

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bernard O’Flynn a prisoner at HMP Thameside on 26 August 2018

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 Bernard O'Flynn died of widespread cancer caused by primary cancer of the pancreas on 26 August 2018, while a prisoner at HMP Thameside. He was 55 years old. I offer my condolences to his family and friends.

I am very concerned that when a prison GP asked for Mr O'Flynn to be escorted urgently to hospital, he was not transferred for 72 hours as healthcare staff did not explain the urgency to prison staff. I am also concerned that when he was not transferred immediately, healthcare staff did not review Mr O'Flynn's condition and did not escalate the issue to the Head of Healthcare.

I consider that this was unacceptable and I share the clinical reviewer's view that the healthcare Mr O'Flynn received was not equivalent to that he could have expected in the community.

This is the fifth investigation into deaths at Thameside since 2016, in which we have concluded that the healthcare provided was not of a standard equivalent to that which could be expected in the community. The Head of Custodial Contracts at Her Majesty's Prison and Probation Service and NHS England South East must now address this highly unsatisfactory state of affairs.

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

October 2019

Contents

Summary	1
The Investigation Process	4
Background Information	5
Key Events	7
Findings.....	13

Summary

Events

1. On 27 October 2017, Mr Bernard O'Flynn was remanded to HMP Thameside, charged with sexual offences. In May 2018, he was sentenced to 14 years in prison.
2. Mr O'Flynn rarely visited healthcare but from April 2018, he began to ask for medication to relieve back pain. He was given paracetamol.
3. In July, Mr O'Flynn continued to have pain in his back which moved to his abdomen and he tried to access healthcare staff over a period of days.
4. At 11.50am on 23 July, a prison GP diagnosed him with an acute abdomen (a medical term meaning sudden and severe abdominal pain that may indicate potentially life-threatening conditions that require urgent surgical intervention). The GP asked for him to be sent to hospital for an urgent assessment. He was concerned that Mr O'Flynn had pancreatitis and needed an abdominal scan.
5. A nurse told the duty manager that Mr O'Flynn needed to be escorted to hospital that day. That afternoon and again in the evening, the duty manager told the nurse that there were not enough staff to escort Mr O'Flynn to hospital.
6. Mr O'Flynn stayed on the wing. A nurse checked his vital signs and gave him paracetamol and ibuprofen for pain relief.
7. The next day, 24 July, healthcare staff did not see Mr O'Flynn and the duty manager did not arrange for him to be escorted to hospital as healthcare staff did not ask again.
8. On 25 July, Mr O'Flynn went to the medicine hatch on his wing, complaining of abdominal pain. A nurse examined him and was concerned that he was still unwell and should have gone to hospital on 23 July. Another nurse told the duty manager that Mr O'Flynn still needed to be escorted to hospital, and was told that he would be transferred later that day when more staff were available.
9. That afternoon, a nurse saw Mr O'Flynn and gave him paracetamol and ibuprofen for pain relief.
10. The duty manager finished her shift, and handed over her role to another prison manager at 5.00pm. It is not clear whether she told him that Mr O'Flynn needed to be escorted to hospital. However, Mr O'Flynn remained on the wing overnight.
11. On 26 July, healthcare staff who had been on duty overnight told a nurse that Mr O'Flynn had still not been taken to hospital. The nurse told the duty manager that Mr O'Flynn needed to go to hospital immediately. The duty manager arranged for Mr O'Flynn to be escorted to hospital that day.
12. Mr O'Flynn was admitted to hospital. His condition deteriorated and on 24 August, he was diagnosed with cancer of the oesophagus.

13. Mr O’Flynn died on 26 August. The post-mortem found that he had widespread cancer.

Findings

Clinical care

14. A GP asked for Mr O’Flynn to be taken to hospital for an urgent assessment. Healthcare staff did not explain the urgency to the Head of Healthcare or prison staff. As a result, Mr O’Flynn was not transferred until three days later.
15. During this time, healthcare staff did not create a clinical plan to manage his health needs. As a result, Mr O’Flynn was left in pain without adequate review or oversight for 72 hours.
16. We agree with the clinical reviewer that healthcare staff should have made it clear to custodial staff that Mr O’Flynn’s transfer was not a matter for debate but a clinical necessity and should have created a joint plan to make this happen. Custodial staff should in turn have respected a clinical decision and facilitated the transfer as a matter of urgency.
17. Healthcare staff should have escalated the failure to transfer Mr O’Flynn to hospital to the Head of Healthcare and senior prison managers.
18. Given the nature of Mr O’Flynn’s illness (widespread cancer), the delay in taking him to hospital is unlikely to have affected the outcome for him. However, this was not known at the time and in a future case, an immediate transfer to hospital might have a direct effect on the outcome.
19. The clinical reviewer concluded that the care Mr O’Flynn received at Thameside was not equivalent to that which he could have expected to receive in the community.
20. This is the fifth investigation into a death at Thameside since 2016 in which we have concluded that healthcare was not equivalent to that expected in the community. We drew this unacceptable state of affairs to the attention of HMPPS and NHS England in September 2018.

Other matters

21. We are concerned that Mr O’Flynn struggled to get healthcare attention before 23 July because he did not know how to use the electronic booking system (CMS).
22. As in previous investigations at Thameside, we have encountered difficulties in obtaining healthcare information and arranging interviews with healthcare staff. We are concerned that this reflects a wider problem of poor communication between healthcare and custodial staff at all levels.

Recommendations

- The Director and Head of Healthcare should ensure that:
 - prisoners receive timely medical treatment;

- there is a clear process, including effective communication between staff, for transferring prisoners to hospital urgently where there is a medical need; and
- there is a clear escalation and clinical care review process for clinical staff to follow if there is a delay in prisoners being transferred to hospital.
- The Director should ensure that there are sufficient staff available to escort prisoners who need to go to hospital urgently.
- The Head of Custodial Contracts at HMPPS should:
 - satisfy himself that there are sufficient staff at Thameside to escort prisoners who need to go to hospital urgently;
 - provide the Ombudsman with an account of what action the HMPPS Controller team has taken, what conclusions he has reached and what, if any, further action he intends to take.
- The Director and NHS England London region should:
 - satisfy themselves that the healthcare provision at Thameside is sufficient to meet patient demand and that healthcare management and services provided are fit for purpose;
 - provide the Ombudsman with their conclusions; and
 - provide the Ombudsman with an account of what action they have taken with Oxleas and Serco to improve healthcare delivery at Thameside and what, if any, further action they intend to take.
- The Director and Head of Healthcare should review the system of requesting healthcare appointments via the CMS system to ensure that it does not disadvantage prisoners with hidden literacy problems.
- The Director should ensure, in line with PSI 58/2010, that following a death in custody the Prisons and Probation Ombudsman is promptly provided with all requested documents and a single point of contact coordinates all requests for information and arranging interviews.

The Investigation Process

23. The investigator issued notices to staff and prisoners at HMP Thameside informing them of the investigation and asking anyone with relevant information to contact her. A prisoner wrote to the investigator and she interviewed him.
24. The investigator obtained copies of relevant extracts from Mr O’Flynn’s prison and medical records.
25. The investigator interviewed 14 members of staff and one prisoner at HMP Thameside in October and November 2018.
26. NHS England commissioned a clinical reviewer to review Mr O’Flynn’s clinical care at the prison.
27. The clinical reviewer interviewed one member of staff by telephone on 30 October and joined the investigator for interviews at HMP Thameside on 17 and 26 October 2018 and 27 November 2018.
28. We informed HM Coroner for Inner South London of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
29. The investigator contacted Mr O’Flynn’s brother to explain the investigation. He did not have any matters that he wanted us to consider and did not want to receive a copy of this report.
30. The initial report was shared with HMP Prison and Probation Service (HMPPS). There were no reported factual inaccuracies and the action plan has been annexed to this report.

Background Information

HMP Thameside

31. HMP Thameside is a local prison which holds up to 1,232 male prisoners who have either been convicted or are on remand. It is managed by Serco. Healthcare is provided by Oxleas NHS Trust. A dedicated healthcare unit has inpatient facilities for 20 prisoners.

HM Inspectorate of Prisons

32. The most recent inspection of HMP Thameside was in May 2017. Inspectors reported that, overall, HMP Thameside was a relatively good prison, and they identified an unusually high number of examples of good practice that other establishments could learn from.
33. However, they reported that healthcare services were not sufficient to meet demand, and they noted that significant staff shortages had affected the delivery of health services, particularly in primary care. They found that there was an appropriate range of primary care services, but some waiting times were too long, especially to see a GP. They found that some patients experienced delays in receiving their medication, and this led to potentially serious gaps in treatment.

Independent Monitoring Board

34. 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 2018, the IMB reported that Oxleas NHS Trust struggled to deliver the expected standard consistently, though there had been improvements during the reporting year (such as health screens for newly arrived prisoners).
35. The IMB noted that transfers of patients to hospital required escort staff employed by Serco. The IMB reported that Oxleas NHS Trust had asked for a review to increase escort capacity because the current resourcing meant that prisoners' hospital treatment was sometimes postponed.

Previous deaths at HMP Thameside

36. Mr O'Flynn was the tenth prisoner to die at HMP Thameside since August 2015, and the seventh from natural causes. There has been one further death since, which is still being investigated.
37. In four previous investigations into deaths at Thameside since 2016, we concluded that the healthcare provided was not of a standard equivalent to that which could be expected in the community. In September 2018 we recommended that the Head of Custodial Contracts at Her Majesty's Prison and Probation Service and NHS England South East should address this highly unsatisfactory state of affairs.
38. In the report of our investigation into a death in 2018, we said that the PPO investigator encountered unacceptable delays in obtaining documentation from Thameside and in arranging interviews with relevant staff. We noted that we had

had similar problems in other investigations at Thameside and said that the prison needed to improve its PPO liaison arrangements.

Key Events

39. On 27 October 2017, Mr Bernard O’Flynn was remanded to HMP Thameside, charged with sexual offences.
40. On 27 October, a nurse completed a first night reception screening for Mr O’Flynn and noted his medical history which included high cholesterol. He noted that Mr O’Flynn had a history of alcohol abuse and completed an assessment which showed that Mr O’Flynn had minimal alcohol withdrawal symptoms. He referred him to a prison GP to be assessed.
41. Later, a prison GP saw Mr O’Flynn. He prescribed medication to manage his alcohol withdrawal symptoms and referred him to the prison drug and alcohol service. He noted that Mr O’Flynn had coeliac disease and high cholesterol, and prescribed medication to manage his cholesterol. (While it was not relevant to Mr O’Flynn’s death, the GP did not consider his diagnosis of coeliac disease and did not recommend that he receive a gluten-free diet. We also note that Mr O’Flynn’s cholesterol was never tested or monitored.)
42. On 28 October, a nurse saw Mr O’Flynn for a secondary screening and a drug and alcohol service assessment. Mr O’Flynn went on to complete an alcohol detoxification programme.
43. On 6 November 2017, it is recorded in Mr O’Flynn’s prison record that he had been getting back pain, that healthcare staff were aware and that he was receiving medication. There is no evidence of this in his medical record.
44. Between 24 April and 18 May 2018, Mr O’Flynn asked for pain relief eight times. Six of those times were for back pain.
45. On 21 May, Mr O’Flynn was sentenced to 14 years in prison, and returned to Thameside.
46. Prisoner A told the investigator that as Mr O’Flynn was functionally illiterate, he sometimes helped him with reading and writing. He said that from early July, Mr O’Flynn was complaining of pain on the left side of his abdomen and that he could not get an appointment with a GP. Prisoner A said that prisoners had to request healthcare appointments on their in-cell computers (known as CMS). The system was quite complex and he did not think Mr O’Flynn would have been able to manage it by himself, although he did not ask him for help. Prisoners who requested an appointment would get a response telling them to look out for an appointment in their electronic calendar.
47. Prisoner A provided the investigator with notes he said he had taken at Mr O’Flynn’s request about his attempts to get help from healthcare staff with his pain from 10 to 25 July. He said these were based on rough notes Mr O’Flynn had kept and that he wrote them up neatly and read them back to Mr O’Flynn to check for accuracy.

Events of 13 to 22 July

48. Prisoner A’s notes record that, after a few days of taking paracetamol for pain in his back, side and stomach, Mr O’Flynn asked an officer to call a nurse on the

- afternoon of 13 July because of continuing and worsening pain. The officer said he would, but no nurse came. Mr O’Flynn pressed his cell bell twice in the night to ask for a nurse because he was in pain. An officer said he would inform healthcare, but no one came.
49. Prisoner A’s notes record that on the morning of 14 July, Mr O’Flynn told prison staff that he had asked to see a nurse in the night but no one had come. An officer said he would get back to him and later told him they had phoned healthcare five times. An officer then went to the healthcare unit to insist a nurse came to see him.
 50. At about 11.00am, a nurse came and, after he explained his symptoms, she said she thought he had a kidney infection. She came back an hour later and gave him a bottle to provide a urine sample. She said she would collect it later, but she did not. In the afternoon, officers phoned healthcare on his behalf and were told the nurse would see him later, but she did not. That night he pressed his cell bell twice and asked to see a nurse because of severe pain. He was told healthcare would be informed, but no one came.
 51. The nurse gave a different account. She told us that she recalled that she was on the wing and saw Mr O’Flynn who was asking to be let out to receive medication. She thought she told officers that he could be let out to attend the medication hatch. She was quite clear that she did not give Mr O’Flynn a urine bottle and said she would have made a note in SystmOne (the medical record) if she had done so.
 52. There is no entry in the SystmOne record for 14 July. If Mr O’Flynn was let out to attend the medication hatch, there is no record of it and no record of medication provided or that he was given a urine bottle.
 53. The cell bell record shows that on 14 July, Mr O’Flynn pressed his cell bell once at 9.23pm. It was answered at 9.23pm and the call lasted for 22 seconds.
 54. On 15 July, Mr O’Flynn told Nurse A (who was on the wing to see another prisoner) that he was in pain. Nurse A recorded in Mr O’Flynn’s medical notes that he examined Mr O’Flynn and found that he had pain on the left side of his abdomen, which spread to his back. He did not offer pain relief or record what advice he gave to Mr O’Flynn.
 55. According to Prisoner A’s notes, Mr O’Flynn asked for pain relief and Nurse A said he would get back to him later, but did not do so. Mr O’Flynn pressed his cell bell two or three times again that night and a nurse came to his cell with an officer. She took the urine sample and said she would return shortly, but she did not come back. There is no record of a urine test on SystmOne.
 56. After seeing Mr O’Flynn, Nurse A arranged for him to see a prison GP. Nurse A said that this was arranged for 16 July, but SystmOne only shows an appointment for 19 July.
 57. According to Prisoner A, Mr O’Flynn believed that Nurse A had booked him an appointment for 16 July. On 16, 17 and 18 July, Mr O’Flynn tried to go to healthcare but was told he was not on the list. He said he was in intense pain.

58. There is no evidence to show if Mr O’Flynn knew about an appointment on 19 July. According to Prisoner A’s notes, Mr O’Flynn tried to go to healthcare on the morning of 19 July, but was told he was not on the list. In the evening, Mr O’Flynn noticed on his in-cell CMS that he had had a healthcare appointment that afternoon, but no one had told him and he had missed it. SystemOne does not record that Mr O’Flynn had not attended the appointment.
59. Mr O’Flynn’s cell bell record shows that on 20 July, he pressed his cell bell at 10:33pm and it was answered two minutes later. It shows the call lasted for 25 seconds.
60. On 21 July, Mr O’Flynn asked for an appointment with the healthcare team as he was in pain. He noted in his request that he had had a urine test, and had been told that it was likely that he had an infection. The urine test is not recorded in his medical records and a prisoner said that healthcare staff told Mr O’Flynn that they did not know about it.
61. Prisoner A’s notes record that Mr O’Flynn was still in pain and asked officers to call a nurse several times on 22 July, but no one came. The pain continued over the weekend.

Events of 23 July

62. According to Prisoner A’s notes, an officer took Mr O’Flynn to the medication hatch on the morning of 23 July and he spoke to a nurse. He felt too ill to stand there and went back to the wing. An officer then went to healthcare and got him an emergency appointment and he went to healthcare at 10.00am to see the triage nurse, who referred him immediately to the doctor. The doctor took another urine sample and said there was no trace of the previous one on the system. The doctor told him that he needed to go to hospital immediately for scans and tests.
63. Mr O’Flynn’s medical notes record that Nurse B examined Mr O’Flynn that morning and referred him to a prison GP. Later, a GP examined Mr O’Flynn. He found that the pain in his back radiated from his abdomen and diagnosed Mr O’Flynn with an acute abdomen. The GP told us that he asked nurses to arrange for Mr O’Flynn to be taken to hospital urgently for an assessment in the accident and emergency department. He was concerned that Mr O’Flynn had pancreatitis and needed an abdominal scan. He said, however, that Mr O’Flynn did not need to be transferred by ambulance.
64. At 2.30pm that day, Nurse A told Custodial Operations Manager (COM) A, the prison’s duty manager, that Mr O’Flynn had seen a prison GP and needed to go to hospital. He recorded in the medical records that COM A promised to send Mr O’Flynn to hospital that day. Nurse A gave COM A the medical paperwork that needed to accompany Mr O’Flynn to hospital.
65. At 7.05pm, Nurse A contacted COM A to ask if she had made arrangements for Mr O’Flynn to go to hospital. He was told that there were not enough staff to facilitate the transfer. Mr O’Flynn remained on his wing.
66. That evening, Nurse C saw Mr O’Flynn and noted that his abdominal pain remained the same. She checked Mr O’Flynn’s vital signs and recorded them as

in the normal range. She gave Mr O’Flynn pain relief (paracetamol and ibuprofen).

67. Nurse C told Nurse A about her assessment, and noted on SystmOne that he said that he would ask the prison GP in reception to see Mr O’Flynn. However, Nurse A told us that he suggested to Nurse C that she should ask the prison GP in reception to see Mr O’Flynn. The GP was not contacted and Mr O’Flynn was not reviewed again that day.
68. COM B took over as the overnight duty manager for the night of 23/24 July. COM A told us that when she handed over to COM B, she informed him that Mr O’Flynn could not be taken to hospital that day because he needed an escort. COM B told us that when he took over from COM A, she did not tell him that he needed to arrange for Mr O’Flynn to be transferred to hospital.

Events of 24 July

69. On the morning of 24 July, COM C took over as the duty manager from COM B.
70. COM A told us that when she returned to work that morning, she told COM C that she had not sent Mr O’Flynn to hospital the day before and that he would probably need to be escorted that day. COM C told us that he did not arrange for Mr O’Flynn to be escorted to hospital as healthcare staff did not ask again for it to be arranged.
71. There is no evidence that healthcare staff saw Mr O’Flynn on 24 July. According to Prisoner A’s notes, Mr O’Flynn asked to see a nurse, but no one came.

Events of 25 July

72. According to Prisoner A’s notes, on the morning of 25 July Mr O’Flynn spoke to an officer who telephoned healthcare on his behalf and then took him to the medication hatch. A nurse examined him, gave him painkillers and anti-inflammatories and told him she thought he would be taken to hospital as an emergency that day.
73. Mr O’Flynn’s medical notes record that he went to the medicine hatch on his wing at 10.00am on 25 July, complaining of abdominal pain. Nurse D examined him and checked his vital signs. She noted that he was pale and clammy, he had a painful abdomen and his vital signs were within the normal range. She also noted that a prison GP had asked for him to go to hospital two days earlier but that no staff were available to escort him.
74. Nurse D told us that she contacted Nurse A as she was concerned about Mr O’Flynn. She had seen from his records that he was supposed to go to hospital and he was still unwell. Nurse D noted that Nurse A said he would speak to the duty manager and an ambulance would be called, if necessary.
75. Nurse A told us that he spoke to COM D, the duty manager, who said that Mr O’Flynn would be taken to hospital when more staff were available. Nurse A noted that he emphasised that Mr O’Flynn needed to be escorted to hospital as an emergency that day, and if he was not taken to hospital, an ambulance may

need to be called. He noted that the duty manager promised that Mr O’Flynn would be taken to hospital that evening.

76. Prison staff completed an escort risk assessment in preparation for Mr O’Flynn’s transfer to hospital. The Assistant Director for Security authorised that Mr O’Flynn should be escorted to hospital by two officers and restrained using a double cuff.
77. At 4.00pm that day, Mr O’Flynn went to the medicine hatch on his wing, where Nurse D saw him. She noted that his pain was the same, his vital signs were stable and he still looked pale. Nurse D gave him medication for pain relief (paracetamol and ibuprofen) and noted that he did not have any future medical appointments.
78. There is no evidence that healthcare staff planned to observe Mr O’Flynn’s condition or manage his pain overnight.
79. COM D told us that the plan was to transfer Mr O’Flynn to hospital between 6.20pm and 7.00pm, when more staff would be available. She told us that she finished her role as duty manager at 5.00pm and ‘would have’ told COM E, who was taking over the role, that Mr O’Flynn needed to go to hospital. COM E told us that he was not told that Mr O’Flynn needed to be escorted to hospital.
80. Mr O’Flynn was not transferred to hospital on 25 July and an ambulance was not called.

Events of 26 July

81. On 26 July, healthcare staff who were on duty overnight from 25 to 26 July, told Nurse E that Mr O’Flynn had not been taken to hospital despite a GP’s request on 23 July.
82. Nurse E spoke to COM D and explained that Mr O’Flynn needed to go to hospital immediately. COM D told COM F, the duty manager, who arranged for Mr O’Flynn to be escorted to hospital.
83. On 26 July, Mr O’Flynn was taken to A&E at Queen Elizabeth Hospital, 72 hours after the GP had first asked for him to be sent.
84. Mr O’Flynn was admitted to hospital and his condition deteriorated while he underwent health investigations.
85. On 24 August, Mr O’Flynn was diagnosed with cancer of the oesophagus. He died on 26 August at 5.45pm.

Contact with Mr O’Flynn’s family

86. Mr O’Flynn’s next of kin was his brother, who was located on the same wing as him at Thameside. After he was admitted to hospital, prison staff arranged for Mr O’Flynn’s brother to visit him, and kept him informed of his condition.
87. The prison appointed a prison chaplain as the family liaison officer (FLO) on 26 August after Mr O’Flynn had died.

88. At 6.30pm on 26 August, the Assistant Director for Governance and Performance and the FLO told Mr O’Flynn’s brother that he had died. They offered their condolences and support.
89. On 6 September 2018, Mr O’Flynn’s brother agreed that all decisions about Mr O’Flynn’s funeral should be made by another brother who lived in Ireland, as it was difficult to manage from prison.
90. Mr O’Flynn’s funeral took place on 13 September 2018 in Ireland. The prison offered to contribute to the cost of the funeral in line with national instructions but the family did not want them to do so.

Support for prisoners and staff

91. The prison posted notices informing other prisoners of Mr O’Flynn’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 it.

Post-mortem report

92. The post-mortem report established that Mr O’Flynn died of widespread cancer caused by a primary tumour in his pancreas. (Although Mr O’Flynn had been diagnosed with cancer of the oesophagus in hospital, the post-mortem found that he did not have a primary tumour of the oesophagus, but that his pancreatic cancer had spread to lymph nodes which were constricting the oesophagus.)

Findings

Clinical care

93. Mr O’Flynn was not a regular user of healthcare services and his functional illiteracy made it difficult for him to access the CMS system. When he did try to access services in July he was frustrated by the appointment system and was not clear when he would be seen.
94. When he was seen by a nurse on 23 July, the triage indicated that he should be seen by a GP and this was facilitated immediately and without the need for an appointment. The clinical reviewer considered that the prison GP’s examination of Mr O’Flynn on 23 July 2018 was thorough, detailed and exactly what would have been expected in the community.
95. The GP diagnosed Mr O’Flynn with an acute abdomen and asked for him to be transferred to hospital for further assessment. The clinical reviewer said that this diagnosis should have left no doubt in the minds of the nursing staff that Mr O’Flynn required urgent surgical assessment in a hospital A&E department. She said that Mr O’Flynn did not require an emergency ambulance because he had a condition which required him to be seen by doctors in an emergency department as soon as possible, but did not require paramedical intervention such as cardiopulmonary resuscitation or assistance with breathing on the journey to hospital. A non-emergency ambulance could have been requested by healthcare staff but they had not done so.

Transferring Mr O’Flynn to hospital and staff communication

96. Thameside has a clear policy about what should happen when a prisoner needs to go to hospital as an immediate emergency. However, there is no clear policy which sets out what should happen when a prison GP or senior nurse identifies that a prisoner needs to be transferred urgently to hospital, but not as an immediate emergency.
97. Nurse A and COM A agree that Nurse A told her on 23 July that Mr O’Flynn needed to be transferred to hospital as he had abdominal pain. Nurse A says that he understood the seriousness of the diagnosis of an acute abdomen and made it very clear to COM A that the GP had said Mr O’Flynn needed to go to hospital that day. COM A says that Nurse A did not stress that Mr O’Flynn needed to go to hospital urgently when she told him on two occasions that there were not enough staff to escort him to hospital that day.
98. The clinical reviewer found that the way in which healthcare staff communicated with prison staff about the severity of Mr O’Flynn’s symptoms and the need for rapid transfer to hospital for urgent further assessment was not sufficiently robust. They did not convey the severity of his clinical condition to prison staff when requesting the transfer and did not make it clear that this was not a routine escort but a case for urgent action.
99. We share the clinical reviewer’s concern that healthcare staff did not communicate clearly or robustly enough to prison staff the urgent need for Mr O’Flynn to go to hospital. As Mr O’Flynn did not require an emergency

ambulance to take him to hospital, prison staff took this to mean that his transfer to hospital was less urgent than it was and did not understand how serious Mr O’Flynn’s condition was.

100. As a result, he was not taken to hospital on 23 July, in line with the GP’s instructions, and his transfer to hospital was delayed until 26 July. Healthcare staff – who should have understood the seriousness of an acute abdomen diagnosis - should have made it absolutely clear that this was not a routine escort, but a case for urgent action.

Escalating the need for Mr O’Flynn to be transferred to hospital

101. Healthcare staff did not escalate the need to send Mr O’Flynn to hospital to the Head of Healthcare.
102. The Head of Healthcare said that healthcare staff record hospital escort issues on handover sheets which she reviews daily, and she then raises any issues with senior prison managers at the daily morning meeting. However, the clinical reviewer found that healthcare staff did not consistently sign, date or time the healthcare handover sheets from 23 to 26 July, and that many of the handover sheets made no mention at all of Mr O’Flynn. It is therefore unclear what healthcare staff told the Head of Healthcare, and when, and there is no record that Mr O’Flynn’s need for an urgent transfer to hospital was discussed at the morning meetings between 23 to 26 July.
103. We consider that if healthcare staff had escalated the issue of Mr O’Flynn’s transfer to hospital effectively, the Head of Healthcare could have raised it with senior prison managers, and it is likely that his transfer would have been facilitated urgently.
104. The clinical reviewer considered that the delay in transferring Mr O’Flynn to hospital was unlikely to have affected the outcome for him, but might be critical in other cases. She said, however, that it meant Mr O’Flynn was left in pain.

Reviewing Mr O’Flynn’s clinical care

105. When Mr O’Flynn was not transferred to hospital on 23 July, there was no clinical plan about how to manage his health needs. Although there were spaces in the healthcare unit, the clinical reviewer found no evidence that healthcare staff thought about moving Mr O’Flynn there. If this had happened, he would have been monitored more closely and given regular pain relief.
106. The clinical reviewer found that healthcare staff did not ask a prison GP to review Mr O’Flynn after 23 July. She found no evidence that healthcare staff checked on his wellbeing or offered him pain relief on 24 July. Healthcare staff should have put in place a plan to observe him and check his condition.
107. The clinical reviewer concluded that the care Mr O’Flynn received at Thameside after the GP saw him on the morning of 23 July was not equivalent to that which he could have expected to receive in the community.
108. We agree. We consider that the delay in transferring Mr O’Flynn to hospital, the failure to escalate the need to transfer him urgently, and the lack of care given to

him while he waited to be taken to hospital, were unacceptable and reflect very poorly on the healthcare staff involved and the management of healthcare at Thameside generally.

109. We recommend that:

The Director and Head of Healthcare should ensure that:

- **prisoners receive timely medical treatment;**
- **there is a clear process, including effective communication between staff, for transferring prisoners to hospital urgently where there is a medical need; and**
- **there is a clear escalation and clinical care review process for clinical staff to follow if there is a delay in prisoners being transferred to hospital.**

The Director should ensure that there are sufficient staff available to escort prisoners who need to go to hospital urgently.

110. The clinical reviewer identified several other concerns about healthcare which did not impact directly on Mr O'Flynn's death, and has made a number of recommendations which the Director and Head of Healthcare will need to address.

111. This is now the fifth investigation into a death at Thameside since 2016, in which we have concluded that the healthcare provided was not of a standard equivalent to that that which could be expected in the community. This is not an acceptable state of affairs.

112. In June 2018, we raised our concerns with NHS England South East and with HMPPS in relation to a death at Thameside in August 2017, and recommended that they satisfy themselves that healthcare provision at Thameside was sufficient to meet demand and that the services provided were fit for purpose.

113. In August 2018, we were told in response that NHS England South East (London Region) had produced a detailed report on the continuing healthcare delivery at HMP Thameside, and that they continued to work with Oxleas and Serco to continually improve healthcare delivery. They said that the new Oxleas staff structure would enable healthcare provision at Thameside to meet current patient demand and be fit for purpose, and that Oxleas' 2018-19 Clinical Effectiveness Plan and Quality Improvement program would ensure communication and record-keeping were audited, offering reassurance to the Trust Quality Board and NHSE.

114. We were also told that "where possible", the Head of Custodial Contracts would support this key work through the on-site HMPPS Controller team.

115. We recognise that Mr O'Flynn's death occurred before some of these actions had had time to make an impact. Nevertheless, it appears that little had changed in healthcare at Thameside between the previous death in August 2017 and Mr O'Flynn's death in August 2018. We, therefore, make the following recommendations:

The Head of Custodial Contracts at HMPPS should:

- **satisfy himself that there are sufficient staff at Thameside to escort prisoners who need to go to hospital urgently;**
- **provide the Ombudsman with an account of what action the HMPPS Controller team has taken, what conclusions he has reached and what, if any, further action he intends to take.**

The Director and NHS England London region should:

- **satisfy themselves that the healthcare provision at Thameside is sufficient to meet patient demand and that healthcare management and services provided are fit for purpose;**
- **provide the Ombudsman with their conclusions; and**
- **provide the Ombudsman with an account of what action they have taken with Oxleas and Serco to improve healthcare delivery at Thameside and what, if any, further action they intend to take.**

Other matters

CMS

116. We are concerned that Mr O’Flynn did not understand how to arrange healthcare appointments using the CMS system and that he missed at least one healthcare appointment because he did not know how to use CMS. Prisoner A described Mr O’Flynn as ‘functionally illiterate’, although there is no evidence that the prison was aware of this. Although electronic self-service systems like CMS generally provide benefits to prisoners, it is clearly essential to ensure that all prisoners are able to use them. We make the following recommendation:

The Director and Head of Healthcare should review the system of requesting healthcare appointments via the CMS system to ensure that it does not disadvantage prisoners with hidden literacy problems.

Liaison arrangements

117. As in previous investigations at Thameside, we had difficulties obtaining some of the information we required from healthcare, and liaison arrangements fell short of our expectations. In particular, although individuals were helpful, it is apparently not possible for the prison’s PPO liaison officer to arrange interviews with healthcare staff or to arrange for the provision of healthcare information. We have not experienced these difficulties at other Serco-run prisons and we are concerned that the problems at Thameside appear to reflect a wider problem of poor communication between custodial and healthcare staff at every level. We repeat the recommendation we made in January 2019:

The Director should ensure, in line with PSI 58/2010, that following a death in custody the Prisons and Probation Ombudsman is promptly provided with all requested documents and a single point of contact coordinates all requests for information and arranging interviews.

**Prisons &
Probation**

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