Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Crome a prisoner at HMP Woodhill on 31 October 2017

A report by the Prisons and Probation Ombudsman

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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*

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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 Crome died on 31 October 2017 of lung cancer, while a prisoner at HMP Woodhill. He was 75 years old. I offer my condolences to all those who knew Mr Crome.

Before his diagnosis, Mr Crome's care was not equivalent to that which he could have expected to receive in the community. Communications between the hospital and prison healthcare were disjointed and as a result Mr Crome missed a number of important appointments. The healthcare unit's record keeping was also poor in relation both to missed appointments and to what happened at appointments that did take place.

I am satisfied that after his diagnosis, Mr Crome's care was equivalent to that he could have expected in the community.

I am, however, concerned that Woodhill were unable to provide all the documents relating to the risk assessments for Mr Crome's hospital appointments, and that some of those that were provided related to a different prisoner. As a result, the investigation has not been able to assess the appropriateness of all the security decisions made. This is not the first time Woodhill have been unable to provide these records and the Governor should ensure that the necessary improvements are made.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **October 2018**

Contents

Summary

Events

1. On 24 October 2016, Mr Crome was recalled to prison for breaching his licence conditions. On 4 November 2016, he was sent to HMP Woodhill.

2. On 23 October 2016, just prior to his recall, Mr Crome was admitted to hospital. He said he had chest pain but examinations did not identify any obvious injury and he was treated with antibiotics for a chest infection. A chest CT (computerised tomography) scan identified an abnormality on his liver.

3. When Mr Crome arrived at Woodhill on 4 November, staff located him on the prison's Clinical Admission Unit because of his COPD (Chronic Obstructive Pulmonary Disorder – progressive lung disease) and angina. He was receiving an extensive range of medication and used a wheelchair.

4. The hospital produced a discharge summary for the hospital admission, but addressed it to Mr Crome's community GP and the prison did not receive it until 17 November. The discharge summary said that Mr Crome needed a follow up appointment in the out-patient respiratory clinic. It did not give a date for the appointment. It appears that the appointment was subsequently arranged for 24 November, although this was not noted in Mr Crome's medical records.

5. Mr Crome did not attend the hospital appointment on 24 November. The Head of Healthcare has not been able to say why.

6. Mr Crome missed at least two more appointments (one on 8 December 2016 and one on 31 January 2017). There is no explanation in Mr Crome's records for these missed appointments.

7. Mr Crome did attend an appointment at the hospital's respiratory clinic on 24 January 2017. The specialist wanted him to have another scan, but the medical record does not confirm if this ever took place.

8. Mr Crome was admitted to hospital from 31 March until 13 April after experiencing radiating chest pain. Hospital staff carried out several investigations and Mr Crome was diagnosed with incurable lung cancer on 12 April. Palliative radiotherapy was explored, but it was decided that this would not be possible because of his COPD.

9. Apart from one appointment to discuss matters with his oncologist on 25 May 2017, Mr Crome declined any further appointments or investigations. He also signed a Do Not Attempt Cardio Pulmonary Resuscitation Order in May. Mr Crome deteriorated but he was regularly reviewed and tended to by healthcare staff at Woodhill. Mr Crome died on 31 October 2017.

Findings

10. The clinical reviewer was not satisfied that the care leading up to Mr Crome's diagnosis was equivalent to that which he could have expected to receive in the community. We agree. Communications between the hospital, community GP and the prison were poor and this delayed Mr Crome's appointments. Record

keeping by healthcare staff at Woodhill was also poor and they were unable to say why some appointments were missed or what had taken place at others.

11. After Mr Crome was diagnosed with lung cancer, staff at Woodhill cared for and supported him appropriately. We agree with the clinical reviewer that this part of his care was equivalent to that which he could have expected to receive in the community.

12. We are concerned that the prison was unable to provide the investigator with all the documentation relating to escorting arrangements when Mr Crome was taken to hospital. We are also concerned that some of the information that was provided to us related to a completely different prisoner. As a result, we have not been able to satisfy ourselves that appropriate decisions were taken on the use of restraints when Mr Crome was escorted to his hospital appointments.

13. For the appointment where information was provided, we are concerned that Mr Crome was restrained by single cuffs and an escort chain when he was clearly unwell and using a wheelchair. Subsequent to issuing our initial report, the prison informed us that the person who carried the medical risk assessment was an administrator and we do not deem this appropriate.

14. This is not the first time Woodhill has been unable to provide all the relevant documentation. Following a previous investigation, the prison accepted our recommendation about providing information to the PPO, and in June 2017, the Safer Custody Manager reminded all heads of function of their responsibility to provide information to the PPO in a timely manner. It is concerning that we have to make this recommendation again.

Recommendations

- The Head of Healthcare should ensure that staff are proactive in ensuring clinical information is up to date, that information about referrals and appointments is tracked and actioned, and that expected notifications of appointments are pursued with external health providers.
- The Governor should ensure that decisions on escort arrangements are fully documented, based on correct information, effectively recorded and securely stored.
- The Governor should ensure that, in line with PSI 58/2010, the Prison and Probation Ombudsman is promptly provided with all requested documents following a death in custody.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital are appropriately qualified and understand the legal position and that risk assessments show clear justification for the use of restraints.

The Investigation Process

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

16. The investigator obtained copies of relevant extracts from Mr Crome's prison and medical records.

17. NHS England commissioned a clinical reviewer to review Mr Crome's clinical care at the prison.

18. We informed HM Coroner for Milton Keynes of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. The investigator wrote to Mr Crome's next of kin to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not raise any matters of concern.

20. The investigation has assessed the main issues involved in Mr Crome's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, liaison with his next of kin and whether compassionate release was considered.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Woodhill

22. HMP Woodhill in Milton Keynes has a dual role as a local prison and a high security prison and can hold 727 men. Central and North-West London NHS Foundation Trust provides health services at the prison. There is an inpatient unit with 12 beds, which provides physical and mental healthcare for prisoners. End of life palliative care is also provided.

HM Inspectorate of Prisons

23. The most recent inspection of Woodhill was in September 2015. Inspectors reported that primary health services were good, although a high non-attendance rate meant prisoners waited too long for some services. The inpatient unit continued to provide good care, but the regime still needed to be more recovery focused. Clinical records were of a high standard and included effective care planning for those with complex health needs.

Independent Monitoring Board

24. 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 their latest annual report, for the year to May 2017, the IMB reported that Woodhill remained a complex establishment which was extremely challenging to manage. Staff shortages and a restricted regime had got worse in 2016/17. Staffing problems extended to healthcare, with 50% of staff employed from agencies. The inpatient unit had relocated to its original location but funds were not available to open it fully. Attendance at some clinics was down, on occasion to 50% and there was room for improved communication from the prison to reduce this waste of clinicians' time

Previous deaths at HMP Woodhill

25. Mr Crome was the eighth prisoner to die of natural causes at HMP Woodhill since January 2016. We have previously made a recommendation about the need for the prison to provide the PPO with records and information relevant to the investigation.

Findings

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

26. On 4 November 2016, Mr Crome was sent to HMP Woodhill after being recalled on 24 October for breaching his licence conditions. He had originally been convicted of sexual offences on 29 January 2010 and sentenced to ten years imprisonment.

27. On 23 October 2016, just before his recall, Mr Crome was admitted to hospital after he was assaulted (although he was vague about the details). Mr Crome said he had chest pain, but examinations did not identify any obvious injury and staff treated him with antibiotics for a chest infection. A CT scan identified an abnormality on his liver.

28. On his arrival at Woodhill on 4 November 2016, a nurse conducted Mr Crome's reception health screen. Mr Crome had COPD and angina and used a wheelchair outside his cell. Staff decided he should be accommodated on the Clinical Admissions Unit because of his conditions and the amount of medication he was prescribed.

29. The hospital produced a discharge summary, but addressed it to Mr Crome's community GP. It is not clear when the hospital produced the discharge summary but the prison's Head of Healthcare told us that the prison received it, via the community GP, on 17 November 2016. The discharge summary said that Mr Crome needed a follow up in the out-patients' respiratory clinic. It did not give a date for the appointment. Someone has put a hand-written note on the prison's copy of the discharge summary asking that the appointment be chased, and the date 24 November has been handwritten on the summary. An escort risk assessment for 24 November was started on 18 November by a healthcare administrator. This suggests that a follow-up appointment was arranged for 24 November, although there is no record of this in Mr Crome's medical records.

30. On 16 November, a specialist in respiratory medicine wrote to the prison informing them that Mr Crome's previous admission had been discussed at the lung multi-disciplinary team meeting and that they wanted to review him. They considered that he might need a bronchoscopy (a procedure to examine the internal airways) and further CT scans. The letter also said that the CT scan in October had identified an abnormality on Mr Crome's liver which needed clarification.

31. The prison received the letter on 23 November, and a prison GP telephoned the specialist to ensure that there was a plan in place to follow up on Mr Crome's liver lesion. The specialist confirmed that there was. There is no record that they discussed the appointment date for Mr Crome's review at the respiratory clinic. It is not clear from the records how the liver lesion follow-up took place.

32. Mr Crome did not attend his respiratory clinic appointment on 24 November. The healthcare administrator told us that there is no information in Mr Crome's

medical records to explain why the appointment was missed. She said that if the hospital had cancelled the appointment, it would be noted in SystmOne.

33. On 8 December, the hospital wrote to the prison stating that Mr Crome had missed a respiratory clinic appointment that day. There is no evidence in the medical notes that anyone at the prison was aware of this appointment.

34. On 14 December, the healthcare administrator noted in the medical records that Mr Crome should have gone for an urgent appointment at the hospital's respiratory clinic on 24 November. She phoned the hospital to try to reschedule the appointment.

35. The healthcare administrator was not able to speak to the specialist's secretary until 20 December. She noted that the hospital had rescheduled the respiratory clinic appointment for 10 January 2017. There is no evidence that the hospital followed this up with written confirmation or that the administrator chased the hospital for confirmation. No attempt was made to send Mr Crome to hospital on 10 January.

36. The hospital rescheduled Mr Crome's respiratory clinic appointment for 24 January 2017 and Mr Crome attended. The specialist discussed Mr Crome's history of working with asbestos and smoking cigarettes with him. He told Mr Crome that a previous CT scan showed some abnormalities and that he needed a further scan and a liver ultrasound. He also noted that he was going to make the scan referral on a two-week wait basis (for patients with suspected cancer) and would review Mr Crome in four weeks' time. He also noted that the liver ultrasound referral had already been made.

37. There is a letter in Mr Crome's medical records noting an appointment on 31 January for lung function tests. Mr Crome did not attend. The Head of Healthcare was unable to explain why, but said that the appointment was rescheduled for 7 February.

38. On 7 February, Mr Crome was at hospital when he developed chest pains and was prescribed prednisolone (a steroid) in the hospital's emergency department. There is no further information about this in Mr Crome's medical records.

39. On 8 February, a prison GP noted that he was waiting for a full hospital discharge letter, but all that is on file is the emergency department's prescription for prednisolone. We assume Mr Crome was at the hospital on 7 February for the lung function tests, but there is nothing in his medical records to say exactly what happened on 7 February or whether he had any tests at the hospital.

40. On 9 March 2017, a prison GP noted that Mr Crome should be urgently referred to a urology specialist as he had blood in his urine. The referral was made the next day. An appointment for a cystoscopy (a procedure where the bladder is looked at internally) was arranged for the same day as a bronchoscopy, but only the bronchoscopy was done. Mr Crome subsequently indicated when discussing the upcoming urology appointment that he did not wish to undergo any further invasive investigations.

41. On 23 March, a prison GP discussed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made) with Mr Crome, given his deteriorating condition. Mr Crome said that he would think about it but also said that he would not want to be resuscitated.

42. On 31 March, Mr Crome was admitted to hospital after experiencing radiating chest pain. He stayed in hospital until 13 April. While he was there he had a bronchoscopy, a biopsy (in which a small amount of tissue is removed and examined) and a CT scan.

43. On 12 April, a nurse contacted the hospital for an update and was told that Mr Crome had been diagnosed with lung cancer. A consultant clinical oncologist wrote to Mr Crome's community GP the next day explaining that the cancer was incurable but palliative radiotherapy could be explored. It was decided that because of his COPD, Mr Crome was not fit for any treatment. The prison received the letter on 27 April.

44. The clinical reviewer shared our concerns that communication between the hospital and the prison was not always effective and that, consequently, Mr Crome missed important appointments. As a result, opportunities for earlier diagnosis of his lung cancer were missed. In addition, there are significant gaps in the prison healthcare's records about missed appointments and what happened at attended appointments. In this respect, Mr Crome's care was not equivalent to that which he could have expected to receive in the community.

The Head of Healthcare should ensure that staff are proactive in ensuring clinical information is up to date, that information about referrals and appointments is tracked and actioned, and that expected notifications of appointments are pursued with external health providers.

Mr Crome's clinical care

45. Mr Crome returned to Woodhill from hospital on 13 April 2017. A nurse attempted to speak to him about his diagnosis, but he did not want to talk about it. He was reviewed by a prison GP on 14 April, and again on 23 April, and talked about his diagnosis and feelings about it then. He reiterated that he did not wish to be resuscitated and signed a DNACPR order on 10 May.

46. On 16 May, Mr Crome told a prison GP that he did not want any further invasive investigations and he wanted an upcoming urology appointment cancelled.

47. On 25 May, Mr Crome met an oncologist, who advised him his prognosis was approximately three months and that the side effects of any treatment would outweigh the benefits.

48. On 8 June, the palliative care team met with Mr Crome and discussed his advanced and end of life care plans. He said that he did not want to go into hospital under any circumstances, but agreed to treatment at the prison to control his symptoms. Staff arranged for him to have a call bell, fortnightly reviews (plus additional reviews where required), and to see a Macmillan

specialist on 22 June, and planned to seek advice from a hospice where necessary.

49. Over the next four months Mr Crome was regularly reviewed, his medication adjusted as and when it became necessary, and good records were kept of his care. By October, Mr Crome's health had deteriorated significantly. He needed assistance with his personal care and to mobilise. He was taking nutritional supplements but spent most of his time in bed. On 5 October, a nurse requested a specialist mattress for Mr Crome which arrived the next day.

50. On 29 October, a nurse noted that Mr Crome was agitated and seemed confused and breathless. His breathing became shallower and staff attended to his needs frequently over the next two days. On 30 October, at 11.10pm, a nurse noticed that Mr Crome had stopped breathing and had no pulse. A prison GP confirmed Mr Crome's death at 00.03am on 31 October.

51. The clinical reviewer concluded that, following his diagnosis, staff regularly attended to and cared for Mr Crome and respected his wishes, and that Mr Crome's care after his diagnosis was equivalent to that which he could have expected to receive in the community.

Mr Crome's location

52. Mr Crome wanted to stay at Woodhill and was located in the prison's Clinical Admissions Unit. Nurses saw him twice and a day and more frequently as his condition deteriorated. Mr Crome wanted to stay close to his friends. We are satisfied that the prison respected Mr Crome's wishes while still delivering a good standard of care.

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. Mr Crome was admitted to hospital from 31 March to 13 April 2017, during which time he received his diagnosis. The prison has not been able to provide any documentation relating to the hospital admission, so we are unable to comment on the security decisions that were made.

55. Prison Service Instruction (PSI) 58/2010 contains a mandatory instruction that "when the PPO is carrying out investigations or enquiries that staff comply with requests for information and assistance". Throughout our investigation, the investigator asked for copies of all the risk assessment documents that justified

the use of restraints on Mr Crome. The prison did not provide all the documents. In a previous investigation, the prison accepted our recommendation about providing information to the PPO and, in June 2017, the Safer Custody Manager reminded all Heads of function of their responsibility to provide information to the PPO in a timely manner. It is disappointing that we have to raise the issue again.

56. The prison has provided the security documentation for Mr Crome's hospital appointment on 25 May. We are concerned that even though Mr Crome was very unwell and using a wheelchair, an administrator did the risk assessment (rather than a medically trained member of staff) and did not comment on whether Mr Crome's medical condition affected his ability to escape. Subsequently, the authorising officer (who is not identified on the form) agreed to a two-person escort with the use of an escort chain and single cuffs. (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.)

57. We are also concerned that when we received the risk assessment paperwork about the appointment on 25 May, it contained some intelligence information about a completely different prisoner. The prison has not been able to tell us if this information was misfiled onto Mr Crome's record at a later date or was in fact considered as part of the May risk assessment.

The Governor should ensure that decisions on escort arrangements are fully documented, based on correct information, effectively recorded and securely stored.

The Governor should ensure that, in line with PSI 58/2010, the Prison and Probation Ombudsman is promptly provided with all requested documents following a death in custody.

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital are appropriately qualified and understand the legal position and that risk assessments show clear justification for the use of restraints.

Liaison with Mr Crome's family

58. On 8 June, the prison appointed a family liaison officer. She spoke to Mr Crome, who named his solicitor as his next of kin and explicitly asked that family members were not to be notified of his death. She carried out his wishes.

59. The family liaison officer spoke to Mr Crome regularly and arranged his funeral, which took place on 21 November 2017. The prison contributed to the cost of the funeral in line with national policy.

Compassionate release

60. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

61. On 8 June 2017, a multi-disciplinary meeting was held to discuss Mr Crome's future care and wishes. Mr Crome attended the meeting and said that he wanted to die at Woodhill and did not want to be released, either to a hospital or hospice for treatment or palliative care, or into the community.

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