Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Croad a prisoner at HMP Wakefield on 19 August 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*

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 John Croad died on 19 August 2018, of a stroke and heart disease, while a prisoner at HMP Wakefield. He was 71 years old. I offer my condolences to Mr Croad's family and friends.

Mr Croad received a good standard of care at Wakefield. The day to day management of his conditions were of a good standard, and prison healthcare and hospital staff worked closely together to ensure that his health needs were met. The end of life care provided by staff in the prison palliative care suite was also good.

We are satisfied that the standard of care Mr Croad received at Wakefield was equivalent to that which he could have expected to receive in the community.

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 **December 2018**

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Summary

Events

1. On 3 May 2000, Mr John Croad was sentenced to life imprisonment for sexual offences. He was transferred to HMP Wakefield on 29 September 2014.

2. In May 2005, Mr Croad complained of chest pains. Hospital staff gave a diagnosis of atrial fibrillation (an irregular heartbeat that can lead to a stroke), caused by heart disease. Following his diagnosis, both healthcare staff and secondary care providers monitored and reviewed Mr Croad regularly. Comprehensive care plans were implemented by the prison's specialist cardiac care clinic to manage his conditions.

3. On 11 July 2018, as part of a routine review, Mr Croad underwent an angiogram (an X-ray which uses a dye administered into the blood stream to produce images of the blood flow in the arteries of the heart) at Pinderfields Hospital, Wakefield. The results indicated that his condition had deteriorated considerably. Hospital staff decided that Mr Croad needed an urgent coronary artery bypass graft.

4. On 18 July, Mr Croad underwent the coronary artery bypass graft procedure. He did not recover from the procedure as well as expected and he was moved to the hospital's critical care unit. Mr Croad was sedated and placed on a ventilator to help him to breathe. He regained consciousness on 25 July.

5. On 13 August, hospital staff identified that Mr Croad had had a stroke. The following day, it was also identified that he had complications with his kidney function. Mr Croad's condition continued to deteriorate and on 16 August, hospital staff decided to withdraw all active treatment. On 18 August, Mr Croad was discharged from hospital to the prison's palliative care suite.

6. At 2.45am on 19 August, Mr Croad died. A hospital doctor gave Mr Croad's cause of death as a stroke and heart disease caused by the narrowing of his arteries.

Findings

7. The clinical reviewer found that Mr Croad received a good standard of clinical care at Wakefield. Healthcare staff appropriately assessed his clinical needs and sought advice from secondary care providers.

8. We are satisfied that the standard of care Mr Croad received at Wakefield was equivalent to that which he could have expected to receive in the community.

9. We make no recommendations.

The Investigation Process

10. 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.

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

12. NHS England commissioned an independent clinical reviewer to review Mr Croad's clinical care at the prison.

13. We informed HM Coroner for the County of West Yorkshire of the investigation. There was no post-mortem examination. We have sent the coroner a copy of this report.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

Background Information

HM Prison Wakefield

15. 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).

16. Care UK provides the healthcare provision at Wakefield. They provide primary healthcare services during normal working hours and overnight, and weekend care in the inpatient unit for prisoners with physical health problems. There is a dedicated palliative care suite in the healthcare unit.

HM Inspectorate of Prisons

17. The last inspection at Wakefield was in June 2018. Inspectors noted that health services were good overall but some parts of the healthcare environment required improvement. Primary care services were very good and had an appropriate emphasis on the care of patients with long-term conditions.

Independent Monitoring Board

18. 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 30 April 2017, the IMB noted the difficulties and challenges presented by the change of healthcare provider. However, they also noted there had been noticeable improvements with the new team.

19. The IMB was pleased to note the new initiatives being put in place by the Head of Healthcare in an attempt to lessen the need to send prisoners to hospital. It noted that nurses would be trained to enable them to administer intravenous drugs and that a review would be carried out following every case in which an emergency ambulance was requested to learn lessons and assess if any alternative treatments could be put in place.

Previous deaths at HMP Wakefield

20. Mr Croad was the 21st man to die while a prisoner at HMP Wakefield since June 2015. All the deaths were from natural causes. There have been three further deaths since, two of which were from natural causes.

Findings

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

20. On 3 May 2000, Mr John Croad was sentenced to life imprisonment for sexual offences and was sent to HMP Belmarsh. In December, Mr Croad was transferred to HMP Wandsworth, and again in 2005, to HMP Frankland.

21. On 17 May 2005, Mr Croad complained of chest pain and palpitations. He was reviewed by hospital staff who diagnosed him with atrial fibrillation (an irregular heartbeat that can lead to a stroke) caused by heart disease. He was prescribed beta-blockers (which relax the heart enabling it to beat slower and less forcibly) and clopidogrel (a blood thinner to avoid clotting) to treat his symptoms.

22. On 16 June 2006, as part of a review by hospital staff, Mr Croad underwent an echocardiogram (an ultrasound scan used to examine the heart and surrounding blood vessels) at Freeman Hospital, Newcastle. Mr Croad was subsequently diagnosed with cardiomyopathy (a progressive disease of the muscles in the heart causing it to weaken and eventually to stop functioning). It was decided that an angioplasty (a surgical procedure in which tubes are inserted into the arteries around the heart to improve blood flow) was the most effective treatment option open to Mr Croad.

23. We are satisfied that healthcare staff appropriately investigated Mr Croad's symptoms, made timely referrals to secondary care providers and discussed his diagnosis with him. There is good evidence in Mr Croad's medical records to indicate that he was reviewed regularly by healthcare and hospital staff.

Mr Croad's clinical care

24. On 3 May 2007, Mr Croad underwent an angioplasty procedure and had four stents fitted in his right coronary artery. Hospital and healthcare staff monitored and reviewed Mr Croad regularly.

25. On 14 May 2010, a consultant cardiologist at Freeman Hospital decided that Mr Croad needed a fifth stent to be inserted into the arteries on the right side of his heart. Mr Croad underwent a second angioplasty on 5 September, and continued to be reviewed and monitored regularly.

26. On 29 September 2014, Mr Croad was transferred to HMP Wakefield. Healthcare staff carried out an initial health screen and referred him to the specialist Cardiac Care Clinic at Wakefield for review. Mr Croad was monitored and reviewed regularly under the care of Wakefield's specialist cardiac nurse. A cardiac care plan was devised in line with NICE (National Institute for Health and Care Excellence) guideline CG172 (cardiac rehabilitation and prevention of further cardiovascular disease).

27. Mr Croad continued to complain of chest pain, which led to further investigations and medical procedures. On 24 December, he had a pacemaker fitted (a small device inserted into the chest which uses an electrical signal to slow, increase or regulate the heart rate). Although Mr Croad was reviewed regularly, he continued to complain of chest pain.

28. In May 2015, it was identified that Mr Croad might have had heart attack and he was referred to hospital for further review. Hospital staff decided that Mr Croad would benefit from a further angioplasty. This procedure was carried out on 2 June. Hospital staff told healthcare staff at Wakefield that if Mr Croad's symptoms returned, it would be necessary for him to undergo a coronary artery bypass graft (a surgical procedure carried out to bypass blocked arteries by grafting healthy veins or arteries taken from elsewhere in the body).

29. Mr Croad's care continued to be managed by the cardiac care clinic at Wakefield, supported by regular reviews by hospital staff. Mr Croad attended hospital on a number of occasions after reporting chest pains, none of which were severe enough to warrant further treatment.

30. On 25 June 2017, Wakefield's specialist cardiac nurse reviewed Mr Croad because he had been experiencing chest pain again. He told the nurse he was awaiting an angiogram appointment (an X-ray which uses a dye administered into the blood stream to produce images of the blood flow in the arteries of the heart). The nurse did not find anything of note, but referred Mr Croad to a consultant cardiologist at Leeds General Infirmary for further review. It is not clear from the medical records if the angiogram was completed.

31. On 6 September, the consultant cardiologist reviewed Mr Croad. It was decided that he needed a coronary artery bypass graft. On his return to Wakefield, a prison GP reviewed him. She noted Mr Croad said that he was happy to undergo the procedure. She reviewed his care plans and adjusted his medication in line with the advice from hospital staff.

32. In the months that followed, Mr Croad's care continued to be managed by the cardiac care clinic at Wakefield, supported by regular reviews by hospital staff. His care plans continued to be reviewed and updated regularly.

33. On 1 January 2018, a nurse reviewed Mr Croad because he was complaining of severe chest pain. The nurse sent him to hospital by emergency ambulance for review. Hospital staff diagnosed Mr Croad with a chest infection. They noted that until the infection had been successfully treated, his planned bypass graft procedure would not be able to go ahead. Mr Croad was discharged to the prison's healthcare inpatient unit the same day.

34. As part of the routine reviews, Mr Croad underwent an angiogram at Pinderfields Hospital on 11 July. The results indicated that Mr Croad's condition had deteriorated considerably. Hospital staff decided his planned coronary artery bypass graft was needed urgently.

35. On 19 July, Mr Croad underwent the bypass graft procedure at Leeds General Infirmary. However, he did not recover as well as expected and it was later identified that he had had a stroke. Mr Croad's condition continued to deteriorate. Later that day, Mr Croad was sedated and placed on a medical ventilator to help him breathe (a machine designed to remove carbon dioxide and administer oxygen to patients who are unable to breathe for themselves). Mr Croad was moved to the critical care unit to enable hospital staff to deliver a more intensive level of nursing care. The prison's healthcare staff stayed in contact with hospital

staff and kept up dated with his condition. Mr Croad was accompanied by two prison officers and was not restrained.

36. On 21 July, Mr Croad regained consciousness. He was moved to the high dependency unit at the hospital.

37. On 31 July, hospital staff noted that the staples used to close the wound in Mr Croad's chest following his surgical procedure, had failed. A further surgical procedure was necessary to wash the wound out and close it again. The procedure was carried out on 6 August. Again, Mr Croad did not recover as well as expected and was admitted to the coronary critical care unit.

38. On 13 August, Mr Croad had another stroke. The following day, hospital staff noted that he had complications with his kidney function.

39. On 16 August, a prison nurse contacted hospital staff for an update on Mr Croad's condition. The hospital told her that Mr Croad's condition had deteriorated and that he would not be receiving any more active treatment. They also said that they had discussed the issue of resuscitation with Mr Croad and he said that he did not want anyone to resuscitate him if his heart or breathing stopped, and signed 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.)

40. The following day, a prison nurse visited Mr Croad in hospital. She noted he could engage in conversation and he understood the seriousness of his condition. She met with hospital staff and it was decided that Mr Croad would be discharged to the palliative care suite at Wakefield for end of life care. Hospital staff advised the nurse that Mr Croad would need a suitable bed, and morphine sulfate injections administered intravenously and when required subcutaneously (under the layers of skin). A urinary catheter was fitted prior to him returning to Wakefield.

41. On 18 August, Mr Croad was discharged to Lily Pad, the palliative care suite at Wakefield. A nurse took over his care and reviewed him every 15 minutes in accordance with his care plan. The door to Lily Pad was left open to enable staff to gain access in an emergency should it be necessary.

42. At 2.45am on 19 August, a nurse noted Mr Croad was having trouble swallowing small sips of water. The nurse used a small suction pipe to clear the mucus from the back of Mr Croad's throat to ease his discomfort. Mr Croad's condition continued to deteriorate, and at 3.30am, Mr Croad died.

43. At 7.00am, an on call out of hours GP confirmed that Mr Croad had died.

44. We agree with the clinical reviewer that the standard level of clinical care Mr Croad received at Wakefield was equivalent to that which he could have expected to receive in the community.

45. The clinical reviewer noted that Mr Croad suffered from significant coronary problems, which impacted on his wellbeing, resulting in a deterioration of his condition over time. His deterioration continued to the point at which he needed

coronary artery bypass surgery and he suffered numerous post-operative complications from which he could not recover.

46. The clinical reviewer found that Mr Croad's health needs were reviewed, managed and evaluated in line with best practice and NICE guidelines. However, the clinical reviewer has made one recommendation in respect of record keeping, which we do not repeat in this report but which the Head of healthcare will wish to address.

Mr Croad's location

47. Mr Croad was located in a single cell on B wing, a residential wing, until his health deteriorated. He was then appropriately moved to the prison's inpatient unit when it was identified that he would not benefit from any further active treatment. Prior to his return to Wakefield (18 August), healthcare staff liaised with hospital staff to ensure all equipment and care plans were in place for his return.

48. We are satisfied that Mr Croad was appropriately located throughout his illness, was quickly taken to hospital on the occasions his condition deteriorated and was moved to the prison's palliative care suite to receive end of life care.

Restraints, security and escorts

49. When prisoners must travel outside the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this must be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk considering factors such as the prisoner's health and mobility.

50. We are satisfied that staff carried out thorough risk assessments. Following his diagnosis, Mr Croad was not restrained.

Liaison with Mr Croad's family

51. On 21 July 2018, the prison appointed a family liaison officer (FLO). The FLO contacted Mr Croad's next of kin, a member of the chaplaincy team who Mr Croad had met while in prison custody at HMP Brixton.

52. The FLO told Mr Croad's next of kin that Mr Croad had had heart surgery, but he was not recovering as well as expected. Mr Croad's next of kin thanked the FLO for the information but said she would not be visiting him and asked to be kept informed of his condition.

53. On 17 August, the FLO was told that Mr Croad's condition had worsened. At 11.15am, he visited Mr Croad in hospital, accompanied by the Head of Healthcare and a nurse. The FLO told Mr Croad that he had informed his next of kin of his admission to hospital and his condition.

54. While the FLO had been reviewing Mr Croad's prison records, he noted that Mr Croad had a sister but he could not find her contact details. He asked Mr Croad if he would like her to be informed of his condition. Mr Croad said that he wanted

his sister to be considered as his next of kin. However, he did not have an up to date address or telephone number to enable the FLO to contact her.

55. At 1.30pm, the FLO returned to the prison. He had found an address for Mr Croad's sister but she no longer lived at that address. At 2.50pm, the FLO spoke to the police liaison officer at the prison, and asked her to try and trace Mr Croad's sister. She found a telephone number but no address details. The FLO telephoned the number but it had been disconnected.

56. On 19 August, following Mr Croad's death, the FLO contacted West Yorkshire Police Headquarters to ask if anything else could be done to trace an up to date address for Mr Croad's sister. The police provided the FLO with an address but they did not have a telephone number for the address. The FLO, accompanied by a prison chaplain, visited the home address provided by the police. However, after speaking with the resident, it soon became apparent that she was not related to Mr Croad.

57. Having had exhausted all avenues open to them, the prison was unable to trace Mr Croad's sister. The FLO contacted the member of the chaplaincy team at Brixton originally listed as Mr Croad's next of kin, to inform her of his death.

58. Mr Croad's funeral was held on 16 October. The prison paid for the cost of the funeral in line with national policy.

Compassionate release

59. 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.

60. Prison staff did not consider an application for release on compassionate grounds. Although Mr Croad's condition was extremely serious, he had not been given a prognosis of less than three months to live.

61. It was not until hospital staff took the decision to withdraw all active treatment on 16 August, that it became clear of the severity of Mr Croad's condition. We are satisfied that there was not sufficient time for an application to be made on his behalf.

62. We make no recommendation.

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