

**Investigation into the circumstances surrounding the
death of a man at a hospital in July 2006,
while in the custody of HMP Stafford**

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

March 2010

This is the report of an investigation into the circumstances of the death of a man who died on an evening in July 2006 in hospital. He had been released on temporary licence from HMP Stafford earlier that day after the seriousness of his condition became apparent. His mother and brother were at his bedside. He was 34 years old.

The Ombudsman investigates the deaths of all prisoners in custody, including those due to apparent natural causes. In this case, the investigation was carried out by one of his investigators. She also commissioned an independent clinical review from South Staffordshire Primary Care Trust (PCT). I am grateful to the clinical reviewer for carrying out the clinical review of the man's care. I am also grateful to the Governor and his staff for their assistance during the investigation.

The man who is the subject of this report died of small bowel ischaemia, a rare disease and very uncommon in someone of his age. It was caused by a tumour on the blood supply to the bowel. He had been receiving treatment for bowel problems before he arrived in prison. In prison, after a sustained period of ill health that led to many tests and hospital appointments, the ischaemia was discovered to be at too advanced a stage to be treatable.

When the man attended hospital appointments he was escorted by prison officers to whom he was handcuffed. He found this distressing and, on a number of occasions, refused to go to hospital as he did not wish to be seen this way. Matters escalated when a consultant refused to examine the man while he was wearing restraints and prison staff refused to remove them for security reasons. The man made a complaint to this office which was partially upheld and the impasse was eventually resolved when the consultant examined the man in the prison. The Ombudsman made a recommendation about the use of restraints during medical consultations. Although the recommendation was accepted, it had not been complied with and so I repeat it here.

I apologise for the length of time it has taken to issue this report and for any additional distress which has been caused. I offer my sincere sympathy and condolences to the man's family for their loss.

I make one recommendation regarding the use of restraints during medical consultations.

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.

Jane Webb
Deputy Prisons and Probation Ombudsman
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SUMMARY

This man was born on 10 June 1972 and died of cancer in July 2006 at the age of 34.

In 2003, the man was sentenced to eight years imprisonment. After a few months at HMP Blakenhurst, he transferred to HMP Stafford, where he remained until his death. During the reception process he told staff that before his imprisonment, he had consulted his doctor about Crohn's disease and had been waiting for an appointment with a consultant gastroenterologist. The prison doctor/the prison medical officer contacted the consultant and asked him to examine the man.

For the following year, the man suffered from bowel problems, for which he had many tests and consultations with medical staff. He was examined by consultants in different areas of medicine as they struggled to identify the cause of his illness. The man lost weight until he weighed just over seven stones.

When the man went to hospital appointments he was escorted by officers to whom he was handcuffed. He did not like to appear in public in this way and on several occasions, he refused to attend consultations.

In August 2005, the man kept an appointment with a consultant endocrinologist (the medical speciality that cares for thyroid disease and diabetes) and again was in handcuffs. The consultant endocrinologist refused to examine him while he was in restraints and the officers, following their manager's instructions, refused to remove them. The consultant endocrinologist ordered some tests for the man but refused to examine him and the man returned to prison without having had an examination.

The man made an official complaint about the handcuffs remaining in place and, after what he saw as an unsatisfactory response, appealed. As he was unhappy with the reply to the appeal, he complained to the Ombudsman. His complaint was partially upheld. In June 2006, the consultant endocrinologist went to the prison and examined the man in the healthcare centre who, by this time, was very frail. The consultant endocrinologist made a provisional diagnosis of chronic pancreatitis and arranged for an urgent scan and other tests.

The man was admitted to hospital for four days in early July, with severe abdominal pain for which he received pain killers. He returned to the hospital on 13 July where he was examined and prescribed medication for irritable bowel syndrome. Two days later, he returned to the hospital, still in severe pain. An x-ray showed an obstruction in the small bowel and staff therefore kept the man under observation to begin with. The man did not improve and, on 19 July, doctors carried out an exploratory operation that revealed ischaemia (restriction in blood supply) to the bowel. No treatment was possible other than pain relief.

Prison staff applied for the man to be released on temporary licence, which was granted. Sadly, the man died that evening, with his mother and brother at his bedside.

THE INVESTIGATION PROCESS

1. The investigation was opened by telephone on July 23 2006. The following day, the notices to staff and prisoners were posted. The prison sent all the man's prison records, including his medical records to the investigator. She added to her documents the papers concerning the man's complaint to the Prison and Probation Ombudsman (PPO).
2. One of the PPO Family Liaison Officers (FLOs) made initial contact with the man's mother, then a further FLO took over FLO responsibilities. The man's mother expressed anger at the National Health Service and the Prison Service. She said that while at her son's bedside a doctor had said that he might not have died had he received more appropriate and timely treatment. I have tried to address this issue in this report and hope I have provided some answers. I regret that this report is delayed which has meant that the man's mother has had to wait for three years before reading of my findings.
3. The Deputy Director of Primary Care, South Staffordshire PCT, commissioned a review of the clinical care the man received. The review began with a meeting of a panel of clinical staff from the PCT who discussed the man's treatment and the issues it raised. One of the members was a consultant surgeon. The review was then carried out by a clinical reviewer.
4. No formal interviews with staff were conducted. The main issue was whether the man was appropriately referred for tests and to consultants. This report is therefore based on a review of all the relevant paperwork, especially the man's medical records, prison records and the clinical review.

HMP STAFFORD

1. HMP Stafford was built in 1794 and, apart from the period 1916 - 1940, has been in continuous use as a prison ever since. It holds 627 category C prisoners. Vulnerable prisoners are accommodated on E, F and G wings. Prisoners on G wing are all on the enhanced level of the Incentives and Earned Privileges Scheme (IEP). E and F wings housed a mixture of prisoners on enhanced, standard and basic levels. (IEP is used as an incentive to reward good behaviour in prisons. There are three levels - basic, standard and enhanced. Incentives include access to in-cell television, more private cash to spend, wearing own clothes, more time out of cell and community visits. Every prison sets its own criteria to obtain each level.) All prisoners work unless there are medical reasons why they cannot do so, or they are past the retirement age.
2. There is a medical hatch on the ground level landing between E and F wings. E and F wings also share a full-time nurse who oversees prisoners reporting sick, treatments and sees prisoners on the wing throughout the day as necessary. There is no in-patient facility at Stafford.
3. The Independent Monitoring Board report for 2005 - 2006 highlights a number of concerns. Issues such as the provision of canteen services, the refurbishment of cells and the type of work available in the workshops would have affected the man, but no more so than any other prisoner.
4. HM Chief Inspector of Prisons carried out a full, announced inspection on 3 - 7 July 2006. Several of her findings and recommendations are relevant to the man's time in the prison.

"Relationships between healthcare staff and prisoners appeared to be good, and mutually respectful. We were disappointed to find that there was no signed service level agreement (SLA) between the prison and the PCT. ... Chronic disease management was patchy, with some examples of good practice, such as the work undertaken with diabetic prisoners. We were also pleased to note that prisoners were risk-assessed for medication.

"The accredited offending behaviour programmes provided were appropriate and sufficient to meet the needs identified in the 2005 area analysis. Prisoners in both parts of the prison had a realistic chance of completing a programme during their time at Stafford.

"Prisoners were generally satisfied with the applications system, but outcomes were not routinely recorded and staff were not proactive in dealing with applications. Complaint forms and

confidential envelopes were not always freely available. The promptness of replies to complaints had improved, and they were courteous and helpful.”

Escorting prisoners to hospital appointments

5. Prison officers escort prisoners to their hospital appointments, often using handcuffs. An escort chain is usually used as an alternative to allow for situations such as a prisoner needing to go to the toilet or for particular treatments to be given. The escort chain has a longer length of chain, with handcuffs at either end. One end is attached to a prison officer's wrist and the other to the prisoner's wrist.
6. A prisoner who needs to remain in hospital, who has not been released from custody on temporary licence, is escorted and monitored by prison officers under the “bedwatch” procedures. This usually means that two officers remain at the bedside and record any significant changes or events.
7. Subject to a risk assessment, the Governor decides whether the prisoner should be handcuffed and the number of officers required to accompany the prisoner. Risk assessments are made when a prisoner attends hospital for in-patient and out-patient appointments. These are dynamic assessments which can be further considered at any stage during the escort or bedwatch required. The location of the consulting room/ward and possible escape routes and the prisoner's offence are considered before reaching a conclusion. The National Security Framework advises governors on matters of security.

KEY FINDINGS

8. The man was arrested on 6 February 2003 and charged with serious offences. The following day, he appeared at a crown court where he was remanded in custody to HMP Blakenhurst.
9. Upon arrival at Blakenhurst, the man underwent a reception health screen which showed that he was not receiving any medication. Staff noted that the man had seen his community doctor recently about Crohn's disease, an inflammation of the bowel. He said that he had suffered from testicular cancer at the age of five. He also said that he had tried to commit suicide after he had committed the offence by taking an overdose of paracetamol.
10. Staff recorded in the man's medical record that he was awaiting an appointment with a consultant gastroenterologist at an outside hospital on 24 February. The man had first seen the consultant gastroenterologist in 1999 regarding his bowel problems when the possibility of Crohn's disease was discussed. However, repeat examinations in May 2001 showed no abnormality.
11. Due to the nature of his offence, the man was placed in the segregation unit. (The purpose of segregation is to maintain safety, order and discipline. A segregation unit provides temporary accommodation for prisoners who have become violent or disruptive, committed offences against prison rules or require protection if they are under threat from other prisoners.) Staff told him that he would remain in the segregation unit under Rule 45 (for his own protection) until a space became available in the vulnerable prisoners unit. On 17 February, the man was convicted of the offences at a crown court and remanded for sentencing.
12. On 15 April 2003, the man was sentenced to eight years imprisonment and the following month he transferred to HMP Stafford. In Reception, staff recorded his weight as 10 stones. On 13 May, the man had his induction and all his paperwork was completed. The following week, the man started working in workshop 1 and was described as a very good worker. Throughout July and August, the man continued to do well at work and on 9 August, he gained the enhanced level of the Incentives and Earned Privileges Scheme.
13. The prison medical officer wrote to the consultant gastroenterologist on 8 October, asking him to re-examine the man regarding his bowel problems. The prison medical officer said that the man was still complaining about diarrhoea and fat in his stools. He had arranged for blood tests to be carried out and would enclose the results for the consultant gastroenterologist.
14. The consultant gastroenterologist responded to the prison medical officer on 31 October. He said that, before the man was imprisoned,

he had thoroughly investigated the man's problem of diarrhoea. He had found evidence of primary bile salt malabsorption for which he had prescribed cholestyramine (a drug which reduces the levels of cholesterol in the blood and improves the itching associated with liver disease). He was not sure if the man had taken this medication appropriately. The consultant gastroenterologist said that he had planned on repeating this but the man had failed to keep his appointments, (although this might have been due to his imprisonment). He also explained that he had suggested that the man was admitted to hospital so that further tests could be done. He added that the prison medical officer agreed to ask for a visit from the man as a matter of routine. He would also discuss the situation with his clinical biochemist and update the prison medical officer on the situation.

15. Four days later, the consultant gastroenterologist again wrote to the prison medical officer to say that he had discussed the man's situation with a consultant clinical biochemist. He had decided to reassess the man's neurotensin levels (a 13-amino acid peptide found in the brain and spinal cord that affects pituitary hormone release and gastrointestinal functions). The consultant gastroenterologist said he would discuss this further with the consultant clinical biochemist but would still see the man as a matter of routine in due course.
16. The prison medical officer wrote to the consultant clinical biochemist on 7 November, asking him to arrange a date for the tests. He asked for a week's notice of the appointment so that an appropriate escort could be arranged. The consultant clinical biochemist arranged an appointment for the man on 4 December. However on 3 December, the day before he was due to be seen, the man refused to attend the appointment as he did not want to be seen in handcuffs in the hospital.
17. In April 2004, the man was given a warning as staff found that he had too many possessions during a routine check of his cell. The following month, staff described him as a good worker and he moved to G wing, which housed enhanced prisoners. However, on G wing the man took time to settle in and was warned about his attitude towards staff on G wing.
18. From May to July, the man's bowel problems worsened and he suffered diarrhoea and abdominal pains. He had lost 11lbs since February and was alarmed at his weight loss. The prison medical officer therefore wrote to the consultant clinical biochemist requesting another appointment, saying that the man had promised to attend this time.
19. The man received further warnings in July regarding his attitude towards staff on G wing. He was told that his attitude and behaviour were not acceptable for an enhanced prisoner on G wing and warned that he would be moved to E wing.

20. On 14 July, staff reviewed the man's completion of the Sex Offender Treatment Programme (SOTP). They recommended that he should complete the Enhanced Thinking Skills and the SOTP Booster programmes. They also suggested that he complete drug and alcohol awareness courses.
21. The following day, the man returned to E wing after continuing poor behaviour on G wing. Entries made in the man's record state that he started feeling sorry for himself at this point and was making claims that he had been victimised. He was considered to have given poor excuses for his behaviour to try to gain sympathy. It was suggested to the man that he should improve his demeanour and attitude. By August, the man had settled down in E wing. An IEP review revealed that the man was no cause for concern and he remained on the enhanced IEP status.
22. During September and October, the man complained of back pains. On 24 September, he went to a lumbar spine (lower back) examination. The resulting report showed that the man's spine was not abnormal and suggested an orthopaedic referral for further investigations. The consultant clinical biochemist wrote to the man on 5 October asking him to attend hospital on 24 October for a blood test.
23. On 2 December, the consultant clinical biochemist presented the test results of a Gut Hormone profile on the man. They provided no evidence of gastroentero-pancreatic neuroendocrine tumours to account for his chronic watery diarrhoea. On 17 December, the records showed that the blood received by the hospital on 20 October was "within normal limits".
24. Shortly before Christmas, the man started work in the greenhouse and gardens. He also requested a single cell because of his medical problems, which he felt produced unpleasant conditions for his cell mate. However, his request was denied due to his behaviour when previously on G wing. A note in his records confirmed that he accepted the decision quite well.
25. A consultant orthopaedic surgeon wrote to the prison medical officer on 1 February 2005, to say that he had listed the man for MRI and DEXA scans. (MRI scanning is used to detect structural abnormalities of the body and a DEXA scan is used to measure the density of bones.) He also said that the man would need to be reviewed by an endocrinologist.
26. The man refused to attend his appointments with the prison medical officer three times in March. He also made another request for a single cell. The same month, staff noted in the man's prison record that he was "having no problems" and was "a polite and respectful man". However, on 10 April, officers expressed concerns over the man's deteriorating health.

27. The consultant gastroenterologist diagnosed primary bile salt malabsorption. He noted that this condition would certainly account for the man's diarrhoea and prescribed cholestyramine, a medication that lowers the cholesterol levels in the blood. However in April, the man refused to take his medication as he said it made him feel worse. A note was made in the man's records that he now also had a pain in his elbow. In July, the man declined to see the doctor and said that he was fit and well.
28. For operational reasons, staff were unable to take the man to an appointment with the consultant endocrinologist on 14 July to an outside hospital. Prison managers had to temporarily halt the movement of people within the prison and all staff had to be on alert. On 1 August, the consultant endocrinologist wrote a letter of complaint to the Governor, saying that he had only received a message from Stafford at 1.45pm on the day to say that the man would not arrive at the hospital until 2.30pm. He said that he could not see the man then as he had other patients but had now arranged another appointment for him. The consultant endocrinologist said that the prison should inform the hospital as soon as possible if they were unable to keep an appointment. He said that Stafford had wasted his time and had inconvenienced the man. In response, the prison medical officer wrote to the consultant endocrinologist and apologised for not keeping the appointment. He explained that situations would sometimes arise within the prison that require a shutdown and all staff had to be on alert. Therefore there were no spare staff to take anyone to appointments. The prison medical officer told the consultant endocrinologist that he appreciated the man being given another appointment.
29. The man was escorted to his appointment with the consultant endocrinologist at an outside hospital on 25 August. He was handcuffed to an officer. The consultant endocrinologist asked for the handcuffs to be removed but the escorting officers refused. This was because the risk assessment did not allow them to do so. The consultant endocrinologist therefore refused to examine the man, although he did arrange for some blood tests to be done.
30. On the man's return to Stafford, he made a formal complaint regarding the refusal by the officers to remove his handcuffs. He wrote on the complaint form that the handcuffs had been removed on previous occasions and asked what would happen when he went for his MRI scan.
31. The following day a senior officer (SO) answered the man's complaint and said:
- “When a prisoner goes out of prison on escort he must not be removed off the handcuffs, this can only happen on the authority

of the duty governor and not the doctor you have an appointment with. I cannot give a reason as to why the doctor did not examine you. Prior to your MRI scan the room will be risk assessed by the escorting staff and permission sought from the duty governor of the day in order to take you off the cuffs.”

32. The man was unhappy with the response from the senior officer and completed an appeal form. He asked why, if this was the policy, that the escorting officer had not telephoned the duty governor. He added that both his and the consultant endocrinologist’s time had been wasted. A man from the security department answered the man’s complaint and reiterated the senior officer’s response, saying:

“When your MRI scan appointment is confirmed a risk assessment of you and the area are going to be completed. The information on these risk assessments will dictate the handcuffing policy.”

33. The man remained unhappy with this response as he felt that it had not answered his question about why the escorting officer had not contacted the duty governor. He said that he had been in a lot of pain and had not given any cause for concern on previous hospital visits.
34. The consultant endocrinologist wrote to the prison medical officer on 31 August to explain that, “as a matter of principle” he would not “interview or examine a man in chains”. He said that he regarded this as malpractice and had apologised to the man for not being able to assess his condition properly. He said that he had, however, arranged for some blood tests to be done and would write to the prison medical officer once the results had arrived. He also informed the prison medical officer that the man’s restraints would have to be removed for the forthcoming MRI scan.
35. The following day, the man made a formal complaint that he had recently wrongly lost his job because of security issues. He said that he had a good relationship with the officer in charge of the gardening party. He also said that he had spoken to his personal officer who told him that his voluntary drug tests (VDT) and mandatory drug tests (MDT) had all been negative. The man asked for the decision to be reversed. In response, the man was told that he had been seen at the rear of G wing, which was an unauthorised place, without being supervised. The man was told that this was the reason why he had been removed from the work party. The fact that he had a good relationship with the officer in charge of the gardening party and had negative VDTs and MDTs was of no significance.
36. The man appealed on 7 September and said that the garden work would not require him to go round the back of G wing without supervision. He said the officer in charge of the gardening party had always given them authorisation to work unsupervised around the

back. The man said if this was the reason then others should be taken off the work party too. He asked for the exact date that was being referred to and asked if the officer in charge of the gardening party could be spoken to in order to confirm the position. Staff reiterated that information had been received from the security department that the man was unsupervised at the back of G wing and therefore he was removed from the garden party. The man explained in his reply that they had not been told that the back of G wing was an unauthorised area. He said that it was impossible to work unsupervised and the officer in charge of the gardening party had said that he was happy as long as they were in the G wing complex. The man again asked for the officer in charge of the gardening party to be spoken to. The man was told that the decision was justified as members of the garden party had previously been told that the area behind G wing required supervision. It was also explained that there was no reason as to why he should not be considered for future employment on the party should the opportunity arise.

37. On 12 September, the prison medical officer forwarded the consultant endocrinologist's letter to the Governor (which set out his refusal to assess a patient in handcuffs) and told him that there was no other doctor to whom the man could be referred. The following day, he wrote to the consultant endocrinologist enclosing the Area Manager's details. The doctor also wrote to the Area Manager, enclosing the consultant endocrinologist's letter.
38. A week later, on 19 September, the man's appeal regarding the removal of his handcuffs was answered by the Head of Operations and Security. He said that there was no record of a request to the duty governor for the handcuffs to be removed.
39. Two days later, the consultant endocrinologist sent the man's test results to the prison medical officer. The consultant endocrinologist's opinion was that there was no "definable abnormality here" and that he did not propose to arrange a follow up. On 22 September, the then Governor replied to the prison medical officer, enclosing a letter that she had written to the Director of Clinical Standards on 27 June. In this letter the Governor set out the prison's policy on hospital escorts. On 29 September, the consultant endocrinologist wrote to the Area Manager, suggesting that a compromise be sought.
40. The then Governor replied to the consultant endocrinologist on 6 October, explaining the policy on restraints. She offered two alternatives - increasing the number of clinics held in the prison or providing a secure consulting room in the hospital. She told the consultant endocrinologist that she would hold a meeting on 18 October with the head of healthcare, head of operations and security and the Director of Clinical Standards. She offered to update him after the meeting. On 10 October, the consultant endocrinologist wrote to

the Area Manager and suggested that consultations in prison should be possible.

41. The consultant endocrinologist wrote to the prison medical officer on 11 October, regarding the outcome of the man's tests. He said that the problem appeared to be primary bile malabsorption and suggested that the man start on cholestyramine. He told the prison medical officer that he had written to the Prison Service regional manager, seeking guidance on whether the man's handcuffs could be removed and, if they were, then he would gladly see the man in the clinic. On 17 October, the Area Manager wrote to the Governor enclosing the consultant endocrinologist's letter. She asked the Governor to keep the consultant endocrinologist informed of the discussions on restraints. On the same day, the Governor wrote to the consultant endocrinologist informing him that the Director of Clinical Standards had cancelled the meeting, but that a further meeting was to be arranged.
42. In November, the man consulted healthcare staff about back pain which got worse throughout the month. On 19 November, the man was admitted to a local hospital with abdominal pain. A consultant surgeon examined the man and said that the abdominal palpitation test revealed some upper abdominal tenderness but no other significant signs. The man remained on the ward for observation and, as his symptoms started to settle, he was discharged with arrangements for an outpatient ultrasound scan. He returned to Stafford two days later on 21 November.
43. Five days later, the man had another IEP review which confirmed that he maintained good behaviour and was usually no problem for staff. He remained on the enhanced IEP level. However, on 23 December, it was noted that the man had abused an officer during the morning roll check. (At various times of the day a full roll check takes place to account for all prisoners, these usually take place at shift handovers.) It was noted in his records that his behaviour needed to be more consistent when dealing with staff.
44. The man's bad back pains continued. In the middle of February, he had a thoracolumbar spine MRI scan. A consultant radiologist concluded that possible malabsorption and a metabolic abnormality was the most likely cause. He said:

“Rather difficult to put these together but the gibbus (the hump of a deformed spine) and vertebral body wedging would be compatible with Scheuermann's disease (known as a hunchback). However, the more diffuse increase in fat content of the lumbar spine and lower thoracic vertebral bodies is more difficult to explain. A metabolic abnormality might account for this although I do not know why the thoracic vertebral bodies are not affected.”

45. The consultant radiologist also referred to "Previous irradiation of the lower half of the body" as the possible cause of the man's abnormal spine. This was presumably a reference to the fact that the man was diagnosed with testicular cancer when he was five years old and received radiation therapy.
46. The man wrote to the Ombudsman's office on 23 February 2006, to complain about the use of restraints during his hospital appointment. He explained that his ill health had prevented him writing within the three month deadline after the response to his appeal. The Ombudsman agreed to investigate the man's complaint and one of his investigators carried out the investigation. She wrote to the consultant endocrinologist on 22 March and telephoned the man two days later.
47. During March, the man's health continued to be poor and he had some time off work. However, a nurse recorded in the man's medical file that he appeared pain free and was happy on the wing.
48. On 4 April, the man made a formal complaint about the food served at Stafford. He said that he now had a problem with the sandwiches served at lunch because he had lost weight. He said that he weighed only eight stones (8 stones, compared to 10 stones when he arrived at Stafford). The prison doctor told him that he was unable to do anything and that it was up to the Governor to decide whether to provide cooked meals. The man said he did not eat sandwiches and he would continue to lose weight if nothing was done. In response he was told that the kitchen had no control over the policy regarding sandwiches at lunchtime and was told to seek medical advice from the doctor as soon as possible regarding his weight loss.
49. Nine days later, the man appealed and suggested that if the menu could not be changed the Governor should consider adding items such as sausage rolls, pizza slices or cheese on toast to the menu. In response, he was told that prison surveys are done annually and that this issue would be raised at the next meeting. The man replied that annual surveys were never taken into account and a better result could be achieved by staff listening to prisoners as they walked around the prison. He added that, if the budget was inadequate, there must be cheaper yet more palatable meal options. In response, the man was told that comments made in the food book and at the prisoner food representatives' council were taken into consideration. Also that the sandwich meal reflected what most of the working public ate for lunch and was in line with the majority of Category C prisons. The response made it clear that there were no plans to change the lunchtime menu at present.
50. On 10 April, the consultant orthopaedic surgeon treating the man reviewed him and assessed the results of the MRI and bone density scans. The consultant orthopaedic surgeon treating the man wrote to

the prison medical officer to explain that the man ideally should be treated with cholestyramine. He said that if this was beneficial in helping the man to gain weight, then he would need to be treated for osteoporosis. The consultant orthopaedic surgeon treating the man undertook two further investigations. These included plasma proteins and electrophoresis of urine for myeloma protein to make sure that the fatty changes in the lumbar spine were due to the osteoporosis. He informed the prison medical officer that he would arrange for the man to be reviewed by a gastroenterologist. The consultant orthopaedic surgeon treating the man then wrote to a further consultant gastroenterologist on 24 April to ask if he would be able to see the man as he thought that he needed to be treated by a gastroenterologist rather than an orthopaedic surgeon. The consultant orthopaedic surgeon treating the man also explained that the man appeared to have a primary bile salt defect and needed treatment with cholestyramine.

51. Records show that on 8 May the man was seen by the consultant orthopaedic surgeon who suggested treatment for osteoporosis. Two days later, the man was taken to an outside hospital for an ultrasound scan and it was noted that the man was well behaved and caused no problems. His restraints were removed for the duration of the scan. The ultrasound was of the abdomen but bowel gases caused difficulty detecting anything and nothing of concern was noted. The man's weight was noted to be 7 stones (a loss of 2.5 stones in the three years since he came to Stafford). On 16 May, the prison medical officer recorded that the man should be referred to the consultant endocrinologist. However a referral could only be made once the Governor had responded to the consultant endocrinologist's letter of 31 August 2005, (when he wrote that he would not interview or examine a man in restraints). Two days later, on 18 May, the man applied to work in the garden again but his application was refused due to his medical condition.
52. At 9.30am on 21 May, a nurse was called to the wing to examine the man as he was complaining of severe stomach pains above the belly button and to the right side of the abdomen. His temperature, blood pressure and pulse checks were taken. On 29 May, prison managers suggested that the consultant endocrinologist examine the man in prison.
53. The then Deputy Ombudsman responsible for complaints investigations issued a draft report on 5 June, partially upholding the man's complaint. She stated that, although the man did not appear to pose a high risk, the escorting officers had behaved appropriately. As I have explained, the National Security Framework (NSF) indicates that there is a presumption that, unless the risk assessment states otherwise, prisoners should not be restrained during treatment or medical examination whilst they attend outside hospital.

54. A risk assessment had been carried out on the man and the assessor indicated that the man was a risk to the public and to hospital staff. However, the then Deputy Ombudsman responsible for complaints investigations was concerned about the accuracy of the information in the risk assessment. The assessment stated that the man did not have a conviction for common assault, which was not the case, although he had received a police caution. The assessment also referred to a "history of drugs", which staff in the security department had been unable to explain to the complaints investigator. Also, it was unclear in what respect the man posed a risk to hospital staff as his custodial behaviour had not given any cause for concern and he had never been involved in an escape attempt.
55. The then Deputy Ombudsman responsible for complaints investigations noted that the man was upset that the escorting officers had not contacted the duty governor for permission to remove the handcuffs when asked to do so by the consultant endocrinologist. The man said that the officers had told him that they did not need to contact the duty governor. The then Deputy Ombudsman responsible for complaints investigations said that the officers were correct in saying this, as the risk assessment made the situation quite clear to the escort staff that the man was to remain restrained throughout his visit, unless his life was in danger.
56. Finally, the then Deputy Ombudsman responsible for complaints investigations recommended that the Governor and Head of Security review the way in which risk assessments are conducted to ensure that the prison complied with the NSF. Also the Governor should contact Mid Staffordshire General Hospitals NHS Trust to discuss arrangements for the treatment and examination of prisoners who cannot safely be removed from their restraints. The recommendations were accepted.
57. The man's weight was noted to have fallen further to 7 stones by 6 June. The following week, he was re-categorised as category D and, on 23 June, the consultant endocrinologist examined him in the prison healthcare centre. He made a provisional diagnosis of chronic pancreatitis (inflammation of the pancreas) and arranged an urgent computerised tomography (CT) scan and other tests. He noted that the man had been referred to the further consultant gastroenterologist but said that he would deal with the matter as it was urgent. The consultant endocrinologist added that if the man's condition deteriorated, it would be necessary to admit him into hospital. On the same day, the consultant endocrinologist wrote to the prison medical officer to inform him that the man's condition had deteriorated, that he had lost more weight and had a good deal of pain.
58. From 4 to 8 July, the man was admitted to outside hospital with severe abdominal pain. On his return to Stafford, a note in the medical record showed that he "looked better, the pain was reduced and was returned

with tramadol and paracetamol". (Both drugs are pain relievers.) Two days later, the man had an appointment with the doctor, who recorded that the CT scan had found nothing abnormal, except for a small pancreas and that he was still in pain. A few days later, the man's weight was recorded as 6.5 stones.

59. On 13 July, the man told healthcare staff that he had central abdominal pain which had lasted for 12 hours. When he was examined he was distressed and tender over most of his abdomen, bowel sounds were present and tramadol was not helping with the pain. The prison medical officer arranged for the man to be sent to outside hospital, where he was examined in the A&E department by a consultant in A&E medicine.

60. The consultant in A&E medicine said in a letter to hospital managers that the man had arrived at the A&E department at 10.27am and he had attended him at 10.49am. He recorded that the man had a history of mid-gut abdominal pain and had sustained a loss of four and a half stones in the past year. He recorded that reports showed that previous investigations of blood, recorded the man did not have any nausea or vomiting. He had no bowel upset and no urinary symptoms. On examination, the consultant in A&E medicine recorded that there was no evidence of anaemia or jaundice and examination of the chest and cardio vascular system revealed no abnormalities. In his notes, the consultant in A&E medicine recorded that

"There was abdominal tenderness on the lightest of abdominal palpitation and recorded that the pressure of his stethoscope when listening to the bowel sounds did not produce any signs of abdominal tenderness. He recorded that the bowel sounds were hyperactive and that the hernial orifices were intact."

61. The consultant in A&E medicine said that his initial diagnosis suggested the possibility of irritable bowel syndrome and perhaps a supratentorial (an area of the brain) problem. The consultant in A&E medicine prescribed Colpermin (capsules containing peppermint oil) for irritable bowel syndrome for seven days and discharged the man.

62. The man returned to the prison on the same day. The escorting officer made a formal complaint to the prison doctor regarding the brevity of the examination carried out by the consultant in A&E medicine. The following evening, wing staff asked the duty nurse to examine the man. She arrived at 7.05pm, and the man told her that he had abdominal pains but did not want to see the out of hours doctor.

63. On 15 July, staff contacted the out of hours doctor as the man was experiencing severe pain. The doctor recorded that the man was very unwell, that his abdomen was very tender, and he asked for an urgent referral to the Emergency Assessment Unit at an outside hospital. At 2.30pm, an ambulance took the man to the hospital. Again he was

wearing handcuffs. He had severe pain and distress on examination and an x-ray showed features of an obstruction in the small bowel. Staff initially managed the man conservatively and made a preliminary diagnosis of pancreatitis associated with an ileus. (An ileus is a partial or complete non-mechanical blockage of the small and/or large intestine. It is most often associated with an infection of the membrane lining the abdomen.)

64. The following day, the man was catheterised and he was treated with intravenous fluids and analgesics (drugs used to relieve pain). A note was made following the ward round by a consultant surgeon which stated that the man's abdominal pain had improved that morning. A subsequent ward round on 17 July recorded that the man had been pain free throughout the night. The prison Head of Healthcare contacted the hospital the same day for an update on the man.
65. No findings were recorded after the ward round on 18 July. The catheter was removed, instructions were given to remove the intravenous fluids and it was recorded that the man could eat and drink. Another note recorded on 18 July said that the man appeared to have small bowel disease. A discussion was undertaken with the consultant surgeon. The advice was that a repeat abdominal x-ray would be undertaken. If the small bowel dilation had not reduced consideration would be given to undertaking a laparotomy (a surgical procedure involving an incision through the abdominal wall to gain access into the abdominal cavity).
66. At 7.00pm on the same day, a junior doctor visited the man. He was complaining of pain and it was noted that he had not passed any urine since the catheter had been removed. A bladder scan revealed 270mls of urine in his bladder. Further x-rays revealed a worsening of the small bowel obstruction and as a result an exploratory laparotomy was undertaken on 19 July.
67. The exploratory operation revealed that the man had ischaemia (a restriction in blood supply, generally due to factors in the blood vessels, with resultant damage or dysfunction of tissue) in the bowel. A section of the bowel had died and the man's condition was beyond treatment. The escort informed healthcare staff that the man had only a "few hours to live". The head of healthcare went immediately to the hospital and at 5.10pm the Head of Operations and Security gave permission for the escort chain to be removed. The escorting officers then moved outside the ward.
68. The man was released on temporary licence and the escorting staff returned to the prison. The man's mother and brother arrived to be with him and, at 7.00pm, he passed away.

ISSUES

The man's health

69. The clinical reviewer compiled her report after a review panel had met to consider the man's clinical care. She noted that:

“[The man] had been seen by both nursing staff and the medical officer. On each occasion his symptoms were taken seriously and a number of referrals had been made to different consultants at different hospitals.”

She also noted that he had had various tests and his medication was regularly reviewed.

70. My investigator's notes of the meeting record that the consultant surgeon on the panel told the other members that this form of cancer is quite rare. It is normally only seen in older people and he had never seen it in someone as young as this man. The clinical reviewer notes the consultant surgeon on the panel as saying:

“[The man's] previous medical history was biased against a laparotomy operation as all the diagnostic tests that had been performed had not revealed anything. [The consultant surgeon] advised the panel that it was impossible to say whether performing the laparotomy any earlier would have made any difference to the outcome in this case as the patient had died of something very rare.”

In his opinion, the ischaemia was:

“most likely to have developed between 15 and 19 July. The blood supply to the small bowel was being invaded and obstructed and therefore it is impossible to tell when the critical instant was.”

71. The consensus of the panel was that the clinical care that the man received was “timely, sensitive and appropriate”. It was equal to the care that he would have received had he been in the community.

72. The clinical review also discusses and makes recommendations concerning actions by members of the PCT, including a complaint raised by a prison officer with the Parliamentary and Health Service Ombudsman about the way in which a hospital doctor behaved towards the man. These matters are outside my remit and I make no comment on them.

Use of restraints

73. As a prisoner, when the man attended his hospital appointments he was handcuffed to a prison officer. This is standard procedure and, given the man's offences, I am satisfied that it was a necessary security precaution. However, the consultant endocrinologist refused to examine him whilst restraints were in place – whether handcuffs or an escort chain. He explained in letters to prison managers that he considered it against human dignity and was “a matter of principle”.
74. The Prison Service's National Security Framework (NSF) sets out the security policy and procedures for prison managers. One section deals with prisoners wearing restraints (either handcuffs or escort chain) to attend hospital appointments. The policy is “unless the risk assessment states otherwise prisoners should not be restrained during treatment or medical examination whilst attending outside hospital”.
75. The officers escorting the man were instructed not to remove the restraints and so they did not, not even when the consultant endocrinologist proposed to begin his examination. The man's complaint was that the officers did not contact the prison managers at the time and ask for further instructions.
76. The then Deputy Ombudsman in charge of the Complaints Team did not uphold that part of the complaint. However, she did uphold the man's complaint regarding two incorrect items of information on which the security risk assessment was based. She also recommended that prison managers reconsider their local policy requiring restraints to remain on during medical consultations, to bring it into line with NSF policy.
77. The recommendation was accepted. However, in subsequent correspondence with the prison security manager, the complaints investigator learned that the prison's policy had not changed to reflect the NSF. I therefore repeat the recommendation here.

The Governor should ensure that the local policy on the wearing of restraints during medical consultations is consistent with and conforms to the National Security Framework.

78. I note that the matter was eventually resolved (after the involvement of the Ombudsman's office) by the consultant endocrinologist examining the man in prison. It would have been better had that arrangement been made several months earlier. I trust that if similar circumstances pertain in the future that this compromise will be implemented as a matter of course.

CONCLUSION

79. The man suffered a long period of ill health, during which he had many tests and saw a number of different consultants. However, it was only in the last few days of his life that the doctors discovered the rare cancer that caused his death. By that time, no treatment was possible.
80. The issue that stands out in this report is how firmly and unfairly the man was caught in the impasse between the doctor's principles and the prison's very strict implementation of security measures. I am pleased that the matter was eventually resolved but less happy with how long it took.

RECOMMENDATION

The Governor should ensure that the local policy on the wearing of restraints during medical consultations is consistent with and conforms to the National Security Framework.

The Prison Service accepted the recommendation. Their response was:

“A local protocol is being drawn up in line with the National Security Framework. The Governor is to raise this at the next PCT (Primary Care Trust) Partnership meeting to ensure their protocols are compliant.”

This was achieved by 20 September 2009.