Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Millward, a prisoner at HMP Birmingham, on 27 August 2019

A report by the Prisons and Probation Ombudsman

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 Alan Millward died of heart failure and sepsis in hospital on 27 August 2019 while a prisoner at HMP Birmingham. He was 58 years old. I offer my condolences to Mr Millward's family and friends.

The clinical reviewer found that the standard of healthcare that Mr Millward received at Birmingham was at least equivalent to that which he could have expected to receive in the community.

I am concerned that the use of restraints when Mr Millward went to hospital was not justified given his poor health and very limited mobility. I have drawn my concerns to the Prison Group Director for the West Midlands.

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 **April 2020**

Contents

Summary

Events

1. On 5 July 2018, Mr Alan Millward was sentenced to nine years and six months in prison, and was sent to HMP Birmingham.

2. Mr Millward had a history of poor health, including heart disease, angina, Type 2 diabetes, problems with his eyesight, peripheral neuropathy (nerve damage), kidney disease, and a history of depression. He had had a pacemaker fitted and had been diagnosed with end-stage heart failure in January 2018. Hospital doctors had advised that he should have palliative care as he had a prognosis of less than 12 months. He was a wheelchair user and needed help with personal care.

3. Nurses drew up care plans to manage Mr Millward's complex health conditions. They monitored him daily and updated his care plans as his condition deteriorated. Mr Millward was unhappy with healthcare staff as he complained that he was not able to take his medication in a timely manner. He often protested about delays.

4. On 18 August 2019, healthcare staff found him unwell and breathless. An ambulance was called and paramedics took him to hospital. Two officers escorted him and used handcuffs for the journey.

5. Mr Millward's condition did not improve and he remained in hospital. He deteriorated further and on 27 August, he died from heart failure and sepsis.

Findings

6. The clinical reviewer found that the standard of healthcare that Mr Millward received at Birmingham was equivalent to that which he could have expected to receive in the community. We agree as healthcare staff appropriately assessed his clinical needs and sought advice from secondary care providers.

7. The prison provided copies of the escort risk assessments used when Mr Millward went to hospital from January 2019. On three occasions, Mr Millward was escorted by two officers and restrained with either a single cuff or an escort chain. However, there is no evidence that the decisions to use restraints were adequately justified given Mr Milward's very poor health and mobility.

8. We have previously made recommendations about the inappropriate use of restraints at Birmingham and although the prison has agreed to implement measures to improve the decision-making process, it clearly continues to be an issue and we now escalate our concerns.

Recommendations

- The Governor and Head of Healthcare 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 the prisoner and are based on the actual risk the prisoner presents at the time.

- The Governor should revise the risk assessment form for hospital escorts to make it clear that:
    - healthcare staff must provide information on the prisoner's current state of health and mobility; and
    - prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.
- The Prison Group Director for West Midlands should assure herself that meaningful action is taken to ensure that this happens.

The Investigation Process

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

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

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

12. We informed HM Coroner for Birmingham and Solihull of the investigation. She gave us the cause of death. We have sent the Coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Millward's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She was concerned about changes to his medication and asked:

    - whether there was evidence that healthcare staff were responsible for Mr Millward's deterioration;
    - whether Mr Millward had received his medication at the correct times or with sufficient time between dosages and if not, how this had affected him;
    - whether his furosemide (diuretic medication for water retention) had been reduced and was no longer effective; and
    - whether Mr Millward was monitored for side effects like sleeping heavily when his pregabalin dose was changed.

14. We passed these questions to the clinical reviewer and he has addressed them in his clinical review. We have also summarised the reviewer's conclusions in this report.

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

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

Background Information

HMP Birmingham

17. HMP Birmingham is a local prison which holds up to 1,450 prisoners. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour healthcare services at the prison and sub-contracts Birmingham Community Healthcare NHS Trust to provide primary care services, including a 15-bed healthcare unit.

HM Inspectorate of Prisons

18. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Birmingham in July 2018. They noted that health services at the prison had improved and the working relationship between health providers and the prison was good. They also noted that the retention of healthcare staff had improved and that staffing levels were adequate. They found that record keeping by healthcare staff was of a good standard.

19. However, inspectors noted that while the environment in the healthcare centre was generally good, many of the wing-based clinical rooms were dirty and failed to meet infection control standards.

20. In addition, they noted a dramatic deterioration in the prison's overall performance since the previous inspection. They judged outcomes for prisoners to be 'poor' against all four of their healthy prison tests – safety, respect, purposeful activity, and rehabilitation and release planning. As a result, HMIP invoked the Urgent Notification (UN) process in August 2018 which committed the Secretary of State to respond publicly to the concerns raised within 28 calendar days. On 1 July 2019, HMPPS took over the management of Birmingham from G4S (who had operated it since 2011).

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 June 2018, the IMB reported a good level of consultation with social services about the care of elderly prisoners being released from custody.

22. However, they had concerns about cancelled hospital appointments and about access to the healthcare department for prisoners with mobility issues.

Previous deaths at HMP Birmingham

23. Mr Millward was the fifteenth prisoner to die at Birmingham since August 2017, including nine prisoners who died from natural causes, two drug-related, two self-inflicted and a further death awaiting classification.

24. We have made recommendations to Birmingham about the need for properly considered risk assessments to justify the use of restraints in a number of previous investigation reports.

Assessment, Care in Custody and Teamwork

25. 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.

26. 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.

27. 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

28. Mr Alan Millward was serving nine years and six months in prison for sexual offences, and had been at HMP Birmingham since 4 July 2018.

29. Mr Millward had had poor health for several years and had a history of coronary artery disease, ischaemic cardiomyopathy (a condition where the heart muscle becomes stretched and thin), angina, Type 2 diabetes, diabetic retinopathy (retina damage from diabetes complications), diabetic macular oedema (damaged blood vessels in the eye), peripheral neuropathy (nerve damage), kidney disease, and a history of depression. He was a wheelchair user and needed help with personal care as he had limited use of his hands and feet.

30. In January 2018, he had had a pacemaker fitted and was diagnosed with end-stage heart failure. Before he entered prison, hospital staff had completed a referral to admit Mr Millward to a hospice as his prognosis was less than twelve months.

31. Mr Millward frequently saw healthcare staff to monitor and treat his medical conditions. Prison GPs prescribed appropriate medications and he was often sent to hospital.

32. Specialist nurses were appointed to help Mr Millward manage his heart conditions. They scheduled appointments for him to see a specialist cardiology nurse, a heart failure nurse and an ophthalmologist, and to attend a cardiac device clinic.

33. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they have a terminal illness and a life expectancy of less than three months. On 28 August, prison staff made an application for compassionate release on Mr Millward's behalf. However, Mr Millward died before the application process could be completed and, due to the nature and number of his offences and the fact that his actual release date was 2023, it is unlikely that he would have met the criteria for compassionate release.

34. On 7 September, Mr Millward told a nurse that he would not take his insulin medication or allow nurses to check his blood sugar levels. He told a nurse that this was because of his perceived poor healthcare treatment and he wanted to send a message to the prison GPs at Birmingham. Both nurses tried to encourage him to take his medication.

35. A clinical nurse specialist met Mr Millward on 11 September to discuss his concerns. Mr Millward told her that his medication refusal was his attempt to speed up his application for compassionate release as he felt he only had three months to live, despite the clinical letters saying it was longer and he had no signs of clinical instability. He said that the time gap between eating his meals and receiving his insulin injections (compared to other prisoners) was increasing to unacceptable levels. She reassured Mr Millward about his care and agreed to make enquiries for him to use a motorised wheelchair. She also agreed to accompany him to his hospital appointments, to clarify his care plans and request

a further medication review. Mr Millward said that he was happy with this and said that he regretted his medication refusal.

36. A prison GP completed a medication review on 13 September and allowed Mr Millward to keep and administer his insulin injections and other medication in his cell.

2019

37. In January and May 2019, Mr Millward told prison staff that he had stopped taking his medication as he was protesting about his treatment from nurses. Staff started suicide and self-harm prevention monitoring, known as ACCT. Records show that he engaged with the reviews. At the reviews, Mr Millward said that his threats had been made in anger and frustration. Staff offered support and encouragement. ACCT monitoring was stopped after wing staff discussed the timing of his medications with healthcare staff.

38. In July, Mr Millward again refused to take his medication in protest at delays in receiving his medication. Prison staff contacted healthcare managers who agreed to issue Mr Millward's medication early in the morning. Mr Millward said that he was happy with this and he resumed taking his medication. There were a number of recorded incidents when Mr Millward was frustrated by prison processes and would stop taking his medication. He was monitored under ACCT procedures after these incidents.

39. Mr Millward had several hospital visits, and each time, staff completed an escort risk assessment. For the risk assessments dated 8 February, 14 March, and 24 April 2019, each escort risk assessment noted that his escape potential and risk of external assistance, hostage taking and to hospital staff were low. His risk to the public and staff and overall assessment of risk was medium. The medical section on each assessment was incomplete. Two escorts and a single handcuff were authorised each time.

40. On 18 August, Mr Millward told a nurse that he felt unwell. She noted that he was breathless and looked pale with a yellow, waxy tinge to his skin. His hands were cold, his ankles and feet swollen. She checked his observations and noted his oxygen saturation level was 97% (normal is over 94%), blood glucose level was 6.5mmol (diabetic range), respiratory rate was 18 breaths per minute (normal range). She suggested that Mr Millward should move to the healthcare unit but he refused so she requested an emergency ambulance.

41. Two officers escorted Mr Millward to hospital, and he was handcuffed for the journey using an escort chain. In hospital, the escort chain remained in place until it was removed on 25 August because Mr Millward's arms began to swell. The restraints were never reapplied.

42. Mr Millward's condition deteriorated and he died in hospital on 27 August.

Contact with Mr Millward's family

43. On 5 September 2018, Birmingham appointed a safer custody investigations/inquest liaison officer, as the family liaison officer (FLO). She met Mr Millward and he told her that he was aware that he had limited time left and

wanted to see his family. The FLO contacted Mr Millward's next of kin to introduce herself and update her on his deteriorating condition and to offer ongoing support.

44. In July 2019, a Custodial Manager took over as the family liaison officer. She maintained contact with Mr Millward's next of kin. When Mr Millward died, she offered her condolences and provided ongoing support. Mrs Millward told her that she was upset with healthcare staff as they had changed his medication, which she believed had caused him to develop sepsis.

45. The prison arranged and paid for Mr Millward's funeral in line with national instructions.

Support for prisoners and staff

46. After Mr Millward's death, the prison duty manager debriefed the escorting staff to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

47. The prison posted notices informing other prisoners of Mr Millward'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 Millward's death.

Cause of death

48. The Coroner noted that Mr Millward had died from decompensated heart failure and sepsis (due to left arm cellulitis) and cardiomyopathy with severe left ventricular systolic dysfunction. He had diabetes, hypertension and had had a previous myocardial infarction (heart attack) which did not cause but contributed to his death.

Findings

Clinical care

49. The clinical reviewer is satisfied that Mr Millward's care and treatment in prison was at least equivalent to that which he could have expected to receive in the community. Healthcare staff liaised effectively with the hospital about his care and there were good, clear, holistic care plans, which were well communicated to healthcare staff and discussed with Mr Millward. Staff looked after Mr Millward well and maintained his dignity throughout his decline. When he began to show signs of deterioration in his heart failure, he was reviewed and transferred to hospital appropriately.

Medication

50. Mr Millward's next of kin was concerned about Mr Millward's prescribed medication.

51. Mr Millward expressed his frustration with the timing of receiving his medications from nurses. His specialist clinical nurse arranged for a medication review which allowed Mr Millward to administer his own medication. Where this was not possible, prison staff contacted healthcare managers to ensure that nurses were tasked to issue Mr Millward's medication in a timely manner.

52. The clinical reviewer is satisfied that the medications prescribed for Mr Millward were appropriate for his medical conditions. He noted that Mr Millward chose not to take his medications on many occasions as a form of protest (stating various reasons for doing so). This resulted in ACCT procedures being opened on several occasions. The records show that Mr Millward was informed of the dangers and risks of not taking his medications, and both the healthcare manager and prison governors met with Mr Millward at his request in an attempt to deal with the issues he raised. The clinical reviewer found that there is evidence that Mr Millward's symptoms were exacerbated when he did not take his medications and that he experience raised blood sugars, oedema, shortness of breath and pain as a result.

Sepsis

53. The clinical reviewer was unable to comment on the issue of "sepsis due to left arm cellulitis" as there is no reference to this in Mr Millward's prison medical records. He noted that sepsis can occur very rapidly, so could have occurred during Mr Millward's hospital admission.

Restraints, security and escorts

54. 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.

55. 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 and kept under review as circumstances change.

56. Mr Millward had several hospital appointments before his last hospital admission. The investigator checked a selection of his risk assessments from 2019 and noted that for all the hospital journeys, only one manager authorised that handcuffs were unnecessary. For the risk assessments from February to April 2019, the medical section on each assessment was incomplete. The investigator noted that there were no medical objections to the use of restraints and very little information about his medical conditions. Each referred to the details of his conviction but only two mentioned that he used a wheelchair. Staff authorised the use of a single handcuff and two escorts each time that Mr Millward went to hospital.

57. The investigator asked the Head of Safety at Birmingham, about their local policy on the use of restraints. She said that after a meeting in July 2019, revised risk assessment documents and briefings were issued to staff which identified the need for healthcare and mobility matters to be considered as part of the decision-making process.

58. We are concerned that on 18 August 2019, just weeks after staff were reminded to consider a prisoner's health and mobility before deciding whether they should be restrained, Mr Millward was restrained when he went to hospital. We acknowledge that the escort asked for the type of restraint to be changed from a single cuff to an escort chain before leaving the prison but Mr Millward was still restrained for the journey and the restraints were only removed two days before his death.

59. 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. It is difficult to see how the escort risk assessments could conclude that a frail, very unwell man with very limited mobility, had the ability to escape unaided from two escort officers. Staff failed to consider the actual risk of escape, as the High Court judgment requires.

60. We have previously made recommendations about the use of restraints and it is disappointing that, despite the prison's assurances that actions have been taken to improve the process, we must repeat the following recommendation:

    The Governor and Head of Healthcare 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 the prisoner and are based on the actual risk the prisoner presents at the time.

61. We also add the following recommendations:

The Governor should revise the risk assessment form for hospital escorts to make it clear that:

- **healthcare staff must provide information on the prisoner's current state of health and mobility; and**
- **prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.**

The Prison Group Director for West Midlands should assure herself that meaningful action is taken to ensure that this happens.

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