Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Crews, a prisoner at HMP Oakwood, on 4 June 2024

A report by the Prisons and Probation Ombudsman

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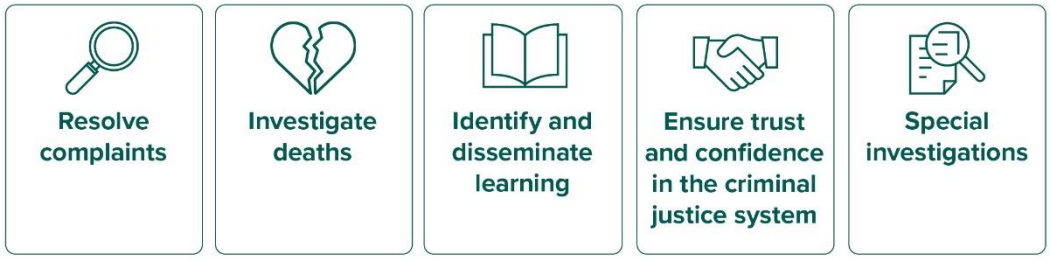
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

1. 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.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. On 24 July 2020, Mr Michael Crews was sentenced to 20 years in prison for sex offences against a child. He died from multiple organ failure on 4 June 2024 while a prisoner at HMP Oakwood. His death was caused by cholecystitis (inflammation of the gallbladder). He also had type 2 diabetes which contributed to but did not cause his death. He was 75 years old. We offer our condolences to Mr Crews' family and friends.

4. The Ombudsman's office wrote to Mr Crews' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

5. NHS England commissioned an independent clinical reviewer to review Mr Crews' clinical care at HMP Oakwood.

6. The clinical reviewer concluded that the clinical care Mr Crews received at Oakwood was of a reasonable standard and was equivalent to that which he could have expected to receive in the community. She found that healthcare staff did not always record or calculate a National Early Warning Score (NEWS2, a tool used to detect and respond to clinical deterioration) for Mr Crews. The prison has since addressed this concern. The clinical reviewer made a number of recommendations which were not directly related to Mr Crews' death but which the Head of Healthcare will want to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Crews' care. We did not identify any non-clinical learning and we make no recommendations.

8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Adrian Usher **April 2025**
Prisons and Probation Ombudsman

9. At an inquest held on 10 June 2025**,** the Coroner concluded that Mr Crews died of natural causes.

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