REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Mr Matthew Trainer, Chief Executive, Oxleas NHS Trust, Pinewood House Pinewood Place, Kent, DA2 7WG** 2. **His Honour Judge Mark Lucraft QC, The Chief Coroner for England and Wales, Chief Coroner's Office, [redacted] Royal Courts of Justice, Strand, London, WC2A 2LL**
1	**CORONER** I am Christopher Williams an assistant coroner, for the coroner area of Inner London South (Southwark Coroners Court).
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/uksi/2013/1629/regulation/28/made and http://www.legislation.gov.uk/uksi/2013/1629/regulation/29/made
3	**INVESTIGATION and INQUEST** An investigation into the death of **Bernard Pius O'Flynn** commenced on the 28 August 2018. The investigation concluded at the end of the inquest on **25 April 2019**. The conclusion of the inquest was that the medical cause of death was 1(a) Carcinomatosis, 1(b) Carcinoma of the Pancreas. The conclusion, as to the death, was "Natural Cause".
4	**CIRCUMSTANCES OF THE DEATH** In May 2018 Mr O'Flynn was sentenced to 14 years imprisonment and was detained at HMP Thameside which is a private prison run by SERCO Limited. The primary health care service at the prison is provided by Oxleas NHS Foundation Trust (Oxleas). In early July 2018 Mr O'Flynn experienced back and abdominal pains. A nurse examined him on the prison wing and noted abdominal pain radiating to the left which was not painful to touch. On 23 July 2018 he was seen by a GP who diagnosed "acute abdomen" noting that urgent hospital admission to the local Accident and Emergency department (A&E) was needed for a scan and a "Lipase/amylase" test. The diagnosis of "acute abdomen is well recognised, by qualified nurses and doctors, to be a condition requiring urgent investigation by a surgeon in hospital. Despite the expectation of the GP the transfer to hospital did not occur until three days later on the 26 July 18. Following his admission to hospital a CT scan showed extensive retroperitoneal lymph nodes with mild left hydronephrosis. Lymphoma was initially suspected and biopsies were performed but were not conclusive.

On 11 August 2018 a repeat CT scan showed an increase in ascites and a repeat biopsy showed no evidence of lymphoma. On 16 August 2018 a gastroscopy revealed a tumour at the Gastro oesophageal junction which was biopsied. In the following days he became increasingly unwell due to ascites causing pleural effusion requiring intensive care and a biopsy of the oesophageal tumour revealed a metastatic adenocarcinoma which was not amenable to treatment. Following discussion with Mr O'Flynn's family he was treated palliatively and died in hospital on 26 August 2018.

I found, based on clear medical evidence, that the three day delay in transfer to hospital following the diagnosis of "acute abdomen" did not, on the balance of probabilities, contribute to the cause of death because the fatal metastatic carcinoma would already have been present when Mr O'Flynn started to experience symptoms in early July.

I heard evidence that the reasons for delay arose from the prison having insufficient security staff for escorts to hospital for cases which were urgent but not immediate medical emergencies.

An independent clinical review, conducted by [redacted] Associates, was highly critical of the prison health care, provided by Oxleas, as was an investigation report by the Prison and Probation Ombudsman (PPO). The conclusions of both reports were that the standard of care fell well below that which would be expected in the community (The reports are attached for ease of reference).

The criticisms in the Clinical Review report were:

- Healthcare staff should have made it clear to custodial staff that 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 facilitate transfer as a matter of urgency.
- There was no apparent agreed system between custodial care and health care which makes clear what should happen when an urgent transfer based on a clear clinical decision made by an appropriate clinician has been made.
- There was no clear system of escalation through health care so that junior staff alert more senior staff to apparent issues.
- Mr O'Flynn's illness was such that the delay in transfer was unlikely to have affected the outcome. However this could not have been known at that time and in a similar case a more effective and immediate response to transfer a prisoner to A&E might have had a more direct effect on the outcome.
- In addition Mr O'Flynn was left in pain without adequate review or oversight for 72 hours.
- In view of this the health care cannot be considered equivalent to that in the wider community.

The Clinical Review recommendations were:

- The head of Healthcare and the director of the prison must establish a system where it is crystal clear that when a clinical decision has been made by a doctor or advanced nurse practitioner that a prisoner requires urgent transfer out of prison, that the clinical decision is respected and facilitated so that the prisoner receives appropriate treatment.

- The head of healthcare and director of the prison are to establish a clear written process to be followed by healthcare and custodial staff which avoids doubts and which sets out clearly the path of escalation.
- The head of health care and lead GP must set out a process for clinical staff to follow that if, for whatever reason, there is an unavoidable delay in transferring out, staff follow an agreed process of escalation. This should include ensuring that the head of Healthcare is aware of the case and ensures that the prisoner is in an appropriate environment to be observed and to be careful that there is a process of medical review whilst prisoners await transfer.

At the end of the Inquest I heard evidence from a senior member of health care staff, employed by Oxleas, and a senior prison officer, employed by SERCO, who provided me with a jointly agreed policy, issued 2 January 2019, for dealing with urgent transfers to hospital which were not within the national guidelines, known as, Code Red or Code blue emergencies (A Code Red is a medical emergency involving bleeding and Code Blue is where there are breathing difficulties both of which require an immediate 999 ambulance call).

The policy has been agreed at joint meetings between Oxleas and SERCO and I was informed that there was going to be a further joint meeting which would include the director of the local A&E department for the Lewisham & Greenwich NHS Trust. A copy of the policy is attached for ease of reference.

The policy contains various categories of urgent cases and the timeframes for transfer to hospital these range from within: 2 - 4 hours; 4 - 8 hours; 8 -12 hours; and 12 – 24 hours

I was informed by an operational manager, on behalf of Oxleas, that the policy had been prepared by nursing management and prison staff. In answer to my questions I was informed that a consultant in emergency medicine had not been involved in the formulation of the policy and the director of Lewisham & Greenwich A&E was not a medical doctor. When I suggested to the witness that it would be helpful for an expert in emergency medicine to have oversight and approve or suggest amendments to policy this was met with full agreement as well as from the Assistant Director employed by SERCO limited.

5 CORONER'S CONCERNS

From the evidence I received, at the inquest, there are matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

The failures identified in the clinical review and PPO reports were, in my view, deeply troubling. That said I am encouraged by the cooperation and efforts made by Oxleas and SERCO to formulate a policy to deal with medical emergencies falling outside the Code Red and Code Blue scenarios.

However I remain concerned that a practising expert in Emergency Medicine has not yet had input into the formulation of the policies promulgated by the joint meeting between SERCO and Oxleas.

	In particular my concern is that there may be medical emergencies which do not fall within Code Red or Code Blue but may, nonetheless, require immediate transfer to hospital within less than an hour. It is possible that an expert in emergency medicine would be able to easily identify whether or not there are residual cases within this category. I am therefore of the view that I am under a duty to report this residual concern to Oxleas NHS Foundation Trust in order to take appropriate action, if so advised by an expert Consultant in Emergency Medicine, to reduce the risk of fatalities in future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take the following action: - The joint policy promulgated since the death should be reviewed, with the assistance of an expert practicing clinician (a Consultant in Emergency Medicine) in order to ensure that the policy is capable of satisfying the recommendations made by the Clinical Review.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the **Tuesday the 3rd of July 2019.** I, the coroner, may extend the period. Your responses must contain details of action taken, or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons who may find it useful or of interest: 1. [redacted] daughter of Bernard O'Flynn. 2. SERCO Limited 3. Lewisham & Greenwich NHS Trust 4. Royal College of Emergency Medicine, 7-9 Breams Buildings, London, EC4A 1DT. 5. The Rt. Hon Matt Hancock MP, Secretary of State for Health and Social Welfare, I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**8th May 2019** **Christopher Williams – Assistant Coroner**