Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Walter Flavell a prisoner at HMP Chelmsford on 1 July 2017

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.

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 Walter Flavell died on 1 July 2017 of peritonitis, in addition to a bowel obstruction and urinary bladder cancer, while a prisoner at HMP Chelmsford. He was 88 years old. We offer our condolences to Mr Flavell's family and friends.

Chelmsford prison was not an appropriate location for Mr Flavell. Staff made attempts to find an alternative prison for him, but without success. We are satisfied, however, that Mr Flavell received a good standard of care and that his care was equivalent to that which he could have expected to receive in the community.

We are concerned to see that an elderly, very ill and frail man was restrained when he attended hospital appointments.

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 **April 2018**

Contents

Summary

Events

1. On 4 May 2015, Mr Walter Flavell was sentenced to 4 years and 9 months in prison for sexual offences. He was sent to HMP Chelmsford.

2. While in Chelmsford, Mr Flavell received ongoing care, both from healthcare staff and via referrals to secondary care providers, for issues with his memory. Good care plans were implemented which were regularly reviewed.

3. During November 2015, Mr Flavell had blood in his urine. Healthcare staff quickly referred him to hospital specialists, who diagnosed him with bladder cancer. Hospital staff discovered three tumours in his bladder, which were removed surgically, followed by a course of immunotherapy. Mr Flavell continued to be cared for by healthcare and hospital staff.

4. In June 2017, Mr Flavell's condition deteriorated. He was taken to hospital for review, where it was discovered he had a large obstruction in his bowel. Due to his physical condition, it was decided that he was not suitable for further surgery. Mr Flavell's family agreed, and the decision was taken to stop all further treatment.

5. Healthcare staff monitored Mr Flavell 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.

6. Mr Flavell's condition continued to decline. He died at 1.00pm on 1 July.

7. Overall, Mr Flavell 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.

8. However, prior to his final admission, on the occasions Mr Flavell required hospital treatment, he was inappropriately restrained. Risk assessments did not properly consider the implications of his very poor health and limited mobility for his risk. The restraints were appropriately removed when he received treatment.

9. Chelmsford was not the best location to cater for Mr Flavell's care needs. Despite their best efforts, prison and healthcare staff were unable to secure a transfer to a more appropriate location.

Recommendations

- **The Head of Healthcare should ensure that there is a clear care pathway between the prison and dementia and memory clinic services to ensure that such health needs are properly met.**

- **The Governor should ensure that risk assessments for prisoners attending hospital appointments fully take into account individual circumstances and are based on the actual risk a prisoner presents at the time.**

- **The Prisons Group Director for Kent and Essex should review pathways and provision of care for very ill and terminally ill prisoners.**

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Chelmsford 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 Flavell's prison and medical records.

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

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

14. The investigator wrote to Mr Flavell's next of kin to explain the investigation and to ask if he had any matters he wanted the investigation to consider. We did not receive a response.

15. The investigation has assessed the main issues involved in Mr Flavell'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.

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

Background Information

HMP Chelmsford

17. HMP Chelmsford is a local prison that takes prisoners directly from the courts. It holds nearly 730 men aged 18 years and older. At the time of Mr Flavell's death, Essex Partnership University NHS Foundation Trust was commissioned to provide 24-hour healthcare, which includes a range of primary care and secondary mental health services. The prison has a 12 bed inpatient unit.

18. Prior to Mr Flavell's death, Care UK had responsibility for delivering healthcare services at the prison.

HM Inspectorate of Prisons

19. The most recent inspection of Chelmsford was in April 2016. Inspectors found progress had stalled since the previous inspection in 2014. Prisoners spoke positively about the care they had received and relationships between staff and prisoners were also noted as being positive.

20. At the time of their inspection, healthcare services at the prison were commissioned by NHS England and delivered by Care UK. They noted the newer part of healthcare included a 12 bed, 24 hour inpatient unit.

21. They considered that the quality of healthcare had deteriorated since their last inspection and provision of healthcare was inadequate, exacerbated by staff shortages and poor clinical governance. The integrated mental health team was noted as not being used effectively to meet the needs of the population.

Independent Monitoring Board

22. 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 August 2016, the IMB noted that despite Care UK making changes to their structure, they repeated their concerns from previous reports that the level of physical and mental health care service at the prison was inadequate.

Previous deaths at HMP Chelmsford

23. Mr Flavell was the second prisoner to die at Chelmsford from natural causes since the beginning of 2016. There are no similarities with this case.

Findings

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

24. On 4 May 2015, Mr Walter Flavell was sentenced to 4 years and 9 months in prison for sexual offences. He was sent to HMP Chelmsford.

25. While carrying out Mr Flavell's initial healthscreen, a nurse noted he had a tremor in his hands. Mr Flavell told the nurse he suffered from Parkinson's disease. He also told her he had been treated for skin cancer before he was imprisoned. The nurse requested his community GP records in order to get more information.

26. The community GP records indicated that in January 2015, a neurologist had reviewed Mr Flavell. He had excluded the diagnosis of Parkinson's disease, but had prescribed him 40 mgs of propranolol medication in an attempt to control his tremors. The neurologist planned to review Mr Flavell in January 2016. The medical records also indicated that Mr Flavell's community GP had removed three skin lesions and had referred him to the dermatology team for a possible skin cancer review. As Mr Flavell was an elderly prisoner, healthcare staff devised care plans to manage his social care and reviewed him regularly.

27. On 7 July, healthcare staff became increasingly concerned at the level of assistance Mr Flavell needed. He had a number of minor falls in his cell and often appeared confused. Staff decided to move him to the prison's inpatient unit; they also made a referral for a psychiatric review to assess his mental health.

28. On the same day, a prison GP reviewed Mr Flavell. He referred Mr Flavell to hospital for a CT scan of his head on 10 July. (CT computerised tomography, uses multiple X-ray images of a structure within the body.) It revealed nothing of concern.

29. Healthcare staff updated Mr Flavell's care plans and Essex Social Services were contacted to advise on his suitability for a care and needs support assessment. Following the assessment, Care UK agreed to supply the extra staff required to care for Mr Flavell and Essex County Council would fund the extra costs.

30. On 20 July, a psychiatrist working closely with Chelmsford reviewed Mr Flavell. He concluded Mr Flavell did not have depression or any other form of mental illness.

31. On 2 September, a prison GP reviewed Mr Flavell after he had fallen in his cell, injuring his elbow and the back of his head. He noted the injuries were not serious and his observations were normal. However, he noted Mr Flavell's condition was deteriorating and he appeared increasingly frail.

32. The same day, due to the concerns about his physical condition, healthcare staff, assisted by Offender Management Unit staff, made enquiries with HMP Whatton and Littlehey as to the availability of a more suitable location for Mr Flavell. As Mr Flavell required support with daily tasks from social carers, he did not fit the criteria for a transfer. Staff contacted HMP Norwich, who advised that while Mr

Flavell did meet their criteria, there were no spaces available. He would however be placed on a lengthy waiting list.

33. On 7 September, healthcare staff became increasingly concerned with Mr Flavell's deteriorating condition. Following a review by a prison GP, Mr Flavell was admitted to hospital for further examination. He remained in hospital as an inpatient until 14 September. Hospital staff diagnosed Mr Flavell as having a urine infection which required treatment with a course of strong antibiotics. They also advised that Mr Flavell should be referred to the Memory Assessment and Support Service, a service provided by Essex Partnership University NHS Foundation Trust within the hospital. A prison GP made the referral as advised. However, the memory assessment team refused the referral due to lack of a commission to undertake testing or treat patients in HMP Chelmsford. There is no evidence in Mr Flavell's medical records that healthcare staff followed up or challenged this refusal.

34. During the weeks that followed, healthcare staff regularly reviewed and updated the care plans that had been put in place to ensure Mr Flavell received the level of care he required.

35. On 9 November, healthcare staff noted Mr Flavell was becoming increasingly confused. A prison GP carried out a mini mental state examination (MMSE used to determine a patients ability to process thoughts, memory and speech, a score of 25-30 being considered normal). Mr Flavell scored 21, indicating mild impairment. He referred him to the neurology department at the hospital.

36. On 21 November, as a result of a regular urine test, a prison GP noted blood in Mr Flavell's urine. There had been a trace of blood in his urine three weeks previously, but it was suspected to be as a result of his ongoing urine infection. The GP made a two week wait referral to the urology department at the hospital.

37. Hospital staff reviewed Mr Flavell on 15 December. They noted a high-grade bladder tumour (high-grade tumours have a high risk of reoccurrence and progression). A surgical pre-assessment carried out on 15 December showed there were three tumours, the largest being 21cm.

38. Hospital staff removed most of the tumours on 4 January 2016, carrying out a bladder resection using a cystoscope (a small camera with a blade attached) inserted into the bladder. They planned to remove the rest in a subsequent surgical procedure scheduled for March, followed by a course of six Bacillus Calmette-Guérin immunotherapy treatments (BCG, a cancer treatment designed to boost the bodies own immune system) directly to the site of the tumour via a catheter. After three satisfactory urine samples, Mr Flavell returned to Chelmsford the following day. Healthcare staff continued to monitor Mr Flavell and carried out regular urine tests. They also implemented a cancer care plan devised in conjunction with hospital staff.

39. On 4 March, the second planned bladder resection was completed. A biopsy taken from the tumour showed Mr Flavell had transitional cell carcinoma, a high-risk form of cancer likely to spread to the muscle walls around the bladder.

40. On 3 May, a visiting psychiatrist reviewed Mr Flavell to assess his mental capacity. He carried out a MMSE, and Mr Flavell scored 23. He considered that Mr Flavell displayed some symptoms of dementia, coupled with fluctuating memory capacity. He felt Mr Flavell would benefit from a series of blood tests and a CT scan of his head. The CT scan was carried out on 15 June, which showed a deterioration in keeping with the ageing process but nothing more serious. He also made a referral to the Memory Assessment and Support Service, but again the team refused the referral. There is no evidence that healthcare staff followed up on the refusal or referred the matter to NHS commissioners.

41. On 16 August, a prison GP reviewed Mr Flavell: he noted that while there were no signs of Parkinson's disease, his tremors had worsened. He was also struggling to mobilise. He considered Mr Flavell could be suffering from progressive supranuclear palsy (an uncommon condition causing issues with memory, walking, balance and vision) and made an urgent referral to the neurology team at the hospital. The appointment was made for 23 November.

42. On 12 September, Mr Flavell attended the hospital for a follow up appointment with the urology team. They considered Mr Flavell required a BCG maintenance program (a lower dose of the initial treatment of BCG) to be administered once a week for three weeks.

43. On 23 October, Mr Flavell had a fall in his cell in the early hours of the morning. He sustained a deep cut to this face and complained of pain in his hip. Mr Flavell was taken to hospital by emergency ambulance. Two prison officers accompanied him and he was restrained using an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). The prison officers removed the escort chain soon after their arrival at hospital and it was not reapplied.

44. When he arrived at hospital Mr Flavell had a series of X-rays and a CT scan on his head. The X-rays showed Mr Flavell had broken his hip, which needed a surgical procedure to repair. He had also sustained a small fracture on his cheek, and required stitches to the cut on his face. He stayed in hospital as an inpatient. Hospital staff considered completing a do not resuscitate order on Mr Flavell's behalf (DNR - in the event of a cardiopulmonary arrest the patient is not to be resuscitated). However, there is no evidence in Mr Flavell's medical records that a DNR was completed while he was an inpatient, or at any other time.

45. While Mr Flavell was in hospital, healthcare staff enquired as to what specialist equipment he would need when he was discharged back to Chelmsford. Hospital staff told them they would require a walking frame, a pressure relieving mattress and cushion. They also needed 24-hour access to Mr Flavell to monitor his diet and fluid intake, provide supervision to reduce the risk of falls while he was mobilising around the cell, pressure area care and to enable them to carry out regular general observations.

46. A multi-disciplinary team meeting was held with representatives from all areas of the prison involved with Mr Flavell's care in order to discuss the hospital staff's advice. Also in attendance were representatives from Essex Social Care and

healthcare representatives from other prisons who had cared for prisoners with similar care needs. All requirements were agreed and complex care plans were put in place. Regular reviews were held to ensure everything was in place for his safety prior to his return from hospital. A Principal Officer carried out the risk assessment for the open-door policy and a Prison Governor authorised it.

47. While Mr Flavell was in hospital, the neurology team reviewed Mr Flavell as a result of a prison GP's earlier referral. They carried out a CT scan which indicated cortical atrophy (a degeneration of the brain cells). They referred Mr Flavell to the Memory Assessment and Support Service. The team accepted the referral on this occasion because Mr Flavell was at the time a hospital inpatient. Mr Flavell returned to Chelmsford on 25 November.

48. Healthcare staff continued to regularly review Mr Flavell, attending to his care needs on a daily basis. His care plans were discussed, and updated, at weekly complex care meetings. In addition, the urology team at the hospital continued to review Mr Flavell due to recurring urine infections. His observations remained normal. However, healthcare staff noted he was losing weight, despite a good intake of food and fluids.

49. On 23 March 2017, a nurse reviewed Mr Flavell. She noted he had a swollen left calf and considered it to be as a result of water retention. As a swollen calf can also be an indicator of deep vein thrombosis (a blood clot) she referred him to a prison GP, who prescribed him Enoxaparin (an anti coagulant used to thin the blood to prevent clotting). He also referred Mr Flavell to the hospital for a Doppler scan to confirm the cause of the swelling (an ultrasound scan used to monitor the blood flow through the veins). Before the scan could take place, the swelling reduced and as a result, healthcare staff cancelled the appointment.

50. On 21 April, a specialist from the Memory Assessment and Support Service, reviewed Mr Flavell's referral but could not complete the assessment because he needed further information about Mr Flavell's family history. He contacted Mr Flavell's son to ask if he could assist with the information he needed to proceed. Another appointment was to be made to review Mr Flavell once the information had been received.

51. A nurse reviewed Mr Flavell in his cell on 24 June. She recorded that his condition was deteriorating and he appeared very lethargic. She noted his observations, his heart rate was higher than normal at 112bpm, and that the night staff had reported that he had been vomiting during the night. She considered he needed to be reviewed by hospital staff and telephoned for an emergency ambulance. Two prison officers accompanied Mr Flavell; he was not restrained.

52. While in hospital Mr Flavell had a CT scan. The scan showed a large bowel obstruction which needed surgical intervention. Hospital staff discussed the need for surgery with Mr Flavell's family. Like the hospital staff, they considered that Mr Flavell was too frail for surgery and, in all likelihood, he would not survive. It was decided to withdraw all further medical treatment and start end of life care. Mr Flavell remained in hospital as an inpatient.

53. Mr Flavell's condition continued to deteriorate and, on 1 July at 11am, Mr Flavell died in hospital.

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

Mr Flavell's clinical care

55. The clinical reviewer noted that Mr Flavell generally received a good standard of care while at HMP Chelmsford. He was appropriately referred to secondary care providers for both skin and bladder cancer and the standard of documentation regarding those referrals was good, ensuring a consistent system of initial referrals and expected follow up dates. There was evidence of good comprehensive care plans being put in place by healthcare staff, which were regularly reviewed and updated. The standard of record keeping was good with clear instructions and actionable dates.

56. As Mr Flavell's condition worsened and his needs increased, social care staff were employed to work in conjunction with healthcare staff. Healthcare staff liaised with secondary care providers to ensure the correct adaptations were made his cell for a safer and more comfortable environment. The mental health team at the prison made good efforts to ensure he understood the treatment options open to him, and that he had the capacity to give consent.

57. Healthcare staff held regular multi disciplinary, complex care, meetings to discuss Mr Flavell's care needs, and to ensure the prison was able to deliver those care needs to a good standard.

58. The clinical reviewer has made a number of recommendations, some of which we do not repeat in this report, but which the Head of Healthcare will wish to address. Despite these recommendations, the clinical reviewer considers that Mr Flavell's chronic medical conditions were managed well at Chelmsford and that his healthcare was comparable with the provision available in the community.

59. We agree with the clinical reviewer that overall the response to Mr Flavell's chronic health problems and his final illness was appropriate, and that the care he received at Chelmsford was good.

60. Mr Flavell did not receive the same level of secondary care for the issue of dementia. Healthcare staff and a visiting psychiatrist made referrals to the Memory Assessment and Support Service, twice: the service rejected those referrals on both occasions. It was not until Mr Flavell was referred by hospital staff while an inpatient at hospital was the referral accepted. We make the following recommendation:

The Head of Healthcare should ensure that there is a clear care pathway between the prison and dementia and memory clinic services to ensure that such health needs are properly met.

Mr Flavell's location

61. When Mr Flavell arrived at HMP Chelmsford, healthcare staff quickly identified that due to the level of care he required, he would not be suitable to be held on normal location. As a result, staff moved him to the prison's inpatient unit.

62. On 28 August 2015, healthcare staff, in conjunction with Offender Management Unit staff, made efforts to secure a bed place at HMP Norwich, a prison more suited to Mr Flavell's increasing care needs, but there were no spaces available. They also made enquiries with HMP Littlehey and HMP Whatton, again without success.

63. We recognise that the prison made good efforts to try and find Mr Flavell alternative accommodation in an establishment better equipped to meet his care needs, but the pressure on a relatively small number of suitable prison spaces in other establishments meant Mr Flavell had to remain at Chelmsford. We make the following recommendation:

    The Prisons Group Director for Kent and Essex should review pathways and provision of care for very ill and terminally ill prisoners.

64. While Mr Flavell received a good standard of care at Chelmsford, this was marred at times by the inability of health and social care staff to have direct contact with him in the inpatient unit to help with his care needs when there were insufficient prison officers on duty to unlock the cells. Staffing level agreements agreed with the Senior Management Team and Prison Officers Association, required two prison officers to be present whenever prisoners in the inpatient unit were unlocked. Since Mr Flavell's death, Care UK, the healthcare provider at the time, and the provider of social care, Essex County Council, reviewed this as unsatisfactory and worked together to supply extra funding and resources. By doing so, they were able to ensure there were enough staff on duty for Mr Flavell's care needs to be met.

65. We also note the Head of Healthcare at Chelmsford informed the clinical reviewer that the current healthcare provider at the prison, Essex Partnership University NHS Foundation Trust, now has agreements in place with the senior management team at Chelmsford to ensure all prisoners in the inpatient unit can be accessed whenever they require care or assessment. In light of these developments, we make no recommendation.

Restraints, security and escorts

66. 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.

67. 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.

68. On 23 October 2016, after sustaining injuries to his hip and face following a fall in his cell, Mr Flavell was taken to hospital by emergency ambulance. Two prison officers accompanied him, and he was restrained using an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). Similarly, on the occasions when Mr Flavell attended hospital for routine appointments, he was escorted by two prison officers and restrained with an escort chain, his restraints being appropriately removed while he was receiving treatment.

69. On Mr Flavell's final admission to hospital on 24 June, two prison officers accompanied him to hospital and he was, appropriately, not restrained. He remained in hospital as an inpatient accompanied by only one prison officer.

70. While we acknowledge that Mr Flavell had been convicted of sexual offences, he was an elderly frail man with serious health issues. It is hard to see that the legal requirements justifying restraint were met prior to his final admission into hospital. Risk assessments did not appropriately take into account his health when deciding on the level of restraint required.

The Governor should ensure that risk assessments for prisoners attending hospital appointments fully take into account individual circumstances and are based on the actual risk a prisoner presents at the time.

Contact with Mr Flavell's family

71. Following Mr Flavell's final admission into hospital on 24 June, healthcare staff contacted his family to inform them of his condition. The family visited Mr Flavell in hospital and were involved in the decisions about his care. Mr Flavell's son requested that he be contacted by telephone when his father died.

72. When Mr Flavell died on 1 July, as agreed, a prison Governor, Head of Residence at Chelmsford, telephoned his son to break the news of his father's death. She offered the family support and advice and told Mr Flavell's son that a Family Liaison Officer (FLO) would be appointed by the prison and would contact them the following day.

73. At 4.30pm on 2 July, the FLO telephoned Mr Flavell's son to arrange a visit to the family home. She offered the family support, advice and answered their questions. She remained in contact with the family until Mr Flavell's funeral.

74. Mr Flavell's funeral was held on 24 July. The prison contributed to the funeral costs in line with national guidance.

75. We are satisfied there was good, supportive liaison with Mr Flavell's family.

Compassionate release

76. 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.

77. Prior to making a formal application for compassionate release, healthcare staff discussed the issue of a suitable release address. The prison considered the option of releasing Mr Flavell to a residential care home but this was not deemed to be a suitable option due to the nature of his offences. They also considered releasing him to a hospice, but similarly it was felt not to be a suitable option, therefore, no formal application for compassionate release was made on Mr Flavell's behalf.

78. We are satisfied that the prison appropriately considered compassionate release for Mr Flavell.