Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Tony McCann, a prisoner at HMP Gartree, on 19 October 2020

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*

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Tony McCann died on 19 October 2020 of secondary bowel cancer while a prisoner at HMP Gartree. Mr McCann was 61 years old. I offer my condolences to Mr McCann's family and friends.

4. Mr McCann first complained of weight loss on 13 April 2019. He did not report any other symptoms until 17 July, when a prison doctor urgently referred him under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

5. Following investigations, a hospital consultant confirmed that Mr McCann had bowel cancer on 23 September. Mr McCann had chemotherapy but this was unsuccessful. On 2 June 2020, the prison applied for Mr McCann's release on a special purpose licence due to COVID-19, but this application was not approved. Mr McCann was transferred to the LOROS Hospice on 13 October 2020 for end of life care. He died six days later, on 19 October, with his family at his bedside.

6. The clinical reviewer concluded that while there were delays in identifying Mr McCann's weight loss, it was not possible to determine whether this delay would have altered Mr McCann's cancer diagnosis, care or treatment thereafter. She concluded that, on balance, the clinical care Mr McCann received at HMP Gartree was equivalent to that he could have expected to receive in the community. She made two recommendations.

7. We found no non-clinical issues of concern. We make no recommendations.

Recommendations

- The Head of Healthcare should implement weight monitoring care plans for patients who report unintentional weight loss.

- The Head of Healthcare should develop a system to alert the healthcare team to missed appointments.

The Investigation Process

8. NHS England commissioned an independent clinical reviewer, to review Mr McCann's clinical care at HMP Gartree. The clinical reviewer's report is attached as Annex 1.

9. The PPO investigator investigated non-clinical issues, including Mr McCann's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

10. The PPO family liaison officer wrote to Mr McCann's next of kin, his partner, to explain the investigation. She did not have any specific questions for us to consider but wanted a copy of the report. She asked us to consider Mr McCann's sister as his next of kin for the purpose of our investigation. Mr McCann's sister later contacted the PPO with a list of questions she had for the investigation. She also provided a copy of a complaint she had raised with the Prison Service about Mr McCann's clinical care, which we passed to the clinical reviewer. The clinical reviewer has addressed the concerns as far as possible in the review attached as the first annex to this investigation.

11. Mr McCann's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at HMP Gartree

13. Mr McCann was the eighth prisoner to die at HMP Gartree since October 2018, the second from cancer. Of these deaths, seven were from natural causes and one was self-inflicted. There have been two further deaths since, one self-inflicted and the other is yet to be classified. There are no similarities between our findings in the investigation into Mr McCann's death and our investigation findings for the previous deaths.

Key Events

14. Mr McCann was remanded to HMP Belmarsh in 2007, charged with murder. In 2008, he was sentenced to life in prison with a minimum tariff of 19 years. He transferred to HMP Gartree on 8 April 2011.

15. On Sunday 13 April 2019, Mr McCann told a nurse he was worried that he had lost weight. The nurse noted that Mr McCann had not attended a previous well-man appointment and offered him a triage appointment. It is not clear from the medical records if this appointment took place. In May and June, he missed two more healthcare appointments to discuss his weight loss.

16. On 28 June, a nurse reviewed Mr McCann. She noted that he was eating normally and there had been no change in his bowel habits but highlighted a family history of bowel cancer. A blood test taken later that day was abnormal. Mr McCann did not attend an appointment on 9 July, to discuss his results.

17. On 17 July, Mr McCann told a prison GP that his bowel movements were now irregular. The GP referred him urgently to Leicester General Hospital under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

18. Mr McCann went to hospital on 13 August, where he was referred for a colonoscopy (a test to check the inside of your bowels) and CT scan to investigate causes for his weight loss and more recent constipation and anaemia. The colonoscopy on 11 September showed a “probable malignant structuring tumour”. At a follow up hospital appointment on 23 September, Mr McCann’s diagnosis was confirmed as carcinoma of the upper rectum, or bowel cancer. Mr McCann started radiotherapy on 11 November, followed by four cycles of chemotherapy (at 21-day intervals) starting on 4 February 2020.

19. On 2 June, the prison applied for Mr McCann’s release on a special purpose licence due to COVID-19 in case he needed to ‘shield’ in the community (if deemed safer than staying in prison). The Governor and Mr McCann’s offender manager did not support this application due to the time he had left to serve and his level of risk. His release was not approved. Healthcare staff told Mr McCann that he was clinically vulnerable to COVID-19, but he chose not to shield.

20. A CT scan on 10 August showed that Mr McCann’s cancer had progressed. He saw his consultant on 29 September, who confirmed that the scan showed new liver metastases and explained that he was too unwell for further chemotherapy. Mr McCann did not want to know his prognosis, so his consultant wrote to the prison GP confirming a life expectancy of less than six weeks.

21. On 1 October, the prison started an application for early release on compassionate grounds with a planned release address to a hospice. Later that day, a prison doctor visited Mr McCann in his cell to complete a ReSPECT form (Recommended Summary Plan for Emergency Care and Treatment). Mr McCann did not want to die in prison and asked to be transferred to a hospice at the end of his life.

22. In line with his wishes, Mr McCann was transferred to the LOROS Hospice on 13 October for end of life care. He was accompanied by two prison officers (wearing civilian clothing) and restraints were not used. The prison's family liaison officer telephoned Mr McCann's partner the same day to introduce herself and provide support. Mr McCann's family were allowed to visit him in the hospice. Mr McCann died six days later, on 19 October. His partner and children were with him when he died. At the time of his death, Mr McCann's application for release was still outstanding while the prison waited for information from his community offender manager.

23. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr McCann's cause of death as metastatic carcinoma of the rectum - cancer that had spread beyond the rectum to other parts of the body.

Clinical Findings

24. The clinical reviewer found that there were some delays in investigating Mr McCann's weight loss and that Mr McCann was not always compliant with healthcare appointments. However, she could not comment on whether this delay would have altered Mr McCann's cancer diagnosis, care or treatment thereafter. The clinical reviewer thought that Mr McCann received good care following his cancer diagnosis. She concluded that, on balance, Mr McCann's clinical care was equivalent to that he could have expected to receive in the community.

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