Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kenneth Miller a prisoner at HMP Oakwood on 15 January 2017

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.

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 Kenneth Miller died on 15 January of a heart attack at HMP Oakwood. Mr Miller was 57 years old. I offer my condolences to Mr Miller's family and friends.

The investigation found that Mr Miller's care was equivalent to that he could have expected to receive in the community. However, there were unresolved problems with the issuing of Mr Miller's medication and a need for staff to carry out welfare checks properly, although neither issue apparently impacted on his death.

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 **September 2017**

Contents

Summary

Events

1. On 18 November 2011, Mr Kenneth Miller was convicted of sexual offences and false imprisonment and on 21 June 2012 he was sentenced to 13 years in prison. He was initially sent to HMP Birmingham and was transferred to HMP Oakwood on 21 April 2016.

2. A nurse completed Mr Miller's reception screen and noted he had diabetes. Mr Miller received an antidepressant and medication for his heart and diabetes. The nurse conducted a 'medication in possession' assessment and agreed that Mr Miller could have all his medication in possession.

3. In practice this did not happen. Mr Miller was given his medication to keep and take as prescribed with the exception of the antidepressant, which he had to collect every day. Mr Miller was dissatisfied with this arrangement and told staff that he sometimes did not take his other medication because he was not given his antidepressant medication in possession.

4. On 15 January 2017, following an oversight which meant that Mr Miller's welfare was not checked at the 2 pm unlock, a prisoner found Mr Miller unresponsive on the floor of his cell and called for help. A prison officer went to the scene and broadcasted an emergency radio code. Staff in the control room immediately called an ambulance and other officers and healthcare staff went to the scene and tried to resuscitate Mr Miller. Paramedics arrived and spent half an hour trying to resuscitate him but declared him dead at 3.01pm.

Findings

5. While the clinical reviewer felt that the care Mr Miller received was equivalent to that he could have expected in the community, it is disappointing that his antidepressant was never given to him in possession even though health professionals decided it should be. The record keeping was poor and it was hard to determine exactly where things went wrong. The clinical reviewer believes that although it would have been better for Mr Miller to take his heart and diabetic medication consistently, his reported occasional abstinence would not have ultimately made a difference to the outcome for him.

6. Staff did not check Mr Miller's welfare when they unlocked his cell in accordance with the Prison Service guidance. Staff could have attended Mr Miller's cell sooner had they done so.

Recommendations

- The Head of Healthcare should review the processes in place regarding medication in possession to ensure that assessment, prescribing and dispensing procedures run smoothly, and that the latter two reflect the decision made by the healthcare professional assessing the request.

- The Director should ensure that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Oakwood informing them of the investigation and asking anyone with relevant information to contact her.

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

9. The investigator interviewed two members of staff by telephone.

10. NHS England commissioned a clinical reviewer to review Mr Miller's clinical care at the prison. She conducted two joint interviews with the investigator.

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

12. The investigator contacted Mr Miller's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not raise any concerns.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Oakwood

14. HMP Oakwood opened in 2012. It is near Wolverhampton, managed by G4S and provides places for up to 1,605 Category C male prisoners.

15. Care UK provides the healthcare services, which include a daily GP clinic, some specialist services and out-of-hours GPs.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Oakwood was in December 2014. Inspectors reported that health services had improved considerably since the last inspection and, overall, were reasonably good. The range of services was appropriate and the management of prisoners with lifelong or complex health needs was very good, although staff shortages had led to a backlog of nurse reviews. Inspectors found that the healthcare rooms were well equipped and staff created appropriate care plans.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board made up 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 March 2016, the IMB reported that, due to the uncertainty arising from the change of healthcare provider (Worcester Health and Care Trust provided healthcare services before April 2016), there were a high number of vacancies and the use of agency staff had lowered continuity of care. The healthcare department worked with MacMillan nurses to provide end of life care, but there was no nurse cover during the night.

Previous deaths at HMP Oakwood

18. Mr Miller is the seventh prisoner to die of natural causes at Oakwood since January 2016. Although we have not made the same recommendations before, we have previously investigated a death where healthcare staff were unsure what medication had been prescribed.

Key Events

19. On 18 November 2011, Mr Kenneth Miller was convicted of sexual offences and false imprisonment and on 21 June 2012 he was sentenced to 13 years in prison. He was sent initially to HMP Birmingham on remand and transferred to HMP Oakwood on 21 April 2016. Mr Miller was a smoker and diabetic, had glaucoma in both eyes, a history of artery blockage, high blood pressure and agoraphobia.

20. On 21 April 2016, a nurse completed Mr Miller's first night reception screen. She noted he had diabetes and conducted a 'medication-in-possession' assessment (which considers whether the prisoner should be allowed to keep their prescribed medication in their possession). The details of the assessment on the medical record are limited but show that the nurse agreed to medication in possession. The medications Mr Miller took at the time were amlodipine (for heart related conditions), aspirin, lumigan (eye drops), metformin (diabetic drug), mirtazapine (an antidepressant also prescribed for anxiety) and rampiril (for high blood pressure).

21. On 28 April, a prison GP prescribed all of the above medications. On 29 April, a nurse noted that Mr Miller refused all his medication because his mirtazapine had not been dispensed to him in possession. He had had it in possession at his previous prison.

22. On 9 May, a nurse saw Mr Miller and noted that he agreed to Mr Miller's request to have his medication in possession and that he had no concerns. He planned to give Mr Miller mirtazapine from stock and the rest of the medication in possession as it was prescribed. The records show that mirtazapine was prescribed and dispensed that day but Mr Miller did not receive a stock of it in possession.

23. On 22 June, Mr Miller reported left sided chest pain to a nurse. He recorded a blood pressure reading of 113/83 (ideal is 120/80) and a pulse rate of 106 beats per minute (ideal is 60-100). Mr Miller told him he had not taken any medication for seven weeks. He sent a task to a GP to prescribe Mr Miller's medication. (The records show that Mr Miller's medication, apart from mirtazapine, was dispensed on a monthly basis during his time at Oakwood and there is nothing to suggest he was not collecting it.)

24. On 23 June, Mr Miller had an electrocardiogram which an un-named GP reviewed and deemed unremarkable.

25. On 26 June, a nurse spoke to Mr Miller. She explained it was important that he took his heart medication and said that mirtazapine had been omitted as an 'in possession' medication in error. There was nothing in Mr Miller's medical record to indicate that she addressed the error (although a GP review took place two weeks later).

26. On 11 July, a prison GP reviewed Mr Miller and noted that the previous ECG was normal, but that his blood pressure had been high at the time. He took Mr Miller's blood pressure and pulse again and both were in the normal range (122/76 and 89 beats per minute). He spoke to Mr Miller about the importance

of taking his medication and of having blood tests to monitor his blood sugars. He also noted that Mr Miller said he had not been taking any of his medications and as mirtazapine could cause irregular heart rhythms he reduced the prescribed dose to 30mg per tablet.

27. On 19 July, Mr Miller had another ECG. The healthcare assistant noted that his pulse was 112 and he had sinus tachycardia (fast resting heart rate). She recorded that a GP was going to review the results. There is no record this happened.

28. On 28 July, a nurse recorded that Mr Miller had not realised he had to request his in possession medication himself via the prisoners' case management system, so his medication had not been prescribed. He also asked for some information about mirtazapine and the nurse noticed that the GP who had requested a review about it had since left the service. She requested a GP review. It is not clear whether a review took place.

29. On 1 August, a nurse issued a repeat prescription for all medication apart from mirtazapine.

30. On 13 October, Mr Miller saw a prison GP. He noted that Mr Miller had previously been on mirtazapine and did not understand why it had stopped. He arranged to re-start Mr Miller on it but at a lower dose of 15mg until he got used to it again. It is not clear what happened to the prescription but on 27 October, Mr Miller saw another GP and said he had still not had his mirtazapine. The GP re-prescribed it.

31. On 4 November, Mr Miller attended the medication hatch and told staff he had not had any of his medications for three days. Healthcare staff could not access the prescription, so no medication was available for Mr Miller over that weekend. The records indicate it was dispensed again on 8 November.

32. On 20 November, Mr Miller reported that he had stomach pains and sickness. A HCA saw him and took his blood pressure which was 154/97 and his pulse rate was 106 beats per minute but no further follow up action was recorded.

15 January 2017

33. On 15 January 2017, at approximately 12.40, an officer visited Mr Miller in his cell. She thought Mr Miller seemed well and he was standing as he spoke to her.

34. At approximately 2.00pm, the officer began unlocking the cells on Mr Miller's wing. She needed to use the lavatory with some urgency and in her hurry did not raise all of the observation panels in the cells (including Mr Miller's) as she unlocked the doors.

35. At approximately 2.15pm, a prisoner who was passing Mr Miller's cell glanced in and saw Mr Miller lying on the floor on is right side. The prisoner went into the cell and tried to rouse him by calling his name but Mr Miller did not respond. The prisoner felt for a pulse on Mr Miller's wrist and neck and when he could not find one he left the cell and shouted 'code blue'.

36. At 2.18pm, an officer heard the prisoner and went to the cell. She broadcast an emergency radio code blue (indicating that someone is unconscious or is having problems breathing) at 2.19pm and put Mr Miller in the recovery position. She also checked for a pulse but couldn't locate one. Staff in the control room called an ambulance. Healthcare staff were alerted and made their way to the scene.

37. A First Line Manager and an officer arrived and neither could find Mr Miller's pulse. An officer started chest compressions and the First Line Manager requested a defibrillator (a defibrillator, and other emergency equipment, is kept within the dispensary unit on every residential unit). The officer returned with a defibrillator and two officers attached it to Mr Miller. It did not advise them to deliver a shock so they continued with chest compressions.

38. At 2.21pm a HCA attended Mr Miller's cell and attached a sats probe (monitors oxygen saturation) to his finger. It did not register any signs of life. The HCA radioed for all healthcare staff to attend. Prison staff continued with cardio pulmonary resuscitation (CPR). Healthcare staff arrived at 2.23pm.

39. A nurse attached an ambu bag (a device to aid resuscitation) to Mr Miller and other staff continued with CPR. They stopped momentarily to allow the defibrillator to advise again and it advised 'no shock'. Staff continued with CPR until the paramedics arrived and took over. The paramedics could not resuscitate Mr Miller and pronounced him dead at 3.01pm.

Contact with Miller's family

40. At 4.15pm on 15 January, two Family Liaison Officers left Oakwood to give Mr Miller's son the news of his father's death. They arrived at 4.55pm, but although the address was that of a family member, the next of kin had since moved. The officers went to the new address, arriving at 7.00pm, and broke the news. The prison continued to offer support and advice after this time.

41. Mr Miller's funeral was held on 28 February 2017. To respect the family's wishes no-one from the prison attended. In line with national policy the prison contributed to the funeral costs.

Support for prisoners and staff

42. On 15 January, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

43. The prison posted notices informing other prisoners of Mr Miller's 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 Miller's death.

Post-mortem report

44. The post-mortem concluded that Mr Miller died of 1a) Ischaemic and hypertensive heart disease and 1b) Type 2 Diabetes Mellitus.

Findings

Clinical care

45. The clinical reviewer concluded that the care Mr Miller received at Oakwood was equivalent to that he could have expected to receive in the community. There were occasions where a lack of GP follow-up was noted. She was also concerned that there was a breakdown in the medication in possession process regarding Mr Miller's mirtazapine. As Mr Miller did not have it in possession, he said that he was not taking his other medication for his heart and diabetes. As he always collected this medication we cannot be sure he was not in fact taking it. The clinical reviewer does not, though, regard the issue as material to the eventual outcome for Mr Miller.

46. The initial assessment for medication in possession at Oakwood was conducted by a nurse when Mr Miller first arrived at the prison. There was no copy of the assessment within the papers provided to the investigator. It is clear that Mr Miller had had mirtazapine in possession at his previous prison and the nurse agreed to all medications being given in possession at Oakwood. When dispensing the medication, staff omitted mirtazapine from the in possession list.

47. According to the medical records, Mr Miller raised the issue about his mirtazapine frequently. A member of staff flagged up his concerns and took the necessary steps to ensure that in future he was given his antidepressant medication in possession, but the matter always defaulted to a position of dispensing a singular dose to him every day.

48. The nurse who saw Mr Miller on 9 May 2016 was unable to explain why Mr Miller's mirtazapine was not given to him in possession. He said that a lot of locum GPs were being used and the problem might have been a lack of continuity of care. The clinical reviewer also told us that during her review she thoroughly analysed the medical records and could not determine what had gone wrong because the records regarding the matter were scant. The Head of Healthcare was also unable to explain the issue. We make the following recommendation:

    The Head of Healthcare should review the processes in place regarding medication in possession to ensure that assessment, prescribing and dispensing procedures run smoothly, and that the latter two reflect the decision made by the healthcare professional assessing the request.

Unlock process

49. Prison Service Instruction 10/2011 states that "there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process".

50. The officer did not check some of the observations panels including Mr Miller's because she urgently needed to use the lavatory. She said that her priority at

that point was to make sure she unlocked all the cells. She said that she would normally raise the observation panels but did not do so in this case purely for that reason. We have made recommendations about unlock procedures at Oakwood on two previous occasions and repeat the recommendation.

The Director should ensure that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Prisons & Probation Ombudsman
Independent Investigations

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