 12.30pm on 27 May, the chaplain and a prison officer visited Mr Mills' daughter at her home to inform her that Mr Mills had died and offered support.
27. Mr Mills' funeral was held on 27 June. A member of the prison chaplaincy team led the service. The prison contributed to the cost of the funeral, in line with national guidance.

Support for prisoners and staff

28. A prison manager debriefed the staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
29. The prison posted notices informing other prisoners of Mr Mills' death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Mills' death.

Post-mortem report

30. The post-mortem examination found that Mr Mills' cause of death was urosepsis (sepsis caused by a urinary tract infection) and peripheral vascular disease (a build up of fatty deposits in the arteries which restricts blood supply to the legs). Diabetes and ischaemic heart disease were also significant contributing factors.

Findings

Clinical care

31. Mr Mills was an elderly prisoner, who was a wheelchair user and had a number of chronic health conditions. He had frequent contact with healthcare staff for review and management of his conditions. When Mr Mills returned to Elmley after his six-week hospital admission, his health deteriorated significantly. Healthcare staff implemented care plans and monitored him closely. We agree with the clinical reviewer that Mr Mills received an appropriate level of care while at Elmley, which was equivalent to that which he could have expected to receive in the community.

Escort Risk Assessments and Restraints

32. 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.
33. 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.
34. Mr Mills attended hospital on seven occasions between October 2016 and May 2017. He was restrained by an escort chain on 30 October 2016 and 2 February 2017, both routine hospital appointments. There was no documented justification for this. The risk assessments recorded that he was a low risk of escape, hostage taking and reoffending. The medical section of the report noted he was elderly and in a wheelchair as he had one leg. The security department produced a new risk assessment for each hospital visit, but the information remained the same.
35. Mr Mills presented minimal risk of escape, was very ill, relied on a wheelchair and was escorted by two members of staff. It is very hard to see that the legal requirements justifying restraint were even considered, let alone met. We are not satisfied that the risk assessment properly took into account how Mr Mills' health and impaired mobility affected his already low risk of escape. We note that managers reviewed the risk assessment appropriately for the majority of his hospital visits.
36. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances and the High Court judgement set out very clearly the conditions which need to be met to justify the use of restraints. It is the Governor's responsibility to ensure that the process is managed properly, and all

prison managers need to show a clear justification for any use of restraints when carrying out the risk assessment.

37. We are very concerned that this is the fourth time we have expressed concern about the inappropriate use of restraints on very infirm prisoners at Elmley. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understands the legal position and that risk assessments show clear justification on the use of restraints.

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