Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Miskin a prisoner at HMP Elmley on 4 March 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*

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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 Brian Miskin died on 4 March 2017 of chronic obstructive pulmonary disease while a prisoner at HMP Elmley. He was 63 years old. I offer my condolences to Mr Miskin's family and friends.

Mr Miskin received a good standard of care and I am satisfied that his care was equivalent to that which he could have expected to receive in the community.

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 **November 2017**

Contents

Summary 1

The Investigation Process 2

Background Information 3

Findings 4

Summary

Events

1. On 13 July 2012, Mr Brian Miskin was sentenced to twelve years in prison for sexual offences. He was sent to HMP Elmley.

2. Mr Miskin had a history of chronic obstructive pulmonary disease (COPD – lung disease) and had suffered a heart attack in 1997. He was a heavy smoker who, despite numerous attempts by healthcare staff, refused to stop smoking regardless of the help and advice offered to him.

3. Both healthcare staff and secondary care providers treated Mr Miskin appropriately. His health declined and, in June 2014, hospital staff told him that surgical intervention would not be an option for him.

4. On 6 October 2015, a prison GP reviewed Mr Miskin. He noted his poor condition and the lack of treatment options available to him. He was of the opinion that Mr Miskin's condition was suitable for palliative care only. He referred him to the palliative care nurse at the prison.

5. Healthcare staff monitored Mr Miskin on a daily basis. The care plans designed for him were thorough and well documented and were adapted to suit his needs as his condition deteriorated. Mr Miskin told staff he did not wish to be resuscitated in the event of a cardio pulmonary arrest.

6. Mr Miskin's condition continued to decline. He died at 9.10am on 4 March.

Findings

7. Mr Miskin arrived into prison with COPD. Despite the advice given to him by healthcare staff and secondary care providers, he continued to smoke. As his condition deteriorated, healthcare staff reviewed him regularly and made prompt and appropriate referrals. His treatment and care was in accordance with National Institute for Health and Clinical Excellence (NICE) guidelines for sufferers of COPD.

8. Overall, Mr Miskin received a good standard of care that was equivalent to that which he could have expected to receive in the community. The clinical reviewer considered that the care provided following his diagnosis was also good.

9. Appropriately, officers did not restrain Mr Miskin when attending hospital appointments and admissions.

The Investigation Process

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

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

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

13. We informed HM Coroner for Mid Kent and Medway District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. Mr Miskin's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

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

16. The investigation has assessed the main issues involved in Mr Miskin's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

Background Information

HMP Elmley

17. HMP Elmley is a local prison on the Isle of Sheppey, and serves the courts in Kent. It holds more than 1,250 men in five wings, with a mixture of single, double and triple cells. Integrated Care 24 Ltd provides 24 hour primary healthcare services, with input from Minster Medical Group. The prison's healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

18. 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 good care for prisoners with the most acute needs, though general access to healthcare services remained a problem. They also found that prisoners sometimes missed routine external hospital appointments because of competing prison priorities for escort staff.

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 October 2016, the IMB reported that despite budgetary constraints, the staff were to be commended for their continuing level of care. The outpatient department in particular was noted as delivering a good standard of care to those prisoners suffering from chronic illnesses.

Previous deaths at HMP Elmley

20. Mr Miskin was the eleventh prisoner to die from natural causes at Elmley since January 2015. There are no similarities to any of the previous deaths at Elmley.

Findings

The diagnosis of Mr Miskin's terminal illness and informing him of his condition

21. On 25 April 2012, Mr Brian Miskin was remanded into custody and was sent to HMP Elmley. On 13 July 2012, he was sentenced to twelve years in prison for sexual offences.

22. Mr Miskin had a history of chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases such as chronic bronchitis and emphysema). He had also suffered a heart attack in 1997. Healthcare staff devised a care plan to manage Mr Miskin's COPD and reviewed him regularly. They referred him to a community respiratory nurse who offered support and advice throughout his time in prison.

23. Despite his poor health, Mr Miskin was a heavy smoker. Healthcare staff offered him smoking cessation advice on a number of occasions, which he refused. In February 2013, healthcare staff prescribed him Champix (used to lessen the cravings for cigarettes). He used it successfully for a short period of time but resumed smoking.

24. On 9 September, a prison GP reviewed Mr Miskin and noted his COPD had worsened. He referred him to the respiratory department at hospital for review. A computerised tomography (CT) scan indicated Mr Miskin had severe emphysema. A myoview scan (used to diagnose heart disease) revealed that he had developed ischaemic heart disease (restricted blood flow to the heart).

25. Mr Miskin began long term oxygen therapy in October 2013 in an attempt to lessen his symptoms. Healthcare staff prescribed Salbutamol and Seretide inhalers and oral steroids. Healthcare staff regularly reviewed Mr Miskin's medications throughout his time at Elmley.

26. Mr Miskin remained under the care of a specialist clinic for his COPD which prompted referrals to secondary care providers. In accordance with National Institute for Health and Care Excellence (NICE) guidelines, healthcare staff offered Mr Miskin an annual influenza injection and monitored him regularly to ensure he used his inhalers effectively.

27. On 4 June 2014, following a routine review at the hospital, staff told Mr Miskin that emphysema had spread throughout his lungs and surgical intervention was not a viable option. Healthcare staff and the specialist clinics continued to review him and the mental health team offered him support.

28. On 19 September 2015, following an exacerbation of his COPD, Mr Miskin was taken to hospital by emergency ambulance. Hospital staff treated him with a course of antibiotics in order to stabilise his condition. Following a chest X-ray, they informed him that his heart disease had worsened. Hospital staff implemented a heart failure care plan (a care plan that monitors blood pressure, heart rate and weight to ensure any early indicators of further decline in function are noted) and he returned to Elmley on 29 September.

29. On 2 October, a nurse reviewed Mr Miskin. She noted that both of his legs were swollen and he had difficulty breathing. She spoke with a prison GP, and he advised her that Mr Miskin should be sent to hospital for review. Mr Miskin refused his advice and told her that he wished to sign a Do Not Attempt Cardiopulmonary Resuscitation Order (DNACPR) as he "wanted to die in his cell".

30. A prison GP discussed the DNACPR with Mr Miskin on 5 October. He noted that he had had a frank discussion with him, and in his opinion Mr Miskin had the capacity to make a decision about DNACPR. He reviewed Mr Miskin's decision the following day. He also had a frank conversation with him about his heart condition and his COPD. Following the review, Mr Miskin asked if he could take more time to consider whether to sign the DNACPR form.

31. The GP noted that, despite his continuing oxygen therapy and the efforts of healthcare staff, Mr Miskin continued to smoke. Noting there was no option for surgical intervention, coupled with his inability to give up smoking, he considered that Mr Miskin was only suitable for palliative care. He referred him to the palliative care lead at Elmley.

32. The palliative care lead reviewed Mr Miskin regularly, offering him advice and support. Healthcare staff monitored his COPD and checked his use of oxygen therapy on a daily basis. The respiratory nurse also assessed Mr Miskin regularly and noted that he did not always comply with the agreed oxygen therapy regime.

33. On 6 January 2016, a prison GP reviewed Mr Miskin. He told the GP that he wished to sign a DNACPR form. The GP considered he had the capacity to make that decision and the DNACPR was put in place. Staff were made aware of Mr Miskin's wishes. After returning from hospital on 9 April, following an exacerbation of his COPD, Mr Miskin told a nurse that he had decided not to renew his DNACPR form. Staff were informed of his decision.

34. On 8 December, a nurse reviewed Mr Miskin, after prison officers reported that he was very short of breath. She felt that Mr Miskin needed to go to hospital and called for an emergency ambulance. While waiting for the ambulance to arrive, a prison GP and the nurse discussed the severity of Mr Miskin's condition and decided to sign a DNACPR form in his best interest.

35. Hospital staff treated Mr Miskin with antibiotics and his condition improved. His long term oxygen therapy was no longer effective, so they supplied him with a Bi-level positive airway pressure machine (BiPAP used to deliver higher level of non invasive (NIV) oxygen therapy). Mr Miskin was discharged to Elmley on 22 December.

36. On 10 January 2017, Mr Miskin met with the palliative care lead and a prison GP. He told them that hospital staff had confirmed that surgical intervention was not an option for him due to his condition. He told the GP that he wished to sign the DNACPR and staff were informed of his decision. Healthcare, mental health in-reach staff and the palliative care nurse continued to review and support Mr Miskin.

37. At 9:10am on 4 March, a prison officer unlocked Mr Miskin's cell, which he shared with another prisoner. He noted Mr Miskin was asleep in his wheelchair and at 9.15am he returned to the cell to check on him. Mr Miskin was unresponsive. He checked for a pulse or signs of breathing, he found none. At 9.16am he radioed a code blue (an emergency code indicating a prisoner is experiencing breathing difficulties or is unresponsive) and the control room called an ambulance immediately. The palliative care lead attended the cell, accompanied by a prison GP. They noted Mr Miskin was sitting in his wheelchair, but his oxygen mask was not on his face.

38. Paramedics arrived at the cell at 9.33am. In accordance with Mr Miskin's wishes they did not attempt to resuscitate him. At 9.36am, the prison GP confirmed that Mr Miskin had died.

39. We are satisfied that Mr Miskin was treated well while in prison and received a good standard of care. Healthcare staff appropriately investigated Mr Miskin's symptoms and referred him to specialists when his symptoms worsened.

Mr Miskin's clinical care

40. Healthcare staff devised, and implemented care plans in order to manage Mr Miskin's chronic health problems soon after his arrival at Elmley. Healthcare staff promptly and appropriately referred him to specialist clinics both within Elmley, and with secondary care providers. They involved him in the choices and decisions about his treatment, pain management and resuscitation. Overall, the response to Mr Miskin's acute health problems and his final illness were appropriate.

41. Mr Miskin was encouraged to stop smoking on a number of occasions. Healthcare staff offered him support, explained to him the dangers of continuing to smoke and prescribed him with aids to help him to stop. While he did so for short periods of time, he eventually returned to smoking.

42. When it had been established that surgical intervention would not be an option for Mr Miskin, he was referred Elmley's palliative care nurse who regularly reviewed him, offering support and advice.

43. The clinical reviewer found that Mr Miskin's chronic medical conditions were managed well at Elmley and his healthcare was comparable with the provision available in the community. We agree with the clinical reviewer that Mr Miskin received a good standard of care at Elmley.

Mr Miskin's location

44. Mr Miskin lived in a double cell on a house block where he felt supported by his friends and had assistance from his cellmate. Nurses reviewed him every day to ensure he was coping, taking his medication and managing his pain.

45. As Mr Miskin's condition deteriorated and required closer observation, healthcare staff moved him to the prison's inpatient unit. When his condition improved, they moved him back to his cell. These moves were made with his consent.

46. In October 2015, the palliative care team discussed with Mr Miskin the option of moving him to a hospice. Both Mr Miskin and healthcare staff did not feel such a move was appropriate at that time. Mr Miskin chose to stay at Elmley as his condition deteriorated.

47. We are satisfied that Mr Miskin was appropriately located throughout his illness and his needs were met in line with his wishes.

Restraints, security and escorts

48. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

49. Mr Miskin was escorted by two officers when he attended hospital. Appropriately, no restraints were applied and the risk assessments took account of his health and risk to the public.

Contact with Mr Miskin's family

50. On 4 March 2017, the prison appointed a prison chaplain as the family liaison officer.

51. At 11.00am, the chaplain, accompanied by a colleague, visited his wife, who was named as the next of kin, to inform her that Mr Miskin had died. There was no one at home.

52. Prison officers had told Mr Miskin's son, who was also a prisoner at Elmley, of his father's death and offered him support. He told the chaplain that his mother was aware of Mr Miskin's death.

53. On 5 March, the chaplain spoke with Mr Miskin's sister. She confirmed that all of the family were aware of Mr Miskin's death. He offered the family the chance to visit the cell in which Mr Miskin died, but they declined. He visited Mr Miskin's son to offer him further support and remained in contact with Mr Miskin's family.

54. Mr Miskin's funeral was held on 4 April. The prison contributed to the funeral costs in line with national policy.

55. We are satisfied there was good, supportive liaison with Mr Miskin's family.

Compassionate release

56. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

57. On 11 April 2015, Mr Miskin applied for release on compassionate grounds. On 12 July, his application was refused due to his high risk of reoffending (Mr Miskin did not admit to aspects of his offending behaviour) and no suitable release

address was in place. Because his circumstances did not change, no further compassionate release applications were made.

58. We are satisfied that the prison appropriately discussed compassionate release with Mr Miskin.

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