

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kenneth Milroy, a prisoner at HMP Northumberland, on 10 March 2020

A report by the Prisons and Probation Ombudsman

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.

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 Kenneth Milroy died at HMP Northumberland on 10 March 2020 from a heart attack. He was 67 years old. I offer my condolences to his family and friends.

The clinical reviewer found that overall, the care Mr Milroy received was of a reasonable standard and was equivalent to that he could have expected to receive in the community. However, she found that there were some failings in how staff responded to Mr Milroy's chest pain in January 2020, though these did not impact 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.

Sue McAllister CB
Prisons and Probation Ombudsman

March 2021

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Summary

Events

1. On 19 November 2004, Mr Kenneth Milroy was given a life sentence for wounding with intent to cause grievous bodily harm. On 29 March 2017, he was sent to HMP Northumberland.
2. Mr Milroy arrived with hypertension (high blood pressure), hyperlipidaemia (a high level of cholesterol in the blood) and obesity. These conditions put him at risk of having a heart attack or stroke.
3. Mr Milroy's blood pressure and cholesterol levels were monitored regularly. Although he accepted medication for his blood pressure, he refused cholesterol-lowering medication.
4. Mr Milroy complained of chest pain in January 2020. He was diagnosed with a chest infection and treated with antibiotics.
5. On the morning of 10 March, Mr Milroy had an argument with another prisoner about him playing loud music. He complained to an officer, who said he would speak to the other prisoner later. The officer walked back to Mr Milroy's cell with him and, when they got there, Mr Milroy collapsed. Staff and ambulance paramedics tried to resuscitate him, but they were unsuccessful.
6. The post-mortem examination found that Mr Milroy died from a heart attack.

Findings

7. The clinical reviewer was satisfied that overall, the healthcare Mr Milroy received at Northumberland was of a reasonable standard and was equivalent to that he could have expected to receive in the community.
8. However, the clinical reviewer had some concerns about how staff responded to Mr Milroy's chest pain in January 2020. She considered that it would have been useful for staff to have carried out a second electrocardiogram (ECG) and taken a blood sample when Mr Milroy experienced further chest pain on the afternoon of 16 January. Staff did not carry out daily observations for four or five days afterwards as advised. Also, mistakes were made in the application of the National Early Warning Score (NEWS) tool.
9. We commend the family liaison officers who broke the news of Mr Milroy's death to his daughter promptly, despite having out of date contact details for her, and they provided a professional and compassionate service to the family.

Recommendations

- The Head of Healthcare should ensure that staff follow the clinical guidance contained in NICE Clinical Guidance 95: *Recent-onset chest pain of suspected cardiac origin: assessment and diagnosis*.
- The Head of Healthcare should ensure that staff adhere fully to advised plans of care.

- The Head of Healthcare should review the training provided to staff on use of the National Early Warning Score (NEWS) to ensure that all staff apply NEWS consistently and respond appropriately to NEWS trigger thresholds.
- The Director should share this report with the family liaison officers so they are aware of the Ombudsman's findings.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and asking anyone with relevant information to contact him. No-one responded.
11. The investigator obtained copies of the relevant extracts from Mr Milroy's medical and prison records.
12. NHS England commissioned a clinical reviewer to review Mr Milroy's clinical care at the prison.
13. We informed HM Coroner for North Northumberland of the investigation. The coroner provided us with the provisional cause of death. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Milroy's next of kin, his daughter, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked whether an altercation her father had had with another prisoner shortly before he died had caused his death. We address this in our report.
15. The initial report was shared with Mr Milroy's daughter. She did not make any comments.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found some factual inaccuracies which have been corrected in this report.

Background Information

HMP Northumberland

17. HMP Northumberland is a category C prison which holds up to 1,348 men. Sodexo Justice Services manage the prison. G4S provided the healthcare services at the time of Mr Milroy's death. Spectrum took over healthcare provision on 1 April 2020.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Northumberland was in August 2017. Inspectors noted that agency staff were regularly used in the healthcare department to cover vacancies and the nursing team struggled to achieve their core functions. Despite this, inspectors found that most healthcare needs were met. As noted above, there has been a change in healthcare provider since that time. Inspectors said that most prison officers [prisoner custody officers] had received appropriate first aid training and had access to defibrillators.

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 31 December 2019, the IMB said they were concerned that with a high number of older prisoners, there were no in-patient facilities or 24-hour healthcare cover. However, on other issues they were hopeful that the new healthcare contract in 2020 would bring improvements.

Previous deaths at HMP Northumberland

20. Mr Milroy was the fifth person to die at Northumberland since March 2018. Of the previous deaths, two were from natural causes, one was drug-related, and one was self-inflicted. The failure to follow National Early Warning Score (NEWS) guidelines for assessing clinical deterioration, was the subject of a recommendation in one of these cases and is again an issue in this report.

Key Events

21. On 19 November 2004, Mr Kenneth Milroy was given a second life sentence for wounding with intent to cause grievous bodily harm. The offence was committed while he was on release on licence following an earlier life sentence for murder. On 29 March 2017, he was sent to HMP Northumberland.
22. Mr Milroy arrived with hypertension (high blood pressure), hyperlipidaemia (high levels of cholesterol in the blood), and obesity. These conditions and a history of smoking put him at an increased risk of having a heart attack or stroke.
23. As a result of his risks, he was monitored regularly at Northumberland for his blood pressure and cholesterol levels. However, while he accepted medication for his blood pressure, he refused to take statins (medication which prevents the formation of cholesterol, to reduce the risk of heart disease and stroke). Mr Milroy was offered, and refused, to take statins on several occasions at his previous prison. He said that he wanted to try and lose some weight before considering statins. He was offered statins again at Northumberland in June 2017. Again, Mr Milroy refused and said he did not want to take tablets. He was also advised about his diet. Although he told his key worker that he was going to try to lose weight, it appears he was unsuccessful.
24. On the morning of 16 January 2020, Mr Milroy complained of chest pain and said he had been breathless overnight. He said he had cold symptoms and a cough, and he described his chest pain as an ache which worsened when coughing. A nurse took his clinical observations and recorded a National Early Warning Score (NEWS) of 1. (NEWS is a clinical tool used to assess the degree of illness of a patient. It is based on clinical observations of respiratory rate, oxygen saturation of the blood, temperature, blood pressure, heart rate, and consciousness and responsiveness. A score is attributed to each clinical observation and then added together – the higher the total score, the higher the degree of clinical support and monitoring required.) The clinical reviewer considered that the NEWS had been calculated incorrectly and should have been 3.
25. Later that morning, a nurse practitioner examined Mr Milroy's chest and diagnosed a chest infection. He prescribed antibiotics and advised daily clinical observations for the next four or five days. He also arranged for an electrocardiogram (ECG - a check of the rhythm and electrical activity of the heart) to be carried out to exclude other causes of chest pain. This showed only a minor abnormality and staff noted that it was unlikely it warranted further investigation (the clinical reviewer noted that minor abnormalities are common and would not cause significant concern).
26. That afternoon, while attending the healthcare centre for a blood pressure check, Mr Milroy experienced heavy chest pain along with feeling clammy and breathless. Staff took his observations and recorded a NEWS of 0. The chest pain resolved but left a residual ache. Staff called an ambulance and Mr Milroy was checked by ambulance paramedics. They found no cause for concern and advised that Mr Milroy should continue to be treated for a chest infection.
27. Staff took Mr Milroy's clinical observations on 17 and 18 January. They were within normal range for him and gave no cause for concern.

28. On 24 January, a nurse saw Mr Milroy after he complained of a tight chest. Mr Milroy said he was 'gassy', and he did not think the pain was heart-related. The nurse took his clinical observations and recorded a NEWS of 4, which included a score of 3 for his breathing rate. This should have triggered hourly observations to determine if Mr Milroy's condition was deteriorating or improving, but this was not done. Mr Milroy was prescribed medication for indigestion.
29. Mr Milroy did not see any healthcare staff for further treatment before he died. He told his key worker on 4 February, that he felt much better and his appetite was nearly back to normal, and on 18 February, that his health issues had cleared up and he felt well.

Events of 10 March

30. Shortly before midday on 10 March, a Prisoner Custody Officer (PCO) overheard an argument between Mr Milroy and another prisoner. Mr Milroy was complaining to the other prisoner that he was playing his music too loudly. They had a verbal argument that lasted 10-15 seconds. The other prisoner switched off his music. Mr Milroy then walked along the landing and spoke to the PCO. He told him that the other prisoner's music was too loud, and he had had enough. The PCO said he would speak to the other prisoner after lunch. Mr Milroy started walking back to his cell and then the argument with the other prisoner flared up again. The PCO said Mr Milroy was very angry and was physically shaking.
31. The PCO told Mr Milroy to calm down and started walking with him towards his cell, but when they got to Mr Milroy's cell door, he collapsed. The PCO used his radio to call a code blue (a medical emergency code used when a prisoner has chest pain, is unconscious or having breathing difficulties, that alerts healthcare staff and prompts the control room to call an ambulance) at 11.58am.
32. There was a prompt response from other officers, and they put Mr Milroy in the recovery position and began cardiopulmonary resuscitation (CPR). Nurses arrived very shortly afterwards. An ambulance crew arrived at the prison at 12.16pm, and a second one at 12.29pm. Despite the combined efforts of all the staff and paramedics, including the application of oxygen and several attempts to shock the heart back into operation, Mr Milroy was declared dead at 1.11pm.

Contact with Mr Milroy's next of kin

33. The prison appointed a Senior Prisoner Custody Officer (SPCO) as the family liaison officer and another SPCO as his deputy. Mr Milroy had listed his daughter as his next of kin. Within an hour of Mr Milroy's death, both SPCOs had arrived at the address on record for Mr Milroy's daughter, but the house was empty. They tried several telephone numbers and, within half an hour, had managed to get hold of Mr Milroy's daughter, who told them she had moved.
34. Both SPCOs went to Mr Milroy's daughter's new address. They explained what had happened and the help they could offer with funeral expenses. The FLO facilitated a visit to the prison by Mr Milroy's daughter and his sister, so they could see where he had lived. He also delivered Mr Milroy's possessions to his daughter.

35. The prison made the arrangements for Mr Milroy's funeral and paid for it in line with national guidance. The funeral took place on 25 March.

Support for prisoners and staff

36. After Mr Milroy's death the duty Director debriefed the staff and the debrief minutes show a good consideration of the issues arising from the incident. All staff who were involved were spoken to by a member of the care team and given advice on follow up support should they need it. The prisoner who was involved in the altercation with Mr Milroy shortly before his death, was also spoken to.
37. The prison posted notices to staff and prisoners informing them of Mr Milroy's death, and offering support.

Post-mortem report

38. The post-mortem report gave the cause of death as myocardial infarction (heart attack) due to hypertensive heart disease (damage to the heart as the result of high blood pressure), and coronary artery atheroma (narrowing of the arteries restricting blood supply to the heart).

Findings

Clinical care

39. The clinical reviewer considered that, overall, the care Mr Milroy received at Northumberland was of a reasonable standard and was equivalent to that he could have expected to receive in the community.
40. Mr Milroy had several conditions, namely high blood pressure, high cholesterol and obesity, which increased his risk of having a heart attack or stroke. Healthcare staff tried to persuade Mr Milroy to take cholesterol-lowering medication to reduce his risk, but Mr Milroy refused. The clinical reviewer found that the management of Mr Milroy's long-term conditions was very good, but she had some concerns about the care he received when he complained of chest pain in January 2020, around two months before his death.
41. When Mr Milroy experienced chest pain on the afternoon of 16 January, it appeared to be slightly different in nature to the pain he had experienced earlier that day. The clinical reviewer considered that staff were correct to call an ambulance, but she thought it would also have been useful to have also carried out another ECG and taken blood samples for cardiac troponins (troponin is a protein that is released into the bloodstream during a heart attack). We recommend:

The Head of Healthcare should ensure that staff follow the clinical guidance contained in NICE Clinical Guidance 95: *Recent-onset chest pain of suspected cardiac origin: assessment and diagnosis*.

42. When the nurse practitioner examined Mr Milroy on the morning of 16 January and diagnosed a chest infection, he advised that Mr Milroy should have clinical observations taken every day for four to five days. Staff took observations on 17 and 18 January but did not do so after that. We recommend:

The Head of Healthcare should ensure that staff adhere fully to advised plans of care.

43. The clinical reviewer noted that the NEWS tool was not always applied correctly. On 16 January, a nurse miscalculated the NEWS as 1, when it should have been 3. On 24 January, a nurse calculated a NEWS of 4, which included a score of 3 for breathing rate and should have triggered hourly observations. This did not happen.
44. We have previously made a recommendation to Northumberland about the consistent use of NEWS. In its action plan, the prison said that it would ensure that 90% of clinical staff had completed e-learning on NEWS by September 2019 and that quarterly audits of the use of NEWS would be undertaken. We are concerned that NEWS is still not being applied correctly by healthcare staff at Northumberland. We recommend:

The Head of Healthcare should review the training provided to staff on use of the National Early Warning Score (NEWS) to ensure that all staff apply NEWS consistently and respond appropriately to NEWS trigger thresholds.

Mr Milroy's argument with another prisoner on the day of his death

45. Mr Milroy's daughter wanted to know if the disagreement her father had with another prisoner shortly before he died contributed to his death. A PCO described Mr Milroy as very angry and physically shaking after his argument with another prisoner on the morning of 10 March, and he collapsed soon after.
46. We note that Mr Milroy had several long-term conditions that increased his risk of a heart attack and he declined medication that may have reduced his risk. The pathologist who conducted the post-mortem examination noted that Mr Milroy would have been at significant risk of a sudden cardiac death at any time but also said, "It is not possible to determine the precise timing of the start of the abnormal heart rhythm...It is also not possible to determine at what point the heart started to become under strain. Nonetheless, there is a strong temporal [time] association with the verbal altercation and therefore it is reasonable to associate the altercation and Mr Milroy's subsequent collapse and death."

Family liaison

47. The FLO and his deputy demonstrated commendable professionalism, both in the efforts they made to avoid delay in passing on the news to Mr Milroy's daughter despite out of date address details, and in the empathy they showed her throughout the process. We recommend:

The Director should share this report with both FLOs so they are aware of the Ombudsman's findings.

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