

**Investigation into the circumstances surrounding
the death of a man at hospital in October 2010, whilst in
the custody of HMP Frankland**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

July 2012

This is the report into the death of a man in October 2010 at hospital whilst in the custody of HMP Frankland. He was 34 years old. A post mortem showed that he died of Hodgkins lymphoma (a cancer originating in the white blood cells) and associated conditions. I offer my condolences to his family.

The investigation was carried out by one of my Assistant Ombudsmen, assisted by a Senior Investigator. I apologise for the lateness of this report and any additional distress this may have caused the man's family.

We would like to thank the Governor of Frankland and his staff for their cooperation with the investigation. The local Primary Care Trust (PCT) commissioned a clinical reviewer to carry out the clinical review, for which we are grateful. However, I am disappointed that the PCT felt unable to support the additional specialist review we requested in relation to some of the treatments the man received.

The man's condition appears to have been rare and complicated, and was clearly difficult to diagnose. He (and his family) chose to pursue private "experimental" treatment at a hospital, as was his right. However, the ensuing disagreements between the PCT and the prison only served to delay the transfer of this very sick man, exacerbated by his refusal to commence chemotherapy at a local hospital whilst he waited for a transfer to another hospital. These disagreements exposed a lack of national guidance to prisons regarding the transfer arrangements for prisoners to out of area hospitals and the management of prisoners requesting private healthcare and I make recommendations to the National Offender Management Service and the Department of Health to address these gaps.

In addition, further recommendations are made regarding the need to improve the recording and monitoring of patient weight by healthcare staff, ensuring a proper balancing of risk assessment for bedwatch arrangements; and the early appointment of a family liaison officer when a prisoner is very sick and in outside hospital. It is to be hoped with action in these areas, the treatment of seriously ill prisoners may be improved.

I am very grateful to the man's family for considering this report at the draft stage; they have a number of concerns but prefer to raise these at the inquest.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

July 2012

CONTENTS

Summary

The investigation process

HMP Frankland

Key events

Issues

Recommendations

SUMMARY

1. The man was born in 1975. He died in October 2010, of Hodgkins lymphoma (and associated conditions), he was 34 years old.
2. He was arrested for an alleged serious offence and remanded into the custody of HMP Durham on 24 January 2006. He was convicted of the offence on 28 September that year and sentenced on 8 December to an Indeterminate Sentence for Public Protection (IPP).¹
3. After an unsuccessful appeal in December 2007, the man was transferred to HMP Frankland on 14 January 2008.
4. On arrival at Durham in 2006, the man confirmed at his initial healthscreen that he had been diagnosed with Crohn's Disease in 1993. (Crohn's disease is an inflammatory disease of the intestines that may affect any part from mouth to anus, causing a number of symptoms. It primarily causes abdominal pain, diarrhoea (which may be bloody) vomiting, or weight loss. It may also cause complications such as skin rashes, arthritis, eye inflammation, tiredness, and lack of concentration.)
5. During 2007 and 2008 the man had a number of flare-ups of the disease which were treated with mesalazine (an anti-inflammatory used to treat mild to moderate Crohn's disease symptoms), prednisolone (a medication used to treat a number of conditions, for example inflammation, asthma, arthritis and allergic reactions) and nefopam (painkiller).
6. He refused to attend a number of outpatient appointments in respect of the management of his Crohn's Disease, either through fear of assault (due to the nature of his offence) or because he said he was depressed. On each occasion he signed a disclaimer to this effect. The records do not show whether his stated depression was ever followed up.
7. From late 2008 and throughout 2009, he had no further flare-ups of his Crohn's Disease.
8. The man had very little contact with healthcare over the remainder of 2009 and the first half of 2010.
9. In July and August 2010, he had several appointments with prison doctors regarding symptoms which were originally treated as a flare-up of his Crohn's disease. However as the weeks went by it became clear this was not a flare-up of Crohn's and medical staff struggled to make a diagnosis. Despite several requests, he refused to be admitted into healthcare.

¹ IPP - a sentence of imprisonment with no definite period of time set during sentencing. Its length is determined during imprisonment based on the prisoner's conduct. In many cases, a minimum term is imposed, or the maximum that can be served is the maximum allowable by law for the particular offence.

10. Following abnormal blood test results, the man was seen by prison doctor on 18 August and agreed to go immediately to hospital.
11. On arrival at hospital the man was initially treated for a sub-acute bowel obstruction (a complication often seen in Crohn's patients). He had a test for tuberculosis (which was negative) and a Computerised Tomography (CT) scan (this is a special X-ray that produces pictures of cross sections of the body).
12. On 23 August, he was referred for surgery, and the following day he had a lymph node biopsy (a biopsy is a medical test where small samples of cells or tissues are removed for further analysis).
13. The man suffered complications following the surgery on 26 August, he also had a low white blood count and preventative treatment was commenced to reduce the risk of infection.
14. As the results of the earlier biopsies were "indeterminate", he underwent a bone marrow biopsy. The results were received on 17 September and confirmed he had Hodgkins lymphoma. He was told this news the following day and was understandably distressed and upset.
15. On 25 September, the man was moved to the medical unit of the hospital for blood related care and on 28 September he was being treated for neutropenic sepsis (a condition arising from low white blood cells comprising the immune system, resulting in bacterial, viral or fungal infection). This is a life threatening condition, so his chemotherapy was delayed.
16. A professor of the Experimental Cancer Unit at another hospital contacted the man's consultant at the local hospital on 28 September. He had been contacted by the man's family and had agreed to take him on as a private patient. The professor and consultant agreed to a transfer of care and ward staff at the local hospital were told on 30 September to prepare him for transfer to London.
17. From this point, the man refused to commence the chemotherapy being offered by the local hospital. On 4 October, the consultant discussed his worsening condition with him and said that he should start chemotherapy straight away, but he refused.
18. The transfer to the other hospital was delayed for several days whilst the Prison Service and Primary Care Trust (PCT) disagreed about funding for the transfer and bedwatch arrangements at the other hospital for the man. His family agreed to cover all health related costs on 4 October.
19. In addition, Frankland had difficulty in obtaining mutual aid from a London prison to provide officers for the bedwatch. This was eventually solved once the Acting Director of the High Secure Estate intervened on 6 October.

20. The man's family wanted him to be transferred by air to the other hospital; this was not possible due to security concerns. He was eventually transferred from the local hospital to the other hospital by road ambulance on 7 October.
21. The man was extremely ill on arrival at hospital, and although chemotherapy was commenced immediately, he died a few days later. His family were present.
22. We make five recommendations concerning recording and monitoring of weight by healthcare staff, the development of policies and guidance by NOMS and the Department of Health in relation to transfer arrangements for prisoners to out of area hospitals and the management of prisoners requesting private healthcare, balanced risk assessment for bedwatch arrangements; and the early appointment of a family liaison officer when a prisoner is very sick and in outside hospital.

THE INVESTIGATION PROCESS

23. The Ombudsman was notified of the man's death on 19 October 2010. The investigation was allocated to an Assistant Ombudsman, assisted by a senior investigator. They visited Frankland on 27 October to open the investigation.
24. The Assistant Ombudsman issued notices inviting staff and prisoners to contact her with any information they thought might be relevant to the investigation. There was a significant response to the notices from staff and prisoners. She was provided with copies of the man's prison and medical records and met with a representative of the Independent Monitoring Board (IMB).
25. The local Primary Care Trust (PCT) asked a clinical reviewer to review the clinical care the man received at Frankland. We are grateful to her for undertaking this review. The Assistant Ombudsman discussed aspects of his treatment both with healthcare staff at Frankland and with the clinical reviewer.
26. The investigators returned to Frankland on 23 and 24 November to interview ten members of staff and six prisoners.
27. On 23 February 2011, the investigator wrote the local PCT, following a recommendation from the clinical reviewer to ask them to commission an independent haemato-oncologist² to further review the man's clinical care. The PCT are not mandated to provide an additional clinical review, and on this occasion refused to do so.
28. On 12 April 2011, the Assistant Ombudsman also spoke on the telephone to a professor at the Experimental Cancer Treatment Centre, during which she asked a number of specific questions which he answered.
29. It is outside the remit of the Prisons and Probation Ombudsman to comment on the treatment received by the man whilst in an outside hospital. However, the clinical reviewer had access to hospital records and the investigator has referred to information from these to build up as clear a picture as possible of his care.
30. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report, which has been received. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.
31. One of our family liaison officers contacted the man's brother to explain the purpose of the investigation and invite the family to raise any questions or concerns. The family raised a number of concerns by letter, which we hope are addressed in this report. With the family's agreement their

² A specialist in blood diseases and cancer

comprehensive letter is appended to this report, however a summary of their concerns is as follows:

- The man became ill at the beginning of July 2010, why did it take so long for him to be admitted to an outside hospital?
 - Why did a doctor tell him there was nothing wrong with him?
 - The family believe that the delay in referring him to hospital from HMP Frankland had a direct impact on the progress of the disease and therefore his death.
 - Why was he unable to gain access to a PET scan and sperm deposit?
 - Why was he not referred to a hospital providing specialist cancer care?
 - The family are concerned that an official or unofficial policy exists at HMP Frankland whereby prisoners requiring outside medical care should be taken and kept at the local hospital and not transferred to other (more suitable) hospitals.
 - Why was there such a delay in transferring him from the local hospital to another hospital.
32. Another of our family liaison officers remained a point of contact for the man's brother and solicitor throughout the investigation.
33. We apologise for the lateness of this report due in part to efforts to obtain all the relevant clinical information and advice required to form a judgement and in part to workload pressures on the investigator.
34. We hope this investigation will provide the family with a better understanding of his time in custody and the circumstances surrounding his care and transfer to another hospital.
35. The man was the fifth death from natural causes at Frankland (or whilst in the custody of Frankland) in 2010, there have been two such deaths since. There are no similarities in the findings of these investigations with that of his.

HMP FRANKLAND

36. HMP Frankland is a high security training prison on the outskirts of Durham. It was opened in 1980 and has an operational capacity of 859 prisoners held in seven accommodation wings. The prison holds high and standard risk category A prisoners, including those remanded in custody by the courts, and category B prisoners serving four years and over. Prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four categories: A, B, C and D, with category A prisoners being the most dangerous. Category B prisoners are people for whom the highest security conditions are not necessary but for whom escape must be made very difficult. The man was a category B prisoner.
37. Healthcare at Frankland is provided by the County Durham and Darlington Community Health Services Primary Care Trust. The healthcare centre is a general practitioner (GP) led 24 hour facility with an in-patient department (IPD). It runs numerous clinics from Monday to Friday.

HM Chief Inspector of Prisons (HMCIP)

38. HM Inspectorate of Prisons last full inspection of Frankland was in February 2008. The Chief Inspector made the following comments:

“The PCT had introduced a no smoking policy throughout healthcare and there had since been a dramatic drop in the number of prisoners admitted. Smokers were offered smoking cessation support. The reduced numbers held in healthcare meant that the number of beds did not reflect need.

“Prisoners with chronic diseases were managed well. A dedicated nurse was compiling registers following a review of all clinical records that had identified 240 prisoners with chronic disease.

“NHS appointments were managed by administrative staff who liaised with local external NHS facilities ... Between October 2007 and January 2008 14% of planned appointments had to be cancelled due to lack of escort staff. Discussions were taking place to reduce the number of external appointments and allow operational managers to decide who could attend outside hospitals. This was unacceptable.”

The Inspectorate recommended that:

“Security procedures should not restrict prisoners’ attendance at external health appointments.”

39. HMCIP followed up their full inspection of Frankland in November 2010 and made the following comment in relation to their recommendation concerning prisoners’ attendance at external appointments:

“[Recommendation] Achieved. Secondary care appointments were well managed. There was a limit on how many prisoners could attend

appointments on any one day but the detail office allowed some flexibility to meet clinical need.”

Independent Monitoring Board (IMB)

40. Each prison in England and Wales is monitored by an independent board of unpaid people drawn from the local community and appointed by the Secretary of State for Justice, whose role it is to ensure that standards of decency and care are maintained. Board members have full access to every part of the prison and all prisoners held there. The Board must produce an annual report, with the latest available for Frankland covering December 2009 to November 2010 says:

“In the view of the Board the standard of care is good. Patients are treated courteously and appear satisfied with the standard of care they receive. The Board receives very few complaints about Healthcare.”

Restraints and Bedwatch Arrangements

41. On each occasion a prisoner is escorted outside of the prison to hospital (either for an appointment or to be admitted as a patient) a risk assessment is completed which considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single handcuffs or two metre long escort chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.

Experimental Cancer Unit

42. The centre started treating patients in April 2008 and is one of a network of nineteen across the United Kingdom. It is funded jointly by the Department of Health and Cancer Research UK, and aims to fast track the introduction of new cancer drugs and treatments, which currently takes an average of ten years.
43. Experts at the centre investigate whether the latest scientific discoveries and cancer treatments work when tested with patients and also why they work. This research will then allow new treatments to be developed for use across the NHS as quickly as possible.
44. Patients are usually only given the new drugs if traditional treatments have failed and only receive small doses of the medication to begin with. Participation in any clinical trial is completely voluntary and counselling is provided to ensure that patients understand exactly what they are signing up for.

KEY EVENTS

45. The man was born in 1975. He had never been in prison before and had no previous convictions.
46. He was well known and thought of by both staff and prisoners on the wing, and there was considerable distress at his death. Prisoners had a collection and made and signed a card for his family. There was also a memorial service held in the prison chapel at the request of prisoners and staff.
47. The man was remanded in custody to HMP Durham on 24 January 2006 for an alleged serious offence. He was convicted of the offence at Crown Court on 28 September that year and sentenced on 8 December to an Indeterminate Sentence for Public Protection (IPP) with a five year tariff (this was reduced to four years in March 2008).
48. Following an unsuccessful appeal in December 2007, he was transferred to HMP Frankland on 14 January 2008.
49. At his initial healthscreen at Durham, the man told a prison doctor that he been diagnosed with Crohn's disease in 1993.
50. He was referred for an appointment with gastroenterology at hospital as a result of pain and diarrhoea in February 2007. This was followed up with the hospital on three occasions by healthcare staff and was eventually arranged for 2 April 2007, but he refused to attend and signed a disclaimer.
51. In June 2007, he saw a prison doctor. He was experiencing loose bowel movements. He also stated that he did not wish to attend any outpatient appointments whilst still a prisoner, saying that he would be at risk of assault due to the nature of his offence. The doctor noted his concerns and prescribed mesalazine. The prison records do not show whether his concerns were discussed further with him.
52. During September that year, the man had a flare-up of Crohn's disease and was admitted to hospital on 4 September. He returned to Durham the next day, having been prescribed prednisolone. Arrangements were made for a follow up appointment with a Gastroenterologist at hospital.
53. During his remaining time at Durham, the man refused to attend two outpatient appointments, saying that he was depressed, on both occasions he signed a healthcare disclaimer to this effect. There is no record of any follow up to his stated depression. He also sometimes refused to take his medication, despite staff explaining that it was to prevent further flare up of his Crohn's disease.
54. On 14 January 2008, he was transferred to HMP Frankland. His reception health screen (a general overview of a prisoners health needs) was carried out by a nurse healthcare officer. He told the nurse that he had Crohn's disease and that this had been diagnosed approximately seven years

previously (which differed slightly from what he had told the doctor on his arrival at Durham in January 2006). He confirmed that he had “the occasional flare-up”.

55. The man saw a prison doctor, on 30 January 2008 and confirmed that his Crohn’s disease affected his bowel, not his mouth or throat. He also confirmed that he had no recent hospital admissions and currently had no symptoms.
56. In March 2008, he had a flare-up of his Crohn’s disease. He saw a prison doctor, on 25 March, who prescribed prednisolone and nefopam.
57. The man had a further flare-up of his Crohn’s disease in October of that year. On 13 October, a nurse was called to the wing and saw him in his cell. He had been vomiting overnight and was suffering with constipation. The nurse gave him advice regarding slowly increasing fluids and to continue with nefopam for pain relief.
58. On 14 October, he saw Prison Doctor A who noted that he looked distressed and was complaining of abdominal pain and sweats. She noted that this should be treated as a Crohn’s flare-up and prescribed prednisolone.
59. In common with previous flare-ups of his Crohn’s disease, he continued to take prednisolone and slowly improved over the next several days.
60. Throughout the remainder of 2008 and throughout 2009, he did not appear to have any further flare-ups of his Crohn’s disease.
61. In June 2009, whilst being treated for a minor skin infection, the man raised concerns that as a cleaner on the wing³, he may have been vulnerable to diseases, such as human immunodeficiency virus (HIV), sexually transmitted diseases (STDs) or hepatitis. Prison Doctor B arranged for a number of tests to be carried out to allay his concerns.
62. Although all the tests were negative, on 24 June the doctor issued a course of hepatitis B vaccines as a precautionary measure. These were administered by healthcare staff in July, September and October 2009.
63. Over the next eight months, the man had very little contact with healthcare apart from dental treatment and treatment for a minor rash on his elbow.
64. On 21 July 2010, the man saw Prison Doctor B. He was complaining of sweating, headaches, body aches, feeling light-headed on standing, pains in his abdomen and groin and shivering. He also was passing only small hard amounts of faeces. He was concerned that this was a Crohn’s flare-up. The doctor ordered urgent blood tests and prescribed prednisolone and paracetamol.

³ Wing cleaner – one of the tasks allocated to prisoners as part of their work routine.

65. The blood results were returned the following day and seen by Prison Doctor A. The results showed an “abnormal but expected” result of serum amylase⁴ and a raised C-reactive protein (CRP)⁵. The prison clinical record shows that, as a result, a working diagnosis of Crohn’s disease appears to have been made and he continued taking prednisolone.
66. The man went to healthcare again on 4 August complaining of pain in his abdomen and this is recorded as an “ongoing episode” of his Crohn’s disease. Records show that further blood tests were requested, although there is no record of the results.
67. Just over a week later on 13 August, the man saw Prison Doctor A. He said that he had been suffering with aching limbs for about four weeks, he felt tired and had no appetite, he was passing small hard faeces infrequently and only small amounts of urine. She examined him and noted that he had a slight temperature, she advised him to stay in healthcare for observation but he declined. She arranged for further blood tests and a urine test. The urine test showed a trace of infection for which he was prescribed antibiotics. The blood tests showed nothing significant. However this set of blood tests did not include CRP levels. The investigator asked her why the CRP test was omitted on this occasion and she replied,
- “possibly because he was known to be Crohn’s, I thought I wouldn’t repeat it because it’s going to be raised and he’s had a recent flare-up possibly, we still didn’t really know.”
68. On 16 August, a nurse responded to concerns raised by wing staff about the man’s weight loss and reduced mobility. He reviewed his weight loss and arranged for him to see a prison doctor the following day. The record does not show his weight at this time.
69. The nurse also saw him in his cell the following day. He complained of ‘bone-type pain in most places’, reduced appetite, increased thirst, feeling tired and pain around his kidneys. He was being treated for a urine infection, and said that he was passing more urine since starting on a course of antibiotics.
70. Later that day, the man was seen by Prison Doctor A. The doctor noted that he had deteriorated since she last saw him and complained of severe aching limbs, lower right sided chest wall pain and a “tight and sore” chest, he was bringing up some phlegm and had a “bit of a sore throat”. She also noted that he was walking with a stoop and performed any movement “with apparent great effort”. The doctor noted that he was now urinating, but with a bit of pain along with pains in his “flanks”. He said that his bowel movement was

⁴ Serum amylase may be measured for purposes of medical diagnosis. A normal concentration is in the range 21-101 U/L. A higher than normal concentration may reflect one of several medical conditions. Raised serum amylase is often observed in patients with Crohn's disease and ulcerative colitis.

⁵ C-reactive protein (CRP) is a protein found in the blood, the levels of which rise in response to inflammation. Elevated CRP alone does not diagnose a specific disease but can be an indicator of the presence of an inflammatory disease, malignancy, tissue injury or necrosis.

loose that morning and dark brown in colour, he wasn't eating a great deal and had previously vomited.

71. The doctor was very concerned and noted it was "hard to make diagnosis as no clinical findings to work on". She wanted to admit him into healthcare for observation, in particular as he also said that he was having shivering episodes. She told the investigator that she wanted to monitor his shivering to find out whether he was having "rigor sweats because he's in fever" or "cold sweats ... where you don't have a fever". He refused "due to other prisoners and recent attack on HC [healthcare]" (this refers to a prisoner on prisoner attack that had taken place some weeks previously). Despite reassurance from her, he still refused to be admitted into healthcare. She ordered urgent blood tests and an urgent chest X-ray, and arranged for him to continue taking his antibiotics.
72. The doctor arranged for healthcare staff to contact the hospital to obtain the blood results the same day. That evening a nurse contacted her at home to convey the results which showed abnormalities. The doctor asked for full observations to be carried out and for an urgent appointment to be made for him to see the prison doctor the following morning.
73. The nurse saw the man on the wing that evening, he had raised blood pressure and a slight temperature and was complaining of feeling feverish. He was advised to take some paracetamol to help reduce the fever and also offered a bed in healthcare as he was clearly very unwell. He did not accept the bed in healthcare.
74. Just after 9.00am the next morning, the man was seen by a prison doctor. As a result of the abnormal blood test results and other clinical histories he agreed to go to hospital for a full investigation.
75. The man was admitted into hospital on 18 August and never returned to Frankland. He was initially considered as having a sub acute bowel obstruction (a complication often seen in Crohn's patients). He had further tests to identify any other cause of his sweats and weight loss. This included a computerised tomography (CT) scan of his chest and abdomen and a test for tuberculosis (which was negative).
76. Over the next 48 hours the hospital record describes how the man's abdominal pain worsened and his medication was adjusted accordingly. The CT scan results confirmed a sub acute small bowel obstruction.
77. He was referred for surgery on 23 August and the following day a lymph node biopsy was taken. On 26 August, he underwent surgery for a bowel obstruction and biopsies of his bowel were taken for further tests.
78. His post operative recovery was complicated by a paralytic ileus (when the contracting and relaxing actions of the small bowel muscles do not occur, causing the movement of wind and faeces to stop – this is a known side effect

of bowel surgery). Also he had a low white blood cell count, increasing his risk of infection. Preventative treatment was commenced by hospital staff to reduce the risk of infection.

79. Over the next nine days, hospital records show that the man was treated for low blood counts and his antibiotic management was reviewed regularly. The results from the initial tests carried out on him were “indeterminate”, and a Consultant Haematologist at hospital carried out a bone marrow biopsy on 7 September.
80. The hospital records show that the man was also being treated for an infected wound and raised temperature, and he required blood transfusions. During this time he was reversed barrier nursed (otherwise known as protective isolation, which is the physical separation of a patient at high risk from common organisms carried by others).
81. On 10 September, one of the bedwatch officers who had a cold was asked to remove himself from the room with him. The officer sat outside the room and his colleague continued to be cuffed to the man. The prison was informed and the change noted in the bedwatch log. It was later confirmed by a management check carried out by a Senior Officer.
82. The results of the bone marrow biopsy were received by the Consultant Haematologist on 17 September; they showed that the man had Hodgkin’s lymphoma stage four⁶. He was informed the following day and was understandably shocked and upset at this news.
83. Following a haematology (blood related) review on 20 September, the need for a Positive Emission Tomography (PET)⁷ scan and sperm banking was noted. Sperm banking is the opportunity for a patient to provide semen to be frozen for use at a later time. In cancer patients this is prior to commencing chemotherapy treatment, which sometimes affects fertility.
84. The hospital record shows that the man was to have chemotherapy when it was considered he was able to cope with the treatment. In addition, sperm banking was discussed with him and he indicated that this is something he would want done. The PET scan was booked for 30 September.
85. On 25 September, he was transferred to the medical unit at the hospital for haematological (blood related) care.

⁶ Hodgkin’s lymphoma is a cancer originating from the white blood cells, which spreads from one lymph node group to another and which develops systemic symptoms: fever, night sweats, weight loss; when the disease is advanced. Stage 4 means the cancer is advanced and has spread to other organs

⁷ A positive emission tomography (PET) scan is used to produce a detailed, three-dimensional picture of the inside of the body. The images clearly show the part of the body that is being investigated and can also highlight how effectively certain functions of the body are working.

86. Three days later it is recorded in the hospital records that he was to be treated as having neutropenic sepsis (a life threatening infection and fever). As the condition was considered life threatening, the chemotherapy treatment for him lymphoma was delayed.
87. The Consultant Haematologist was contacted by a professor (Experimental Cancer Unit at another hospital) on 28 September. This was as a result of conversations between the man's brother and the professor in the preceding days, during which the professor agreed to accept the man as a private patient.
88. The Consultant and professor agreed to a transfer of the man to the Experimental Cancer Unit as a private patient of his.
89. On 30 September, ward staff were informed of the impending transfer and asked to prepare the man to be moved. He was very ill and the hospital notes state that he was now not fit for a PET scan or semen harvesting.
90. It appears that the man became very focused on the treatment on offer at the other hospital and refused to start the chemotherapy regime at the local hospital. It is not clear if he believed that by starting treatment would reduce his chances of transfer to the other hospital, but the professor confirmed to the investigator that this was not the case.
91. The transfer of the man was delayed by several days, whilst the Prison Service, Primary Care Trust (who provide healthcare at the prison) and the man's family negotiated the terms of his transfer into the care of the professor as a private patient.
92. The man's family agreed to cover all health related costs on 4 October. The family wanted him to be transferred by air to the other hospital, but were told this was not possible due to security concerns.
93. On 4 October, the Consultant Haematologist discussed with the man his worsening condition. She told him that she believed he should commence chemotherapy straight away, but he refused treatment.
94. The prison log of events records that on Monday 4 October a fax was received by the prison from the man's solicitor asking for confirmation that their client would be transferred "sometime within the next 24 hours".
95. The duty Governor received a telephone call at 12.30pm from the man's brother asking when he would be transferred to the other hospital. A call was received 10 minutes later from the family's solicitor asking the same question. The duty Governor said that Frankland's healthcare department would be "giving this consideration".
96. The prison log shows that at 1.00pm the same day, the Head of Healthcare at Frankland informed the duty Governor that the Consultant Haematologist from

the hospital had confirmed that the man required an urgent transfer to the other hospital for “non-licensed unconventional chemotherapy” under the care of a professor, and that this was “the prisoner’s only chance of survival”.

97. The prison began the transfer process by seeking mutual aid from North London prisons to assist with bedwatch (often when a prisoner is transferred out of area, prisons will make arrangements with a nearer establishment to provide staff to cover bedwatch duties).
98. However at 2.15pm the Head of Healthcare raised a concern with the duty Governor over who would cover the cost of the bedwatch. She told the investigator that, because the proposed treatment at the other hospital was “non licensed/unconventional”, it would not be provided on the NHS. Normally if another prison is providing staff to cover bedwatch duties, they recharge the ‘home’ prison, who in turn recharges the PCT responsible for the ‘home’ prison. However in the man’s case, because the treatment he was due to receive was not being paid for by the NHS, she confirmed to the investigator that the NHS “didn’t approve a transfer so wouldn’t pay for the costs”.
99. At 3.00pm that day, the Consultant Haematologist spoke to the Duty Governor. She said that the man’s family would be meeting the cost of treatment, transfer and bedwatch costs. She said that she would prefer the transfer to be via air ambulance. The Duty Governor told the investigator:

“... it wasn’t feasible because the air ambulance wouldn’t carry the number of staff that would be required to transfer the patient. Because not only would it be the patient in the craft, it would probably be a paramedic or two, there would be at least two staff to go with him ... I don’t think the air ambulance would carry than many people ... also there was some kind of grey area about who was going to pay for this.”
100. Over the course of 5 October there a number of telephone calls and e mails between the prison and the Head of Commissioning, NE Offender Health of County Durham PCT discussing who should cover the costs of bedwatch.
101. Also on 5 October, the Head of Commissioning raised the concern that the man had not apparently agreed to the transfer to the other hospital. The prison obtained his agreement in writing later that day.
102. At 1.15pm the same day, a Governor spoke to the Consultant Haematologist, who stressed the urgency of the transfer and said that any further delay could be fatal to the man.
103. That evening, the prison received a fax from the man’s brother, confirming the family’s undertaking to pay all health related costs in relation to his transfer and stay at the other hospital. At 8.30pm, a Governor contacted the Head of Commissioning to confirm that, although the PCT had an agreement with the man’s family to recoup the escort costs, the prison would still need to invoice the PCT in the normal way. The Governor pointed out that the agreement

with the family was not with the Prison Service or Frankland. He also said that “it is not normal prison service policy to produce prisoners into private healthcare”.

104. At 11.45pm that night, the Head of Commissioning forwarded an e-mail received from the man’s brother expressing his concerns around delay and confirming that the family would have an ambulance available the following day [6 October]. He asked that the prison authorities provide escort officers to be available as soon as the ambulance was ready.
105. In a further e-mail from the Head of Commissioning the same night, she confirms that the PCT would “not fund any aspects of the care and treatment, including bedwatch and escort costs”. She also confirmed that the man’s family had agreed to cover all healthcare related costs.
106. At 9.57am on 6 October, Frankland approached Prison Service Headquarters for assistance in arranging mutual aid from a London prison and advice regarding moving the man. Later that morning a fax was received from the man’s solicitors asking for an answer by 12 noon, otherwise they would be making an application in the High Court for a mandatory order.⁸
107. There were further faxed documents from the man’s solicitors at 1.23pm and 3.03pm that day, requesting that he be transferred to the airport (for air transfer) and copying an e-mail from the professor stating that any further delay would cause further deterioration in him. These were highlighted to Prison Service Headquarters.
108. At 5.12pm that day, advice was received via e mail from the Acting Director, High Secure Estate. He said that given the medical evidence and absence of any clear response from the PCT, the transfer of the man to another hospital should go ahead. Subsequently HMP Belmarsh agreed to provide officers for bedwatch duties at the other hospital.
109. Also on 6 October (the time is unclear), a response from the PCT in the form a letter was faxed to the Acting Director from the North East Director of Commissioning for Mental Health, Learning Disabilities and Offender Health. The letter confirmed that County Durham PCT would not support the funding of the man’s treatment at the other hospital or any of its associated costs (escorts and bedwatches).
110. Whilst the man remained at the local hospital, the Consultant Haematologist continued to review him on a daily basis.
111. He was eventually transferred to the other hospital on Thursday 7 October, by road ambulance (due to his level of security risk) and escorted by two prison officers from Frankland. Officers from Belmarsh took over bedwatch duties at 8.20am on 8 October.

⁸ A court may make a mandatory order to compel an authority to do its duty or to stop it from acting illegally.

112. An experimental chemotherapy regime was commenced by the professor, but the man was extremely ill and continued to deteriorate. He sadly died a few days later with his family present.
113. A family liaison officer from HMP Belmarsh attended the hospital and met with the man's family to explain the family liaison officer role, he also gave them contact details for the family liaison officer at Frankland. He explained that the prison would help with funeral expenses. This was also followed up with a letter to the man's brother from a duty Governor of Frankland.
114. There was a debrief for the Belmarsh bedwatch officers the same day. The officers were offered further staff support but declined.
115. Frankland prisoners and staff were informed of the man's death the same day. Staff were offered support and prisoners were given access to a Listener if required. (Listeners are prisoners who are trained by the Samaritans to provide a confidential listening service to fellow prisoners.)

Post Mortem

116. A post mortem was carried out on 21 October 2010. It concluded that death was due to natural causes as a result of multi-organ failure, disseminated aspergillus, immune deficiency and Hodgkin's Lymphoma.

ISSUES

Management of the man's Crohn's Disease

117. The man was diagnosed with Crohn's disease prior to entering prison. The condition is an inflammatory bowel condition characterised by "flare-ups" which need to be clinically managed. His condition appears to have been appropriately managed throughout his time in prison. However, he quite often refused treatment or to attend clinic appointments in relation to his Crohn's disease. Staff explained the risks involved in him not accepting treatment and he appears to have understood.
118. His last documented Crohn's flare up was in October 2008. From October 2008 through to July 2010, he had little interaction with the healthcare department at Frankland and does not appear to have been troubled by his Crohn's disease.

Diagnosis of Hodgkin's Lymphoma

119. The most common symptom of Hodgkin's lymphoma is one or more painless swellings in the neck, armpit or groin. These swellings are enlarged lymph nodes. About 70% of people diagnosed with Hodgkin's lymphoma have a swollen lymph node in their neck. Usually, the swollen nodes don't hurt, but some patients say they ache and sometimes cause a stiff neck. Sometimes there are more general symptoms (often called 'B symptoms'). They can include heavy sweating (especially at night), temperatures that come and go, and losing a lot of weight. Some people experience itching. If the disease affects nodes in the chest or lungs it can cause a cough or breathlessness.⁹
120. On 21 July 2010, the man saw Prison Doctor B. He complained of sweating, headaches, body aches, feeling light-headed on standing, pains in his abdomen and groin and shivering. He also was passing small hard faeces. The doctor ordered urgent blood tests for the following day, which showed a raised CRP¹⁰ level. The clinical reviewer notes that a working diagnosis of a Crohn's flare-up appears to have been made and prednisolone and paracetamol were prescribed.
121. Prison Doctor A told the clinical reviewer that, on 22 July, she noted that the man's CRP was raised and that this pointed to an inflammatory response somewhere in the body. However she said that she did not feel it was highly suggestive of a malignancy. When further blood tests were ordered on 13 August, she told the clinical reviewer that she did not believe that a further CRP test would clarify a diagnosis because the test is an indicator of inflammation and Crohn's is an inflammatory disease "so a clear diagnosis would not be possible from that test alone".

⁹ List of symptoms provided by Cancer Research UK

¹⁰ C-reactive protein (CRP) is a protein found in the blood, the levels of which rise in response to inflammation. Elevated CRP alone does not diagnose a specific disease but can be an indicator of the presence of an inflammatory disease, malignancy, tissue injury or necrosis.

122. The doctor told the investigator that the man did not have the most common symptom of Hodgkins lymphoma “he did not present with lymphatic swellings that you’re obviously palpating [examine by touching]”. She confirmed to the investigator that she “wasn’t thinking Crohn’s” by the second time she saw him “it had gone beyond that because he just didn’t have the typical features of Crohn’s”.
123. A number of prisoners and staff came forward during the investigation and, when interviewed, expressed concerns that the man had lost a significant amount of weight over a short period of time and appeared to be in considerable pain. Wing officers confirmed that they had raised these concerns with healthcare staff. An officer said that he had concerns about him for some time and by the “middle of July” had tried to encourage him to go to the doctor. As he was reluctant to go, the officer said that he approached healthcare and requested that someone see him urgently.
124. Another officer also confirmed that he was alarmed at the significant weight loss in the man, which was particularly stark on the officer’s return from a period of summer leave. He told the investigator that he tried to convince him to go to healthcare because “he wasn’t in good shape” but he refused to go because he couldn’t smoke on the healthcare unit. Eventually he spoke to his brother on the telephone and told the officer that his brother also thought he should go to healthcare and that he was prepared to go. The officer told the investigator that often there was a delay in getting healthcare appointments, so he went down to see the nurse on duty and asked for someone to see him urgently. As a result of his request, a nurse visited him in his cell and arranged for him to see the doctor the following day. The officers interviewed were not clear about the dates involved, however having checked the records the investigator was able to ascertain from the clinical notes that this was the 16 and 17 August.
125. The investigator asked Prison Doctor A if she observed any weight loss in the man in the period from 21 July. She confirmed that she didn’t observe this visually but said she was sure she did confirm that his weight had gone down by comparing two readings. She was not able to say what those readings were, but said that she was satisfied he had lost weight. In addition, a nurse reviewed his weight on 16 August, following the concerns raised by staff. However, both the investigator and clinical reviewer were not able to find any note of his ongoing weight in the records provided to this investigation, which would have made realistic comparison of weight over time difficult. The doctor told the investigator and the clinical reviewer that his symptoms were not clearly pointing to any particular diagnosis. The clinical reviewer considers that an accurate record of his weight could have aided diagnosis “as marked weight loss in a short period of time in the absence of other obvious causes can be a trigger for raising the index of suspicion of malignancy”. If his weight was not recorded and therefore effectively monitored, we consider this a significant omission and concur with the clinical reviewers recommendation:

We recommend that the Head of Healthcare ensure that staff consistently and accurately take and document the weight of individual patients as an integral component of the care plan.

126. The man was well known on his wing for being extremely fit and a regular user of the gym. However other prisoners and staff told the investigator that from early in July he stopped using the gym, began having trouble eating, lost weight and became weak. It is clear that he was being seen by healthcare staff during this period, and Prison Doctor A recorded the fact that she considered his condition worrying. There were no conclusive results to the blood tests and many of his symptoms were non-specific. The doctor said:

“When I saw him for the first time ... he described generalised symptoms of whole body hurting, feeling tired, very non specific symptoms that are hard to pinpoint to any particular system

“I remember him saying he was hurting in his arms and his legs, again so vague. And then if you pressed on those places he wasn’t tender; it was very difficult to assess him but he didn’t look well and had lost weight

“So again I was left thinking what is the matter; I know he’s poorly but I don’t know what’s causing it”

127. When the doctor saw him on 17 August, she asked him to come into healthcare so that he could be monitored, particularly in relation to the sweats he had complained of. She told the investigator that she wanted to find out whether the sweats were in relation to a fever (rigor sweats) or cold sweats, which she described as “cold sweats is more like the lymphoma, classical symptom of lymphoma”. Unfortunately, he refused to be admitted into healthcare. It is not clear why he wouldn’t agree to be admitted on this occasion. However the investigator noted that he was a smoker (which is not allowed in healthcare). It is also known that he was nervous of staying in healthcare as a result of an incident (which did not include or affect him) earlier in the year. It is possible that this was still something he was worried about.
128. A number of prisoners came forward during the investigation and told the investigator that the man had told them that the doctor did not believe him and thought he was making it up. Several prisoners interviewed said that he had said “she thinks it’s all in my head” and he had been considerably upset by this.
129. Prison Doctor A was clearly confounded by the man’s unclear symptoms and she admits to “just shooting questions at him to try and find something positive”. She told the investigator that “this was a very difficult history and he had a bit of this and a bit of that, not very much ... those sorts of answers which didn’t really focus me in any particular direction”.
130. She also said that she initially had to consider the possibility that he was “manipulating” because she was unable to find any clinical signs to support

the symptoms he was describing to her. However, she quickly concluded that he was genuine and that she found him “very pleasant, not difficult, sincere”.

131. The man was eventually admitted to hospital on 18 August, where he was initially treated for a bowel obstruction. However, following an inconclusive lymph node biopsy taken on 24 August, a Consultant Haematologist carried out a bone marrow biopsy on 7 September. It was after the results of this biopsy that on 18 September (one month after being admitted to hospital) he was informed he had Hodgkin’s lymphoma stage four. It is clear that despite being obviously seriously ill, his condition proved difficult to diagnose.
132. The clinical reviewer notes that within the national cancer waiting times¹¹ it is expected that a person found to have a malignant diagnosis will receive their first definitive treatment within 31 days of the consultation where they make the decision to have treatment. For the man, the date would therefore be the date he was told of the diagnosis (18 September), this means according to national waiting times, he would have needed to receive treatment by 19 October. (For the purposes of clarification: the clinical reviewer states these dates to be 17 September and 18 October respectively, however the investigator notes that 17 September was when the consultant received the result, but he was told the following day at 9.25am.) However this does not take into account any delay in diagnosis.
133. The care of the man was ultimately transferred to a professor of the Experimental Cancer Unit on 7 October. The investigator asked the professor whether he felt everything was done to get him to a timely diagnosis and treatment. He said:

“The fact that the man’s disease was so very far advanced meant that there had either been a significant delay in his diagnosis or this was an extremely aggressive form of Hodgkin’s disease. He told me about the symptoms he had been suffering for some time: night sweats and fevers; weight loss; low energy – he had been a regular gym user and did not have the energy to go; no appetite or unable to eat. These symptoms, along with his history of Crohn’s disease should have indicated that something serious was going on.”
134. The investigator asked whether the man should have been referred to hospital earlier, despite the blood tests, carried out whilst he was still in prison, being inconclusive. The professor said “with those symptoms it was clear that something was going on. It seems to me that he should have been referred to hospital earlier”.
135. The Ombudsman’s investigators are not clinically trained, and it is clear that there were a number differing clinical opinions relating to the man’s diagnosis. The clinical reviewer appointed by the local PCT stated that she is not a haematology cancer specialist. As a result, and on the recommendation of the clinical reviewer, the investigator (on behalf of the Ombudsman) contacted

¹¹ As set down in the National Cancer Plan (2000)

Durham PCT on 23 February 2011 and asked them to commission an independent haemato-oncologist to carry out a further review into the man's care. The PCT are not obliged to agree to a further clinical review, and on this occasion turned down the Ombudsman's request.

136. It is not within the remit of the Ombudsman to comment on the standard of care received by a prisoner once that person is under the care of an outside consultant or hospital. The care provided by prison healthcare is within remit.
137. The clinical reviewer concludes that the man received comparable healthcare to that which he would have received in the community. On the available evidence, we remain less clear.
138. On 21 July, the man first presented to prison healthcare; on 18 August, he was admitted into hospital and on 17 September he was diagnosed with Hodgkin's lymphoma. However, the symptoms he was presenting to prison healthcare staff, although apparently not conclusive, were significant and he was clearly very ill. As non-clinicians it is not possible for us to say whether a referral to hospital a matter of weeks earlier would have resulted in an earlier diagnosis and therefore treatment for him. However, we believe the combination of such severe symptoms, albeit inconclusive, should have raised sufficient concerns for the consideration of a referral to have been made at an earlier point.

Arrangements for transfer of the man to another hospital

139. As a result of conversations on 28 and 29 September, agreement was reached between the Consultant Haematologist and professor for the man to be transferred to the Experimental Cancer Unit as a private patient of the professor. He was not transferred until 7 October. There are a number of factors to consider.
140. When a prisoner attends outside hospital either for an appointment or as an in-patient, they will be escorted by prison staff. In April 2008, the responsibility for the funding of escort and bedwatch costs from public sector closed prisons transferred from HM Prison Service to Primary Care Trusts (PCTs). The management of security for escort and bedwatch functions remained with the National Offender Management Service (NOMs).¹² In this case this would be County Durham PCT. However, once the man's family made arrangements for him to be a private patient of the professor, the PCT refused to pay for bedwatch or the transfer of him to the Experimental Cancer Unit. The transfer of him could not go ahead until there was an undertaking from his family to cover the costs of bedwatch and transfer. This was received on 4 October.
141. Despite this agreement from the man's family, the investigator has uncovered a complicated picture of differing opinions and understanding from the prison

¹² As set out in the Concordat between NOMs and the NHS (June 2010)

service and County Durham PCT, which created a delay in arranging the transfer. Frankland kept a log of events.

142. According to the prison log of events the Head of Commissioning for County Durham PCT was initially of the view that the receiving PCT (the PCT covering the other hospital) should cover the cost of bedwatch once the man was admitted there. She also believed that his family should pay for the escorting officers (while he was being transferred between hospitals). She was also of the firm opinion that as he was going out of area for treatment it was the responsibility of the Prison Service to transfer him to a London prison.
143. A Governor contacted the Head of Commissioning to confirm that, although the PCT had an agreement with the man's family to recoup the escort costs, the prison would still need to invoice the PCT in the normal way. He pointed out that the PCT agreement with the family was not with the Prison Service or Frankland. He also said that "it is not normal prison service policy to produce prisoners into private healthcare".
144. The same night, the Head of Commissioning confirmed that the PCT would "not fund any aspects of the care and treatment, including bedwatch and escort costs". She also confirmed that the man's family had agreed to cover all healthcare related costs and that:

"Clearly a decision needs to be made by the prison service as soon as possible and communicated to the brother and the patient at the earliest opportunity."
145. The prison log shows that part of the delay was because Frankland were initially unable to get a London prison to accept a transfer of bedwatch duties due to "the commitment of costs and possible DIC (death in custody) implications". The security governor at Frankland confirmed during interview that Frankland tried HMP Holloway, HMP Pentonville and HMP Wandsworth without success.
146. Staff at Frankland eventually approached prison service headquarters for assistance and advice on 6 October. The Acting Director, High Secure Estate replied, advising the transfer of the man to the other hospital should go ahead. Subsequently, HMP Belmarsh agreed to provide officers for bedwatch duties at this hospital.
147. A response from the PCT in the form a letter was also received on 6 October, although the time is not clear. The letter was from the North East Director of Commissioning for Mental Health, Learning Disabilities and Offender Health, and confirmed that County Durham PCT would not support the funding of the man's treatment at the other hospital or any of its associated costs (escorts and bedwatches). This letter was faxed to the Acting Director.
148. The man was eventually transferred to the other hospital on Thursday 7 October, by road ambulance (due to his level of security risk).

149. There was continued disagreement between the PCT and prison over responsibility. The prison log for 11 October states:
- “Head of Commissioning saying HMP are at fault for moving him to another hospital and should have sought a transfer then his case would have moved to another PCT. I [Governor] stated that we were transferring one prisoner from hospital to hospital and the PCT Commissioners are responsible for their Consultant and the agreement with the family.”
150. It is clear there was considerable confusion over who was responsible for what, this confusion added to the delay of an effective transfer of the man to the care of the professor at the other hospital.
151. The investigator asked the professor if, in his view, the delay had an effect on the chances of any treatment being effective for the man. He said that a seven to 10 day delay would not normally be an issue. However, the man was very sick indeed and was presenting very rare symptoms, chemotherapy would be his only chance of survival and time was needed to “clear out the cancer cells and replace them with healthy cells”. He told the investigator that the man arrived at the hospital “in a moribund state”¹³.
152. The investigator made enquiries with the NOMS, Offender Safety, Rights and Responsibilities Group (OSRRG) in relation to what policy or guidance there is in place covering the transfer of prisoners between prisons as a result of out of area hospital admission. There is no national policy covering such moves, which are usually managed on a prison to prison basis.
153. The investigator also asked what policy or guidance was in place for prisons managing prisoners who request private medical treatment. There is no national policy covering these circumstances.
154. Whilst accepting that the issues around the transfer of the man were unusual, perhaps rare for the Prison Service, the absence of any clear policy or guidance left HMP Frankland in a dilemma, which most certainly added to the delay in getting him to the other hospital.

We recommend that NOMS and the Department of Health (DOH) develop a policy setting out clear guidance on the transfer and arrangements for prisoners between prisons as a result of out of area hospital admission.

We recommend that NOMS and the DOH develop a policy that provides clear guidance to prisons on the management of prisoners requesting private medical treatment.

Release on Temporary Licence (ROTL) or Compassionate release

155. When a prisoner needs to attend outside hospital either for an outpatients appointment or as an in-patient, the prison should consider whether it is

¹³ Moribund – near death

appropriate for that person to be released on temporary licence (a decision that can be made locally by the Governor) or whether an application should be made for compassionate release (a decision made at NOMS or Ministerial level).

156. We looked at whether ROTL or compassionate release had been considered for the man. The investigator discussed this with a Governor who confirmed that as he was a category B prisoner (for whom escape should be made difficult) and because of security risks relating to his offence, he was not considered an appropriate candidate for ROTL or compassionate release. It is not easy to balance the needs of a seriously ill prisoner with the risks they may present to the community if released. However, the investigator had access to the relevant records and we are satisfied that appropriate decisions were made in relation to him.

Bedwatch and restraints

157. In common with any prisoner admitted to outside hospital, the man was risk assessed, and the decision made to keep him under restraint with two officers and an escort chain (which was removed for treatment and then reapplied) throughout his time at the local hospital. This continued for the first four days at the other hospital.
158. There is a difficult balance between appropriate levels of security and the wellbeing and dignity of the prisoner concerned. There were security risks noted due to the nature of the man's offence. As a result of this assessment, it was deemed necessary to keep him under restraint. Regular risk assessments (in keeping with prison service policy) were carried out, and the restraints were removed for treatment purposes. Bedwatch logs were kept in good order at both hospitals.
159. On 10 September, the man was being treated for a wound infection, raised temperature and was receiving blood transfusions. He had reduced immunity and was therefore being reverse barrier nursed. Records show that one of the bedwatch officers who had a cold was asked by medical staff not to remain in the same room as him. The officer concerned removed himself from the room and sat outside. The other officer remained cuffed to him. A SO carried out the management check that day, and confirmed the new arrangements and that "nursing staff have no concerns over the bedwatch".
160. The investigator asked the Head of Security and Operations whether the approach to bedwatch was affected if the prison was informed a patient had reduced immunity. He said that it would depend on the mobility of the prisoner concerned; however bedwatch would ordinarily be assessed on a case by case basis. The investigator also pursued this with the Security Department, who stated reduced immunity would not necessarily be considered as part of the risk assessment. The Security Governor said "possibly not because the risk is still that the person harms others ... unless he was so disabled that he couldn't get up and move away".

161. Whilst accepting that the risk to others and the risk of escape should be considered most seriously when assessing bedwatch arrangements, when a patient has reduced immunity all possible risk of infection should be reduced. Such information should be readily available from medical staff and should be taken into account when carrying out the risk assessment.
162. Once the man became gravely ill, we would expect that serious consideration would be given to removing any restraints. We find it concerning that in referring to him as “moribund” that the professor also said:
- “What did surprise us here though, was that this very sick man arrived at the hospital shackled to prison officers”.
163. We accept that during long transfer between hospitals the risks may have been higher. However, once he arrived at the other hospital, given his serious condition, the restraints should have been removed to allow him appropriate dignity.
164. The man commenced chemotherapy on 8 October at the other hospital, but remained under restraints until medical staff requested their removal on 11 October. The restraints were removed and, following risk assessment, were not reapplied. However following this decision he was accompanied at all times by one officer in the room and two outside of the room.
165. We are concerned that he was kept under restraint far longer than acceptable in view of his very serious condition and would draw the Governors’ (both of Frankland and Belmarsh) attention to the concordat between NOMS and the National Health Service of June 2010, in particular section 5.6 which says: “Using handcuffs or other restraints on terminally ill or seriously ill prisoners is considered inhumane by the courts, unless justified by security considerations”¹⁴

We recommend that the Governors of both Frankland and Belmarsh review their local security policies relating to bedwatch risk assessment, to ensure they appropriately implement the concordat between NOMS and National Health Service (2010), and properly take into account and balance medical risks alongside security risks.

The man’s refusal of treatment

166. Throughout his time in prison the man often exercised his right to refuse treatment and signed a disclaimer on each occasion to this effect
167. Whilst at HMP Durham, he refused to attend two outpatient appointments in late 2007, and on these occasions he signed a disclaimer on which he stated

¹⁴ In part due to a Judicial Review, case of Allen where the judge found the Prison Service to be in breach of Article 3 (inhuman and degrading treatment), when restraints were applied to a prisoner who was undergoing a course of chemotherapy without, in his opinion, adequate evidence to support the view that their application was justified.

that he was depressed. There does not appear to have been any follow up to his stated depression.

168. Healthcare staff in both Durham and Frankland appeared satisfied that the man's refusal of treatment on these occasions was not related to any mental health matter. However, we consider it good practice to arrange mental health follow up when there is consistent refusal of treatment or to attend appointments.
169. He also refused to be admitted into healthcare on a number of occasions, including on 13 and 17 August 2010. On the latter occasion he said he was afraid to go into healthcare because of a previous incident that had occurred (which had not involved him). On previous occasions he had been nervous about being attacked due to the nature of his offence.
170. Smoking is not allowed in the healthcare department, and the man was a smoker. It is possible that this also played a part in his refusal to be admitted into healthcare. It was of course his right to refuse, but this denied healthcare staff the opportunity to monitor him effectively.
171. Once he knew that the professor had agreed to accept him as a patient he refused any conventional chemotherapy offered at the local hospital. There are conflicting accounts as to whether this would have increased his life expectancy.
172. The clinical reviewer states that two Staff Nurses caring for the man at the local hospital said that he had initially consented to chemotherapy at another hospital (where patients from the local hospital are referred for chemotherapy). The Consultant Haematologist confirmed to the clinical reviewer that the chemotherapy offered was the approved regional cancer network regimen and in line with national guidance. She said that it offered him "as good a chance of improving his condition as the regime ultimately offered at the other hospital".
173. The clinical reviewer also states that the nursing staff said they had discussions with the man about the critical nature of his condition and the need for treatment as soon as possible. The nurses stated that he seemed to be completely focused on his only option being at the other hospital.
174. The Consultant Haematologist discussed the man's worsening condition with him on 4 October and that she believed he should start chemotherapy immediately, but he refused.
175. She told the clinical reviewer that the chemotherapy on offer locally was comparable to that on offer in London.
176. Possibly because of his refusal to receive treatment, on 4 October she told Prison Doctor A (Frankland) that an urgent transfer to the other hospital was required and this was his only chance of survival.

177. On 6 October, a Governor e-mailed the professor asking for clarification on two matters relating to the man's refusal of conventional treatment: if he had started conventional treatment would this have prevented him from undergoing the treatment on offer by the professor; and if successful would conventional treatment be a cure or simply prolong life.
178. The professor replied "there is evidence to suggest that the very first treatment received is the most important", he went on to say that there was good data to suggest that the treatment he was proposing in London increased the chance of cure compared with the UK standard. He stated:
- "The man has not yet been treated and therefore has not responded poorly, but his clinical features suggest he WOULD respond rather poorly to conventional therapy."
179. The investigator spoke to the professor on the telephone and asked him whether the man's refusal to commence the treatment offered by the local hospital and therefore the delay in commencing any treatment for Hodgkin's lymphoma adversely affect his chances of survival. He replied:
- "Earlier treatment at Durham could have made a difference, particularly as the man was deteriorating so fast. As I said earlier, both myself and the Consultant Haematologist tried very hard to persuade him (and his family) to start treatment at Durham, but he refused. It is possible that if he had started his treatment at Durham and did well, that we could have treated him with subsequent cycles of treatment at the other hospital".
180. As already stated earlier in this report, it is not within the remit of the Ombudsman to comment or recommend action in relation to the care and treatment provided outside of the prison. However the above paints a confused and often conflicting picture in which the man, his family, the PCT and the prison were trying to make decisions and take appropriate action.

Exceptional Cases Funding

181. Sadly, the issue of funding was a significant factor in the delay in transferring the man to the other hospital. There was the suggestion from the Consultant Haematologist on 4 October that he might be under the care of the professor for six to nine months, during which time bedwatch would need to be funded. This clearly was an expense that County Durham PCT did not wish to take responsibility for.
182. It wasn't until the man's family agreed to bear the cost that matters began to be resolved (although still delayed by disagreements and difficulties in arranging bedwatch with a London prison).
183. The clinical reviewer discusses 'exceptional case funding' in her report. Where an individual requires treatment that is not within the recommendations of the National Institute of Health and Clinical Excellence, then a consultant

clinician is able to make a formal request to the PCT to consider the case as an “exceptional case” for funding of the treatment. If a case is not supported, an appeal can be made. If funding support is still not available then the person is expected to fund the treatment themselves, should they still wish to proceed. The PCT process can be treated as an urgent matter if the condition of the individual is deteriorating rapidly, directly through the PCT’s Chief Executive.

184. The clinical reviewer confirms that the records she reviewed indicated that the man’s case was expedited directly through the PCT’s Chief Executive. The prison log shows that on 6 October the PCT referred his case to the Exceptional Case Conference Chair, and the Chief Executive. The results of the referral are not known however, if approved, it is likely that the funding would only have supported his treatment and the other hospital, not necessarily the transfer or bedwatch arrangements.
185. This is another grey area, where responsibilities are not clear. Whilst the issue of exceptional case funding in this case is outside of the Ombudsman’s remit, we would expect that, when considering our recommendation to develop a policy in relation to prisoners requesting private medical treatment, NOMS and the DOH also take into account the implications of exceptional case funding.

Family liaison

186. Prison Service Order 2710 Follow up to death in custody, requires the prison to nominate a family liaison officer to assist the family of the deceased wherever possible. Both Frankland and Belmarsh nominated family liaison officers to assist the man’s family. A chaplain from Belmarsh visited and advised the family at the hospital on the day he died. The family liaison officer from Frankland liaised with the man’s brother to return his property and to offer help with funeral expenses and send flowers. The family declined any further assistance.
187. When a prisoner is seriously ill and particularly when in an outside hospital, this office considers it good practice for the prison to appoint a family liaison officer. During such a difficult and often emotional time, the family benefit from a consistent prison service contact, who can readily answer any questions and offer support. We are therefore disappointed to note that neither family liaison officer was available to the family prior to the man’s death. The family have expressed some concerns about the relationship between Frankland and the local hospital. These concerns may have been mitigated to some extent, if the prison had provided consistent advice and support to the family during his time in hospital.
188. At the draft report stage, HMP Frankland said that prior to the man’s death his family were in contact with operational staff and Governor. The family had confirmed that they did not want additional contact with the Family Liaison Officer and these wishes were respected.

We recommend that the Governor of Frankland extends the family liaison officer role to include offering advice and support to the families of prisoners who are seriously ill and in outside hospital.

189. It is important to note that the man's family, particularly his brothers, appear to have been a constant source of support during his time in prison and specifically during his illness and leading up to his death. In addition to their wish to obtain the best possible treatment for him, records show that they were regular visitors to both the prison and hospital.

RECOMMENDATIONS

The National Offender Management Service response to the recommendations made is included in italics under each separate recommendation.

1. We recommend that the Head of Healthcare ensure that staff consistently and accurately take and document the weight of individual patients as an integral component of the care plan.

Accepted – Monitoring an individual’s weight is completed as part of ongoing care and this is determined by the clinical circumstances.

2. We recommend that NOMs and the Department of Health (DOH) develop a policy giving clear guidance on the transfer and arrangements for prisoners between prisons as a result of out of area hospital admission.

Accepted – PSO 3050 “Continuity of Healthcare for Prisoners” provides guidance for the continuity of healthcare for prisoners and focuses on the vulnerable points of the system when the prisoner is moved into, or out of prison; when they are leaving and re-entering prison for court visits, and when transferring to another prison or being discharged from custody. Key issues which need to be considered are individual risk management and sharing of information to ensure as smooth a transition as possible.

3. We recommend that NOMS and the DOH develop a policy that provides clear guidance to prisons on the management of prisoners requesting private medical treatment.

Accepted in principle – NOMS and Offender Health will consider in what circumstances prisoners may access private medical treatment. As with all new policy initiatives this will be prioritised alongside other work.

4. We recommend that the Governors of both Frankland and Belmarsh review their local security policies relating to bedwatch risk assessment, to ensure they appropriately implement the concordat between NOMS and National Health Service (2010), and properly take into account and balance medical risks alongside security risks.

HMP Frankland Accepted – Levels of restraint used on prisoners must at all times be proportionate to the perceived security risks and be balanced by considerations of care and decency for the prisoner. Terminally or seriously ill prisoners may present a lower risk of escape and this is considered as part of the assessment process. The use of restraints on terminally or seriously ill prisoners is reviewed regularly taking into account clinical input, and the level of restraints will be adjusted in accordance with any deterioration in the prisoner’s clinical condition or the intensity of the treatment they are receiving. In addition a fresh risk assessment is carried out each time a prisoner is moved or their clinical condition is reviewed, in order to assess the appropriate level of restraint for transportation to or from hospital and during the prisoner’s stay at hospital.

HMP Belmarsh Accepted – managers carry out daily management visits to any bedwatch prisoners and complete a new risk assessment when changes in circumstances arise (which includes consideration about the appropriateness of the use of restraints).

5. We recommend that the Governor extends the family liaison officer role to include offering advice and support to the families of prisoners who are seriously ill and in outside hospital.

HMP Frankland Accepted – This is already (and was at the time) embedded practice at HMP Frankland.

HMP Belmarsh Accepted – It is accepted that families/NOK should be contacted at the earliest opportunity, and this is now considered with all prisoners who are taken to outside hospital for serious conditions. Where the individual is a high risk to security, it is not always appropriate to do so without further checks being carried out.