Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Clifford Mills a prisoner at HMP Belmarsh on 3 May 2018

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*

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 Clifford Mills died in hospital on 3 May 2018 of heart failure while a prisoner at HMP Belmarsh. He was 55 years old. I offer my condolences to Mr Mills' family and friends.

Mr Mills had several serious health conditions, including heart disease, when he arrived at Belmarsh. I am satisfied that healthcare staff managed his conditions appropriately and that his clinical care was equivalent to that which he could have expected to receive in the community.

However, I am concerned that Mr Mills was restrained when he was taken to hospital in the early hours of 3 May. Mr Mills was a wheelchair user and was in very poor health. The use of restraints was clearly not justified.

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

Sue McAllister CB
Prisons and Probation Ombudsman **February 2019**

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Summary

Events

1. Mr Clifford Mills was serving a life sentence for murder and had been at HMP Belmarsh since February 2012. He had several serious health conditions including coronary heart disease, peripheral vascular disease, type 2 diabetes and progressive supranuclear palsy (a severe degenerative neurological condition). Mr Mills had poor mobility and used a wheelchair. He lived in the prison's inpatients unit throughout his time at Belmarsh.

2. Healthcare staff developed care plans to manage Mr Mills' conditions and prison GPs referred him to hospital specialists when necessary.

3. When Mr Mills refused to take his insulin or allow blood glucose monitoring, prison GPs assessed his mental capacity and were satisfied Mr Mills understood the risks to his health.

4. At 2.40am on 3 May 2018, Mr Mills complained of chest pain and a nurse arranged for an emergency ambulance to take him to hospital. Two officers escorted him and restrained him with an escort chain.

5. At 8.07am, Mr Mills' condition deteriorated and officers removed the escort chain. Mr Mills died at 8.43am.

6. The post-mortem examination showed that Mr Mills died from acute cardiac failure, caused by ischaemic heart disease. Diabetes and hypertension (high blood pressure) were contributory factors.

Findings

7. The clinical reviewer concluded that Mr Mills' care was equivalent to that which he could have expected to receive in the community. Healthcare staff appropriately managed his complex clinical and social care needs and assessed his mental capacity to refuse his medication.

8. The clinical reviewer concluded that Mr Mills' final illness was an acute event which could not have been foreseen or prevented.

9. When Mr Mills was taken to hospital by emergency ambulance on 3 May, prison staff used an escort chain to restrain him which was not removed until half an hour before his death. Mr Mills had very limited mobility and was in extremely poor health. The decision to restrain Mr Mills was clearly not justified.

Recommendations

- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

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

11. Miss Masterton obtained copies of relevant extracts from Mr Mills' prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Mills' clinical care at the prison. Our investigation was suspended between 2 August and 22 October 2018 while we awaited the clinical review.

13. We informed HM Coroner for Southwark of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. The investigator wrote to Mr Mills' 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 initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Belmarsh

16. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It holds approximately 900 men. Oxleas NHS Foundation Trust provides healthcare services. There is 24-hour healthcare cover and a 32-bed inpatient unit.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Belmarsh was in January and February 2018. Inspectors reported that health services had improved and were now good. Primary care services were comprehensive, and prisoners could see a GP the same day for urgent matters, although too many prisoners did not attend appointments.

18. The inpatient unit was adequate and the prison planned to refurbish the showers in 2018. There were 26 men in the 33-bed inpatient unit but not all had been admitted for clinical reasons. Most prisoners had complex mental health problems, many were frail and 25% had intimate social care needs. Part of the unit was used for palliative care, when it was required. While an officer managed the unit well, the competing needs of differing groups meant some experienced a fragmented regime. Clinical leadership and multidisciplinary working was strong and working relationships with the prison were excellent.

Independent Monitoring Board

19. 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 30 June 2017, the IMB reported that they remained concerned about the high volume of mental health inpatients. The additional care required by these patients affected the regime of other inpatients.

Previous deaths at HMP Belmarsh

20. Mr Mills was the ninth prisoner at Belmarsh to die since May 2015. Five of the previous deaths were due to natural causes and three prisoners took their own lives.

Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

22. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in

place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

23. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction 64/2011 on safer custody.

Key Events

24. On 9 February 2011, Mr Clifford Mills was remanded in custody charged with murder and sent to HMP Brixton. On 6 February 2012, he was sentenced to life in prison and sent to HMP Belmarsh. He remained in HMP Belmarsh until his death on 3 May 2018.

25. Mr Mills was in poor health when he arrived at Belmarsh. He had type 2 diabetes and a history of coronary heart disease, peripheral vascular disease and stroke. Mr Mills had poor mobility and used a wheelchair. Prison GPs noted his complex health and social care needs and admitted him to the prison's inpatients unit. Prison GPs prescribed insulin for diabetes and medication to manage the symptoms of heart disease and high blood pressure. Nurses created care plans to manage his prescribed medication, health conditions, mobility and social care needs.

26. Nurses saw Mr Mills daily in accordance with his care plans. The local authority provided Mr Mills with social care and supported him with daily living.

27. In January 2017, prison GPs noted that Mr Mills' mobility had deteriorated and he appeared confused. On 1 February, Mr Mills saw a consultant neurologist at King's College Hospital, London. Investigations found that Mr Mills had progressive supranuclear palsy (a severe degenerative neurological condition).

28. On 14 May, Mr Mills assaulted a female healthcare assistant. Prison staff placed Mr Mills on basic regime and removed his television. On 16 May, a multidisciplinary team meeting discussed Mr Mills' healthcare. A prison psychiatrist said that Mr Mills was refusing to take his insulin or allow glucose monitoring. The psychiatrist said that he had assessed Mr Mills' mental capacity and was satisfied he understood the risk to his health if he refused his insulin.

29. On 25 May, Mr Mills told a prison nurse he was refusing his insulin because he wanted to die. As a result, prison staff monitored him under suicide and self-harm procedures (known as ACCT). Mr Mills agreed to start taking his insulin medication on 28 May and prison staff stopped the ACCT monitoring the same day.

30. On 9 June, a prison GP saw Mr Mills and noted he had ulcers on his toes. He referred Mr Mills to a podiatrist who saw him on 15 June. The podiatrist noted that the ulcers were not infected.

31. On 29 June, the podiatrist examined Mr Mills again and noted that the ulcer on his right second toe was infected. A prison GP arranged for an emergency ambulance to take Mr Mills to Queen Elizabeth Hospital, Woolwich.

32. Hospital doctors diagnosed acute osteomyelitis (an infection in the bone) and treated Mr Mills with intravenous antibiotics. Hospital doctors decided to amputate Mr Mills' right second toe to completely remove the infection. Mr Mills returned to Belmarsh on 11 July.

33. On 28 July, a prison nurse saw Mr Mills who complained of chest pain. The nurse gave Mr Mills glyceryl trinitrate spray (GTN - used to relieve the symptoms

of angina) which stopped Mr Mills' pain. At 2.15am on 28 July, Mr Mills complained of chest pain again and was taken to Queen Elizabeth Hospital by emergency ambulance. The same day, Mr Mills was moved to St Thomas' Hospital. Hospital doctors inserted three stents (used to treat narrow or weak arteries) and Mr Mills was returned to Belmarsh on 31 July.

34. On 8 August, Mr Mills complained of chest pain again which was relieved by his GTN spray.

35. On 14 August, a prison GP discussed with Mr Mills whether he should be resuscitated if his heart of breathing stopped. Mr Mills signed a Do Not Attempt Active Resuscitation (DNAR) order.

36. On 11 October, a prison GP examined the ulcers on Mr Mills' feet. He prescribed antibiotics for an infection. A multi-disciplinary team meeting took place on 24 October and a podiatrist noted that Mr Mills' ulcers had deteriorated. Mr Mills had a poor diet and often refused to sleep in his bed at night.

37. On 1 November, Mr Mills refused to take his insulin. A prison GP assessed Mr Mills' mental capacity to refuse his medication and noted he was satisfied that Mr Mills understood the risks to his health.

38. On 9 November, a consultant cardiologist (heart specialist) saw Mr Mills at Queen Elizabeth Hospital. The cardiologist noted that Mr Mills was experiencing chest pain once or twice a week and was not taking his insulin medication. He reminded Mr Mills of the importance of taking his medication to prevent stent blockage. Mr Mills agreed to take his insulin and records show that he took it as prescribed.

39. On 2 January 2018, a consultant endocrinologist saw Mr Mills in the diabetic clinic at Queen Elizabeth Hospital. The endocrinologist noted that Mr Mills' diabetes was poorly controlled and changed his insulin medication.

40. On 8 January, a prison psychiatrist completed a mental capacity assessment and noted he was satisfied that Mr Mills understood the risk to his health if he did not take his insulin.

41. The same day, a consultant chest physician saw Mr Mills in the respiratory clinic at Queen Elizabeth Hospital to discuss the results of an overnight pulse oximetry test (to measure the oxygen level in the blood). The consultant said the results indicated that Mr Mills did not need respiratory support.

42. On 28 February, Mr Mills refused to take his insulin or allow nurses to monitor his blood glucose level. On 2 March, a prison GP saw Mr Mills and noted he was refusing his insulin because he was unhappy with the prison food.

43. Nurses saw Mr Mills daily and he continued to refuse his insulin medication. Mr Mills took his other medication as prescribed.

44. On 6 March, Mr Mills told a prison nurse he was refusing his insulin because he wanted to die. As a result, prison staff monitored him under ACCT procedures. During an ACCT review, Mr Mills told a prison officer he was refusing his insulin because he no longer wanted to be in prison.

45. On 27 March, a MDT meeting discussed Mr Mills' mental capacity to refuse his insulin. A prison GP noted that healthcare staff were satisfied that Mr Mills understood the risks to his health if he continued to refuse his insulin. Prison staff noted that Mr Mills was not at risk of self-harm and stopped ACCT monitoring the same day.

46. On 3 April, a prison GP saw Mr Mills in the diabetic clinic at Queen Elizabeth Hospital. She noted that Mr Mills continued to refuse his insulin and prescribed an additional oral diabetic medication.

47. On 15 April, a prison nurse saw Mr Mills who complained of chest pain. Mr Mills' blood pressure was high, as was his pulse, but his oxygen saturation level was normal. Mr Mills' blood sugar level was high. The results of an electrocardiogram (ECG - to measure the rhythm of the heart) were normal.

48. On 18 April, Mr Mills agreed to start taking his insulin. A prison GP arranged a full set of blood tests. The results were received on 23 April and showed a normal renal and liver function. Mr Mill's cholesterol levels were also normal. The GP noted that Mr Mills' glucose was poorly controlled because he had not taken insulin for almost six weeks. Mr Mills continued to take his insulin as prescribed.

Events of 3 May

49. At approximately 2.10am on 3 May, Mr Mills complained of chest pain. A prison nurse recorded his pulse as fast, blood pressure as normal and oxygen saturation level as normal. She noted that Mr Mills was pale but not sweaty. The nurse gave Mr Mills his GTN spray.

50. At approximately 2.40am, Mr Mills complained of chest pain again and was vomiting. A prison nurse arranged for an emergency ambulance to take Mr Mills to Queen Elizabeth Hospital. Two officers escorted Mr Mills using an escort chain (a long chain with a handcuff at each end, one of which is attached to an officer).

51. At 6.42am, hospital doctors asked prison officers to remove the escort chain while they treated him. At 6.50am, prison officers re-applied the escort chain.

52. At 8.07am, Mr Mills' condition deteriorated and prison officers removed the escort chain. Mr Mills died at 8.43am.

Contact with Mr Mills' family

53. When Mr Mills was taken to hospital in July 2017, the prison appointed a prison officer to act as family liaison officer (FLO). The FLO arranged for Mr Mills' daughter, his nominated next of kin, to visit Mr Mills in hospital and to attend meetings at the prison to discuss Mr Mills' healthcare.

54. After Mr Mill's death on 3 May, the FLO visited Mr Mills' daughter and informed her of his death. She offered condolences and support. The FLO remained in contact with Mr Mills' daughter until Mr Mills' funeral on 31 May. The prison contributed to the costs in line with national instructions.

Support for prisoners and staff

55. After Mr Mills' death, 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.

56. 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 examination

57. The post-mortem examination found that Mr Mills died from acute cardiac failure, caused by ischaemic heart disease. Diabetes and hypertension (high blood pressure) also contributed to Mr Mills' death.

Findings

Clinical care

58. Mr Mills lived in the prison's inpatients unit which allowed healthcare staff to manage his medical conditions. The clinical reviewer found that healthcare staff regularly discussed Mr Mills' complex clinical and social care needs. Mr Mills had been diagnosed with heart disease before he arrived at Belmarsh in February 2012 and his condition was relatively stable until June 2017. When Mr Mills experienced chest pain in June 2017, prison GPs referred him for specialist care.

59. In the year before his death, Mr Mills often refused to take his insulin and would not allow healthcare staff to monitor his blood glucose level. The clinical reviewer was satisfied that healthcare staff appropriately assessed Mr Mills' mental capacity to refuse treatment and he understood the risks to his health.

60. When Mr Mills complained of chest pain on 3 May, he was quickly taken to hospital. The clinical reviewer concluded that Mr Mills' final illness was an acute event which could not have been foreseen or prevented.

61. The clinical reviewer found that Mr Mills' clinical care was equivalent to that which he could have expected to receive in the community.

Restraints

62. 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.

63. A judgment in the High Court in 2007, made it clear that prison staff need to distinguish between the 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 he has a serious medical condition. The judgment indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

64. The emergency risk assessment for Mr Mills' hospital admission on 3 May 2018 noted that he was a Category B prisoner who was a high risk to the public and hospital staff and a low risk of hostage taking and escape. There were no medical objections to the use of restraints but a nurse said that Mr Mills was unable to walk and his medical conditions restricted his ability to escape unaided. Two officers accompanied him, using an escort chain to restrain him.

65. Public protection is critical, but security measures must be proportionate to a prisoner's individual circumstances. We are concerned that prison staff decided that it would be appropriate to use an escort chain to restrain Mr Mills. It is difficult to see how the assessment concluded that a seriously ill man who used a wheelchair had the ability to escape unaided from two escort officers.

66. 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. We are not satisfied that managers appropriately considered his condition and mobility at the time and how this affected his risk. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

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