Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Flanagan a prisoner at HMP Gartree on 16 May 2016

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 Anthony Flanagan died of widespread abdominal cancer and acute pancreatitis on 16 May 2016 at HMP Gartree. He was 75 years old. I offer my condolences to Mr Flanagan's family and friends.

The clinical reviewer found that much of Mr Flanagan's care at the prison was good, but identified some areas for improvement, including the need for healthcare staff to review deteriorating prisoners more frequently. I am concerned that no one followed up Mr Flanagan's report of significant pain and weight loss, particularly as such symptoms can be indicators of a serious underlying condition.

When Mr Flanagan was found unresponsive, control room staff did not call an ambulance immediately and there was a delay escorting the ambulance. I am satisfied that this did not affect the outcome for Mr Flanagan, as staff responded promptly, but in other circumstances, it could be crucial.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Richard Pickering
Deputy Prisons and Probation Ombudsman **December 2016**

Contents

Summary

Events

1. In March 1996, Mr Anthony Flanagan was sentenced to life imprisonment for murder. He had been at HMP Gartree since August 2010. He had a number of long-term health conditions, including chronic back pain, chronic obstructive pulmonary disease (COPD – the name for a collection of chronic lung diseases such as chronic bronchitis and emphysema) and high blood pressure. He had limited mobility and used a wheelchair.

2. Nurses managed Mr Flanagan's medical conditions in line with his care plans. Prison GPs reviewed his prescriptions regularly, although they had not seen him in person for over two years before he died. As Mr Flanagan became less mobile, nurses treated him and dispensed his daily medication on the wing. While receiving medication on 5 December 2015, he reported feeling unwell, with symptoms of increased pain, reduced mobility and weight loss. A GP planned to review him, but no action was taken on the request for an appointment.

3. On 13 May 2016, a nurse smelt vomit and noticed Mr Flanagan had lost weight. Concerned for his health, she liaised with a senior nurse and they arranged for a blood test and GP appointment on 16 May. Over the next two days, another nurse reviewed Mr Flanagan twice and offered to call an out-of-hours GP, but he preferred to wait for his appointment.

4. On 16 May, at 5.50am, a night patrol officer found Mr Flanagan unresponsive in his cell and issued an emergency medical code. Additional staff arrived within a few minutes and a nurse began cardiopulmonary resuscitation (CPR). At 5.56am, the control room called an ambulance, which arrived at the prison at 6.08am, but the paramedics did not get to Mr Flanagan's cell until 6.25am. The paramedics took over CPR but, at 6.57am, they confirmed that Mr Flanagan had died.

Findings

5. We are concerned that Mr Flanagan's perceived symptoms of increased pain and weight loss were not fully investigated in December 2015.

6. The clinical reviewer noted that much of Mr Flanagan's care was good, but considered that closer monitoring of his deteriorating condition might have led to emergency medical care.

7. The investigation found that staff did not have good knowledge of the expected emergency procedures. This delayed the paramedics' arrival at the prison and gaining access to Mr Flanagan's cell.

Recommendations

- The Head of Healthcare should ensure that significant symptoms in prisoners, such as increased pain and unexplained weight loss, are investigated and monitored to determine the underlying cause.

- The Head of Healthcare should ensure that healthcare staff use the MEWS system and pain scale appropriately to assess the severity of acute symptoms and increase the level of monitoring, when indicated.
- The Governor should ensure that all prison and healthcare staff understand their responsibilities during medical emergencies, as outlined in PSI 03/2013 and the local Medical Emergency Response Protocol, so that there are no delays in calling, directing or discharging ambulances. In particular, control room staff should call an ambulance immediately on receiving an emergency medical code and staff should be familiar with the procedures for opening vehicle gates in an emergency.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Gartree informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

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

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

11. The investigator, clinical reviewer and one of the Ombudsman's fatal incidents managers interviewed four members of staff and one prisoner at Gartree on 27 June 2016. The investigator interviewed two members of staff by telephone on 28 June and 28 July.

12. We informed HM Coroner for Leicester City and South District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Flanagan's daughter to explain the investigation. She had no specific matters for the investigation to consider.

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

15. The initial report was shared with the prison service. The prison service did not find any factual inaccuracies.

Background Information

HMP Gartree

16. HMP Gartree near Market Harborough in Leicestershire holds up to 708 men sentenced to life imprisonment and other indeterminate sentences. Leicestershire Partnership Trust is responsible for delivering primary physical and mental health services in the prison and Northamptonshire Healthcare NHS Foundation Trust runs secondary mental health in-reach services. Nursing staff are available 24 hours a day.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Gartree was in March 2014. Inspectors were positive about the range and standard of health services. Prisoners' access to healthcare services was very good and waiting times for all clinics were short. Nurses held triage clinics daily with open access for prisoners with urgent needs. Prisoners were able to see a GP routinely within three days.

Independent Monitoring Board

18. 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 November 2015, the IMB reported that a delay in renewing the healthcare contract had caused some uncertainty but it had been decided that the existing providers would continue until 2017. The IMB was concerned that the growing number of older prisoners and those suffering from terminal illness or in need of operations would create a major problem in providing staff for escorts. Leicestershire County Council was working closely with the healthcare provider and the prison to help meet the social care needs of a number of older prisoners.

Previous deaths at HMP Gartree

19. Mr Flanagan was third prisoner to die of natural causes at HMP Gartree since November 2014. There has been one subsequent death. There were no similarities with the circumstances of the previous deaths.

Key Events

20. Mr Anthony Flanagan had been in prison since 27 January 1995. In March 1996, he was sentenced to life imprisonment for murder. He spent time at a number of prisons and had been at HMP Gartree since 20 August 2010. Over time, Mr Flanagan developed several long-term health conditions including chronic back pain, chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema) and high blood pressure. He had poor mobility that worsened over time and used a wheelchair to get around.

21. Healthcare staff at Gartree monitored Mr Flanagan's chronic conditions, prescribed appropriate medication and created care plans for COPD and high blood pressure. As his mobility decreased, nurses dispensed his daily medication on the wing and in his cell. Mr Flanagan did not leave his cell during the last year of his life, though other prisoners, who acted as his carers, brought him his meals and healthcare staff visited him in his cell. Mr Flanagan often refused additional support.

22. On 5 December 2014, a nurse told Mr Flanagan that as tramadol (an opioid painkiller) was a controlled drug, healthcare staff could no longer take it to the wing. The same day, another nurse told Mr Flanagan that he would still receive gabapentin (a medication used to treat nerve pain) and requested a GP review. Mr Flanagan failed to attend appointments on 11 and 15 December and the reasons for his non-attendance were not recorded in his medical record. On 30 December, a doctor replaced his tramadol prescription with one for dihydrocodeine (a painkiller used to treat moderate to severe pain).

23. Over the next 12 months, nurses continued to issue Mr Flanagan's daily medication on the wing and review his care plans. Prison GPs did not see him, although they frequently reviewed his prescriptions. Healthcare staff offered Mr Flanagan medical appointments several times, in January, June and November 2015, but he did not want to see a GP.

24. On 5 December, Mr Flanagan told a nurse that he felt generally unwell. He reported pain, weight loss and difficulty moving around, sometimes falling. She arranged for a prison GP to review Mr Flanagan's medication with a view to increasing his gabapentin. On 7 December, the GP requested an appointment to see Mr Flanagan as he was already receiving a high dose. There is no evidence that this appointment was arranged, or took place and healthcare staff did not follow up Mr Flanagan's concerns.

25. Nurses continued to monitor Mr Flanagan, issue daily medication and review his care plans. GPs reviewed his prescriptions regularly but they did not see him in person. Between mid-December 2015 and May 2016, there is no record that Mr Flanagan mentioned an increase in pain, or weight loss to healthcare staff.

Events from Friday 13 May to Monday 16 May 2016

26. While dispensing Mr Flanagan's medication on 13 May, a nurse noticed that he had lost weight since she last saw him a few weeks before. Mr Flanagan did not mention any concerns, but the smell of vomit and his general presentation

prompted her to return to his cell later that morning. She shared her concerns with Mr Flanagan, who told her that he had been vomiting for a couple of months, not opened his bowels for 10 days and had abdominal pain. She had already had a discussion with the physical health manager and told Mr Flanagan that she would arrange for a blood test and a GP appointment on 16 May. She took his clinical observations and applied a modified early warning system score (MEWS - a clinical assessment based scoring system aimed at the early identification of deteriorating patients) of two (a score of one to two would indicate a low cause for concern).

27. On 14 May, at a review with a nurse, Mr Flanagan reported feeling generally unwell. She offered to call an out-of-hours GP, but Mr Flanagan wanted to wait for the GP appointment, due the next day. She took his clinical observations and documented a MEWS score of two. The next morning, she noted that Mr Flanagan had still not opened his bowels and offered to call out a GP, but he declined once more. She took his clinical observations and applied a MEWS score of one. A friend of Mr Flanagan's told the investigator that he had complained of stomach pain and vomiting for some time, but he did not want healthcare staff to know the extent of his health problems.

28. At approximately 5.50am on 16 May, while conducting the morning roll check (count) of prisoners, an operational support grade found Mr Flanagan unresponsive in his cell. He immediately called an emergency code blue (which indicates that a prisoner is unconscious or has breathing problems). Within minutes, a prison manager, an officer and a nurse arrived on the wing. The manager opened the cell door and went in. She noticed that Mr Flanagan's face was blue and his eyes were glazed.

29. After failing to get a response from Mr Flanagan, the nurse moved him onto the floor with the help of the manager. He applied a defibrillator, issued oxygen and started cardiopulmonary resuscitation (CPR) at 6.00am. In the meantime, the manager radioed the control room and confirmed that an ambulance was required. The control room called the ambulance at 5.56am, six minutes after the operational support grade's code blue call at 5.50am.

30. The manager instructed the officer to unlock the main vehicle gate to allow the ambulance to get into the prison and explained the process to him. She then asked another officer to escort the ambulance from the gate. The ambulance arrived at the prison at 6.08am, entered the sterile area at 6.12am and was already there when the officer arrived. The control room opened the main internal gate and escorted the ambulance to the wing through four additional gates. At 6.25am, the paramedics arrived at Mr Flanagan's cell and took over CPR from the nurse. At 6.57am, the paramedics confirmed that Mr Flanagan had died.

Contact with Flanagan's family

31. Later that morning, the prison appointed an offender supervisor and an officer as the prison's family liaison officers, who went to the address listed for Mr Flanagan's daughter to break the news of his death, but found she no longer lived there. They made several unsuccessful attempts to contact her. The offender supervisor eventually managed to speak to Mr Flanagan's son and

broke the news. On 19 May, after liaising with other family members, the offender supervisor spoke to Mr Flanagan's daughter, who lives in Australia. By then she was already aware that her father had died. The offender supervisor offered support and remained in contact with the family.

32. Mr Flanagan's funeral took place on 8 June 2016. The prison contributed to the funeral expenses, in line with national Prison Service policy.

Support for prisoners and staff

33. After Mr Flanagan's death, a 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.

34. The prison posted notices informing other prisoners of Mr Flanagan'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 Flanagan's death.

Post-mortem report

35. The coroner confirmed that Mr Flanagan died of widespread intra-abdominal cancer and acute pancreatitis. Pancreatic cancer was the underlying cause.

Findings

Clinical care

36. The clinical reviewer found that much of Mr Flanagan's medical care in prison was of a good standard. Healthcare staff created care plans, managed his chronic conditions well and prescribed appropriate medication. While we are satisfied with the care Mr Flanagan received for his long-term conditions, we are concerned that healthcare staff did not explore his symptoms of increased pain and weight loss on 5 December, or follow-up the GP's request for an appointment with him. We make the following recommendation:

The Head of Healthcare should ensure that significant symptoms in prisoners, such as increased pain and unexplained weight loss, are investigated and monitored to determine the underlying cause.

Monitoring Mr Flanagan's declining condition

37. During the last three days of Mr Flanagan's life, nurses used the MEWS system to monitor his condition while they waited for a GP appointment. The clinical reviewer stated that a score between one and two indicated the need for clinical observations every four hours, but there was no evidence that Mr Flanagan received this additional monitoring. The clinical reviewer also noted that a pain scale (a self-report scale used to measure the intensity of a patient's pain) should be used when monitoring a prisoner's deteriorating condition, as the MEWS tool does not monitor pain. While we recognise that Mr Flanagan chose to wait to see a GP, more frequent monitoring might have provided a clearer picture of the extent of his deterioration and allowed for emergency intervention.
We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff use the MEWS system and pain scale appropriately to assess the severity of acute symptoms and increase the level of monitoring, when indicated.

38. The clinical reviewer identified the need for improvement in some aspects of the prison's healthcare services, such as the co-ordination and integration of medical care. The Head of Healthcare will need to address separately those matters not covered in this report.

Emergency response

39. The operational support grade responded quickly when he found Mr Flanagan unresponsive and called the correct emergency code. He was fully aware of the policy about risk assessments and entering cells at night, but told the investigator that he consciously did not enter Mr Flanagan's cell as he did not feel it was safe to do so alone. He could not see Mr Flanagan's face or hands and did not have any knowledge of his medical history, so decided to wait. Although this caused a short delay in Mr Flanagan receiving attention, staff responded promptly. We are satisfied that the operational support grade's decision not to open Mr Flanagan's cell until additional support arrived was reasonable in the circumstances.

40. The control room received the code blue at 5.50am, but did not call an ambulance until 5.56am. In line with Prison Service Instruction (PSI) 03/2013 on emergency medical response codes, Gartree's local emergency response protocol states the control room should call an ambulance automatically as soon as a code blue emergency is called. However, the control room did not call an ambulance until the prison manager confirmed an ambulance was required.

41. The ambulance arrived at the prison 12 minutes after the control room requested it. It then took 17 minutes to escort the paramedics to Mr Flanagan's cell. In line with PSI 03/2013, Gartree's local emergency response protocol states that staff should follow local instructions to facilitate the swift entry and exit of emergency vehicles by giving them priority and minimising waiting times. An officer had to guide the ambulance through a series of four vehicle gates, manually unlocking and locking the locks and separate bolts on each one. He told the investigator that it was the first time he had carried out this task and he felt that it might have been done quicker by someone more experienced. He said that operational support grade staff, rather than officers, usually escorted vehicles through the prison. Although we recognise that Mr Flanagan was receiving emergency treatment from healthcare staff, we are concerned that an apparent lack of training and general awareness of local procedures delayed the paramedics' arrival.

42. While there was no evidence that calling an ambulance immediately or ensuring that the paramedics reached the wing earlier would have altered the outcome for Mr Flanagan, it is important that there is no avoidable delay in any emergency. We make the following recommendation:

The Governor should ensure that all prison and healthcare staff understand their responsibilities during medical emergencies, as outlined in PSI 03/2013 and the local Medical Emergency Response Protocol, so that there are no delays in calling, directing or discharging ambulances. In particular, control room staff should call an ambulance immediately on receiving an emergency medical code and staff should be familiar with the procedures for opening vehicle gates in an emergency.

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