

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Crawford a prisoner at HMP Wakefield on 1 December 2017

A report by the Prisons and Probation Ombudsman

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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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.

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

Mr James Crawford died on 1 December 2017 of sepsis caused by bronchopneumonia, while a prisoner at HMP Wakefield. He was 63 years old. I offer my condolences to Mr Crawford's family and friends.

Mr Crawford was relatively frail and had multiple chronic conditions that affected his health. Healthcare staff managed his medical conditions appropriately and reviewed him frequently. I am satisfied that Mr Crawford received a good level of clinical care while at Wakefield.

I am very concerned that when Mr Crawford was found unconscious on the floor, an emergency radio code was not called to alert prison and nursing staff. This meant the control room did not call an ambulance immediately and the nurse did not take an emergency bag to his cell. When the emergency bag did arrive, it had an empty oxygen cylinder. This is unacceptable and effective auditing procedures need to be implemented to ensure it does not happen again.

Mr Crawford's next of kin were not notified of his hospital admission for over seven hours. His condition was critical and the prison should have contacted his next of kin much sooner.

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

December 2018

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Summary

Events

1. Mr James Crawford was serving a life sentence for murder and had been at HMP Wakefield since 2002. He had many chronic health conditions and saw healthcare staff daily for medications and frequently for review. He did not complain to prison or healthcare staff of feeling unwell in the days prior to his collapse.
2. On 30 November, the prisoner next door to Mr Crawford heard a bang come from his cell. Mr Crawford did not respond to the prisoner, so he pressed his cell bell. He said an officer arrived within a minute. The officer was unable to get a response from Mr Crawford, who was face down on his cell floor. The officer did not have a radio, so asked another officer to radio for staff assistance. The second officer did this immediately, but did not use an emergency code.
3. The assistant night manager arrived at the cell within a minute. Mr Crawford was unconscious and unresponsive. While they waited for a nurse to arrive, they put Mr Crawford into the recovery position. The nurse arrived about 10 minutes later, but without an emergency bag as an emergency code had not been used on the radio. The nurse asked for an ambulance to be requested, which the assistant night manager did immediately, at 1.40am.
4. Another officer went to get the wing emergency bag. Mr Crawford's oxygen saturations were low, but the nurse was unable to give him oxygen as the bottle was empty. The paramedics arrived at 1.56am and applied their oxygen while an officer was looking for another oxygen bottle.
5. Mr Crawford was taken to hospital. A hospital doctor said he was in multi-organ failure and he was moved to the intensive care unit on life support. Hospital staff removed the life support at 3.10pm and Mr Crawford was pronounced dead at 0.30am on 1 December.

Findings

6. Prison healthcare staff reviewed Mr Crawford regularly for his chronic conditions and referred him to secondary services when needed. Mr Crawford's care was well delivered and staff were compassionate. The clinical reviewer concludes that the clinical care Mr Crawford received while at Wakefield was equivalent to that which he could have expected to receive in the community. We agree.
7. Because staff did not use an emergency code when they found Mr Crawford collapsed in his cell, the nurse did not know what she was responding to and did not bring an emergency bag.
8. The control room did not know to call an ambulance until the assistant night manager asked for one over 10 minutes after Mr Crawford was found. Although these delays did not affect the outcome for Mr Crawford, the delay could be critical in other circumstances.

9. The oxygen cylinder in the wing emergency bag was empty and could not be used to help Mr Crawford's low oxygen saturations.
10. Although Mr Crawford had many chronic conditions and was generally frail, the only means of alerting staff if he needed help was via a call bell next to the cell door. Mr Crawford was found collapsed on his cell floor and unable to press his call bell for assistance. If his neighbour had not heard him fall, Mr Crawford could have ended up lying on the cold floor for a significant amount of time.
11. Although Mr Crawford was taken to hospital at 3.04am, his next of kin was not notified until over seven hours later. He was unconscious and unresponsive and clearly in a critical condition. The prison should have made attempts to contact the next of kin much earlier.
12. We make five recommendations.

Recommendations

- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff enter cells as quickly as possible in a life-threatening situation.
- The Governor should ensure that all prison staff understand their responsibilities during medical emergencies. Staff should use an emergency code immediately when there are serious concerns about the health of a prisoner, so that there is no delay in calling an ambulance and that responding staff bring appropriate emergency equipment.
- The Head of Healthcare should ensure that there is a safe, auditable Standard Operating Procedure for checking the healthcare emergency bags are complete, that drugs are in-date and that equipment is operational.
- The Governor should ensure prisoners who have chronic health conditions or have limited mobility are able to contact staff in an emergency without having to rely on the cell bell system.
- The Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that prison staff inform the next of kin of seriously ill prisoners immediately when they are admitted to hospital, to allow the opportunity to visit if they wish to do so.

The Investigation Process

13. 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. Two prisoners wrote to the investigator with information he considered during the investigation.
14. The investigator obtained copies of relevant extracts from Mr Crawford's prison and medical records.
15. Another investigator took over as investigator and interviewed three members of healthcare staff at Wakefield on 20 March 2018. The second investigator also interviewed three prison staff and a prisoner via telephone.
16. NHS England commissioned a clinical reviewer to review Mr Crawford's clinical care at the prison. The clinical reviewer also attended the interviews on 20 March.
17. 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.
18. One of the Ombudsman's family liaison officers contacted Mr Crawford's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Crawford's sister asked if Mr Crawford received all his relevant medication and if he received an appropriate level of clinical care. She also wanted to know the events, timings, and actions of staff when Mr Crawford collapsed in his cell.
19. Mr Crawford's sister received a copy of the initial report. She did not make any comments.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Wakefield

21. HMP Wakefield is a high security prison and holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (a small unit aiming to provide a supportive, safe, structured and consistent environment for some of the most challenging offenders).
22. Care UK provide all healthcare provision at Wakefield. There is an inpatient unit which provides overnight and weekend care for prisoners with physical health problems. The inpatient unit also has a dedicated palliative care suite.

HM Inspectorate of Prisons

23. The most recent inspection of HMP 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

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 its latest annual report, for the year to April 2017, the IMB reported that a Prisoner Patients Forum had been established to discuss any health-related matters with representatives of the healthcare professionals. This encouraged open discussion and debate, and was a successful means of improving the services which were provided to the prisoners. The Board was confident that the general level of medical care given in the prison was very satisfactory.

Previous deaths at HMP Wakefield

25. Mr Crawford was the thirteenth prisoner to die of natural causes at HMP Wakefield since January 2016. We have raised the importance of using medical emergency codes in two previous investigations, and the importance of notifying the next of kin when a prisoner is critically ill in one previous investigation in the last three years.

Findings

Key Events

26. Mr James Crawford was serving a life sentence for murder and had been in custody since 2001. He had been at HMP Wakefield since 2002.
27. Mr Crawford had a number of chronic conditions which were under review and others for which he was receiving treatment, including renal anaemia, emphysema, chronic obstructive pulmonary disease (COPD), pulmonary hypertension, ulcerative colitis for which he had an ileostomy (where the bowel is diverted through an opening in the abdomen), and hepatitis B and C infection with cirrhosis of the liver. He also had stage 5 kidney disease, for which he had been having dialysis until October 2016, when he was no longer suitable for it. Mr Crawford had squamous cell carcinoma of the lung removed in May 2015, but had had a recurrent diagnosis in September 2017 for which he was having on-going investigations, but was not considered suitable for surgery. He also had a deep vein thrombosis (DVT, a blood clot) in his left leg, for which he was receiving anticoagulant medication.
28. Mr Crawford saw healthcare staff daily for medications and frequently for review. His records note that he engaged well with healthcare staff.
29. On 27 November, a prison GP reviewed Mr Crawford and prescribed antibiotics for cellulitis (skin infection). There was evidence of a DVT in his left leg, but the prison GP noted that Mr Crawford was already having anticoagulant therapy. The prison GP planned to review Mr Crawford in three days.
30. On 28 and 29 November, Mr Crawford saw nursing staff for his medications. There is no evidence that he complained of feeling unwell or raised any health concerns.
31. The prisoner in the cell next to Mr Crawford said that on 30 November, he heard a loud thud come from Mr Crawford's cell, so he tapped on the sink to see if he was ok. Mr Crawford did not tap his sink in response, so the prisoner pressed his cell bell for assistance from prison staff. It was about 1.20am and the prisoner said Officer A responded in less than a minute. The prisoner asked Officer A to check on Mr Crawford, which he did immediately. Officer A said Mr Crawford was lying on his cell floor unresponsive.
32. Officer B said that she had been in the wing office with Officer A when the cell bell alarm went off and she followed Officer A to the cell about thirty seconds later as she realised he did not have a radio. As she got near to the cell, Officer A said he was not able to get a response from Mr Crawford and asked her to radio for assistance, which Officer B said she did immediately. The radio call was not logged in any of the prison documentation so it is not known when it was made or what information was given.
33. The prison's assistant night manager responded to Officer B's radio call and said he was at the cell within a minute. He said when he arrived, he opened the cell and they found Mr Crawford face down on the floor. He was unresponsive, but breathing and Officer A put him in the recovery position. They observed Mr

Crawford while they waited for the nurse to respond and his condition did not change.

34. A nurse said she was in the healthcare centre when the call for assistance came through. She said she does not have keys at night so had to wait to be let out of the unit and then had to be escorted over to the wing. She said she did not know what she was responding to and did not take an emergency bag with her. It took about ten minutes for her to get to the cell.
35. The nurse said when she arrived at the cell, she asked the assistant night manager to request an ambulance, which he did. The time was 1.40am. The nurse asked another officer to get the emergency bag, which was on the wing. The nurse took Mr Crawford's basic observations including heart rate, blood pressure and oxygen saturations. She tried to put Mr Crawford on oxygen, but the oxygen bottle was empty. An officer went to retrieve another when the paramedics arrived at 1.56am and applied their oxygen.
36. The paramedics took over Mr Crawford's care from the prison staff and took him to hospital at 3.04am. No restraints were applied.
37. Hospital staff said Mr Crawford was in multi-organ failure. He was moved to the hospital's intensive care unit and put on a life support machine. The life support was removed at 3.10pm and Mr Crawford was pronounced dead by a hospital doctor at 0.30am on 1 December.

Contact with Mr Crawford's family

38. A prison manager appointed a family liaison officer as the prison's family liaison officer at 10.30am and asked her to contact Mr Crawford's next of kin, his sister, as the hospital wanted to discuss his condition with them. The family liaison officer tried to telephone Mr Crawford's sister at 10.55am, but was unable to make contact. The family liaison officer managed to make contact at 11.10am and gave the contact details of the hospital for Mr Crawford's sister to speak to hospital staff.
39. The family liaison officer met with Mr Crawford's family at hospital and stayed to provide support. The bedwatch officers moved from the bedside to offer the family privacy.
40. After Mr Crawford's death, the family liaison officer provided on-going support to Mr Crawford's sister. In line with national guidance, the prison offered a financial contribution to Mr Crawford's funeral, which was held on 20 December.

Support for prisoners and staff

41. After Mr Crawford's death, a prison manager debriefed the escort staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
42. The prison posted notices informing other prisoners of Mr Crawford's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Crawford's death.

Post-mortem report

43. The post-mortem report shows that Mr Crawford died from sepsis, caused by bronchopneumonia. Other factors listed in the post-mortem report, which did not contribute to the cause of death, are cirrhosis, squamous cell carcinoma of the left lung, ulcerative colitis, end stage chronic kidney disease and coronary artery atherosclerosis.

Findings

Clinical care

44. Mr Crawford had many chronic conditions for which he took appropriate medications. Prison healthcare staff reviewed Mr Crawford regularly and referred him to secondary services when needed. Mr Crawford did not complain to healthcare staff of feeling unwell in the days before his collapse. The clinical reviewer says that Mr Crawford's care was well delivered and staff were compassionate. The clinical reviewer concludes that the clinical care Mr Crawford received while at Wakefield was equivalent to what he could have expected in the community. We agree.
45. Although Mr Crawford's clinical care was good, there are some recommendations in the clinical review, not directly relevant to Mr Crawford's death, that the Head of Healthcare should consider.

The emergency response

Entering the cell

46. Officer B followed Officer A to answer the cell bell as he did not have a radio. Despite Mr Crawford being unresponsive on his cell floor, the officers did not enter the cell until the assistant night manager arrived. Both officers said they did not enter the cell immediately due to how quickly the assistant night manager arrived. However, it would have been at least two minutes before the cell was opened. This two minute delay compounded the confused emergency response that ensued.
47. Prison Service Instruction 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment. We cannot say whether not entering the cell immediately affected on the outcome for Mr Crawford. Nevertheless, it is important that prison staff understand their roles in a medical emergency, as early intervention can be critical. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff enter cells as quickly as possible in a life-threatening situation.

Emergency codes

48. When Officer A said Mr Crawford was unresponsive and they needed assistance, Officer B radioed the nurse for assistance but did not use an emergency code to convey the type of emergency. If she had used a code blue (which means a

prisoner is unconscious or having difficulty breathing) nursing staff would have known the appropriate emergency equipment to bring.

49. Due to night security protocol, it took the nurse about 10 minutes to get to Mr Crawford's cell. As she did not know what she was responding to, she did not take an emergency bag and asked an officer to get one when she arrived at the cell. Mr Crawford had already been unconscious on his cell floor for at least 15 minutes and the nurse could not do any examinations or treatment without an emergency bag. Although it only took a couple of minutes to get the emergency bag on the wing, this is valuable time in an emergency.
50. Officers A and B told the investigator that they would not request an ambulance themselves as they are not medically trained and would wait for healthcare staff to make the decision as to whether an ambulance is required. As Mr Crawford was lying on the cell floor unconscious and unresponsive, it is difficult to understand what clarification was needed to request an ambulance.
51. If the officers had used a code blue, as they should have done, the control room would have called an ambulance immediately. The control room staff were not aware that an ambulance was required until the assistant night manager requested one at 1.40am. Unfortunately, this added extra time before paramedics could attend Mr Crawford.
52. We make the following recommendation:

The Governor should ensure that all prison staff understand their responsibilities during medical emergencies. Staff should use an emergency code immediately when there are serious concerns about the health of a prisoner, so that there is no delay in calling an ambulance and that responding staff bring appropriate emergency equipment.

Emergency bags

53. Mr Crawford's oxygen saturations were low, but the nurse was unable to provide oxygen from the emergency bag as the bottle was empty. The officer then had to go and find another oxygen bottle.
54. It is unacceptable to have unusable equipment in an emergency bag. Fortunately, the paramedics arrived soon after the officer left and could provide Mr Crawford with oxygen. We make the following recommendation.

The Head of Healthcare should ensure that there is a safe, auditable Standard Operating Procedure for checking the Healthcare emergency bags are complete, that drugs are in-date and that equipment is operational.

Cell bells

55. Mr Crawford had a call bell in his cell that he could press to summon help from prison officers if needed. The bell was located next to the cell door. When Mr Crawford collapsed in his cell, he would not have been able to use his call bell to summon help. Prison staff were only made aware Mr Crawford had collapsed because the prisoner in the neighbouring cell heard him fall. Had this not happened, he could have spent some time on the floor before being found.

56. Given Mr Crawford had many chronic conditions and was quite frail, it is surprising that the only way for him to summon help was to walk across his cell from his bed to the cell door. If he had had a personal alarm that he could wear, for example, he would not have had to rely on the neighbouring prisoner to alert staff. We make the following recommendation:

The Governor should ensure prisoners who have chronic health conditions or have limited mobility are able to contact staff in an emergency without having to rely on the cell bell system.

Contact with Mr Crawford's family

57. Prison Rule 22 requires that when a prisoner becomes seriously ill, the governor should "at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed". This is reflected in Prison Service Instruction (PSI) 64/2011, which requires prisons to contact the next of kin of prisoners who are seriously ill.
58. Mr Crawford was taken to hospital at 3.04am. He was unconscious and unresponsive. He was critically unwell and was moved to the intensive care unit. Despite this, the prison did not appoint a family liaison officer or consider informing the next of kin until the hospital suggested they do so at 10.30am, over seven hours after Mr Crawford went to hospital.
59. We consider the prison should have tried to inform Mr Crawford's sister of his hospital admission much earlier. In line with Prison Rule 22 and Prison Service Instruction (PSI) 64/2011, we make the following recommendation:

The Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that prison staff inform the next of kin of seriously ill prisoners immediately of their admission to hospital, to allow the opportunity to visit if they wish to do so.

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