Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Clifford Milton a prisoner at HMP Brixton on 4 November 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 Milton died of a heart attack caused by coronary artery thrombosis (a narrowing of the coronary arteries) while a prisoner at HMP Brixton. He was being treated for cancer but died unexpectedly in hospital on 4 November 2018. He was 83 years old. I offer my condolences to his family and friends.

I am satisfied that the healthcare Mr Milton received at Brixton was equivalent to that he could have expected in the community.

I am concerned, however, that Mr Milton was restrained when he was taken to hospital on 1 November and that his restraints were not removed until two days later, the day before he died.

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

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## Annexes



### Additional Documents:

# Summary

1. On 5 August 2016, Mr Milton was sentenced to seven years in prison for sexual offences, and sent to HMP Bullingdon. He was transferred to HMP Brixton on 21 February 2017.

## Events

*2.* Mr Milton had a number of complex health needs before he went to prison, including an irregular heartbeat and localised skin cancer.

*3.* In April 2017, Mr Milton was referred to a cardiologist because he was breathless and had an irregular heartbeat. The cardiologist saw him in October, and he was given medication to prevent strokes.

*4.* In October, Mr Milton was referred urgently to a surgeon under the suspected cancer pathway as he had a lesion on his left ear. In November, he was diagnosed with cancer of the left ear and the cancerous tissue was removed the following month.

5. In June 2018, Mr Milton was referred to a cardiologist as blood tests showed that he was at risk of heart failure, but in August a heart scan showed that he did not have heart failure.

*6.* Also in June, Mr Milton was diagnosed with neck cancer. He had surgery to remove the cancer in October.

7. On 1 November, Mr Milton was taken to hospital for a urology appointment and was admitted as an inpatient as he was unable to empty his bladder. He was restrained with an escort chain on his way to hospital and the restraints remained in place until 3 November.

8. While in hospital, Mr Milton had a heart attack and he died on 4 November.

## Findings

9. The clinical reviewer concluded that the care that Mr Milton received at HMP Brixton was equivalent to that which he could have expected to receive in the community. He found that Mr Milton's death was unexpected and staff could not have foreseen or prevented it.

10. The clinical reviewer found that Mr Milton was appropriately referred using the two-week suspected cancer pathway, and that prison healthcare staff facilitated his treatment and provided satisfactory care.

11. Mr Milton was restrained during his final admission to hospital on 1 November 2018 and the restraints were not removed until 3 November. Staff failed to take into account the impact of his poor health and limited mobility, as they should have done.

12. We consider that a family liaison officer should have been appointed as soon as Mr Milton was moved to the critical care unit in the early hours of 3 November.

## Recommendations

- **The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners taken to and admitted to hospital understand the legal position, that assessments fully take into account a prisoner's health and are based on the actual risk he presents at the time.**
- **The Governor should ensure that a family liaison officer is appointed to engage with the next of kin when a prisoner becomes seriously ill.**

## The Investigation Process

13. The investigator, Ms Lizzie Laing, issued notices to staff and prisoners at HMP Brixton informing them of the investigation and asking anyone with relevant information to contact her. One prisoner wrote to her.

14. Ms Laing obtained copies of relevant extracts from Mr Milton's prison and medical records.

15. NHS England commissioned Dr Amer Salim to review Mr Milton's clinical care at the prison.

16. We informed HM Coroner for Inner South London District of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The investigator wrote to Mr Milton's wife 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.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

# Background Information

## HMP Brixton

19. HMP Brixton is a medium security resettlement prison in London that holds up to 810 convicted and sentenced adult male offenders. Care UK, an independent company providing health and social care, provides healthcare services. The prison has five wings, including a sex offender unit and a drug recovery unit.

## HM Inspectorate of Prisons

20. The most recent inspection of HMP Brixton was in January 2017. Inspectors reported that health services were reasonable. They found that access to nurses and GPs was good, with reasonable care for men with long-term conditions. They noted that there were no established procedures to support men with social care needs. Inspectors found that the management of medicines was good, but that prison officers did not supervise the administration of medicine well. The use of professional health trainers and peer mentors to motivate and educate prisoners to improve their health was excellent.

## Independent Monitoring Board

21. 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 2018, the IMB reported that healthcare services on the wings and in consultations were generally of a good standard. They found that waiting times for appointments echoed those in the community, with the exceptions of dentistry and optometry. The IMB considered that the absence of the Head of Healthcare during a long period of illness increased pressure on the team, although there was some cover. The IMB noted that cancelling hospital escorts was costly and wasteful. Over seven months, 2.7% of escorts were cancelled by the prison, while 34% were cancelled for other, unspecified reasons.

## Previous deaths at HMP Brixton

22. Mr Milton was the third prisoner to die at HMP Brixton since November 2015. One of the previous deaths was caused by a drugs overdose and the other cause of death has not yet been established. There were no similarities between Mr Milton's death and the previous deaths at Brixton.

# Key Events

23. On 5 August 2016, Mr Milton was sentenced to seven years in prison for sexual offences, and sent to HMP Bullingdon.

24. Before Mr Milton went to prison, he had a complex medical history including rheumatoid arthritis, an irregular heartbeat, high blood pressure, nerve impairment in his legs, localised skin cancer, glaucoma, cataracts, visual impairment and a vitamin B deficiency. He took medication to manage these conditions.

25. On 21 February 2017, Mr Milton was transferred to HMP Brixton. That day, Nurse Tandie Mkize saw him for an initial health screen and noted his medical history. The healthcare team continued to monitor and manage his medical conditions. He was assessed as suitable to live in a shared cell in the sex offender unit.

26. On 21 April, Dr Hossain Namjou, a prison GP, examined Mr Milton as he was breathless and had an irregular heartbeat. Dr Namjou referred Mr Milton to the cardiology department at King's College Hospital.

27. On 13 October, Dr Namjou examined Mr Milton as he had had a lesion on his left ear that sometimes bled. He referred Mr Milton urgently to a hospital surgeon under the two-week suspected cancer pathway.

28. Later that day, Mr Milton attended an appointment at the cardiology department at King's College Hospital. The cardiologist arranged for him to receive medication to prevent a stroke.

29. Mr Milton attended a hospital appointment with a dermatologist on 24 October. The dermatologist examined the lesion on Mr Milton's left ear and arranged a skin biopsy.

30. On 9 November, the dermatologist confirmed that Mr Milton had a skin cancer on his left ear and arranged for him to have surgery to remove the cancerous tissue. On 6 December, Mr Milton had surgery at King's College Hospital to have the cancerous tissue removed. Between December and January 2018, prison healthcare staff changed his dressing three times a week.

31. The hospital's dermatology department continued to monitor Mr Milton. On 18 January, he had an ultrasound scan which showed that he had a lump in his left parotid gland (glands on either side of the mouth, in front of the ears). The radiologist recommended a follow-up scan in three months.

32. Between 8 May and 18 September 2018, Mr Milton attended counselling sessions as he was concerned about his health and that of his wife.

33. On 5 June, a hospital dermatologist saw Mr Milton for another ultrasound scan. It showed that the lymph node in his left parotid gland had got bigger and he was referred to a maxillofacial surgeon (a specialist in diseases affecting the mouth, jaws, face and neck).

34. On 7 June, Dr Nandana Jayaram, a prison GP, referred Mr Milton to the cardiology department at King's College Hospital as blood tests showed that he was at risk of heart failure.

35. On 12 June, the hospital took a biopsy of the lump on Mr Milton's left parotid gland. This showed that he had neck cancer. A maxillofacial surgeon saw Mr Milton on 17 July, and referred him to the head and neck clinic at Guy's Hospital.

36. On 19 July, Dr Jayaram saw Mr Milton who wanted to know if the cancer was terminal. Dr Jayaran told him that there was no evidence that this was the case and that some cancers could be cured. Mr Milton said that he found counselling very useful.

37. On 3 August, a hospital cardiologist saw Mr Milton and arranged for him to have an echocardiogram (a heart scan). It showed that Mr Milton did not have heart failure.

38. On 10 August, a head and neck surgeon examined Mr Milton at Guy's Hospital and arranged tests to find out the size of the cancer. On 15 August, Mr Milton attended Guy's Hospital for a CT scan and pre-assessment for an operation to remove the cancer.

39. On 17 August, Dr Namjou examined Mr Milton as he had blood in his urine. He referred him urgently to the accident and emergency department at St Thomas' Hospital, where he was referred to the urology department for a follow-up appointment as an outpatient.

40. On 24 August, Dr Jayaram saw Mr Milton as he had had three falls in the past two months (10 and 19 July and 15 August) that had resulted in superficial cuts. Dr Jayaram recommended that Mr Milton should use a walking stick and a wheelchair when he attended hospital appointments.

41. On 2 September 2018, Mr Milton was moved to a single cell at his request.

42. Mr Milton was admitted to Guy's Hospital on 17 October for surgery to remove the left parotid gland and lymph nodes in his neck. It was planned that he would have radiotherapy at a later date. Mr Milton's wife and son-in-law visited him while he was in hospital. On 20 October, he returned to Brixton.

43. On 25 October, Dr Namjou saw Mr Milton, and noted that he was doing very well after his surgery and was not in much pain.

44. On 1 November, Mr Milton attended a urology appointment at Guy's Hospital. He was restrained with an escort chain and escorted by two officers. That day, Mr Milton was admitted to hospital as he was unable to empty his bladder, and he had a catheter fitted.

45. While Mr Milton was in hospital, he developed acute coronary syndrome (a range of conditions associated with sudden, reduced blood flow to the heart) and acute heart failure. At 5.00am on 3 November, Mr Milton was moved to the critical care unit as he had difficulty breathing. His restraints were removed temporarily between 7.00am and 8.00am for medical treatment.

46. At 9.00am that day, Custodial Manager (CM) Sharon Hollingsworth visited Mr Milton in hospital, and a nurse told her that Mr Milton had difficulty breathing overnight but that there was no expectation that he would die imminently. Mr Milton's restraints were removed permanently at 11.20am after CM Hollingsworth conducted a visual assessment of Mr Milton's condition and risk to others and escape.

47. At around 1.15pm, Mr Milton collapsed unexpectedly. At 2.00pm, CM Hollingsworth returned to the hospital. A nurse told her that Mr Milton had recovered and that his collapse was unexpected.

48. On 4 November at 8.10am, Mr Milton had a cardiac arrest and died at 8.40am.

### Contact with Mr Milton's family

49. Mr Milton's next of kin was his wife. He was in frequent contact with his family.

50. At 12.30pm on 3 November, Ms Julie McGowan, a duty governor, Mr Simon Stanley, a prison manager, CM Alexandra Fiddes and CM Hollingsworth met at Brixton to discuss Mr Milton. They noted that his condition was critical but stable, and he could talk. Mr Milton had asked if his family could visit him, and Ms McGowan authorised this. The prison escort staff told Mr Milton. He wanted to tell his family himself about his condition and that he had been admitted to the critical care unit, but he did not know the telephone number. CM Fiddes was tasked with obtaining it for him.

51. At 1.15pm, CM Fiddes was informed that Mr Milton had collapsed (before she had given him his wife's telephone number) and that staff were trying to resuscitate him. She telephoned his wife and daughter several times but was unable to make contact with them.

52. After Mr Milton collapsed, Ms McGowan appointed Safer Custody Analyst John Sydney as the family liaison officer (FLO). Mr Sydney was unavailable so CM Fiddes tried again to contact Mr Milton's wife.

53. CM Fiddes finally made contact with her at 3.40pm and told her that Mr Milton was in hospital. That day, Mrs Milton, her daughter and son-in-law visited Mr Milton.

54. Mr Milton died at 8.40am the next day. CM Fiddes told us that Mrs Milton had visited the hospital on 3 November but she did not know if she had stayed in London overnight as her home address was outside London. As CM Fiddes did not know where Mrs Milton was, she made several attempts to call her but did not get through until 9.20am. CM Fiddes then told Mrs Milton that her husband had died. CM Fiddes told us that while she knew that it was not the standard protocol to tell the next of kin of the death by telephone, she had to find out where Mrs Milton was, and she felt that it would have been dishonest and inappropriate not to tell her that Mr Milton had died.

55. CM Fiddes told Mrs Milton that the prison FLO would meet her at the hospital.

56. CM Fiddes contacted Mr Sydney but he was unavailable to go to the hospital. She then contacted CM Mikala Miller who was also a family liaison officer.

57. Mrs Milton, her daughter and son-in-law arrived at the hospital three hours after Mr Milton died. CM Miller and CM Hollingsworth met them there, offered their condolences and explained that Mr Sydney would be in contact.

58. On 5 November, Mr Sydney telephoned Mr Milton's daughter to introduce himself as he could not get hold of Mr Milton's wife. He and CM Miller visited them later that day, and offered their condolences and support.

59. Mr Milton's family arranged his funeral which took place on 23 November. Brixton contributed to the costs of the funeral in line with national instructions.

### Support for prisoners and staff

60. The prison posted notices informing other prisoners of Mr Milton'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 Milton's death.

### Post-mortem report

61. The post-mortem report said that Mr Milton died of an acute myocardial infarction (a heart attack) caused by coronary artery thrombosis (a narrowing of the coronary arteries). It was established that the removal of Mr Milton's left parotid gland, hypertension (high blood pressure) and atrial fibrillation (an abnormal heart rhythm) contributed to but did not cause his death.

# Findings

## Clinical care

62. The clinical reviewer concluded that the care that Mr Milton received at HMP Brixton was equivalent to that which he could have expected to receive in the community. He concluded that Mr Milton's death was unexpected and could not have been foreseen or prevented as he did not have any symptoms of coronary heart disease. He identified that a cardiologist saw Mr Milton in October 2017 and July 2018 but did not identify any symptoms, and that Mr Milton had had a comprehensive pre-operative assessment in hospital in September 2018 and a heart scan in August 2018 which showed normal results.

63. The clinical reviewer found that there was no delay in Mr Milton being diagnosed with cancer on his left ear. He considered that Mr Milton received satisfactory treatment and that healthcare staff recognised the need for him to be urgently referred to a specialist. The clinical reviewer found that healthcare staff facilitated Mr Milton's treatment in hospital and gave him satisfactory care after his surgery.

64. The clinical reviewer also concluded that there was no delay in diagnosing Mr Milton's neck cancer and that healthcare staff facilitated follow-up tests.

65. The clinical reviewer was also satisfied that prison healthcare staff provided Mr Milton with psychological support and managed his long-term conditions satisfactorily.

## Restraints, security and escorts

66. 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 a prisoner's health and mobility. 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 he has 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 and kept under review as circumstances change.

67. On 1 November 2018, Mr Milton was transferred to Guy's Hospital for an appointment. Medical staff completed an escort risk assessment. They did not object to the use of restraints but appropriately noted that the restraints may need to be removed for a procedure. Security staff noted that Mr Milton looked very frail and needed assistance with stairs. It was noted that he posed a high level of risk to the public and a medium level of risk of hostage taking, potential to escape, of external assistance, to females and to hospital staff.

68. Ms Abby Sloan, the Head of Security, concluded that two officers should escort Mr Milton, using 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) and that the restraints should only be removed for medical treatment with prior approval.

69. Mr Milton was admitted to hospital on 1 November, following a routine appointment. At 4.30am on 3 November, Ms R'Sean Smith, a prison manager, gave permission for Mr Milton's restraints to be removed temporarily for medical treatment. This did not happen immediately as Mr Milton did not have treatment straight away. However, when he received treatment a few hours later between 7.00am and 8.00am, Mr Milton's restraints were removed but reapplied after treatment.

70. On 3 November, Ms Julie McGowan, the duty governor, was told that Mr Milton had been moved to the critical care unit overnight, and authorised the removal of his restraints. They were removed at 11.20am.

71. We are concerned that Mr Milton was restrained when he was escorted to hospital and that the approach Ms Sloan applied to the use of restraints was inconsistent with the provisions of the High Court judgement. The Prison Service has a responsibility to protect the public but security must be balanced with humanity. Mr Milton had mobility issues and was described as very frail when he was transferred to hospital. This clearly impacted on his ability to escape. Too much weight was given to his offences without considering his actual risk at the time. It is good to see that when this was reviewed again two days later, Ms McGowan considered Mr Milton's health and mobility and appropriately authorised the removal of the restraints. We make the following recommendation:

**The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners taken to and admitted to hospital understand the legal position, that assessments fully take in to account a prisoner's health and are based on the actual risk he presents at the time.**

### Family liaison

72. Prison Rule 22(1) states: "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

73. Mr Milton wanted to tell his family himself that he had been moved to the critical care unit on 3 November, and we consider that it was reasonable for staff to respect his wishes provided he did so promptly. However, Mr Milton's condition was critical and we consider that the prison should have appointed a family liaison officer at that time, even if Mr Milton was going to speak to his family himself. The family liaison officer's role is not just to inform the family that a prisoner has died, but to provide a single point of contact for the family of a seriously ill prisoner, for example to arrange hospital visits and answer questions.

74. In addition, when a family liaison officer was appointed after Mr Milton collapsed, the prison should have appointed one who was available to undertake the role. Because Mr Sydney was not available, CM Fiddes had to tell Mrs Milton that her

husband had collapsed and later of his death. Mr Sydney was also unavailable to meet the family at hospital after Mr Milton's death (although he later visited them).

75. CM Fiddes told us that at the time, Mr Sydney and CM Miller had recently completed their family liaison training, they were the only family liaison officers at the prison and there was no rota in place. She said that it was more appropriate to initially appoint Mr Sydney as the family liaison officer, to be a consistent point of contact, as CM Miller was due to start night shifts the following week. She told us that CM Miller re-arranged her duties so that she could meet with the family and that CM Hollingsworth attended as she was an experienced member of staff who would be competent at speaking to the family. CM Fiddes told us that a family liaison rota system is now in place.

76. While we are concerned that the appointed family liaison officer was not available to undertake the role immediately, we are satisfied that the new rota system addresses the issue.

77. We recommend:

**The Governor should ensure that a family liaison officer is appointed to engage with the next of kin when a prisoner becomes seriously ill.**

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