

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Frederick Cranston, a prisoner at HMP Birmingham, on 3 April 2020

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



© Crown copyright 2020

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

## 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 Frederick Cranston died of stomach cancer, which had spread to the liver and lungs, on 3 April 2020 while a prisoner at HMP Birmingham. He was 93 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that overall, the general healthcare that Mr Cranston received at Birmingham was of a reasonable standard and was equivalent to that which he could have expected to receive in the community. However, the clinical reviewer said that the care that Mr Cranston received in relation to his cancer diagnosis was not equivalent to that which he could have expected to receive in the community.
5. Mr Cranston's abnormal blood tests were not reviewed in a timely manner and it took almost a month before a nurse tried to repeat blood tests. When a prison GP said that Mr Cranston should be referred under the two-week suspected cancer pathway, there is no record that a referral was made.
6. We did not identify any non-clinical concerns.

## Recommendations

- The Head of Healthcare should ensure that healthcare staff complete and review blood tests promptly so that abnormal results are followed up in a timely manner.
- The Head of Healthcare should ensure that there is a robust system in place so that prisoners with suspected cancer are referred within 24 hours of seeing a prison GP for specialist care under the two-week wait process.

## Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Cranston's clinical care at HMP Birmingham. The clinical review is attached to this report at Annex 1.
8. The PPO investigator has investigated the non-clinical issues in Mr Cranston's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. The PPO family liaison officer wrote to Mr Cranston's next of kin to explain the investigation. He did not have any specific questions.
10. Mr Cranston's next of kin received a copy of the initial report. He did not respond.
11. We shared the initial report with the Prison Service. There were four factual inaccuracies and this report has been amended accordingly, three factual

inaccuracies in the clinical review and their action plan has been appended to this report.

12. This version of the report, published on the PPO website, has been amended to remove the names of staff and prisoners involved in the investigation.

### **Previous deaths at Birmingham**

13. There were five deaths from natural causes and one self-inflicted death at HMP Birmingham in the two years before Mr Cranston's death. There are no significant similarities between our findings in the investigation of Mr Cranston's deaths and our investigation of the other deaths.

## Key Events

14. In 2016, Mr Frederick Cranston was convicted of sex offences and was sentenced in February 2017 to 12 years in prison. He was sent to HMP Birmingham.
15. On 12 January 2020, Mr Cranston told a nurse that he had had diarrhoea for three weeks. The nurse arranged for Mr Cranston to see a GP urgently. On 16 January, a prison GP saw Mr Cranston who said that he no longer had diarrhoea. Four days later, Mr Cranston had diarrhoea again. Mr Cranston had blood tests which showed that he had significant inflammation in the body but it did not specify the cause of the abnormal results. The prison filed the results as satisfactory.
16. On 24 January, a prison GP saw Mr Cranston and was concerned that he may have colorectal cancer. He noted that he would make an urgent referral under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. A healthcare administrator waited for further information about the referral but there is no record that the appointment was made.
17. On 19 February, a prison GP saw Mr Cranston and was concerned by his altered bowel habits. The Prison GP reviewed his previous blood test results and saw that they were abnormal. The prison GP asked for further blood tests and intended to refer Mr Cranston under the NHS pathway after he had seen the results of the further blood tests.
18. On 13 March, a nurse tried to carry out blood tests but was unable to because Mr Cranston's veins collapsed. That day, Mr Cranston was unwell and a nurse sent him to hospital by ambulance. Mr Cranston stayed in hospital and on 18 March, hospital staff carried out a CT scan which showed that he had tumours on his lungs and liver. On 19 March, a hospital consultant told Mr Cranston that he had stomach cancer which had spread to his liver and lungs.
19. Hospital staff had a multidisciplinary team meeting and put him on a palliative care pathway. On 29 March, Mr Cranston went to a Palliative Care Unit at a hospital, Birmingham. On 3 April, Mr Cranston died of stomach cancer which had spread to the lungs and liver.

## Findings

### Cancer diagnosis

20. Mr Cranston had blood tests in January 2020 after he told healthcare staff that he had diarrhoea. The clinical reviewer said that the results were significantly abnormal but a prison GP recorded them as satisfactory. When a prison GP asked for further blood tests, there was no attempt to take these for almost a month. The clinical reviewer is concerned that blood tests were not promptly completed and there was no system in place to follow up abnormal blood test results. We make the following recommendation:

**The Head of Healthcare should ensure that healthcare staff complete and review blood tests promptly so that abnormal results are followed up in a timely manner.**

21. On 24 January 2020, a prison GP referred Mr Cranston under the NHS pathway. The clinical reviewer said that the referral was handwritten and that there was no copy of it in Mr Cranston's medical records. The clinical reviewer said that even though Mr Cranston did not have bowel cancer, he should have been referred to a gastroenterology specialist for investigations. The clinical reviewer is concerned that there is not a robust system in place to ensure that prisoners with suspected cancer are promptly referred under the NHS pathway. We make the following recommendation:

**The Head of Healthcare should ensure that there is a robust system in place so that prisoners with suspected cancer are referred within 24 hours of seeing a prison GP for specialist care under the two-week wait process.**

**Caroline Mills**  
**Assistant Ombudsman**

**October 2020**

