Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Crute a prisoner at HMP Stafford on 16 February 2018

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.

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 Peter Crute died of myocardial fibrosis (a thickened heart muscle) on 16 February 2018 after he was found unresponsive in his cell at HMP Stafford. He was 46 years old. I offer my condolences to his family and friends.

Mr Crute was morbidly obese and had a number of health concerns for which he received treatment. A few days before his death, his behaviour changed markedly and he showed symptoms of psychosis. Prison staff monitored him appropriately under prison service procedures for prisoners at risk of suicide. His death, however, appears to have been from natural causes.

I am satisfied that the clinical care that Mr Crute received was of a good standard and equivalent to that which he could have expected to receive in the community.

I am, however, concerned about the significant delay in prison staff calling an ambulance after they found Mr Crute unresponsive. We cannot say whether this affected the outcome for Mr Crute.

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

Sue McAllister CB
Prisons and Probation Ombudsman June 2019

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Summary

Events

1. In July 2014, Mr Peter Crute was sentenced to 11 years in prison for sexual offences. He moved to HMP Stafford on 3 November 2017. He was morbidly obese and had a number of health concerns. Healthcare staff gave him dietary advice, referred him for weight loss surgery and devised a care plan to manage his diabetes.

2. On 13 February 2018, Mr Crute was referred to the mental health team after his cellmate raised concerns about his behaviour and that he appeared preoccupied with religious thoughts. Mr Crute told the nurse who assessed him that he had thoughts of self-harm but did not have a clear plan to take his life. The nurse began monitoring him under suicide and self-harm prevention procedures, known as ACCT. She recorded that Mr Crute appeared to have acute psychosis and made an appointment for him to see a psychiatrist on 19 February. Staff moved him to a single cell close to the staff office so that they could monitor him more easily.

3. On 14 February, Mr Crute refused to eat, drink, wear clothes or take any medication. A nurse was concerned about his condition and asked for an ambulance to be called when his eyes rolled back into their sockets. He was taken to hospital and discharged the same day after he recovered and refused any further investigations.

4. Mr Crute continued to be observed regularly under ACCT procedures. At 7.55pm on 16 February, an officer saw him standing naked in his cell, staring into a corner. When she returned at 8.10pm, she saw Mr Crute lying on the floor behind his cell door. With the assistance of another officer, they pushed the door partly open and saw him face down. They could not detect a pulse and asked for a prison manager to attend. One arrived at 8.20pm but he did not radio a medical emergency code. At 8.21pm, he left Mr Crute in his cell unattended while he telephoned the control room to call for an ambulance. Ambulance service staff attended at 8.37pm and pronounced Mr Crute dead at 9.08pm.

Findings

5. Mr Crute received a good standard of healthcare at Stafford.

6. Staff did not initially treat Mr Crute's collapse as a medical emergency, as they should have. While we accept that there was a slight delay in opening the cell door due to Mr Crute's body weight behind the door, a medical emergency code should have been radioed as soon as Mr Crute was found unresponsive. This would have triggered an ambulance to be called immediately. We cannot know whether this might have changed the outcome for Mr Crute.

Recommendation

- The Governor should ensure that all prison staff understand the requirements of PSI 03/2013 and their responsibilities during a medical emergency, including that they radio the appropriate medical emergency code and ensure that there are no delays in calling an emergency ambulance.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Stafford informing them of the investigation and asking anyone with relevant information to contact her. One prisoner asked to see the investigator when she visited Stafford on 22 March 2018 and gave her a letter about Mr Crute's behaviour. The investigator spoke informally to another prisoner who was one of Mr Crute's friends.

8. The investigator obtained copies of relevant extracts from Mr Crute's prison and medical records and interviewed nine members of staff between March and September 2018. NHS England commissioned a clinical reviewer to review Mr Crute's clinical care at the prison. She conducted five joint interviews with the investigator in March 2018.

9. We informed HM Coroner for South Staffordshire of the investigation who gave us the results of the post mortem examination. We have sent the Coroner a copy of this report.

10. One of the Ombudsman's family liaison officers contacted Mr Crute's friend to explain the investigation and to ask if he had any matters they wanted the investigation to consider. He wanted to know whether prison staff checked Mr Crute at least every 15 minutes, and whether his health needs were appropriately addressed.

Background Information

HMP Stafford

11. HMP Stafford is a medium security prison. It holds up to 750 sentenced men, all of whom have been convicted of sexual offences. 45% of its population is over 55 years old, and many prisoners are elderly and have multiple health conditions. Care UK provide primary health and social care. South Staffordshire and Shropshire NHS Foundation Trust provide mental health and substance misuse services. At the time of Mr Crute's death, its healthcare service operated from 8.00am to 6.00pm, with access to an on-call service outside of core hours. Since May 2018, healthcare coverage has been 24 hours a day.

HM Inspectorate of Prisons

12. The most recent inspection of HMP Stafford was in February 2016. Inspectors reported that it was a safe, clean, well maintained environment with a sense of calm and order. They noted that relationships between staff and prisoners were good. They found that meeting the healthcare needs for an ageing population needed to improve, especially the cancellation of hospital appointments due to a lack of staff. During a night visit, most staff were unaware of where to find a defibrillator and some night staff lacked confidence in dealing with potentially life-threatening situations.

Independent Monitoring Board

13. 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 there was a positive emphasis on humane treatment with staff and prisoner carers showing exceptional care towards terminally ill and frail prisoners. They noted that Care UK had introduced additional services and clinics which reduced the need for many external hospital appointments.

14. There were eight deaths in the 12 months before Mr Crute's death. All were from natural causes, which is not remarkable, given the profile of the population, but there are no similarities with the circumstances of Mr Crute's death.

Key Events

15. In July 2014, Mr Crute was sentenced to 11 years in prison for sexual offences. During July and August 2014 at HMP Elmley and HMP Lewes he was monitored under prison service procedures for supporting prisoners at risk of suicide or self-harm, known as ACCT. He did not harm himself during either period and staff stopped monitoring him. He moved from HMP Rye Hill to HMP Stafford on 3 November 2017.

16. At Mr Crute's initial health screen, a nurse noted that his medical history included a deterioration of kidney function, varicose eczema, irritable bowel syndrome, vertigo (dizziness) and hypertension (high blood pressure), diabetes and sleep apnoea. He was morbidly obese: his body mass index was 61.29 and he weighed 30st 3lbs. Healthcare staff gave him dietary advice, referred him for weight loss surgery and a specialist healthcare manager put in place a diabetes care plan.

17. On 23 November, a prison GP reviewed Mr Crute's healthcare and noted that he had lost 10lbs in weight and his blood pressure was within the normal range. Mr Crute subsequently reduced his weight to 28 stones. On 13 December, the prison GP referred Mr Crute to a local hospital for weight loss surgery. As Mr Crute's blood sugar level remained high, the specialist healthcare manager discussed Mr Crute's case with a community diabetes specialist on 24 January 2018 who suggested that he should be prescribed metformin, a medication that encourages the production of insulin. On 1 February, she discussed this with Mr Crute, and explained that a GP would need to check that the medication was compatible with his kidney condition.

18. Mr Crute's cellmate, gave the investigator a letter which said that Mr Crute's behaviour had been strange on 10 and 11 February when he talked about God non-stop. On 12 February, he put his medication into a locker, said that he no longer needed it and threw the key under their cell door. An officer returned the key to Mr Crute. Mr Crute insisted that his cell-mate should pray with him and walked up and down the cell, holding his Bible and talking to himself.

19. On 13 February 2018, Mr Crute appeared short of breath and threw his food into the bin and toilet. His cellmate spoke to staff about Mr Crute's behaviour and preoccupation with religious thoughts. An officer urgently referred him to the mental health team. Mr Crute told a nurse who assessed him that he had thoughts of self-harm but did not have a clear plan to take his life. The nurse began ACCT procedures. She recorded in his clinical record that Mr Crute appeared to have acute psychosis as he was expressing delusional beliefs. She made an appointment for him to see a psychiatrist on 19 February. Staff moved Mr Crute to a single cell opposite the staff office so that staff could monitor him more easily.

20. On 14 February, Mr Crute refused to eat, drink, wear clothes or take any medication. A nurse saw him in his cell at 3.10pm and was concerned about his condition. She asked for an ambulance to be called when his eyes rolled back into their sockets. A nurse examined Mr Crute at 4.09pm and concurred that he appeared generally unwell and dehydrated. His vital observation signs appeared

normal but did not include blood pressure, temperature or blood sugar readings. Ambulance staff examined Mr Crute at 4.25pm but were reluctant to take him to hospital as they considered him physically well. A nurse said at interview that she had to insist he was taken to hospital. Mr Crute was discharged from hospital and returned to prison the same day after he recovered and refused any further investigations.

21. On 15 February, Mr Crute continued to be observed five times an hour and nursing staff conducted physical checks. A nurse went to his cell and though he did not speak to her, she noted that he did not appear distressed and appeared to be keeping his eyes voluntarily shut. He remained naked apart from a sheet and refused his meals but staff observed several cartons of milk and biscuit wrappers in the bin.

22. On 16 February, a review into Mr Crute's risk of self-harm took place. A nurse recorded that Mr Crute refused to take part but he did not appear tense or distressed. Staff agreed that they would continue to monitor him five times an hour.

23. Mr Crute lived on F Wing. CCTV footage of F Wing shows that an officer observed Mr Crute through the cell door observation panel at about 7.51pm. She said that he was standing naked in his cell staring into a corner.

24. When she checked on Mr Crute at 8.10pm, she saw him lying on the floor behind his cell door. The CCTV footage shows the officer kick the cell door five times to try to get a response from Mr Crute. She went to the staff office which was opposite his cell and said that she was not happy with Mr Crute lying on the floor. With the assistance of another officer, they pushed the door ajar, which was a challenge due to Mr Crute's physical size, and found him face down. An officer shook Mr Crute's shoulder and the other officer felt Mr Crute's neck but, although he felt warm to the touch, he could not detect a pulse.

25. Another officer was passing the cell as an officer said she could not get a response. An officer told the investigator that she went in and looked for signs of injury or blood but did not see any. An officer radioed for the most senior prison manager on duty to attend. He arrived at 8.20pm and went into Mr Crute's cell with two officers. They managed to roll Mr Crute over on to his back. His face was a bluish colour.

26. Although the senior prison manager was carrying a radio, he did not use it to transmit an emergency code. He left Mr Crute in his cell unattended while he contacted the control room by telephone at 8.21pm to request an ambulance. An officer and the senior prison manager returned to the cell and began cardiopulmonary resuscitation (CPR). Ambulance service staff attended at 8.37pm and declared Mr Crute dead at 9.08pm.

Contact with Mr Crute's next of kin

27. Mr Crute had nominated a friend as his next of kin. Two Supervising Officers were appointed as family liaison officers (FLO) and visited the friend on the morning of 17 February to break the news of Mr Crute's death. Stafford contributed to the costs of Mr Crute's funeral in line with national instructions.

Support for prisoners and staff

28. After Mr Crute's death, a senior manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

29. The prison posted notices informing other prisoners of Mr Crute's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Crute's death.

Post-mortem report

30. A post mortem examination took place on 2 March 2018. Toxicology tests showed no traces of illicit substances. The cause of death was established as myocardial fibrosis (a thickening of the heart muscle). The pathologist added that in his opinion, Mr Crute most likely died of arrhythmia (an irregular heart beat), secondary to myocardial fibrosis (a thickened heart muscle) and gross obesity.

Findings

Clinical care

31. The clinical reviewer found that the care that Mr Crute received at Stafford was at least equivalent to that which he could have expected to receive in the community. Mr Crute had a number of complex medical conditions which were managed with medication and regular reviews. It is unclear why his mood and behaviour changed markedly a few days before his death. When it did, Stafford acted appropriately in monitoring him closely, and we note that healthcare staff and officers worked together to ensure that he received a good level of care.

Emergency response

32. Mr Crute was morbidly obese. When he was discovered in his cell, it was difficult for staff to go into the cell and move him so that they could try to resuscitate him. When he was found unresponsive, staff should have radioed a medical emergency code. This did not happen.

33. When the prison manager arrived, there were a number of staff present but they remained outside the cell and he did not instruct them to begin CPR. We are concerned that they left Mr Crute lying face down and alone in his cell and that the prison manager telephoned for an ambulance, even though he was carrying a radio. Mr Crute had been found lying face down at least 10 minutes earlier and might have been in that position for a further 15 minutes.

34. The delay in responding meant that it was increasingly less likely that Mr Crute could be resuscitated, particularly given his weight. The prison manager told the investigator that he did not want prisoners to hear his radio message so he opted to use the telephone instead. He should have radioed a code blue (used when a prisoner is not breathing or has breathing difficulties) which would have prompted an ambulance to have been called immediately. We make the following recommendation:

    The Governor should ensure that all prison staff understand the requirements of PSI 03/2013 and their responsibilities during a medical emergency, including that they radio the appropriate medical emergency code and ensure that there are no delays in calling an emergency ambulance.

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