Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wilfred Crooks a prisoner at HMP Wakefield on 11 June 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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.

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

Mr Wilfred Crooks died from a collapsed right lung and pneumonia, due to emphysema and metastatic primary prostate cancer, at HMP Wakefield on 11 June 2016. He was 69 years old. I offer my condolences to Mr Crooks' family and friends.

Throughout his time at Wakefield, healthcare specialists regularly saw Mr Crooks. When his death became foreseeable, healthcare staff managed his palliative symptoms well and they implemented various care plans. Healthcare and prison staff supported Mr Crooks while he received end of life care and demonstrated a high level of compassion towards him.

I am satisfied that Mr Crooks received a high standard of care at Wakefield that was at least equivalent to that he could have expected to receive in the community.

It is disappointing that, despite Mr Crooks' poor condition and limited mobility, managers repeatedly authorised officers to restrain him with handcuffs or an escort chain. This is not the first time we have had to remind Wakefield of the legal position and the Prison Service guidance on restraints.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **January 2017**

Contents

Summary

Events

1. In 1999, Mr Wilfred Crooks received a life sentence for sexual offences. He spent time at a number of prisons and moved to HMP Wakefield in June 2009. Mr Crooks suffered from a number of chronic health conditions, including tuberculosis (TB – an infectious disease, which generally affects the lungs), chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema) and Human Immunodeficiency Virus (HIV). In March 2011, doctors diagnosed Mr Crooks with prostate cancer, which was treated with hormone treatment and regular reviews by a consultant urologist. Prison healthcare staff and hospital specialists saw Mr Crooks regularly.

2. In January 2013, Mr Crooks went to hospital to be treated for an exacerbation of his COPD. In May, Mr Crooks was given a wheelchair to aid his mobility around the prison.

3. In March 2015, Mr Crooks went to hospital for an acute exacerbation of COPD and doctors diagnosed emphysema, a respiratory tract infection and acute kidney injury.

4. In June, a Macmillan nurse created a palliative care plan for Mr Crooks. The following month, a consultant urologist told Mr Crooks that his prostate cancer had progressed.

5. In November, due to his complex health conditions, a prison GP explained to Mr Crooks that resuscitation would not be in his best interests. Mr Crooks agreed that staff should not attempt resuscitation if his heart or breathing stopped.

6. In February 2016, Mr Crooks received treatment in hospital for pneumonia.

7. In March, an oncologist told Mr Crooks that his prostate cancer was incurable and told prison healthcare staff to provide him with palliative care. Prison healthcare staff created care plans, which ensured that they regularly reviewed Mr Crooks. The prison also asked a prisoner carer to help Mr Crooks with day to day tasks.

8. Mr Crooks deteriorated further and he died in the prison's healthcare unit on 11June.

Findings

9. Prison healthcare staff managed Mr Crooks' chronic conditions well and hospital specialists saw him regularly. When his death became foreseeable, healthcare staff managed his palliative symptoms well in accordance with the Gold Standards Framework (a systematic, evidence-based approach to supportive and palliative care). We are satisfied that Mr Crooks received a high standard of care at HMP Wakefield that was at least equivalent to that he could have expected to receive in the community.

10. Mr Crooks was restrained during visits to hospital during 2016 and we are not satisfied that the prison fully took into account Mr Crooks' health and mobility when assessing his risk.

Recommendation

- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Wakefield informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Crooks' prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Crooks' clinical care at the prison.

14. We informed HM Coroner for West Yorkshire Eastern District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers attempted to contact Mr Crooks' mother, his next of kin, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. However, the liaison officer was told that Mr Crooks' mother suffered with severe dementia and could not take on the role of his next of kin. No other members of his family were prepared to take on the role.

16. The investigation has assessed the main issues involved in Mr Crooks' care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

17. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Wakefield

18. HMP Wakefield is one of eight high security prisons in England and Wales. It holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (a small therapeutic centre aiming to provide a supportive, safe, structured and consistent environment for some of the most challenging offenders).

19. Care UK took over all healthcare provision at Wakefield on 1 April 2016. Prior to this Spectrum CIC (Community Interest Company) provided primary healthcare services during normal working hours and Humber NHS Foundation Trust (intermediate care) employed the nurses in the inpatient unit, which provides overnight and weekend care for prisoners with physical health problems. There is a dedicated palliative care suite in the healthcare unit.

Her Majesty's Inspectorate of Prisons

20. The most recent inspection of Wakefield was in July 2014. Inspectors found that health services were good overall but some parts of the healthcare environment, including the inpatient unit, were poor. Primary care services were very good and had an appropriate emphasis on the care of patients with long-term conditions.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to April 2015, the IMB noted the importance of healthcare because the prison had a large number of older prisoners. The IMB considered that health services were well managed and the quality of care was high.

Previous deaths at HMP Wakefield

22. Mr Crooks was the thirteenth prisoner to die from natural causes at Wakefield since January 2015. Two prisoners have died from natural causes since. There were no similarities between the circumstances of Mr Crooks' death and previous deaths at the prison. We have raised issues about restraints before.

Findings

The diagnosis of Mr Crooks' terminal illness and informing him of his condition

23. On 14 January 1999, Mr Crooks was sentenced to life imprisonment for rape. He spent time at a number of prisons and moved to HMP Wakefield on 19 June 2009. Mr Crooks suffered from a number of chronic health conditions, including tuberculosis (TB – an infectious disease caused by bacterium which generally affects the lungs), chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema), lumbar spondylosis (age-related wear and tear of the spinal column) and Human Immunodeficiency Virus (HIV).

24. Despite suffering with COPD and TB, Mr Crooks continued to smoke up to 20 cigarettes a day. Healthcare staff regularly gave him advice to stop smoking, which he rejected.

25. On 11 January 2011, Mr Crooks complained of long standing abdominal pain and painful swallowing. A prison GP arranged an urgent endoscopy (a camera on a tube is inserted down the throat through the stomach and into the duodenum). Mr Crooks had the endoscopy on 18 February. A consultant oncologist noted that the endoscopy results were normal but after reviewing Mr Crooks' blood results, he decided that Mr Crooks would benefit from a prostate ultrasound scan and a biopsy to exclude prostatic malignancy. On 17 March, biopsies taken from Mr Crooks showed he had prostate cancer. On 15 June, a consultant urologist reviewed Mr Crooks at Pinderfields Hospital, Wakefield and prescribed him regular hormone treatment, monitored by blood tests. Thereafter, a consultant urologist regularly reviewed Mr Crooks at the hospital.

26. Mr Crooks was under the care of several hospital specialists, who reviewed his cancer, respiratory conditions and HIV. Prison doctors regularly sought advice from the hospital specialists. Mr Crooks received frequent scans and regular examinations of his mental state. His HIV and prostate cancer were controlled by medication.

27. Mr Crooks often suffered from shortness of breath and received treatment in the prison's healthcare centre. On 22 January 2013, Mr Crooks went to hospital by emergency ambulance, as he was short of breath. When in hospital, doctors treated him for an exacerbation of his COPD.

28. On 22 May, the prison gave Mr Crooks a wheelchair to aid his mobility around the prison.

29. On 28 January 2015, a respiratory consultant saw Mr Crooks at a respiratory clinic following an acute exacerbation of COPD. The consultant diagnosed severe emphysema and noted Mr Crooks was a persistent smoker. Mr Crooks continued to smoke despite healthcare advice to stop.

30. On 26 February, a consultant urologist saw Mr Crooks and noted that his prostate specific antigen (PSA – a protein produced by the prostate gland) had doubled in six months, which suggested Mr Crooks' prostate cancer was spreading. The consultant arranged a computed tomography (CT) scan to

assess this and informed Mr Crooks of the advantages and disadvantages of receiving chemotherapy treatment.

31. On 27 March, a prison GP saw Mr Crooks and referred him to Pinderfields Hospital for further management of an acute exacerbation of COPD. The hospital admitted Mr Crooks and a scan of his throat confirmed emphysema. Doctors also diagnosed Mr Crooks as having a lower respiratory tract infection and an acute kidney injury.

32. On 31 March, a prison doctor examined Mr Crooks and diagnosed bronchopneumonia with underlying COPD. She arranged for Mr Crooks to be admitted to Pinderfields Hospital, as his HIV had affected the efficiency of his immune system. While in hospital, doctors treated him with intravenous antibiotics. They moved Mr Crooks to St James' Hospital, Leeds and, following further tests, doctors diagnosed Mr Crooks with influenza and enlargement of his prostate.

33. The hospital discharged Mr Crooks on 17 April to the inpatient unit at Wakefield. Healthcare staff created a care plan, which included frequent observations and support to promote his independence. Mr Crooks steadily improved and was discharged back to his wing on 4 June where he continued to be supported by primary care nurses and the outreach team.

34. During a Gold Standard Framework (GSF) meeting, on 12 June, healthcare staff decided that Mr Crooks' severe COPD and HIV affected his prognosis. As a result, a Macmillan Nurse created a Gold Standard Palliative Care Framework palliative care plan for Mr Crooks.

35. On 6 July, the consultant urologist informed told Mr Crooks and prison healthcare staff that he had progressive prostate cancer.

36. On 29 August, the respiratory consultant saw Mr Crooks, who had increasing breathlessness. The consultant prescribed antibiotics and steroids for COPD.

37. On 14 October, the respiratory consultant told Mr Crooks that resuscitation would not be in his best interests if his heart or breathing stopped, due to his poor health and COPD. Mr Crooks said he would like to think this through but, on 18 November, he agreed that he did not want healthcare staff to attempt resuscitation.

38. On 19 January 2016, the consultant urologist saw Mr Crooks and told him that his PSA had nearly doubled in a year and his last CT scan showed that cancer had spread. Mr Crooks said he was keen to undergo further treatment. The consultant told Mr Crooks treatment was unlikely to prolong his life but might improve his quality of life and referred him to oncologists to discuss systemic therapy in greater detail.

39. On 3 February, a prison GP examined Mr Crooks after he complained of extreme breathlessness and, suspecting pneumonia, she requested an emergency ambulance. Pinderfields Hospital admitted Mr Crooks and he received treatment for pneumonia by intravenous antibiotics. The hospital discharged Mr Crooks, on 8 February, and he moved to the prison's healthcare centre for three days of observation, before returning to his wing.

40. On 15 March, Mr Crooks attended St James Hospital in a wheelchair. A consultant oncologist discussed Mr Crooks' prostate cancer with him and said that further treatments would not cure him. Mr Crooks said he understood his cancer was incurable. The consultant discharged Mr Crooks from her clinic and advised prison healthcare staff to provide Mr Crooks with palliative care.

41. We agree with the clinical reviewer that Mr Crooks' long term conditions were managed well and in accordance with guidance.

Mr Crooks' clinical care

42. Prison healthcare staff made a holistic assessment of Mr Crooks' needs and co-ordinated his care. They discussed Mr Crooks' diagnosis, prognosis and preferred place of death with him and made sure he understood the advice, services and support available to him. Healthcare staff created care plans to ensure that he was regularly assessed. The prison also asked a prisoner carer to support Mr Crooks with day to day tasks.

43. As Mr Crooks' health declined, activities became more difficult for him. Mr Crooks said he wanted to stay on his normal wing for as long as it was possible but agreed to be moved if he deteriorated further. On 25 April, Mr Crooks slipped over in the shower and a nurse admitted him to the healthcare centre.

44. On 29 April, Mr Crooks told the respiratory consultant he felt he could not use his legs as they had no power. On examination, the respiratory consultant suspected Mr Crooks might have spinal cord compression and noted that he was wheelchair bound. The consultant referred Mr Crooks for a scan, which took place at St James Hospital on 2 May. The scan confirmed Mr Crooks' cancer had spread throughout his spine and had compressed it. Hospital doctors prescribed one dose of radiotherapy and steroids to reduce inflammation. The hospital discharged Mr Crooks back to Wakefield for end of life palliative care.

45. During May, Mr Crooks deteriorated further and prison GPs prescribed medication to manage his pain, nausea and agitation. By 16 May, Mr Crooks was unable to attend the chapel but the chaplaincy team visited him regularly in his cell.

46. On 17 May, a Macmillan Nurse assessed Mr Crooks. From this date, she continued to visit and support Mr Crooks, providing specialist support and one-to-one assessment.

47. On 6 June, the healthcare team leader, a nurse and a doctor held a GSF meeting to discuss Mr Crooks' deterioration and assess his needs. They decided that Mr Crooks' prognosis was noted to be days, so they confirmed that his pain should be monitored and his medication be adjusted when breakthrough pain occurred. Close supervision continued and Mr Crooks received midazolam for agitation. On 10 June, the end of life pathway (ELP) was commenced. (ELP sets the standards of care patients should receive in their last few hours or days prior to death). Mr Crooks' level of consciousness deteriorated and he was unable to swallow. Healthcare staff used a syringe driver (a small pump, which gives pain relief continuously under the skin) to administer medication.

48. At 5.00am on 11 June, a nurse noted Mr Crooks had stopped breathing. The nurse requested an ambulance, which arrived at 5.17am, and paramedics verified Mr Crooks' death at 5.31am.

49. We agree with the clinical reviewer that when Mr Crooks' death became foreseeable, healthcare staff managed his palliative symptoms well in accordance with the Gold Standards Framework (a systematic, evidence-based approach to supportive and palliative care) and they treated him with compassion throughout. We are satisfied that Mr Crooks received a high standard of care at HMP Wakefield that was at least equivalent to that he could have expected to receive in the community.

Mr Crooks' location

50. On 24 June 2011, the prison moved Mr Crooks to a ground floor cell to help with his mobility.

51. When his condition began to deteriorate significantly, Mr Crooks said he wanted to stay on the wing for as long as it was possible. The prison allocated a prisoner carer to allow this to continue for as long as possible. However, on 25 April 2016, after slipping in the shower, a nurse admitted him to the healthcare centre.

52. Mr Crooks remained in the healthcare centre until he died and we are satisfied that Wakefield appropriately located him throughout his illness.

Restraints, security and escorts

53. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

54. Between June 2010 and May 2016, Mr Crooks attended numerous hospital appointments. On each occasion, prison managers decided that officers should restrain him with handcuffs or an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer), as healthcare staff never objected to the use of restraints.

55. From May 2013, Mr Crooks used a wheelchair to aid his mobility around the prison and, from March 2015, doctors confirmed he had emphysema.

56. Although the Prison Service has responsibility to protect the public, security must be balanced with humanity. We are not satisfied that the use of restraints was justified by fully considered risk assessments, as his health and mobility were significantly diminished in 2015 and 2016. Therefore, we are not satisfied that

the prison had appropriately distinguished his risk of escape in light of his significant medical conditions. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Crooks' family

57. On 13 May 2016, the prison appointed an officer as Mr Crooks' family liaison officer. Mr Crooks had listed his mother as his next of kin. The family liaison officer discovered that Mr Crooks' mother was a resident in a nursing home and suffered from severe dementia, so was incapable of acting as his next of kin. The family liaison officer contacted Mr Crooks' son, grandson and ex-partner but they each explained that they were estranged from Mr Crooks and did not want to be classed as his next of kin.

58. Mr Crooks' funeral was held on 26 July. The prison arranged and paid for it, in line with national instructions.

Compassionate release

59. Release on compassionate grounds is a means by which prisoners that are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section of the National Offender Management Service.

60. On 6 May 2016, the healthcare team leader explained to Mr Crooks that he could be eligible for compassionate release. Three days later, healthcare staff started the application for compassionate release and agreed to support it if there was a suitable location for Mr Crooks to go to. Mr Crooks' offender supervisor agreed that release would be both appropriate and decent.

61. Due to the absence of any family support, the healthcare team leader felt Social Services needed to be contacted to consider the support that they could provide in relation to the complexity of Mr Crooks' needs. Unfortunately, Mr Crooks died before this issue was resolved.

62. We are satisfied that Wakefield started Mr Crooks' application for compassionate release but that without an appropriate release address, the application was likely to be unsuccessful.

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