

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Derek Flynn a prisoner at HMP Buckley Hall on 15 September 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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 Derek Flynn died on 15 September 2015 of pneumonia and chronic obstructive pulmonary disease, while a prisoner at HMP Buckley Hall. He was 43 years old. I offer my condolences to Mr Flynn's family and friends.

The investigation found that, generally, healthcare staff treated Mr Flynn's health conditions appropriately, and could not have prevented his death. However, medical records were poor and did not always clearly show the reasons for clinical decisions. While this did not affect the outcome for Mr Flynn, I consider the prison needs more effective record keeping.

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

May 2016

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Summary

Events

1. On 14 June 2014, Mr Derek Flynn was recalled to prison after breaching licence conditions from a previous sentence. He had been at Buckley Hall since 5 August 2014. He suffered from epilepsy, depression and paranoid schizophrenia. He had a history of drug and alcohol misuse and received methadone treatment for opiate dependency. Mr Flynn smoked cigarettes.
2. In September 2014, Mr Flynn said he was having seizures each week. He was referred urgently for a neurology appointment but did not have one until August 2015. Officers and healthcare staff suspected Mr Flynn used new psychoactive substances (NPS) but he usually denied this. In March 2015, he was treated in hospital for pneumonia. Doctors diagnosed chronic obstructive pulmonary disease (COPD) and he admitted using NPS.
3. On 29 May, Mr Flynn had a bad reaction to using NPS. He was taken to hospital for review and returned to the prison later that day.
4. In July, Mr Flynn was treated in hospital for pneumonia. He had pneumonia again in September and returned from hospital on 10 September. At 7.35am on 15 September, he collapsed in his cell and then stopped breathing. Healthcare staff and officers attempted cardiopulmonary resuscitation. Paramedics arrived and took him to hospital. Mr Flynn did not recover and hospital doctors recorded his death at 9.30am. A post-mortem examination found that he had died of pneumonia and COPD.

Findings

5. Healthcare staff generally treated Mr Flynn's health conditions appropriately. Although there was no named nurse to coordinate his care, there were some good examples of joint working across healthcare teams. However, the clinical reviewer identified some areas for improvement, including medical record keeping, which was poor and did not clearly show the reasons for clinical decisions or effectively document care plans. Although this would not have changed the outcome for Mr Flynn, there was no system to follow up hospital referrals. The emergency response was quick and appropriate.

Recommendation

- The Head of Healthcare should ensure that all healthcare staff follow professional guidance for record keeping, including making clear, prompt and accurate entries in medical records, which reflect all major diagnostic investigations and care plans.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Buckley Hall informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.
7. The investigator visited Buckley Hall on 21 September. She obtained copies of relevant extracts from Mr Flynn's prison and medical records and interviewed two prisoners. She interviewed one member of staff by telephone on 30 October.
8. NHS England commissioned a clinical reviewer to review Mr Flynn's clinical care at the prison.
9. We informed HM Coroner for Greater Manchester North District of the investigation, which was suspended until we received the cause of death. The coroner's office sent the investigator the post-mortem report on 12 January 2016 and we resumed the investigation. We have sent the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted Mr Flynn's parents to explain the investigation. They did not have any specific additional matters for the investigation to consider.
11. Mr Flynn's family were informed the initial report was available, but did not wish to receive a copy or make any comment.
12. The prison has also submitted an action plan detailing what they have done to address the issues we raised.

Background Information

HMP Buckley Hall

13. HMP Buckley Hall is a medium security prison holding just over 400 men. There are four residential blocks, one of which is a dedicated drug recovery wing. Manchester Mental Health and Social Care Trust provide healthcare seven days a week with a multidisciplinary team of GPs, general and mental health nurses.

HM Inspectorate of Prisons

14. The most recent inspection of Buckley Hall was in April 2012. Inspectors reported that prisoners were generally satisfied with the access they had to health services and the quality of care provided, although waiting times were long. There was a good range of specialist clinics. Emergency resuscitation equipment was available on each wing.

Independent Monitoring Board

15. 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 July 2015, the IMB reported that the changes in healthcare provider and to medication practices did not appear to affect the services provided, which were to a good standard.

Previous deaths at HMP Buckley Hall

16. Mr Flynn was the second person to die of natural causes at Buckley Hall since January 2014. There were no similarities with the circumstances of the other death.

New psychoactive substances (NPS)

17. New psychoactive substances (NPS) are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.
18. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances, while in prison can lead to debt, violence and intimidation.
19. In July 2015, we published a Learning Lesson Bulletin about the use of NPS including the dangers to both physical and mental health and the possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Key Events

20. Mr Derek Flynn was sentenced to three years in prison on 27 February 2012, for violent offences. He was released on licence on 13 May 2014. On 14 June 2014, he was recalled to HMP Manchester, for breaching the conditions of his licence. At an initial health screen a prison GP noted that Mr Flynn was overweight and smoked cigarettes. He suffered from epilepsy, depression and paranoid schizophrenia. He also had leg pain. He had a history of drug and alcohol misuse. He took medication for his physical and mental health problems and was on a methadone maintenance programme for opiate dependency.
21. On 5 August, Mr Flynn transferred to HMP Buckley Hall. On 11 August, an officer recorded that, while he had been out of prison on licence, he had used alcohol and new psychoactive substances (NPS). A mental health nurse reviewed Mr Flynn on 3 September, who said he had one to four seizures in a week. The nurse referred Mr Flynn urgently to the neurology department at hospital. (He had an appointment on 30 October 2014 and a follow-up appointment on 21 August 2015.)
22. In October and November 2014, Mr Flynn attended a course to help give up smoking but did not stop. At least five times between February and May 2015, officers reported that Mr Flynn seemed to be under the influence of drugs, such as NPS. However, he always denied this. Mr Flynn sometimes behaved strangely as a result of his medication. Mr Flynn was regarded as vulnerable and his care and management was often discussed at prison safer regimes meetings.
23. On 30 March, Mr Flynn was taken to hospital as an emergency, after an officer found him unresponsive in his cell and nurses noted his oxygen saturation levels were low. He was admitted to hospital and treated for pneumonia. Doctors diagnosed chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema). While in hospital, Mr Flynn admitted to using NPS. He returned to prison on 5 April, with antibiotics and a prison GP also prescribed inhalers to help his breathing.
24. Records show that Mr Flynn repeatedly smoked “Spice” (a new psychoactive substance in the form of a synthetic cannabinoid) and misused his medication. On 4 May, a nurse examined Mr Flynn when officers found him incoherent and sleepy. Mr Flynn denied any illicit drug use and asked for his prescribed medication. However, against advice, he refused to take his epilepsy medication. That day, an officer began a TASA (tackling anti-social attitudes) support plan, as staff were concerned that Mr Flynn was at risk of being bullied.
25. On 12 May, a dentist noted that Mr Flynn had an ulcer on his tongue, which she considered was potentially cancerous. The dentist monitored the ulcer and, on 26 May, made an urgent referral under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. The SystemOne notes did not clearly show that this referral had been completed, but the prison provided evidence that this was done on 8 June 2015.
26. On 29 May, officers asked a nurse to examine Mr Flynn in his cell because he was unwell. Mr Flynn was unable to follow simple instructions, had difficulty lifting his head or opening his eyes, and his oxygen saturation level was low. He

denied taking any illicit substances and a nurse sent him to hospital. Hospital doctors reviewed him and he returned to prison the same day. He was held in the segregation unit.

27. On 1 June, Mr Flynn admitted that he had used NPS and that this had caused him to be unwell on 29 May. He wanted to go back to his usual wing but staff thought he would go back to using drugs there. The next day he was moved to D Wing, the enhanced unit, to complete a short recovery programme and where he could get more support.
28. On 18 July, officers were concerned about Mr Flynn as he was acting strangely and had slurred speech. A nurse examined him and he denied using NPS. His oxygen levels were low and he was wheezing. He said that he had felt short of breath for a few days, but had not used his inhalers as they did help. The nurse sent him to hospital, where doctors diagnosed severe pneumonia. The hospital treated Mr Flynn with antibiotics and discharged him the next day. On 29 June, Mr Flynn asked to go on a waiting list for a class to help give up smoking.
29. On 28 July, a prison GP recorded that Mr Flynn's oxygen levels were low and his feet were swollen. He had a distended abdomen, a fast heart rate and a slightly raised temperature. He sent Mr Flynn to hospital for further assessment. Mr Flynn returned the same day, with more antibiotics. There was no discharge record from the hospital.
30. Officers noted that Mr Flynn found it difficult to move about the wing. On 31 July, social care workers assessed him and told him he needed to be more active. Staff and other prisoners said that Mr Flynn was unsteady on his feet and often became dizzy. Prison and healthcare staff monitored him daily. On 12 August, a nurse reviewed his COPD and noted a sputum sample was clear.
31. On 8 September, a prison GP reviewed Mr Flynn, who was generally well but his oxygen level was very low and the doctor sent him to hospital for oxygen treatment. Hospital doctors diagnosed pneumonia again, and gave him antibiotics and a nebuliser (a machine which dispenses medication in a fine mist). Mr Flynn returned to the prison on 10 September. Staff recorded that he seemed better and told him that he needed to report symptoms earlier, so that he did not become so unwell before receiving treatment.

15 September 2015

32. Sometime between 7.05am and 7.15am on 15 September, Officer A did a roll check of prisoners. He said he saw Mr Flynn sitting on his bed at the time. He had no concerns about him. He left D Wing, to work on C Wing, and handed over to Officer B at about 7.15am. Officer B said she was in the wing office, when she heard a loud bang at about 7.35am.
33. Officer B went to Mr Flynn's cell, looked through the observation hatch and saw Mr Flynn on the floor. She called his name and thought she heard a murmur. She radioed a code blue (indicating a medical emergency when a prisoner is unconscious or not breathing). The control room called an ambulance immediately. She put her key in the lock and waited before going into the cell

until Officer C arrived about a minute later. (We are satisfied that this very slight delay in going into the cell did not affect the emergency response.)

34. Mr Flynn was unresponsive and the officers moved him to the landing where there was more room. A nurse arrived quickly with emergency equipment. Initially, she noted Mr Flynn was breathing abnormally, and then he stopped breathing. She inserted an airway and started cardiopulmonary resuscitation with the help of officers and other nurses.
35. Paramedics arrived at 7.48am and continued emergency treatment. The paramedics took Mr Flynn to hospital but he did not recover. At 9.30am, he was pronounced dead.

Contact with Mr Flynn's family

36. At 10.00am on 15 September, a senior prison manager went to see Mr Flynn's parents, informed them of his death and offered condolences and support. The prison appointed a prison manager as their family liaison officer. He visited Mr Flynn's parents on 17 September to support them and remained in contact with them.
37. Mr Flynn's funeral was on 23 October. The prison contributed towards the costs in line with national policy.

Support for prisoners and staff

38. After Mr Flynn's death, a senior 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.
39. The prison posted notices informing staff and prisoners of Mr Flynn's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Flynn's death.

Post-mortem report

40. The post-mortem found that Mr Flynn died of pneumonia. Chronic obstructive pulmonary disease, emphysema and obesity were contributing factors to his death.

Findings

Clinical care

41. The clinical reviewer considered there were some examples of positive clinical care for Mr Flynn. He received appropriate treatment for COPD and epilepsy and for his substance misuse and mental health problems. Although there was no record of a named nurse to coordinate his care, there was good joint working across the teams to plan and implement his treatment. The emergency response was good. We are satisfied that there was nothing healthcare staff at Buckley Hall could have done to prevent his sudden death from pneumonia. However, medical record keeping and evidence of management of urgent referrals was poor. The clinical reviewer had made additional recommendations for improvements in health services at the prison, which the Head of Healthcare will need to address.

Medical record keeping

42. The clinical reviewer was satisfied that clinicians at Buckley Hall prescribed the correct medications for Mr Flynn's medical conditions, although he often refused to take his epilepsy medication. However, care plans were unclear and the reasons for clinical decisions were not always recorded. The clinical reviewer considered that record keeping was poor. Although this did not affect the outcome for Mr Flynn, poor recording has the potential to affect a patient's standard of care. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff follow professional guidance for record keeping, including making clear, prompt and accurate entries in medical records, which reflect all major diagnostic investigations and care plans.

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